’I don’t have any emotions’: feeling rules and surface acting in the emergency department …

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Abstract

The National Health Service (NHS) in England is under significant pressure. It is undeniable that the challenges facing the NHS have implications for the staff tasked with delivering care. Low rates of well-being have a direct impact on the quality of care delivered (Boorman, 2009). English nurses' rates of stress, burnout and intention to leave the profession are among the highest in Europe and are higher than those in America (Aiken et al, 2012). Despite evidence showing the importance of positive nurse well-being, the emotional component of the role (a great influencer in well-being) (Warren, 2016; Johnson and Spector, 2007), is overlooked (Smith, 2012). An integral part of nursing is often neglected: the emotional labour of nursing.

I have applied Hochschild's theory of emotional labour to a previously unexplored clinical speciality: emergency care. Emergency departments (EDs) are struggling to meet demand, with increasing patient attendance over the last 70 years (The King's Fund, 2018) and intense government targets (NHS England, 2018). In spite of these challenges, and the nature of EDs, an exploration of ED nurses' emotional labour is missing from current understanding. We know little of how the ED environment influences the management of emotion. There is also limited knowledge of how nursing specialties, such as emergency care, drive the 'speciality-specific' feeling rules.

The ED therefore offered a fitting case study to explore and contribute to the concept of emotional labour. Ethnography, through an interpretivist philosophy, enabled immersion in the ED setting, gathering the lived experiences and narratives of the ED nursing team. I undertook direct and first-hand observations, using an ethnographic approach. This allowed room for the dynamism of the setting, workload and pace. Semi-structured interviews were also undertaken with ED staff and the wider 'well-being' team. I used two departments for a rich and illuminative dataset.

I firstly aimed to understand how the environmental, institutional and organisational dynamics of the ED instrumented the emotional labour. I found that elements of time and space were 'moderators' of ED nurses' emotional labour – in essence, understanding these moderators' integrated relevance offers the first contribution to knowledge. Understanding the moderators of emotional labour from an organisational 'meso-level' perspective, in addition to the study of the more familiar micro level exploration is of interest to those outside of the case study. In particular, those studying organisational behaviour and sociology. Secondly, I aimed to understand the feeling rules driving and underpinning this behaviour. I found that ED nurses' feeling rules were grown from the distinctive context and that four feeling rules drove their emotional labour, offering a further contribution. These contributions are aimed at both practice based

and academic nursing audiences. The recommendations from this thesis relate to working environments and nursing education. Although an ED case study was utilised, the findings can be applied to other healthcare settings, specialties and professionals, along with organisations outside of health. In addition, the findings are applicable to healthcare policy.

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Conferences and Presentations

Organisational Ethnography PhD Course and Workshop, University of Oslo, October 2016 – Presentation and discussion of study.

Insight Visit to UF Health, University of Florida, Hospital and Emergency Room (to visit Professor Bob Wears), May 2017 – Seminar to present findings and share research with US colleagues.

Centre for Health Innovation, Leadership and Learning (CHILL) Seminar, University of Nottingham Business School, July 2017 – On return from US to present findings with UK colleagues.

European Group for Organisation Studies (EGOS) PhD Colloquium, University of Oslo, July, 2017 – Presentation and discussion of study.

Organisational Behaviour in Health Care (OBHC) Conference, Centre Mont Royal, Montréal, May 2018 – Oral presentation and travel scholarship.

CHILL Seminar, University of Nottingham Business School, May 2017 – Brown Bag presentation.

British Sociological Association and European Sociological Association Joint Conference on Emotions, University of Edinburgh, August 2018 – Oral presentation.

List of Abbreviations

A&E – Accident and emergency

ANP – Advanced nurse practitioner

CPR – Cardiopulmonary resuscitation

ECG – Electrocardiogram

ED – Emergency department

EDA – Emergency department assistant

ITU – Intensive therapy unit

IV – Intravenous

NA – Nursing assistant

NHS – National Health Service

RCN – Royal College of Nursing

'Resus' – Resuscitation

S/N – Staff nurse

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Chapter 1: Introduction

1.1 Inspiration, Motivation and Reflection

The purpose of this opening section is to offer an insight into the personal and professional stimuli for this study. This approach helps to ground the research that follows and will introduce the two stories on which the study is based. The latter section of this introductory chapter will offer a contextual background and the thesis structure.

On becoming a newly qualified registered nurse, I gained a position as a staff nurse (S/N) in the emergency department (ED) of a large teaching hospital. I had always been drawn to emergency medicine and nursing, both prior to and during my nursing degree. The changeability and diversity of work in emergency care and the need for adaptability appealed to me over ward-based care or that in the community. As I progressed as a nurse, I was keen to develop both academically and professionally. After undertaking a Health Education England East Midlands research internship for an insight into the world of research, the MA in Research Methods (Health Pathway) was a natural and welcome progression. It was only when I had the opportunity to step away from the clinical environment during this doctoral programme that I began reflecting on the experience of nursing in EDs in some depth. It was during one particular seminar that I had a significant 'light bulb' moment! The seminar leader

presented us with papers on the theory of 'emotional labour' from sociologist Arlie Hochschild's original work in the 1970s and 1980s.

My nursing colleagues and I already knew that ED nursing was challenging in many ways. It was physically tiring for staff, who would often walk miles within 12-hour shifts, alongside undertaking the regular manual handling necessary for acutely unwell patients. It was mentally taxing, juggling and prioritising seemingly never-ending tasks and completing complex drug calculations, often under pressurised circumstances. There were also the challenges of clinical competency and the many extended skills, which included invasive tests, procedures and extra training. However, these elements did not seem to encapsulate the challenges of the role in its entirety and the distress I had seen my colleagues' faces. The concept of emotional labour resonated and helped to fill this void. The following two stories offer some insights into my experiences of this reflection and the subsequent motivation for this study.

1.1.1 Story One

I had been working in the ED for over two years. On this particular shift, I was working within the resuscitation area – the shift had been busy but manageable. We received a pre-alert phone call from the ambulance crew. The crew were alerting us to a patient they were bringing to the hospital: a female patient who was middle-aged and

critically unwell. She was bleeding from a major artery. In response to the call, the information was dealt with practically, ensuring that there was space for the patient in the resuscitation area, that equipment was ready and that the relevant specialist surgical doctor had been notified of the patient's imminent arrival. The patient arrived and we engaged in the 'usual' reassuring conversation with her. Clinically, we began the standard procedures and tests, including monitoring observations, intravenous (IV) cannulation and the taking of blood samples – all of which would also help to prepare the patient for the anticipated theatre.

This work was routine, and although it encompassed physical work, mental concentration and clinical competency, there was a sense of capability and normalisation amongst us all. This was despite the clinical instability of the patient, who could have suffered a cardiac arrest at any moment if the bleeding intensified. The challenge instead was presented when the patient informed us that she did not want the life-saving surgery required to stand a chance of survival – without which she would certainly die, most likely within minutes or, at most, hours.

After frank conversations between the patient and a variety of medical and nursing staff, including me, it became clear that this was an informed decision made by the patient. The patient had the right

to make this decision. This change in care trajectory, from the expected fast-paced, life-saving intervention to arranging palliative care on a medical ward, was not 'normal' for my colleagues or me. The air in the resuscitation area had changed from proficient and well versed to feelings of unease, incompetence and sadness. After a short time, which the patient spent with her family, she was taken to the ward to die. A nursing assistant (NA), the patient's family and me accompanied the patient on the journey to the side room.

The physical, mental and clinical skill and 'work' involved in looking after this patient did not pose any particular challenge to us. However, this was still an incredibly demanding case – the care we delivered was totally unexpected and went against the norm. Patients died often in the resuscitation area, but not usually without us trying to 'save' them first. In addition, patients would receive end-of-life care in the ED, but they were frequently too ill to communicate and the care plan had often already been formulated outside of the hospital. As such, we were tasked with carrying out this established route of care. It was rare for a patient to be fully compos mentis and making these decisions for themselves. Other considerations included caring for the patient's family (her husband and children), who were aware of the patient's choice and the consequences it held. It presented ethical dilemmas for both the surgical and nursing staff as

we suppressed our personal opinions, frustrations and wide range of feelings.

At the time, I could appreciate that caring for this woman and her family was indeed challenging. However, it was not until I had the time and opportunity to reflect on this event through the lens of emotional labour (outside of practice) that I could appreciate the emotional complexity involved. It became clear that in caring for this woman, other staff and I had undertaken complicated, multifaceted, emotional work. Colleagues behaved in a variety of ways in response to the case. For example, one of my senior colleagues was seemingly unmoved, so much so that she overcompensated by being inappropriately jovial, which felt uncomfortable. The surgical doctor was in a state of disbelief, almost as though she felt rejected and offended; she seemed to be trying to hide her hurt. Other nursing colleagues stayed away; they knew of the case but perhaps were too 'busy' to engage fully. I juggled a mixture of emotions: respect for the patient and her decision, great sadness for the loving family she would leave behind and helplessness that we were not given the chance to prolong life. All of this was hidden from the patient and her family. The case offered much to reflect upon – it had been clear that those involved had not found the source of labour to be physical or mental work.

1.1.2 Story Two

The resuscitation area is also the setting for the second case study. Although this example is again memorable, the emotional complexities it presents are much more commonplace for ED staff, which is why it offers a further, helpful insight. The area was full to capacity, which was relatively routine, and was incredibly busy, with a mixture of trauma, medical and surgical patients. Each one of my four patients required different clinical and nursing interventions. One young man had taken an overdose of an illegal substance and was not fully conscious. In his semi-conscious state, his behaviour was unsafe and unpredictable. Another male patient was bleeding internally and awaiting surgery; his clinical stability fluctuated. In addition, an acutely unwell cardiac patient was awaiting transport to a specialist unit for surgical intervention. Finally, an elderly woman was awaiting a bed on a hospital ward to receive end-of-life care. My colleagues working within the resuscitation area had similar workloads.

In contrast to the first story, this situation required a higher intensity of physical work, as the patient numbers were much greater – capacity outstretched resource. The mental work required was also significant due to the prioritisation of care required, constantly changing to adapt to the patients' needs. Non-routine drug administration was also a source of mental work.

At the same time, a two-year-old paediatric patient in a nearby resuscitation bay (a few metres away) was receiving treatment for meningitis. Following a substantial and sustained attempt at resuscitation by the paediatric team, he died. Although neither my adult-trained colleagues nor I were caring for this patient directly, it was apparent from the noise of the nursing and medical intervention how treatment was progressing and when it was unsuccessful. This was confirmed further when the child's parents were told the news and brought in to see their child – the screams and cries of grief were heard above all other noise and were unforgettable.

Again, in the moment and hours afterwards, it was clear that the shift had been difficult for staff. I had comforted an upset junior colleague during the shift, and other staff gave brief insights into their feelings and experiences when 'handing over' to the night shift. However, the opportunity to fully reflect afterwards showed the emotional complexity involved for both my colleagues and me. Again, the concept of emotional labour helped me to explore this. Some of the hard work came from the need to still deliver care to our adult patients (most of whom were unaware of the child's death due to their own clinical conditions), despite the communal awareness amongst staff of the enormous distress close by. The need to hide this sorrow whilst still juggling great workloads, the pressure of

organisational targets and other patients' seemingly more 'trivial' needs required complex emotional labour.

These stories present only two of the many examples I experienced directly. There are many more. The nature of the ED lends itself to emotionally complex situations.

This array of insights, together with broader motivations to contribute to the existing literature (explored below) and the potential practical application of healthcare research, fuelled my motivation to undertake this study. I was keen to explore and understand an under-recognised area of practice: the emotional labour of nursing in the ED. In line with these personal and professional motivations and inspirations, the following section of this introduction will provide a brief background and contextual overview for this study. The structure of the thesis will then be outlined, prior to a comprehensive review of relevant literature.

1.2 Background to the Study

The delivery of healthcare, and nursing care in particular, is, by its very nature, physically and mentally intense. The role involves a variety of different forms of labour, as described briefly in the stories above. The physical tasks completed by the nurse can vary dramatically depending on the individual setting but most commonly

include caring for patients' daily living requirements and involvement with medicine management and intervention (James, 1992). These physical tasks, and, importantly, their visibility, result in them often being described as the principle component of nursing (James, 1992).

Despite this emphasis, there are many other forms of labour in nursing that fall under the category of invisible work (Nardi and Engeström, 1999; Allen, 2014). The invisibility of this work can be physical, for example completing tasks out of sight of others, or due to the actual invisibility of the work itself, including the mental work involved in prioritising and planning care. Invisible work can also be unseen due to the lack of value or skill assigned to it (Allen, 2015). Organising work is another example of invisible nursing work (Allen, 2015). The concept of organising work encompasses much of the unseen work that nurses do and includes four main domains: the creation of working knowledge and the communication between healthcare providers; articulation – ensuring the correct service processes flow together; bed management and flow through the care setting; and the transfer of care between areas or specialties (Allen, 2015). Much of this nursing work is taken for granted by healthcare organisations and, by its concealed nature, is difficult to quantify and even describe. Allen (2015, p.19) argues:

> Nursing has many features that make visibility problematic. It is often assumed to rest on the natural caring talents associated with women and it involves bodywork and engagement with intimate aspects of people's lives and death, making it difficult to talk about…

A further form of invisible work (Kosny and MacEachen, 2010), and the caring strongly associated with women's work, involves the management of personal emotion. This is different to simply being emotional or experiencing emotion. In the private setting, the management of emotion is known as emotion work and involves controlling our experienced, felt emotion and presenting this to our family and friends (Brook, 2009).

Emotional labour, in contrast, is emotion work undertaken to meet the requirements and expectations of an organisation – the labour element resulting from a form of paid employment. This is an important distinction. Emotional labour is a concept developed by Arlie Hochschild in the 1980s (*The Managed Heart: Commercialisation of Human Feeling*). Hochschild describes emotional labour 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' (1983, p.7). In relation to nursing specifically, emotional labour recognises the additional form of labour associated

with caring for people who are sick (James, 1992). This view considers emotional labour as a specific skill (Bolton, 2004; James, 1989; Payne, 2009). Such a stance acknowledges that nursing ill people is emotionally charged and emotionally complex.

The incidence of emotional labour has become increasingly prominent in professions since the 1970s as the volume of public service work has grown and the management of emotion has entered the public domain (Wharton, 2009). It is now a formal job requirement within many services and professions (Wharton, 2009). Prior to this, the management of personal feeling had long been a private matter: a consequence of community and family-driven expectations (Wharton, 2009).

In healthcare specifically, the expectation that nurses will manage their emotions to some degree has always been relevant. However, the emotional labour undertaken, in direct exchange for payment, is influenced by the nature of contemporary practice. In particular, it is influenced by the changes in the provider–patient relationship, where the patient is often seen as a 'customer', and the growing expectations and rights associated with these developments (Ham, 2018).

The direct pressures facing the National Health Service (NHS) in England are also relevant and are likely to influence the emotional

labour expected and required of healthcare staff. The challenges affecting the NHS have changed in its 70-year history. Many of the contemporary issues are well publicised, including complex funding issues, vast advancements in available treatments and changes in patient needs and demographics, amongst others (Ham, 2018).

All of these considerations have implications for the staff delivering care. The increase in the acuity of patients, their complex needs, associated financial constraints and the availability of resources have a significant impact on the pressures facing nurses and other healthcare professionals (Williams, 2012). In addition to this, the increased need for efficiency and quicker throughput through the services (whilst still meeting the expectations of patients and their relatives) add to the difficulties facing today's workforce (Williams, 2016).

Much less publicised, discussed and (arguably) understood are the implications of these challenges for those staff tasked with delivering care and the emotional component of this work (Smith, 1992, 2012; Theodosius, 2008). This is despite established links to well-being (Brotheridge and Grandey, 2002; Huynh, Alderson and Thompson, 2008; Pugliesi, 1999; Warren, 2016; Johnson and Spector, 2007). English nurses' rates of stress, burnout and intention to leave the profession are amongst the highest in Europe and are higher than those in America (Aiken et al, 2012). Despite its relevance, emotional

labour is overlooked in practice (Smith, 2012), leaving a significant component of nursing depreciated and undervalued.

The nature of the work that healthcare professionals do and their experience of this work are relevant to quality and outcomes from an individual, organisational and patient perspective. The implications of poor experiences of work and poor well-being are significant (Aiken et al, 2012). In NHS organisations, rates of poor well-being have a direct impact on the quality of care that patients receive, including increased infection rates and reduced satisfaction scores from patients (Boorman, 2009).

An area of practice offering a 'window' (Hou and Chu, 2010) into the challenges facing healthcare more widely is that of emergency care. EDs in particular are struggling to meet the growing patient demand, and there has been an upward trajectory of patient attendance over the last 70 years. Together with the generic healthcare challenges, the ED setting also has its own distinctive pressures (NHS England, 2018). These include intense and strictly monitored governmental time-critical targets (such as the four-hour wait and ambulance turnaround time) and a diverse and variable patient population. These considerations, together with the nature of the ED (usually a 24-hour service without prior appointment and no cut-off to the number of patients who are seen), present ethical challenges for staff

as they strive to meet the demands of the service and their patients (Basu, Qayyum and Mason, 2016). Working in this environment and with these challenges will undoubtedly influence the range of emotions experienced by staff, particularly nurses. Importantly, these considerations are also likely to have consequences for the management of emotion and the subsequent emotional labour undertaken in response.

Moreover, the case study of the ED offers a significant opportunity to explore and develop various components of emotional labour theory in both nursing and broader sociological understanding. Emotional labour is offered as a tool for exploring emotions in the workplace and specific social worlds (Wharton, 2009; Steinberg and Figart, 1999; Erickson and Ritter, 2009). Its application to EDs is largely missing from current knowledge, thus offering numerous spaces for exploration. There is little understanding of the emotional labour undertaken in this setting, examining how the contextual, institutional and organisational dynamics influence the management of emotions. There is firstly, therefore, an opportunity to explore these elements as moderators' (Grandey and Gabriel, 2015) of nurses' emotional labour. This potential for theoretical contribution looks outside of the ED case study and has resonance and relevance outside of the healthcare context. Understanding the moderators of emotional labour from a meso-level, in addition to the micro level

(between social actors) extends the contribution to an organisational studies audience. Secondly, there is also a gap relating to ED nurses' feeling rules. The existing nursing and healthcare literature has often viewed nurses' feeling rules generically, giving the opportunity to explore those that are influenced by the ED speciality and likely to be speciality specific.

To address these gaps in understanding, this study undertook an exploratory ethnography of two ED case studies. It sought to uncover the accounts and narratives of the nurses' experiences 'doing' emotional labour in the ED. In line with these insights and the broader background summary, the following section of this introduction will outline the structure of the thesis and provide a plan of the chapters to follow.

1.3 Structure of the Thesis

To begin, a review of the literature will form the second chapter of this thesis. In this chapter, there will be an overview of the relevant literature, starting with the broad challenges currently facing the NHS. The discussion will then move on to the speciality of emergency care. This will include both its history and the challenges facing contemporary practice, including time-critical targets and the upward trajectory of patient attendance. Most crucially, the role of the

emergency nurse will then be outlined. These sections will provide points of reference for the exploration that follows.

The second half of the literature review offers a comprehensive examination of Hochschild's theory of emotional labour, as conceptualised and proposed in *The Managed Heart* (1983). Focus will be given to the specific *feeling rules* driving behaviour in different settings and organisations. In addition, the progression and conceptualisation of the theory since Hochschild's introduction of it will be presented. Most importantly, this chapter will give insights into the application of emotional labour to healthcare and, specifically, to nursing practice. It will identify gaps in existing knowledge and understanding and, in light of these, introduce the aims of this thesis, along with the main research question and supporting questions.

The third chapter will explore the methodological and philosophical underpinnings of the empirical research undertaken, in line with these aims. This will include the rationale for certain choices, including the relevant ontological and epistemological assumptions. A practical explanation for undertaking the research will be included with details of the methods used to collect and analyse data, including how and why they were used. The associated ethical and moral standards adhered to will also be discussed here, along with the central role played by the researcher.

In the fourth and fifth chapters, the empirical data will be presented. Chapter 4 will focus on a descriptive walkthrough of the ED to introduce the ED environment as a framework for scene-setting. It will aim to show the conditions that yield ED nurses' feeling rules and emotional labour. Furthermore, this chapter will offer insights into the importance of time and space as moderators of nurses' work. Chapter 5 will unpack the speciality-specific feeling rules of nurses' emotional labour. It will present four feeling rules in this chapter, born, in part, from the distinctive setting. It will also offer an exploration of the consequential emotional labour. The sixth chapter will be a discussion of these findings in relation to the wider literature and theory. This chapter will offer both empirical and theoretical contributions to knowledge in line with these findings.

The final chapter will present the conclusions of this research. This will include a discussion of the recommendations for practice. These recommendations fall under two headings: those exploring the environmental implications and those relating to nursing self-awareness, knowledge and education. This chapter will close with the limitations of this study and final thoughts.

Chapter 2: Literature Review

2.1 Introduction

The first half of this literature review will present a brief overview of the contemporary NHS before moving on to a detailed exploration of emergency care. This will include the development of the speciality and the evolution of the 'ED'; the purpose of these sections is to set the background for emergency care and emergency nursing as a speciality. The sources of demand and pressure affecting ED services in contemporary practice will be explored, prior to focusing specifically on the role and work of the ED nurse. This section of the review will also encompass the sources of challenge for the nurses tasked with delivering care in the ED environment.

The second half of the literature review will introduce and then explore *emotional labour* and specifically Hochschild's emotional labour theory (1983). Within this, key theoretical components will be unpacked with examples, including surface and deep acting and a specific focus on the feeling rules of different contexts and professions. The concept of emotional labour will then be applied to nursing practice, and the practical impact of emotional labour for patient and nurse will be explored. The overarching aim of this literature review is to offer a foundation for the empirical study which will follow.

2.1.1 Sources of Challenge for the NHS

In 1948, the NHS was founded upon the belief that quality healthcare should be provided to all and free at the point of access, irrespective of the individual's ability to pay (Gorsky, 2008). Since then, in its 70-year history, the demands, pressures and needs placed upon the NHS have steadily grown. The growth of consumerism in society generally has led to a concomitant development in the concept of patients' rights, shown through the Patient's Charter and the NHS Constitution (Ham, 2018). Patients' expectations have changed in line with this, with ever-increasing demands for greater services (Ham, 2008). In addition, medical advancement has increased the scope and availability of treatment and intervention. This also increases patients' expectations of the NHS and the services it may offer them (Ham, 2008, 2018). Furthermore, changes in demographic patterns resulting in an older and larger patient population have also raised service demands and expectations (Ham, 2008). Greater numbers of patients have long-term illnesses, which are often complex and require significant care, intervention and treatment.

The funding of the NHS to meet patient needs presents further challenges and contentious issues across political parties. Although health spending grew from 7.7% of public spending in 1955/1956 to 18.4% of public spending in 2015/2016, the amount of national income spent on health (9.8%) is well below many other countries,

including the US (16.9%), Japan (11.2%), Germany (11.1%) and France (11.0%) (IFS, 2017). Furthermore, it is predicted that the costs of funding healthcare will increase considerably still over the next 50 years. Considering this and other current challenges in financing the NHS, a long-term and sustainable plan is required (IFS, 2017).

Notwithstanding the sources of these challenges, a specific area of care where pressure and demand can be demonstrated on an almost daily basis is emergency care. Both anecdotally and within academic literature, the ED has been described as a 'window' into the broader healthcare organisation and as a representation of the national and international healthcare challenges facing communities and populations (Hou and Chu, 2010). Many of the demands facing EDs are as a direct consequence of, or are entwined with, the broader pressures affecting the NHS. The front-line ramifications of these challenges will be presented below, following a brief history of emergency care delivery in previous centuries. This will bring us up to date with what we know of today's ED practice. This descriptive overview will establish the context and background for the chapters that follow.

2.2 Emergency Care

2.2.1 The History of the Speciality and EDs

Care delivered through some form of emergency setting has had a long history. Particular advancements in such services have often been made during times of war, for example during the First and Second World Wars, when trauma interventions and treatments were developed for soldiers (Kaneria, 2015). At the same time, the public seeking emergency services during the early 1900s relied on charitable services that ran, as the name implies, 'casual' casualty departments for the poor (Kaneria, 2015). Although the introduction of the NHS in 1948 provided healthcare for all, emergency services were often still inadequate and under-resourced (Sakr and Wardrope, 2000). As motor vehicles became more accessible, the demand for casualty services increased further. With this progression came the need for skilled and complex trauma care, although this was not yet widely available (Kaneria, 2015).

A further call for the improvement of emergency care was outlined in the Platt Report (1962). The report was a significant milestone in the history of contemporary emergency care. It recommended that all general hospitals needed to provide certain standards of facility and staffing (both medical and nursing) to ensure optimal emergency care for patients (Kaneria, 2015). The report also made the first explicit

attempt to encourage patients with non-urgent need to seek care elsewhere (Jones, 2008). The attempt to deter patients was in part done through a name change of the service from 'casualty' to 'accident and emergency' (A&E) in 1962 (Jones, 2008). The Platt Report also outlined the primary aim of A&E, stating that its priority was to treat those with serious injuries. Patients with less urgent medical needs, those described as casual attenders, were seen as secondary (Jones, 2008, p.2).

After the Platt Report, the speciality of emergency medicine began to develop and grow in its own right. However, problems were encountered, largely in relation to the difficulty of recruiting staff, in part due to poor resources and environments (Sakr and Wardrope, 2000). From a medical perspective, doctors felt that A&E was lacking in senior opportunities (Sakr and Wardrope, 2000), and they were therefore reluctant to establish careers in the field. In response, consultant roles were made available, and the Casualty Surgeons Association was founded in 1967 to advocate the development of A&E as a medical specialty (Kaneria, 2015).

Although the specialty was developing significantly, the care received by patients, particularly those presenting with trauma, had not improved, with little change in outcomes between the 1940s and 1980s (Kaneria, 2015). In 1988, the standard of trauma care was critiqued and changes were introduced, including the implementation

of specialist trauma training and the trialling of major trauma centres (MTCs) (Kaneria, 2015). MTCs are specialised care centres for patients with 'multiple serious injuries that could result in death or serious disability, including head injuries, life-threatening wounds and multiple fractures' (NHS Choices, 2014). They offer improved trauma mortality rates and are based at specific A&E sites throughout the UK (Kaneria, 2015).

In 2004, the name of the service was changed for a second time – from 'accident and emergency' to 'emergency department' (Jones, 2008). This change was a further attempt to alter the public's perception of the service offered, emphasising the importance of the emergency, trauma and urgent aspects of the service, and to reduce attendances from those with less urgent need (Jones, 2008). This objective remains as, if not more, significant today, as services are being increasingly stretched and are in ever high demand.

2.3 Contemporary ED Practice

2.3.1 Increasing Attendance

Despite the various name changes discussed above and other attempts to direct patients away from EDs (through media campaigns and health-promotion strategies), statistics show a clear and continuous upward trajectory of patient attendance. This pattern

began in the 1970s (Jones, 2008). Statistics from the last ten years show that in 2012/2013, 18.3 million people attended ED services (NHS Choices, 2015). Then, between April 2014 and January 2015, 19.3 million attended (Health and Social Care Information Centre, 2015). The most recent figures available (at the time of writing – October 2018) show that 2017/2018 recorded 23.8 million attendances (NHS Digital, 2018). The rates of attendance are increasing year on year (by an average of 1.7%). The 2017/2018 figures show a 22% increase in attendance from 2008/2009 (NHS Digital, 2018).

These patients encompass a range of illnesses, both physical and mental (including minor and serious infections, heart attacks, overdoses and self-harm). They also have various injuries (including broken bones, lacerations and serious trauma) and social problems (e.g. those who have suffered abuse, those in need of safeguarding and patients with drug/alcohol problems).

Despite this general increase in patient numbers, The King's Fund (2018) argues that it is the rise in the number of patients being admitted to hospital from EDs (emergency admissions) that has the most impact on the overall performance of EDs. These patients are likely to require more-complex treatment and intervention whilst they are in the ED, which is time-consuming for staff. They attend the ED

with complaints that require ongoing care – they must therefore stay within the ED until suitable hospital beds are located for them (The King's Fund, 2018).

Patients requiring emergency admission to hospital must be moved to appropriate hospital beds or transferred to another hospital within a four-hour window. This is part of the four-hour target and applies to all patients attending EDs. This is a significant contemporary consideration of emergency care and, in particular, nursing delivery – this will be discussed below.

2.3.2 The Four-Hour Target and Other Time-Critical Service Indicators

The four-hour target is a quality service indicator:

> Clinical Services Quality Measures (CSQMs) provide an at-a-glance indication of how well services are performing… Clinical Services Quality Measures are a series of metrics that, for example, will allow for comparisons between services such as units within hospitals; providing better information for patients, clinicians and citizens… The measures will be developed according to statistical principles and will be assured by clinical and technical experts…
>
> (NHS England, 2018)

For EDs, many of the quality indications focus on the length of time needed for specific processes or episodes of care, largely in relation to the following points:

- Left ED before being seen for treatment
- Re-attendance
- Time to initial assessment
- Time to treatment
- Total time in A&E

(NHS England, 2018)

The total time in A&E is the most emphasised quality indicator and receives much media attention. Although all of the indicators outlined above will influence care delivery in EDs, it is arguably the four-hour target that most significantly influences the work of ED staff (Crouch and Dawood, 2017). The four-hour wait target is fundamental to the way in which care is delivered to patients in the ED. It was introduced in response to poor standards of care (Mason et al, 2012), with patients waiting in the ED for long periods of time.

The target offers an incentive for Trusts to improve waiting times and holds NHS managers to account when the target is not achieved (NHE, 2016) – trusts are fined when it is breached without clinical exception. By 2004, the NHS intended that no patient should stay

longer than four hours in the ED (Mason et al, 2004). Therefore, 100% of patients should be assessed by medical staff; given appropriate treatment or intervention; and then admitted to the hospital, transferred to another specialty or discharged home (Mason et al, 2012). After 2005, the threshold was lowered and it was proposed that 98% of all patients should meet this target (Mason et al, 2012). In 2010, the target was reduced further to 95%, as the number of patients exceeding the four-hour target had increased (Qualitywatch, 2015).

Statistics collated since the implementation of the four-hour target in 2004 show that performance in achieving the desired percentage has varied (Qualitywatch, 2015). In 2005/2006 (after the threshold had been adjusted from 100% to 98%), the 98% target was achieved (Qualitywatch, 2015). During the next five-year period, the percentage of patients achieving the target ranged between 98% and 96%. The threshold was then lowered to 95% in 2010, which remains the current figure (Qualitywatch, 2015). Despite lowering the threshold, in 2014/2015, the percentage of patients meeting the target had fallen to 88% (Qualitywatch, 2015). In 2016/17, levels of performance dropped to 85%, then to 78% in January 2017, which was the lowest figure recorded since the target's implementation (Qualitywatch, 2017). The most current statistics available at the time of writing are for 2017/2018, which has so far shown a similar

pattern to that of the previous year. In October 2017, 85% achieved the target – official statistics for the winter period are not yet available, but media reports suggest poor performance (Qualitywatch, 2017).

In seeking ED staff members' experiences of the target, Mortimore and Cooper (2007) found that nurses perceived the benefits of the target to be in line with the original aims, describing improvements in the patient experience through the reduction of long waiting times. They spoke of experiences before the target's implementation, when patients might have waited for the equivalent of a whole (12-hour) shift or more (Mortimore and Cooper, 2007).

The development of the target has, however, been heavily criticised, particularly regarding the inadequacy of design and planning (Mortimore and Cooper, 2007). It is argued that there was a lack of empirical evidence for fixing the time period at four hours (Mason et al, 2012). The justification behind the selected four hours (rather than five hours or three hours, for example) is not clear, and critics have argued that the evidence base utilised is not appropriate to the specific clinical setting (Mortimore and Cooper, 2007).

In their important paper recognising the contribution and development of nursing within the ED, Crouch and Dawood (2017) also argue that the four-hour target can prevent emergency nurses

from seeking promotion and leadership roles. These roles are seen as heavily related to patient flow (ensuring patients move through the department without delay) and the achievement of the four-hour target. This focus is less appealing to staff and contributes to the challenge of recruiting into senior roles (Crouch and Dawood, 2017). A further unintended consequence of the target relates to the quality of care that nurses feel able to deliver. It is seen negatively, which results in unsupportive attitudes towards the target (Mortimore and Cooper, 2007). ED doctors expressed similar concerns when asked by the British Medical Association (BMA) back in 2003. Members felt that EDs prioritised 'achieving the target at the expense of clinical quality and staff well-being' (Mortimore and Cooper, 2007, p.402).

Additionally, in the same study, staff expressed concerns surrounding the high rate of staff turnover in the ED and the increased pressure on available support systems – both of which were felt to be linked to the target (Mortimore and Cooper, 2007). Weber et al (2011) argue that the responsibility of achieving the target falls heavily on ED nursing staff, who must clock-watch and probe medical staff and others for decisions to be made. The nurses are also responsible for escalating any delays to senior colleagues (Weber et al, 2011). The high workload experienced by staff, together with the unpredictability of the load and a shortage of staff, exacerbate the difficulty in achieving the four-hour target (Flowerdew et al, 2012). Although

formal sanctions for staff responsible for breaching the target are not documented, they are likely to exist, considering the governmental emphasis and importance placed upon its achievement. The target is unsurprisingly seen as a source of stress for both ED nurses and doctors (Flowerdew et al, 2012).

In seeking to improve the overall achievement, efficiency and effectiveness of the target, Weber et al (2011) argue that a more holistic and inclusive approach needs to be taken, with an emphasis on the broader organisation. A practical example of this is the need for inpatient beds to be available on hospital wards. Without them, patients who are to be admitted from the ED have nowhere to move onto, extending the time they spend in the ED. Considerations such as this link the four-hour target to the pressures and challenges facing the NHS more broadly. The shortage of hospital beds within the system is particularly relevant. The King's Fund (2017) explains that the total number of acute hospital beds, which includes speciality beds (beds for those with mental illness, beds for patients with learning disabilities, beds for maternity patients and day-only beds), has more than halved in number over the past 30 years (The King's Fund, 2017) – from 299,000 to 142,000 available beds. Alongside this decrease, the number of patients using the NHS has increased greatly (The King's Fund, 2017). Compared to similar healthcare systems, the NHS has fewer acute hospital beds in relation to the

population size (The King's Fund, 2017). Together with an increase in emergency admissions (The King's Fund, 2018), this can result in a 'bottleneck' of patients in the ED, waiting to move through the hospital system.

Patients waiting in the ED for hospital beds often have different care needs, which can have implications for those delivering care. For example, nutrition and hydration, which are arguably less important on initial arrival, become crucial. Similarly, the care and protection of skin integrity (pressure sore prevention) also become relevant. Although these care needs are recognised as part of initial assessments in EDs, they are secondary to much acute care and treatment. As a patient's stay in the ED is lengthened, the type of care provided by the ED team must be adapted to meet these needs. This may be problematic for ED staff who are not used to considering or delivering ongoing care, which is usually associated with the ward setting. In addition, the practical physicality of the setting (which is not designed as a hospital ward) and the lack of resources (including space and available equipment, such as hospital beds) will also influence the nurses' work and their experience of this work.

This, and other factors, results in the ED becoming overcrowded – a notion often used to describe an ED that is treating patient numbers above its designed capacity. Patients waiting for hospital admission

are in addition to the stream of patients walking into the ED or brought via ambulance. The appropriateness of these patients in their 'choice' to attend the ED is questioned and is often seen as adding to already overstretched services. The notion of the 'inappropriate ED attender' will therefore be explored below, again with the potential impact on the work of the ED nursing team.

2.3.3 Inappropriate Attenders

As established, the number of patients attending EDs continues to increase. Although the direct impact of this on ED service delivery is questioned by some (who argue that broader organisational issues and challenges are more significant), the idea that patients may be attending EDs 'inappropriately' is relevant to the nature of the work completed by staff and their experiences. EDs are in a unique position within healthcare; Hillman (2014, p.486) explains that this relates to two main considerations:

> … Firstly, [the ED is] arguably the most open service existing at a threshold between public in need and hospital care. Secondly, they function as gatekeepers controlling access to acute care through the admission of patients to acute hospital wards. The ED is a site of potential conflict between the valued work of emergency medicine – constituted as expert medical

intervention with fast, measurable results – and the needs and demands of those who attempt to gain entry.

Related to the notion of the inappropriate ED patient is a sense of legitimacy. What constitutes a 'legitimate patient' is not clearly defined. Llanwarne et al (2017) argue that the ideal patient is somewhat elusive – in general practice, a legitimate attendance includes the consideration of many factors, including the nature of the complaint, the time of attendance and the frequency of attendance. It is likely that ED staff consider similar aspects in their assessment of legitimation – an idea that speaks to the original work of Parsons (1951). This work focused on the level of self-responsibility attached to illness or injury when assessing legitimacy. Moreover, the work of Jeffery (1979) identified 'good' (legitimate) patients (those with serious injuries or illnesses and willing to receive treatment) and those seen as 'normal rubbish' (those with 'trivial' complaints and 'self-inflicted' conditions). These patients were seen as less deserving and their attendance at the ED less legitimate.

The conversation around the inappropriate ED patient in contemporary practice is equally as controversial and also lacking in clear definition. Of course, the perception of what is deemed an emergency differs amongst patients, and between patients and healthcare professionals, and perceptions of the same condition

amongst staff also vary. The argument has been presented that the change to general practitioners' (GP) contractual responsibilities, to provide or not to provide out-of-hours care, has exacerbated the problem of increased demand (The King's Fund, 2018) and subsequent inappropriate attendance at EDs. In addition, patients struggle to book GP appointments in-hours and can be confused about the most appropriate place to get treatment (The King's Fund, 2018). Figures from NHS Digital (2017) show that 11% of patients who attend EDs are discharged home without treatment. A further 39% of patients are discharged home with verbal advice or guidance from the ED (NHS Digital, 2017). The King's Fund (2018) argues that these patients have not attended inappropriately or unnecessarily. Instead, their attendance is justified, as they required clinical assessment or information from ED staff.

Despite this, Brenn and McCann (2013) argue that a major contributor to the overcrowding and other problems facing the ED is the inappropriate attender – patients who, they argue, could have used a different service. Patients who attend the ED under these circumstances are often described as presenting with a complaint of a minor injury or minor illness (Saunders, 2000). Saunders (2000) found that, when asked, ED staff had no universal definition of an inappropriate attender, but the following three themes emerged: patients presenting with non-accidents and non-emergencies;

patients with symptoms that had been ongoing for more than 24 hours; and, finally, patients with illnesses or injuries that could have been treated through a different service, for example a GP. Arguably, because of the subjective nature of inappropriate attendance and the lack of an agreed definition, it is difficult (if not impossible) to quantify the number of patients who do indeed attend EDs inappropriately. Green and Dale (1992) found that 42% of patients were attending for emergency care inappropriately, although similar research has found the variability and subjectivity in relation to the criteria too great to determine.

Aside from figures and statistics, Saunders (2000) found that ED staff felt that the inappropriate use of emergency care was problematic for the service and their work. Likewise, over ten years later, Breen and McCann (2013) found similar concerns: 98% of the multidisciplinary emergency staff questioned agreed with the statement 'does inappropriate attendance exist?' The staff also felt that patient education would be significant in aiding the problem of inappropriate attendance, advising patients on when it was deemed appropriate to attend (Breen and McCann, 2013). This stance suggests that ED staff feel that the responsibility lies with the individual patient.

In light of the increased ED attendance, time-critical targets and other challenges facing emergency care, the following section will turn to focus on the ED nurse's role.

2.4 The ED Nurse's Role: A Brief History

The purpose of this section is to offer an overview of the ED nurse's work as a framework for the empirical research. It will start by introducing and exploring the history and development of nursing in the emergency setting. The chapter will then move on to the contemporary work and practice of the ED nurse.

> … the evolution of emergency medicine, combined with social, political and economic forces in healthcare, have provided a fertile environment for innovation and role development. The ED holds great appeal for nurses who are prepared to challenge and step outside of traditional boundaries in the interests of patients…
>
> (Crouch and Dawood, 2017, p.65)

Developments in emergency nursing have been considerable, particularly within the last 50 years. During this time, the role has progressed significantly (Jones, 2008). Up to the 1960s, the role of the emergency nurse was to mainly undress the patient on their arrival and take initial observations for the emergency doctor (Crouch

and Dawood, 2017). Much of the role during this time was seen as an assistant to the doctor. After 1967, the role started to change. The next 30 years saw the introduction of multiple specialist courses and programmes aimed at upskilling staff and promoting the nursing specialty. The 1970s introduced both the A&E Nursing Forum via the Royal College of Nursing (RCN) and the first national A&E nursing course, which was designed to equip nurses with skills and knowledge specific to emergency care (Crouch and Dawood, 2017), such as immediate life support and trauma training.

The 1980s saw the introduction of joint and collaborative working between the nursing bodies and the (then) Casualty Surgeons Association, again promoting the speciality. The 1990s saw significant advancements in emergency nursing skills and training, with the introduction of two trauma nursing courses (the Advanced Trauma Nursing Course and the Trauma Nursing Core Course) (Crouch and Dawood, 2017).

Dawood and Crouch (2017) describe 1994 as a 'watershed' year for emergency nursing, with the publication of the RCN document *Accident and Emergency Nursing: Challenging the Boundaries*. This document encouraged the potential of the emergency nurse, advocating and supporting the development of extended skills and nurse practitioner roles (Dawood and Crouch, 2017). Support and

relevant frameworks throughout the 1990s and early 2000s – such as the Manchester triage system – increased the emergency nurse's autonomy and scope of practice (Crouch and Dawood, 2017). More-recent developments, including master's-level education, emergency nurse consultants and the RCN A&E Association National Curriculum and Competency Framework, have ensured the progression of various career possibilities in emergency nursing (Crouch and Dawood, 2017). These frameworks also support more-traditional managerial career progression in emergency nursing (such as the roles of sister, charge nurse and matron).

2.4.1 Emergency Nursing in Current Practice

In contemporary practice, the ED is likely to be the first point of care when a patient attends the hospital, whether by ambulance, via GP or via self-referral. In response, all ED staff must be ready and able to manage and treat patients (and manage their relatives) who present with a range of diverse illnesses, conditions and traumatic injuries (NHS Careers, 2015) – this results in a dynamic, changeable and diverse workload for the ED nurse. Crouch et al (2009, p.2) write:

> Emergency nursing is one of the most challenging specialities in nursing. It requires nurses to manage ambiguity and rapid changes in pace and intensity of work and to have a knowledge of a significant number of clinical presentations, diseases and

> conditions. The emergency nurse must also be able to relate to and have an understanding of all ages from the very young child to the elderly. Emergency nursing is not for the faint hearted!

More specifically, Endacott et al (1999, p.5) describes the emergency nurse's role as follows:

> The provision of immediate care to people that have defined their problem as an emergency, or where nursing intervention may prevent an emergency arising… the emergency nurse accepts, without prior warning, any person of any age requiring healthcare, with undifferentiated and undiagnosed problems originating from social, psychological, physical, spiritual or cultural factors.

The nurse is the first professional to assess the patient when they arrive at the ED. During this interaction, the nurse is likely to complete an initial assessment and triage the patient, using both organisational protocol and individual clinical judgement for criteria (see above regarding the Manchester triage system). Gillboy (2010) describes this process as a sorting of patients – those with life-threatening conditions who must be attended to immediately are identified. This process must therefore be completed quickly. The aim is to ensure that the correct patient is in the correct place at the

correct time for the correct reason (Gillboy, 2010). This work is particularly important when large numbers of patients arrive at the ED, as it helps to dictate the order in which patients should be seen by a doctor (Gillboy, 2010). If the order of this assessment were only influenced by the time of arrival, those with serious and life-threatening conditions would deteriorate clinically, becoming more unwell. In contemporary practice, the four-hour target and other time-critical targets are also relevant to the order in which care is delivered.

Following triage, the nurse is responsible for the patient's variety of ongoing care needs. The focus of this care is monitoring the patient's haemodynamic status (clinical stability), recognising signs of deterioration and then intervening appropriately (Howenstein and Sandy, 2011). The care delivered by the nurse also includes personal care and care for other elements of well-being. Howenstein and Sandy (2011, p.454) write: 'patients look to the emergency nurse for comfort, understanding, education, and empathy', whilst 'families look to the emergency nurse for information, education, and reassurance'.

The nurse's role also involves broader organisation and planning: it includes the wider organisation of care (the management of large patient loads), in addition to individualised care plans (RCN, 2007,

cited in Jones, 2008). This element is described by Howenstein and Sandy (2011) as the 'wheel' that keeps the system moving – it also speaks to the notion of invisible work (Allen, 2015). This work involves the co-ordination of multidisciplinary professionals from various medical specialties (Jones, 2008).

The physical skill remit of the emergency nurse has also expanded considerably since the 1960s – far beyond the traditional bedside caring role and the role as the doctor's assistant (Neades, 1997; Jones, 2008; Crouch and Dawood, 2017). The emergency nurse now requires additional medical, clinical and extended skills and must perform interventions that historically would have been completed by a doctor. The list of these is extensive and dictated by experience and individual hospital trusts. To offer some examples, these extended skills include the initiation and undertaking of blood tests, cannulation (in which an IV cannula is inserted into the vein to administer treatment), the completion of electrocardiograms (ECGs), the insertion of urinary catheters and the administration of a wide variety of mediation, both orally and via the IV route. Additionally, some nurses may also prescribe medication, debride and suture wounds, and request x-rays and other interventions. Often, many of these extended skills are performed by relatively junior ED nurses. In routine practice, it is not necessary for an ED nurse to be in a senior clinical or managerial role (such as nurse practitioner, sister / charge

nurse or nurse consultant, as described above) to undertake many of these extended clinical tasks.

In line with the expanding skills and responsibilities of the ED nurse, and the service demands described earlier, it is perhaps unsurprising that many commentators see nursing in the ED as particularly challenging (Basu, Qayyum and Mason, 2016). The following section will therefore outline the perceived sources of challenge for ED nurses and their relevance to nurses' routine work.

2.4.2 Sources of Challenge for Nursing and ED Nursing

The nursing profession is experiencing sustained pressure and stress. The sources of these relate to a lack of resources, staff shortages, patient demands and expectations, the increased acuity of patients, organisational demands and the various requirements of regulatory bodies (Sawbridge and Hewison, 2013; Williams, 2012). These challenges are exacerbated when not met with adequate structural support mechanisms relating to the organisational culture (West, 2016). This can include a lack of formal and informal support, unclear role requirements, poor staff relationships, discrimination, how valued staff feel in their roles and the amount of control that staff feel they have over their work (Basu, Qayyum and Mason, 2016; West, 2016, Maben, 2010).

Furthermore, and as noted earlier, the nature of nursing work is changing. Bolton (2001) argues that the introduction of the market mentality means that nurses and other healthcare practitioners now have an added dimension to their work. This shift towards and focus on consumerism more broadly results in staff managing situations that are more common for those working within 'for-profit' settings (Bolton, 2001). In line with this, nurses strive to meet the heightened expectations of patients. The provider–patient relationship has changed, and the patient is now often viewed as a customer, with associated rights and authority (Ham, 2018). The media is also relevant to nurses' experiences. In the press, nurses are often portrayed negatively and are vilified when patients receive poor care (RCN, 2012). This publicity, together with media attention relating to unachieved targets (such as the four-hour wait in EDs), may impact on the public's perception of nursing and may constitute yet another challenge.

The nature of nursing work can also exacerbate feelings of stress. Factors that influence the perceived level of pressure experienced often include the nature of the tasks to be completed, the levels of responsibility, the degree of unpredictability and the exposure to potentially traumatic situations (Adriaenssens et al, 2015). These factors are outlined in important work by Adriaenssens et al (2015) examining the causes and consequences of occupational stress in

emergency care. It is perhaps unsurprising that nurses working in ED 'score' highly when considering these factors in turn.

We have established that the level of responsibility is likely to be high for ED nurses through triage, the prioritisation of workloads, care management, patient acuity and extended clinical skills (Jones, 2008). In terms of unpredictability and variability, these can also be intense for the ED nurse, with work often described as hectic and constant (Adriaenssens et al, 2015). This unpredictability fuels uncertainly and a lack of control over the workload, which are likely to add to the level of pressure experienced (Adriaenssens et al, 2015).

Exposure to traumatic incidents (Adriaenssens et al, 2015) is also likely for ED staff. This may include exposure to accidents but also suicide, gun and knife crime, domestic violence, and child abuse. Although these incidents are likely to be traumatic in themselves, they are compounded by the psychological distress of caring for family and loved ones. Cases that include sudden and unexpected death, perhaps of a child or young adult, are likely to be a source of challenge. Yang et al (2002) also highlight the potential exposure to violence and aggression from patients and their families as particularly relevant within the ED setting. ED staff experience rates of both physical and verbal abuse that are significantly above the

national average, when compared to other healthcare workers (NHS Security Management Service, 2010).

On examination of these factors, it is perhaps undeniable that staff within the ED are likely to experience tension and stress from a variety of sources. Crouch and Dawood (2017, p.144) write:

> … it is well recognised and documented that the pace and pressure of work in the ED is unsustainable over time and burnout, loss of compassion and indifference to suffering will affect some…

When compared to other healthcare specialists, ED staff are also likely to experience higher rates of anxiety and depression (Basu, Qayyum and Mason, 2016). The likelihood of experiencing burnout for ED staff is higher, too (Adriaenssens et al, 2015). The retention of ED staff (both medical staff and nurses) is consequently problematic (Sawatzky and Enns, 2012). Sickness absence is also high, along with staff choosing to take an early retirement from emergency care (Basu, Qayyum and Mason, 2016). Staff who stay in such work may be more likely to suffer from psychological illness, may be more likely to make medical errors and may develop defective and abnormal lifestyle behaviours (Basu, Qayyum and Mason, 2016). Importantly, these damaging effects also extend beyond the nurses' experience

and into patient outcomes and their experience of care. This will be explored below.

2.4.3 Nurse Well-Being: The Impact on Patient Care

The experiences and well-being of staff (including nurses and other healthcare professionals) have a direct impact on the quality of care that patients receive. The associations of nurse experiences and well-being with patient outcomes are not new. In a landmark paper published in 1960, psychoanalyst Menzies explored some of the reasons why student nurses were leaving the profession. The research suggested that high levels of anxiety contributed to the problem. Menzies (1960) also showed that high levels of nurse anxiety impacted patients' experiences and the standard of care delivered. Adverse consequences included slower recovery rates and increased rates of stress in patients (Menzies, 1960). Similar findings were discovered by Revans (1959) around the same time. Here, the morale of nursing staff was shown to directly impact the recovery rates of hospitalised patients (Revans, 1959).

Much more recently, in 2009, the Boorman Report on the Health and Well-Being of NHS Staff (Boorman, 2009), mentioned earlier, found that trusts with positive staff well-being had improved patient satisfaction, stronger quality scores and better outcomes (Boorman, 2009a, pp.2-3). The financial implications are also significant: the

estimated cost savings in relation to well-being and reducing absenteeism are predicted to be £555 million (Boorman, 2009). Similarly, Aiken et al (2012), in the large-scale RN4CAST nurse survey, also found a strong relationship between nurse well-being and care standards.

Despite this and other evidence showing the importance of nurse well-being, the emotional component of the nurse's role, a great influencer in well-being (Warren, 2016; Johnson and Spector, 2007), is routinely overlooked in contemporary nursing practice (Sawbridge and Hewison, 2013). Nurses must manage and control their emotions routinely to cope with the pressures of the health system outlined earlier and to meet professional expectations and standards of behaviour (Smith, 1992; Theodosius, 2008). This is intense work that requires considerable effort (Steinberg and Figart, 1999). Despite the relevance of this management of emotions, its significance is not appreciated (or even recognised) in nursing practice (Smith, 2012). This is the emotional labour of nursing.

2.5 Conceptualising Emotional Labour

In line with the considerations above, the second section of this literature review will examine Hochschild's theory of emotional labour (1983). The in-depth exploration of the original theoretical concepts will include sections on *surface acting* and *deep acting.* In addition,

attention will be given to *feeling rules* and how they differ between contexts. The progression of research on emotional labour since Hochschild's seminal work will also be explained. The focus will then move on to emotional labour specifically within the nursing profession, unpacking the existing literature on the value assigned to emotional work and the consequences of undertaking this form of work. Studying emotions is now recognised as an important field of sociological endeavour (Wharton, 2009):

> … employees… use their emotional abilities to actively manage physical and emotive displays, as well as those of colleagues and services recipients, using a range of complex and sophisticated abilities, while also conforming to regulated feeling rules that are determined by an employer…
>
> … some emotional displays are more appreciated and encouraged by employers than others. In this regard, the economy of feelings is central to 'who we are', but it is also affected by managerial design and control systems that are intended to shape emotions displayed towards 'higher' organisational interests, such as increasing productivity, profitability and performance…
>
> (Vincent, 2011, pp.1370-1371)

Those examining organisations and organisational behaviour have paid considerable attention to emotions within the workplace (Ashforth and Humphrey, 1993). In particular, there has been a great deal of interest in the influence of employees' work on their emotions and the emotional reactions they experience towards their roles (Wharton, 2009). Goffman (1967) originally discussed the process of 'being public' with emotions (Bolton, 2001). This sociological understanding of emotion works with the idea that individuals consciously manage their emotions to follow the values and beliefs within a specific situation or community (Bolton, 2001). Goffman (1967) described this as 'face-work', in which individual actors have direct control over their 'performance' and the management of their emotional performance (Bolton, 2001). The performer is a 'harried fabricator of impressions involved in the all too human task of staging a performance' (Goffman, 1959, p.220). This fabricator is the 'character' with qualities to be shared – the performance is designed to evoke and display these qualities (Goffman, 1959). In this analysis of emotion management and performance (Goffman, 1967), the actor and the character they play are influenced by the 'traffic rules of interaction' (Bolton, 2001, p.87). These rules enable the actors to manage not only their own emotions but also those of others. We do this by 'reflexively' adjusting our performance in action, using rules to guide and steer them (Bolton, 2001). Goffman (1959, p.221) writes:

> … The whole machinery of self-production is cumbersome, of course, and sometimes breaks down, exposing its separate components: back region control; team collusion; audience tact; and so forth. But, well oiled, impressions will flow from it fast enough to put us in the grip of one of our types of reality – the performance will come off and the firm self-accorded each performed character will appear to emanate intrinsically from its performer…

For many years, emotions and the necessary performances were seen as an inconvenience in organisational settings, 'threatening to taint or contaminate the clean rational logic of efficiency. In this sense, emotions were seen as marginal or disruptive to the functioning of the modern organisation' (McMurray and Ward, 2014, p.1128). It was in 1983 that the work of Hochschild, influenced by Goffman, sought to challenge this established position. The concept of emotional work, and specifically the theoretical concept of emotional labour, products of Arlie Hochschild's *The Managed Heart (1983)*, offered those studying the workplace a new lens through which to explore workers' emotions (Wharton, 2009). Its introduction gave a means of exploring emotions within the workplace, specific organisations and social worlds more broadly (Wharton, 2009; Steinberg and Figart, 1999; Erickson and Ritter, 2009).

Hochschild (1983) provided insights into two fields of study: the social foundations of emotion (Wharton, 2009) and the effects of work within a service society (Wharton, 2009). Combining these areas of development produced the conceptualisation of Hochschild's emotional labour theory (1983). Based on empirical studies of flight attendants and debt collectors, Hochschild argues that employees are required to work on their emotions. Both groups undertook emotional labour in their roles. The flight attendants managed both their own emotions and those of their customers. They undertook this work to deliver a sense of calm, comfort and reassurance to passengers. Conversely, the debt collectors performed emotional labour to show aggression to those owing money – they generated a sense of fear. To achieve these states, both the debt collectors and the flight attendants suppressed and limited the emotions that they outwardly displayed to the various audiences (Hochschild, 2012). In other words, they managed their emotions in response to their surroundings and audiences. Tukey and Hayward (2011, p.1502) describe this flexibility:

> When an individual attends to an internally or externally psychologically relevant situation, the situation is appraised to imbue it with personal meaning and relevance. In turn, an emotion is initiated along with the cognitive, physiological, and behavioural response… However, emotions and their response

> patterns are not fixed. They can be manipulated to change the type, intensity, duration, and trajectory of emotions likely to be or being experienced…

This management of emotion is described as *emotional labour* because it is part of the workers' paid employment (Choi, Kim and Kim, 2014). The flight attendants, for example, were specifically trained and paid to supress their emotion to ensure a particular atmosphere on board the plane (McMurray and Ward, 2014). Emotional labour is therefore defined 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' (Hochschild, 1983, p.7). There are common characteristics found in roles that require significant *emotional labour* from the employee:

- Direct contact with the public – this may be face-to-face or voice contact
- Employers within the organisation exercise a degree of emotional control over the emotional activities of employees – this is likely to be undertaken through training and supervision methods
- Producing certain emotional states for another group

(Hochschild, 1983; Staden, 1998; Gray, 2008)

Employees shape and mould their emotional displays in response to the requirements of their institution or organisation, which is seen to constrain these efforts (Wharton, 2009). Hochschild therefore saw the commodification and control of feeling as an often-exploitative process (Ward and McMurray, 2016) – feelings are exchanged for a wage. It is important to reaffirm that this is different to *emotional work*. *Emotional work* also involves the manipulation of emotion but is outside of the workplace, free from organisational expectations and control. *Emotional work* is the process of managing and then presenting our emotions to our family and friends (Brook, 2009) – the private aspects of our lives outside of the workplace.

2.5.1 Surface Acting and Deep Acting in Emotional Labour

In undertaking *emotional labour* and managing emotion, employees are acting. The following section of this chapter will unpack the two forms of acting that underpin Hochschild's (1983) theory: surface and deep acting. The feeling rules guiding and dictating this behaviour will then be outlined.

Both surface acting and deep acting involve the regulation of emotion but are often labelled as 'authentic versus inauthentic emotion', as the following section will explore:

> Surface acting entails the manipulation of observable behaviour to be congruent with organizational and professional expectations… despite inner feelings (which remain unchanged)…
>
> (Tuckey and Hayward, 2011, p.1502)

Surface acting is often linked to feelings associated with inauthenticity, which consequently alienates the professional self from the personal self, and the felt emotion (Tuckey and Hayward, 2011). When individuals engage in surface acting, they alter their body language to change how they appear outwardly (Hochschild, 2012). Surface acting is often undertaken using facial expressions, mannerisms and gestures to change how they appear to those around them (Hochschild, 2012). Drawing on her case studies, Hochschild (2012) argues that when surface acting, flight attendants and debt collectors are acting with their bodies alone: they are not acting with their 'souls'. The employee acts or displays a feeling but does not feel it emotionally – they are acting by using their mannerisms. Hochschild (1983, p.38) writes: 'the art of a raised eyebrow here, an upper lip tightened there. The actor does not really experience the world from an imperial viewpoint, but he works at seeming to'.

Flight attendants may show facial expressions imparting sympathy towards an upset passenger who is afraid of flying. Perhaps the attendant may tilt their head to the side or place a reassuring arm on the passenger's shoulder. This body and facial language will be used to accompany reassuring and calming language. The aim of this behaviour is to reassure the passenger that they are safe. However, the flight attendant is not experiencing actual feelings of sympathy; indeed, they may be feeling frustrated, impatient and unsympathetic towards the passenger. They use this behaviour and body language to hide their true emotion from the passenger. Crucially, in surface acting, the employee does not suppress or try to change their emotion – if this were the case, it would be *deep acting*, which will be explored below.

> Positive emotional requirements can elicit dissonance due to mistreatment by customers or fatigue, but the employee can reduce emotion–display rule dissonance by changing attitudes and moods to be consistent with the expressions expected. Surface acting maintains dissonance between expression and feelings, but deep acting attempts to bring moods and attitudes in line with emotional requirements…
>
> (Grandey and Gabriel, 2015, p.334)

The process of deep acting also involves the regulation of emotion but aligns with actual feelings with various expectations. These are likely to include personal and professional expectations (Hayward and Tuckey, 2011).

> Deep acting is an example of antecedent-focused emotion regulation whereby the perception, appraisal or situation is altered before emotions are generated…
>
> (Pisaniello, Winefield and Delfabbro, 2012, p.580)

Here, the emotion experienced internally and the emotion displayed externally are in alignment (Hayward and Tuckey, 2011). This suggests that deep acting is less detrimental to overall employee well-being (an exploration of the relevance to well-being will be undertaken later in this chapter). In deep acting, the employee must suppress their true emotion and try to feel differently to how they actually feel (Hochschild, 2012). This deep acting is most likely in response to an expected social norm. Hochschild (1983, p.39) gives example phrases: 'I psyched myself up, I squashed my anger down, I tried hard not to feel disappointed, I forced myself to have a good time, I mustered up some gratitude, I put a damper on my love for her, I snapped myself out of the depression'.

In again using the flight attendants as a case study, an example may involve the suppression of fear at an aggressive or abusive passenger. Here, the passenger may be displaying threatening behaviour towards staff. The flight attendant may use deep acting to try to feel differently, perhaps unafraid, confident and undeterred by the intimidation – they would suppress the actual emotion of fear. This acting would also display the desired front to the passenger: one of control and confidence. Hochschild (1983) also argues that both surface and deep acting are driven by complex *feeling rules*. Considering the importance of these drivers, an exploration of feeling rules will be offered below.

2.5.2 The Feeling Rules of Emotional Labour

Feeling rules are implicit in both emotional labour and emotional work, as they provide standards in feeling management, determining what is owned and accepted between individuals in 'the currency of feeling' (Hochschild, 1983, p.18). Feeling rules are the moral stances that guide and effect how we behave (Smith, 2012). In emotional work, they are influenced and shaped by the norms of our community and society, in addition to our individual priorities, values and judgements (Smith, 2012). In emotional labour, feeling rules are also influenced by the organisation. Hochschild (2012, p.56) explains:

> Feeling rules are what guide emotion work by establishing the sense of entitlement or obligation that governs emotional exchanges. This emotion system works privately, often free of observation. It is a vital aspect of deep private bonds and also affords a way of talking about them. It is a way of describing how – as parents and children, wives and husbands, friends and lovers – we intervene in feelings in order to shape them…
>
> (Hochschild, 2012, pp.56-57)

We recognise feeling rules by the assessment we carry out on our own feelings, both in the moment and after it. In addition, we seek the assessment of our emotion displays from others around us; sanctions from ourselves and others highlight if we are conforming to appropriate feeling rules (Hochschild, 2012). The most obvious examples from daily life can be seen at events where certain feelings are meant or expected to be felt and performed outwardly. These norms are often driven by societal expectations and align with the norms seen as appropriate to the event (Hochschild, 2012). Feeling happy and joyful at a wedding or celebration is expected; likewise, sadness and grief at a funeral or bereavement are the norm and are expected from the family of the bereaved and the guests. Those experiencing the grief must experience and show it in line with the given feeling rules. More specifically, the type of emotion that is

shown outwardly (through body language and mannerisms) and the degree to which any outward emotion is shown must align with these rules. Hochschild (2012) argues that there are many ways in which a griever can 'misgrieve' – falling outside of assumed and expected feeling rules, for example grieving too much or too little, over-managing or under-managing grief, and selecting the correct amount of stoicism at any given time or location (Hochschild, 2012). When a display does not align with the feeling rules and diverts from the measures of what is seen as culturally appropriate, we search for insight into why it may seem strange (Hochschild, 2012).

An example of the feeling rules relating to grief is offered by Hochschild (2012). The example refers to a family. One of the children in the family had cancer; the prognosis was poor and the parents had been told by the hospital staff that the child would die. The parents showed stoicism in their response to this news and as a consequence went against assumed feeling rules for the situation. The hospital staff were surprised by the parents' behaviour, as the staff had likely expected outward grief and distress. The medical staff caring for the child described the parents as lacking in warmth and concern. The family's outward behaviour was different to what the hospital staff were used to and expected for the situation and did not align with the feeling rules, which predicted an emotional outpouring or displays of shock. Perhaps feeling or sensing this disapproval, the

family explained their behaviour to the healthcare staff. They explained how they felt confused and held a sense of guilt towards their child's illness; they described their restraint in preventing a public emotional outpouring. Arguably, they felt the need to explain their behaviour and feelings in response to the judgement received from the healthcare team. Most likely, they wanted to ensure that the staff felt that they were good parents, despite not conforming to the expected feeling rules and emotional displays in terms of location, timing and behaviour. Hochschild (2012, p.68) argues that in response to juggling the myriad of feeling rules, it is a 'remarkable achievement to grieve well – without violating the astonishingly exact standards we draw from culture to impose on feeling'.

The feeling rules expected of a bride on her wedding day are also intense, and any outward display of emotion that does not correlate with them is seen as strange. Not only does the audience see the behaviour as unexpected or surprising but so too does the bride herself. Again, Hochschild offers a vivid example (2012) in which a bride described how she felt during her wedding ceremony. She was depressed and disappointed by her family's lack of support or explicit approval. She had also been let down by some of her close friends who were unable to attend. The bride felt incredibly nervous and, as a result, cried. It was not until she saw her husband waiting for her that she felt happy.

This experience was heavily influenced by a variety of feeling rules. The first was the expectation that a bride should feel happy – she 'assumes the right and obligation to experience a certain skew of vision and elation' (Hochschild, 2012, p.60). When the bride in this example did not feel as she expected, the feeling rules guiding her expectations resulted in attempts to make herself feel happy. The bride talked to herself, trying to convince herself to be happy (and if not for her, for her friends, her relatives and the gifts received) (Hochschild, 2012); how she truly felt did not align with how she hoped or expected to feel. There was a space between the ideal feeling and the actual feeling (Hochschild, 2012). The bride drew upon her knowledge and understanding of how a bride should behave and feel (in line with the feeling rules) and acted accordingly by prompting herself to be happy (Hochschild, 2012). This acting was deep acting and required the bride, as described above, to feel physically different from the actual emotion experienced.

As conveyed in the above, feeling rules are perpetuated by those around us and are reaffirmed by the way in which others respond to what they think we may be feeling (Hochschild, 2012). For example, when someone shares news that is assumed to be good, an appropriate reaction that agrees with the sentiment is expected (Hochschild, 2012). Hochschild (2012) uses 'rule reminders', which alert us to behave appropriately for the situation regarding when we

are allowed to feel certain emotions (e.g. sad, angry, upset, etc.) and clarify and confirm the assumed emotions and feeling rules (Hochschild, 2012).

In addition to these societal expectations and norms, feeling rules are heavily influenced by one's work and status as an employee, as noted previously. In relation to employees and the specific influence of the organisation, Theodosius (2008, p.17, emphasis added) writes that feeling rules are:

> … the means through which individuals understand what the emotions they feel are, and… the means by which they know what emotions they *should* express and to what degree they should express them…

The 'should' emphasised in this quote will be different, depending on the professional group and particular organisation. Organisations introduce feeling rules to employees to ensure and maintain the desired level of service quality (Brook, 2009). Brook (2009, p.533) explains this further:

> … these rules dictate the form, content and appropriateness of workers' emotional displays to customers, thereby separating them from the design and control of the emotional labour

> process. Workers, therefore, are not only estranged from their emotional product but also the process of its production…

Hochschild's original studies shone light on the differences and similarities between debt collectors' and flight attendants' feeling rules. Perhaps the most significant contrast between them relates to the customer's status during the interaction. The flight attendants' behaviour aligned with feeling rules that enhanced and heightened the status of the passenger, subordinating their own status and feelings (a notion that is relevant to nursing). The airline staff deployed emotional labour to these means: 'the passenger may not always be right, but he's never wrong' (Hochschild, 1983, p.139). Roles that involve the feeling rule of 'deference' (meaning to lower one's status below that of the customer) are usually occupied by disadvantaged groups (including women) (Wharton, 2009). Other feeling rules for low-status employees include the need for continuous happiness and 'service with a smile'. Staff working within the hotel industry have feeling rules that prioritise this politeness and happiness (shown through a smile), even when faced with complaints from guests (Igbojekwe, 2017). Similar feeling rules are applicable to other areas of service, such as fast-food restaurants (Leidner, 1993; Wharton, 2009). Here, organisations direct employees to be friendly to customers (and to greet them with a smile). Other examples of

relatively low-paid workers who experience such feeling rules include retail staff (Godwyn, 2006; Sutton and Rafaeli, 1988).

In contrast, an important feeling rule for Hochschild's male debt collectors was to deflate the *customer's* mood, status and sense of importance. For them, the emphasis was placed upon emotional labour that achieved a sense of threat and intimidation. This increased the status of the debt collector. The degree of threat portrayed was adjusted in line with the debtor's level of resistance to paying their debts. Contrary to the lack of power illustrated in the roles above, the debt collectors were encouraged, through their feeling rules, to assert power and masculinity. They did not need to remain courteous, be polite or sustain a 'smile'. Masculinity was also found to be relevant to the feeling rules of insurance salespeople. Leidner (1991) found that although these employees required adherence to the feeling rules of friendliness and politeness (Steinberge and Figart, 1999), the male salespeople focused on the perceived aggressiveness (and element of contest) needed to win sales to drive their emotional labour.

Professional employment is also significant to the feeling rules driving emotional labour. Despite professionalism and its associated status, many feeling rules are still influenced by gender. For example, in her study of paralegals, Pierce (1995) found that feeling rules differed for

men and women who were undertaking the same paralegal role. The women at the firm were still expected to act in a nurturing and supportive manner; the male paralegals were not expected to conform to these rules (Steinberg and Figart, 1999).

The feeling rules at work in educational contexts also offer interesting insights into the gendered nature of feeling rules. In their study of female teachers, Sachs and Blackmore (2010) found that the profession had feeling rules relating to what were assumed to be female qualities. These rules encouraged and expected women to be compassionate and understanding with both students and staff members (Sachs and Blackmore, 2010). Conversely, Benesch (2018) found that hyper-vigilance, indignation and retribution were all especially relevant to teachers' emotional labour. In higher education settings, much of this was undertaken to uphold university policy. For example, academics were encouraged to be hyper-vigilant in their management of student plagiarism. This feeling rule promoted an impersonal and unempathetic relationship in the discipline of students who had plagiarised. The teachers undertook emotional labour in response – largely in relation to the conflict between professional expertise/responsibility and empathy for the student (Benesch, 2018). This tension between competing expectations is also relevant to nurses' feeling rules and will be considered later in this chapter.

2.5.3 Development of Hochschild's Theory

Since Hochschild's original theory was honed in 1979 and published in her book *The Managed Heart*, the notion of emotional labour has been debated and developed at length. As noted by Ward and McMurray (2016), Hochschild's (1983) work was intended to offer an opening into exploring emotional labour and invited others to develop the concept. In addition to examining various employment sectors, as discussed above, theorists have provided adapted and progressive definitions of the term *emotional labour* itself (Choi, Kim and Kim, 2014, p.78):

- Ashforth and Humphrey (1993): 'act of displaying the appropriate emotion'
- Morris and Feldman (1996, 1997): the 'effort, planning, and control needed to express organizationally desired emotion during interpersonal transaction'
- Grandey (2000): a 'process of regulating both feelings and expressions for organisational goals'
- Krual and Geddes (2000a): 'what employees perform when they are required to feel or at least project the appearance of certain emotions'
- Diefendorff and Richard (2003): the 'management of emotions as part of the work role'

- Johnson (2007): an 'expression of organizationally desired emotions by service agents during service encounters'

Various examinations and reviews of emotional labour since Hochschild's introduction have highlighted the progression of the theory in relation to the fields of social psychology, organisational sociology and human resource management (Steinberg and Figard, 1989; Wharton, 2009, Ashkanasy and Humphrey, 2011, Grandey and Gabriel, 2015; Barry, Olekalns and Rees, 2018). Grandey and Gabriel (2015, p.325) offer an overview of the foci of these contributions:

- Emotional labour – including emotional requirements, emotional regulation and performance
- Moderators – referring to the relational and contextual factors that influence emotion management
- Focal outcomes – with an emphasis on employee and organisational well-being
- Focal antecedents – including the relevance of personal and event characteristics to emotional labour

The focus on 'focal outcomes' – namely the detrimental influence of emotional labour on the well-being of employees undertaking it – has been especially prominent (Brotheridge and Grandey, 2002; Huynh, Alderson and Thompson, 2008; Pugliesi, 1999). This work has often

used job satisfaction and job burnout as recognition of employee well-being (Grandey and Gabriel, 2015). Much focus has also been placed on the long-term consequences of emotional labour on the individual, such as intention to leave employment and levels of stress (Yagil and Medler-Liraz, 2013; Huynh, Alderson and Thompson, 2008; Johnson and Spector, 2007; Bartram et al, 2012; Hsieh, 2014; Myung and Guy, 2009; Cheng et al, 2013; Yang and Chang, 2007; Chou et al, 2011).

Although these links to well-being have been established, some areas of study have moved away from the detachment and alienation from the self that Hochschild argued is achieved through deep and surface acting (Payne, 2009). There is now an appreciation that emotional labour in practice is more complex, as explained by Payne (2009). There is agreement that workers often display genuine feelings towards their customers. In addition, it is the lack of ability to control the specific emotional labour performance (rather than emotional labour) that is seen as most detrimental to well-being (Payne, 2009; Korczynski, 2002). This important point will also be re-examined in relation to nursing later in this chapter.

Other critiques and developments of Hochschild's work include the view that it is too simplistic, particularly in relation to the distinction between the emotion management undertaken in private and the

emotional labour undertaken in the workplace (Butler and Stoyanova Russell, 2018). Bolton and Boyd (2003) argue that Hochschild uses an 'over-simplified dichotomy' between the two forms of emotion management. Instead, Bolton and Boyd (2003) conceptualise the more-nuanced elements of emotional labour. They present these under four conceptual categories: presentational, philanthropic, prescriptive and pecuniary emotion management, outlined below, working with the idea that emotional labour in organisations does not fit neatly into one heading. Instead, Boyd and Bolton (2003) argue that, moving on from Hochschild's *The Managed Heart* (1993), emotion-self management in the workplace is in fact more complex:

- Presentational emotion management relates to our socialisation and expectations in relation to how we think and feel
- The philanthropic management of emotions relates to feelings for others outside of those relating to the organisation
- Prescriptive emotional labour is in line with organisational expectations
- Pecuniary emotion management looks at specifically 'commercialised' feeling rules (for customer expectations)

(Butler and Stoyanova Russell, 2018, p.5; Bolton and Boyd, 2003)

This work argues that the forms of emotion management noted above are used by actors interchangeably within the workplace, driven by a variety of feeling rules. Their study also examines the work of flight attendants, and the rules they identify include organisational regulation, expected professional norms and broad social standards. The different forms of emotion management were used to achieve different outcomes, including conformity and empathy (Bolton and Boyd, 2003). They offer an example:

> … 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'…
>
> (Bolton and Boyd, 2003, p.295)

Other developments in emotional labour research have involved the application of Hochschild's theory within service roles outside of the airline industry, for example supermarket employees (Sutton and Rafaeli, 1988); restaurant staff (Hall, 1993); childcare workers (Macdonald, 1996); paralegals (Pierce, 1995); engineers (Van

Maanen and Kuda, 1989); teachers (Constanti and Gibbs, 2004); and hairdressers (Parkinson, 1996), to name but a few.

A further body of literature has focused on employees outside of the private sector, working within public domains. This has also had implications for the development of Hochschild's original theory. Studies have looked at the emotional labour involved in social work (Aldridge, 1994), caregiving (Lively, 2000), and nursing and midwifery (James, 1992; Lopez, 2006; Huynh et al, 2008). In line with the focus of this research, the following section of this chapter will offer a detailed examination of emotional labour in nursing practice.

2.6 Emotional Labour in Nursing

It is unsurprising that emotional labour theory has been applied to healthcare and social service work because these roles require employees to 'do' particularly intense emotional labour (Hochschild, 2012). In relation to healthcare, the literature focuses on four main considerations (Reily and Weiss, 2014, pp.11-12): the 'professionalisation of emotion and gendered aspects of emotional labour' relating to caring as women's work; the 'intrapersonal aspects of emotional labour', particularly in managing bereavement, trauma and death; the 'collegial and organisational sources of emotional labour', which recognise the labour of relationships and conflict; and

the support and training needs of professionals associated with emotional labour (Reily and Weiss, 2015, pp.11-12). These elements will be discussed below.

Emotional labour is seen to be 'at the heart of nursing' (Gray, 2009, p.174). The concept of emotional labour separates nurses' ideal emotions from those they truly feel but are unable to display (Huynh, Alderson and Thompson, 2008). Emotional labour is therefore an indispensable component of nursing. Nurses seek to provide the standards of care expected by patients, their relatives, the organisation more broadly and the profession (Cheng et al, 2013; Chou et al, 2011). This stance sees the 'art and act' of caring and the associated emotional cost as work requiring significant resources (Reily and Weiss, 2015, p.6).

Nurses manipulate their feelings in response to the emotional demands of their role (Reily and Weiss, 2015). Broadly speaking, they must perform emotional labour when their true feelings do not align with organisational and professional expectations relating to how they are expected to think and behave (Reily and Weiss, 2015). Despite these obvious connections, Hochschild's theory of emotional labour was not applied to nursing until the late 1980s.

As a starting point, James (1989), a nurse and sociologist, described care delivery as a form of work. She argued that in caring for hospice

patients, the emotional work undertaken by nurses was comparable (in terms of challenge and intensity) to the mental and physical work and job demands (James, 1989; Smith, 1992). James (1989, p.16) argued:

> … the management of emotions has many of the connotations associated with labour as productive work but also the sense of labour as difficult, requiring effort and sometimes pain. It demands that the labourer give something of themselves, and not just a formulaic response…

In a further theoretical development, Smith (1992) published *The Emotional Labour of Nursing: How Nurses Care*, in which she applied Hochschild's theory to nursing. Smith (1992) argued that nurses must be 'emotionally caring' and manage their emotions in similar ways to the flight attendants in Hochschild's original study. Smith (1992) argued that, also akin to Hochschild's flight attendants, nurses must supress their personal feelings, even 'subordinate' them, to ensure that patients feel cared for and safe.

Despite these similarities, Williams (2011) argues that Hochschild's (1989, 2003) theories are derived from an environment that focuses on commercial gain and is highly competitive – not a traditional characteristic or component of nursing or the NHS. Although these differences stand, Bolton (2001) argues that the introduction of

'market rationality' to NHS management has resulted in similar implications for emotional labour, as services have become accountable to the public. In the NHS, emotional labour is still used as a tool to manipulate the image of nursing for financial and political means (Bolton, 2001). This view sees Hochschild's original work in the private sector as all the more important to emotional labour in healthcare.

In more recent theoretical development, Theodosius (2008) argued that the distinctive nature of nurses' emotion management results in particular (and unique) forms of emotional labour:

- Therapeutic emotional labour, which highlights the relationships and communication with the patient and their family/relatives
- Instrumental emotional labour, which relates to the undertaking of clinical tasks and the process of offering the patient reassurance during them, ensuring that they feel safe
- Collegial emotional labour, which recognises the communication and relationships between nurses and their colleagues

Bolton (2000) also recognises the distinctive nature of emotional labour in nursing. The author describes nurses' emotional contribution to their work as a 'gift'. This idea refers to the distinction between the demands of private and public emotion in that *emotion work*, as distinct from *emotional labour*, would be undertaken within the privacy of the home (Reily and Weiss, 2015). In this gift-giving relationship, the nurses do not exchange their emotional labour for anything in return; instead, it is driven by the satisfaction they gain from making a difference (Bolton, 2000). Theodosius (2008) critiques this argument. It is important, Theodosius (2008) argues, that we should consider the interaction between the nurse and the patient as an emotional exchange in which both parties benefit. The nurse undertakes emotional labour and consequently delivers emotional care to the patient. In response, the patient, or the patient's relative, shows the nurse appropriate gratitude and thanks (Theodosius, 2008). There is, however, a lack of balance in the amount of emotion exchanged between the parties because the patient is in need and, to some extent, vulnerable. It is easy for the nurse to take advantage of this imbalance of power. Theodosius (2008, p.34) argues further:

> Believing that nurses are intrinsically kind and considerate, and genuinely concerned with the health and well-being of their patient, mimics the freely given exchange which takes place in

private relationships. It suggests that the public can trust the nurse who has power over them to care.

The emotional exchange between nurse and patient discussed by Theodosius (2008) demonstrates some of the many differences between emotional labour in the airline industry (Hochschild, 1989) and in other service roles, such as nursing. Theodosius (2008, p.35) argues that there are three significant differences:

- Nurses' emotion work is 'private emotion work', rather than 'consumer-orientated emotion work' (as in the work of flight attendants and similar service roles)
- Power is balanced between the patient and the nurse and negotiated through the 'freely given emotional exchange'; the nurse holds power due to the patient's vulnerability and need
- The emotional labour between the nurse and the patient is an 'interactive' exchange and relationship, in which neither party is 'passive'. These interactions are also less predictable and orchestrated. This is seen as different to the flight attendant's interactions, which are often 'controlled and scripted'

2.6.1 Spectrum of Nurses' Emotion Management

Arguably, one of the most important distinctions between the emotional labour of nurses and that of other employees (including flight attendants) is the range of emotion managed routinely. The management of this extensive spectrum can, unsurprisingly, be emotionally draining and particularly effortful (Huynh, Alderson and Thompson, 2008). Bolton (2001, pp.88-97) echoes the notion that nurses work hard on their emotions, undertaking the emotional complexity of caring for individuals; they are able to 'move into different frames of action, performing according to different sets of feeling rules'. Nurses are described as 'emotional jugglers', with the capability and capacity to present a spectrum of different and appropriate faces (Bolton, 2001, p.97). Nurses 'calibrate their performances according to the frame of action, choosing whether to match feeling with face' (Bolton, 2001, p.97). More specifically:

> … As a distinctive occupational group nurses are particularly adept at changing faces; seemingly effortlessly moving from cynical to sincere, from backstage to frontstage. They are able fully to embrace certain aspects of their allocated role, whilst distancing themselves from others…
>
> (Bolton, 2001, p.98)

Such descriptions give insights into the diverse management of emotions of nursing practice, depicting the nurse as a social actor and performer (Bolton, 2001), adapting to meet various needs. These terms align strongly with Goffman's (1959) 'presentation of self' and impression management, in which employees adopt a specific outward appearance of the expected emotions for the 'stage' whilst their true emotions remain supressed and out of sight (Huynh, Alderson and Thompson, 2008; Bolton, 2001), as discussed earlier.

The spectrum of emotion managed by nurses is also influenced by the nature of the physical tasks undertaken. By its very nature, nursing work, Menzies (1960) argues, includes tasks that by usual standards are (at times) disgusting and frightening, requiring the nurse to perform emotional labour. Moreover, nurses care for patients from all social backgrounds, irrelevant of status, race, ethnicity, age, gender, religious beliefs or lifestyle choices. This consideration increases the spectrum of emotion management further – this labour is intrinsic to the relationships between professionals and patients, aiding and maintaining trust and allowing intimacy (Theodosius, 2008).

Nurses must adapt their care to suit patients and must form relationships irrespective of these considerations. For example, in dealing with a potentially embarrassing situation for a patient, perhaps an intimate examination or intervention, the nurse will use

emotional labour to supress any outward disgust or disapproval. Surface acting in particular changes the body language or facial expression, hiding any visual clues of distaste – a form of *instrumental* emotional labour. Such acts reassure the patient and allow for closeness or a degree of privacy between the patient and the nurse, ensuring that a trusted and intimate relationship can be formed (Theodosius, 2008). A further example can be shown when managing aggressive or threatening behaviour from patients or relatives. It is possible in these cases that the nurse may feel frightened and intimidated. Despite this, the nurse is unlikely to show this upset or fear. More commonly, they will again remain calm and neutral to prevent the situation from escalating further. Both of these examples require the nurse to engage with the 'performance' necessary. Surface acting is used to change the outward face of the nurse, perhaps presenting a neutral exterior. This example would relate specifically to *therapeutic* emotional labour (Theodosius, 2008). Theodosius (2008, p.33) writes:

> … The role of emotional labour in nursing is an essential part of the exchange between the individual being cared for and the carer. Feeling rules based on the ideal of nurses being naturally caring operate as 'moral' guidelines by which the patient allows the nurse to care for their intimate physical body, and by which they can impart personal and private information about their

> feelings, thoughts and way of life. Such a relationship, usually part of intimate private family life, is reproduced in nursing care and is a crucial component of nurses' emotional labour…

The degree to which different forms of emotional labour are relevant in nursing is also dictated by the distinctive characteristics of the clinical setting. The variability in the nursing role (which presents differences in terms of physical and mental work) is also relevant to the spectrum of emotion. This relates in part to the nature of work but also to the level of exposure to various emotions. A tangible example and illustration of this may be seen in relation to how often the nurse deals with the emotions associated with bereavement. We would expect this to be much more frequent and likely for an intensive therapy unit (ITU) nurse or cancer specialist nurse, rather than a nurse based in a dermatology or sexual health clinic (or any other setting in which the patients are less clinically unstable). Despite this diversity of nursing roles, it is arguably the case that most nurses routinely experience a spectrum of emotions because people who are unwell may be frightened, depressed or aggressive – a situation not often associated with the responsibilities of other forms of paid work (Williams, 2011).

2.6.2 Nurses as an Emotional Buffer

It is routine for nurses' work and their subsequent emotional labour to include bereavement, frustration and happiness (Hawken, 1983). Nurses often support and comfort patients and their relatives in times of suffering, when they are dying and at times of immense happiness (e.g. the birth of a child or receiving life-changing news) (Sawbridge and Hewison, 2013). This diverse and sometimes dichotomous catalogue of emotions also distinguishes nurses' emotional labour from that of others.

In these intense and highly emotional circumstances (Ballat and Campling, 2013), it is often the nurse who experiences the most significant impact of the emotions involved (Sawbridge and Hewison, 2013). For example, in experiencing the bereavement of a patient, the nurse may feel personal distress or upset. The degree of this impact may be influenced by many factors, including personal connections to the case or the level of relationship built with the patient and their family. Whilst communicating with the patient or their relatives, the nurse's exterior (facial expressions, body language and communication) is likely to show a sense of calm and reassurance through their emotional labour, helping to minimise the patient's and their relatives' distress.

Nurses are also seen by many as the 'go-to' for much-needed support, clarification and guidance – Smith (1992) describes nurses as an 'emotional buffer'. For example, a doctor will tell a patient bad news about their prognosis. After the conversation, the nurse will be called upon by the patient and their family for support – a role that would not have occurred between the patient and the doctor. The nurse often spends the most time with the patient and has the greatest opportunity to form a relationship. As a consequence of this relationship and the associated intimacy, it is perhaps unsurprising that the nurse will often experience the intense and immediate 'hit' of emotions when delivering care (Sawbridge and Hewison, 2013).

In contrast, the source of the emotional labour may not be from dealing with a patient or relative directly but may instead be indirect, such as supporting a colleague through a distressing case (collegial emotional labour). Moreover, there may be no direct contact with those involved – instead, emotional labour may simply require being within the same environment or space. This is the consequence of working in emotional and emotive environments. These and other characteristics distinguish nurses' emotional exposure from that of other service providers.

Nurses also undertake emotional labour as a means of 'balancing' this level of emotional 'engagement' with their patients (Badolamenti et

al, 2017). This ensures that an 'appropriate degree' of detachment is achieved, allowing the nurses to accomplish various tasks (Badolamenti et al, 2017). Considering the importance of this emotional distancing, the latter section of this chapter will focus on its relevance. Achieving this detachment and other 'appropriate' behaviours and feelings summarises emotional labour in nursing.

2.6.3 Undervalued Emotional Labour as 'Women's Work'

> … prevailing masculine hegemonic culture can influence expectations around gendered aspects of emotional labour and ways professionals are socialized to manage their emotions, principally by suppressing or controlling their feelings…
>
> (Reily and Weiss, 2015, p.14)

Society invites women, more than it invites men, to focus away from action and focus instead on emotion (Hochschild, 2012). Consequently, women suppress their own feelings and emotions more routinely than men do. Historically, the assumption within service work was that women excelled in emotion management and emotional labour within the workplace (Erickson and Ritter, 2001). As illustrated in Hochschild's study of flight attendants and alluded to earlier, women at work are expected to suppress any feelings of frustration or anger though emotional labour. They must encourage

happiness and deliver a sense of warmth and friendliness readily and naturally (Erickson and Ritter, 2016, p.147). In contrast, men, who Hochschild studied working as bill collectors, are generally expected to do emotional labour to display the opposite, showing strength and using aggression in their work (Erickson and Ritter, 2001) to ensure that their clients experience fear. Hochschild (1983) argues that many of the jobs requiring emotional labour are more likely to be undertaken by women due to long-standing stereotypes that assign the genders to different roles (Wharton, 2009). Often, female roles call for employees to create a sense of well-being in others (Wharton, 2009; Hochschild, 1989) and to achieve this state easily.

This assumption that women are 'naturally' able to display warmth and other kind and caring personality traits devalues much of the work they do (Jaggar, 1983; Kosny and MacEachen, 2010). This point is crucial when considering emotional labour in nursing. Ward and McMurray (2016, p.4) argue that the association between women's work and emotional labour casts a 'long dark shadow over the study and practice of emotional labour'; as such, gendered accounts of managing emotion can be interpreted as a dark side of work. They argue that this is work that:

> … the rest of society would rather not think about, the often-unseen work that is emotionally disturbing, exhausting,

> upsetting and stigmatizing. This is work that is simultaneously undesirable and rewarding, work whose tasks are eschewed and yet necessary for the effective function of individual organisations and society at large…
>
> (Ward and McMurray, 2016, p.4)

The dark side of emotional labour, in particular that undertaken by women, has thus been accorded substantially less value than intellectual or physical labour has (Jaggar, 1983) and is often described as invisible (Kosny and MacEachen, 2010). Caring naturally and easily (and invisibly) is also relevant to the discussion of care work and nursing. Care work is seen as similar to the work that takes place within the home: unchallenging and simple (Kosny and MacEachen, 2010; Gray, 2010; Barron and West, 2007). It is also assumed that the emotional characteristics necessary for nursing and caregiving, described by Dixon (2009) as assumed to be gender specific, are not only natural for women and associated with mothering but also easy to do (Jaggar, 1983).

These gendered expectations are fundamental to understanding emotional labour in nursing. It is important to acknowledge that women dominate many of the lower-status caring roles (Nixon, 2009). Women are also underrepresented in professional employment opportunities within healthcare (Nixon, 2009). This reflects broader

national employment trends, where women outnumber men in roles receiving lower pay and status (Stewart, 2013). Most crucially, women are also seen to be overrepresented in roles with the highest levels of emotional labour (Hochschild, 2012).

The total female working population in the UK is 47%, but the NHS workforce is 77% female (The Health Foundation, 2016). There are 957,458 female workers in the NHS compared with 287,073 men (The Health Foundation, 2016). Around 90% of the UK's registered nursing workforce is female (Regan, 2012). Smith (2012) argues that the high number of women in healthcare and nursing helps to explain why emotional labour is undervalued and underappreciated.

The skills specifically required for emotional labour in nursing have been argued as possessed by women generally (O'Brien, 1994, p.399, cited in Steinberg and Figart, 1999). Steinberg and Figart (1999, p.17) argue that this stance devalues the effort that is required within nursing by 'naturalising and essentialising' the skill involved. Many others see emotional labour as complex work and label it skilful (Bolton, 2004). This perspective refers back to the original work of Goffman (1967). Here, 'highly sophisticated and skilled social actors' practise and manage their emotions in line with a 'complex array of implicit feeling rules, conventions or rituals' (Payne, 2009, p.351). This argument refers to the technicality and skill

involved in pitching the correct social interaction for a customer or patient (Payne, 2009; Bolton, 2004; Korczynski, 2005). Developing scales and measures that capture the 'technical content' of emotional labour would support the case that emotional labour is indeed skilful (Vincent, 2011).

The intangible nature of emotional labour also proves problematic when trying to capture its worth in nursing (Philips, 1996; Bone, 2002; Smith, 2012). Despite increasing recognition within the academic literature that emotional labour is an important part of nursing (Timmons and Tanner, 2005; Smith, 2012, Bolton, 2000; Theodosius, 2008), there is little awareness of it from a practical clinical, organisational or political perspective (Sawbridge and Hewison, 2013). Consequently, the emotional labour in nursing is not acknowledged, supported or rewarded (Sawbridge and Hewison, 2013). The following section of this thesis will outline the relevance of this important point and the broader implications of emotional labour in nursing practice.

2.6.4 Emotional Dissonance and Other 'Consequences' of Emotional Labour

It is evident that emotional labour is a routine, prominent and essential component of nursing. It is, as previously stated, intrinsic to the relationship between professionals and patients. Patients are

reliant on nurses undertaking emotional labour to achieve these relationships. It aids and maintains trust and allows for intimacy (Theodosius, 2008).

Despite the centrality of emotional labour to nursing practice, there is also agreement amongst theorists of the potentially negative consequences of working within a role that requires significant emotional labour (Hsieh, 2014; Myung and Guy, 2009; Johnson and Spector, 2007; Cheng et al, 2013; Yang and Chang, 2007; Bartram et al, 2012; Chou et al, 2011). Hochschild (1983) found the effects of such emotional labour on employees to be draining and demanding, with a potentially negative impact upon well-being (Warren, 2016; Johnson and Spector, 2007).

The emotional labour undertaken by employees is underpinned by organisational and professional feeling rules that demand compliance with certain behaviours and the associated necessary suppression of emotion (Brook, 2009). This process of supressing emotion to act in ways that do not align with how we truly feel, particularly when undertaken for long periods, is associated with adverse effects for the individual and others (Brook, 2009; Reily and Weiss, 2015). It is also important to recognise the lack of control that nurses have over the emotional labour they are required to perform. As noted earlier, this

can be most significant when acknowledging the impact on well-being (Payne, 2009; Korczynski, 2002).

Researchers have found that one of the costs or consequences of emotional labour in the private sector can be a loss of connection between employee and customer. Yagil and Medler-Liraz (2013) write:

> Employees' identity as service providers comprises internalized display rules and strategies of emotional labour that inhibit authentic self-expression. For service employees, their feelings are objects they have learned to govern and control rather than spontaneous natural occurrences… employees may experience emotional numbness during interaction with customers, loss of access to their own emotions, or emotional dissonance…

Such considerations are important in understanding the potential effects of emotional labour on the nurse–patient relationship and on the levels of connection and empathy within this relationship. The nurses studied by Smith (1992) used a variety of techniques to manage the emotional component of their role, including trying to 'switch off' from their emotional work. It is perhaps unsurprising that this sustained act may lead to nurses forming superficial connections (Smith, 1992) with their patients. Nurses can develop estrangement

from themselves and their patients, resulting in distress and disconnection.

To prevent this from occurring, the nurse must develop the ability to remain involved therapeutically (Smith, 1992), which relates to the work of Theodosius (2008) discussed earlier. This requires the use of deep acting – in Hochschild's study, the experienced flight attendants were able to develop a healthy degree of estrangement between their personal and work selves, preventing the risk of burning out from emotion management (Smith, 1992). Nurses often respond by developing their own protective mechanisms, protecting them from the guilt, fear, anger and sense of failure that can be associated with nursing practice (Smith, 1992). These feelings are likely to be experienced when their expectations (of the standard of care they would like to deliver or the type of nurse they want to be) are not met. These expectations relate back to the earlier discussion of the 'good' nursing narrative, sustained through education, policy and professional bodies. This can result in feelings of guilt and disappointment.

Korczynski (2003) also discusses employees' responses to emotional labour. He found that collective coping within organisational communities is also relevant to the overall emotional tone of co-workers and their well-being (Korczynski, 2003). These protective

strategies work to prevent emotional disconnection and dissonance (Wharton, 2009) and are especially relevant to those working within healthcare (Reily and Weiss, 2015). Emotional dissonance, as described by Hochschild (2012, p.90), can build over time through intense and sustained emotional labour:

> Maintaining a difference between feeling and feigning over the long run leads to strain. We try to reduce this strain by pulling the two closer together either by changing what we feel or by changing what we feign. When display is required by the job, it is usually feeling that has to change; and when conditions estrange us from our face, they sometimes estrange us from feeling as well.

Other potential costs of emotional labour stretch beyond the relationship between patient and nurse, directly impacting upon the well-being of the labourer – an area of existing literature that has been assigned much attention by scholars. Focus is given to roles that undertake high levels of emotional labour, and the impact on individuals' risk of burnout is a recurring theme (Huynh, Alderson and Thompson, 2008; Theodosius, 2008; Hochschild, 2012; Johnson and Spector, 2007; Bartram et al, 2012; Hsieh, 2014; Myung and Guy, 2009; Cheng et al, 2013; Yang and Chang, 2007; Chou et al, 2011).

It is important to note, however, that surface acting and deep acting influence well-being differently. Surface acting, endangering the sense of self (Hochschild, 2012), is related to dissonance and disconnection. Conversely, deep acting appears to be unrelated to emotional dissonance and is also linked (positively) to levels of job satisfaction (Grandey and Gabriel, 2015). In addition, surface acting is associated with emotional exhaustion – a component of burnout (Johnson and Spector, 2007). As noted earlier, deep acting is seen as an alignment between one's true self and the emotions displayed visually; consequently, it does not impact upon one's sense of self as intensely as surface acting does (Uy, Lin and Ilies, 2017).

Those studying the direct effect of emotional labour on the nursing profession have argued similar consequences. Bartram et al (2012) found that emotional labour was positively associated with burnout. Additionally, the intention of nurses to leave their jobs increased with the frequency of emotional labour undertaken (Bartram et al, 2012). Preventing burnout in nursing is fundamental for the retention of staff, an issue causing significant concern for the profession (Cheng et al, 2013). Chou et al (2011) found that surface acting was particularly harmful for nurses, with an increased likelihood of experiencing emotional exhaustion. This is particularly concerning when examining nurses' high levels of surface acting (Pandey and

Singh, 2016). Studies into the effects of deep acting, however, are less decisive (Chou et al, 2011; Mikolajczak et al, 2007).

2.6.5 Nurses' Feeling Rules

> Despite the functional utility of naturally emerging emotions, contextual (i.e. societal, professional, and organizational) norms may dictate the appropriateness or inappropriateness of expressing particular emotions in the workplace, such as anger or frustration towards customers…
>
> (Tuckey and Hayward, 2011, p.1502)

The feeling rules associated with nursing, underpinning the emotional labour undertaken, are determined by many factors. As explored previously, the organisation is intrinsic to an employee's feeling rules and subsequent emotion management. The aim is to commodify emotions, expecting employees to act, behave and feel certain ways to achieve and sustain organisational expectations (Reily and Weiss, 2015; Hochschild, 1983).

There is also a degree of debate in relation to how organisational feeling rules are learnt, which is important in examining nurses' feeling rules specifically. There are two schools of thought: the first is that the organisation works to sculpt employees to adhere to fixed feeling rules, whilst the second looks at employees' existing

emotional competence (Seymour and Sandiford, 2005; Fineman, 1996). The first approach includes the deployment of specific training and courses, directly teaching employees about their emotional conduct. Such formal approaches to teaching feeling rules and associated emotional labour are often utilised in large companies (Seymour and Sandiford, 2005). The alternative method, as discussed by Fineman (1996), relies upon the individual's existing skills; in such cases, it is expected that the individual will understand and comply with organisational feeling rules, but specific training is not given (Seymour and Sandiford, 2005). Consequently, the feeling rules and management of emotion required for the organisation are learnt through socialisation (Seymour and Sandiford, 2005). It is thought that this second stance is the more powerful of the two. The weight attached to the feeling rules taught in formal training is outweighed by socialisation and unofficial instruction; feeling rules are instead learnt through relationships with junior and senior colleagues, past experiences, interactions with customers, and regulation of the self (Bolton and Boyd, 2003; Seymour and Sandiford, 2005).

Nurses' feeling rules are arguably learnt and taught through a mixture of the two approaches described above. Explicit and formal training in emotional labour, often seen in many large organisations outside of healthcare, is not utilised. There is, however, training

(usually on induction to a trust or organisation when commencing as a nurse or other healthcare professional) in relation to expected standards of behaviour. This often includes the importance of behaviour related to 'professionalism', 'kindness', 'respect' and 'politeness' and may be repeated annually as part of essential or mandatory training. Although the messages disseminated through organisations do not specifically mention emotional management, labour or work, in achieving such values consistently, the employee will most certainly need to 'act' or 'perform' outward displays of the espoused values. Such instances will be required when their true feeling does not align with these expected behaviours.

Without formal training or education outlining the emotional labour necessary, it is likely that this work is completed without a conscious understanding of the process – a notion that is supported by existing literature and one that will be explored further later in this thesis. It is most likely that the development of nurses' broad feeling rules is a process influenced by a variety of different audiences. The aim of this section is to show their relevance.

The Nursing and Midwifery Council (NMC) is likely to influence all registered nurses' feeling rules. The NMC sets out some formal requirements through 'The Code'. This document outlines a set of standards that all registered nurses and midwives must uphold; if

these standards are not abided by, disciplinary action may be taken (NMC, 2015). As a consequence, the document acts as a point of reference for expected behaviour and what it means to be a 'professional' nurse. Examination of this code gives insights into how feeling rules are developed. In addition to requirements regarding clinical skills and practice behaviours, The Code also emphasises the requirement for nurses to promote a continuous professional character (NMC, 2015). These stipulations are likely to provide an underpinning and grounding for nurses' feeling rules. Nurses must 'put the interests of people using or needing nursing or midwifery services first [and]… make their care and safety' their priority (NMC, 2015, p.4). Nurses must also 'withhold the reputation of the profession' at all times and ensure that they act as a 'model of integrity', maintaining objectivity whilst delivering care (NMC, 2015, p.15). These expectations reintroduce the lack of power and sense of subservience – nurses must ensure that the needs of their patients are their first priority, above their own needs.

Similar messages are disseminated to nurses through national campaigns, strategy and policy – these elements are also likely to influence nurses' generic feeling rules. For example, the three-year '6Cs' campaign worked to promote care, compassion, competence, communication, courage and commitment (NHS England, 2018c). The 6Cs are described as a framework for nursing, midwifery and care

staff through the promotion of compassion in practice. These campaigns and messages delivered through the NMC have implications for feeling rules relating to professionalism, control, kindness, dedication and devotion – again offering insights into the basis for nurses' feeling rules. The need for nurses to maintain an unwavering professional front, and arguably undertake a degree of emotional labour to do so, is a significant requirement of formal nursing registration.

The expectations of The Code are taught and reiterated to nurses both during their nursing training and following qualification – a process that begins the commodification of feeling. Echoing Hochschild's (2012) feeling rules, the social norms and formal standards guide what the nurse believes is appropriate and what they are expected to feel or not feel (Hochschild, 2012).

Society also has expectations of how nurses should behave, acting as another audience for the production of nurses' feeling rules. Theodosius (2008) argues that the public perceive nurses as showing a natural ability to care – a sign of devotion to their work. As noted earlier, nurses should generally have strong empathy skills and an ability to offer comfort to patients, with seemingly little effort (Theodosius, 2008). These idealised expectations and standards relate to nursing as a vocation and an inherent drive to care and be

kind (Bolton, 2001). Such expectations from patients are heavily gendered, as discussed earlier in this chapter. These standards are perpetuated in the media. When they are perceived to have not been met and patients receive poor care, nurses are often vilified (RCN, 2012). Here, nurses use emotional labour because they become aware that under these constraints and pressures, their feelings do not always align with what they believe they should be feeling (Huynh et al, 2008). Their feelings often do not align with outdated and ideological expectations that relate to inherent and unwavering kindness. McQueen (2004, pp.103-104) states:

> When nurses do not feel as they think they ought to feel in particular situations, they engage in emotional labour to manage, control, or alter their emotional status to correspond with what they believe is appropriate for the situation.

2.7 'Gaps' in the Conversation: Emotional Labour in the ED

Emotional labour is an intrinsic component of nursing practice (Smith, 2012; Gray, 2008; Theodosius, 2008; Timmons and Tanner, 2005; Bolton, 2000; Philips, 1996; James, 1992). This emotional labour is influenced, in part, by the generically relevant expectations and feeling rules discussed above. In addition, however, nursing specialties are also likely to be relevant to the production of specific feeling rules, although regrettably little emphasis is given to these in

the current literature. This thesis addresses this gap, which will be discussed below.

Previous applications of emotional labour theory have included the following clinical specialties: palliative care nursing (Skillbeck and Payne, 2003; Funk et al, 2017); gynaecological nursing (Bolton, 2000; McCreight, 2004); theatre and recovery nursing (Timmons and Tanner, 2005); intensive care nursing (Stayt, 2009; Hammonds and Cadge, 2014); and neonatal nursing (Cricco-Lizza, 2014).

The nursing specialty is therefore seen to be relevant to the emotional labour undertaken. For example, it is perhaps unsurprising that the feeling rules of palliative care nurses often relate to the management of grief (Funk et al, 2017). The focus is on ensuring that patients experience a 'good' death. When the nurses are unable to facilitate, they feel guilt and anger but suppress these feelings (Funk et al, 2017). The palliative care nurses' feeling rules also relate to the maintenance of reverence and solemnity. Showing grief (through tears) is also especially relevant and discouraged (Funk et al, 2017).

In studying the role of the theatre nurse, Timmons and Tanner (2005) found that much of the nurses' emotional labour was driven by the nature of the close nurse–physician relationship. The nurses were seemingly responsible for upholding a convivial and light-

hearted mood in the operating theatre (Timmons and Tanner, 2005); their feeling rules and emotional labour reflected these expectations.

In studying neonatal nursing, Cricco-Lizza (2014) argued that the drivers behind the nurses' emotional labour related to remaining 'unruffled' and calm in the face of critically unwell babies and their parents. Studies in other intensive care settings (such as the adult ITU, studied by Stayt, 2009) found that emotional labour to ensure protective distancing was also important. The ITU nurses' feeling rules seemed to relate to self-preservation, deploying emotional labour to maintain functional and practical relationships with patients' families (Stayt, 2009).

These previous studies have highlighted the relevance of the nursing speciality to the feeling rules of the setting and the subsequent emotional labour. However, we know very little about the feeling rules in the ED or how emotional labour plays out in the emergency setting. This study will begin to address this gap. Insights from research on emotional labour in the ambulance service (Boyle, 2005, p.62) may relate to emergency nursing, specifically with respect to the balancing of feminine and masculine qualities, described as a 'paradoxical mix of cultural values and practices'. The research found that the ambulance employees needed to show self-control and stoicism to maintain a degree of masculinity whilst still remaining

empathetic, cheerful and compassionate (Boyle, 2005, p.62). It is likely that these rules are relevant to emergency nurses' feeling rules, as the setting is unlike many other nursing specialties.

The diversity of patients cared for by the ED nurse is also likely to be relevant to ED nurses' feeling rules and is a unique element compared with other areas of nursing. Patients arrive at the ED with a variety of conditions and complaints. As highlighted earlier, these include relatively minor illnesses or injuries through to those that are life-threatening or life-changing. Such variety in conditions and needs is likely to influence the nurses' management of emotions, although the understanding of this is largely underexplored in the current literature. In examining the work of 911 call takers, Newman et al (2009) briefly note a similar challenge for employees. They found that the call takers undertook increased emotional labour in managing the variability between prank phone calls and those that were stressful and highly charged, dealing with life-threatening emergencies. Similar emotional labour may be undertaken in the ED when the nurses care for so-called 'inappropriate attenders' – often seen by staff as problematic to their work (Brenn and McCann, 2013).

Thus far, the relevance of emotional labour in the ED has only been touched upon within a broader study (Bailey et al, 2011). The research acknowledged the emotional labour undertaken by ED staff

in the management of patients receiving end-of-life care in EDs. This emotional labour was exhausting, especially when patients were clinically deteriorating and expected to die (Bailey et al, 2011). ED nurses saw closeness with their patients as problematic and detrimental to their own well-being. They reported distancing themselves from the direct 'emotional impact' that such cases would bring (Bailey et al, 2011, p.3367).

Despite this insightful paper and other contributions to emotional labour theory, there remains a compelling space to understand the management of emotion in the ED. As explained by Halford and Leonard (2005, p.658), 'even under the shared cultural umbrella of the NHS, different organisations and different parts of the same organisation offer distinctive experiences, resources and subjectivities to employees.' Direct research within the interesting and distinguishable case study of the ED is an obvious choice for such an exploration. The emergency specialty is, by its character, emotionally charged. Considering the acute nature of this setting, it is likely that ED nurses' emotional labour is likewise distinctive. However, our understanding of this space is limited. Furthermore, we know little about the 'specialty-specific' feeling rules driving this emotional labour. This too is a fruitful area for further examination.

Considering the moderators of emotional labour within the distinctive ED setting is also crucial in understanding the challenges facing ED staff. The existing literature examining the moderators of emotional labour (outside of the ED and healthcare) has largely focused on job status and the degree of autonomy in work; the financial rewards for the emotional labour undertaken; and the degree of social support available to employees (Grandey and Gabriel, 2015). As part of this, attention has been paid to formal job-based financial and psychological resources (autonomy, money and status) and informal social or energy resources (Grandey and Gabriel, 2015, p.325). Emotional labour was found to be less depleting (to employee well-being) when these resources were available (Grandey and Gabriel, 2015).

Noting the pressures facing the ED, including a lack of resources, it is likely that these and other environmental elements act as moderators of ED nurses' emotional labour. It has already been established that psychological responses, such as motivation and attitude towards work, are influenced by the working environment (Humphrey, Nahrgang and Morgeson, 2007). In particular, the physical demands, work conditions and ergonomics of the setting affect stress and motivation. Although the work of Humphrey, Nahrgang and Morgeson (2007) is not related to employees' experiences of emotional labour directly, it does confirm that environmental work considerations are

relevant to staff members' psychological reactions. This suggests that the constrained environmental elements of the ED are likely to influence staff members' emotional labour, acting as previously unexplored moderators of this labour. Such elements include:

> … the physical, organisational, institutional, and legislative structures that enable and constrain, and resource and realize, people and procedures.
>
> (May et al, 2007, p.3)

To summarise this chapter, it is reasonable to assume that the management of emotions in the ED setting, particularly that undertaken by nursing staff, is distinctive. Although we can draw upon research from other nursing specialties and professional groups, the emotional labour of the ED setting is largely unexplored. This offers an opportunity for contribution though two avenues. The first is examining the specialty-specific feeling rules that are anticipated to underpin the emotional labour of the ED nurse. The second is exploring the relevance of the distinctive ED environment to the emotional labour – namely, the unexplored moderators of ED nurses' emotional labour.

2.7.1 Research Questions

The following research question was therefore a fitting start to this exploration:

Why and how is emotional labour accomplished in the ED?

With three supporting questions:

Which environmental elements of the ED influence the emotional labour undertaken?

What are the speciality-specific feeling rules of the ED?

How is emotional labour in the ED perceived from a broader organisational perspective?

2.8 Conclusion

The theory of emotional labour introduced by Arlie Hochschild (1979) offers a means for examining the broad emotional aspects of private and professional life. It offers insights into the management of emotions and the feeling rules driving this behaviour. Emotional labour underpins nursing practice. It is crucial to the relationship between healthcare professional and patient. The nurse manages a vast range of emotions to ensure that the face presented to the

patient and the nurse's colleagues is professional and in line with that expected for the situation.

Despite the significance of emotional labour in nursing, the acknowledgement, understanding and support offered in 'shop-floor' practice remain invisible. Considering the links that high emotional labour, particularly surface acting, has with poor well-being, stress and burnout, its relevance should not be underestimated. Broader problems with poor well-being and absenteeism in the NHS are a significant financial burden and impact heavily and directly on patients' experiences and outcomes.

At the same time, the NHS and EDs in particular are experiencing unwavering and sustained pressure to deliver services. These pressures impact not only the care received by patients but also, and less discussed, the staff delivering the care. An area of care under particular strain is that of emergency care.

The distinctive ED setting presents an exciting backdrop to explore and develop emotional labour theory, both empirically and theoretically. The nature of the service and care delivered in the ED results in an environment that is dynamic, changeable and emotionally volatile. Understanding the nature of the emotional labour in the ED and the associated specialty-specific feeling rules offers areas of potential contribution. In addition, exploring the

impact of distinctive environmental elements as moderators of emotional labour offers further contributions to knowledge.

Chapter 3: Methodology and Methods

3.1 Introduction

This chapter will outline, describe and analyse the philosophical and methodological considerations underpinning this study. It will begin by restating the research question and supporting research questions before describing the aims of this research. The underpinning philosophy will then be introduced. After that, the discussion will move on to the methodology and the strengths of the ethnographic approach. The methods used for data collection will also be discussed from a practical perspective. Perhaps most crucially, considerations for achieving quality in a qualitative study will then be introduced. Finally, the details of the data analysis process undertaken will be outlined, paving the way for the empirical data chapters.

3.1.1 Research Question

Why and how is emotional labour accomplished in the ED?

3.1.2 Supporting Questions

Which environmental elements of the ED influence the emotional labour undertaken?

What are the speciality-specific feeling rules of the ED?

How is emotional labour in the ED perceived from a broader organisational perspective?

3.2 Aims of the Study

This study aimed to empirically explore and understand the concept of emotional labour. It also aimed to make a theoretical contribution and advancement to the existing emotional labour literature. These contributions relate to the emotion management of the distinctive ED setting. In line with the research questions outlined above, the contributions of this study aim to sit within two areas of underexplored literature: understanding the nature of the emotional labour in the ED and the moderators of this emotional labour and, in addition, understanding the feeling rules driving this behaviour.

As part of this, I will explore the frequency, ease and intensity of the emotional labour undertaken specifically by ED nurses. I will unpack and explore how environmental and institutional factors, aesthetic characteristics, organisational dynamics, gender customs, patient populations and patient expectations influence the emotional labour undertaken by staff within this environment.

To address these aims, I observed and spoke with staff in the ED, witnessing their work and collecting their spoken accounts of their experiences through ethnography. I used the research questions

above to frame an in-depth, exploratory approach. I was keen to give emphasis to their perceptions and understanding of their professional role, their work and the challenges within this. I wanted to explore and understand the values, expectations and beliefs (feeling rules) that they perceived as driving their behaviour. I sought to uncover the accounts of their (individual and collective) experiences of 'doing' emotional labour in the ED. In supplement to this, I sought the experiences and perspectives of staff outside of the ED to offer an insight into the wider organisational context. For this, I needed to gather the accounts of staff related to nurse well-being more broadly.

This ethnographic style of exploratory data collection lends itself to qualitative research and the philosophical approach of interpretivism, a philosophy that attempts to understand the 'life world' of individuals in the studied situation (Gherardi, 2014). It is an approach that focuses on meaning and meaning-making in specific contexts (Gherardi, 2014). Interpretivism is therefore appropriately adopted when the aim is to gather accounts of the experiences of a specific group, with the intention of exploring a particular social phenomenon, such as emotional labour (Hammersley and Atkinson, 2007). Interpretivism offered access to the relevance and significance of the staff members' experiences and perceptions of their emotion management (Hammersley and Atkinson, 2007). Through interpretivism, I was able to unpack these experiences and begin to

understand the values and beliefs of the staff that influenced, guided and dictated their behaviour and consequent nursing practice (Hammersley and Atkinson, 2007). These epistemological and methodological ideas will be explored in further detail in the following section.

3.3 Epistemology and Methodology

An interpretivist approach can be used as a way to recognise, explore and value an individual's or group's lived experience and is an alternative to the traditions of positivist enquiry (Ormston et al, 2014). The emphasis in an interpretive study is to understand the social world (Blaikie, 2000) – in this case, the social world of the ED. This world has been created, and continues to be created, through social actors – in this instance, the healthcare staff (Blaikie, 2000). Occupational communities, such as the ED nursing staff, have 'local knowledge, both tacit and explicit', which influences and dictates behaviour and decision-making (Gherardi, 1995, p.19). The exploration of this community through ethnographic interpretivism offers a 'serviceable key' to understanding the culture (Gherardi, 1995) and consequently the drivers behind the emotional labour undertaken.

As with all qualitative studies, this work saw people as the predominant (but not only) source of data. In adopting a specifically

interpretivist approach, the concentration was on perceptions and gathering insiders' views (Blaikie, 2000). This insiders' experience, including interpretations and perceptions, taken largely from informal and formal conversation, formed the focus of the data (Mason, 2002). This focus on the perceptions of human experiences was the purpose of the qualitative study and was crucially important in understanding the ED staff members' accounts of their work. This approach allowed for the generation of rich and deep data through a process of illustration and translation (Ormston et al, 2014).

The following section of this chapter will consider the central aspects of an interpretivist approach, including subjectivity, objectivity and reflexivity. Understanding and knowledge are social constructs in the interpretivist philosophy (Broom and Willis, 2007). That is to say, knowledge is created through interactions between individuals and their interactions with the natural world (Williams, 2016). From this perspective, meaning and explanation are constructed by these social actors and the interpretation of their knowledge (Benton and Craib, 2001). The concept of subjectivity, assuming that reality is an output of 'human cognitive processes' (Johnson and Duberley, 2016, p.180), is also therefore central to interpretivist thought. An explanation of the social world is established in an individual's subjective understandings, and, crucially, these subjective understandings can only be accepted in relation to the social context (Williams, 2016).

The behaviour of staff in these environments is shaped by often-unconscious subjective values and rules from a range of internal and external sources (Hammersley and Atkinson, 2007). These values and rules are likely constructed through a variety of influences, including professional, personal and organisational, amongst others, reaffirming the need to explore this research question through the narrated and interpreted lived experience (Ormston et al, 2014). The exploration was specifically in relation to the management of emotions, seeking to understand how this behaviour is impacted and influenced by a variety of subjective cultural norms, values and expectations (Benton and Craib, 2001). This involved observing a social group of ED staff in their work and unpacking these experiences through informal conversations and interviews. Experiences were also gathered from leaders and well-being staff within the organisation more broadly to set the context of the ED. The emphasis was on developing emotional labour theory through the perceptions, insights and lived experiences of healthcare staff, valuing these intricate and unique experiences as knowledge (Mason, 1996), and addressing gaps in the current literature.

The power of interpretivist study is to understand how the dynamics of a particular setting work (Mason, 2002). Interpretivism embraces the subjectivity of staff members' experiences, not only how this varies from person to person as described above but also how the

evolution of each individual's perceptions is changed and affected by countless stimuli at different times (Hammersley and Atkinson, 2007). Interpretivism therefore lends itself to the dynamic ED environment, an environment that involves physical evolvement and change; particular patterns; and complex relationships and interactions (to be discussed in detail in Chapter 4). It embraces multiplicity, intricacy and versatility, too (Mason, 1996). Mason (2002, p.1) explains that through qualitative research and interpretivism more specifically:

> … we can explore a wide array of dimensions of the social world, including the texture and weave of everyday life, the understandings, experiences and imaginings of our research participants, the ways that social processes, institutions, discourses or relationships work, and the significance of the meanings that they generate… through methods which… celebrate richness, depth, nuance, context, multi-dimensionality and complexity rather than being embarrassed or inconvenienced by them…

Subjectivity and objectivity are also relevant in relation to the role of the researcher, a further dimension of qualitative research. Attempting to adopt an objective stance would support the idea that we are able to study in a way that transcends our own values and

beliefs (Williams, 2016). This research accepts, instead, that it is not possible to leave behind these personal ideals, beliefs and standards (Williams, 2016). The following section of this report will therefore explore the role of the researcher.

3.4 The Researcher's Role

The researcher is 'centrally implicated in the production of knowledge' (Mason, 1996, pp.140-141). This influence was intrinsic to this research. The researcher is an integral part of the social world being studied, working to communicate with it directly (Benton and Craib, 2001). Rather than trying to hide this influence, interpretivism encourages honesty. Considering my professional background as an S/N, interpretivism was therefore an appropriate methodology to adopt. It embraced both the professional and personal experiences of this role, welcoming the values and beliefs that were the result of these experiences (Creswell, 2009).

In accepting this influence and the subjectivity that my nursing experience brings, the next step was to understand the relevance of it and the implications for the research. This raised a further concept central to interpretivism and qualitative research more broadly: reflexivity. Reflexivity is giving critical thought to the research process and practice, acknowledging the role of the researcher and its impact (O'Reilly, 2009).

In adopting a reflexive stance, my position as the researcher was an obvious and significant challenge. It was crucial to acknowledge the predetermined values, beliefs, perceptions that my previous nursing experience in EDs brought to the process and my simultaneous 'insider/outsider' position (which will be explored later). It was important to accept that these personal experiences, practices and products would impact how I constructed the field (Mason, 2002). It was important to acknowledge and accept that these interests and prejudices would influence the accounts and conclusions drawn (Gherardi, 1995).

Ethnography is an 'embodied experience', shaped by the researcher's implicit choices in relation to what should be observed, what should be left out and what should be treated as powerful (Law and Singleton, 2013, p.495). The rationale behind these choices is dictated by personal, political and theoretical agendas (Law and Singleton, 2013). These agendas and past experiences influenced what I observed and what I did not observe in the field. My perception of what was ordinary compared to a researcher who had not worked in an ED or a researcher without a nursing background was very different. I was aware of this from the outset and aware that, as a result, much of the work undertaken by the staff could be missed. This awareness prior to starting the data collection was important, as it allowed me to prepare to some degree for this

consideration. This perspective is understood as the 'sociological imagination' in the work of Mills (1959). It calls upon the researcher to step outside of usual routines and practices and ensure a degree of self-awareness. Part of this process involved preparing written key phrases to take into the field as a visible reminder, prompting my thinking and encouraging me to unpack my initial observations at a deeper level. For example, the most powerful phrase was: 'where is the evidence for my thinking?' I found this and other prompts especially useful in attempting to see past initial assumptions and explain my thought processes. Mason (2002, p.77) argues that providing the 'fullest possible justification' for any decisions during the research process is crucial. This process of questioning my own assumptions ensured transparency in the thought processes undertaken. I recognised that my previous experiences and research interests were driving what I found to be relevant and what was subconsciously omitted from my writing (Mason, 2002).

Of further relevance is how I, the researcher, was perceived by those I was studying. The 'insider/outsider' discussion often refers to two separate positions, both of which have research implications. Those on the inside are considered members (in some way) of the organisation and community under study (Humphrey, 2012). In this instance, individuals will likely be au fait with the 'micro-politics' but are also likely to take for granted much of what they observe around

them (Thomson and Gunter, 2011). In comparison, outsiders are not directly connected. They are likely to be new to the setting and community and, as a consequence, may be able to offer a 'fresh set of eyes' for the analysis (Thomson and Gunter, 2011).

Arguably, my status as an ED nurse meant that I was an insider. However, more-recent distance from clinical practice, together with my additional identity as a PhD student and researcher, brought a degree of complexity to the distinction. Fortunately, in recent years, the insider/outsider dichotomy has been challenged, substituted by a fluid perspective that shifts between the two (Thomson and Gunter, 2011). Dwyer and Buckle (2009) suggest that the relationship is not dichotomous but instead can be represented by positions on a continuum, offering the researcher the opportunity to occupy both roles. Such theories offer a more appropriate insight into where I might have sat. I was juggling at least two identities: a student and a nurse, and I was perceived differently in relation to these depending on the audience. Using a 'fluid' approach to the insider/outsider argument (Thomson and Gunter, 2011) is helpful to describe this position. My gender was also relevant to the research process and how the nurses perceived me.

Whatever the label attached to my status as a researcher, it is perhaps more important to focus on the implications of this status for

the research. The influence was far-reaching and impacted upon all the stages, beginning with the initial motivations and research design through to the more-obvious stages, such as the data collection and analysis.

3.5 Ethnography

In ethnographic traditions, there is a unique emphasis/focus on studying social groups and their cultures through direct observation (Atkinson, 2001). Contemporary ethnography has been defined as 'both first-hand empirical investigation and the theoretical and comparative interpretation of social organisation and culture' (Hammersley and Atkinson, 2007, p.11). In focusing directly on the participants' usual context and surroundings, rather than one created by the study, the researcher works to understand the beliefs and behaviours through tangible observation (Hammersley, 2002). By immersing themselves in the field (such as the ED setting in this study), the researcher is able to have direct access to the nature and behaviour of the specific social group (Hammersley, 2002) in their 'natural' setting (Mason, 2002).

The following section will consider the aspects of ethnography that were of particular relevance to this research. These strengths centre on the ability of ethnography to study discrete behaviours, which was fundamental to this work. Arguably, ethnography was also the only

method that could offer insights into some of the instinctive and perhaps less obvious nuances of the ED culture, such as relationships and associated interactions (McNaughton Nicholls et al, 2014). These working elements are less easily collected, as such, their investigation is often only possible through direct observation (McNaughton Nicholls et al, 2014). The ethnographic observation of organisational practices (such as those in the ED) allows the researcher to unpack the shared belonging of a community through these emotional and discrete behaviours, in addition to other more-hands-on practices (Strati, 2012). Aesthetic knowledge is the 'form of organisational knowledge which is personal and collectively socially constructed at once' (Strati, 2012, p.4), for example the 'elementary relationships that underpin social interactions in societies' (Strati, 2016, p.257). It was, in particular, the opportunity to observe these discrete relationships and interactions that made the ethnographic methodology a valuable approach for this study.

The ED environment involves complicated interplays between a vast range of parties; it includes complex interactions and processes (McNaughton Nicholls et al, 2014, p.245). These include interactions between a wide variety of healthcare professionals, including nurses (of various ranks and experience), doctors (also diverse) and other staff (including care assistants and those not permanently based within the ED), together with patients and their families and friends.

This diverse population is brought together in the ED through often highly emotional, stressful and traumatic events. This combination of individuals and challenging circumstances also lends itself strongly to ethnographic observation (McNaughton Nicholls et al, 2014).

The study of discrete behaviour is relevant to the study of emotional labour. The internal management/suppression of emotion is subtle, hidden and often complex in its presentation. The doing of emotional labour by professionals may be, in many cases, so entwined in daily healthcare practice that staff have no conscious awareness that they are indeed doing it – it may be classed as a subconscious action (McNaughton Nicholls et al, 2014). Direct observation in the field of the ED offered a means of witnessing the behaviour of healthcare staff directly and therefore an opportunity to potentially see practices of emotional labour first-hand (McNaughton Nicholls et al, 2014). Using this data to guide and prompt the staff gave them the cues from which they could expand and describe their interpretations and perceptions of events. This will be discussed further later in this chapter.

Ethnographic methods also provided the opportunity to explore and understand the social norms and influencers driving these behaviours (McNaughton Nicholls et al, 2014). Through ethnography, I was able to unpack these feeling rules (Hochschild, 1989) and, as such, the

way in which healthcare employees' work may be controlled and even dictated by a variety of complex audiences. These may include expectations from professional or regulatory bodies, the individual organisation, the staff themselves, patients and undoubtedly many others, all of which are likely to be challenging for staff to describe, both in their choice of words and emotively. Crucially, I wanted to actualise the lived experiences of these influences in the field, witnessing the way in which these elements guided the ED nurses' feeling rules. Observation allowed for these salient and innermost themes to come to the forefront on immersion into the ED. The aim was to explore, understand and interpret the emergency nurses' experiences, beliefs and perceptions (Delamont, 2007), addressing the likely disparity between individuals' accounts of their experience and the direct observation of this in practice. In light of these considerations, the following section of this report will describe the process of undertaking the ethnography 'in the field'.

3.5.1 In the Field

Ethnographic research is usually carried out within one or two sites, with a focus on the quality of data, rather than quantity through multiple sites (Hammersley and Atkinson, 2007). In focusing on the various features offered by EDs (largely in relation to size and the services offered), I decided to focus on two EDs. The EDs chosen

were different (one in a teaching hospital and the other in a district general hospital). The specific details of each will be outlined below.

3.5.2 Site-Specific Details and Demographics

Although the sites contrasted in terms of the wider hospital setting and the scale of the ED, the intention was not to directly compare the two. Instead, to offer a diversity of settings and a diversity of staff experiences. The use of two sites was also considered feasible within the scope of the study whilst not compromising the in-depth exploration of each. The sections below provide details on the size of each service, to set the context for data collection.

3.5.2.1 Research Site 1

Site name	District ED
Number of patients a year (2017/2018)	100,000
Number of patients in 24 hours (average)	300
Four-hour target average (2017/2018)	89%
Number of nurses employed	70
Number of nurses on a single shift	14
Number of consultants employed	12

Table 1: Site Details (District ED)

3.5.2.2 Research Site 2

Site name	Teaching ED
Number of patients a year (2017/2018)	180,000
Number of patients in 24 hours (average)	500
Four-hour target average (2017/2018)	78%
Number of nurses employed	145
Number of nurses on a single shift	23
Number of consultants employed	25

Table 2: Site Details (Teaching ED)

3.5.3 Ethical Approval

The process of gaining ethical approval and access was completed through the University of Nottingham Business School. In addition, the Health Research Authority gave its approval for the study to take place. The Research and Development Department at each site was also contacted directly, and authorisation for access was granted by each. As a member of staff at the larger hospital trust (Teaching ED), I did not require any specific checks prior to entering the hospital. I did, however, need a 'research passport' for the other Trust (District ED). The participants were informed that they could leave the study at any time (via a poster, explained later in this section, and through my verbal explanation). All identifiable data was stored securely in accordance with guidance from the University of Nottingham.

Prior to the start of the formal observations, I met with senior staff and gatekeepers at both sites to introduce myself and explain the

details of my study; this also helped with recruitment through a snowballing effect. As part of this initial introduction, I was also shown around both departments to become orientated. As part of the ethics application process, the relevant documentation was completed and can be viewed in the appendices:

Appendix	**Document**
Appendix 1	Consent Form
Appendix 2	Participant Information Sheet
Appendix 3	Interview Schedule (Topic Guide)
Appendix 4	Poster Advertising Study
Appendix 5	Ethics Application Certificate

Table 3: Ethics Documentation

3.5.4 Observation

The bulk of the observation was completed in the EDs of the hospitals; the process will be detailed below. I also observed outside of the EDs. These external observations focused on a variety of organisational events, meetings and discussions, all of which were linked to staff well-being and/or staff support. Examples included induction days for new student nurses and other staff, preceptorship support days for newly qualified staff, and senior nurse leader

meetings. The aim of these observations was to explore the organisational dynamics and perspectives on emotional labour and to define the context and background for the observation in the ED that followed.

The most significant phase of observation was completed within the ED, comprising 200 hours of observation in total. As noted, the EDs were split into different areas, depending on the severity of illness or injury. All of these areas were observed to witness the variety of work completed by staff. The formal observation was restricted to the adult ED, although paediatric staff shared their experiences during the informal interviews. This included the minor injuries areas, assessment areas, resuscitation area and the 'majors' area of the ED (a space in which those patients who were not appropriate for minor injuries or resuscitation care were treated). All areas within the ED were observed from close-up or more-distant vantage points when appropriate, in order not to interfere with the flow of care delivery (Kusenbach, 2003). It is important to note that the observation was completed both during the day and at night (in a 24-hour timeframe). The table below offers specific information regarding the periods of observation.

Site	Area of ED	Total time spent	Sessions
District	Walking through	30 minutes per area	3
District	Reception/waiting area	15 hours	3.5
District	Triage and minors	21 hours	4
District	Majors	17 hours	4
District	Resuscitation	22 hours	5
District	Staff room	3 hours	2
Teaching	Walking through	30 minutes each area	3
Teaching	Reception/waiting area	8 hours	2
Teaching	Initial assessment	8 hours	3
Teaching	Minors	7 hours	2
Teaching	Majors	18 hours	3
Teaching	Resuscitation	23 hours	4
Teaching	Staff room	5 hours	3

Table 4: Periods of Observation

The observation started by exploring the setting and 'setting the scene' of each individual area. This observation focused on the work

of the ED staff, in particular the ED nurses. This included the physical visibility and invisibility of the staff at work, who was where and when, for how long, how they moved around the space, specific environmental features, noise and the general atmosphere. In addition, information on material items (equipment described by Bruni (2005) as anything 'non-human') was noted to show the items' relations to the setting and consequently the work completed.

Following this period of scene-setting, the observation then moved on to focus on the physical tasks and non-physical work undertaken by the staff. By nature, this is challenging to describe, but the following description will aim to offer a degree of insight. The observation encompassed physical work (e.g. physical nursing interventions), mental work (e.g. cognitive workload planning and the prioritisation of workloads) and emotional work. I observed when emotions were suppressed during this work – there were often clear examples when an episode was observed in full. The nurse would present themselves in a certain way to colleagues, patients and relatives and then when the opportunity presented itself, their true emotion would be released (through language, body language and facial expressions). I documented the stages of this process. I also looked at how these tasks and responsibilities were managed. I directly examined the work of the different staff members. This included the observation of staff relationships (e.g. who communicates with whom, for how long,

the interaction style, and the nature and style of their conversations and discussions) and the nature of their behaviour (e.g. physical body language, facial expressions, posture and touch). Attention was given to the norms, irregularities and consistencies within these behaviours and what seemed to govern them. Other considerations included notions of responsibility (e.g. the nature of the work tasked to individuals and their behaviour in response) and the operationalisation of power (e.g. who was delegating work and how). Also relevant were gender, professional and organisational influences, all of which were likely to guide the feeling rules. As suggested by Gherardi (2015, pp.128-129), I focused on the 'connections among aspects of our surrounding circumstances', known as 'aesthetic knowledge'. All of the note-taking was informed by the research questions and aim of the study; as a consequence, it was structured around the theme of emotional labour, as well as associated issues and ways of seeing it (Mason, 2002). I made reflections during and after the observations. I also made an explicit effort to refer back to the specifics of emotional labour theory when individual periods of observation had finished.

It became apparent in the early stages of data collection, particularly in the ED settings, that some staff were intrigued by me and even apprehensive in some instances. Bruni, Gherardi and Poggio (2004) report this status reversal (in which the observed observe the

observer) as common practice, where participants try to decide whether they can trust the researcher. This level of curiosity, apprehension and general awareness of my presence seemed to be heavily influenced by how busy the area for observation was at the time. In quieter areas of the ED, staff asked for clarity about my background and the aims of the study, whilst in busier times and places, such questions were not forthcoming.

Although I am an experienced ED nurse, before entering the field, I decided to limit any participation. I made this decision, in part, because of my nursing background and an already present 'blurring' of the insider and outsider roles. When staff were interested in my presence, we discussed this and I let them guide the conversation (Atkinson et al, 2001). I found that by simply describing the nature of my research to staff, they were forthcoming with initial opinions and thoughts on the study.

Other forms of informal dialogue between the participants and me provided opportunities to clarify observations immediately after the events occurred. I encouraged staff to discuss their emotion-filled interactions, which in some respects lent itself to the fast-paced nature of the work and the changeability of the setting. This ensured that the moment was not missed. In many instances, however, it was this intensity of workload that prevented this opportunity, as staff

rushed on to their next task with little or no opportunity for clarification in-between.

From a practical perspective, the recording of the observations was restricted to written notes. The use of any recording equipment (visual or auditory) was prohibited due to patient confidentiality issues. My note-taking focused on key words and phrases (Emerson et al, 2001). I quickly realised that due to the extreme diversity and changeability of the environment, particularly within the ED, the approach of no note-taking in the field would result in many key details being lost. At times, it was difficult to keep up with the speed of jotting that was required. In response, jotted notes were turned into more-detailed and in-depth accounts later (Emerson et al, 2001). I used these notes from both phases of observation to inform and construct my discussions with the nurses. The notes also influenced the topic guide, which guided the formal interviews that followed.

3.4.5 Interviews

Kusenbach (2003, p.459) argues that it is difficult to get to 'concurrent experiences and interpretations' through observation alone. As a result, I also conducted interviews. My aim was to discuss the staff members' experiences, perceptions, assumptions, beliefs and values in relation to their emotional labour (Bryman, 2008). The

data gained from the observations and interviews was mutually enriching (Hammersley and Atkinson, 2007).

This approach also addressed some of the difficulties associated with studying subconscious behaviour and experiences of emotion. Although during the periods of observation there were relatively clear examples of emotion management by staff, I realised that much of this behaviour was likely to be subtle. The opportunity to observe practice first-hand, and then disentangle interpretations during the interviews, resulted in better-quality data. This included following up particular observations and clarifying my interpretations. The respondents' accounts helped me to do this. Using these perceptions of events was crucial in understanding the human experience of emotional labour (Mason, 2002).

Furthermore, the privacy offered by the interview setting was appropriate to the emotive and intimate topic of emotional labour. The respondents were able to offer clarification and to raise questions without the fear or judgement of others (Lewis and McNaughton Nicholls, 2014). Experiences of socially unacceptable behaviour that did not align with professional expectations were more likely to be shared in these private, one-to-one settings (Lewis and McNaughton Nicholls, 2014).

The professional status of healthcare staff and associated professional expectations significantly influenced both the observed behaviour and the discussions. A registered nurse, for example, is likely to feel apprehensive in revealing experiences that are perceived to contradict professional regulations, codes or rules of conduct. To reiterate, the NMC Code of Practice, adhered to by all registered nurses and midwives, stipulates that professionals are expected to maintain high standards and reputations 24/7, with an emphasis on maintaining integrity (NMC, 2008). I undertook interviews with the aim of easing conversation and getting beyond the 'official' and socially acceptable story.

3.4.5.1 Practical Considerations: Undertaking Interviews

In total, 35 formal interviews were completed across two hospital sites (in addition to the informal interviews and conversations). The respondents were categorised into two groups of participants. I took a different approach to interviewing each group. The first were staff who worked outside of the ED. These staff held roles related to staff well-being. The second were those staff working in the ED directly (including staff who had left their roles). The interviews took place in a variety of locations (in line with the respondent's request), including offices and other private spaces. One of the interviews was conducted over the phone and notes were taken. The majority of the interviews were also recorded via Dictaphone after gaining formal written

consent. The only exceptions to this were when the participant requested the interview not be recorded, the telephone interview noted above and when on one occasion the sound quality was too poor. In these instances, comprehensive notes were taken.

Following each interview, I took time to reflect on what had been discussed. As part of this process, I also made a short set of notes with standout points. These notes were uploaded to the data analysis software (details of which will be outlined later in this report). The tables below show the details of the interviews at both sites, including job roles, pseudonyms and the lengths of the interviews.

Pseudonym	**Job Role**	**Interview Length**
Bev	ED nurse	26 minutes
Carly and Lily	ED nurse and student nurse	26 minutes
Mark	Matron	39 minutes
Veronica	Chaplain	40 minutes
Ann	Chaplain	33 minutes
Shelly	Nurse divisional director	28 minutes

Bev and Yvonne	Matrons	28 minutes
Tim	ED management	35 minutes
Sally	ED nurse	25 minutes
Cathy	ED sister	40 minutes
Jill	ED sister	20 minutes
Mike	ED nurse	20 minutes

Table 5: Participant Information – District ED

Pseudonym	**Job Role**	**Interview Length**
Tom	Education team – ED	34 minutes
Michelle	Preceptorship team	37 minutes
Becky	ED nurse	36 minutes
Sarah and Jane	Well-being team	38 minutes
Sara	ED nurse	42 minutes
Suzie	ED nurse	30 minutes

Adam	ED nurse	50 minutes
Evie	ED sister	30 minutes
Bill	Project improvement	34 minutes
Liz	Nursing development	40 minutes
Lucy	ED nurse	31 minutes
Jane	ED sister	37 minutes
Karen and Jill	Occupational health managers	48 minutes
Lara	Occupational health nurse	46 minutes
Sue	Nurse divisional director	45 minutes
Layla	Nursing board team	38 minutes
Alison	ED sister	31 minutes
Bill	Chaplain	40 minutes
Clara	Advanced nurse practitioner	30 minutes

Table 6: Participant Information – Teaching ED

The aim of this first set of interviews was to understand the broader organisational context of emotion work and perceptions of it. I attempted to define the frame of reference against which experiences of emotional labour within the ED were claimed to be set. As such, these interviews focused specifically on the staff groups involved in and linked to nurse well-being and the support services at each trust. This included senior nursing managers; occupational health staff; staff involved in nursing education, training, support and practice development; individuals working within staff health and well-being; and chaplains involved in staff counselling. Unexpectedly, a minority of these staff had direct experience of working in the ED. In response, the interview was adapted to ensure that the discussion of these personal experiences could also be included. In total, 17 staff from the various specialties listed were interviewed.

These staff were recruited easily via a snowballing technique (Robinson, 2014). This was particularly relevant for nursing leaders. Meetings with key stakeholders resulted in them disseminating my project to other leaders, identifying other possible respondents (Ritchie et al, 2014) and essentially acting as gatekeepers. This led to seven senior informants volunteering for interview.

All of these interviews were completed in the hospital setting, usually in an individual's private office. The interview lengths varied in time

(see Tables 5 and 6 above) but were all under an hour. These interviews followed a semi-structured approach with a predefined topic guide (see Appendix 3). This ensured the flexibility of conversation whilst helping to ensure that key points were covered and that the interview stayed on topic (Arthur et al, 2014). The questions focused on asking the individuals to describe their direct and in-direct experiences of supporting nurses with their work, particularly ED nurses. The emphasis was on the exploration of how they had found emotions to be implicated within this work and the relevance of their own emotions within the support they delivered. The questioning aimed to unpack the perceptions surrounding the knowledge, understanding and recognition of emotional labour in the ED and how, from an organisational perspective, emotional labour was or was not positioned, observed and recognised, as well as to what degree. The conversation then progressed to discussing these experiences in direct relation to emotional challenges and the management of these challenges. The relevance and consideration of gender were also raised in relation to emotional labour.

Although these interviews were arranged with the intention of a one-to-one discussion, in four of the cases, two-to-one interviews were completed at the participant's request. I interviewed two occupational nurses at the same time, two health and well-being officers, an S/N with her nursing student, and two matrons. This proved an

unexpected opportunity for a degree of collegial discussion, which appeared to stimulate new ideas (Lewis and McNaughton Nicholls, 2014).

The second group of staff interviewed were ED staff. In this instance, the study was advertised through email, through paper and electronic posters and in staff briefing sessions within the ED. The poster informed potential participants about the observation (and gave them the opportunity to withdraw from it). The poster also invited staff to be interviewed, consistent with a purposive approach to participant recruitment (Mason, 2002). This targeted those nursing staff or other healthcare professionals who held key characteristics, namely relevant healthcare experience or expertise, which would enable the exploration and understanding of the central research themes (Ritchie et al, 2014). I also targeted nurses (at various levels of seniority) who had front-line clinical experience of working within the ED.

Junior staff proved challenging and difficult to recruit in the first instance. This might have been for a variety of reasons. As described previously, staff were apprehensive about my presence during certain periods of observation, and this might have impacted their willingness to be interviewed. These difficulties were especially relevant at the District ED (where I had not worked previously and, as a consequence, did not know any of the staff). This improved with time

as the staff fed back to their colleagues their experience of completing the interview. At Teaching ED (where I had worked previously), recruitment was helped when senior staff members who had worked with me previously spoke about my study. This appeared to give junior staff the conformation they needed to feel able to speak with me. Another difficulty in recruitment was working around the nurses' clinical duties. Due to the pressures facing both departments, finding time in clinical hours was particularly challenging, even with the support of senior nursing staff. It took some time to work out how, logistically, the interviews could be completed. I overcame this challenge in part by changing my approach to planning the interviews, particularly with junior staff. It was not possible to plan in advance a specific time for an interview due to the unpredictability of ED workloads. Instead, I arrived at the start of a nurse's shift and waited for the nurse to become available. In some instances, there was more than one willing participant on the same shift, which ensured that this approach was particularly effective.

Having overcome these practicalities, the interviews were conducted in a variety of quiet settings, both inside and outside of the departments. I encouraged the staff to state where they would prefer the interview to take place (Yeo et al, 2014). This was for practical reasons, in case the time in clinical hours could not be found, but also with the aim of encouraging a relaxed style and aiming to support the

flow of discussion. This seemed especially relevant when considering the nature of the topics to be discussed. As staff were sharing experiences that did not align with professional expectations, they were likely to benefit from an interview location outside of the department or even the hospital. In two instances, the participants asked me not to record the interview but to instead take notes.

The interviews included different grades of nurse, from junior staff through to advanced nurse practitioners (ANPs). In total, 18 staff from the EDs were interviewed. I started the interview by introducing myself and giving a brief history of my nursing and research background. The questioning focused on the characteristics that staff use to describe an ED nurse and the characteristics that ensure that a nurse is 'successful' in this environment (see Appendix 3). These interviews offered the room to explore staff members' perceptions of the emotional challenges of their roles. Furthermore, it provided an opportunity to unpack the definitions assigned to highly emotional and less emotional experiences and how both are managed. I questioned staff on the perceived relevance of gender in their work and their experiences of emotional labour.

All interview scenarios involve complex power dynamics, which constantly change and evolve (Anyan, 2013). As argued by Anyan (2013, p.2), the interplay of power can be influenced and affected by a variety of factors, including the 'socioeconomic status, educational

or professional background, and gender or ethnic identity' of both the researcher and the participant. As described above, the junior nurses did not want to come forward; here, I was likely seen as more powerful. This was likely to be a result of apprehension about the purpose of my study.

The power dynamics during the interviews were multifaceted. Here, I felt that much of the power was taken by the participant (Anyan, 2013). Although to a certain degree I determined the topics we discussed, there was an overwhelming sense that the participants were the primary source of data in this setting. They were in control of how much or how little they offered (Anyan, 2013), and their willingness to share this experience was paramount.

It is impossible to speculate exactly how the respondents felt in relation to the power dynamics; however, it is likely that, at some point during the interaction, they felt a reduced sense of power (Anyan, 2013). To counteract this imbalance, it was important that I worked to establish a sense of rapport, ensured an empathetic relationship and tried to build a sense of mutual trust in the interview (Karnieli-Miller et al, 2009, p.5). This was particularly relevant, as I was asking the respondents to share intimate and private experiences (Karnieli-Miller et al, 2009) in relation to their workplace challenges, particularly the emotional labour involved. The relationships we built

during the interviews were influenced by my previous nursing experience. Many of the ED nurses spoke freely and frankly about moving and emotive experiences – this required a degree of trust, as Karnieli-Miller et al (2009) discuss, and the equal distribution of power. Arguably, this was eased, for both parties, because of my nurse role. This brought a sense of identification to the interaction, and there was a feeling of assumed understanding, suggested through comments such as 'you know what I mean?' by the participants. Much of the body language was relaxed, and diverse feelings were shared by the junior nurses – including both laughter and tears. This openness reaffirmed a degree of ease with conversation, which might have been the result of my perceived insider status.

Although this aided the process for both the interview participants and me, a sense of assumed understanding should be taken with caution. Thomson and Gunter (2011) argue that this can not only result in both parties making assumptions about the knowledge being shared but also, and as a consequence, the researcher can overlook key data. In response, in each interview, I used phrases from the respondent (which suggested I understood their point) as an 'alarm bell' for further questioning. This approach works on the understanding that the assumptions about knowledge will be given through especially clear signals, when in reality this will not always be

the case. Again, reflexivity proved a useful tool here, and I took time after the interviews to note down my reflections.

Seeking feedback on the field notes from my supervisory team also assisted the process of reflexivity. Through others reading my data (particularly individuals who were not healthcare professionals), I was able to gauge the depth and nature of my note-taking. This helped to ensure that I was offering a degree of justification for the judgements I was making, prior to the formal data analysis stage (Mason, 2002).

3.6 Metaphors

Reflecting on the first round of interviews and initial periods of observation, I noticed the recurrent use of specific metaphors. I decided to consciously use these in the interviews that followed. Metaphors 'form our conceptual system and thus play a central role in defining our everyday realities' (Tietze, Cohen and Musson, 2003, p.37). They present a route to understanding how we 'conceptualise our reality' and how we make meaning (Kuntz and Presnall, 2012, p.738). As a consequence, they can be a strength in helping individuals to communicate the concealed through the translation of a well-known phrase (Gowler and Legge, 1989). Due to the familiarity and frequency of using metaphors, they can be helpful in studying organisational life (El-Sawad, 2005). My field notes from the previous observations from both sites were subsequently re-read and the

metaphorical terms used by the ED staff were drawn out, including 'firefighting', 'warzone', 'dungeon' and 'bunker', amongst others (the full list is available in Appendix 3). The resonance of the metaphorical phrases helped to stimulate conversation in the interviews. To aid the process further, I also showed visual pictures of the metaphors to the participants (see Appendix 6). This combined approach prompted interesting and lively discussion in the interviews, revealing insights inaccessible without these metaphorical triggers. The respondents were asked if they could relate to any of the terms; dependent on their responses, further questioning took place to unpack the understanding and interpretation of the metaphors and their experiences.

Other images (not associated with metaphors directly) were also used to stimulate conversation during the interviews (Appendix 7). These images were of three EDs and showed a different area within each: an ambulance bay, a majors area and a corridor. The similarity between the images was how busy each ED was – each picture showed a degree of overcrowding. This was illustrated through multiple ambulances outside the ED and the long queue of ambulance patients waiting to hand over their patients' care to the ED staff. The final image depicted an ED that had likely run out of cubicles, with patients waiting in close proximity on trollies. As in the case of the

metaphorical images, these images were also emotive for staff – they too prompted vivid discussion of the respondents' own experiences.

An example that illustrates the increased depth of data and understanding using this method can be seen with the 'ED swan', a phrase used by a nurse during a period of observation in the resuscitation area. The nurse used this phrase to describe the demanding work undertaken to appear calm under any circumstance (like a swan as seen above water), when underneath she is paddling furiously. She related these feelings of anxiety to the swan's webbed feet, under the water and out of sight, which she described as paddling 'frantically'. When this phrase was used with associated images in the interviews, all the respondents were affected, as expressed visually through their body language, facial expressions and dialogue. They gave knowing smiles or laughed, pointing at the picture and nodding enthusiastically; they used words and phrases such as 'exactly' and 'just like that'. The participants described at length their similar experiences, past and present, in a variety of different circumstances and through a variety of emotions. Subsequently, taking the transcripts of these interviews and using them together with the field notes and reflections offered a wealth of rich data for analysis. These and other quality considerations will be explored below.

3.7 Quality in Qualitative Research

Mason (2002) argues that the ideas behind notions of validity and reliability used in quantitative research can be used to think about quality judgements in qualitative research. However, the process of achieving or demonstrating quality in qualitative research is not through simple technical measurement (Mason, 2002). Instead, in qualitative research, quality is often associated with accountability and rigour (Mason, 2002). This can be demonstrated, in part, through the ability to show the 'methodological, theoretical and practical/pragmatic steps' (Mason, 2002, pp.40-41). This openness shows that meaningful, appropriate and accurate steps were taken (Mason, 2002).

Considering these points, using interviews as part of a combined approach with observation helped to give an understanding of the context behind the collected narratives (Mason, 1996). It offered a sense of orientation with the scene-setting of the first-hand observation. This gave me the opportunity to delve in and examine the respondents' recounted experiences in the interviews within a deeper contextual framework. The process of checking and reaffirming observations and interpretations with healthcare staff to ensure understanding also assisted with the quest for quality.

It is also important that data are given the correct status from the outset. For example, despite the obvious advantages described earlier of using interviews, it was crucial to maintain that they were not used as a substitution for observation of the actual behaviour of staff – an inaccurate status (Heritage, 1984, cited in Silverman, 1997). Instead, the interviews were treated as an interpreted social event (Hammersley and Atkinson, 2007). As the researcher, I could not 'get inside' the respondents' thoughts or heads, so I treated the interview data as the respondents' recounted experiences (Mason, 1996). These recounted experiences were socially constructed narratives (Silverman, 2010), not descriptions of the actual events (Mason, 1996). The accounts were the result of the 'complex negotiation' conducted within the interview discussion (Gherardi, 1995, p.15). The opportunity to examine the ED nurses' experiences of emotional labour was offered when the data showed recurring themes (Mason, 2002).

To ensure quality in qualitative research, we must also accept subjectivity, as discussed earlier, and its influence upon the subject formation of 'social, discursive and material processes' (Kuntz and Presnall, 2012, p.737). Gherardi (1995, p.23) argues that 'plausibility is the validity criterion for ethnographic research'. However, due to the subjectivity of the interpretation process, it is crucial that the researcher outlines all aspects of the methods involved and the data

collected (Gherardi, 1995). Achieving quality judgements in ethnographic research requires transparency with respect to these judgements, decisions and theorisation (Lewis et al, 2014). This stance is crucial in building any form of trustworthiness and consequently reliability in the findings (Lewis et al, 2014). The final section of this chapter will outline this need for transparency in relation to data analysis. The following section will begin with practical considerations.

3.10 Data Analysis

3.10.1 Transcription and Data Storage

The one-to-one semi-structured interviews were transcribed verbatim by a professional transcribing service used regularly (and formally approved) by the University of Nottingham. The transcriber was asked to use individual pseudonyms from an early stage to protect the anonymity of the participants. All other data were in electronic format and was in its raw form, written by me, including observational notes (around 30,000 words) and notes accompanying the interviews.

Emphasis was given to protecting respondents' anonymity and privacy. I told participants that the data would be anonymised, the details of any prominent or identifiable experiences would be

changed. Pseudonyms have been used throughout. Advice on how to store data securely was sought by the relevant ethics officer. All data was stored safely in line with the University of Nottingham's guidance – utilising a password protected laptop for the electronic data. Hard copies of consent forms have also been stored securely. At the end of the study, the electronic data will be deleted from the laptop and transferred to storage with all other hard-copy documentation for 7 years (as per guidance).

3.10.2 Process of Analysis

A reflexive, interpretive approach was taken to analyse the data, in line with the epistemological and ontological assumptions established for this study. The aim of this approach was to discover patterns within the data (Spencer et al, 2014) and to recognise and locate myself as the researcher within the generation of data (Mason, 2002). This was an appropriate choice, particularly when considering my insider/outsider position and the associated subjectivity discussed above (Kuntz and Presnall, 2012). The importance of deploying a systematic process was considered from the outset. This ensured that a detailed and logical account of the stages was provided, the aim of which, as also stated earlier, was to ensure the trustworthiness of the findings (Lewis et al, 2014).

The process of ethnographic data analysis is described by Hammersley and Atkinson (2007) as a non-distinct stage of the research, without a defined beginning. Instead, it is an ongoing, continuous and interactive progression that occurs during data collection and develops upon its completion (Hammersley and Atkinson, 2007). Analysis did indeed begin in the field, through informal note-taking and reflection (Hammersley and Atkinson, 2007). In fact, following a period of formal observation, time was purposively put aside to allow reflection and the processing of notes and thoughts.

Although the data and notes were read and re-read during periods within the field, this in-depth reading also occurred following the formal completion of the data collection period. This occurred once all data sources had been transcribed and collated and so began a lengthy phase of familiarisation (Spencer et al, 2014). Arguably, a further significant milestone within the data analysis was to upload all the data, including the interview transcripts, accompanying interview notes and all observational field notes, to the NVivo 11 software (categorised only, at this stage, by the specific source of the data). This electronic approach to data management was taken, in the first instance, for practical reasons. The volume of raw data was vast, and NVivo offered a consistent and manageable method of bringing together all of the text (Mason, 2002). Another practical

consideration related to the confidentially and safe storage of the data. NVivo also offered this, keeping data together and in a secure place (Mason, 2002). Similarly, the software offered the opportunity, at a later date, to run searches through the data for key words, themes or sources in a comprehensive and instant manner (Hammersley and Atkinson, 2007). Although NVivo was used for the storage of data and as a tool during some early stages of the analysis, it is important to note that phases of analysis were also completed without the software. In these instances, analysis was aided with a hands-on approach, using hard copies to formulate and refine a visual framework of final themes, the details of which will be discussed later in this chapter.

As explained earlier, the interview data were collected from two groups of participants: staff working within the ED and staff working within the organisation more broadly (e.g. those involved in well-being services, training, education and occupational health). It was anticipated from the outset, that the well-being related staff would have significant experience of supporting, ED staff with their work. Although these participants brought diverse perspectives and experiences, few had direct experience of the ED specialism - their experiences of supporting ED staff specifically, were minimal. Instead, their work related to the broader organisational context of nursing staff, outside of any single speciality.

It became apparent during analysis that this interview data (from the well-being staff) was sitting separately to the interview data collated from the ED staff. Although the two datasets were related, there was a clear distinction between the emergent themes from each. After much consideration and discussion, I therefore decided to give less focus to the non-ED staff interview transcripts. This was done for two main reasons. The first related back to the original focus, aims and research questions of the study. These were largely directed towards the experiences of ED staff and consequently drew upon the themes prevalent in the data sought from this staff group. The experiences of the well-being staff were sought to set the context and were less fundamental to the overarching purpose of the study. I was aware that splitting the rich data included in the thesis, across two staff groups, was likely to detract from this original purpose. As a consequence, although there are intermittent references to this set of data, the substantial analysis, themes and discussion will not be included within the data chapters. This data largely relates to the supporting question:

How is emotional labour perceived from a broader organisational perspective?

The development of 'labels' or 'codes' (or, as they are known in NVivo 11, – 'nodes') utilised both non-cross-sectional and cross-sectional

approaches. In the first instance, formal coding began with a non-cross-sectional approach or, as described by Mason (2002), a contextual data analysis practice. A non-cross-sectional approach was taken, in part, to explore the distinctiveness of each source (Spencer et al, 2014). This analytical process of applying initial nodes helped to group together extracts that were describing similar and related excerpts (Spencer et al, 2014) to help to show commonalities. Each source of data (interview transcripts, accompanying notes and observational data) was taken individually, and an inductive approach allowed for the emergence of nodes. The initial nodes encompassed a mixture of descriptive, analytical and potentially theoretical recurrences. However, this was an iterative process, as suggested by Hammersley and Atkinson (2007), which constantly evolved as further reading (of the same data sources and initial nodes) took place. As confidence developed and further familiarisation occurred, the analytical and theoretical nodes were most prevalent.

A refined list of nodes and sub-nodes (examples provided below) was established from each individual source. This decision was based upon the workability of each node (Mason, 2002) and when it was felt that deep and thorough data saturation had been reached. A broader cross-sectional approach then allowed for the unveiling of common patterns across the entirety of the data (Spencer et al, 2014). This phase began the process of reducing and refining the nodes.

Naturally, there was a degree of overlap, where two or more nodes explained the same phenomenon or observation. On the contrary, there were also instances in which a larger node needed refinement; here, further nodes were created within it, detailing, specifying and advancing the content. It was important at this stage to see past individual sources of data and instead see the dataset in its entirety.

Once a set of nodes had been honed for the remaining dataset (a process that was supported by the supervisory team), the deployment of diagrams, charts and visual representations of the data was undertaken. From a personal perspective, this stage of the analysis proved to be especially welcome and helpful. In particular, organising the data diagrammatically offered an opportunity to develop analytical thinking by visually showing the relationships and connections between the nodes (Mason, 2002). In addition, the diagrams (both electronic and in hard copy form) gave the opportunity to share the processes and outcomes of the analysis with others more concisely and more clearly (Mason, 2002). They showed the multidimensional nature of the dataset and proved an invaluable tool (Mason, 2002). In offering further transparency, the data extract examples also offered below show the 'progressive focusing' (Hammersley and Atkinson, 1995) used to take examples of specific initial data through coding to a higher level of conceptual abstraction. Two final and overarching concepts are offered.

First concept:

1) Moderators of ED Nurses' Emotional Labour: Time and Space

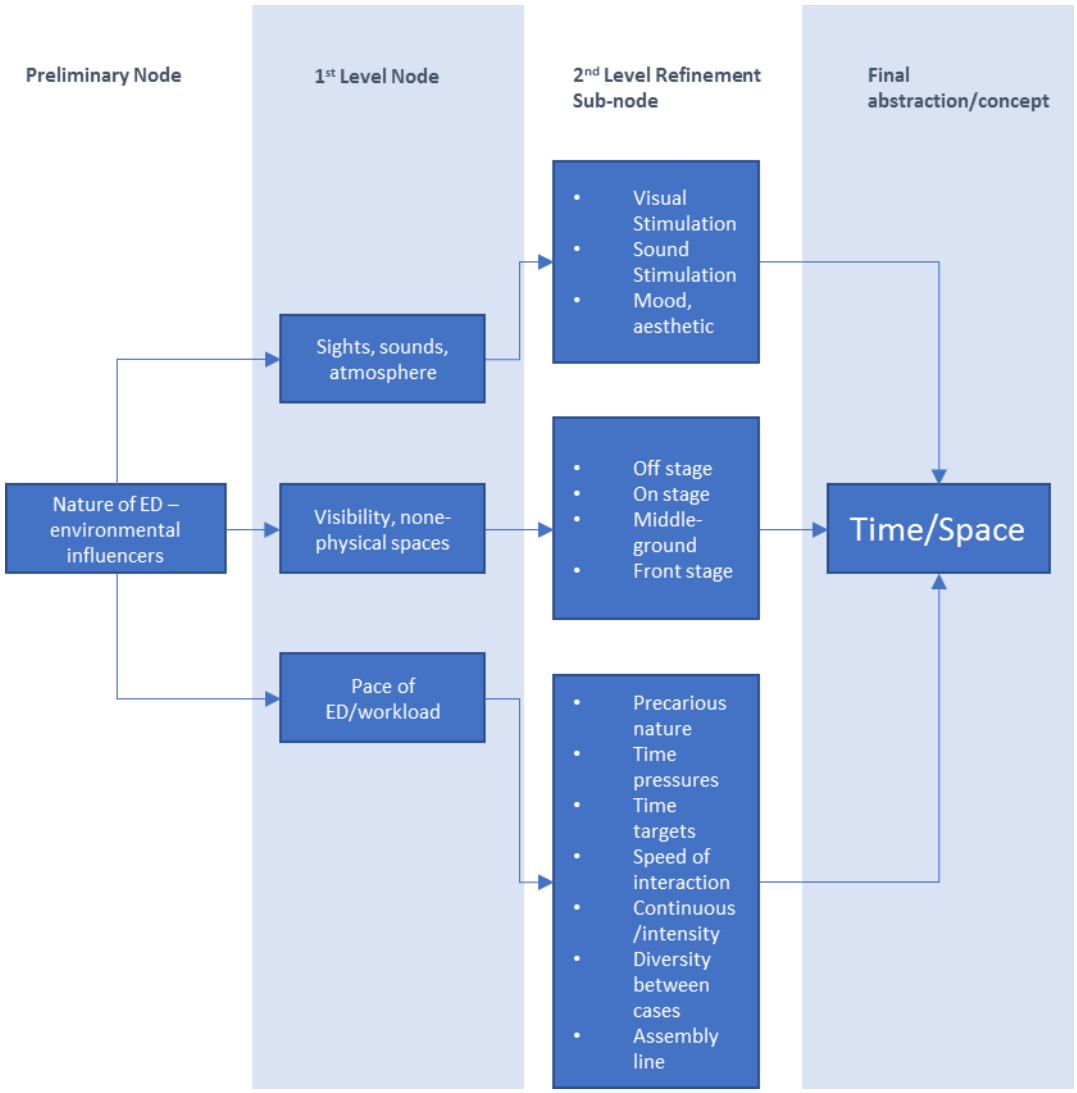


Figure 1: Refinement of Nodes: Moderators of ED Nurses' Emotional Labour

In line with the framework above, the data extract below offers an example of the coding process:

Respondent: Yeah, I'd say most of them are scenes that I've seen obviously in our department. Obviously, there's a lot in the adult departments, lots of overcrowding… obviously the ambulances queue down the corridor on a daily basis at certain times. So it's not unusual at all.

Interviewer: … does it make you feel anything in particular?

Respondent: Stress… Sometimes you just feel like you just don't know where to start. Sometimes in the environment where it's overcrowding like that, you can feel very enclosed and it can feel quite pressurised because… you're there as a person who can be seen like on stage and you can feel like everyone is sort of looking at you; it can feel quite daunting and it's quite pressurised… Everyone is there and their relatives are there; obviously they are just concerned about their relatives, but you feel like everybody is looking at you, so I think sometimes practitioners and doctors get to escape that because they are sometimes sitting in the back office. As a nurse, particularly as a co-ordinator, you're there. Or even just as a nurse, actually, when you're just nursing, you're there on show all the time and people are watching what you're doing all the time.

Interviewer: And what's that like?

Respondent: Stressful, stressful. It's quite noisy as well, a noisy environment, so you can just... I can describe it that you would torture somebody with the same sort of amount of pressure and noise and sort of four people at once asking you what, asking you something; it's stressful.

Working this extract through the framework above, the extract was initially coded as the *preliminary node*:

Nature of ED – environmental influences

The *first-level node* was then:

Visibility, non-physical spaces

The *second-level refinement sub-node* was:

Onstage

Then, the final *abstraction/concept* was:

Moderators of ED nurses' emotional labour: time and space

The process below offers a second example of this refinement:

Respondent: I've actually used that term: it's like a production line of patients. So, majors, you've got crews coming in constantly. I mean, it's quiet at the moment, but later in the day it will be constant, constant. You take handover from the crew, do the basics, move on to your next patient. Take handover, do the basics, move on to your next patient. You might not even see that patient again. Sometimes the crews come back in and say "what happened to so and so", and it's like I don't know because it's all about keeping the flow of the department going, in some people's opinion. Which you do have to do, but it means that you know there's a definite lack of care there, I would say… So you go home feeling very dissatisfied and it becomes quite monotonous and boring, actually. 'Cause you're not getting involved with your patient, you're just doing the basics.

The extract was initially coded as the *preliminary node*:

Nature of ED – environmental influences

The *first-level node* was then:

Pace of ED/workload

The *second-level refinement sub-node* was:

Assembly line

Then, the final *abstraction/concept* was:

Moderators of ED nurses' emotional labour: time and space

The second overarching concept was:

2) ED Nurses' Speciality-Specific Feeling Rules

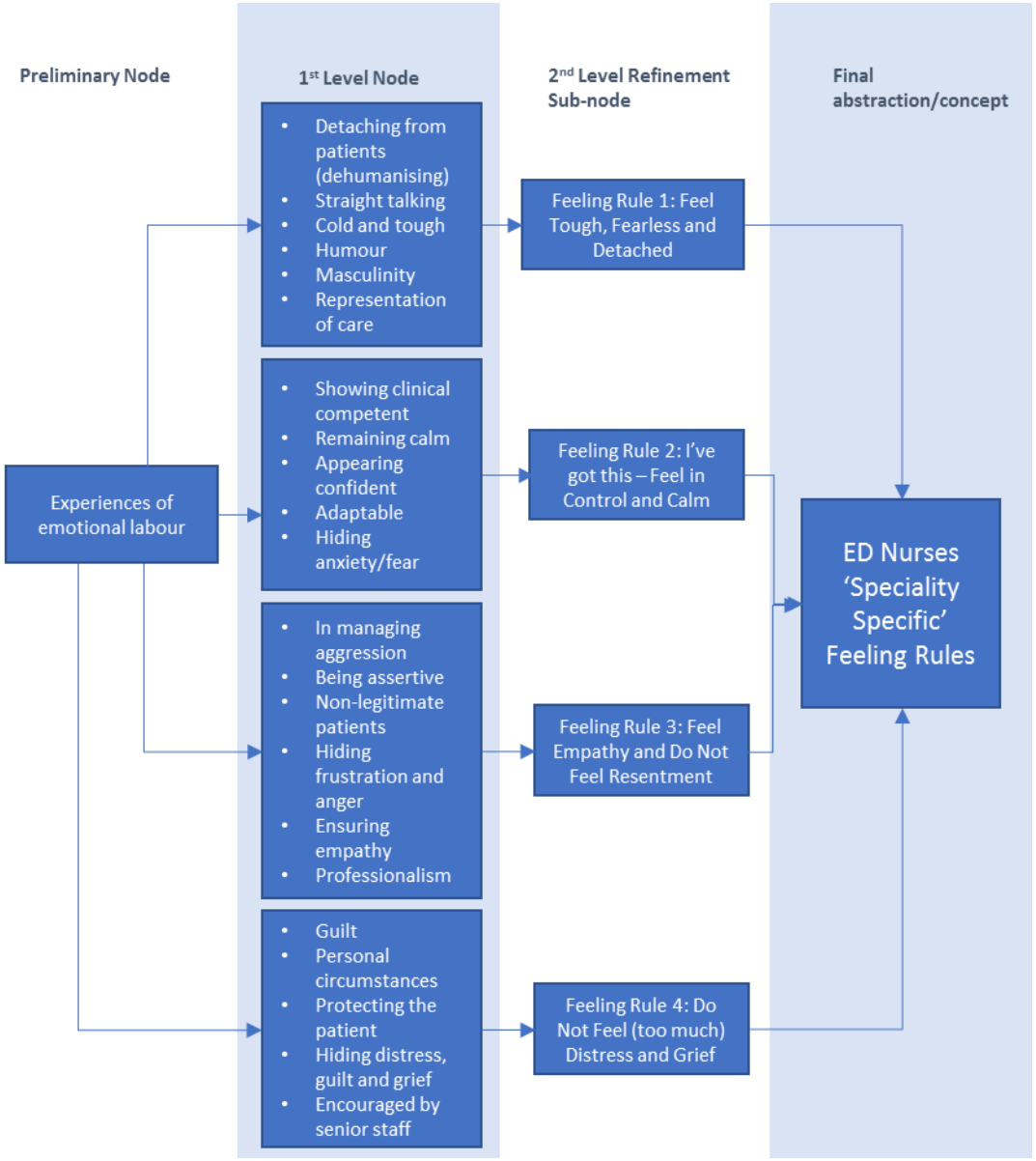


Figure 2: Refinement of Nodes: ED Nurses' Feeling Rules

The following data extracts help to show the process of node refinement for this concept:

Respondent: … even if you're really busy and really stressed, you've got to try your best not to show it in front of patients… I know it's difficult not to, but you've got to try not to.

Interviewer: Why do you feel that you've got to try not to?

Respondent: Because you're not providing the best patient care. I mean, they're there to be looked after. It's not their fault that you've necessarily got ten other people who all need things doing.

Interviewer: What's that like? Is that hard?

Respondent: Yeah. Stressful [laughs].

Interviewer: And do you always manage not to show the stress?

Respondent: I think it depends how irritating my patient is, to be honest. Am I allowed to say that?

Interviewer: Of course you are…

Respondent: People who don't necessarily need to be here with us. Patients can be very rude to staff unnecessarily. I mean, I understand that they can get frustrated because they're sitting there waiting and they want things doing now, but sometimes when people keep going on and on and on at you because they're waiting… you're just doing the best you can, it's difficult to keep a happy face on [laughs].

Working this extract through the framework above, the extract was initially coded as the *preliminary node*:

Experiences of emotional labour

The *first-level node* was then:

Non-legitimate patients

The *second-level refinement sub-node* was:

Feeling rule 3: feel empathy and do not feel resentment

Then, the final *abstraction/concept* was:

ED nurses' speciality-specific feeling rules

A second example shows a further process of node abstraction for this concept:

Interviewer: Why do you feel you have to be calm?

Respondent: Because the thing is, if you panic, then the patients will panic, and they don't need that.

Interviewer: So are they relying on you for that calm?

Respondent: Yeah. This reminds me of a time when I was in the lift once actually with a patient taking the patient up, and the lift's a bit dodgy. It creaks [laughs]. I was with quite a seriously ill patient and the lift actually just dropped a little bit... And I remember just literally dropping and then the patient's relative and the patient looked straight at me and I didn't really show much panic on my face even though I went "Oh, that's a bit, you know, scary"… But because I was quite calm about it, I think they remained calm because they literally just looked at me. I think as a nurse or a doctor or any healthcare professional, you're actually like a parent to everybody. You're everybody's mum. So on the surface you do have to look calm and you have to look like you're in control because they're vulnerable and you can't be panicking because it's just not going to solve anything, whereas underneath you might not have a clue what to do, but you have to come up with something and you might be crapping yourself basically like I was in the lift, but you just have to be like… It's just a mask again, isn't it?

Again, looking at this extract within the framework above, the extract was initially coded as the *preliminary node*:

Experiences of emotional labour

The *first-level node* was then:

Remaining calm

The *second-level refinement sub-node* was:

Feeling rule 2: feel in control and calm

Then, the final *abstraction/concept* was:

ED nurses' speciality-specific feeling rules

In light of the processes outline above, two empirical data chapters will follow. Each is assigned to one of the two overarching concepts: *moderators of ED nurses' emotional labour: time and space* and *ED nurses' speciality-specific feeling rules.* The data chapter plan described below offers an overview of these chapters and the practical details of how the data is displayed within them.

3.10.3 Data Chapter Plan

The empirical data presented in the data chapters that follow was taken from the formal one-to-one interviews, accompanying notes, field notes from observations, informal interviews and interactions, as described above. It includes extracts taken from both hospital sites. As is common with much ethnographic writing, the segregation between 'data' and writing regarding the description of the setting is less dichotomous. There is an overlap between the two. Additionally, the description of the setting as a social organisation in this study is of particular importance (Mason, 2002). This includes its physicality, as well as other multidimensional considerations that influence and control the work of staff and consequently their emotional labour. In response, the data chapters will adopt an inclusive approach towards the extracts used. This will include both descriptions of the context (usually in the form of observational field notes) and passages that are more easily defined as traditional data – for example, quotes taken directly from the formal one-to-one interviews. To ensure that the context of the individual extracts is not missed, some are lengthy. I have therefore used italics to provide a clearer focus and to assist with analytical emphasis.

Any bold in the extracts is used to highlight my voice as the interviewer. The exact source of the data (including the context, site and participant, where relevant) will also be highlighted following

each data extract. This will be done with the use of a pseudonym to protect participants' anonymity. It is also important to note that where metaphorical pictures were used (during the formal one-to-one interviews), this has also been stated to show how the conversation was initiated or prompted. Finally, when staff described a particular patient case in detail, key clinical details or elements might have been changed (but the essence of the experience remains the same). Again, this was done to protect participants' identities but also patients' anonymity in especially unique or distinctive circumstances of illness or injury.

As described in the previous chapter, the themes and subthemes were inductive, coming from the data directly, but they also speak to some of the existing literature. Subsequently, the process of developing these concepts and themes was iterative. It evolved into an ongoing conversation between the data and the literature. A synopsis of each chapter and the subsequent plan for the presentation of these chapters will be outlined below.

3.10.3.1 Moderators of ED Nurses' Emotional Labour: Time and Space

This first empirical chapter is descriptive and introduces the ED environment. This data will be presented as a walkthrough of the ED, introducing the different areas, layouts and environments that

collectively form the ED in its entirety, including 'offstage' and 'onstage' areas. The walkthrough will include descriptions of:

- The outside space, the waiting room and reception
- The triage room and minor injuries
- The initial assessment area and corridor
- The majors area
- The resuscitation area

The purpose of this chapter and the observational data is to set a landscape and point of reference for later discussion. It will show the conditions of the ED that influence the ED nurses' feeling rules and subsequent emotional labour (which will be explored in the second data chapter). The first walkthrough data chapter relates to answering the supporting research question:

Which environmental elements of the ED influence the emotional labour undertaken?

In this walkthrough, I will also introduce the environmental elements of 'time' and 'space'. These were found to be important and influential to the nurses' work and the emotional labour undertaken in the ED (particularly when integrated together) – they are moderators of this labour. Each space calls for different emotional labour in response to the varying audiences and means. The nature of this emotional

labour and the feeling rules driving it will be explored within the second data chapter.

3.10.3.2 ED Nurses' Speciality-Specific Feeling Rules

This second empirical chapter shows the speciality-specific feeling rules of the ED nurses and explores their emotional labour in detail. The development of these four feeling rules was inductive, coming directly from the data. This chapter will therefore help to answer the following research questions:

Why and how is emotional labour accomplished in the ED?

What are the speciality-specific feeling rules of the ED?

These feeling rules are a product of the ED environment (shown through the first data chapter). The ED nurses' feeling rules (driving their emotional labour) broadly relate to feeling tough, fearless and detached; feeling in control and calm; feeling empathy and not resentment; and feeling little distress and grief. I argue that those nurses who can work with and accept the feeling rules are seen as 'ED nurses'; those who cannot may be seen as nurses who 'just' work in the ED.

3.11 Conclusion

Concluding this methodology chapter, this research aimed to explore emotional labour theory in the ED. The empirical study was conducted at two different hospital trusts. The spoken experiences of nurses and healthcare staff, both inside and outside of the ED, were gathered to address the aims of this research.

By using an interpretivist paradigm for this study, I had the opportunity to try to understand the social worlds of both EDs (Blaikie, 2000). This included accessing staff members' perceptions of the emotional labour they do in their work and their lived experiences of this work (Mason, 2002). It also presented the opportunity for exploring the influences behind these experiences and behaviours (Hammersley, 2002).

Furthermore, the qualitative methodology and ethnographic approach to data collection enabled invaluable first-hand immersion (Atkinson et al, 2001) in these experiences through direct observation. This methodology and method allowed for and elucidated the nuances of the department and the changing dynamics within it. Complementary interviews, which are well suited to eliciting sensitive and personal subjects such as emotions (Lewis and McNaughton Nicholls, 2014), resulted in a vast, rich and varied dataset.

These data were analysed thematically and reflexively (with the assistance of computer software). This process of analysis found two key and overarching conceptual themes: *moderators of ED nurses' emotional labour: time and space* and *ED nurses' speciality-specific feeling rules.* These themes form the basis of the following two empirical data chapters.

During this research process and theme development, reflexivity and transparency were of critical importance (Gherardi, 1995). This is standard practice for achieving quality in qualitative research but was arguably even more relevant here due to my position as the researcher and my interesting insider/outsider role. This experience shaped and influenced my approach to this research and to the data I did and did not collect (Law and Singleton, 2013). This is reflected in the two empirical chapters that follow.

Chapter 4: Walking Through the ED: Time and Space as Moderators

This descriptive walkthrough chapter will set the scene. It will aim to show the conditions that yield the ED nurses' feeling rules and emotional labour – in particular, the importance of time and space as moderators of the nurses' work. These feeling rules and the subsequent emotional labour undertaken by the ED nurses will then be discussed within the second data chapter.

> Staff outside of the ED tell me about their perceptions regarding the reputation of the ED; there is a sense of surprise and disbelief at what they have seen in the ED as 'outsiders', which comes attached to their comments. They share these insights during the one-to-one interviews and with no prompting. It's 'hyper-acute – another level' (Student Nurse, District ED), 'not like anything else I've ever seen before' (Project Manager, Teaching ED) and 'I was gobsmacked when I first went to the ED – so full on' (Nursing Development Nurse, Teaching ED).

The ED is a distinctive clinical environment. Irrespective of size, EDs are most often split into different areas or spaces based on the clinical need of the patient (e.g. minor injuries, majors and resuscitation). There is therefore a group of individual environments and spaces that together form the ED. This collection of spaces and

the staff within them treat and manage a diverse range of illnesses, injuries and complaints. The work that is undertaken by ED staff to manage this diversity and variety is distinctive when compared to other healthcare settings. These spaces have competing priorities, different audiences and different environmental constraints. As I guide the reader through the ED, I will argue that elements of time and space are especially relevant as moderators of ED nurses' emotional labour.

4.1 The Outside Space, the Waiting Room and Reception

The data presented in this walkthrough section was taken from a two-week observation period and was drawn from both sites. It is important to note that although the layouts of the District and Teaching EDs differ and there are slight differences in the services offered (and therefore the layouts of the specific ED areas), the way in which a person (such as a patient) would move through the spaces is fundamentally similar.

The space outside of the ED indicates the tone that continues inside. Large red illuminated signs greet patients (and staff): 'EMERGENCY'. These are noticeably different to any other hospital signage. They are bold and eye-catching. Red quickly becomes a salient colour throughout the ED. There is a sense of urgency, priority and importance to the ED, even before you enter. There are multiple

ambulances queued outside; there are also multiple police cars. These sights are a regular and daily feature of the ED entrance and present a potentially intimidating window of what may be inside, highlighting the distinctiveness of the setting.

Through automatic doors, a large, locked bin is positioned in the entrance (Teaching ED) – it is apparent from the poster that visitors (including both patients and relatives) may use the bin to dispose of any weapons they are carrying before they enter the building. The presence of a security guard is also noteworthy. He is dressed in black, is a large male and wears a stab-proof vest. Both the amnesty bin and security guard add to the story of the ED space: such additions are not standard on hospital wards or clinics and are not a routine sight in healthcare facilities. They suggest an environment that has the potential to be volatile, aggressive and hostile – a space that may experience conflict. All of this proves to be particularly relevant to the social world of the ED, the feeling rules derived from this culture and the subsequent emotional labour undertaken here by staff. An NA explains on my first morning in the ED: 'we are soldiers and A&E is the battlefield' – he describes A&E as a 'warzone' (N/A Steve, District ED, Informal Interview). Many other staff used and related to this metaphorical phrase in describing the ED space. Examples were in relation to aggression and 'drunkenness' from

patients, but others used the term to describe the ED in relation to other considerations, such as seemingly relentless workloads:

> I've used it [the phrase 'warzone'] quite a few times, when you've got trolleys everywhere… full of patients and you don't know where to turn next. What to do for whom next, and I have said it's like being in a warzone because you can imagine it. That's what it would be like in a field hospital… what do I do next?... you know it's dangerous but you've just got to do the best you can do. And I've heard other people use that term as well. Just how it makes you feel but something kicks in and you just get on with it.
>
> (ED S/N Bev, District ED, Formal Interview)

At both sites, the waiting room spaces are busy, and the only significant difference between the two is the size of the space. Elements of physical space and the restrictions upon it quickly become meaningful for the nature of the ED nurses' emotional labour. Both waiting rooms are nearly full to capacity, with queues eight or ten deep to the reception desks. The waiting room space feels overloaded: a hustling and bustling space with a constant stream of people entering and leaving. A mix of patients and their families and friends occupy the seats and standing space. They are of mixed age, gender and ethnicity, and there is little conversation between them.

The noise heard in this space comes largely from the main ED, filtering through into the waiting room and offering a hint of the audible sound – a merge of voices, alarms and general movement. It is a distracting environment.

The receptionists sit behind glass, which covers the space between the desk and the ceiling, with a small strip removed at head height to aid communication. It again hints to the potentially unpredictable and menacing nature of the environment and puts a physical barrier between staff and patients, suggesting a need for protection. As the observation continues over the days and weeks, it is apparent that many physical and non-physical mechanisms (including emotional labour) are used to protect the staff in the ED in a bid for emotional 'survival'.

Informal conversations with reception staff suggest a general acceptance that managing violence and aggression is part of their role. One female receptionist in her 50s, who has worked at District ED for 15 years, tells me in a blasé manner: 'I've been called everything under the sun'. The reception is the gateway to the ED, and there is a sense that the receptionists are therefore gatekeepers to the ED. This can cause conflict. As a consequence, this entrance space is also likely to be volatile.

The ED nurses give me many examples of dealing with this volatility in terms of their multiple experiences of aggressive patients and situations. Managing direct aggression is an expected part of the nursing role in the ED. These experiences are shared freely during both informal conversations and the one-to-one interviews. The numerous descriptions and examples of combat and aggression management given by the ED staff at both sites are not routinely associated with the warm relationships and good-natured expectations of nursing and care delivery. This adds a distinctive layer to the nature of ED behaviour. These environmental influences begin to build a picture of the ED context and culture. Perhaps unsurprisingly, staff from armed service backgrounds are seen to fit in well to the ED workforce:

> A&E nurs[ing] does attract a certain type of person I would say… we see a lot of army medics come through the [ED], sort of people who are… armed services, whether that's medical or nursing, and they seem to fit…
>
> (ED S/N Tom, Teaching ED, Formal Interview)

Patients progress (one at a time) from this often-volatile waiting room area into the main ED space. They move into the triage room, called through by a nurse after booking in at the ED reception. These patients have usually self-presented at the ED and have not arrived

via ambulance. The following section will offer insights into this next stage of the walkthrough.

4.2 The Triage Room and Minor Injuries

This is a small room, next to the waiting room, in which streaming or triage takes place: 'the process of allocating patients to different physical areas/services, pathways or processes' (RCEM, 2017). The nurse aims to identify any patients with life-threatening complaints. This is one of many insights into the essentiality of both *time and space as moderators* of the nurses' work and emotional labour (the extensive exploration of which will take place in Chapter 5). The triage process is often this patient's first interaction with an ED clinician, usually a nurse. The process should be completed within 15 minutes of the patient arriving at the ED (RCEM, 2017). This is the first of many time-critical targets influencing the way in which the ED nurses carry out their work – their emotional labour responds accordingly.

The triage nurse, or nurses, for that shift must ensure that a queue of patients does not form. This queue is not a physical queue of patients but shown on a computer screen only visible to the nurse. The patients cannot see this screen. The constant checking of this queue adds a sense of pressure. The nurse is aware that patients are waiting to be triaged, with the risk that their clinical conditions will

deteriorate. Time pressures and constant demand are recurring features in the ED and influence all areas within it, creating a sense of intensity. Time, including a lack of available time, time-critical targets, time-critical clinical conditions and specific periods of time, has significant implications for the emotional labour required from the ED staff.

During the brief assessment interaction in the triage room, the nurse asks the patient about their presenting complaint, takes a medical history and undertakes a set of clinical observations. Following the completion of this assessment, the nurse will direct the patient to the most appropriate clinical area in the department, to be seen by a practitioner (a doctor or an ANP) and receive the required intervention. There is a weight of responsibility associated with this brief initial assessment. In any one-hour period (a further acknowledgement of the relevance of time – a particular time period), a great diversity and variety of patients arrive in the ED, and the nurse must ensure that those patients with the potential to deteriorate are sifted out and attended to. I observe the assessment of a middle-aged man who has had back pain for three years. He is sent back to his GP. This is in contrast with the next patient, who has a collapsed lung and following assessment is sent straight to the resuscitation area. She is a 23-year-old and is usually fit and well.

The spectrum of clinical needs observed is large. Patients are sent to various areas of the ED for ongoing care based on this degree of clinical need. These individual spaces are often separated by a short corridor and a door or two, some of which remain open. This lack of physical space between the spectrum of needs has significant implications for the nurses' emotional labour. In practical terms, this may mean that, routinely, patients receiving interventions for minor injuries, for example a small laceration, are receiving care only a short walk (approximately 5 metres) and a closed door away from those patients in cardiac arrest receiving life-saving care. This spatial element is critical for the nurses' management of emotion, as are other restrictions upon the space (including the excessive visibility of staff) and the movement of staff and patients through the space. A senior nurse leader recognises the relevance of the spectrum (of patient need) to the ED and the work of the ED nurse:

> … In terms of the unique challenges, I think the ED is incredibly unique because no other service sees neonates, the healthcare of the older person, mental health and patients with a dependency on whatever. There's no other area that sees those patients in an uncontrolled manner… we have no idea who's coming, do we? What I'm saying is that a range of patients could perhaps all go to outpatients, but you've got the notes. You know that they're arriving. They've got a scheduled time.

> It's all planned. The ED team have no idea what they will face today… You have to be quite a unique person to be able to emotionally manage that kind of unpredicted work.
>
> (ED Matrons Bev and Yvonne, District ED, Formal Interview)

An ED nurse manager from District ED offers insights into similar distinctive characteristics of the ED; she also recognises the spectrum of patient need and clinical diversity:

> … there's also a lot of patients who attend who have got very acute mental health needs. *There are patients who attend the service who have been victims of domestic abuse and violence. There are patients who attend who are intoxicated by drugs or alcohol… it's a very demanding front-door service, the front door of the hospital. Obviously not forgetting we have some very sick children attending, you know, some ladies who come in and have stillbirths*. There are some very distressing emotional things that can happen in that service.
>
> (ED Nurse Manager Shelly, District ED, Formal Interview)

The patient groups noted by Shelly can arrive at the ED at any time. On their arrival, the route through the ED is likely to be different to that described above (through triage) if they arrive at the ED via

ambulance. In this instance, they are most likely taken to the initial assessment area by the ambulance crew. The following section will offer an insight into the initial assessment area.

4.3 The Initial Assessment and Corridor

The journey to the initial assessment area involves walking down a long corridor. This corridor space is filled with queuing patients (on ambulance trollies). As a consequence of this queuing, the ambulance staff are unable to hand over the care of their patients to the ED staff and are therefore unable to attend other 999 calls. Ambulance-to-nurse handover should take place within 15 minutes of arrival at the ED, and handover times of 30 minutes or more can lead to hospital fines (NHS England, 2014). Again, this target presents time as a moderator of the ED nurses' work and subsequent emotional labour (the nature of which will also be explored within Chapter 5). The queuing of patients within the corridor space is seen negatively. If the ambulance turnaround time is not met, this affects patient flow through the department. When flow is not achieved, patients become stuck and cause a backlog in the system, described as 'bottlenecking'. This may occur if a more than average number of patients arrive at the same time and cause a queue as ambulance staff wait to hand over their patients to the nurses for assessment. The vision of patients waiting along the corridor is a familiar occurrence,

particularly at Teaching ED. Discussion is prompted during interviews when the nurses are shown related images:

> Well they [the pictures] make me think of this department and the reality of it on a busy day. And how stressful it is when it's like this. This one is when crews are queuing up to get a nurse to take handover. That's how it works here when it's this busy, they do queue down the corridor. We never leave patients in the corridor. However, it's when the crews are queuing up for us to allocate them to a place for us to then take handover. And you can have some very sick people in that queue. They could be waiting for a long time.
>
> **What about it in particular is making you feel stressed?**
>
> Because it means it's a very busy shift and I'm not going to be able to look after everybody properly, and people aren't always getting adequate care… Yeah, it's horrible when you go home feeling you've not done your best, you've not looked after people properly.
>
> (ED S/N Bev, District ED, Formal interview)

The corridor space is oppressive. There is no natural light, there are low ceilings and the clinical lighting is stark. These environmental elements do not permeate a sense of healing; in fact the opposite atmosphere is created. The corridor is long and thin, and this restricted space is exacerbated and narrowed further by the queuing – half of the length of the corridor is lined with patients on ambulance trollies and the ambulance personnel waiting alongside them. Patients are close together; space is limited, so conversations and interactions are therefore public. Although the corridor is not actually very loud, it still seems noisy: the noise of frustrated and irritable patients and ambulance crews. The state of emotion, angst and palpable tension builds before patients arrive at the initial assessment area. The sense of pace increases once the patient arrives at the front of the queue. The initial assessment is physically small and restrictive. Despite this restriction on space, there is constant movement – it is difficult to keep track of the processes.

> … it is never stationary and is constantly changing. As soon as one patient's assessment is complete, they are wheeled out and another is wheeled in – rarely are the cubicles empty. There is an 'assembly-line' approach to this space. The next crew are called to bring in their patient as soon as soon as a cubicle comes available. There is a queue of patients waiting to come into these cubicles – a constant demand and targets

> to meet. The ambulance crews need to hand over their patients to attend further emergency calls. There is no time in-between each case to reflect – before staff have finished writing notes or tasks for a patient, another has been put in their place. The pace is intense, unforgiving and constant.
>
> (Observational Notes, Teaching ED)

ED S/N Adam talks about his experience of the individual patient assessment process that takes place here. This detailed insight helps to show the role of the ED nurse in the initial assessment area and the nature of the work completed here. Adam also acknowledges the pressures he feels working within this space specifically – various elements of time are prominent here. In particular, he refers to the restrictions on time (through the time-critical targets) but also the length of the shift time cycle (through which the work is maintained):

> The ambulance crews book a patient in. That patient then will wait [on the corridor] until one of the triage bays [is available]. The patient will then be moved into that bay, either transferred onto a trolley or already on a hospital ED trolley. The crew will then hand over the patient to us. We will then assess the patient… decide on their treatment options or any investigations that the doctors will then need for later on. Perform them and then move them to the appropriate area in

the department. They may or may not need a review from a decision-maker, doctor or advanced clinical practitioner, and we make that call… Even though they have the ambulance crews with them, you need to make sure if they do need any treatment, you get it started soon. There's pressure to move the crews along, get them out and get the patients handed over because what will happen again then. The crews will just be coming back in again exactly the same way in one big flood, and you'll be in exactly the same position again. Then there's pressure from inside the department from the nurse in charge or the doctors… Why are things taking so long?

So it's time?

There is a big time element, which puts a lot of pressure on you because the idea is that these people are meant to be handed over within eight minutes of arrival. *Within 15 minutes of the ambulance putting their handbrake on outside, the crew are meant to be in, transferred, handed over and then back out in their vehicle…* Then can you imagine on this particular day we had patients coming into the cubicle who'd been booked in for an hour and a half. *It's hugely frustrating. When it gets to that stage… relentless… powerless about the situation…* you get the pressure from the crew standing there

> staring at you and all I can think of… is… 'Why aren't you working a little bit faster?' *What I'd like to say to them is 'please come and try working here for twelve and a half hours'.*
>
> (ED S/N Adam, Teaching ED, Formal Interview)

Perhaps unsurprisingly, then, the interactions between nurse and patient within the initial assessment area are often fleeting and intense. The limited time moderates this work, importantly, and is exacerbated by the minimal space available (a crucial point for exploration within Chapter 5). As acknowledged earlier, there is again an 'assembly line' nature to the interactions and care delivered here – a metaphor used by many staff sharing their experiences of working in this space. The restrictions on time directly influence the nature of the nurses' work, the relationships the nurses develop with their patients and the necessary emotional labour. ED S/N Bev offers her experience, describing how her care delivery responds to the lack of time available and how this makes her feel about her work:

> *I've actually used that term [assembly line] – it's like a production line of patients…* you've got [ambulance] crews coming in constantly… it's quiet at the moment, but later in the day it will be constant, constant. You take handover from the crew, do the basics, move on to your next patient. Take

> handover, do the basics, move on to your next patient. You might not even see that patient again. Sometimes the crews come back in and say 'what happened to so and so' and… I don't know, because it's all about keeping the flow of the department going, in some people's opinion. Which you do have to do, but *it means there's a definite lack of care there, I would say…*

I ask Bev how she finds working with this lack of time. She replies:

> *… I go home feeling very unsatisfied* because you've not cared for people, you've just checked their observations, given them any immediate treatment they need, but the actual caring aspect of it, you've not really done any of that… it becomes quite monotonous and boring actually. *'Cause you're not getting involved with your patient, you're just doing the basics.*

ED S/N Louise offers similar insights from Teaching ED. Louise uses related transactional metaphors. Here, the restrictions on time are also seen to have direct implications on the nurses' work (and subsequent emotional labour). The style of caring in response to these restrictions and demands on time in the ED is seen as different to other forms of nursing. With minimal time available, the ED nurse has a 'different representation' of caring:

> … we discussed the nature of the care that is delivered in the ED, and she described how she perceived this to be very task orientated and like a *'production line'* and a *'factory'*. Within this, there is an emphasis on targets and 'getting them [the patients] out'. She feels that ED staff, on the whole, have a different *'representation of caring'*, which isn't traditional or stereotypical and has very different nursing practices and norms to elsewhere. She tells me… *ED nurses are mostly not like other nurses: 'they're hardly Florence Nightingale, are they?!' They don't 'mop brows!'*
>
> (ED S/N Louise, Teaching ED, Informal Interview)

Once the nurse has finished the assessment and initial treatment within the initial assessment area, they hand over the care to a member of another nursing team – the selection of the area and team is dependent on the patient's clinical status, condition and complaint. The initial assessment 'pit stop' is not a service offered by all EDs (as in the case of District ED). In this instance, patients brought by ambulance will most likely be taken straight to the relevant clinical area (most likely, the majors area). On arrival, there will be a handover to a nurse (the ambulance staff give the nurse a history of the patient and their complaint), and the nurse may direct them to another area within the department if this is appropriate.

Once the patient arrives in the designated space for their condition, they wait to be seen by an ED doctor or an ANP. The speed of this is largely dictated by clinical need and prioritisation. For example, the patient may be transported at pace to the resuscitation area or sent to the majors area, where the wait to be assessed could be significantly longer. Irrespective of area, it is largely the ED nurse's responsibility to care for the patient throughout their time in the ED. Many of these patients are transferred to the majors area, as described below.

4.4 The Majors Area

> There is a smell of disinfectant, which comes and goes in strength. Halfway along one of the corridors, you are brought out to a large open space that is surrounded by lines of individual cubicles; the curtains are pulled across. On this occasion [at around 5am], this area is clear; however, from previous experience, I appreciate that when the department gets busier and all the cubicles are full, this area is used for patients. Again, there are no windows, and harsh strip lighting lights lead the way, which, accompanied by the cream and grey wall colours, add to the clinical atmosphere. Due to the lack of windows, neither staff nor patients will know if it is day or night, as there is no natural light entering the department… it results in the department being shut off to the outside world –

> the ED feels like a bubble or separate world, distinctive and all of its own.
>
> (District ED, Observational Notes)

The majors area of the ED is the largest physical space within the ED. During much of the observation, it is noisy with a blended mixture of conversation, the movement of trollies and other equipment and the constant ringing of phones. The intensity of the environment is again prominent and, at times, overbearing.

> The whole area is a hive of activity. This area cares for a wide variety of patients with a vast range of complaints – medical, social and psychological (including cases of domestic violence, safeguarding and vulnerable adults, in addition to patients with mental health problems). These are not patients with minor injuries, nor are they patients who need the care of the resuscitation department. However, they do need to be nursed on a trolley because they are not well enough to walk, sit or stand with ease.
>
> (Teaching ED, Observational Notes)

There is a large and open central space with curtained cubicles surrounding it. All of the cubicles are usually full. The patient is taken

into a cubicle for their assessment with a practitioner, for the delivery of test results or the plan of care, and for the administration of an intervention or medication; in these instances, the curtains are closed for privacy. Patients are moved in and out of cubicles interchangeably, to and from x-ray and other scan areas and to hospital wards. Those patients without a cubicle (often patients who are waiting to be assessed or have already been assessed) are lined up on trollies in the large central space. This area can become increasingly congested, three or four rows deep, so much so that it is difficult to manoeuvre – this lack of physical space is relevant to the nurses' work and their emotional labour. Caring for patients in this space occurs when patient demand outweighs the available cubicle space. Staff describe to me how they feel 'guilty' and 'responsible' for poor care in these instances. The restricted physical space is seen as a barrier to completing tasks efficiently and to delivering the desired standard. The space subsequently acts as a moderator for the emotional labour (again, the details of this will be explored within Chapter 5). ED S/N Becky explains her experience of starting her role in the ED and, in particular, her experience of working within the majors area. This quote offers insights into the context of the nurses' work here, the style of care delivery and the challenges this presents for those tasked with delivering care:

> Initially, I did think: *'what the hell have I let myself in for'.* Everyone says: 'Oh, where we work is busy', but everywhere in the NHS is busy, isn't it, and pressurised and I… thought… I understood it was going to be different, *but it did feel quite overwhelming… the number of patients.* I couldn't quite understand. I keep comparing it to where I worked before, where I'd know 'I've got these bays. This is who I'm responsible for', whereas you come to the ED and *it's just fluctuating all the time, the number of patients and who you're meant to be looking after, depending on which area you're working in, and it just felt really kind of chaotic and no one was able to really explain to me like how the systems worked or how I was meant to keep an eye on what I was meant to be doing…* People were just like: 'Oh, you'll get used to it. You'll get used to it.
>
> (ED S/N Becky, Teaching ED, Formal Interview)

This style of working within the majors space described above by Becky (in particular, the intensity of the workload, the prioritisation of tasks and the fluctuation in patient numbers) calls for significant multitasking from the nurses. This is discussed at length during the formal interviews (prompted by a visual aid). These descriptions also offer insights into the nature of the nurses' work and are therefore helpful to understanding the backdrop for their emotional labour. In

summary, the 'balls' (various tasks and responsibilities) that need to be juggled (completed and managed) by the ED nurses are perceived as:

- Patients: their expectations, care needs, different care pathways (e.g. end-of-life care or sepsis treatment plan), observations, medications, pain/comfort and safety. These needs are changeable and constantly changing, being prioritised and re-prioritised
- The expectations of patients' relatives and friends about standards of care and dignity
- Other staff, junior colleagues and professional relationships
- Managerial tasks, including checking/ensuring bed availability, completing up-to-date nursing documentation, co-ordinating the care plan, delegating tasks appropriately and managing the four-hour breach time (relevant to all ED patients)

A practice development nurse who supports newly qualified nursing staff offers her perspective and experience of the nurses' work within the majors space, which is intensified by the limited time available. Here again, the limited time to complete tasks (due to the time-critical targets) and the fast pace (to maintain patient flow through

the department) are critical to the nurses' work. In particular, this example shows how the pace of the work impacts on the nature of the care delivered and how the nurses have limited control over their workloads. All of these considerations (around time and consequential pace) have significant implications for the nurses' emotional labour.

> *… it's so fast-paced…* the whole aim, and particularly with the pressures at the moment, is to get the patient through, assessed, seen, diagnosed, some care and then off to the wards. *So it's a huge pressure constantly about time-keeping* and getting the patients to the base wards… when you've got 130 people in the department or more… care delivery can be very… fractured because you're having to move [the patients] at very short notice… for a newly qualified nurse, that's really difficult because you can't judge your workload… they're always thinking: 'I've got to do this now and get it sorted out'…
>
> … on a ward… you can say: 'Right. Actually, time-management-wise, I can do my assessment, then I can do my drugs, and I know that I've got Mrs Jones until three o'clock this afternoon. So, actually, if I leave her wash, it doesn't matter because I'll get on and do it.' *Whereas in the ED, you don't have that luxury. You've got to just crack on and get everything done*

because you never know when somebody within ten minutes might be saying: 'Right. They've got to go to the ward now'…

(Practice Development Nurse Liz, Teaching ED, Formal Interview)

The layout of the majors space (at both sites) has a computer station at the centre. This is where the ED nurses document the care delivered and where other non-clinical activities take place. This is the only time that the nurses stand still. The area is visible to patients and their relatives. Behind this station (and therefore not visible to patients and their relatives) is a similar computer station for the doctors and ANPs. The nurse leading the area spends much of their time stood or sat here at a computer – it is a hub or central point for the management of the four-hour target. This time-critical target is intrinsic to the way in which care is delivered within the ED and has a profound impact on the nurses' emotional labour (this will also be explored at length in Chapter 5). The leading nurse co-ordinates the area and manages the maintenance of the four-hour target. The extract below talks through this role, in particular how managing the target is particularly challenging (requiring significant patience and restrained communication – the regulation of emotion is crucial):

They've got three phones ringing. It's a very stressful job, actually. I would struggle to do that particular role [laughs]… I

think that takes a very special person… only the Band 6s or the Band 7s do that role in the ED.

When you say special, what do you mean?

Well, again, it's about controlling yourself, being an excellent communicator. Their communication skills are tested every day… because they've not only got to be able to speak to and communicate with healthcare assistants, their team and doctors, there'll be the site manager, who's at them saying: 'Where are we? What are we doing?' There'll be matron and me popping in five minutes later asking them to repeat everything they've already just said, *and they'll say it with such patience and tolerance to us…*

Do they always say it with patience and tolerance?

Generally. Well, sometimes, they'll say tongue in cheek: 'Oh, I've just said that to…', and I'll go: 'Oh, sorry. I wasn't here.' *So the patience and tolerance needed to co-ordinate the ED are vast.* Then they've got ambulance crews arriving all unplanned, unless the red phone's gone to say that there is a stroke coming in or a significant patient with exceptional resus needs… They've got paediatrics to make sure is flowing. So

majors, minors, paediatrics, ambulance crews, us coming in and out going: 'What's happening? What's happening?' The board's getting congested… *And they still look quite fresh towards the end of the day generally, and generally have kept their calm and cool. I mean, not always. Sometimes I have seen staff bubble over, or I've had to just pull them to one side to say: 'Just go for your break. Have you been for your break?' because sometimes they don't get their breaks, and we have a responsibility for the welfare of staff…* but generally I just think they're angels. They're very, very skilled staff.

(ED Senior Nurse Manager Shelly, District ED, Formal Interview)

The many computers show patient information (including name and condition) and a countdown timer for each one – this indicates how long the patient has been in the ED and consequently how long they have until they 'breach' their four-hour target. This information is visible on a large computer screen (District ED only) on the wall and on individual computers (both sites). This information is also colour coded for each patient. The colour changes depending on how long they have left until they breach. If they have less than 1.5 hours left until their breach time, the colour is noticeably red – again, this colour draws attention and is observed to be significant. Similarly, the list of patients is ordered according to those who are closest to their

breach times (out of sight of patients and their relatives) – this acts as a constant visual reminder and 'countdown', which again reintroduces the constant pressure of limited time. This focus and emphasis on time-critical targets are filtered through the organisation to all staff, restricted time is hugely influential. Tim, a senior nurse, describes his experience:

> *There is constant pressure, you know, obviously our performance… But everybody's in a goldfish bowl in the ED… Everybody's got an opinion, or an eye on us, 24 hours a day…* it's not like, you know, the rheumatology clinic or sat down in the corner of the hospital ticking along just nicely… *the four-hour thing is a massive thing for any ED… the constant pressure of things like having those turnaround times, streaming times, the four-hour target.* All them kind of things that every man and his cat in the trust know, *that's a massive pressure*. Also, another massive pressure is… the increasing workload, and not just increasing numbers… And people get pressured about doing the right thing at the right time. So… with the increased workload… are we getting things / the job done as we want to… So, the increased workload impacts on quality.
>
> (Senior ED Nurse Tim, District ED, Formal Interview)

Not only does this quote from Tim show the relevance of the time-critical targets but it also refers to the relevance of space – on this occasion, space is important through the excessive visibility of working in the ED (he describes how the ED feels like a 'goldfish bowl'). There is, as a result, a sense of constant pressure and intensity: the job is never complete and the process (of undertaking this work) is visible.

A senior nurse manager, Shelly, explains the importance of maintaining patient flow (and maintaining the four-hour target) from her managerial perspective. This insight reiterates the importance of flow:

> *… flow is about giving patients the most efficient pathway through urgent and emergency care…* For anybody who attends the ED, that means that clinically, as long as they're well enough, they are seen within the four-hour target… *it's about making sure that my front-door teams have adequate knowledge, skills and experience and that the medical staff have the pathways and resources available for patients to have the most efficient care and that we get patients seen within the four-hour current target, which I think is an excellent quality target, actually. I'm a big supporter of it.* So that's what I mean by flow. If patients are not flowing through the ED and the

numbers increase in the ED, that is your biggest risk in a hospital for serious incidents to happen. If you've got an overcrowded, congested ED, it's a very, very risky area.

(ED Nurse Manager Shelly, District ED, Formal Interview)

Tim, an ED nurse manager, explains his experience of overcrowding and poor flow. Again, space holds relevance here, as patients are required to flow or move through the ED space (and 'poor flow' results in a more congested space):

It still makes me feel like shit… it's a really sore point, isn't it?… It's really, really poor quality… so when you're in the ED and you've got flow and you're seen, you're sorted, you go ahead and treat them, get what they need and they go out. That's OK, that's meant to happen. *When they can't go out and they keep coming in, nobody's getting the service they need.* So, if they're [the patients] in majors and they are queuing up the corridor, they can't come in because they can't go out [as they are waiting for hospital beds]. So, it's a knock-on effect, really. *This makes you feel like downbeat because you're not doing your job right.*

(ED Nurse Manager Tim, District ED, Formal Interview)

The tensions described by Tim, brought about by time limitations and restricted space, can be seen, perhaps most profoundly, in the resuscitation area. The following section will offer detailed observations of the final stage in this walkthrough chapter.

4.5 The Resuscitation Area

This is the area of the ED where the most clinically unwell patients are cared for. They may be brought here directly by ambulance, through initial patient triage, from the initial assessment area, or from majors or minor injuries if their clinical condition deteriorates. The workload and pace fluctuate. I observe an infrequent period of relative stillness:

> After lunch, the resuscitation area is empty – it becomes clear that this is unusual, as staff walk around looking suspicious at the quiet. They say statements such as: 'it's the calm before the storm!' and that they are unnerved by the lack of sick patients. 'It's usually evil!' one nurse states (in referring to the level of business). The staff don't expect this quietness to last long. The area is clean, ready and prepared for any patients who may arrive – it is as though the staff and the environment are both poised and ready…
>
> (District ED, Observational Notes)

More routinely, the space is busy and full. The visual and auditory stimulation of the resuscitation area 'hits' you as you walk in. It is a symphony of alarms, varying in pitch and volume. The description below, taken from the field notes at Teaching ED, offers a detailed snapshot of the resuscitation area and the work completed within it. I have decided to include this notably long data extract to offer an insight into a specific period of time: a two-hour period one weekday morning. Noting the relatively short timeframe for the nature and amount of work completed offers a helpful perspective when examining the nature of the ED nurses' work. Much of this description is therefore taken directly from the field notes.

> There are minimal distorted windows, high on the walls. All that can be seen through them is flashing lights from the ambulances as they arrive and depart. This gives a sense of being cocooned and incredibly isolated from the other areas of the department but also isolated from the hospital more generally.
>
> The resuscitation area is a large area. It is set up with nine bays in a rectangular room, and cubicles line the outside of the space – this includes one bay specifically for paediatric patients. The bays are segregated by blue curtains, and equipment is allocated to each patient space. Each patient space is next to

the other, with no room between them – this is important to the nurses' work, their communication and their emotional labour.

The curtains are pulled back when there are no patients present, which makes the space look open. Each space has a large arm hanging from the ceiling, which supplies the space with oxygen and other medical gases – there are multiple pipes and tubes. Each bay also has a patient trolley, ready to receive a patient. There are movable storage units, stocked with various pieces of equipment and medical supplies. A large, movable examination lamp also hangs from the ceiling. Equipment for resuscitation hangs in bags, ready to be undone and used at speed if needed. The bays are clinical, clean and still. The bays are awash with wires, pipes, medical equipment, screens and pumps to give various medication. It could easily be seen as an intimidating environment through the eyes of a patient.

The space in its entirety is large and open plan. As a consequence, there are no visible options for staff to escape the intensity of the environment except the sluice (a small room used to dispose of contaminated waste); staff appear to use this room infrequently and for seconds rather than minutes.

Staff are visible at all times in the space: only when they are behind curtains with their patients are they out of sight, so there is no opportunity for 'offstage' time. This spatial element (excessive visibility), specifically the lack of offstage opportunities, again proves significant for the nurses' emotional labour (the details of which will be unpacked in Chapter 5).

When I arrive, I am struck by the noise. There are seven patients for the nine bays (individual spaces that are separated by curtains and screens, which also protect staff against x-rays). It seems that 95% of the time, the curtains to each bay remain open – like the opening to a stage. Within a couple of minutes of my arrival, a loud and piercing phone rings (known as the 'red phone'). It is a startling sound, heard clearly above all other noise (which is significant). This phone is alerting the staff to the arrival of a further two patients who are on their way: one is a teenager who has been hit by a car, and the other is a 60-year-old with heart problems. Whilst I'm typing this, it rings a third time: it is alerting the staff of another child who has been hit by a car. This red phone is only used by ambulance personnel to contact the resuscitation room– I observe how answering it is a priority for the staff over the majority of other tasks.

A team of extra staff arrive from elsewhere in the hospital to deal with the first trauma victim. They are known as the 'trauma team' and are made up of staff from outside the ED, including anaesthetists and surgeons. There are around ten extra staff – the number of ED staff seems minimal in comparison. Each of the trauma bays has a mini team of its own. Police are also present due to the nature of the patients' injuries, and their involvement in car accidents makes them a priority. The trauma staff again stand outside of the imaginary curtain wall (the curtain is open) and look inwards at the patient. It is as though they are watching a play unfold in a theatre, with further references to Goffman. They give the other staff room to work, and they move forward into the curtained space when it is time for their specialism.

At the same time, another individual cubicle is being prepared for the other trauma victim, who is due to arrive any minute. A space has been cleared for their arrival – it is very busy with preparation from the paediatric ED staff. Another nurse is here for the arrival of the patient. She has been pulled from the main paediatric department. There is a moment of calm once everything (equipment) is ready and the individual space is relatively still for around a minute, whilst the rest of the area remains a hive of activity. Time becomes relevant once more as

the staff ‘count down’ for the patient’s arrival, and the sense of anticipation builds.

The whole area is incredibly noisy: there is a rustle of plastic aprons and the sound of feet walking at pace; in some instances, this is as quick as a jog. The area is so noisy that it would not be possible to have a normal conversation with someone over the noise, unless they were stood closely by your side. Other sounds include a child crying out in pain, a machine blowing warm air to warm up a patient’s body temperature, trolleys being wheeled from one space to the next and constant buzzers and alarms, which vary in pitch and pace and compete with one another. At the same time, older patients call out in pain, a nurse tries to reassure a lady and regular phones ring in tandem. There isn’t always someone available to answer them; when they do, they are multitasking (e.g. typing notes or directing other tasks to be done). Ventilators add to the noise as they pump out gas. There is the hum of numerous computer motors and screens and the jangle of the keys of the nurse in charge (NIC). In addition to noise, the staff within the space are constantly moving equipment or doing something. Similarly, the monitor screens and the information on them are constantly changing – the monitors flash numbers in bright colours (again, red is prominent), alerting staff to various

figures and warning them to act. The pace of the staff moving in the area increases further still, and urgency in voice is heightened, but there is still no running or shouting. Visibly, the staff still seem calm. I learn through later interviews that these nurses are acting – restricting their emotional displays through their emotional labour.

The red phone alarms again: this time, a baby has stopped breathing. I see the NIC (whilst still on the phone) raise her eyebrows to another nurse. She hangs up and I see her mouth 'shit' discreetly. The area is already incredibly busy and full to capacity. Patients are moved about to make a physical space for the next arrival. The paediatric nurse starts to prepare another space – she is now moving at nearly running pace between the already present paediatric patients.

The doorbell sounds, again heard over the loud blur of noise – this could be an ambulance crew who have a patient they would like to bring into the resus area or the friends and family of those patients already here who want to visit. It rings another two times, but there is no one free to answer it. A qualified nurse or doctor must answer the doorbell; if it's an ambulance crew, they must be able to assess whether the patient needs

care in the resuscitation area or whether they can be cared for in the main ED.

The NIC is on the phone to a nurse from the main department. They have a patient who needs bringing into the resus area for elevated care. Another patient is brought back from a test outside of the resus area; in her absence, another patient has been put in her cubicle. The NIC must manoeuvre patients around to accommodate her. The nurse still appears calm, but the environment is incredibly changeable and appears hectic – the lack of physical and non-physical space is profound and an important observation for the nurses' emotional labour.

Both the NIC and the other ED nurses do not stop moving, directing and communicating. Despite this, there are no signs of visible distress (again, I unpack this later during the on-to-one interviews). They search for specific bits of equipment for their various clinical tasks. They intermittently dash back to the computer to type up their brief bullet point notes. All of their movement appears to be done with purpose, direction and great speed. Their fingers move at a quick and hard pace on the keyboards. They talk on the phone whilst they type about different issues to those they are typing about. They are heavily occupied. This computer activity takes place in the centre of the

resus area: a large central desk runs nearly the length of the area and almost divides it in two. It is a hub of activity and buzzing with staff and tasks; they mingle around one another at speed but never clash.

The mounting tension is palpable. The atmosphere is intense and is growing in intensity as the seconds pass; the speed of the staff in their work increases further still. The limited time (due to the delivery of time-critical medication, the countdown to further patients arriving and the time-critical targets) is shown most prominently. The noise levels rise and conversations increase further – it is extremely noisy. The NIC looks around at her options. You can almost see her logically trying to think through the options of where to put all of the patients – there is no space and the situation is serious.

Senior nurses (a sister and a charge nurse) arrive and cubicles start to be split in half with an extra curtain – one already small space becomes two, becoming incredibly small. It is unsurprising that this further impedes the nurses' work and their emotional labour. One nurse has a degree of 'banter' with the patients – one patient who is well enough jokes and smiles back. There is a constant battle where staff fight to keep a

cubicle free in case another patient needs to come into the resus area.

A patient is wheeled passed me at speed and with a sense of urgency. He has been brought here after having a scan. He looks very unwell and is extremely pale. He is taken into one of the newly formed cubicles. A trail of blood has been left behind him; other staff dashing around tread in it before the NIC has the chance to fetch a mop and bucket. I overhear a couple of minutes afterwards that the 'major haemorrhage pack' needs activating for the same man.

Relatives stand at the edge of their patients' cubicles – on the 'non'-trauma side, they look dazed and confused, longingly looking for staff to ask questions, but there is no one available. At one point, I count 35 staff from various trauma teams dealing with three patients, in comparison with the five nurses working in the resus area today. I heard earlier in the day that the department is short of seven nurses today (out of 24). I'm reassured by the NIC of the whole department (not just resus) that everything is still 'OK'; again, this is later shown to be a degree of acting.

I observe one of the consultants talking to the patients on the other side of the resus area. This is the first time I've seen a

consultant talk with a patient, apart from when two doctors walked around at speed saying out loud which patient was going where (e.g. which hospital ward) – they were doing this to try to make space. This time, he speaks in a relaxed and approachable tone, like he has all the time in the world. He reassures them that they are looking better. The information is minimal, but the patients and their relatives are visually pleased with his attention. Their faces light up.

I talk to one of the nurses briefly over the still intense noise. She knows about my study and says to me: 'I'm probably not someone you should observe because I'm leaving soon.' She tells me: 'I'm not an ED nurse.' She says she has found that out working here; she tells me that she came for the experience but that she's going back to 'more that way' – her kind of ward-based care. She has this conversation with me as she is walking past, providing insights into what it means to 'be' an ED nurse. This is a significant consideration regarding the ED nurses' feeling rules (and will therefore be explored in Chapter 5).

Alarms are still sounding – there is so much noise. The area is still packed to bursting with staff and patients, with the phones ringing relentlessly and the doorbell sounding. I head to the

> NIC to tell her that I'm leaving. She is in the cubicle that is in the furthest corner from me; the curtains are still open but it is difficult to see inside the cubicle from anywhere else other than directly in line with it. I go to her, and in the cubicle is a tiny baby receiving cardiopulmonary resuscitation (CPR) – its heart has stopped. It must only be a few months old. The team are well established – they haven't just arrived that minute. It takes me by surprise. How could I have not seen this baby arrive? I'm shocked that I've missed this. I think to myself: 'in what type of situation and space does something as significant as this goes unnoticed?' 'Oh my gosh,' I say to the nurse. 'Are you OK?' I am not only referring to the baby but also to what she has just worked through and taken charge of. She is glazed over – her eyes look through me. 'I've had it a lot worse,' she says with a distant smile. 'I'm OK.' But I wonder how she can be.
>
> (Teaching ED, Observational Notes)

As noted earlier, although I observe how areas of the ED, including the resuscitation area, can be still and even quiet, the extract above offers a fair representation of how the work is most often. As also highlighted previously, offering this complete picture of the nurses' work over a fixed period of time (through this lengthy data extract) aids the process of contextualisation. Considering this observation

and the rest of this data chapter, the conclusion that follows will offer a summary of the most salient and poignant themes. The conclusion will also outline the key concepts for progression to the second empirical data chapter.

4.6 Conclusion

This first empirical data chapter offered a walkthrough of the ED setting. The purpose of this chapter was to establish the ED landscape as a reference point for the second data chapter. It aimed to show the environment that produces the ED nurses' feeling rules and their emotional labour. This descriptive chapter helped to offer insights into the following research question:

Which environmental elements of the ED influence the emotional labour undertaken?

Various elements of time and space are crucial to the nurses' work and their subsequent emotional labour, particularly when integrated and considered together. Time includes considerations relating to the lack of available time for the nurses' work; the various time-critical targets; the importance of time-critical clinical conditions; and specific periods of time (timescales, including shift length). Spatial elements include the relevance of physical space, the restrictions upon it and the layout, in addition to movement through the space.

Other important considerations include the excessive visibility of staff and the lack of 'offstage' spaces and opportunities. All of these elements, and their impact on the ED nurses' emotional labour, will be explored within Chapter 5.

The walkthrough chapter began outside of the ED. It is evident that the tone of the ED is set even before entering the building. The colour red is introduced, as is the metaphorical term 'warzone'. There is a sense of volatility and combat (through the police, security guards and amnesty bin, amongst other observations), which does not align with traditional perceptions of healing. Staff share multiple examples of dealing with aggression from patients and their relatives; the setting thus attracts masculinity and suits those from a military background. These observations are notable and important to the ED nurses' feeling rules.

The triage room and minor injuries areas of the ED are often the sites of initial patient–nurse interactions on arrival at the ED. Here, there is the first indication of time as a significant moderator of the nurses' work (and subsequent emotional labour). The various countdowns begin – the nurses strive to meet the time-critical targets whilst still delivering 'quality' care. The distinctive spectrum of patients and their clinical needs is also notable within the triage area; time is also important in this sense. The observations show how the extremes of

patient need can be presented in a short timeframe. The patients are directed from here to the relevant area in the ED for their clinical condition – the physical space separating these areas is also important to the nurses' emotion regulation.

Within the initial assessment area and the corridor, the relevance of time is also prominent, largely through the ambulance turnaround target, which restricts the amount of time available for each patient. The intensity of this is again exacerbated by the space (which is restricted and congested) and the scope of patient diversity (which is extensive). The style of care and interaction is transactional in nature, responding to these restrictions and moving interchangeably between them. A further layer of challenge is presented by the length of time that this work (and the subsequent emotional labour) must be sustained: often 12.5 hours.

The setting presents as anything but healing and comforting. Instead, phrases such as 'assembly line' and 'production line' are used repeatedly by the staff. ED nurses care differently, I am told: 'they're hardly Florence Nightingale, are they?' Despite this, the ED nurses share how they feel negatively towards the quality of care they are able to deliver.

The majors area also offers little comfort or sense of warmth – it is a hive of clinical activity. Spatial elements are also important to the

majors area of the ED. The space is often overcrowded and congested; it is noisy and full. There is little room for quality care delivery or reprieve for the nurses. Offstage space is stark, and the excessive visibility of staff (in front of patients and their relatives) is most prominent here. This also has implications for the nature of the emotional labour undertaken. Simultaneously, elements of time also impact the nurses' work, with significant consequences. The nurses multitask to meet the demands of the four-hour target and to maintain the flow of patient movement through the space. This again sees time as an intrinsic and powerful moderator of their consequential emotional labour.

Finally, the resuscitation area epitomises the sense of pressure in the ED; environmental features of time and space, and the restrictions upon them, are encapsulated here. Various countdowns and timescales show the importance of time. Equally, restrictions on space, the movement within it and the lack of offstage opportunities show the importance of space. The stimulation of the resuscitation environment is overbearing: a mash of disturbing noises, visual stimulation and smells. The nurses' work responds and adapts accordingly to this intense setting, as too does their emotional labour. The staff shared their experiences of regulating their feelings and emotions during the one-to-one interviews.

All of these observations are profound for the nurses' emotional labour. In light of this first data chapter, the experiences of the ED nurses' emotional labour and the speciality-specific feeling rules driving it will now be explored in length in the second data chapter: Chapter 5: ED Nurses' Feeling Rules.

Chapter 5: ED Nurses' Feeling Rules

The purpose of this second empirical data chapter is to explicate the feeling rules and emotional labour of the ED. The feeling rules are an entwined mix of those associated with the ED specifically and other generic feeling rules that align with the nursing profession more broadly. This chapter will place particular focus on those that are a product of the distinctive ED setting – those that are speciality specific. I present four feeling rules in this chapter, which emerged directly and inductively from the data. The feeling rules drive ED nurses' emotional labour. As such, I will explore both the rules and the subsequent surface acting at the same time.

These feeling rules are shaped and influenced by the setting described in the first data chapter; the moderators of time and space are shown. I argue that those nurses who can work with and accept these feeling rules are labelled and seen as ED nurses. Those who cannot are seen as 'just' nurses who work in the ED – 'you're either an A&E nurse or you're definitely not' (S/N Sally, District ED, Formal Interview), I am told often at both sites. The descriptions are seen as black and white. ED S/N Adam offers an insight:

> I think, traditionally, you'd compare emergency nurses to other nurses; they are seen as quite tough-skinned. They can be seen as quite forward. They seem quite, I don't know, gung-ho is not

> the right word, but they don't seem to be… scared of anything… tackle what comes our way. They're not put off by whatever comes in really; whether it's a trauma or if it's someone with breathing difficulties, they should be able to deal with it regardless. They're held in a similar kind of regard to a nurse who works in intensive care, I think. There are often parallels drawn between the two similar stressful environments but for different reasons. But, from my experience, they say there are two different types of nurses who work in A&E: either you're a nurse who works in A&E or you're an A&E nurse.
>
> (ED S/N Adam, Teaching ED, Formal Interview)

It is also important to note that the vast majority of the emotional labour undertaken by the ED nurses was found to be surface acting. This was largely shown through the one-to-one interviews, where the nurses described how they altered their body language and facial expressions (Hochschild, 2012) to appear differently (outwardly) to how they truly felt. For the ED nurses, the emotion experienced internally and the emotion displayed externally were not in alignment (Hayward and Tuckey, 2011), resulting in significant surface acting. I have therefore decided to focus this exploration on surface acting. This consequential surface acting will be explored in line with each feeling rule. It is also important to note that, as surface acting is

frequently linked to alienation from the true self (Tuckey and Hayward, 2011) and has negative implications for well-being, this finding is particularly important. The subsequent implications for nursing practice will be outlined at the end of this thesis in response.

5.1 Feeling Rule 1: 'There's Not Much Time for Faffing Around Here' – Feel Tough, Fearless and Detached

> Sitting in the staff room over the lunch break period, around 40% of the staff visiting the staff room are male. These staff are stereotypically 'macho' men in appearance: larger build; short, sharp haircuts; and, in some instances, tattoos. Arguably, such a character would not be seen commonly working within other nursing environments, such as delivering ward-based care or working within the community setting. These nurses are not the 'stereotypical' and 'traditional' image of a nurse – both historically and the image that is portrayed by the media.
>
> (Staff Room, Teaching ED, Observational Notes)

The opening extract above offers insights into the visual differences between the ED nurses and the stereotypical feminine nurse. The ED nurses related to this observation and shared their perceptions of why gender is relevant to ED nursing, stating that it is an

environment and nursing style that suits masculinity. The larger proportion of male nurses in the ED is also relevant to the production of feeling rules and subsequent emotional labour. It becomes apparent that men feel more comfortable working within the ED, rather than other areas of nursing:

> She states that the proportion of male nurses is not only higher in the ED but also in other critical care areas, such as the ITU. She can relate strongly to the portrayed image of the ED nurse in relation to being 'tough' and 'hard' and other so-called masculine characteristics. She feels that these staff are likely to enjoy the associated drama and aggression of the environment. Similarly, the increased levels of technology and technicality also draw more males to the ED. In contrast, she feels that the ward environments can be too feminine for this type of character; these care settings are often more likely to be based on the idea of 'caring' and 'nurturing'. She feels that these characteristics are less applicable to the ED.
>
> (ED S/N Claire, Teaching ED, Informal Interview)

So-called masculine characteristics also fit with the aggressive nature of the ED – a setting that requires self-protection and a hard-faced exterior (requiring surface acting for some). During an informal group interview, I am informed that the 'drama of it all', the sense of

heroism and the necessary 'toughness' appeal to some of the nurses. This particular feeling rule (feel tough, fearless and detached) results in staff performing emotional labour that presents the appropriate front to conform with these expectations and stereotypes. Through the observations and interviews, I saw how the nurses hid feelings such as fear or nervousness in response. Examples of this feeling rule and the subsequent emotional labour will be offered throughout this section.

The nurses described how you need to develop a 'backbone' to work in the ED. Likewise, ED S/N Lucy told me that nurses must be 'straight-talking… there's not much time for faffing down here'. During a training session at District ED, the staff were actively encouraged to feel fearless and act accordingly. This example was in dealing with a potential major terrorist incident and the staff members' expected response. The nurses were encouraged to feel unafraid; therefore, if they felt fear, they were expected to supress and hide this through surface acting. The phrase 'crack on' regarding any anxiety was used to describe what was expected of the ED nurse, particularly in potentially frightening situations:

> There is an obvious relaxed style to the training – this is seen through there being no uniform, the language style used and the humour. There is 'banter' between staff, and they laugh with one another. Laughter was also used when previous

serious incidents were managed by the department. There is a sense that these were not and are not routine, but there is still no anxiety or stress shown… *The training includes the use of videos that show simulated terrorist incidents and discuss terrorist incidents that have previously taken place around the world. They are 'hard-hitting' and powerful, even harrowing. Scenes are shown in which patients have lost limbs or died in traumatic ways – the scenario is realistic.* The videos show the staff members' role in a variety of incidents. This includes wearing chemical weapon suits and performing a technical decontamination procedure. There are real risks highlighted to staff; for example, if a chemical incident were to occur, staff members may be contaminated. Despite this, the content is discussed relatively normally amongst staff, with no obvious distressed reactions.

The emergency service staff in the video are male; the way in which they speak to the patients is strong and assertive, in some cases aggressive… *One of the trainers in the session tells staff in relation to managing such an incident: 'do what you need to. Stay calm and get on with it'.* He goes on to talk about how staff manage their usual work and gives the example: *what do you do when the emergency buzzer alarms? You don't say: 'Oh, I need more experience', you just go and get on with*

it. This 'keep calm and carry on' notion is prevalent. Staff encourage each other to take part in the training exercises, for example: 'crack on then'…

(Terrorist Incident Training, District ED, Observational Notes)

There is a strong sense through this training, and many other periods of observation, that to be ED nurses and to fit in, the nurses must prove themselves as able to cope with the setting and circumstances. Again, adhering to this feeling rule requires surface acting for many of the nurses, as they do not feel as tough as required: they supress feelings associated with signs of weakness or fear. They must surface act to be blasé about the nature of the work (trauma, suffering, abuse, etc.) and must 'shrug their shoulders' (as the extract below will describe). In another reference to achieving a fearless front, an NA told me that new starters to the department have to 'earn their stripes' before people befriend them (one of many references to the military). Participants also spoke of the associated characteristics of being an ED nurse. One nurse in particular used words such as 'brash… loud… very confident' (ED S/N Becky, Teaching ED, Formal Interview). The perceptions of the senior nurse managers in the organisation also supported the expectation of characteristics that align with the junior nurses' perceptions and the need for toughness:

> I think, to some, they could portray – this is my take on it – I think some ED nurses can be portrayed as *quite sassy and a little bit gobby, assertive, shrugging their shoulders.* Not that they don't care, but I think to be able to cope… there has to be an element of being able to *control how emotionally involved you get* with what you see. So, there's a certain brand of ED nurse, and I can't put it into any other words.
>
> (ED Nurse Manager Shelly, Formal Interview, District ED)

The phrases, tone and behaviours described above are not often associated with the traditional warm and in some cases 'mothering' perceptions of nursing. For some of the nurses working in the ED, the associated feeling rules of traditional nursing (surrounding compassion, tenderness, comfort and sensibility) were still influential to their work. This brought a degree of tension as they juggled these with the masculinity and toughness expected to be felt in the ED. The work of Boyle (2005) found a similar merge of feminine and masculine 'faces' in studying the emotional labour of ambulance staff. Here, staff demonstrated a 'paradoxical mix of cultural values and practices'. The ambulance staff in Boyle's study also juggled between the two. They felt expected to show 'compassion, empathy and cheerfulness to their patients' – arguably more feminine qualities. At the same time, they needed to maintain masculinity ('self-control and

stoicism'), despite the traumatic nature of their emergency work (Boyle, 2005, p.62).

These competing feeling rules were a source of conflict for some of the ED nurses, as each carries different expectations for the type of care delivered. Traditional expectations surrounding the nature of care relate to feeling and showing warmth, body contact, affection and connection between nurse and patient. Conversely, toughness and masculinity are associated with task-based care that is practical and remains emotionally disconnected from patients. The emphasis in the latter is not on building relationships. Lara explained:

> I've known a lot of nurses who are quite, almost, I wouldn't say masculi*ne, but, you know, they're not interested in looking after patients in that way. That's why they work in the ED, they say. They don't want to be doing washing, dressing, stuff like that.* They want to give them drugs. They want to assess them. They want to move them on. I mean, yes, they will chit-chat and they will develop relationships with patients, *but not on a real kind of dignity personal kind of level, you know…*
>
> (Previous ED S/N Lara, Teaching ED, Formal Interview)

This perception was shared by those outside of the ED, too, as the extract below shows. The nature of the care delivered within the ED

and, importantly, by ED nurses is seen as different to that elsewhere in nursing – the representation of care is different. Restrictions upon time are also seen as influencers and moderators of the type of care delivered in the ED (and what is possible in the limited time available). Tara was described by her friend as 'brave' for choosing to work within the ED:

> She tells me how when she initially came to work in the ED, her nursing colleagues thought she was 'brave'. *She had a friend who also came to work in the ED on qualification, and she was surprised – I ask her why, because she is so caring.* I ask her to unpack this. She describes the differences between their nursing styles – her friend took much time when looking after her patients, and she thought she'd be suited to somewhere that allowed this time. *She is quick to assure me that she 'does care' but that it's just a different style of nursing.*
>
> (ED S/N Tara, Teaching ED, Informal Interview)

The phrase 'the greatest good for the greatest number' was therefore shared with me often during informal conversation. This phrase comes with a degree of acceptance that it is not possible in the ED to give all patients the care they may expect or need. In many instances, the nurses are unable to offer the traditional style of care they have been trained to deliver (driven by traditional nursing

feeling rules). This stance, then, supports the feeling rule that encourages emotional disconnection and distancing. In striving to meet the demands of the service, staff must undertake care rationing (and the associated emotional labour) as they 'decide' who and where to focus their care delivery with the limited time and resources (namely space) available. To offer a point of reference for this discussion, the concept of 'care rationing', is defined below:

> … the withholding or failure to carry out necessary nursing tasks due to inadequate time, staffing level, and/or skill mix, [which] may be a directly observable consequence of low staffing levels and poor practice environments'
>
> (Schubert et al, 2007, p.2)

Care rationing was therefore seen as an important component of ED nursing; there was a sense that in being and feeling 'tough', the nurses should also feel able to cap their physical and emotional offerings to patients. I observed how staff limited themselves during their interactions with patients. In this sense, surface acting was used as a defence against connecting with patients. ED S/N Becky offered her own experience of this emotional labour:

> *… it [the time pressure] makes me consciously avoid asking [patients] certain questions* because I think: 'Well, if I do that,

I open the floodgate', so I'm probably keeping my interactions with patients and relatives much shorter than I have done previously.

How does that make you feel?

… I don't think that it's very helpful. *Putting up a bit of a defence…* I know if I ask certain questions or if I go and try to find out certain answers, *it's going to take time. I haven't got time to do that.* Then that makes me feel bad that I can't do it… where I worked before, a lot of our patients would come in and out [for treatment]. So we would know them for six or eight months. *I think I'm having to adjust from having that sort of relationship to just stabilising patients and being able to reassure them but probably not in a very meaningful way, which is what I was able to do before.*

(ED S/N Becky, Teaching ED, Formal Interview)

Similar observations were offered by Michelle. In this example, she describes how staff use surface acting as a physical barrier, deploying their body as a shield – again distancing themselves from patient connection. Michelle found this form of surface acting too difficult to undertake; she felt unable to adhere to the feeling rule driving the

associated toughness and disconnection. She told me that she 'cares too much':

> … I've been in A&E when it's been really, really busy and somebody goes up to a member of staff and they stand with their back towards them, so they don't have to turn around and talk to people, and there's somebody stood waiting to ask a question because they're so busy. *They think it's one more thing to add on to everything else they're doing… [so they] ignore people…*
>
> *… I think you need to be quite stony-hearted because it's a hard place to work… I care too much.* I can't walk past somebody that says: 'Can you help me?', and unfortunately you don't have time. In A&E, you don't have time to stop for every person who says 'excuse me'. *You need to be able to walk past people…*
>
> (Previous ED Nurse Michelle, Teaching ED, Formal Interview)

Care rationing and the necessary emotional detachment were easier for some nurses than for others in the ED. Unlike Michelle above, those ED nurses who could adhere to this feeling rule had a sense of acceptance that it was essential to the overall running of the department. Tim, a senior ED nurse manager, explained how he

offers a degree of justification for the rationing of care through assessing risk. He had adjusted his expectations to fit with the limitations of the service, making the emotional labour required easier and less intense:

> *… you cannot give every single patient 100% of the care they need.* You've got to balance it out and give them what they need, prioritising what they really need and what could wait a bit. If you get a patient who is… 25 with chest pain, he's going to get the bare minimum, you know. In comparison to the 99-year-old with pressure sores who... can't swallow… She's going to get more care because she actually needs it. Whereas a 25-year-old, as long as he's safe and well, assessed, treated, discharged, admitted… *And that is a constant challenge* between doing all that, as well as being very time aware as well.

And you think that affects staff emotionally?

> I think consciously, it affects the conscience. It does me… *You know, I want to do the best for every single patient who I come into contact with, but I just know it's not humanly possible…* So, the way I personally work is by minimising any

> risk... What's safest? And that's how I *justify* some patients not getting 100% of what they need.
>
> (ED Manager Tim, District ED, Formal Interview)

Considering the importance of delivering this efficient and tough style of care (e.g. the ability to overlook patients in need), it is unsurprising that those who still desired to deliver more-time-consuming 'ward-style' care to patients (and connect with them) were seen as not being 'good' ED nurses. Lara, a nurse who had worked in the ED previously, also shared her experience:

> I think they [ED nurses] get the characteristics… *you're too caring if you're a ward nurse…* which sounds awful… I was quite efficient, but at the same time I spent quite a lot of time with my patients comforting them… it wasn't just about the four-hour target. That didn't really matter much to me at all, but because of that… I would never [get a promotion]… I got told I'm probably not suited as an ED nurse, not by seniors but my fellow [colleagues] because… I like spending time with my patients …
>
> (Previous ED S/N Lara, Teaching ED, Formal Interview)

ED S/N Jess shared similar experiences of 'being', or in this case 'not being', an ED nurse:

> I talk to one of the nurses briefly... She knows about my study and says to me: 'I'm probably not someone you should observe because I'm leaving soon'. She tells me: *'I'm not an ED nurse.'* She says she's found that out working here; she tells me that she came for the experience but that *she's going back to 'more that way' – her kind of ward-based care.*
>
> (ED S/N Jess, Teaching ED, Observational Notes)

There was often, therefore, a misalignment of priority for the nurses of speed and detachment (delivered through the ED nurses' feeling rule: tough, fearless and detached) against connection, intimacy and a slower pace (driven by 'traditional' feeling rules of the nursing role). The latter are the priority in the examples offered below. To suppress their frustration (at having to ration their caregiving), the nurses undertook surface acting, often in the interactions with their senior colleagues. This emotional labour related to the suppression of frustration, disappointment and guilt at being unable to care as they had hoped or expected to in the ED. ED S/N Becky offered a specific example of the conflict she experienced when encouraged by colleagues to ration her care. In delivering time-consuming care anyway, she was 'rebelling' against what it is to 'be' an ED nurse:

> I was in [initial assessment] and a man, he was like leaking from… he'd had a biopsy… Some sort of bowel cancer or something… it was just like really… faecal, I don't know, but disgusting and he was absolutely covered in it, and before doing anything else, I wanted to clean him up, before even cannulating and doing bloods because, yes, he needs to go for a scan, but I can't cannulate someone aseptic… and they're covered in some sort of faecal matter. It was everywhere and I was being just constantly *'Just get on with it. You haven't got time to do that.'* For me, I need to clean him first, before we do anything, just for dignity.
>
> (ED S/N Becky, Teaching ED, Formal Interview)

Michelle, another former ED nurse, described similar experiences. Here, she had to supress her sadness and disappointment at being unable to deliver the standard of care she expected of herself:

> *You can't be the sort of nurse you might want to be… You can't nurse people properly in the ED… you can't nurse people in A&E like they would be nursed on a ward.* You don't have the staff or facilities to do that and it's just getting worse… I think it's one of the major things that make it a hard place to work because you feel that *you're not doing the best for the people you're looking after… it can actually grind you down. As nurses,*

you want to care for people. You want to make a difference… you can't always do that in A&E…

One incident changed my outlook on A&E, when I actually thought to myself: *'I can't work here anymore'.* It was a really, really busy November day, and we had 100+ people in the department. Trolleys were stacked… through majors, and right in the middle I had a *little old man of 88 who started fitting and I could do nothing but stand in the middle of majors, in all of those people, holding his head. I just thought that if that was my granddad, I'd be disgusted…* [the participant became upset and we moved the conversation to a different topic.]

(Previous ED Nurse Michelle, Teaching ED, Formal Interview)

For Michelle, and others, these experiences (and the emotional labour required to manage them) were especially powerful. In Michelle's case, the necessary suppression of frustration, disappointment, guilt and sadness was 'too much' – she moved on to a different nursing role outside of the ED environment.

5.2 Feeling Rule 2: 'I've Got This' – Feel in Control and Calm (do not show you are busy, or don't have time)

… I suppose from the outside it could appear that you're managing well, you're getting to your patients, you're putting

on a front, you're smiling, you're happy. *You present yourself.* You tell them what the plan is, what's going to happen, what to expect next. Then you're whisking off to take the next patient or moving on to another area. *So, yeah… patients' or relatives' perception could be that it doesn't look as busy because they don't see what's going on behind the scenes.* They don't see what resus is like, that there's minus two beds in there… Or the walk-in side… there could be probably five or six people in the waiting room wanting to know why they've not been seen straightaway because it doesn't look busy, whereas resus is just behind the doors and there could be massive traumas going off. *[Don't let them] see you're stressed and flustered…* It gives them reassurance… *To show patients that you're confident and you can get on with it, but obviously you know that you're not going to be [laughs] calm in every situation.*

(ED S/N Carly and Student Nurse Lily, District ED, Formal Interview)

The ED nurse must ensure that, irrespective of the circumstances, they present a competent, capable, calm front – they must show that they are in control. This feeling rule therefore encouraged the nurses to feel calm and to supress any feelings of anxiety or stress through their surface acting. Examples of this emotional labour were abundant during the observations and interviews. This surface acting

often occurred when the nurse deemed the patient's illness or injury to be more of a priority than the patient did. In these instances, the nurse might have noticed a time-critical or serious illness or injury that the patient was unaware of. The nurse undertook this emotional labour to reassure the patient but also to maintain the expected calm exterior to colleagues. The nurse acted to hide the anxiety they felt (about the clinical instability or urgency of the patient's condition). Specific examples of this will be offered within this section.

Although this particular form of emotional labour is most likely to occur in the resuscitation space, it may be undertaken within an initial assessment area also, before the patient has been taken to the appropriate area for the severity of their condition. In the quotation below, ED S/N Lara shares her experience of this. The first part of this extract shows the emotional labour sometimes involved in caring for acutely unwell patients more broadly. The challenge involved in managing these patients is elevated when the department is full (they need to be cared for in the resuscitation area) – there is no space to take them to the relevant area for their need (showing the influence of physical space). ED S/N Lara used surface acting to hide her true feelings of fear and hesitation presented by the situation:

> [You can be really] worried about [a patient] and there's nowhere to put them… you want to take them to resus because

> they're really sick and [resus is] full… *So you have to still remain calm…* because they've got enough on their plate... You've just got to go: 'Right. OK… Resus is full but we'll sort it.' *You've always got another plan in your head, but [laughs] behind all that, you're going: 'Crap!' …* because you're thinking: 'Well, this person needs to be seen right now, but there's no space', *but you have to just… be really calm…* if you panic, then the patients will panic, and they don't need that…

In the second part of this extract, Lara offers a prominent example of this emotional labour. Her surface acting was intensified when she became stuck in a lift with the patient and his wife:

> This reminds me of a time when I was in the lift… I was with quite a seriously ill patient and the lift actually just dropped a little bit… *and then the patient's relative and the patient looked straight at me and I didn't really show much panic on my face… But because I was quite calm about it, I think they remained calm…* I think as a nurse or a doctor or any healthcare professional, you're actually like a parent to everybody. You're everybody's mum. *So on the surface you do have to look calm and you have to look like you're in control* because they're vulnerable and you can't be panicking because it's just not going to solve anything, *whereas underneath you might not*

have a clue what to do, but you have to come up with something and you might be crapping yourself… like I was in the lift… *It's just a mask again, isn't it?*

(Previous ED S/N Nurse Lara, Teaching ED, Formal Interview)

Presenting outwardly as calm and 'unflappable', regardless of the circumstances is crucial; even if the nurse feels out of their depth, they must hide these feelings of anxiety. ED S/N Sally offered her experience of 'looking like' she was in control, which she also felt was driven by the desire to reassure the patient:

… and be able to portray that you know everything [laughs]… *But always look like you're in control of the situation and knowing what you're supposed to do in that situation.* Because you can have people just run in with like a poorly baby and you need to know from that second, know exactly what you need to do. *And look like you've got it under control and you're calm for the family who will be there…* in distressing times… Cause they [the family] want to think that you know exactly what you're gonna do in this situation…

(ED S/N Sally, District ED, Formal Interview)

A further example of this feeling rule and associated surface acting was offered during an informal interview. Again, the example relates to caring for sick children:

> I have a conversation with a senior nurse about looking after paediatric patients (children and babies); this is something that causes fear and anxiety for her, and she speaks as though she is not alone in feeling this way. *A clear example of emotional labour follows: the nurse states that to the family (of the child patient), she appears all calm and reassuring and shows no signs of worry, and then inside she says she is 'ahhhhhh!!!'* This internal scream is referring to the worry she is experiencing (but not outwardly showing) looking after children…
>
> (District ED, Informal Interview)

Although presenting as calm and competent for the patient and their family was seen as an important agent in this labour, the acting involved was also seen as essential to being a 'good' ED nurse. Again, this shows how those nurses who can conform to ED feeling rules are perceived differently to those who cannot:

> *I can see other people looking pretty calm whilst everything around them looks kind of chaotic… I think they are good*

nurses and are people who I'm trying to learn from and maybe copy… they can do this.

So it's something you see as a quality?

Yeah. I think it's a good thing. I think it can help put patients at ease if everything else is looking really chaotic but the person who's dealing with them *appears to be really calm and is just dealing with them and ignoring everything else. I think that can be quite a reassuring thing.*

(ED S/N Becky, Teaching ED, Formal Interview)

The need to maintain a calm front through surface acting again relates to the need for bravery and fearlessness, as discussed earlier. In these specific examples, however, the surface acting was less about achieving masculinity and 'earning stripes' and more to do with nurturing, protecting and, in some ways, mothering the patient (and their relatives).

Nurses shared how stressed they felt internally, wanting to scream with fear, but knowing that they had to keep this form of emotion 'at bay' (ED S/N Sara, District ED). In a further example, ED Sister Ellie (District ED) spoke to me about experiences of managing a full resus

area and juggling tasks and responsibilities. She had felt the pressures of these types of situations (having to juggle managerial tasks with clinical care) on a recent shift, where she had seven acutely unwell patients, which included two babies who had stopped breathing and a young woman who had suffered a cardiac arrest. It was particularly difficult, she stated, because she had to be directly responsible for patient care whilst also dealing with managerial responsibilities and organisational pressures (such as the four-hour target). I asked her how she managed this type of extremely busy situation, and she replied: 'it's the A&E swan – on the surface, all calm; underneath, going like mad!' With this, she peddled her arms at speed, frantically, like the feet of a swan swimming through the water. She stated: 'we are taught to show we are coping' (surface acting) – whatever the circumstances.

These data introduced the metaphor of 'the A&E swan' or 'duck paddling', which was then taken into the formal interviews. It offered staff the opportunity to share many similar experiences of the surface acting in supressing feelings of anxiety or panic. Staff related strongly to this metaphor and image, saying that, 'oh yeah', this was a 'normal' part of the role. Specific examples of this in action were offered by ED S/N Sally:

Yeah, that's the exact thing that I always describe to everybody. When they always say that *'you don't look panicked'.*

Do people say that to you?

Yeah, sometimes if you're in resus in a situation… *They always say that you don't look panicked. And I just say: 'I am inside.'*

…what kinds of situations then?

The other day, I had a situation where I had a little three-day-old baby who I had to take into resus. It was not very responsive, and I'm not a children's nurse. *It was one of them situations where you think... 'I do not want to be the one looking after this.'*

On the outside, would anyone know you were feeling like that?

No, no, the parents thought that I knew everything about children and they wanted me to stay with them. *But on the inside, I could go: 'help'. I think you've got to be quite good at doing that here.*

Any others…?

Yeah, all the time. If it's really busy as well, *you have to look like you've got it all under control and that it's not a stressful, panicked situation. You have to act like everything is fine.*

(ED S/N Sally, District ED, Formal Interview)

Maintaining a calm exterior also relates to the surface acting required in managing the workload more generally. The ED nurse must also undertake this emotional labour to ensure that they do not look busy, even when they are. As noted earlier, multitasking was a source of this busyness, particularly in the majors space – this work was described at length during the formal interviews when using the 'juggling' metaphor. Juggling is especially relevant to the feeling rule: feel in control and calm.

ED Sister Evie had much experience of co-ordinating this work within majors. She regularly worked from the computer station and described how the layout of the environment meant that she and her nurse colleagues were constantly visible – there were no offstage spaces (this refers to the work of Goffman). Consequently, there was little or no opportunity for reprieve. The need to surface act was intense. Evie needed to show that her care delivery and the management of this workload were done naturally and with ease,

irrespective of the circumstances. She shared her experience, also highlighting the prominence of sound to the intensity she felt:

> … it's a mixture of stress. Sometimes you just feel like you just don't know where to start. Sometimes in the environment where it's overcrowding like that, you can feel very enclosed and it can feel quite pressurised because… *you're there as a person who can be seen like on stage and you can feel like everyone is sort of looking at you*; it can feel quite daunting and it's quite pressurised.

She went on to explain this further:

> Everyone is there [in the central majors area] and their relatives are there; obviously they are just concerned about their relatives, *but you feel like everybody is looking at you,* so I think sometimes practitioners and doctors get to escape that because they are sitting in the back office. As a nurse, particularly as a co-ordinator, you're there. Or even just as a nurse, actually, *you're there on show all the time and people are watching what you're doing all the time.*

I asked Evie what this felt like:

Stressful, stressful. It's quite noisy as well, a noisy environment… I can describe it that you would torture somebody with the same sort of amount of pressure and noise and sort of four people at once asking you what, asking you something; it's stressful.

(ED Sister Evie, Formal Interview, Teaching ED)

As well as looking as though they are not busy (even when they are), the nurses must also use surface acting to show that they have unlimited time, even when time is short. This emotional labour is also driven by the feeling rule of feeling calm and in control. ED S/N Alison introduced the relevance of working quickly to her experience of nursing in the ED:

Has ED met your expectations?

…the lack of patient care that I gave because it was so busy [was unexpected]. *I felt an expectation to do things quickly*. It made me feel uncomfortable. Just pressure all the time, in pretty much whatever area you worked in. There was always this constant pressure to move quickly, which I hadn't felt when I was a student... So, it was a shock when I came here.

(ED S/N Alison, District ED, Formal Interview)

The need to hide the lack of time available for the delivery of care is fundamental to ED nurses' surface acting. This surface acting shows the powerful relevance of time as a moderator of the nurses' emotional labour. The ED nurses were also required to supress any emotions that related to being short on time and feeling rushed – this was essential throughout the entirety of the department. Much of the surface acting relating to time was in response to the pressure of the time-critical targets in the ED (e.g. the four-hour target and the ambulance turnaround time). Many of these time-critical targets are unique to emergency care. 'The need for speed' is essential to ED nurses' work. Achieving it and undertaking the associated emotional labour are seen as identifiable and desirable characteristic of the ED nurse. Spatial elements are important here, as the emphasis is on moving patients through and out of the ED space – momentum is key. Michelle offered an insight into the implications of the four-hour target on her time with patients. Here, surface acting was undertaken to hide this sense of pressure and limited time from the patients:

> *Time is a challenge for everywhere, but in A&E, it's like sometimes you're constantly being rushed to get them [the patients] out…* [so they don't breach]… that was one of my problems, my priority was my patients. It wasn't four hours.
>
> (Previous ED S/N Michelle, Teaching ED, Formal Interview)

The four-hour target is particularly significant when considering this feeling rule, as it directly influences the performance required of staff. Often, this surface acting is in specific response to the feelings of frustration and challenge around the maintenance and prioritisation of the target. Allowing patients to breach the target, without clinical exception, is seen as unacceptable and can be a source of tension. The example below offers an insight into this:

> Observing the paediatric area, there is anxiety about a patient who is approaching the four-hour breach. He is waiting for a speciality doctor (outside of the ED) to review his x-rays to see what the plan is (whether he be admitted or sent home). The relative, his mother, is becoming more and more agitated, wanting to know what is happening. The ED doctor is on the phone to the speciality doctor. The nurse is dashing between this (and the tasks associated with pre-empting the decision – e.g. trying to arrange him a bed) and other clinical tasks for other patients – it is clear that she can't allow the patient to breach the four-hour target and that this is a priority. Because the case has been rushed and involves a last-minute decision, the ED staff are worried about transferring the patient to the ward. This is because of the hostility they are likely to receive from the ward staff.

The tension at the nurses' station is palpable as they await a decision from the speciality doctor and at the same time try to plan for every possible outcome to prevent the breach. A nurse begins to get frustrated, as none of the speciality nursing staff will take the patient's details before the consultant has looked at the x-ray, despite the importance of preventing the breach. The clock is ticking down and the nurse is ringing more-senior staff; the speciality doctor is still unreachable. *Frustration and tension are mounting, which can be seen in the nurse's facial expressions and body language. She sighs, has her hand on her hip and looks at her most tense – despite this, her language on the phone has changed very little. She remains calm and becomes a little more assertive but does not raise her voice.* With only a few minutes to go, the speciality doctor arrives in the ED. The problem resolves and the patient is admitted to the ward. *The release of tension in preventing the breach can be felt.* The nurse explains that most ward staff don't 'get it' regarding the priority given to patients breaching the target.

This period of observation showed a clear example of the surface acting required in managing the four-hour target. During the period outlined, the nurse remained outwardly calm (she was not rude, did not raise her voice and did not change the tone/speed of her speech). However, through her visibly growing frustration, seen in her body

language (tension in hands and shoulders) and facial expressions (rolling of eyes and gritting of teeth), it was evident that she was struggling to maintain this exterior as the situation escalated. In undertaking this emotional labour, she maintained her calm approach – the colleague on the phone would most likely be unaware of the frustration experienced.

Moreover, after the tension had subsided and the patient had been moved, the nurse reaffirmed to me how she had needed to 'bite her tongue'. She also explained how the dynamics of maintaining the four-hour target regularly require this management of emotion. The suppression of feeling, especially frustration, was seen to be an essential component of effective communication, particularly when interacting with those outside of the ED (without the organisational understanding in relation to the target). In this instance, and in the example given above, the ED nurse gives importance and priority to maintaining the target; the ward nurse does not share this priority. In response, the ED nurse undertakes surface acting to supress the frustration surrounding the lack of time before the patient breaches.

Supressing the emotional challenge associated with a lack of time also relates to another time-critical target: the ambulance turnaround time. This emotional labour occurs specifically within the initial assessment space. On one occasion, the NIC of this area was

especially young. Outwardly, she appeared calm, as the feeling rule states; however, it became apparent that she was surface acting. She told me how she was supressing anxiety surrounding the limited time available, the various clinical targets and the subsequent mounting pressure. Again, the emphasis was on moving patients through and out of the assessment space to ensure continuous flow:

> I see one of the nurses taking a handover off a crew member; she smiles at him and he has a joke with her. She is also the nurse who is 'in charge' of the area. I speak to the nurse (very briefly) about her role. *I ask her if she feels as 'in control' as she looks. She laughs and, still smiling, says 'NO!' She tells me that inside, she is experiencing 'blind panic' and 'total fear'. I respond by saying that 'you'd never know'; she reassures me strongly that this is how she is feeling.*
>
> (ED S/N Ellie, Teaching ED, Observational Notes)

The limited time between individual patients in the initial assessment area is also relevant to the nurses' surface acting. The minimal time (and space) between patients leaves no downtime for the nurses. They must move between two or more cubicles interchangeably and within seconds. Again, this shows the relevance of time as a moderator of the nurses' emotional labour. A further layer of complexity relates to the diverse spectrum of clinical, physical and

emotional needs between patients (to be discussed within the following feeling rule). The transitions between these 'multiple mask changes' and the intimate interactions are constrained, pressurised and intensified by the limited time available. As a result, the nurses must change faces or masks at speed. As part of this, the ED nurse must go from 'zero to hero' (taken from the extract below) during the fleeting and transient interactions. The patient is subsequently unaware of the minimal time available to the nurse. I was told that the ability to build a rapport with patients in a minimal timeframe is an essential component of ED nursing. It is important that the patient is unaware of the time limitations and pressures. Sue explained:

> They [ED nurses] build a relationship with that individual enough to get that part of the job done. 'Cause you've got to go from *zero to hero*, as far as I'm concerned… Never knowing somebody to doing something really, really intimate... *So you've got to get to know them really quickly, for them to be able to trust you.*
>
> (Deputy Divisional Nurse Sue, Teaching ED, Formal Interview)

The ability to build this rapport and intimacy quickly through these transient and speedy interactions, and to stay in control, drives this emotional labour: 'That's one thing I've noticed with patients… to get that rapport… you only meet them [patients] for snippets of time…'

(ED S/N Suzie, Teaching ED, Formal Interview). Again, this surface acting ensures that the patient remains unaware of the time limitations driving the nurses' work.

5.3 Feeling Rule 3: 'A Mountain out of a Molehill' – Feel Empathy and Do Not Feel Resentment (even when patients are attending unnecessarily)

> Patients and, more routinely, their relatives are distressed. This is particularly apparent when parents bring their children to the [reception] desk. In the queue, these parents look visibly anxious and upset; in some instances, they are in tears. They often carry the children in their arms. The children have various problems, such as a rash or general illness.
>
> A relative then pushes to the front of the queue. They are looking for their father/grandfather, who was brought to the ED by ambulance earlier that day. They are visibly anxious and stressed and target this in part at me; they are frustrated and aggressive in their tone, wanting someone to help them. They talk under their breath, swear and 'tut'. The staff manage this as part of their usual work and seem unfazed by the aggression… The staff direct the individual to their relative and then explain to me that they get a great deal of aggression aimed at them but say little more – this seems an expected

part of the role. Aggression is clearly something the staff are used to, as is evident in the way in which they reacted to and managed the incident.

The staff return to the [next in the queue], only to be 'interrupted' by another relative pushing to the front of the queue… with this there is tension. The male is quite aggressive and bolshie, and I hear him state: 'if your leg is hanging off, you are in trouble here, aren't you?' He is visibly panicked about his child, who he is holding. The receptionist starts to book him in. A few seconds after, another parent approaches the desk – they are also very worried and are concerned that their child is blue (the child does not look blue). He is agitated. The first receptionist is still booking in the first patient and tries to explain this to the parent, but it only distresses him further. Another staff member offers to book his child in. After both parents have been booked in and directed to the paediatric department, the receptionist turns to me and states: *'you nearly saw my angry side!'* These examples demonstrate clear emotional labour from the receptionists, who tried not to show their frustration. With that, the staff go back to other tasks, booking in fracture clinic appointments and other more 'mundane' tasks.

(District ED, Observational Notes)

In many cases and as acknowledged earlier, the seriousness of an actual injury or illness is likely to be perceived differently by the patient experiencing the condition, their relatives and the staff caring for them. This feeling rule offers examples of consequential emotional labour in response to the reverse - when the ED staff member perceives the patient's need as less great than the patient does. The extract above introduces this, showing the concern and distress of parents who bring their sick children to the ED. In one particular case, a father stated that his child was blue (although the child did not look blue), and his worry turned quickly, and understandably, into verbal aggression and agitation when the receptionists did not show him that they shared his immediate concern. The receptionists performed surface acting to visibly hide their frustration at the behaviour they were experiencing from the father (reaffirmed when one stated: 'you nearly saw my angry side!', suggesting that she was suppressing the urge to show this). The receptionists were not medically trained but still, they did not share the urgency of the father of the child. They saw and experienced this behaviour as unwarranted and unreasonable. As a consequence of the surface acting, those in the queue, and the agitated father, were unaware of any frustration felt.

ED nurses must also perform essential surface acting for similar means; it is arguably however, more complex. The ability to move

between the spectrum of needs (as noted in the previous feeling rule) and still offer universal reassurance to patients and relatives is seen as essential, irrespective of personal feelings:

> … you know, you see quite a lot of bad things. You deal with a lot of complex things and… You do have to put up a front, a very professional front, and you have to deal with different levels of communication as well. You'll get someone with mental health problems one minute, get someone with a broken finger the next minute, someone's collapsed… *Then you just have to mould yourself into a different personality… to communicate with them, to get on their level of their need.*
>
> (S/N Lara, Teaching ED, Formal Interview)

Between the ED nurse and the ED patient, there is often an imbalance between the level of significance given to the condition. In other words, there can be a 'mismatch' between the carer and the cared for relating to the priority given to the illness or injury. We saw a mismatch earlier when the nurse was attaching higher priority to the patient's condition than the patient was. In this instance, the opposite occurred. Here, the nurse deemed the patient's illness or injury as low clinical priority, whilst for the patient it was high priority. This disparity between prioritisation requires a specific form of surface acting as the nurse attempts to deliver reassurance to the

patient. This specific form of emotional labour is driven by the expectation that nurses should feel empathy and not resentment, irrespective of the patient's condition. This surface acting is commonly found in specific areas of the ED, usually the triage area (and, as noted later, the minor injuries area):

> … there are different emotions [associated with] each [area], so… assessment/streaming, i.e. sometimes you can feel a bit resentful towards people just because of what they come into hospital with, or if they have come in regularly, or they are known to have lots of social problems. And sometimes you can't help but think sometimes things are self-inflicted in people who come in again and again and again, and *sometimes you can feel a bit resentful because obviously you have to try and control your feelings towards them… It can be [hard] when that patient is not behaving in a very nice way as well. It would be easy to, to lash out at them and say what you think, but obviously you can't.*
>
> (ED S/N Evie, Teaching ED, Formal Interview)

As highlighted in the above extract, this form of emotional labour is particularly relevant during the process of streaming and triage before the patient has been allocated to a specific area based on their

clinical need. To ensure displays of reassurance outwardly to the patient, the nurse must internalise their truly felt frustration:

> The triage nurse explains how she has 'stopped trying to educate patients' about their choice of service 'a long time ago'… patients who attend 'inappropriately' 'won't listen anyway'… it's easier to, *'internalise this frustration'* and not 'battle' with them. *It is not obvious she is frustrated (in front of patients), but this is expressed strongly when we are alone.*
>
> (ED S/N Julie, District ED, Informal Interview)

ED S/N Lara gives a specific example of this when assessing a patient who presented at the ED after being unable to sleep. This example was also taken from the triage/assessment area. There was again a mismatch of priority: the patient felt that this was urgent, but Lara did not. As shown in the extract below, Lara felt little empathy but still showed the patient empathy through her surface acing – she did not show the patient resentment for presenting at the ED:

> *… sometimes you have to do your best not to get annoyed with people who are moaning about… a superficial thing [illness or complaint]…* They just see their problem, which is fair enough.

… how do you not show that frustration?

You just try not to. Sometimes I think everyone's caught out every now and then about it, but it's not helpful, is it? A lot of people say: 'Oh, there's a lot of violence and people kick off in A&E', but I think it's how [staff] deal with those kinds of people. If you come across very negative and say: 'Well, you should see this person in resus. They're dying. Blah-blah-blah'… It'll get their back up because they don't see that. They see that they're in pain, you know, and that's it… You're not going to change that, *but… if you're just patient with them… even if you do think: 'Well, you're making a mountain out of a molehill here',* but they don't know that. They're not educated, most of them, to the level that you are in A&E. They don't work there. They don't have a clue, do they? Unfortunately, I had one chap… I was still trying to be professional with him, but he came into A&E [laughs]… Because it was nightshift and I [assessed] him and he said: 'I'm not sleeping.' And I went: 'OK. How long have you not been sleeping for?'… 'Have you been to your GP?' 'No. Well, I just want something to make me sleep.' I said: 'Well, what are we going to do for you here? It's not an accident or emergency'… *And you do get a little bit mad with something like that because they are actually really well.* He's just not sleeping. I mean, it's quite ironic because a

> lot of nurses don't sleep anyway [laughs]. *So you're just thinking: 'Well, I'm not feeling much sympathy'…* you can be mad about it or you kind of move on to the next thing. You just have to think: 'Well, you can stay and wait, or you can go to your GP or whatever.'
>
> (Previous ED S/N Lara, Teaching ED, Formal Interview)

These examples also introduce the notion of legitimacy. Importantly, less management of emotion is required if the patient's attendance at the ED is deemed legitimate by the nurse. When the patient is not seen as legitimate, it is harder for the nurse to feel empathy towards them and not resent their attendance at the ED; in response, the surface acting required (to not show this outwardly to the patient) is intensified. Compassion and reassurance in response to patients' and relatives' anxiety are easier when the nurse deems the patient as legitimate. Legitimacy in this sense refers to the 'inappropriateness' of the patient's attendance, as discussed earlier. The example of the patient not sleeping (offered by Lara) shows a patient deemed illegitimate. These ideas relate to the work by Jeffery (1979) on deviant patients and 'normal rubbish'. There is little or no allowance made for patients with seemingly minor complaints who are still scared or stressed:

> *What is difficult is when they perceive their problem to be of equal worth to somebody who's having a heart attack when they potentially have an inconvenience, and it's difficult for me when those people can't see the difference. They perceive their emergency as the end-all of all emergencies, when really, realistically, they have not been involved in a car crash and are not about to lose one of their legs…* If they're understanding, that's fine because they're not causing a problem, but if they start getting aggressive, people start shouting, people start demanding to be seen, when there's a reason that they haven't been seen… If you've come to the ED and you're not the top priority, it's probably a good thing. And you've been assessed and clinically you're well and you're stable, it's probably a good thing. You need to be worried when everybody's around you and you're seen potentially within five minutes of walking through the door because then there is something wrong with you. Then that is the time to think there is an issue that needs fixing, amending, treating…
>
> (ED S/N Adam, District ED, Formal Interview)

Similarly, ED S/N Lucy also described her experience of patients whose attendance at the ED was perceived as less legitimate. In the example below, she focuses on when she deemed a patient to be

'irritating'; this irritation was felt due to the perception that their need was less great. She checked with me that it was 'OK' for her to call patients irritating, which suggested that she was discussing behaviour outside of professional expectations.

The emotional labour involved in the legitimation and perception of patient need relate to 'emotional dirty work' (Ward and McMurray, 2014). This is a concept that recognises the work involved in managing emotions that are seen as burdensome, undesirable and disruptive (Chiappetta-Swanson, 2005). ED nurses are often tasked with emotional dirty work, including the management of less appealing groups, such as so-called 'inappropriate/illegitimate attenders'. Such work is mentioned in the example from Lucy below. In particular, she stated that in dealing with the burden of inappropriate attenders, 'you feel like you could be giving your time to someone who really needs it'. The surface acting she undertook was to hide her feelings of agitation and not show the patient her frustration. In doing this surface acting, she still offered the patient reassurance:

> … *even if you're really busy and really stressed, you've got to try your best not to show it in front of patients… I know it's difficult not to, but you've got to try not to…* Because you're not providing the best patient care…

And do you always manage not to show the stress?

I think it depends how irritating my patient is, to be honest. Am I allowed to say that?

Of course… what would be an irritating patient?

People who don't necessarily need to be here with us. Patients can be very rude to staff unnecessarily. I mean, I understand that they can get frustrated because they're sitting there waiting and they want things done now, but sometimes when people keep going on and on and on at you because they're waiting and this and that and there's other people waiting as well and you're just doing the best you can, *it's difficult to keep a happy face on [laughs].*

So it's easier to not show that stress when you feel that the person does need to be [in the ED]?

Yeah. I think so.

Why do you think that is?

> Just because, I mean, *they're there for a reason. They need your time, and it can be irritating when you've got loads of people to look after… and you feel like you could be giving your time to someone who really needs it and instead you're having to give them less care because there's someone there who doesn't necessarily need to be there.*
>
> (ED S/N Lucy, Teaching ED, Formal Interview)

Legitimacy, in many cases, also relates to the actual source or cause of the illness or injury. The surface acting involved in offering reassurance is harder still when the reason for presentation is deemed 'self-inflicted' – there is a further sense of resentment towards these patients. I was told by numerous ED nurses that the workload was already 'massive' and that some patients did not 'need to be there', seen as not particularly 'in need'. Nurses must also care for and reassure patients who display behaviour or lifestyle choices they disagree with – a further call for surface acting and an example of emotional dirty work. The ED cares for many patients who are involved in illegal drug taking and excessive alcohol consumption and who are perpetrators of violence. The example below offers an insight into a specific example of this emotional labour. The nurses were caring for a patient who had been taking illegal drugs. They used

surface acting to hide their disapproval of the behaviour. This allowed them to still act sympathetically towards the patient and to offer reassurance. This extract shows the observation of a conversation in the staff-only area of the majors space, out of the direct sight and hearing of patients:

> I hear a further conversation that is unlikely to be discussed in the patient environment. This is in relation to a nurse who has been caring for patients who were taking drugs whilst in the vicinity of their children. *The nurse states how she 'hates doing that bit': interacting with them. Another nurse agrees and describes her lack of sympathy for these patients and how, as a result, their role is difficult. This is an example of emotional labour, as staff find hiding their lack of sympathy a challenge but still feel the need to do so.* Although this area is 'offstage' to a certain degree, staff are still acting; it seems like a middle ground between the clinical 'shop floor' and the coffee room – or, further still, home.
>
> (District ED, Observational Notes)

A further important layer of tension for the surface acting relating to legitimacy is linked to the limited physical space between patients. This again recognises space (this time, the layout and restricted space) as a significant moderator of the ED nurses' emotional labour.

The nurses must move between patient groups, often separated by only a few steps and/or a door, and adapt their 'masks' to suit. This contrast between patients intensifies the surface acting needed for illegitimate patients:

> They [the ED nurses] feel that much of the stress and difficulty of managing their emotions in the ED comes from the stark contrast between the types of care they deliver (e.g. traumatic incidents and then more-'trivial' work). *They find this difficult: one minute they can be dealing with a patient experiencing a distressing trauma or death (and their relatives), then they move to (within minutes) caring for someone with much less of an emergency. They 'act' like nothing has happened previously…* One of the nurses tells me: *'I don't have any emotions'. She explains that this is the way the ED 'makes you'. She says that you become impatient and less tolerant of those [patients] who attend the ED with 'inappropriate' complaints…*
>
> (ED Nurse Staff Meeting, Teaching ED, Observational Notes)

ED S/N Lara also offered her insights on moving between these different patient groups (with different perceived levels of legitimacy) and her experience of the surface acting involved:

… you'll go to… minor injuries and there'll be someone moaning about how long they had to wait, which I can understand because they're sitting there. It must take, in their eyes, forever, to be seen and they're in pain… They might have a nasty wound or dislocated something or broken something, but unless the limb or whatever's compromised, really, they're not a priority, a top priority. You want to see them and sort them, but then you've just come from resus where you've kind of had to take someone up to the ward who's passing away and dealing with that. *So, you have to kind of put yourself into different sections of thinking…* You could go to [initial assessment] and you've got to assess someone and then move them on, but then the next minute you're working in [majors] where they're based and waiting for a doctor and you've got to sort things out and then take them to the ward. *It's just different tasks and different mentalities and different communication skills, and sometimes you have to do your best not to get annoyed with people who are moaning about what people probably think overall is a superficial thing, but to them a lot of people are boxed in, aren't they?* They just see their problem, which is fair enough.

(ED S/N Lara, Teaching ED, Formal Interview)

Not only is the physical space separating these patient groups (e.g. resuscitation and minor injuries patients) minimal but so too is the physical space between individual patients – acting again as a moderator of the nurses' emotional labour. Patients in the same clinical area can still warrant varying surface acting from staff to achieve an empathetic front (and to adhere to the feeling rule). Patients deemed legitimate can still differ dramatically. These patients are often only separated by thin disposable curtains, which are the only physical barrier between the changing of 'multiple masks'. The case study examples below offer (one of many) insights into this. The patients below were cared for in the resuscitation area within the Teaching ED, yet they were perceived very differently by staff in terms of their legitimacy. Moving between these patients with little physical space between, intensified the surface acting for the staff:

> In one cubicle is a 25-year-old male; he is of a large stature and build. He has taken illegal drugs and is intoxicated after attending a music festival. He has been brought to the ED after collapsing and requires a period of cardiac monitoring. His heart rate is abnormally and dangerously high – a consequence of the drugs consumed. He is awake and conscious, is verbally aggressive towards staff, is pulling off clinical monitoring equipment and wishes to leave the ED, against medical advice.

He is there with his girlfriend, who has also been drinking alcohol and is verbally aggressive towards staff.

Next to him (and separated by a thin paper curtain) is an elderly lady who has end-stage cancer and is receiving palliative care. She has been brought to the ED with an infection that cannot be managed in the community setting. She is gravely unwell and despite treatment is not expected to survive; she has a 'do not resuscitate' (DNR) order in place. She is waiting for a side room on a medical ward. She is drowsy but polite to staff and is reassured by their communication and company. She has no family locally so attends the ED alone.

I observe many instances when the spectrum of need (and perceived associated legitimacy) is such as this or more dichotomous still. The physical space exacerbates the differences in the patients' legitimacy and the surface acting required to supress resentment whilst still aiming to achieve reassurance and empathy.

(Observational Notes, Teaching ED)

Legitimacy is also relevant to the surface acting required for aggression management. The nurses must not respond to aggression with aggression, as such action would likely result in disciplinary

action. Instead, they must comply with the feeling rule and not show their resentment. This emotional labour is seen as prominent within the minor injuries areas of the ED. The extract below offers an insight into this observation:

> [Patients and relatives] are [most] likely to be aggressive in the areas where they are least ill [making empathy and emotional labour harder for staff]. *The management of aggression is different in areas where patients are most ill because you can understand it more [more empathy and compassion naturally, resulting in less intense emotional labour].*
>
> (ED S/N Suzie, Teaching ED, Formal Interview)

In some instances, a patient's aggression is excused due to the source of the behaviour (in the extract below, the source offered as an example is dementia). This changes the nature of the surface acting required. Bev still felt frustrated, but the legitimacy of the patient made compliance to the feeling rule easier:

> No, it's not always easy [supressing anger in relation to aggression]…
>
> **So, you're calm on the outside. Are you feeling calm?**

No [laughs]. I'll readily admit that, no.

How are you feeling?

Angry sometimes, frustrated.

So, some of the time you're able to keep that inside?

Yeah, the majority.

What happens if you can't?

I probably say what I'm thinking to the person, but this would only be in a situation where they're an extremely rude, aggressive person who's not doing it because of a physiological reason or because they are just being aggressive and rude and unreasonable, when we're trying to do our best for them. And I think there's less tolerance of that these days.

So, if someone is ill and that's making them aggressive?

No, absolutely not. Obviously, they can't help that at all…

In that instance… are you still feeling angry but you're showing calm?

Well, sometimes you do. *I suppose with dementia… I don't feel angry, I feel frustrated sometimes. If you've got a dementia patient who's constantly repetitive, you know, and they can hit out at you and pinch you or whatever. But it doesn't make you feel angry because they can't help it. It can be a bit frustrating sometimes, and you do have to walk away.* Because it's frustrating and you don't get anywhere with them as well – you're constantly repeating yourself.

(ED S/N Bev, District ED, Formal Interview)

Likewise, if the patient's behaviour during a particularly unpleasant intervention is deemed reasonable and legitimate, this eases the surface acting involved. In the example below, the ED staff were carrying out a relatively simple but uncomfortable procedure on a patient. Compassion for anxiety and aggression is much easier when those involved can relate to the patient's experience:

Staff experience verbal abuse from a patient who is receiving an intervention for a significant nose bleed – the patient calls one of them a 'bastard'. The NA states to the doctor who had been delivering the care and consequently received the abuse:

> *'I think I would have called you a bastard' (if she had been receiving the painful treatment in question). Staff make allowances for bad language and abuse when they can recognise the patient's discomfort. The doctor replies: 'I can completely understand why she [the patient] didn't want it [the intervention] done.'*
>
> (District ED, Observational Notes)

Conversely, in the example offered by ED S/N Jo, the patient's verbal aggression was not seen as reasonable or legitimate (he was agitated due to waiting times). The surface acting required by Jo (to meet his aggression without resentment) was intense and almost unmanageable. Adherence to the feeling rule for Jo was therefore especially challenging:

> … it was particularly busy and he was having to wait to be seen by the doctor (the doctor had been called off to the resuscitation area); he was waiting with a minor injury. She offered him assistance, as he was struggling to walk. He shouted at her (in front of a full waiting room, including children): *'Why don't you just fuck off and die?' She said she was shocked; the entire waiting room was staring back at her. She said she couldn't speak. Her 'blood was boiling' but she was also frightened. She 'couldn't engage with him' so walked away,*

afraid she would shout back or cry if she tried to speak. She explains further: 'had I been outside of work, I wouldn't let people speak to me like that'. She describes the reasons why patients might need to wait to be seen and how she wishes that, sometimes, she could show them, giving the example of a baby being resuscitated.

(ED S/N Jo, District ED, Informal Interview)

The internal frustration and fear that Jo experienced were so great here that her acting only achieved silence – she was unable to speak or act like she was not affected by the incident. ED S/N Jo felt that her only choice was to walk away; arguably, the acting required of the situation was too great. She did, however, stop her tears (during the incident) and stopped herself 'shouting back' at the patient (and meeting his aggression with further aggression). She said that outside of work, she would respond differently, implying that different feeling rules would then apply – empathy would not be expected, and resentment would be seen as a reasonable response.

5.4 Feeling Rule 4: 'Don't Take It Too Much to Heart' – Do Not Feel (Too Much) Distress and Grief (hide any upset)

It sounds harsh, but I haven't seen any real emotion whilst I've been down in the department, I don't think. I've heard some

terrible stories and witnessed some interesting things, and people have explained to me things that have gone on, and I'm fairly mature in years. I'm 60-odd years old, and some of the nurses who are talking to me, they're like kids, you know. You look at them and think: 'I don't know how old you are – 17, 18, 19.' I don't know how old you have to be to be a nurse, but *some of the things that they're telling me about things that have happened, I'd be in bits. As a full-grown, experienced man, I would be in pieces. 'How do you cope with that?' And there's not a flicker. You might get a laugh or they'll say: 'Oh, it's alright.'* And you think that's interesting but kind of scary in a way. *You've got these kids who are sewing people's scalps back on and it doesn't seem to register* and then they'll come in and have a chocolate biscuit and a cup of coffee. *So, I don't know what it is. I don't know whether they're able to detach themselves from what they do or whether they're crying inside.* I don't know, but it fascinates me, and these are people you're asking to try and turn an ambulance around a bit quicker as well…

(Project Leader Bill, Teaching ED, Formal Interview)

The data extract above was taken from an interview with a member of staff from outside of the ED visiting the department on

improvement work (focused on increasing the speed of ambulance turnaround times). The experience offers a degree of insight into the lack of visual displays of emotion seen in the ED. In this sense, emotion is specifically describing feelings of distress and upset, encouraging the nurses to feel these infrequently, if at all. This feeling rule ensures that much of this visual emotion is 'written out', as staff surface act to hide any signs of distress. This feeling rule also prompts a further form of emotional detachment. Senior ED managerial staff outline and reinforce the need for suppression of visible upset. The ability to do this surface acting is seen as a sign of competence and, therefore, a sign of a 'good' ED nurse:

> … if you came into the ED and a nurse started blubbering because of your story, what would you feel like as a patient? *So, we probably are good at emotions but actually we're good at also not showing them. It doesn't mean to say we don't feel them… The more competent you become as a nurse, the more you actually learn that you have to suppress that…* If you get a baby that comes in and the parents are screaming and crying, they don't want the nurse doing the same thing. They want the nurse to be efficient, to know what they're doing and to assist them. They do not need an emotional wreck to be dealing with them. They need someone to actually help, and that is part of the role… *you appear to become hard because*

> *what you can't do is actually transfer your angst and emotion onto the people who you're trying to help… I see people who are very efficient and probably come across as quite cold…* I would expect a nurse not to fall apart, and if somebody were falling apart in front of a patient, I would remove them from the situation. *So maybe that looks like we don't do emotion.*
>
> (Bev and Yvonne, ED Matrons, District ED, Formal Interview)

This suppression of upset and distress is seen to be for the patient's benefit, ensuring that the practical elements of nursing care can be delivered effectively. This relates back to the second feeling rule: feel in control and calm, where nurses undertake surface acting to protect the patient from further stress. The difference here is the nature of the emotion being supressed. In this fourth feeling rule, the nurses are specifically discussing surface acting to hide personal sadness, grief and upset. Junior S/N Adam also offered his experience of this:

> There are elements of the job where you do need to have resilience and be tough because sometimes when you're faced with aggressive patients or a particularly tragic – sounds a bit melodramatic – *but a particularly sad situation…* yes you can wear your emotions on your sleeve, but if they're always on show, then you might find that it can potentially interfere

> because you'll have this [patient], that [patient]… and five minutes later you'll have to go in to another patient and see them… From my perspective, *I wouldn't want my nurse coming to me crying and they'd be like: 'Well, why are you crying?' 'Oh, it's nothing to do with you', but trying to sort me out with tears running down their face…*
>
> (S/N Adam, District ED, Formal Interview)

Despite this, the surface acting in hiding personal distress and sadness is a careful balancing act – the nurses must still offer enough emotion to their patients and relatives to show that they care, but not too much. The display of the nurse's feelings is seen as secondary to the feelings of the patient and their family. Again, their well-being takes priority, and the focus is on clinical competence and support:

> I can think of probably a handful of times where it was wholly appropriate that I showed a family or a parent how it affected me, and that enabled that parent to reach a level of understanding or at least to come to some sort of terms that it is OK to feel as bad as they did because *'Look. Even the nurse is crying', but it was still a level… I can't completely lose it because this parent needs me to be sort of their advocate or act sort of on their behalf to help them through this.* So, somebody needs to still remain technically in control of that

situation. So, it was still: *'I completely feel for you in this situation and I'll show you an amount of…'*

You're controlling it?

you don't wish to go beyond where you are losing control because then that parent has nobody to take control of the whole situation or their respect for you may be diminished a little bit: 'this is my situation' but 'I'm looking to somebody to help me through this because I've never experienced this before. So, I'm looking for somebody to guide me through this', and they would look to the professional for that… *'I'm still in control but I'm showing you a little bit of how it does affect me.'*

(ED S/N Tom, District ED, Formal Interview)

In these examples, the nurses described the purpose of surface acting as for the patient – a balance between showing care and concern whilst remaining 'professional' and clinically useful. Undoubtedly, this prioritisation of the patient's condition and well-being is a driving factor in the restriction of emotional displays. In addition, staff are actively encouraged to disconnect emotionally from their patients, particularly in relation to difficult cases. They are

expected not to feel too much sadness or distress. This places a different kind of barrier between the nurse and the patient. This is seen to be a protective mechanism – again, by detaching emotionally, emotional survival is maintained. ED S/N Sally had recently cared for a dying patient and had suffered a family bereavement at a similar time. She felt uncomfortable working within the resuscitation area as a result and was concerned that she would be upset following her own experience. She was 'forced' by her manager to detach emotionally and carry on (aligning with the feeling rule). This resulted in significant surface acting for Sally:

> *…because everyone else is quite blasé about it, it kind of makes you… like that. So, you don't take it too much to heart…* Cause you need to carry on for the next patient who comes in… you kind of get on with the next thing… *sometimes you think: 'Well, oh, I don't want to carry on working', like 'I don't want to carry on working in resus today'. ''Cause I've literally had the worst situation.' Someone's died. Whereas they'll [her manager] just force you back there, and say: 'Carry on with your shift.'* And then it goes away, that sort of feeling of sort of apprehension, for the next thing that's gonna come in…

… it helps?

> Yeah. Otherwise I think it would put you off. I think that's how you learn not to be sort of phased by anything that you deal with.
>
> (ED S/N Sally, District ED, Formal Interview)

The example given by Sally also introduces the importance of the nurse's family circumstances to their surface acting through particularly distressing and upsetting cases. Although most visual displays of this emotion are written out of the setting, there are specific instances in which such outward emotional displays are acceptable. This breach of the feeling rule is made when patients and their relatives remind the nurses of home – if the source of the display of emotion can relate back to personal circumstances, adherence to the feeling rule is more flexible:

> I can remember when I first started A&E and seeing my first child death… It was a cot death, baby of about five months, and it made me cry the first time I saw a baby being resuscitated.
>
> **Were those tears in the moment or after or both?**
>
> In the moment. I wasn't caring for that patient. I was going through resus. My colleagues were looking after the little one

and just seeing the sight upset me. I think it was my first kind of experience or contact.

And does that ever get easier?

No. I think you just learn to manage your emotions.

How?

I don't know, to be fair. I don't know. *I can also think of an experience a couple of years ago when I was pregnant with my little boy. Resuscitating another child at the time. Yeah. That was a baby. It sticks with you. It definitely does. I was looking after another one. Sorry [participant starts to get upset].*

Don't apologise.

That was having seizures. It was a two-year-old little one in resus, and when I finished my shift, I'd gone home, but it was on my mind all night and I was wanting to ring back and check. *Obviously, I've got no connection to that little one… you can relate it to your own children as well, put yourself in those*

parents' shoes. I do find children quite challenging and difficult emotionally…

(ED S/N Carly and Student Nurse Lily, District ED, Formal Interview)

Further, similar experiences (relating to home) were shared by ED S/N Bev:

… There was a lady dying in resus, probably about a month ago, and I looked after her and her family, and I found that very emotional and found myself becoming emotional… sometimes you just can't hold the tears, because they were all there and I did shed a tear. Which isn't always the most professional, but you can't help it sometimes. That one springs to mind, and *I think it's 'cause I related to them as a family, they were a nice family, you know, and they were just obviously a close family.*

Relate to the family?

Yeah, and they clearly cared for… their mum… because obviously you get some people come in and they are all on their own and there's no one to care for them.

One of the reasons it was particularly emotional was because you could relate to the family?

Yeah because they were a close family, I suppose, like my family. And you think, you know, how would you feel if it were your family member. And they obviously cared deeply for this lady as well…

(ED S/N Bev, District ED, Formal Interview)

There is a sense, however, that impingement and flexibility of this feeling rule (feeling too much distress and showing upset) will only go so far in excusing the nurses from their expected emotionless surface acting. Ultimately, the expectation of an ED nurse is for them to surface act and put on a 'brave' mask to continue their duties. An ED sister, Jane, offered an insight into this – she too had experienced a patient case that was seen as close to home. Jane began with an insight into her experiences of supporting her colleagues. She described how she could see visual cues suggesting that staff were struggling with achieving the required level of surface acting in these instances – unable to supress their distress:

So, you can see it in their face, their actions?

They sometimes might look very angry. They might be a bit tearful. They might be very hot. They might be sweaty. They might have pressure of speech. They might have done something out of character… I would then be questioning: 'Is that member of staff alright? Why have they done that?'

…are there any particular instances those situations occur…?

…if there's something that's particularly close to home with a patient, if somebody who looks like a relative who's died recently who's not very well at all or something like a road traffic accident with patients a similar age to a member of their family or close friends… We're not as good as the ambulance service and the police… [if they] have something that's very sensitive to deal with, they're taken out of circulation and they don't have to deal with anything else, and they often have somebody sent to them to support them at the time, but *in A&E we don't have that luxury. We are still part of the numbers and we need to see the next patient.* There may be a time when you have to send somebody off for an extra drink… on a very rare occasion, somebody has to go home after something that's happened at work because they aren't psychologically able to continue with the shift at that

time, but, *generally speaking, we have to put a brave face on it and continue. So certainly, that's my own personal experience of a family member who's died whilst I've been on shift… and I was the NIC and had to continue because there wasn't anybody else in the middle of the night who I could have called to come and take over from me.*

(ED Sister Jane, Teaching ED, Formal Interview)

This extract shows the visual cues present when ED nurses are unable to perform the required surface acting – instances where the mask slips. Jane's experience also offers her personal insight into the relevance of cases seen as close to home. In addition, Jane also introduces the lack of physical opportunity for the release of distress and upset, driven by the demands of the service. Although the need for sustained performance was noted in relation to the second feeling rule, this surface acting is intensified by the personal and delicate nature of the emotion at hand. The cases remembered and shared by the nurses strike a chord. In these examples, the distress felt by the nurses related to grief, sorrow, remorse and mourning.

ED S/N Becky felt void of any time or space to process her emotions before the next patient arrived under her care – this is a further example of time and space as moderators of ED nurses' emotional labour. If a case has been particularly sad or moving, there is little

room to show this. Moving her attention immediately to another patient was a significant source of emotional labour for Becky – she did not have the time or space to process the case until the drive home:

> … he wasn't a trauma… he was a medical patient [moved] into one of my bays and 'We were treating him for chest sepsis. Everything's been done.' He just obviously wasn't well… Even though everything had been done, nothing was improving. Obs were still really rubbish and he was quite an obese man, really quite large, and he'd asked me like twice if I could help change him and I kept going: 'I'll come back to you. I promise I'll do it. I promise I'll do it', and then I had to go on my break and handed over and said: 'The only thing that needs doing is that man needs changing' [by 'changing', Becky is referring to the process of washing and changing the patient into a clean hospital gown / bed sheet after an episode of incontinence]. Went on my break. Came back. Obviously, he hadn't been changed, which is fair enough. That's OK because it was really busy in resus. His obs had got worse. So, I went to go and find a doctor to come and like just have a look at him, and that might have taken about 15 minutes. Came back with a doctor into the bay and he'd died and arrested like in that time… we started CPR and there was this kind of like panic: 'Oh, has he

got a DNR?', and no one really knew and the doctor was a junior doctor and he was asking me all these questions… I didn't know a thing. As we were doing the CPR, all this kind of faecal matter's coming out of his mouth and his nose and he's choking, and it was like we were shouting for help to get someone to come and suction and people weren't coming. *It was just really horrible.* What I thought I was looking after was completely wrong… *I just felt really rubbish. I didn't actually know his proper history… the last thing he'd asked is can someone just like clean him up. I just felt really shit about that. So, I cleaned him up. Put him in the viewing room and the next patient came in… I felt really bad.*

… Do you stop thinking about it immediately?

I did because the next patient was also really unwell. *So it wasn't 'til going home, driving home thinking about it. I still remember him really clearly… and no one, like the person who was in charge, no one came to ask if we were alright or anything… You know when we were talking about what's the stereotype of an ED nurse and they just get on with it. Well, yeah, but it's not OK, is it?*

(ED S/N Becky, Teaching ED, Formal Interview)

It is evident from both the interviews and the observations that there are few opportunities to show or release these intense emotions. This lack of opportunity is sustained by the blasé culture of being an ED nurse (related to the first feeling rule) but, as noted above, is also exacerbated by the lack of physical time and space available. Opportunities for emotional downtime or performance reprieve are restricted; consequently, staff are forced to use clinical areas but those out of direct sight of patients and colleagues. ED S/N Alison introduced this (she used 'the back' – a store room and kitchen area – to remove her 'mask'):

> **Is there anything else you want to add, before I turn the recorder off?**
>
> I was just thinking that*, you deal with a lot of things. Really tough things. And then sometimes, it's the littlest thing that can then just tip you over and make you upset…* it isn't that one thing, but it's just everything else that you've had to deal with. Like pharmacy not delivering a medication quickly enough and patients getting a bit annoyed, which is *normally fine one day but because yesterday you'd dealt with a death or something that's upset you. This just tips you over and you feel yourself getting stressed and upset.*

Tip you over the edge, visually?

Sometimes… you just kind of run into the back, maybe have a few tears, then get back on with it.

(ED S/N Alison, Teaching ED, Formal Interview)

Nurses seek out unconventional spaces to vent and for reprieve from their performance of surface acting; these are often backstage. Ironically, the sluice room is often used for tears and other restricted emotional displays – an offstage space, when looking to the work of Goffman. Again, this highlights the importance of space as a moderator of ED nurses' emotional labour. This is a small space largely reserved for the disposal of waste products. It is a small, cramped and unpleasant-smelling room that to a certain degree is seen as less visible (and most certainly out of patient sight). Here, bodily waste is disposed of, along with staff members' emotional baggage. It provides an opportunity to vent and discharge away from the gaze of others. For some nurses, their emotional retreat and release are saved for spaces outside of the ED completely. The final data extract below offers an insight into these experiences, closing this second data chapter:

He describes how important it is that staff realise how what they see and experience is not 'normal' and that there are

> undoubtedly consequences of this, for example the normalisation of trauma. He describes how people deal with and let these emotions out. In his experience, this is through drinking, crying alone on the journey home and ending up with burnout – he says all of this is unsustainable. Staff informally come to them looking for help and support, walk in on the way past or can be found sat in the chapel.
>
> (Chaplain Mike, District ED, Telephone Interview)

5.5 Conclusion

The second empirical data chapter elucidated and analysed the 'feeling rules' of ED nurses and the emotional labour that is undertaken in response to them. This chapter therefore offered insights into the following research questions:

What are the speciality-specific feeling rules of the ED?

Why and how is emotional labour accomplished in the ED?

These feeling rules are a product of the ED environment (explored within the first walkthrough data chapter), often influenced by elements of time and space. I have presented four feeling rules that underpin the surface acting of the nurses in the ED:

1) ‘There’s not much time for faffing around here’ – feel tough, fearless and detached

2) ‘I’ve got this’ – feel in control and calm (do not show you are busy, or don’t have time)

3) ‘A mountain out of a molehill’ – feel empathy and do not feel resentment (even when patients are attending unnecessarily)

4) ‘Don’t take it too much to heart’ – do not feel (too much) distress and grief (hide any upset)

Those nurses who accept and adhere to the feeling rules outlined are seen as ‘ED nurses’; those who are unable to do so are likely to be seen as nurses who ‘just’ work in the ED. As part of this conclusion, I will offer a brief summary of each feeling rule and the associated consequential emotional labour.

Feeling rule 1: feel tough, fearless and detached introduces the expected character of the ED nurse, described as a ‘brand’ in its own right. ED nurses must be unfazed by the setting, be blasé and hide any signs of fear or being afraid through surface acting – to ‘earn their stripes’. The ED nurse does not fit the stereotypical image of a nurse, also introducing the relevance of gender. For many, adhering to this feeling rule is a significant source of surface acting, as they

juggle meeting these so-called masculine expectations with those that are more feminine and arguably traditional. In feeling and behaving tough, the nurses must also stay disconnected from their patients. They must deliver functional care to meet organisational demands, maintain patient flow through the ED space and achieve specific time-critical targets (examples have been given of space and time as moderators of emotional labour). The nurses therefore use surface acting as a defence against relationship building and becoming 'too' involved.

Feeling rule 2: feel in control and calm is essential to being a 'good' ED nurse. In response, this feeling rule calls for surface acting that presents a competent and cool exterior, irrespective of the circumstances. A prominent example of this emotional labour is in the management of patients with serious and time-critical clinical conditions (again showing the relevance of time to the emotional labour undertaken). The nurse would supress their own stress to protect the patient and hide their awareness of the patient's potential instability or deterioration. Furthermore, this feeling rule is relevant to supressing any signs of being busy or feeling flustered; again, seeming calm is crucial, even when the workload feels overwhelming. In addition, ED nurses must not show that they feel rushed or tight on time. The four-hour target and ambulance turnaround times are especially important here. Consequential surface acting is also

undertaken in hiding feelings of frustration (from both senior colleagues and patients) when the focus is seen to be on achieving targets, rather than quality patient care. The emphasis is on moving patients through the ED space quickly and efficiently. Again, this shows the importance of both time and space as moderators of ED nurses' emotional labour. The nurses work to mask their busyness and restricted time from the patients and their relatives. Many of the physical spaces call for consistency with this acting, with intense visibility and little opportunity for reprieve. This spatial element is also important for the emotional labour within many areas other areas of the ED.

Feeling rule 3: feel empathy and do not feel resentment offers many other examples of consequential emotional labour. For many ED nurses, a measurable source of surface acting comes from supressing their resentment of patients who give their clinical conditions higher priority than the nurses do. This is a further example of emotional labour born from a mismatch in priority. The assigned level of legitimacy is also relevant: when the patient is not seen as legitimate, it is harder for the nurse to feel empathy towards them and not resent their attendance at the ED. This emotional labour is intensified further by the extremes of patient need (and legitimacy in the ED) and, importantly, the space between these patients, which is often minimal (offering an important example of space as a moderator of

emotional labour). The nurses must move between these patient groups, often only separated by a few steps, and adapt their 'masks' to suit – this contrast between patients intensifies the surface acting needed for illegitimate patients. Legitimation is also relevant to the surface acting in managing aggressive patients; again, the legitimacy of the patient makes compliance with the feeling rule easier, with less resistance.

Feeling rule 4: do not feel (too much) distress and grief encompasses the need for ED nurses to be stoic. They must not feel excessive sadness or grief for their patients, even when the circumstances are particularly challenging, traumatic or emotive. The suppression of upset is seen as a sign of competence and is actively encouraged by senior members of the ED team. This consequential emotional labour is seen to be completed for the patient whilst maintaining expectations of what it is to 'be' an ED nurse and in a bid for emotional survival. Adherence to the feeling rule is more flexible when particular cases relate to personal circumstances – this allows for a degree of outward sadness or grief. Again, time and space are relevant to this feeling rule. These elements moderate the emotional labour completed as staff meet organisational and departmental demands. For example, when working within the resuscitation area, there is often little time or space for the nurses to 'process' their own grief or upset. In response, unconventional spaces both inside and

outside of the ED space are sought for mask removal and emotional reprieve.

Chapter 6: Discussion

6.1 Overview of Findings

This study aimed to examine and explore Hochschild's theory of emotional labour (1983) within the distinctive clinical context of the ED setting. An ethnography of two ED case studies offered insights into the nature of ED nurses' emotional labour, the environmental elements that influence it and the feeling rules guiding it. This discussion chapter will begin with a summary and overview of the findings from each chapter before situating them within the wider literature and detailing the contributions of this study.

6.1.1 Chapter 4 Summary: Walking Through the ED: Time and Space as Moderators

The purpose of this first empirical chapter was to provide a vivid account of the ED environment and to offer new insights into the conditions underpinning ED nurses' emotional labour and the feeling rules that shape it. This chapter depicted the unique character and ambience of the ED: the setting for ED nurses' 'performance'. There are significant gaps in current understandings of emotional labour within the ED, as detailed in Chapter 5.

It is evident that the ED is a distinctive setting in terms of healthcare delivery and, subsequently, the delivery of nursing care. The physical

layout of the environment is a combination of individual spaces that are separated by the clinical needs of patients. Together, these individual areas collectively form the ED. The descriptive walkthrough portrayed the nurses' work within each. This was the context for the exploration of emotional labour that followed.

The ED setting is incredibly busy and noisy in terms of workload and in terms of other sources of visual and auditory stimulation. The ED tone is set from outside and on entering the waiting room, where the visitor is greeted by clues to the environment's potential volatility and unpredictability. There is an overriding sense of intensity and momentum throughout the ED 'journey', which starts in the waiting room.

The various countdowns begin as soon as the patient books into the department. This introduces the relevance of time: the multiple time-driven targets, namely the four-hour target, ambulance turnaround times and time to the initial nurse assessment. Patients who have self-presented move through to triage, where the spectrum of patient need is introduced – the extremes of this spectrum can be presented in a short timeframe. The nurses switch their communication and interactional approach between those who require swift clinical intervention through to those who present at the ED with chronic conditions. This and other considerations about the patient's status

(e.g. if their injury or illness is seen as self-inflicted) are relevant to the nurses' sense of whether they present as legitimate patients. This notion of legitimacy permeates through all areas of the ED, through the nurses' work and their emotional labour.

Patients and staff are hardly ever still, and there is a pervasive sense of relentlessness – observed most prominently in the assessment areas. The relevance of time is also prominent here, largely through the ambulance turnaround target, which restricts the amount of time for each patient interaction. The intensity of this communication is exacerbated by the restrictions on space and the extensive scope of patient diversity.

The majors space is also often bustling. Here, the nurses multitask in a frequently overstretched and under-resourced environment. There is little room for quality care delivery, as staff must ensure that patients move through the space and out of the department efficiently. The four-hour target is managed in the majors space (for the whole department) – this target is a powerful moderator of the nurses' consequential emotional labour.

Finally, the chapter described the resuscitation area. This space epitomises the intensity of the ED: the sights, sounds and atmospheric aspects. The restrictions on time and space continuously moderate the nurses' work and subsequently shape their emotional

labour. The multiple countdowns and timescales show the importance of time, in addition to the restrictions on space and the movement within it. The lack of physical space and therefore reprieve from the intensity and pressure is also relevant here – the nurses are constantly visible as they work.

This chapter showed that many elements of time and space are crucial to the nurses' work and their subsequent emotional labour (the details of which were explored in the second data chapter). It is important to recognise that these two elements are particularly important and influential when integrated together: namely, the restrictions on both and how these intensify the surface acting required of ED nurses.

When considering the relevance of time, the lack of available time for the nurses' work, the multiple time-critical targets and time-critical clinical conditions are all relevant. In addition, specific periods of time within the ED, for example timescales, including shift length, are also influential. In terms of space, this includes the various physical spaces, the restrictions upon the availability of space, the layout of the ED and the movement through the space. It is also crucial to note the excessive visibility of staff and the minimal opportunity for reprieve. It is important to recognise that the feeling rules above and

their consequential emotional labour are often space specific and less/more likely to occur within specific spaces of the ED.

6.1.2 Chapter 5 Summary: ED Nurses' Feeling Rules

The second empirical data chapter examined the emotional labour that ED nurses perform, born from the ED context described above. The specific feeling rules of ED nurses, which up to now have not been addressed by the literature, were identified and explained. Four feeling rules were outlined in this chapter. These feeling rules drive ED nurses' emotional labour. The details of this consequential emotional labour were also explored within this chapter. This emotional labour was largely found to be surface acting; the exploration therefore focused on this work. Time and space as moderators of the nurses' emotional labour were salient to all four of the feeling rules outlined.

Feeling rule 1: feel tough, fearless and detached: To be an ED nurse, you must feel unafraid and strong, unfazed by the setting. The consequential surface acting of this feeling rule relates to being outwardly 'blasé' and hiding feelings of fear. This feeling rule also introduces the relevance of gender, in particular masculinity. In feeling 'tough', the nurses must ensure that they do not become too connected and involved with their patients, delivering practical and functional care (in response to the restrictions on time and space).

The phrase ‘the greatest good for the greatest number’ was often used to describe the ‘style’ of nursing care in the ED. Again, this feeling rule brings up the relevance of time. Caring too much is seen as problematic and too time-consuming in the ED, potentially disrupting the flow of patients through the department (particularly within the majors area). For many ED nurses, adhering to this feeling rule prompts surface acting – there is tension as they still finding traditional nursing values influential. Hiding feelings of frustration caused by these competing priorities is a further source of consequential surface acting for ED nurses.

Feeling rule 2: feel in control and calm highlights the performance expected, regardless of circumstances. The nurses are expected to supress their personal stress and anxiety to present a cool front. This labour is often completed when patients present as seriously unwell. Here, the nurse hides their awareness of the patient’s clinical instability to protect the patient from further worry. This feeling rule is also important in the management of the workload more generally – working on the idea that the nurses’ work should be done with relative ease, the ‘A&E swan’ is a sign of a ‘good’ ED nurse. The nurses use surface acting to hide that they feel rushed and do not have time, showing its significance once more. The four-hour target acts as a source of tension and surface acting, often in relation to supressing frustration and angst. This and other time-critical targets

also influence the amount of time the nurses have to interact with their patients. The term 'zero to hero' summarises the nature of the interaction between nurse and patient, with implications for surface acting. The nurses also work to mask their busyness through the ED space – there is intense visibility and little opportunity for respite (a salient and widely relevant observation).

Feeling rule 3: feel empathy and do not feel resentment examines the relevance of patient legitimacy to the nurses' emotional labour. In cases where a patient's attendance is seen as illegitimate, the nurse's surface acting ensures that the patient is unaware of this mismatch of perceived priority and legitimation. This emotional labour is exacerbated by the space and time between patients, which are often minimal. In particular, the emotional labour required for those patients deemed illegitimate is heightened. The legitimacy of the patient is also relevant when managing patient aggression – it is much less testing for staff when the patient and their behaviour are seen as legitimate and, in some cases, even understandable.

Feeling rule 4: should not feel (too much) distress and grief shows how ED nurses must not feel too much sadness and should use surface acting to hide any upset. It shows how visual displays of emotion are largely written out of the ED. Cases that relate to personal home circumstances more broadly provide allowances to this

feeling rule. However, the circumstances around these exemptions are specific and only relate to 'alarming' or traumatic circumstances (often occurring in the resuscitation area). Outside of less alarming circumstances, emotional displays are seen as unfitting, inappropriate and, in many cases, a sign of weakness. The nurses seek out spaces away from patients and other colleagues, such as the 'emotional sluice', to discharge their emotions, sometimes elsewhere in the hospital or on the car journey home. Again, this shows the importance of time and space to ED nurses' emotional labour.

6.2 Situating the Findings in the Wider Literature

6.2.1 Emotional Labour in the ED

It is well established that nurses do emotional labour routinely in their practice; it is a significant but underappreciated and under-recognised aspect of their role (Smith, 1992, 2012; Theodosius, 2008; Staden 1998 and Gray, 2009). Moreover, the application of Hochschild's emotional labour theory (1983) to specific areas of nursing practice is evident in the literature. Examples include palliative care nurses (Skillbeck and Payne, 2003); neonatal nursing teams (Bolton, 2000); gynaecology nurses (McCreight, 2004); theatre recovery nursing staff (Timmons and Tanner, 2005); nurses caring for geriatric patients (Wegge et al, 2014); and nurses within the ITU environment (Stayt, 2009). However, up to now, an

exploration of emotional labour in the work of emergency nurses has been largely missing.

This study offered a further application of Hochschild's theory (1983) to a previously unexplored clinical context: emergency care. Prior to the research at hand, only one study had noted the emotional labour within the ED. The study of Bailey and colleagues (2011, p.3365) focused on the 'professional developmental processes involved in effectively managing the critical aspects of death, dying and bereavement'. As part of this, the study looked at how staff manage the emotional impact of end-of-life care in the ED, including nurses, doctors and others. Although emotional labour was not the focus of this study, the authors mention that the ED nurses and their colleagues managed their feelings in times of bereavement; this was found to be a source of significant stress for the ED staff. Bailey et al (2011, p.3368) argue that those ED nurses who were unable to cope with the emotional labour linked to end-of-life care:

> … frequently developed distancing behaviours as a coping mechanism when confronted with a dying patient or their relatives in an attempt to avoid their own grief.

The empirical research undertaken as part of this thesis also highlighted the experiences of ED nurses' emotional labour in managing bereavement. However, more than this, it provided new

insights into many other calls for emotional labour in the ED. This research revealed the pervasiveness of emotional labour in ED nursing, offering new knowledge through exploration, and understanding the details and nature of this work. Based on the evidence provided, I argue that ED nurses do a great deal of emotional labour within their role; it is a routine part of their practice. The consequential surface acting fluctuates and adapts to meet the needs of the setting. It 'ebbs and flows' to suit the audiences within the specific ED setting and in line with the requirements and expectations of colleagues, patients and patients' relatives.

The emotional labour undertaken in the ED most often is surface acting. Although the reasons why ED nurses do more surface acting than deep acting (or vice versa) were not the focus of this study, it is still important to consider why this may be the case. It is likely that the large proportion of surface acting is influenced by the intensity of the true feelings experienced by the ED nurses, making them difficult to change. This stance aligns with the established differences between employees undertaking surface or deep acting:

> Surface acting involves attempts to change one's emotional expressions without modifying one's feelings; in contrast, deep acting involves attempts to bring one's felt affect in line with display rules.
>
> (Diefendorff et al, 2011, p.172)

To offer a specific example, the four-hour target and other time-critical targets were a significant source of surface acting for many of the nurses in the ED. They often undertook surface acting to hide the tension and frustration they felt at the lack of time available. To undertake deep acting instead, the nurses would have to change how they truly felt about the targets directly (to then change the emotions they felt in response). For many of the nurses, this seemed unlikely, considering the strength of perception relating to the targets. Similar ideas related to other points of tension in the ED and may offer a degree of insight into why the nurses undertook surface acting, rather than deep acting. As noted earlier, this form of emotion management is most commonly related to emotional dissonance when compared to the impact of deep acting (Grandey and Gabriel, 2015) – another important consideration when examining the work of ED nurses.

My focus on surface acting does not deny the possibility of deep acting in the ED. As discussed earlier, in deep acting, the emotion

displayed externally and the emotion that is felt internally, are in alignment (Hayward and Tuckey, 2011). Hochschild (2012) argues that this means employees must try to feel differently to how they truly feel, in a bid to achieve organisational standards.

In the ED, deep acting would mean that ED nurses needed to change their feelings surrounding many aspects of their work, for example, and as discussed above, the feelings associated to various time-critical targets. Although this seemed unlikely for most of the nurses I interviewed, there was the impression that, over time, some of the ED nurses may 'grow' to deep act. There was already a sense of acceptance for the more experienced ED nurses, surrounding the impossible nature of the setting. They had established early in their work that organisational pressures, and other distinctive challenges were a source of tension (prompted uncomfortable and unpleasant feelings). Arguably, in working to align true feeling with the feeling rules, and accepting the nature of ED nursing for how it was and is, this was easier. Conversely, for some nurses, this seemed impossible. This 'emotional misbehaviour' and other consequences of emotional labour in the ED will be explored in the following sections.

More specifically, the remainder of this chapter will outline the contributions of this research, developing them further and situating them within the existing literature and established theory. This will

take place under two headings: *Time and Space as Moderators of Emotional Labour in the ED* and *ED Nurses' Feeling Rules*.

6.2.2 Time and Space as Moderators of Emotional Labour in the ED

This thesis offers two contributions to knowledge. The first relates to the moderators of emotional labour. Influential moderators (Grandey and Gabriel, 2015, p.325) of emotional labour have included the exploration of relational factors (emotional traits/abilities, identification/values and relational power/intimacy) and contextual factors (job status/autonomy, financial rewards and social support). The findings from this research show that, more than this, physical and non-physical resources – in particular, time and space – are especially influential to emotional labour. Recognising and understanding the integration of these two elements as moderators (Grandey and Gabriel, 2015) are important findings.

Furthermore, the sociology of emotions, including the study of emotional labour has often focused on micro-analysis, between individual social actors, with little attention to the influence of meso and macro structures (Stets, 2010; Turner and Stets, 2006). Understanding the moderators of emotional labour (both time and space), from a meso, organisational perspective, offers further theoretical development.

6.2.2.1 Time: Noon and Blyton (1997)

In examining the relevance of both time and space to ED nurses' experiences of emotional labour, it is important to define what is meant by each. Noon and Blyton (1997, p.55) offer particularly useful theorisation to explain the relevance of time to contemporary work and in particular, its relevance to the ED:

> The clock is critical in every contemporary work organisation, allowing the coordination of multiple, simultaneous, and complex activities in ways which could not be achieved without the close synchronisation made possible by accurate time measurement. This ability to synchronise individual activities within an overall production process has been a key feature of industrial development. The ability to measure time in finely divided units has allowed greatly improved levels of co-ordination, and thereby a growth in the scale and complexity of operations.

Arguably, the most critical time 'cycle' in the ED is the four-hour target. This has the most notable influence over the nurses' work because it results in the restriction of time for various nursing care and patient interaction. Noon and Blyton (1997) acknowledge the implications of employees feeling that they have 'too little time' at work, especially to complete allocated tasks. The consequences of

this are likely to be a significant source of employee stress. I argue that, in addition to this stress, the time cycles of the ED, and other elements of time, have implicit implications for the nurses' emotional labour (which offers additional new insights).

Of further relevance still is the proportion of time spent working in periods of productivity within these specific time cycles and the way in which this time is utilised (Noon and Blyton, 1997) in the ED. Both the length and frequency of ED nurses' productivity are notable – the amount of non-productive time in a shift time cycle, for example, is often minimal. This intensifies the nature (Noon and Blyton, 1997) of the ED nurses' work and, notably, the implications for their emotional labour. Surface acting must be sustained for these long periods.

The time-critical targets (such as the four-hour target and ambulance turnaround times) provide further examples of important time cycles (Noon and Blyton, 1997) in the ED. Because of the lengths of these time cycles, and the quantity and complexity of the work that needs completing within them, the interactions between nurse and patient are brief most of the time. The existing literature tells us that the actual duration of emotion display is relevant to how intense the work is deemed to be. Previous research (Morris and Feldman, 1993; Lin, 2000; Yang and Chang, 2008) has argued that short interactions require less effort than those that are over a long period. This is

because shorter interactions in service roles tend to be scripted (Sutton and Rafaeli, 1988), requiring less depth of emotional labour. Conversely, in longer interactions, the relationship between employee and customer develops: the employee starts to relate to the customer and subsequently finds it harder to hold in personal feelings and relatability (Morris and Feldman, 1993). Moreover, intensity and duration are also related. Long interactions are more likely to require the display of more-'intense' emotions. Morris and Fieldman (1993, p.991) write:

> Thus, clients do not expect emotional intensity in short scripted interactions with tele-marketers, but they do expect more intense exchanges in longer, non-scripted interactions with nurses…

Based on the findings presented, this thesis does not support the arguments highlighted above by Morris and Fieldman (1993). Despite the often brief nurse–patient interactions in the ED, and consequently the short 'bursts' of emotional labour, the level of connection expected between a patient and a nurse is still expected to be sincere. Pytel et al (2008) found that a top priority for patients visiting ED (in the US) was communication with the nurse; they prioritised compassionate communication that showed genuine concern. Uy, Jia Lin and Ilies (2017) explain that by prioritising speed

and efficiency (in service roles more broadly), achieving quality service interactions (between customer and employee) becomes more challenging. The more 'sped up' a service is required to be, the higher the likelihood of surface acting (Uy, Jia Lin and Ilies, 2017; Hochschild, 1983). These considerations are especially relevant to the ED nurses' surface acting.

I argue that, instead, the transient (surface acting) interactions in the ED are intensified by the short duration, not eased, which goes against the existing literature. These interactions are heightened further when time-critical clinical conditions are involved and a patient is likely to deteriorate as time passes. A probable explanation for this finding is the lack of 'scripted' emotional labour, namely surface acting (the element ensuring that short interactions are easier for employees) (Sutton and Rafaeli, 1988). The emotional labour of the ED nurses is the opposite: not scripted and often impromptu or improvised, particularly in response to challenging patients – those who are aggressive in nature, are intoxicated, are under the influence of drugs or have other communication issues (perhaps they are acutely medically or mentally unwell). This may offer an explanation as to why a short duration of interaction, in this case, does not decrease the level of intensity.

6.2.2.2 Space: Lefebvre (1991)

The influence of time on ED nurses' emotional labour is made more relevant when integrating spatial elements. Space within the ED is also a social production that is lived, experienced and maintained by the staff (Tyler and Cohen, 2010). This stance is based on the theorisation of space by Lefebvre (1991), involving physical, mental and social elements. The theoretical focus on the social elements of space within Lefebvre's theory was particularly fitting for the purpose of this research. It was helpful to draw on the concept of social space, described as the lived space. The individual production of spaces within the ED, for example the minor injuries space, are constructed by those who 'live' within them. Halford and Leonard (2003, p.202) note that 'people make spaces':

> … [the] distinctive material and symbolic construction of hospital spaces shape nurses' workplace experiences… these spaces are implicated in the performance…

Viewing the ED as a system, and as a collection of spaces, fits with the organisational description offered by Halford and Leonard (2003, p.661), seeing it as a 'configuration of multiple, distinctive and differentiated spaces offering different potentials for subjectivities.' Emphasis is placed on moving patients through and out of the space (achieving flow) and preventing a build-up of patients within the ED –

this relentless, assembly line nature of the work is also significant to the nurses' emotional labour. Together with the limitations on time through various time cycles, this spatial element adds to the sense of the ED as a conveyor belt that must keep moving.

A further important point is the layout of the individual lived ED spaces: the differences and similarities between, for example, the resuscitation space and the triage room. As understood through the work of Lefebvre (1991), each space is constructed by the staff working within it and the nature of the work taking place. The physical layout of this collection of spaces means that different patient groups (with, in many cases, dichotomous nursing needs) are within close physical proximity of one another. For example, the resuscitation area is within a five-second walk of the minor injuries area – two dramatically different patient groups in terms of clinical need and the subsequent nature of the emotional labour required for each. The lack of physical space between these performance areas intensifies the surface acting for staff. This is particularly relevant when considering the staff members' perceptions of varying patient legitimacy (as defined in the previous chapter).

The physical space is also a moderator (Grandey and Gabriel, 2015) of the emotional labour regarding the physical closeness of *individual patients*. For example, on one occasion during the observations,

within close proximity were a polite and quiet elderly lady with a broken hip (deemed legitimate by staff) and a young, loud and aggressive male who had taken drugs (deemed illegitimate or less deserving by staff). Such patients are often separated by a thin curtain or a short walk; therefore, the variety of the emotional displays is intensified by the limited physical space between cases. This limited space intensifies the surface acting required for patients deemed illegitimate. The nurses often tend to them immediately after patients whose status is deemed more legitimate. This also influences the performance of staff, as they have little physical space to 'change masks' between contrasting cases.

A further important spatial consideration is the lack of offstage space and subsequent opportunity for reprieve from undertaking the described degree of emotional labour. Although these findings also speak to the social construction of space offered by Lefebvre (1991), they most strongly relate to the work of Goffman. In particular, it relates to the 'presentation of self' (1959) recognised earlier, in which employees choose their performance based, in part, on where they are located ('front stage' or 'backstage'). This is critical to ED nurses' emotional labour. The ED has little backstage space (Goffman, 1959) away from the patient audience. This is most prominent in large, open spaces where there is constant visibility from the patient audience and, most notably, their relatives. For many of the nurses,

particularly those in charge of a specific space (e.g. the majors or resuscitation spaces), there is little if any respite or offstage/backstage opportunity. This emotional labour is different to that described above – this role requires less variety or diversity of masks (as there is less direct contact or interaction with patients). Much of the challenge instead comes from the excessive visibility and consistency required (of being front stage) in presenting a professional version of the 'self' (Goffman, 1959).

The audiences include, not only patients and their relatives, but also other members of staff. This is a source of collegial emotional labour (Theodosius, 2008). This collegial form of emotional labour sustains relationships between nurses and other professionals – here, roles (status and power) are especially important. This emotional labour is intrinsic to the effective delivery of care, as elements are passed between different individuals and professional groups (Theodosius, 2008). The ED nurse supresses a myriad of feelings in these instances to maintain the expected 'front' (fearlessness, calmness and stoicism, amongst others) to their colleagues.

The visibility of the nurse to the various audiences increases the intensity of this emotional labour – a factor that was previously missing from exploration but is now seen as especially relevant to both physical and emotional work (Boyd, 2012). Again, rather than

the duration of an individual interaction (Morris and Fieldman, 1993; Lin, 2000; Yang and Chang, 2008), this intensity is seen as dependent on the duration of the front-stage period. It is also exacerbated and intensified by the general sights and sounds of the ED, which are noisy and distracting; further effort is then required in supressing stress or anxiety (described often by the ED nurses).

Although the existing literature can offer us insights into the likely relevance of interaction duration (Morris and Fieldman, 1993; Lin, 2000; Yang and Chang, 2008) and the variety of emotions supressed (Morris and Feldman, 1996) to the intensity of performance, this research offers insights into the emotional labour undertaken when combining these variables. It also recognises the pertinence of physical space.

The ED calls for an extensive spectrum of emotional labour, which is influenced and moderated by the restrictions on resources, namely time and space. The relevance of these elements is most profound when they are integrated and considered together. These insights into the broader organisational, arguably meso moderators of emotional labour in ED are particularly helpful insights when existing emotional sociology has often focused on individual actors, therefore examining the micro viewpoint (Stets, 2010; Turner and Stets, 2006).

6.2.3 ED Nurses' Feeling Rules

A second contribution of this research is through the development of four feeling rules underpinning ED nurses' emotional labour. Those applying the concepts of emotional labour to the nursing profession have often noted generic professional feeling rules. When nurses' feelings do not align with what is expected, they 'do' emotional labour in response. As noted earlier, McQueen (2004, pp.103-104) states:

> When nurses do not feel as they think they ought to feel in particular situations, they engage in emotional labour to manage, control, or alter their emotional status to correspond with what they believe is appropriate for the situation.

Despite this understanding, there is a gap in the existing literature relating to the feeling rules of individual clinical settings, particularly that of the ED. This research contributes by offering insights into the social world of the ED and the subsequent speciality-specific feeling rules born from it. Conforming to feeling rules in the ED (and undertaking emotional labour accordingly) is essential to being a 'good' ED nurse, rather than 'just' a nurse who works within the ED. The emphasis in achieving the former is placed on showing you are able to cope with the distinctive setting. Taken together, there are therefore three key aspects to note: gender, legitimation and

emotional survival. The rest of this chapter will examine the relevant wider literature that relates to each of these points.

6.2.3.1 The Influence of Gender

ED nursing is seen as a 'macho' form of nursing (Fielden and Burke, 2014). Yet, as noted by Gray (2008, p.169), most images of nursing still 'reverberate with that of the caring female, particularly with the prototype of Florence Nightingale'. These outdated, gendered images are important in considering the need for ED nurses to be tough and fearless (aligning with the first feeling rule: *feel tough, fearless and detached*). Gray (2009) found that perceptions of caring, intimacy in nursing and emotional labour were all seen as natural roles for female S/Ns. In comparison, male nurses were generally seen as more appropriate for working within mental health, where the role was perceived to be more masculine and therefore acceptable for males (Gray, 2009). In mental health settings, the nurses need to deal with physical aggression and, as a consequence, need to be physically stronger. Gray (2009) also found that male nurses often felt uneasy with more-traditional and perceived female nursing roles and the associated depth of emotional exchange. Gray (2009) explains that many of these assumptions relate back to the notion of the healthcare team as a family, with the objective male doctor as the father and the subjective female nurse as the mother. Such engrained stereotypes are relevant to the feeling rules of the ED

nurse; a merge of these two (masculine and feminine) values and expectations is a source of conflict and therefore emotional labour. Such findings also relate to the work of Boyle (2005) on ambulance employees, as noted earlier. The feeling rules here were driven by a mix of values: staff had to juggle both compassion and stoicism to meet the expectations of competing audiences.

This tough and masculine nursing style also relates to detachment from patients and their relatives: it is important not to feel too attached or close. In this study, some of the nurses in the ED found the emotional labour associated with this detachment and care rationing easier than others did. For some of the nurses, their feeling rules centred around the idea that 'quality' care related to giving their patients time and connection; for others, the priority in terms of quality was associated with strong organisational demands to maintain flow. Being able to maintain flow through the department (therefore keeping patient interactions and connections brief), irrespective of patient overcrowding and short staffing, was seen as a skill of a 'good' ED nurse. Those who did not adhere to the necessary surface acting rejected this rule in favour of rules associated with more-traditional styles of nursing. As the demands on the service grew, the ability to adhere to detachment and care rationing related to feeling rules became more valuable and desirable. Some staff

juggled and battled these competing demands and expectations – a significant source of surface acting.

Showing signs of nervousness or being ruffled did not conform with the expected behaviour of 'being' an ED nurse either (*feel in control and calm*); similar feeling rules were again noted in Boyle's (2005) study of ambulance staff. I found that the ED nurses were often acting 'for' their patients (to offer calm) – a characteristic ranked as a high priority when studying the experiences of ED patients in the US (Pytel, 2008). In addition, the ED nurses were also surface acting to adhere to broader expectations of being good and strong ED nurses (to peers and senior colleagues). The need to show competence and calm (even when the nurses felt incapable and flustered) also sustained the image that the role was effortless.

As part of this effortlessness, the ED nurses needed to hide any feelings associated with feeling too busy or like they did not have time for the workload. This element not only relates to being a calm ED nurse but also to expectations of nurses more generally. Gender is particularly relevant here, too. There is a requirement, often more so for female nurses, to show that care delivery is natural and consequently easy; there are feeling rules that relate to being inherently kind and caring (Bolton, 2000; Fineman, 1993). This finding relates to the wider literature debating the 'art' and 'science'

of nursing. There is still a perception amongst patients (and nurses themselves) that nursing is a vocation and, more than this, that nurses have an inherent drive to care (Bolton, 2000). It is likely that nurses use surface acting to perpetuate the idea that their work is indeed natural and in-built.

6.2.3.2 'Normal Rubbish' and Legitimation in the ED

Legitimation is also a significant driver of ED nurses' feeling rules, most crucially those driving the delivery of surface acting for reassurance (*feel empathy and do not feel resentment*). ED nurses undertake emotional labour to respond to mismatches in prioritisation between their perceptions of a patient's needs (assigned prioritisation) and behaviour and the patient's own perceptions. Hillman (2014, p.486) argues that there are two fields of thought relating to the categorisation and legitimation of patients in the ED. The first groups patients in relation to the 'professional interests of clinicians and the broader organisational structures and institutional cultures of medical practice'; the second relates to 'personhood and the perceived moral worth of patients and their families' (Hillman, 2014, p.486).

Although these tensions relating to legitimation are expected to be relevant to nursing outside of the ED, it is less likely to occur to the same degree in other specialties. This is because of the variety of

patient need and the subsequent variety of emotional labour needed in the ED. Morris and Feldman (1996, p.991) explain the relevance of variety more generally, in relation to the emotional labour of service work:

> The greater the variety of emotions to be displayed, the greater the emotional labour of role occupants will be. Service providers who must alter the kinds of emotions expressed to fit specific situational contexts have to engage in more active planning and conscious monitoring of their behaviour.

For example, in the ITU, there is much less variety of need and arguably less variety of emotional labour. Although the ITU shares similarities with the ED (in terms of technology and specialism), in the ITU setting, there is no question of triviality in terms of patient need: all of the patients are gravely unwell and subsequently require life-saving care (and are more likely to be seen as legitimate). It is the extent of the spectrum of patient need and legitimation in the ED that is particularly relevant to ED nurses' emotional labour. Most crucially, changing between this variety of differing need, often done at speed and within close physical proximity.

Much of the emotional labour in the ITU is done to manage the consequences of bereavement and loss (Stayt, 2009). Staff in the ED undertake similar forms of emotional labour in managing

bereavement and traumatic cases, but it is the emotional labour required in changing from these seriously ill patients to those much less serious or even those perceived as illegitimate that is arguably most relevant in the ED. In these instances, significant surface acting is required to supress the sadness or shock they feel after the traumatic case, as well as to supress the frustration and annoyance they feel at having to empathise with more 'trivial' cases. A similar form of emotional labour was briefly discussed in a study of 911 call takers (Newman et al, 2009). The variability between prank phone calls and those that were highly charged, dealing with life-threatening emergencies, increased the intensity of the emotional performance for staff.

Much of this legitimation-related emotional labour also speaks to the concept of emotional dirty work (Ward and McMurray, 2014), as explained by Chiappetta-Swanson (2005, p.108):

> Just as there are workers who physically clean the streets or tackle social deprivation or enforce moral codes, so too there are those who manage the burdensome and disruptive emotions of others. As with other forms of dirt, dealing with emotions that are burdensome, threatening and out of place is important in so far as such work is necessary for the smooth functioning of wider organizational and societal systems…

Chiappetta-Swanson (2005) studied the work of genetic termination nurses who dealt with the 'moral dirt' of foetal termination, both physically and emotionally (Ward and McMurray, 2014). It was left to the nurse to ensure that the patient was supported when other healthcare staff had removed themselves to ensure that they were not 'tainted' (Ward and McMurray, 2014; Chiappetta-Swanson, 2005). Such emotional dirty work and associated emotional labour are undertaken by ED nurses. ED nurses are often 'left' with patients perceived as less desirable, exciting or in need. For example, in the resuscitation area, the emotional labour associated with caring for an elderly patient with a frequently seen and experienced medical condition was left to the nursing staff. Likewise, nurses were also left with patients from other less appealing groups, such as so-called 'inappropriate attenders'. Emotional dirty work was also particularly relevant when the nurse saw the patient's lifestyle choices (e.g. drug or excessive alcohol use) as undesirable and morally wrong. The emotional labour involved with all of these patients also adheres to the feeling rule encouraging feelings of empathy and hiding feelings of resentment.

6.2.3.3 A Bid for Emotional Survival and Misbehaviour

Calling for restrictions on feelings of distress and grief optimises being an ED nurse and again speaks to the need for stoicism. This finding also relates to personal protection and well-being in an

environment where the nurses already feel overwhelmed. Nurses can often be used as the 'emotional buttress' (Smith and Gray, 2009) for patients and their relatives, especially in challenging times, such as bereavement. Nurses 'choose' their level of emotional engagement in response: a spectrum that holds emotional engagement and emotional detachment at either end (Msiska et al, 2014). This offers ED nurses a degree of protection from becoming too involved in an already (physically and emotionally) stretched environment. Nurses may try to switch off from the emotional component of their work using surface acting (Smith, 2012). Smith (2012) argues that such distancing and detachment have negative implications for the connection between patient and nurse.

In this study, there was also a strong perception that patients and their families did not want a nurse who was seen as outwardly emotional – a key consideration and justification for this feeling rule:

> A balance between detachment and concern in the context of this culture of nursing may be especially difficult… in medical contexts in which serious illness and death are prevalent… detachment norms are publicly dominant... Emotional outbursts are discouraged because of the potential to undermine care…
>
> (Cadge and Hammonds, 2012, p.271)

In surface acting to suppress their distress, the ED nurses saw their sadness as secondary. This surface acting proved more of a challenge when the nurse could relate the patient's circumstances to their own – a finding that speaks to previous work (Wilson & Kirshbaum, 2011; Funk et al, 2017). These studies found that grief and bereavement were more complicated for healthcare staff when patients were the same gender and age as the staff.

Ultimately, those nurses who felt as though they did not 'fit in' and explicitly told me 'I'm not an ED nurse' experienced conflict and tension adhering to the four feeling rules outlined. In these instances, it is likely that they felt unable to show their nursing authenticity. Yagil and Medler-Liraz (2013, p.473) argue:

> Service environments offer organisational cues indicating that individuals must express service role regardless of personal tendencies. Nevertheless, individuals have an inherent drive toward authenticity… we expect fluctuations in service employees' thoughts, feelings, and behaviours relating to the experience and expression of their true selves in interactions with customers.

For many of these nurses struggling with the feeling rules of the ED, they used emotional labour as a survival mechanism through 'facades of conformity' to fit in with the desired and expected ED behaviour

(Hewlin, 2003; Yagil and Medler-Liraz, 2013). The nurses shared how they needed to supress their feelings and 'pretend to embrace' the values of the department (Hewlin, 2003; Yagil and Medler-Liraz, 2013). Moreover, again echoing the work of Yagil and Medler-Liraz (2013), those nurses who were unable to adhere to these feeling rules were seen as disloyal and experienced social rejection. This rejection for not fitting in was not from customers (as in the work of Yagil and Medler-Liraz, 2013) but instead from other ED nurses.

For some, this battle (between enacting the desired feeling rules and their desire to show authenticity) and the associated surface acting necessary was too much. Some nurses had left or were considering leaving ED nursing due to this dilemma. They felt disengaged with their work and unable to harness their full selves (Uy, Jia Lin and Ilies, 2017; Kahn, 1990). For others, they stayed nursing in ED but 'broke' or 'breached' these feeling rules as described above. These nurses told me how they did not belong within the ED and felt that their nursing styles would prevent them from promotion. Vincent (2011) describes this protest as 'emotional misbehaviour', often the result of emotional displays that are misaligned with organisational interests. In this case, the emotional displays (taking too much time and showing outward empathy, warmth and so-called feminine characteristics) are seen as not conforming to the ideals (Vincent, 2011). Moreover, in performing highly 'resistant emotional

misbehaviour' through these 'morally contestable' emotional displays and demands, the workers (in this instance, ED nurses) 'use their agency to self-consciously pursue interests that are known to be alternative to those of their employer' (Vincent, 2011, p.1390).

It is likely that nurses experience a degree of conflict from their emotional labour because of the meaning they take from their work, particularly for those whose meaning relates to connection and developing relationships with their patients. Korczynski (2003, p.57) explains how certain employees are 'positively disposed' to customers, or in this case patients, and will consciously take pleasure from their role and helping. In contrast, when the communication and relationship between the two parties are challenged (e.g. by the patient being abusive), the nurse is likely to experience pain in response.

It is also important to recognise that the phrase 'emotional labour' was not known to the ED nurses. This aligns with the existing literature. The ED nurses could, however, relate strongly to its explanation and application in their practice once defined. This acknowledgement was universal with all those interviewed (formally and informally). There was little doubt that the management of emotions was a significant part of their role – one that was well understood once explained. There was generic recognition that

emotional labour was an essential part of practice and being professional, which also supports the existing literature addressing emotional labour in nursing more broadly (Reily and Weiss, 2015; Cheng et al, 2013; Chou et al, 2011; Huynh, Alderson and Thompson, 2008; Badolamenti et al, 2017). Finally, and in addition, the sense that the emotional labour required from staff is undervalued in terms of attention, recognition or support within the ED also supports the findings in the nursing literature more broadly (Smith, 2008; Staden, 1998; Gray, 2008; Henderson, 2001; McCreight, 2005; Bolton, 2000). In line with this discussion, the following chapter will explore the relevance of these findings to practice.

Chapter 7: Conclusion

This final chapter will conclude the thesis. A brief summary of the study will be outlined to begin. Recommendations for practice will then follow. The limitations of the study will be recognised prior to the final reflections and remarks.

7.1 Overview of the Thesis

This thesis has applied Hochschild's theory of emotional labour to a previously unexplored clinical speciality. Emergency care is a service facing considerable challenges and pressures. In addition, elements of this setting are unique in terms of nursing delivery; as such, it offered an interesting and fitting case study for this research. The ethnographic exploration set in two EDs offered many new insights into the emotional labour of the ED. Firstly, it found that elements of time and space are moderators of ED nurses' emotional labour A finding which is relevant to both the healthcare, and broader organisational sociology audiences. Secondly, this study found that ED nurses' feeling rules are grown from the distinctive ED context and that four feeling rules underpin their emotional labour, particularly their surface acting. This second finding offers new insights for nursing literature, both practice based and academic. The implications for this study are applicable to practitioners, educators, in addition to healthcare policy makers and manages.

7.2 Recommendations for Practice

The recommendations from this thesis in light of the findings described are outlined below. They are categorised under two headings: *Environmental Implications* and *Implications for Nursing Education*.

7.2.1 Environmental Implications

There are well-established relationships between emotional labour (particularly surface acting) and well-being. At the same time, there are challenges facing nurse retention in the ED (and more widely in the profession, which have been linked to well-being). Understanding the relevance of the healthcare environment to staff members' experiences of emotional labour, therefore, is likely to be a useful tool in counterbalancing the potentially negative consequences of this work. In particular, understanding the relevance of environmental elements to the emotional labour offers tangible opportunities for improvement. Suggested measures and interventions to alleviate the consequences of this intense work are therefore of importance and value. Recommendations in line with this will be outlined below.

As already established, the nature of the ED (largely in terms of the limited time, the variety in patient needs and the limited physical space, worsened by overcrowding) proves a challenging space to nurse. A reorganisation of services to improve the working

environment for staff is unlikely in the already constrained and pressurised NHS. Perhaps more practically, then, services should focus on small environmental changes that are more feasible to improve the staff experience.

In particular, the four-hour target and other time-critical targets limit the amount of time available to nurses. This has a direct impact on the nature of the interaction between nurse and patient. The emotional labour in response is fleeting and intense, as the nurse must try to meet the patient's expectations in a short timeframe. At times, nurses will limit their connections with patients to shorten the interactions; arguably, then, there is also an impact on the quality of the patient experience.

Such findings are relevant for those leading on the development and maintenance of time-critical targets in the ED. In striving to provide timely care, it is important to recognise the indirect impact of such targets, namely the intensity of nurses' emotional labour. The findings and recommendations are also important to healthcare policy more broadly, outside of the ED setting. As the health service faces increased pressure, the implications for staff tasked with delivering care in an under-resourced environment grow. Although increasing attention is being given to the well-being of staff (partly in response

to staff recruitment and retention), little, if any focus, is given to the consequential emotional labour.

Also relevant to those managing service delivery is a generically perceived need for a sustained performance from the ED nurses, with little opportunity for reprieve when this feels particularly intense. Although this is largely dictated by the continuous workload, it is also apparent that the space and the individual spaces within it (e.g. minor injuries, assessment and resuscitation) provide little or no 'offstage' space for the nursing staff. As a consequence, when staff do have the opportunity to cease a degree of surface acting, there is no room or space to do so. Arguably, the recommendation for counterbalancing this is to ensure adequate offstage or backstage space for nursing and other staff. Such spaces should also be incorporated into clinical areas (rather than focusing upon break rooms or rest areas), where staff may retreat to, in-between patients. These spaces could be used for tasks that do not require direct patient contact, such as writing up notes or making phone calls. Leonard and Halford (2003) raise similar recommendations in their study of hospital nurses' working lives and associated levels of stress. They argue that, in the absence of offstage spaces, nurses create 'internal private and personal spaces for themselves, free (or freer) from the ever-possible demands of others' (Leonard and Halford, 2003, p.207). This again has implications for broader nursing

practice, healthcare policy, interprofessional relationships and those receiving care.

7.2.2 Implications for Nursing Education and Knowledge

It is long established that the emotional labour undertaken by nurses is a fundamental component of practice and is intrinsic to the relationships between patients and staff. Although it is essential, it is not without cost: high levels of emotional labour (especially surface acting) can be detrimental to employee well-being. Bailey et al (2011, p.3368) warn that ED nurses in particular are 'at risk of developing ineffective and potentially harmful coping mechanisms that could lead to stress, ill-health and withdrawal from practice' in response to the emotional challenges that their work can present. The one-to-one interviews in this research offered insights into the exhausting and draining emotional labour routinely involved in ED nursing. It is concerning that much of this emotional labour was found to be surface acting (considering its well established links to well-being). It is important to recognise that the ED nurses' emotional labour was intensified when they deemed the quality of their care to be poor.

There is a consensus that supportive work environments are important in counteracting the negative effects of emotional labour (Duke et al, 2009; Diefendorff et al, 2011). Leaders are encouraged to foster emotionally supportive contexts and cultures that are

conducive to staff helping one another (Uy, Jia Lin and Ilies, 2017). Arguably, the first step in developing these work environments is to acknowledge the emotional labour of daily practice. The ED nurses in this study were able to relate strongly to and speak freely on the descriptions provided of emotional labour, although it was so entwined and intrinsic to their role that the awareness of it as 'labour' was missed. Subsequently, the consequences and costs of intense emotional labour (as found routinely in the ED) for nurse and patient are likely to be unidentified. This supports the existing literature showing that the emotional component of nursing roles is unknown (Warren, 2016; Johnson and Spector, 2007; Smith, 2012) and often taken for granted. Although direct links between emotional labour, specifically that in the ED, and staff retention have not yet been studied, it is reasonable to assume that the emotional stress of the ED is one of the many challenges facing the staff.

It is therefore crucial that the emotional labour in the ED (and healthcare more widely) is acknowledged in the first instance. This research offers four recommendations to the existing debate. The first calls for support and formal supervision to help staff to manage the emotional implications and expectations of their work (Reily and Weiss, 2015). In spite of sustained efforts by nursing scholars and large-scale reviews (e.g. the Boorman Report, 2009), it is only relatively recently that organisations such as the NHS have

recognised the importance of staff experience and well-being. This not only relates to staff retention but also is directly associated with patient outcomes and the patient experience.

Current nursing practice does not offer formal support for nurses in relation to the emotional component of their roles (Sawbridge and Hewison, 2013; Ballat and Campling, 2013). Such support and practical mechanisms are often inconsistent and are not embraced and sufficiently valued by organisations (Badolamenti et al, 2017). Recently, promising schemes such as the Schwartz Rounds, reviewed by Maben et al (2017), have offered healthcare staff the opportunity to share and explore their emotional experiences. Such interventions (Sawbridge and Hewison, 2013) can potentially counteract the negative consequences of surface acting.

Even less well documented is the existing support specifically targeting staff working within the ED. There is an argument that this should be specialist in nature, in line with the work of ED nursing (Joseland, 2008) – a proposal that this research supports. The ED nurse is particularly susceptible to stress, exhaustion and more-serious outcomes (such as post-traumatic stress disorder (PTSD)), all of which are likely to be exacerbated by the emotional labour undertaken. Therefore, interventions that support ED nurses with

their emotional labour are likely to be of significant value (to nurses, patients and the broader organisation).

The second recommendation relating to staff well-being is that emotional labour should be introduced into pre-registration nursing programmes (Huynh, Alderson and Thompson, 2008). Education that offers insights into the emotional labour of nursing and techniques to manage it would better prepare staff for the challenges of contemporary practice. Post-registration, emotional labour awareness and support would also be helpful if offered during mandatory performance appraisals, career development conversations and other training opportunities.

Thirdly, it is important to note that nurses are often grouped together as one profession with the same behaviours and values, irrespective of speciality. These assumptions do not acknowledge the diverse emotional challenges of these different roles. Understanding the differences between specialties (particularly in relation to speciality-specific feeling rules) would recognise this diversity. In turn, this could offer the opportunity to assist nurses in their career choices and ongoing training and development, as well as support them through the unique challenges. Considering the demands facing nursing as a profession, most prominently in relation to retention and recruitment, understanding the complexity and variability of the profession and

the associated emotional labour may prove useful in the ongoing nursing crisis.

A final point also applies to the broader challenges facing the nursing profession and the associated professional values. For the ED nurses in this study, there was often a mismatch between their professional values and the demands of the service. The nurses knew that the care they were delivering did not align with what is described widely by the profession as 'good care'. The notion of good care is set out in policies such as the 6Cs (described earlier) and by professional bodies (e.g. the NMC), guiding nurses' perceptions of good practice. Anything less than holistic, patient-centred and one-to-one care is seen as substandard. I observed that these standards were impossible in the context of the ED. More importantly still, the work that was being completed instead was arguably more critical to patient safety. This notion speaks to the arguments presented by Allen (2018) in examining the invisibility of much nursing work. Allen (2018) found that nurses were spending much of their time completing essential organising work, acting as the glue of the healthcare system. Despite the essentiality of this work, the nurses still felt that they were not doing a good job (Allen, 2018). This sentiment was echoed by the ED nurses in this study and resulted in significant emotional labour as they juggled the competing, and at times impossible, demands of contemporary practice.

7.2.3 Limitations and Final Thoughts

This thesis has offered new insights into nursing in the ED context and the emotional labour involved in this work. Despite the wealth of rich data generated, there is an awareness, as in all ethnographic work, that the findings cannot be directly extrapolated to make assumptions about other settings (Seymour and Sandiford, 2005). Instead, as recommended by Wolcott (2001, p.123):

> … rather than striving for closure, see if you can leave both yourself and your readers pondering the essential issues that perplex you…

Considering this, it is hoped that the findings presented may offer a starting point for further research studying emotional labour in the ED. For example, there is opportunity to explore the ED staffs experiences of deep acting and other focused areas of their emotional labour. In addition, it is hoped that this research will also prompt the study of emotional labour in other distinctive healthcare contexts. It may also be possible to utilise the findings in settings outside of health and nursing. Understanding the relevance of nursing environments and specialties to emotional labour is likely to provide practical solutions for supporting it, and the potential detrimental consequences of it, in practice.

Above all, it is hoped that this research will provide new insights and the grounding for further study; initial indications and encouragement suggest exciting opportunities for postdoctoral study as the next stage in this process. I am completely inspired by the possibilities offered by this work and feel optimistic that this PhD is just the beginning!

Bibliography

Adler, P. and Adler, P. 2012. The Epistemology of Numbers. In: Baker, S, E. and Edwards, R. 2012. Expert voices and early career reflections on sampling and cases in qualitative research: How many qualitative interviews is enough? [online]. Southampton: National Centre for Research Methods. [viewed 31 July 2016]. Available from: http://eprints.ncrm.ac.uk/2273/4/how_many_interviews.pdf

Aiken, L., Sermeus, W., Van den Heede, K., Sloane, D., Busse, R., McKee, M., Bruyneel, L., Rafferty, A, M., Griffiths, P., Moreno-Casbas, M. T., Tishelman, C., Scott, A., Brzostek, T., Kinnunen, J., Schwendimann, R., Heinen, M., Zikos, D., Strømseng Sjetne, I., Smith, H. L., Kutney-Lee, A. 2012. Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. [online]. British Medical Journal. [viewed 09 May 2016]. Available from: BMJ 2012;344:e1717

Adriaenssens, J., De Gucht, V. and Maes, S. 2015. Causes and consequences of occupational stress in emergency nurses, a longitudinal study. Journal of Nursing Management. Vol 23(3), p. 346 – 358.

Aldridge, M. 1994. Unlimited liability? Emotional labour in nursing and social work. Journal of Advanced Nursing. Vol 20(4), pp. 722 – 728.

Allen, D. 2014a. Inside bed management: ethnographic insights from the vantage point of UK hospital nurses. Sociology of Health and Illness. Vol 37(3), pp. 370 – 384.

Allen, D. 2014b. The invisible work of nurses: hospitals, organisations and healthcare. London: Routledge.

Allen, D. 2018. The invisible of nurses. [online]. Cardiff. [accessed 08 October 2018]. Available from: https://theinvisibleworkofnurses.co.uk/

Anyan, F. 2013. The influence of power shifts in data collection and analysis stages: a focus on qualitative research interview. The Qualitative Report. Vol 18(36), pp. 1 – 9.

Arthur, S., Mitchell, M., Lewis, J. and McNaughton Nicholls, C. 2014. Designing fieldwork. In: Ritchie, J., Lewis, J., McNaughton Nicholls, C. and Ormston, R. ed. Qualitative Research Practice. 2nd ed. London: Sage.

Ashforth, B. and Mael, F. 1989. Social Identity Theory and the Organization. The Academy of Management Review. Vol 14(1), pp. 20 - 39.

Ashforth, B. and Humphrey, R. 1993. Emotional Labor in service roles: the influence of identity. Academy of Management Review. Vol. 18(1), pp. 88 – 115.

Ashkanasy, N. and Humphrey, R. 2011. Current emotion research in organizational behavior. Emotion Review. Vol 3(2), pp. 214 – 224.

Atkinson, P., Coffey, A., Delamont, S., Lofland, J. and Lofland, J. 2001. Handbook of Ethnography. Sage: London.

Aveyard, H. 2010. Literature reviews in Health and Socail Care. 2nd ed. Berkshire: Open University press.

Badolamenti, S., Sili, A., Caruso, R., and Fida, R. 2017. What do we know about emotional labour in nursing? A narrative review. British Journal of Nursing. Vol 26(1).

Bailey, C., Murphy, R. and Porok, D. 2011. Professional tears: developing emotional intelligence around death and dying in emergency work. Journal of Clinical Nursing. Vol 20, pp. 3364 – 3372.

Baker, S, E. and Edwards, R. 2012. Expert voices and early career reflections on sampling and cases in qualitative research: How many qualitative interviews is enough? [online]. Southampton: National Centre for Research Methods. [viewed 31 July 2016]. Available from: http://eprints.ncrm.ac.uk/2273/4/how_many_interviews.pdf

Ballat, J. and Campling, P. 2013. Intelligent kindness: reforming the culture of healthcare. 1st ed. Glasgow: Bell & Bain Limited.

Barron, D., West, E. and Reeves, R. 2007. Tied to the job: affective and relational components of nurse retention. Journal of Health Service Research Policy. Vol 12(1), pp. 46 – 51.

Barry, B., Olekalns, M. and Rees, L. 2018. An ethical analysis of emotional labor. Journal of Business Ethics. (forthcoming) pp. 1 – 18.

Bartram, T., Casimir, G., Djurkovic, N., Leggat, S. and Stanton, P. 2012. Do perceived high performance work systems influence the

relationship between emotional labour, burnout and intention to leave? A study of Australian nurses. Journal of Advanced Nursing. Vol 68(7), pp. 1567 - 1568.

Basu, S., Qayyum, H. and Mason, S. 2016. Occupational stress in the ED: a systematic literature review. [online] Emergency Medicine Journal. [viewed 21 February 2017]. Available from: 10.1136/emermed-2016-205827

Becker, H. 2012. Expert Voices. In: Baker, S, E. and Edwards, R. 2012. Expert voices and early career reflections on sampling and cases in qualitative research: How many qualitative interviews is enough? [online]. Southampton: National Centre for Research Methods. pp.15. [viewed 31 July 2016]. Available from: http://eprints.ncrm.ac.uk/2273/4/how_many_interviews.pdf

Benesch, S. 2018. Emotions as agency: Feeling rules emotion labor, and English language teachers' decision-making. [online]. System. [viewed 07 September 2018]. Available from: https://doi.org/10.1016/j.system.2018.03.015

Benton, T. and Craib, I. 2001. 1st ed. Philosophy of social science: the philosophical foundations of social thought. Basingstoke: Palgrave.

Birch, M., Miller, T., Mauthner, M. and Jessop, J. 2005. Introduction. In: Mauthner, M., Birch, M., Jessop, J. and Miller, T. ed. Ethics in qualitative research. London: Sage Publications Ltd. pp. 1-14.

Blaikie, N. 2000. Designing social research: the logic of anticipation. Polity Press: Cambridge.

Blake, E. and Ashforth, C. 1989. Social identity theory and the organization. Academy of Management Review. Vol 14(1), pp. 20-39.

Bolton, S. 2001. Who cares? Offering emotion work as a 'gift' in the nursing labour process. Journal of Advanced Nursing. Vol.32(3), pp. 580 - 586.

Bolton, S. and Boyd, C. 2003. Trolley dolly or skilled emotion manager? Moving on from Hochschild's Managed Heart. Work, Employment and Society. Vol 17(2), pp. 289 – 308.

Bolton, S. 2004. Conceptual confusions: emotion work as skilled work. In: Warhurst, C., Grugulis, I. and Keep, E. ed. The Skills that Matter. Basingstone, Palgrave Macmillan.

Bolton, S. 2005. Emotion management in the workplace. Management, Work and Organisations. Basingstoke, Palgrave Macmillan.

Bolton, S. 2009. Getting to the heart of the emotional labour process: a reply to brook. Work, Employment and Society. Vol 23(3), p. 549 – 560.

Bone, D. 2002. Dilemmas of emotion work in nursing under market-driven healthcare. International Journal of Public Sector Management. Vol 15(2), pp. 140 - 150.

Boorman, S. 2009. NHS Health and Well-being, Final Report. London: Department of Health.

Boyd, C. 2002. Customer Violence and Employee Health and Safety. Work, Employment and Society. Vol 16(1), pp. 151 – 169.

Boyle, M. and Healy, J. 2003. Balancing mysterium and onus: doing spiritual work within an emotion-laden organizational context. Organization. Vol 10(2), pp. 351 – 373.

Boyle, M. 2005. "You wait till you get home", emotional regions, emotional process work, and the role of onstage and offstage support, in Hartel, E.E.J., Zerbe, W.J., Ashkansy, N.M. ed. Emotions in Organisational behaviour. 2005 Lawrence Erlbaum Associates, New Jersey.

Brannen, J. 2005. Mixing methods: The entry of qualitative and quantitative approaches into the research process. International Journal of Social Research Methodology. Vol 8(3), pp. 173 - 184.

Brenn, B. and McCann, M. 2013. Healthcare providers attitudes and perceptions of 'inappropriate attendance' in the Emergency Department. International Emergency Nursing. Vol 21, pp. 180 – 185.

Brook, P. 2009. In critical defence of 'emotional labour': refuting Bolton's critique of Hochschild's concept. Work, employment and society. Vol 23(3), pp. 531–548.

Broom, A. and Willis, E. 2007. Competing paradigms and health research. In: Saks, M. and Allsop, J. ed. Researching health: qualitative, quantitative and mixed methods. Sage: London.

Brotheridge, C. and Grandey, A. 2002. Emotional labour and burnout: comparing two perspectives of people work. Journal of Vocational Behaviour. Vol 60(1), pp. 17 – 39.

Brotheridge, M. and Lee, R. 2003. Development and validation of the emotional labour scale. Journal of Occupational and Organizational Psychology. Vol 76, pp. 365 – 379.

Bruni, A. 2005. Shadowing software and clinical records: on the ethnography of non-humans and heterogeneous contexts. Organization. Vol 12(3), pp. 357 - 78.

Bruni, A. 2006. Access as trajectory: entering the field in organizational ethnography. Management, Vol 9(3), pp. 137 - 152.

Bruni, A., Gherardi, S. and Poggio, B. 2004. Doing gender, doing entrepreneurship: an ethnographic account of intertwined practices. Gender, Work and Organization. Vol11(4), pp. 406 - 429.

Bryman, A. 2008. Social research methods. 3rd ed. Oxford: Oxford University Press.

Buckle, J. and Dwyer, S. 2009. The space between: on being an insider-outsider in qualitative research. International Journal of Qualitative Methods. Vol 8(1).

Butler, N. and Stoyanova Russell, D. 2018. No funny business: precarious work and emotional labour in stand-up comedy. [online]. *Human Relations*. [viewed 11 July 2018]. Available from: https://doi.org/10.1177/0018726718758880

Cadge, W. and Hammonds, C. 2012. Reconsidering detached concern: the case of intensive-care nurses. Perspectives in Biology and Medicine. Vol 55(2), pp. 266 – 282.

Constanti, P. and Gibbs, P. 2004 Higher education teachers and emotional labour. International Journal of Educational Management, Vol 18(4), pp. 243 – 249.

Cheng, C., Bartram, T., Karimi, L. and Leggat, S. 2013. The role of team climate in the management of emotional labour: implications for nurse retention. Journal of Advanced Nursing. Vol 69(12), pp.2812 – 2825.

Chiappetta-Swanson, C. 2005. Dignity and dirty work: nurses' experiences in managing genetic termination for fetal anomaly. Qualitative Sociology. Vol 28(1), pp. 93 – 115.

Choi, Y., Kim, K. and Kim, S. 2014. A study on the concept, dimensions and consequences of emotional labour. Industrial, Financial and Business Management. Vol 2(3), pp. 77 - 81.

Chou H. Y., Hecker, R. and Martin, A. 2012. Predicting nurses' well-being from job demands and resources: a cross-sectional study of emotional labour. Journal of Nursing Management. Vol 20, pp. 502 – 511.

Creswell, J. 2009. Research Design: qualitative, quantitative and mixed methods approaches. 3rd ed. London: Sage Publications Ltd.

Cricco-Lizza, R. 2014. The Need to Nurse the Nurse: Emotional Labor in Neonatal Intensive Care. Qualitative Health Research. Vol 24(5), pp. 615 – 628.

Crouch, R., Charters, A., Dawood, M. and Bennett, P. 2009. Oxford Handbook of Emergency Nursing. 1st ed. Oxford: Oxford University Press.

Crouch, R. and Dawood, M. 2017. Emergency nursing: recognising and celebrating the contribution. [online] Emergency Medicine Journal. [viewed 15 April 2017]. Available from: http://emj.bmj.com/content/35/3/144

Delamont, S. 2007. Arguments against autoethnography. Qualitative Researcher. Vol 4, pp. 2 - 4.

Delgadoa, C., Upton, D., Ranse, K., Furness, T. and Foster, K. 2017. Review Nurses' resilience and the emotional labour of nursing work: An integrative review of empirical literature. International Journal of Nursing Studies. Vol 70, pp. 71 – 88.

Department of Health. 2006. Direction of travel for urgent care: a discussion document. London. Department of Health.

Diefendorff, J. and Richard, M. 2003. Antecedents and consequences of emotional display rule perceptions. Journal of Applied Psychology. Vol 88(2), pp. 284 – 289.

Diefendorff, J, Erickson, J., Grandey, A. and Dahling, J. 2011. Emotional display rules as work unit norms: A multilevel analysis of

emotional labor among nurses. Journal of Occupational Health Psychology. Vol 16, pp. 170–186.

Duke, A., Goodman, J., Treadway, D. and Breland, J. 2009. Perceived organizational support as a moderator of emotional labor/outcomes relationships. Journal of Applied Psychology. Vol, 39(5) pp. 1013 – 1034.

El-Sawad, A. 2005. Becoming a 'lifer'? Unlocking career through metaphor. Journal of Occupational and Organizational Psychology. Vol 78, pp. 23 - 41.

Emerson, R., Fretz, R. and Shaw, L. 2001. Participation observation and fieldnotes. In: Atkinson, P., Coffey, A., Delamont, S., Lofland, J and Lofland, J. ed. 2001. Handbook of Ethnography. Sage: London.

Erickson, R. and Ritter, C. 2001. Emotional labor, burnout, and inauthentidty: does gender matter? Social Psychology Quarterly. Vol 64(2), pp. 146 – 163.

Ewbank, L., Thompson, J. and McKenna, H. 2017. NHS hospital bed numbers: past, present, future. [online]. The Kings Fund. [viewed 21 December 2017]. Available from: https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers

Feng-Hua, Y. and Changb, C. 2008. Emotional labour, job satisfaction and organizational commitment amongst clinical nurses: a questionnaire survey. International Journal of Nursing Studies. Vol 45, pp. 879 – 887.

Fielden, S. and Burke, R. 2014. Gendered careers in nursing. Gender in Management: An International Journal. Vol 29(2).

Fineman, S. 1993. Emotion in Organisations. London: Sage.

Fineman, S. 1996. Emotional subtexts in Corporate Greening. Organization Studies. Vol 17(3), pp. 479 – 500.

Flowerdew, L., Brown, R., Russ, S., Vincent, C. and Woloshynowych, M. 2012. Teams under pressure in the emergency department: an interview study. Emergency Medicine Journal. Vol 29(12), pp. 1 - 6.

Floyd, A. and Arthur, L. 2012. Researching from within: external and internal ethical engagement. International Journal of Research and Method in Education. Vol 35(2), pp. 171 - 180.

Foucault M. 1980. Power/Knowledge: Selected Interviews and Other Writings, 1972-1977. In: Gordon, C. ed. Brighton, Pantheon Books.

French B. 2005. Contextual factors influencing research use in nursing. Worldviews on Evidence-Based Nursing. Vol 2, pp. 172 – 183.

Funk, L., Peters, S., and Roger, K. 2017. The Emotional Labor of Personal Grief in Palliative Care: Balancing Caring and Professional Identities. Qualitative Health Research. Vol 27(14), pp. 2211 - 2221.

Gherardi, S. 1995. When will he say: “today the plates are soft”? the management of ambiguity and situated decision making. Studies in culture, organisation and society. Vol 1, pp. 9 – 27.

Gherardi, S. and Strati, A. 2012. Learning and Knowing in practice-based studies. Cheltenham: Edward Elgar.

Gherardi, S. 2015. Why Kurt Wolff matters for a practice-based perspective of sensible knowledge in ethnography. Journal of Organizational Ethnography. Vol 4(1), pp. 117 - 131.

Gillboy, N. 2010. Triage. In: Kunz-Howard, P. and Steinman, R. ed. Sheehy's Emergency Nursing: Principles and practice. 6th ed. Missouri: Mosby Elsevier.

Gillham, B. 2000. The research interview. 1st ed. London: MPG Books Ltd.

Gowler, D. and Legge, K. 1989. Rhetoric in bureaucratic careers: managing the meaning of management success. In: Arthur, M., Lawrence, D. and Hall, T. ed. Handbook of career theory. Cambridge University Press: Cambridge.

Glass, L. and Brand, K. 1979. The progress of women and nursing: parallel or divergent. In: Women in stress: a nursing perspective. 1st ed. London: Prentice-Hall, Inc.

Glomb, T.M. and Tews, M.J. 2004. Emotional labor: a conceptualization and scale development. Journal of Vocational Behavior. Vol 64(1), pp. 1 – 23.

Godwyn, M. 2006. Using emotional labor to create and maintain relationships in service interactions. Symbolic Interactions. Vol 29(4), pp. 487 – 506.

Goffman, E. 1959. The presentation of self in everyday life. Middlesex: Penguin Books.

Goffman, E. 1967. Interaction ritual. New York: Penguin.

Goerdeler, K.J., Wegge, J., Schrod, N., Bilinska, P. and Rudolf, M. 2015. "Yuck, that's disgusting!" – "No, not me!": Antecedents of disgust in geriatric care and its relation to emotional exhaustion and intention to leave. Motivation and Emotion. Vol 39(2), pp. 247 – 259.

Gorsky, M. 2008. The British National Health Service 1948–2008: A Review of the Historiography. Social History of Medicine. Vol 21(3), pp. 437 – 460.

Grandey, A. and Diamond, J. 2010. Interactions with the public: bridging job design and emotional labor perspectives. Journal of Organizational Behavior. Vol 31, pp. 338 – 350.

Grandey, A. and Gabriel, A. 2015. Emotional Labor at a Crossroads: Where Do We Go from Here? Annual Review of Organizational Psychology and Organizational Behavior. Vol 2(1), pp. 323 – 349.

Gross, J. and Thompson, R. 2007. Emotion regulation conceptual foundations. In: Gross, j. ed. Handbook of Emotion Regulation. New York: Guilford Press.

Gray, B. and Smith, P. 2000. An emotive subject: nurses' feelings Nursing Times. Vol 96(27), pp. 29 – 31.

Gray, B. and Smith. 2009. Emotional labour and the clinical settings of nursing care: the perspectives of nurses in East London. Nursing Education in Practice. Vol 9, pp. 253 – 261.

Gray, B. 2008. The emotional labour of nursing – defining and managing emotions in nursing work. Nurse Education. Vol 29, pp. 168 - 175.

Halford, S. and Leonard, P. 2003. Space and place in the construction and performance of gendered nursing identities. Journal of Advanced Nursing. Vol 42(2) pp. 201 - 208.

Halford, S. and Lenoard, P. 2005. Place, Space and Time: Contextualizing Workplace Subjectivities. Organization Studies. Vol 27(5) pp. 657 – 676.

Hayward, R. and Tuckey, M. 2011. Emotions in uniform: How nurses regulate emotion at work via emotional boundaries. Human Relations. Vol 64(11), pp. 1501 – 1523.

Hall, J. 1993. Smiling, deferring and flirting: doing gender by giving 'good service'. Work and Occupations. Vol 20(4), pp. 452 – 471.

Ham, C. 2004. Health Policy in Britain. 5th ed. Palgrave Macmillian: New York.

Ham, C. 2018. The compact between the public and the NHS. [online]. The Kings Fund. [viewed 13 February 2018]. Available from: https://www.kingsfund.org.uk/blog/2018/01/compact-between-public-and-nhs

Hammersley, M. 1992. What's wrong with ethnography? 1st ed. London: Routledge.

Hammersley, M. 2002. Educational research, policy making and practice. Paul Chapman: London.

Hammersley, M. and Atkinson, P. 1995. Ethnography: Principles in Practice. 2nd ed. Routledge: London.

Hammersley, M. and Atkinson, P. 2007. Ethnography: Principles in Practice. 3rd ed. Routledge: London.

Hammonds, C., and Cadge, W. 2014. Strategies of emotion management: Not just on, but off the job. Nursing Inquiry. Vol 21(2), pp. 162 - 170.

Hayward, R. and Tuckey, M. 2011. Emotions in uniform: how nurses regulate emotion at work via emotional boundaries. Human Relations. Vol 64(11), pp. 1501 – 1523.

Hawken, P. 1983. Foreword. In: Jacobson, S. and McGrath, M. Nurses under stress. 1st ed. Canada: John Wiley & Sons, Inc.

Hewlin, P. 2003. And the award for best actor goes to...: facades of conformity in organizational settings. The Academy of Management Review. Vol 28(4), pp. 633 - 642.

Hillman, A. 2014. 'Why must I wait?' The performance of legitimacy in a hospital emergency department. Sociology of Health & Illness Vol 36(4), pp. 485 – 499.

Health and Social Care Information Centre. 2015. Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatients and Accident and Emergency Data - April 2014 - January 2015. [online] Health and Social Care Information Centre. [viewed 15 February 2017]. Available from: http://www.hscic.gov.uk/catalogue/PUB17413

Henderson, A. 2001. Emotional labor and nursing: an under-appreciated aspect of caring work. Nursing Inquiry. Vol 8(2), pp. 130 – 138.

Hochschild, A. R. 1983. The managed heart: Commercialization of human feeling. 1st ed. Berkeley: University of California.

Hochschild, A. R. 2012. The managed heart: Commercialization of human feeling. 2nd ed. London: University of California Press Ltd.

Hogg, R., Hanley, J. and Smith, P. 2018. Learning lessons from the analysis of patient complaints relating to staff attitudes, behaviour and communication, using the concept of emotional labour. Journal of Clinical Nursing. Vol 27(5).

Hou, X. and Chu, K. 2010. Emergency department in hospitals, a window of the world: A preliminary comparison between Australia and China. World Journal of Emergency Medicine. Vol 1(3), pp. 180-184.

Howenstein, J. and Sandy, L. 2012. Case management and the expanded role of the emergency nurse. Journal of Emergency Nursing. Vol 38(5), pp. 454 - 459.

Hsieh, B. 2012. Burnout Among Public Service Workers: The Role of Emotional Labor Requirements and Job Resources. Review of Public Personnel Administration. Vol 34(4), pp. 379 – 402.

Humphry, C. 2012. Dilemmas in doing insider research in professional education. Vol 12(5), pp. 572 - 586.

Humphrey, D. and Morgeson, N. 2007. Integrating motivational, social, and contextual work design features: a meta-analytic summary and theoretical extension of the work design. Journal of Applied Psychology. Vol 92(5), pp. 1332 – 1356.

Humphrey, S.E., Nahrgang, J.D., and Morgeson, F.P. 2007. Integrating motivational, social, and contextual work design features: a meta-analytic summary and theoretical extension of the work design literature. The Journal of applied psychology. Vol 92(5), pp. 1332 - 1356.

Huynh T., Alderson M. and Thompson M. 2008. Emotional labour underlying caring: an evolutionary concept analysis. Journal of Advanced Nursing. Vol 64(2), pp. 195–208.

Igbojekwe P. 2017. A Study of Emotional Labour Coping Strategies in Some Hotels in South East Nigeria. Journal of Hotel and Business Management. Vol 6(161).

Jaggar, A. 1983. Feminist Politics and Human Nature: Philosophy & Society. 1st ed. Lanham: Rowman & Littlefield Publishers.

Jacobson, S. 1983. Burnout: a hazard in nursing. In: Jacobson, S. and McGrath, M. Nurses under stress. 1st ed. Canada: John Wiley & Sons, Inc.

James, N. 1989. Emotional labour: skill and work in the social regulation of feeling. Sociological Review. Vol 37(1), pp. 15 – 42.

James, N. 1992. Care = Organisation + Physical Labour + Emotional Labour. Sociology of health and illness. Vol 14(4), pp. 488 - 509.

Jeffrey, R. 1979. Normal rubbish: deviant patients in casualty departments. Sociology of Health & Illness. Vol 1(1), pp. 90 – 107.

Jin, M. and Guy, M. 2009. How emotional labor influences worker pride, job satisfaction, and burnout. Public Performance & Management Review. Vol 33(1), pp. 88 – 105.

Johnson, P. and Duberley, J. 2000. Understanding management research. London: Sage.

Johnson, H. and Spector, P. 2007. Service with a smile: do emotional intelligence, gender and autonomy moderate the emotional labor process? Journal of Occupational Health Psychology. Vol 12(4), pp. 319 – 333.

Jones, G. 2008. Introduction: Nursing in emergency care. In: Dolan, B. and Holt, L. ed. Accident and Emergency: Theory into practice. 2nd ed. London: Bailliere Tindall Elsevier.

Josland, H. 2008. Stress and stress management. In: Dolan, B. and Holt, L. ed. Accident and Emergency: Theory into practice. 2nd ed. London: Bailliere Tindall Elsevier.

Kahn, W. 1990. Psychological conditions of personal engagement and disengagement at work. Academy of Management Journal. Vol 33, pp. 692 – 724.

Kaneria, A. 2015. The history and development of trauma and emergency care in England. Trauma. Vol 17, pp. 52 - 57.

Kanuha, V.K. 2000. 'Being' native versus 'going' native: Conducting social work research as an insider. Social Work. [online]. EBSCO. Vol 45(5) 439-447. [viewed 23 August 2017]. Available from: http://web.b.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=512bb61d-13c6-48b9-8a3b-c30e021d6c43%40sessionmgr114&crlhashurl=login.aspx%253fdirect%253dtrue%2526scope%253dsite%2526db%253drzh%2526AN%253d2000080097%2526msid%253d201359200&hid=107&vid=0

Karnieli-Miller, O., Strier, R. and Pessach, L. 2009. Power relations in qualitative research. Journal of Qualitative Health Research. Vol 19, pp. 279 - 289.

Kelly, M. and May, D. 1982. Good and bad patients: a review of the literature and a theoretical critique. Journal of Advanced Nursing. Vol 7, pp. 147 - 156.

Khalili, L. 2011. The ethics of social science research. In: Heacock, R. and Conte, E. ed. Critical research in the social sciences: a transdisciplinary east-west handbook. Palestine: Ibrahim Abu-Lughod Institute of International Studies, Birzeit University, pp.65-77.

Korczynski, M. 2003. Communities of coping: collective emotional labour in service work. Organisation. Vol 10(1), pp. 55 - 79.

Korczynski, M. 2005. Skills in service work: an overview. Human Resource Management Journal. Vol 15(2), pp. 3 – 14.

Kosny, A. and MacEachen, E. 2010. Gendered, Invisible Work in Non-Profit Social Service Organizations: Implications for Worker Health and Safety. Gender, Work & Organization. Vol 17, pp. 359 - 380.

Kuntz, A.M. and Presnall, M.M. 2012. Wandering the tactical: from interview to intraview. Qualitative Inquiry. Vol18(9), pp. 732-744.

Kusenbach, M. 2003. Street phenomenology the go-along as ethnographic research tool. Ethnography. Vol 4(3), pp. 455 - 485.

Law, J. and Singleton, V. 2013. ANT and politics: working in and on the world. Qualitative Sociology. Vol 36(4), pp. 485 - 502.

Leidner, R. 1991. Selling hamburgers and selling insurance: Gender work, and identity in interactive service jobs. Gender and Society. Vol 5(2), pp. 154- 177.

Leidner, R. 1993. Fast food, Fast talk: Service work and the routinisation of everyday life. Berkeley. University Press.

Lefebvre H. 1991. The Social Production of Space. Blackwell, Oxford.

Lewis, J. and McNaughton Nicholls, C. 2014. Design issues. In: Ritchie, J, Lewis, J, McNaughton Nicholls, C, and Ormston, R. ed. Qualitative Research Practice. 2nd ed. London: Sage.

Lin, S. 2000. A study of the development of emotional labour loading scale. Sun Yat-Sen Management Review. Vol 8(3), pp. 427–447.

Lin, Y. and Chang, W. 2015. Physician Emotional Labour and Job Performance: The Mediating Effects of Emotional Exhaustion. Journal of Health Management. Vol 17(4), pp. 446 – 457.

Llanwarne, N., Newbould, J., Burt, J., Campbell, J. and Roland, M. 2017. Wasting the doctor's time? A video-elicitation interview study with patients in primary care. Social Science & Medicine. Vol 176, pp. 113 – 122.

Locker, T. E., & Mason, S. M. 2005. Analysis of the distribution of time that patients spend in emergency departments. British Medical Journal. Vol 330(7501), pp. 1188 –1189.

Lopez, S. 2006. Emotional labour and organisaed emotional care: conceptualising nursing home care work. Work and Occupation. Vol 33(2), pp. 133 – 160.

Maben, J. 2010. Work environments must support staff wellbeing: Nursing Times Opinion. Nursing Times. Vol 106(18).

Maben, J. 2013. How NHS staff well-being effects patient care. Health Service Journal [online]. EMAP Publishing Limited. [viewed 27 April 2017]. Available from: http://www.hsj.co.uk/home/innovation-and-efficiency/how-nhs-staff-wellbeing-affects-patient-care/5057528.article

Mason, J. 1996. Qualitative researching. 1st ed. London: Sage.

Mason, J. 2002. Qualitative researching. 2nd ed. London: Sage.

Mason, S., Weber, S., Coster, J., Freeman, J. and Locker, T. 2012. Time patients spend in the emergency department: England's 4-hour rule-a case of hitting the target but missing the point? Annals of Emergency Medicine. Vol 59(5), pp. 58 - 64.

May, C., Finch, T., Mair, F., Ballini, L., Dowrick, C., Eccles, M., Gask, L., MacFarlane, A., Murray, E., Rapley, T., Rogers, A., Treweek, S., Wallace, P., Anderson, G., Burns, J. and Heaven, B. 2007. Understanding the implementation of complex interventions in healthcare: the normalization process model. [online]. BMC Health Services Research. [viewed 30 June 2018]. Available from: doi:10.1186/1472-6963-7-148

May, D. and Kelly, M. 2008. Chancers, pests and poor wee souls: problems of legitimation in psychiatric nursing. Sociology of Health & Illness. Vol 4(3), pp. 279 - 301.

Mazhindu, D. 2009. Ideal nurses and the emotional labour of nursing. Nurse researcher. Vol 16(2), pp. 91 - 94.

McCreight, B. 2005. Perinatal grief and emotional labour: a study of nurses' experiences in gynae wards. International journal of nursing studies. Vol 42, pp. 439 - 448.

McDermid, F., Peters, K., Jackson, D. and Daly, J. 2014. Conducting qualitative research in the context of pre-existing peer and collegial relationships. Nurse Researcher. Vol 21(5), pp. 28 - 33.

McDonald, G., Jackson, D., Wilkes, L. and Vickers, M. 2012. A work-based educational intervention to support the development of personal resilience in nurses and midwives. Nurse Education Today. Vol 32, pp. 378 - 384.

McDonald, L. and Sirianni, C. 1996. Working in the service society. Philadelphia: Temple University Press.

McMurray, R. and Ward, J. 2014. 'Why would you want to do that?': Defining emotional dirty work. Human Relations. Vol. 67(9), pp. 1123 –1143.

McMurray, R. and Ward, J. 2015. The dark side of emotional labour, Routledge, London.

McNaughton Nicholls, N., Mills, L. and Katecha, M. 2014. In: Ritchie, J, Lewis, J, McNaughton Nicholls, C, and Ormston, R. ed. Qualitative Research practice. 2nd ed. London: Sage.

McQueen, A. 2000. Nurse-patient relationships and partnership in hospital care. Journal of Clinical Nursing. [online]. Wiley. [viewed 24 August 2017]. Available from: http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2702.2000.00424.x/pdf

McQueen, A. 2004. Emotional intelligence in nursing work. Journal of Advanced Nursing. Vol 47(1), pp. 101 – 108.

Menzies, I. 1960. A case-study in the functioning of social systems as a defence against anxiety. Human Relations. pp. 95 – 121.

Mikolajczak, M., Menil, C., & Luminet, O. 2007. Explaining the protective effect of trait emotional intelligence regarding occupational stress: exploration of emotional labour processes. Journal of Research in Personality. Vol 41, pp. 1107 – 1117.

Mills, C.W. 1959. The Sociological imagination. Oxford University Press, New York.

Morris, A. and Feldman, D. 1996. The dimensions, antecedents, and consequences of emotional labor. The Academy of Management Review, Vol, 21(4) pp. 986 – 1010.

Mortimore, A. and Cooper, S. 2007. The "4-hour target": emergency nurses' views. Emergency Medicine Journal. Vol 24, pp. 402 - 404.

Msiska, G., Smith, P., Fawcett, T. and Mkwinda Nyasulu, B. 2014. Emotional labour and compassionate care: What's the relationship? Nurse Education Today. Vol 34(9), pp. 1246 – 1252

Murphy, E. and Dingwall, R. 1998. Qualitative methods in health services research. In: Black, N., Brazier, J., Fitzpatrick, R. and Reeves, B. ed. 1st ed. Health Services Research Methods. London: BMJ Publishing Group.

Murphy, E. and Dingwall, R. 2003. Qualitative methods and health policy research. 1st ed. New York: Walter de Gruyter, Inc.

National Health Executive, 2016. The 4-hour target: what's the point? [Online]. National Health Executive. [viewed 31 March 2018]. Available from:

http://www.nationalhealthexecutive.com/Comment/the-four-hour-target-whats-the-point/158287

Neades, B. 1997. Developing the role of the nurse specialist: Expanding the role of the nurse in the Accident and Emergency department. Postgraduate Medical Journal. Vol 73. pp. 17 - 22.

Newman, M., Guy, M. and Mastracci, S. 2009. Beyond cognition: affective leadership and emotional labor. Public Administration Review. pp. 6 – 20.

NHS Digital, 2017. Hospital Accident and Emergency Activity, 2016-17. [online]. NHS Digital. [viewed 10 June 2017]. Available from: http://digital.nhs.uk/catalogue/PUB30112

NHS Digital, 2018. Hospital Accident and Emergency Activity, 2017-18. [online]. NHS Digital. [viewed 05 November 2018]. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2017-18

NHS Careers. 2015. Careers in the accident and emergency department. [online] NHS England. [viewed 23 January 2016]. Available from: http://www.nhscareers.nhs.uk/promotions/career-in-focus-%E2%80%93-ae/

NHS Choices. 2014. Major trauma services. [online] NHS England. [viewed 14 February 2017]. Available from: http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Majortraumaservices.aspx

NHS Choices. 2015. Urgent and emergency care services in England. [online] NHS England. [viewed 23 January 2017]. Available from: http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/AE.asp

NHS England, 2013. Effective approaches in urgent and emergency care paper 4 improving ambulance handover – practical approaches. [online]. NHS Interim Management and Support. [viewed 03 January 2018]. Available from: https://www.nhsimas.nhs.uk/fileadmin/Files/IST/Paper_4_-_Improving_Ambulance_Handover_2013.pdf

NHS England, 2018. Urgent and emergency care. [online]. NHS England. [viewed 22 March 2018]. Available from: https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/urgent-and-emergency-care/

NHS England. 2018a. Provisional Accident and Emergency Quality Indicators - England, by provider for January 2018. [online]. NHS England. [viewed 18 June 2018]. Available from: https://digital.nhs.uk/data-and information/publications/statistical/accident-and-emergency-quality-indicators/provisional-accident-and-emergency-quality-indicators-england-by-provider-for-january-2018

NHS England, 2018b. Clinical Services Quality Measures (CSQMs). [online]. NHS England. [viewed 30 June 2018]. Available from: https://www.england.nhs.uk/ourwork/tsd/data-info/open-data/clinical-services-quality-measures/

NHS England, 2018c. The 6 C's. [online]. NHS England. [viewed 06 September 2018]. Available from: https://www.england.nhs.uk/leadingchange/about/the-6cs/

NHS Security Management Service. 2010.Violence Against Frontline NHS Staff: Research Study Conducted for COI on behalf of the NHS Security Management. [online]. Ipsos, MORI. [viewed 22 September 2016]. Available from: http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/NHS_SMS_Workplace_Safety_Report_FINAL_MERGED.pdf

Nixon, D. 2009. 'I Can't Put a Smiley Face On': Working-Class Masculinity, Emotional Labour and Service Work in the 'New Economy'. Gender, Work and Organization. Vol 16(3), pp. 300 – 322.

Noble, H. and Smith, J. 2015. Issues of validity and reliability in qualitative research. Evidenced Based Nursing. [online] BMJ. vol.18(2). 34-35. [viewed 15 August 2016]. Available from: http://ebn.bmj.com/content/18/2/34.full

Noon M., Blyton P. (1997) Time and Work. In: The Realities of Work. Palgrave, London.

Nursing and Midwifery Council. 2008. The Code: Standards of conduct, performance and ethics for nurses and midwives. London: NMC.

Okasha, S. 2002. Philosophy of Science. Oxford: Oxford University Press.

O'Reilly, K. 2009. Key concepts in ethnography. London: Sage.

Ormston, R., Spencer, L., Barnard, M. and Snape, D. 2014. The Foundations of Qualitative Research. In: Ritchie, J., Lewis, J., McNaughton Nicholls, C. and Ormston, R. ed. Qualitative Research practice. 2nd ed. London: Sage.

Pandey, J. and Singh, M. 2016. Donning the mask: effects of emotional labour strategies on burnout and job satisfaction in community healthcare. Health Policy and Planning. Vol 31(5), pp. 551 – 562.

Parkinson, B. 1996. Changing moods: the psychology of mood and mood regulation. New York: Addison Wesley Longman.

Parry, R. 2013. Communication and compassion need time and support: Insights from end of life care. International Journal of Therapy and Rehabilitation. Vol 20(10), pp. 278 - 279.

Parsons, T. 1951. The Social System. New York, Free Press.

Payne, J. 2009. Emotional Labour and Skill: A Reappraisal. Gender, Work and Organization. Vol 16(3).

Phillips, S. 1996. Labouring the emotions: expanding the remit of nursing work? Journal of Advanced Nursing. Vol 24, pp. 139 - 143.

Pierce, J. 1995. Gender trials: emotional lives in contemporary law firms. Berkley: University of California Press.

Pisaniello, S., Winefield, H. and Delfabbro, P. 2012. The influence of emotional labour and emotional work on the occupational health and

wellbeing of South Australian hospital nurses. Journal of Vocational Behavior. Vol 80(3), pp. 579 – 591.

Platt H. 1962. Report of the standing medical advisory committee, accident and emergency services. London: HMSO.

Pytel, C., Fielden, N., Meyer, K., Albert, N. 2009. Nurse-Patient/Visitor Communication in the Emergency Department. Journal of Emergency Nursing. Vol 35(5), pp. 406 – 411

Pugliesi, K. 1999. The consequences of emotional labor: effects on work stress, job satisfaction, and well-being. Motivation and Emotion. Vol 23(2), pp. 125 – 154.

Qualitywatch. 2015. A&E waiting times. [online]. The Nuffield Trust and the Health Foundation. [viewed 18 November 2016]. Available from: http://www.qualitywatch.org.uk/indicator/ae-waiting-times

Qualitywatch, 2017. A&E waiting times. [online]. The Nuffield Trust and the Health Foundation. Accessed 31 January 2017. Available from: http://www.qualitywatch.org.uk/indicator/ae-waiting-times

Rashotte, J., Fothergill-Bourbonnais, F. and Chamberlain, M. 1997. Paediatric intensive care nurses and their grief experiences: A phenomenological study. Heart & Lung: The Journal of Acute and Critical Care. Vol 26(5), pp. 372 - 386.

Revans, R. 1959. The hospital as an organism: a study in communication and morale. Institute of Management Services (6th Annual Meeting presentation). London: Pergamon Press.

Royal College of Nursing. 2012. Media – Friend or Foe? Congress agenda 2012. [online] London: RCN. [viewed 15 August 2017]. Available from: https://www.rcn.org.uk/newsevents/congress/2012/submit_an_agenda_item/11_media_-_friend_or_foe

Reily, R. and Weiss, M. 2016. A qualitative thematic review: emotional labour in healthcare settings. Journal of Advanced Nursing. Vol 72(1), pp. 6 – 17.

Ritchie, J., Lewis, J., Elam, G., Tennant, R. and Rahim, N. 2014. Designing and selecting samples. In: Ritchie, J., Lewis, J., McNaughton Nicholls, C., and Ormston, R. ed. Qualitative Research Practice. 2nd ed. London: Sage.

Robert, G., Philippou, J., Leamy, M., Reynolds, E., Ross, S., Bennett, L., Taylor, C., Shuldham, C. and Maben, J. 2017. Exploring the adoption of Schwartz Center Rounds as an organisational innovation to improve staff well-being in England, 2009–2015. [online]. BMJ Open [viewed 10 March 2018]. Available from: doi: 10.1136/bmjopen-2016-014326

Robinson, O. 2014. Sampling in interview-based qualitative research: a theoretical and practical guide. Qualitative Research in Psychology. Vol 11(1), pp. 25 - 41.

Rochefort, C.M. and Clarke, S.P. 2010. Nurses' work environments, care rationing, job outcomes, and quality of care on neonatal units. Journal of Advanced Nursing. Vol 66(10), pp. 2213 – 2224.

Ruchti, L. 2012. Catheters, slurs and pickup lines: professional intimacy in hospital nursing. 1st ed. Philadelphia: Temple University Press.

Sachs, J. and Blackmore, J. 2010. You Never Show You Can't Cope: Women in school leadership roles managing their emotions. Gender and Education. Vol 10(3), pp. 265 - 279.

Sakr, M. and Wardrope, J. 2000. Casualty, accident and emergency, or emergency medicine, the evolution. Journal of Accident and Emergency Medicine. Vol 17, pp. 314 – 319.

Sanders, J., 2000. A review of health professionals attitudes and patient perceptions on 'inappropriate' accident and emergency attendances. The implications for current minor injury service provision in England and Wales. Journal of Advanced Nursing. Vol 31(5), pp. 1097 – 1105.

Saunders, J.M., Valente, S.M. 1994. Nurses grief. Cancer Nursing, Raven Press Ltd. Vol 17(4), pp. 318 - 325.

Sawatzky, J. and Enns, C. 2012. Exploring the key predictors of retention in emergency nurses. Journal of Nursing Management. Vol 20(5), p. 696 – 707.

Sawbridge, Y. and Hewison, A. 2013. Thinking about the emotional labour of nursing - supporting nurses to care. Journal of Health Organisation and Management [online]. ProQuest LLC. [viewed 24 July 2017]. Available from: http://search.proquest.com/docview/1315349447?accountid=8018Individual works

Schubert, M., Glass, T.R., Clarke, S.P., Schaffert-Witvliet, B. and De Geest, S. 2007. Validation of the basel extent of rationing of nursing care instrument. Nursing Research. Vol 56(6) pp. 416 – 424.

Schubert, M., Glass T.R., Clarke, S.P., Aiken, L.H., Schaffert-Witvliet, B., Sloane, D.M. and De Geest, S. 2008. Rationing of nursing care and its relationship to patient outcomes: the Swiss extension of the International Hospital Outcomes Study. International Journal for Quality in Health Care. Vol 20(4), pp. 227 – 237.

Seymour, D. and Sandiford, P. 2005. Learning emotion rules in service organizations: socialization and training in the UK public-house sector. Work, employment and society. Vol 19(3), pp. 547 – 564.

Silverman, D. 1997. The logics of qualitative research. In: Millar, G. and Dingwall, R. Context and method in qualitative research. 1st ed. London: Sage.

Silverman, D. 2006. Interpreting Qualitative Data: Methods for analysing talk, text and interaction. 3rd ed. London: Sage Publications.

Silverman, D. 2010. Doing qualitative research. 3rd ed. London: Sage Publications Ltd.

Silverman, D. 2013. Doing qualitative research. 4th ed. London: Sage Publications Ltd.

Skillbeck, J. and Payne, S. 2003. Emotional support and the role of Clinical Nurse Specialists in palliative care. Journal of Advanced Nursing. Vol 43(5), pp. 521 – 530.

Smith, P. 1992. 1st ed. The emotional labour of nursing: how nurses care. Basingstoke: The Macmillian Press, Ltd.

Smith, P. 2012. 2nd ed. The emotional labour of nursing revisited: can nurses still care? Basingstoke: Palgrave Macmillian.

Spradley, J. P. 1979. The Ethnographic Interview. 1st ed. New York: Holt, Rinehart and Winston, Inc.

Squires, J., Graham, I., Hutchinson, A., Linklater, S., Brehaut, J., Curran, J., Ivers, N., Lavis, J., Michie, S., Sales, A., Fiander, M., Fenton, S. Noseworthy, T., Vine, J. and & Grimshaw, J. 2014. Understanding context in knowledge translation: a concept analysis study protocol. Journal of Advanced Nursing. Vol 71(5), pp. 1146 – 1155.

Sreedevi. V., Sumathi, A. and Ramalingam, S. 2014. Emotional labour models: differing perspectives. International Journal of Enterprise Network Management. Vol 6(1).

Staden, H. 1998. Alertness to the needs of others: a study of the emotional labour of caring. Journal of Advanced Nursing. Vol 27, pp. 147 - 156.

Stayt, L. C. 2009. Death, empathy and self-preservation: the emotional labour of caring for families of the critically ill in adult intensive care. Journal of Clinical Nursing. Vol 18, pp. 1267 - 1275.

Steinberg, R. and Figart, D. 1999. Emotional labour since the managed heard. The Annals of the American Academy of Political and Social Science. Vol 561, pp. 8 - 26.

Stets, J. 2010. Future directions in the sociology of emotions. Emotion Review. Vol 2(3), pp. 265 – 268.

Stewart, L. 2012. Family Care Responsibilities and Employment: Exploring the Impact of Type of Family Care on Work–Family and Family–Work Conflict. Journal of Family Issues. Vol 34(1), pp. 113 – 138.

Stoye, G. UK health spending. [online]. Institute for Fiscal Studies. [viewed 18 June 2018]. Available from: https://www.ifs.org.uk/publications/9186

Strati, A. 2003. Knowing in Practice: Aesthetic Understanding and Tacit Knowledge. In: Nicolini, D., Gherardi, S. and Yanow, D. ed. Knowing in Organizations. NY, M.E.

Strati, A. 2016. Aesthetics and design: an epistemology of the unseen. In: Mir, R., Willmott, H. and M. Greenwood. Ed. The Routledge Companion to Philosophy in Organization Studies. London: Routledge.

Sutton, R.I. and Rafaeli, A. 1988. Untangling the relationship between displayed emotions and organizational sales. Academy of Management Journal. Vol 31, pp. 461 – 487.

The Health Foundation, 2017. Rising pressure: the NHS workforce challenge. Workforce profile and trends of the NHS in England.

[online]. The Health Foundation. [viewed 22 January 2018]. Available from: http://reader.health.org.uk/rising-pressure-nhs-workforce-challenge

The Kings Fund, 2018. What's going on with A&E waiting times? [online]. The Kings Fund. [viewed 13 March 2018]. Available from: https://www.kingsfund.org.uk/projects/urgent-emergency-care/urgent-and-emergency-care-mythbusters#ae-attendances

The Royal College of Emergency Medicine. 2017. Initial assessment of emergency department patients: service design and delivery. [online]. RCEM. [viewed 23 February 2018]. Available from: https://www.rcem.ac.uk/docs/SDDC%20Intial%20Assessment%20(Feb%202017).pdf

Thomson, P. and Gunter, H. 2011. Inside, outside, upside down: the fluidity of academic researcher 'identity' in working with/in school. International Journal of Research & Method in Education. Vol. 34(1), pp. 17 – 30.

Tietze, S., Cohen, L. and Musson, G. 2003. Understanding organisations through language. London: Sage.

Timmons, S., and Tanner, J. 2005. Operating theatre nurses: Emotional labour and the hostess role. International Journal of Nursing Practice. Vol 11, pp. 85 – 91.

Theodosius, C. 2008. Emotional labour in healthcare, the unmanaged heart of nursing. London: Routledge.

Trochim, W. 2006. Qualitative Validity. [online] The Research Methods Knowledge Base: Web Centre for Social Research Methods. 2nd ed. [viewed 20 July 2016]. Available from: http://www.socialresearchmethods.net/kb/qualval.php

Turner, J. and Stets, E. 2006. Sociological theories of human emotion. Annual Review of Sociology. Vol 32, pp. 25-52.
Uy, M. And Jia Lin, K. 2017. Is it better to give or receive? the role of help in buffering the depleting effects of surface acting. Academy of Management Journal. Vol 60(4), pp. 1442–1461.

Van Maannen, J. and Kunda, G. 1989. 'Real feelings': emotional expressions and organisational culture. In: Research in Organisational Behaviour. ed. Staw, B. and Cummings, L. Greenwich: JAI Press.

Vincent, S. 2011. The emotional labour process: An essay on the economy of feelings. Human Relations. Vol 64(10), pp. 1369 – 1392.

Wallbank, S. and Hatton, S. 2011. Reducing burnout and stress: the effectiveness of clinical supervision. Community Practitioner. Vol 84(7).

Wallbank, S. 2012. Health visitor needs: National perspectives from the restorative clinical supervision programme. Community Practitioner. Vol 85(4).

Wallbank, 2015. Restorative clinical supervision. [online]. London: Institute of Health Visiting. [viewed 1 May 2017]. Available from: http://www.ihv.org.uk/uploads/Restorative%20Clinical%20Supervisory%20Hand-out.pdf

Watson, T. 2013. Making organizational ethnography. Journal of Organizational Ethnography. Vol 1(1), pp. 15 - 22.

Weber, E., Mason, S., Carter, A. and Hew, R. 2011. Emptying the corridors of shame: organizational lessons from England's 4-hour emergency throughput target. Annals of Emergency Medicine. Vol 57(2), pp. 79 - 88.

West, M. 2016. Creating a workplace where NHS staff can flourish. [online]. The Kings Fund, London. [viewed 30 July 2018]. Available from: https://www.kingsfund.org.uk/blog/2016/01/creating-workplace-where-staff-can-flourish

Wharton, A. 2009. The sociology of emotional labour. Annual Review Sociology. Vol 35, pp. 147 - 165.

Williams, A. 2012. Emotion work in paramedic practice: the implications for nurse educators. Nurse Education Today. Vol 32(4), pp. 368 – 372.

Williams, A. 2013. Hochschild (2003) – The managed heart: The recognition of emotional labour in public service work. Nurse Education Today. pp. 5 - 7.

Williams, M. 2016. Key concepts in the philosophy of social research. London: Sage.

Wilson, J. and Kirshbaum, M. 2011. Effects of patient deaths on nursing staff: A literature review. British Journal of Nursing. Vol 20, pp. 559–563.

Wharton, A. 2009. The sociology of emotional labor. Annual Review of Sociology. Vol 35(1), pp. 147 – 165.

Wolcott, H.F. 2001. Writing up Qualitative Research. 2nd ed. London: Sage.

Wright, B. 1998. Just part of the Job. Accident and Emergency Nursing. Vol 6(3), pp. 125.

Yang, F. and Chang, C. 2007. Emotional labour, job satisfaction and organisational commitment amongst clinical nurses: a questionnaire survey. Vol 45, pp. 879 - 887.

Yagil, D. And Medler-Liraz, H. 2013. Moments of truth: examining transient authenticity and identity in service encounters. Academy of Management Journal. Vol 56(2), pp. 473 - 497.

Yeo, A., Legard, R., Keegan, J., Ward, K., McNaughton Nicholls, C. and Lewis. 2014. In-depth interviews. In: Ritchie, J., Lewis, J., McNaughton Nicholls, C., and Ormston, R. ed. Qualitative Research practice. 2nd ed. London: Sage.

Appendices

Appendix 1: Consent Form

IRAS ID: 211927
(Draft Version 4.0 / Final version 1.0 07/11/16)

Title of Study: Emotional labour in the emergency department: feeling rules, gender stereotypes and emotional stoicism.

IRAS Project ID: n/a

Name of Researcher: Kate Kirk

Name of Participant:

1. I confirm that I have read and understand the information sheet version number Draft Version 4.0 / Final Version 1.0 dated 07/11/16 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 my medical notes and 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

Appendix 2: Information Sheet



Participant Information Sheet

(Draft Version 4.0 / Final version 1.0: 07/11/2016)

IRAS Project ID: 211927

Title of Study: Emotional labour in the emergency department: feeling rules, gender stereotypes and emotional stoicism.

Name of Researcher(s): Kate Kirk

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 staff in the emergency department, this type of management is known as the theory of emotional labour. The study hopes to explore this theory from both the perspective of emergency department staff, and also wider professional groups outside of the emergency setting. As described later in this information sheet, the study is being undertaken as part of a PhD qualification.

Why have I been invited?

You are being invited to take part because you are a staff member in the targeted health professional group for this study. We are inviting around 20 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 take part in an interview with the researcher, which will be on a one-to-one basis and will last approximately 1 hour. It is likely that only one interview will be necessary. In this interview, the interviewer will ask you about your experiences of your role, and work. Some of the questions in the interview will be pre-scripted, while others will the result of conversation between researcher and participant. The interviews will be recorded for transcription. This research will take place in an acute care setting and periods of observation will also be carried out.

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 to taking part in this study. However, it appreciated that discussing previous experiences, some of which may be emotional in nature, can be difficult and uncomfortable to do. In response, it should be reaffirmed here that the confidentiality of participants, and their stories will be treated with the strictest of 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 the emotional component of work, and how this influences patient care and staff experience.

What happens when the research study stops?

The study findings are likely to be written up for publication in an academic journal, they may also be shared at events, such as research conferences. The findings from this study may also inform future research into similar areas.

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 Gerardo Patriotta, Director of Doctoral Programmes, Business School, University of Nottingham, Gerardo.Patriotta@nottingham.ac.uk

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 forms the basis of a PhD study. Therefore, it is part of an educational qualification. As mentioned earlier, it is likely that the results of the research study will also be published in an academic journal, and also disseminated through other platforms, such as research conferences. This process will be continuous through the PhD study, but most prominently on completion (2018). You will not be identified in any report or publication.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by Collaboration for Leaders in Applied Health Research and Care (CLAHRC) and the Centre for Health Innovation, Leadership and Learning (CHILL).

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 University of Nottingham Research Ethics Committee.

Further information and contact details:

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Supervisor:

Dr Alison Edgley, Health Sciences, University of Nottingham

Alison.Edgley@nottingham.ac.uk

Appendix 3: Topic Guide

Emotional Labour in the Emergency Department:

Questions aimed at preceptorship and support nurses, occupation health nurses, and individuals in practice development:

- Do you have experience of supporting nurses and others from emergency care?
- Can you tell me about your experiences of supporting nurses?
- Do they experience challenges in relation to their emotions and the emotions of others?
- If so, are there any particular instances which call for this type of work? And how do they manage this?
- What's the role of gender in all this?

Questions aimed at emergency department staff:

- Can you tell me about your experiences of working in the ED?
- What does an A&E nurse look like?
- What are their characteristics?
- What makes a good or successful A&E nurse?
- Has the role met your expectations?
- What are the challenges of your role and how do you manage the challenges of your work?
- Are their emotional challenges to your role?
- Do you think your gender and the gender of others effects your role?

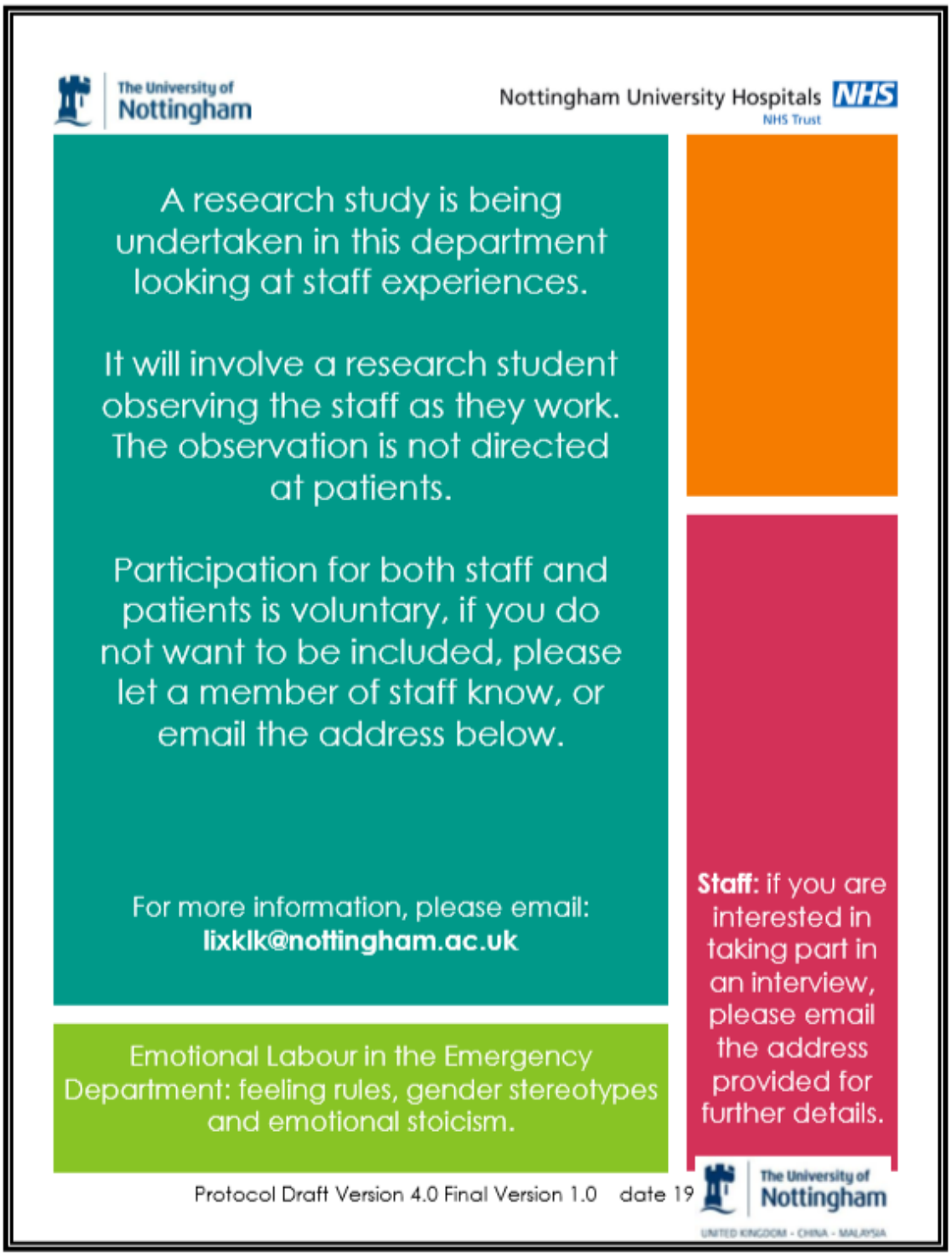
Metaphors – Do any of these (images or metaphors) speak to you in relation to your experiences of working in ED?

- Assembly line
- Juggling
- Bunker/Dungeon
- A&E Swan/Duck
- Warzone

- Firefighting

  Photos:
- Corridor full of trollies
- Outside the ED – ambulance bay
- Overcrowding in ED

Appendix 4: Poster Advertising Study



Appendix 5: Letter of HRA Approval

NHS
Health Research Authority

Dr Stephen Timmons
Nottingham University Business School
Jubilee Campus, Wollaton Road
Nottingham
NG8 1BB
stephen.timmons@nottingham.ac.uk

Email: hra.approval@nhs.net

08 November 2016

Dear Dr Stephen Timmons

Letter of HRA Approval

Study title:	**Emotional labour in the emergency department: feeling rules, gender stereotypes and emotional stoicism.**
IRAS project ID:	**211927**
Protocol number:	**16077**
REC reference:	**16/HRA/4505**
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 email the HRA at hra.approval@nhs.net. Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

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/

IRAS project ID	211927

Your IRAS project ID is **211927**. Please quote this on all correspondence.

Yours sincerely

Joanna Strickland
Assessor

Email: hra.approval@nhs.net

Copy to: *Miss Katherine Kirk [PhD student] lixklk@nottingham.ac.uk*
Ms Angela Shone [sponsor contact] sponsor@nottingham.ac.uk
Dr Maria Koufali and Alison Steel, Nottingham University Hospitals NHS Trust [Lead R&D contact] rdappl@nuh.nhs.uk

IRAS project ID	211927

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 [Poster]	3.0	30 August 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [insurance certificate]		20 July 2016
IRAS Application Form [IRAS_Form_30082016]		30 August 2016
Letter from sponsor [Letter from Sponsor]	N/A	30 August 2016
Other [amended SoA-dated]	1	08 November 2016
Other [SoE-dated]	1	07 November 2016
Other [Signed delegation log]	N/A	30 August 2016
Participant consent form [Amended consent form]	4	07 November 2016
Participant information sheet (PIS) [Amended PIS]	3	07 November 2016
Research protocol or project proposal [Protocol]	3.0	30 August 2016
Summary CV for Chief Investigator (CI) [CV]	N/A	30 August 2016
Summary CV for student [Students CV]	N/A	27 August 2016
Summary CV for supervisor (student research) [CV]	N/A	27 August 2016

IRAS project ID	211927

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:

Sponsor name: Ms Angela Shone
Email:sponsor@nottingham.ac.uk

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	The Participant Information Sheet and Informed Consent Form have been updated in line with HRA standards and in accordance with the Data Protection Act as a minor amendment.
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The Statement of Activities will act as agreement of an NHS organisation to participate. There will not be any other agreement used by the sponsor.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the

Section	HRA Assessment Criteria	Compliant with Standards	Comments
			activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	External funding has been secured by CLAHRC East Midlands & Centre for health innovation, leadership and learning (CHILL). There will be no funding available to research sites.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	The PIS has been updated in accordance with the DPA.
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 NHS site type where emergency care staff will be observed and interviewed as per the Schedule of Events. Study documents will not be shared with participating NHS organisations in England because this is

a staff only study. No specific arrangements are expected to be put in place at each organisation to deliver the study.

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 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** to allow student access to the emergency departments.

- 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 is needed at each NHS site to facilitate access by the University student to the emergency department and arrange space to observe and interview staff.

No training will be provided to staff by the sponsor and there are no training expectations of staff.

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

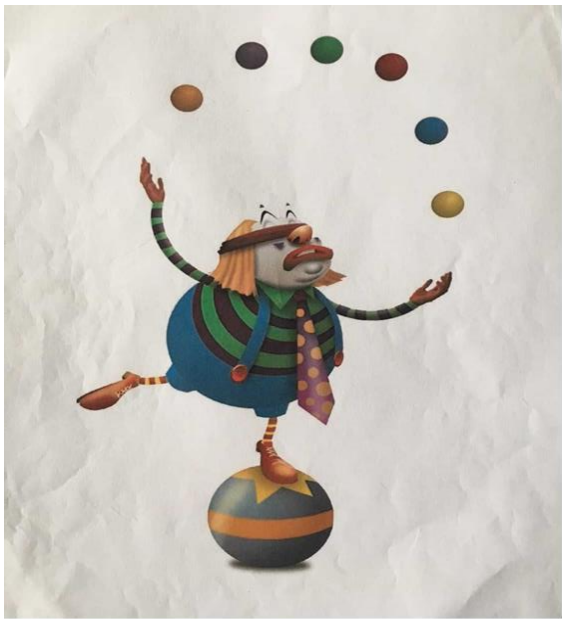
A letter of access, pre-engagement and occupational health checks will be required for research members who do not have contractual arrangements in place with the NHS Trusts.

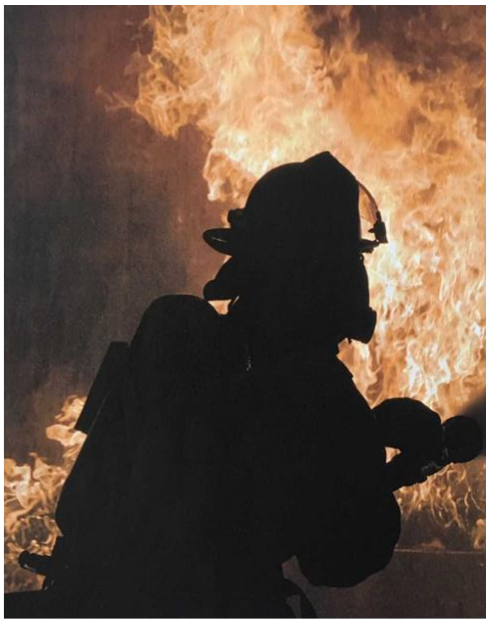
IRAS project ID	211927

Other Information to Aid Study Set-up

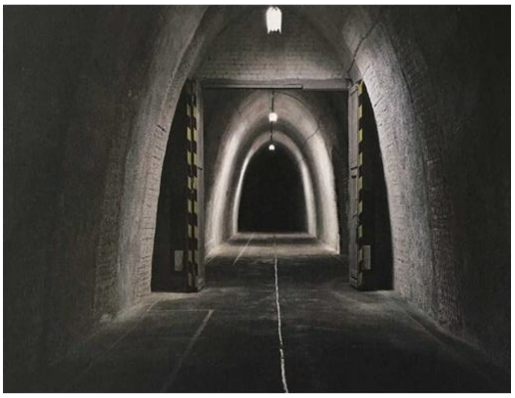
This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 6: Metaphor Images













Appendix 7: ED Images





