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Compassion Dignity and Smiles: reassessing the emotional labour of nursing

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A review of the research on emotions, nursing and health care and the new compassion and smiles agenda: what does it mean and who cares for whom?

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Abstract

This paper reviews the literature on emotions, nursing and health care covering Menzies' (1960) psychoanalytic study of student nurse attrition, Hochschild's (1983) original emotional labour study of flight attendants and Smith's (1992) application to nursing. The recent compassion and smiles agenda within UK nursing and healthcare and new conceptualizations of emotional labour are also discussed with illustrative case studies and commentaries. The paper concludes with an invitation to set the new emotions agenda within the context of interdisciplinary research, professional and practice networks.

Paper

Introduction

In the UK compassion and smiles have been placed very firmly on the National Health Service agenda: 'Nurses to be rated on how compassionate and smiley they are' (Department of Health Press Release 18.06.08 and John Carvel's Guardian article 18.06.08). Both press release and article stressed the importance of nurses' compassion and smiles to ensure patients receive good care, which in turn may aid their recovery. Although such statements are portrayed as news, research since the 1960s has shown similar tendencies.

Revans' (1964) research reported how high standards of morale in hospitals had a positive impact on nurses and patients. Good communication between all grades of staff was a key finding. One indicator of good communication identified in the research was the frequency with which the ward sister had contact with student nurses. In those hospitals with high morale, recruitment and retention were good while student nurse attrition, sickness rates and absenteeism were low. Patient stays were also shorter. Revans concluded that staff well-being was closely associated with that of patients. In a classic psychoanalytic study, Isabel Menzies (1960) investigated reasons why large numbers of student nurses in a prestigious teaching hospital were leaving nursing. She found nurses

caring for seriously ill patients would focus on routines and organizational procedures to protect them from engaging directly with patients' emotions as a way of managing their anxiety. She concluded that: 'The nursing service attempts to protect the nurse from the anxiety of her relation with the patient by splitting up her contacts with them'.

Asking nurses to be compassionate and smile may actually require them to dismantle the systems they have developed to protect themselves against anxiety. However, there are alternative ways to manage that anxiety as my research undertaken in the 1980s showed. During my investigation to find out how student nurses learned to care I discovered that ward sisters were critical because of the influence they had on 'how the students work and on the way they feel, their morale'. Patients were reported to be aware if there was a tense atmosphere on a ward, which filtered down to them and made them feel 'unhappy whereas on other wards they're much more relaxed'. As one patient observed 'if staff work well with sister then the atmosphere of the ward is well' (Smith, 1992; p. 79–80). I also experienced caring as labour during interviews when the language used by students conveyed a sense of the hard emotional work required to maintain a smile or stay calm.

The expectation that nurses smile and are compassionate is a form of emotional labour, which has generated a lively debate about its impact on their emotional well-being and the role ward sisters play in this by making them feel safe and cared for and better able to care for others.

Emotional Labour

What is emotional labour? It is an under-reported, invisible component of service sector 'people' work largely undertaken by women. Emotional labour can also be used to explore the feeling rules within an organisation required to sustain relationships in situations that are often demanding and difficult. In a ground-breaking study of the work of flight attendants, Hochschild (1983; p. 7) describes emotional labour as 'The induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial, safe place'.

Characteristics of emotional labour jobs include:

Face to face or voice to voice (and internet) contact with the public

Requirement by the worker to produce an emotional state in another e.g. gratitude or fear

The employer may exercise a degree of control over the emotional activities of their employees through training and supervision.

Emotional labour varies with context

Emotional labour varies with context in which different feeling rules apply and deep and surface acting are required to produce different external behaviours which do not always match internal feelings. There are variations in how different types of work are valued and recognised. A literature review shows that a wide range of disciplines and occupations have embraced the concepts such as bankers, social workers, call centre

operators, doctors, care assistants and midwives as well as nurses. Hochschild's ideas have captured the sociological imagination, and diverse disciplines and occupations have embraced her middle range theory, highlighting emotions as a legitimate area of study with important and urgent implications for leadership, management and practice. Emotional labour gives a language and meaning to care and offers a device to understand the emotional work undertaken by a range of workers.

Graham (1983) links emotions, feeling and caring in her accounts of women's paid and unpaid work as 'a labour of love'. She says:

'Everyday conversations about caring are conversations about feelings. When we talk about caring for someone we are talking about our emotions'.

In my study, I was also able to make the link between caring, emotions and feelings as expressed by one student nurse who described the caring ward as a place to learn to care. She said:

'When I know the ward sister cares then I feel a bit more at ease. Otherwise I feel I have to take the whole caring attitude of the whole ward on my shoulders'.

A follow up study – Leadership for learning in the 2000s

In 2007 I undertook a follow up study to find out who currently leads learning and caring in the wards (Allan et al 2008). UK student nurses are no longer counted in the workforce as they were when I undertook my original study and they spend 50% of their time in practice and 50% in the university. Ward sisters' roles have changed and their work includes increased management responsibilities which take them away from patients and nurses. Students are supervised by clinical mentors who also care for patients.

The study also showed that the way in which health care is organized and managed has changed since I undertook my study in the 1980s. Ward managers reported that their role had been affected by the target driven nature of modern health care committed to efficiency and effectiveness and evidence based health care. This view is apparent in the following quote from a nurse manager who had previously worked as a ward sister and explained how her role had changed over the past 20 years. She said:

Obviously the NHS climate has changed since 2001. I think the target culture is here and is unavoidable. It's financial

She described how the priorities had changed with 'frightening' consequences:

One of the priorities is to increase discharges and there's no mistake made about that to make sure discharges were going through to increase the throughput in the hospital and you become a sort of, I don't know – what would you call it? ... You're just like an automaton, I sometimes come into the ward and I'm looking at the board with the list of patients as numbers and I get quite frightened sometimes because I'm forgetting that they're people and I have to pull back.

In this instance the ward manager felt she was being turned into an ‘automaton’ as a result of what Bolton (2000) terms ‘prescriptive’ emotion management a form of emotional labour dictated (in this case) by organisations to increase patient throughput and discharge. During fieldwork we observed that the target driven health service, was experienced as a form of commercialization and ‘speed up’ of the work process which had impacted on the current mode of care delivery in the wards with the result that there had been a move away from a holistic approach to care, apparent when I had undertaken my study in the 1980s, to a modified form of task allocation in order to meet targets (Allan et al. 2008). This form was linked to a need to carve the work up into a series of tasks (such as discharges) to ensure that these targets were met as the example above illustrates. The ward manager was frightened on the effect it was having on her perception of patients as numbers.

The Compassionate Care Agenda

As if to counteract targets and subsequent speed-up, a recent trend within the health service has been to promote compassion and dignity. This trend has taken on different perspectives in England and Scotland. In England a quality framework supported by metrics has been proposed by Lord Darzi in his report *High Quality Care for All* (Department of Health 2008). The idea is that this quality framework will score how compassionate nurses are towards patients and what is required to give empathetic care. Components of compassion include indicator smiles and by inference emotional labour as in the ‘the induction or suppression of emotions to make others feel safe and cared for’ (Hochschild 1983, Smith 2008). The compassion index also includes measures of dignity (supported by the Royal College of Nursing’s high profile campaign), good nutrition, hand washing and safety as key indicators of quality care.

In Scotland the compassionate care agenda is being taken forward by the Compassionate Care Project set up between NHS Lothian and Edinburgh Napier University in a variety of health care settings to enhance ‘patient care by promoting compassionate nursing practice’ by supporting the development of leadership skills. One approach that has been adopted is the use of ‘emotional touch points’ to identify and describe narratives of compassionate care (Bate and Robert, 2007).

(<http://www.napier.ac.uk/fhlss/nmsc/compassionatecare/Pages/Home.aspx>)

So is asking nurses to be compassionate and smile asking them to do even more emotional labour over and above their normal workload?

Emotional labour and care – New conceptualisations for the 2000s

The care deficit: or learning to live without care

Arlie Hochschild has suggested that the commercialisation of care work and ‘speed-up’ in a globalized health economy has resulted in a ‘care deficit’ (Hochschild 2003). Hochschild (2003) has identified four different images of care characterised as distinct models which she suggests ‘appear in public discourse on social policy and so provide a tool for decoding that discourse’ (p. 218). The models appear along a cultural continuum

from 'traditional', 'post modern', 'cold modern' and 'warm modern' solutions to the care deficit which at its extreme is to learn to live without care.

The traditional solution reverses the changes that have taken place in women's entry into the workforce and places them very firmly back in the home, absolving men from any of the responsibility to care. The post modern solution demands the removal of the central image of the caring mother figure, leaving men and women in the workforce and the need for all sectors of society to learn to live without care. Cold modern institutionalises all forms of human care while the warm modern model values care at the individual, family and public level.

Bone (2009) differentiates between the emotional labour of nurses as 'therapeutic' and that of flight attendants which she sees as 'instrumental'. However she also notes that changes in the US health care system have had a negative impact on the emotional labour of nurses where 'cost containment, medical control and profit making' have eclipsed 'those types of work that prioritize interpersonal and psychosocial care' (Bone 2009: p. 57). Bone concludes that nurses therefore alter the care they give and patients must often learn how to do without'. This situation she attributes to the conversion of many health and human services into commodities which in turn reduces the availability of both paid and unpaid carers resulting in an extreme 'care deficit' (Hochschild 2003). This state of affairs is very obvious to Bone in the context of her US studies but is becoming increasingly obvious in the UK and elsewhere.

Further conceptualisations of emotional labour

Bolton's theoretical developments of emotional labour over the last decade (Bolton 2000, 2001, Bolton and Boyd, 2003) have made important contributions to unravelling the complexity of emotions in health care in general and nursing in particular. Bolton proposes a typology of workplace emotions and a range of motivational factors at individual and organisational level. Bolton (2000) suggests there are four types of emotion management which I interpret as motivational factors: presentational (emotion management according to general social 'rules'); philanthropic (as in emotion management given as a 'gift'); prescriptive (emotion management as prescribed by organisations/professional rules of conduct) - referred to above - and pecuniary (the performance of emotion management for gain).

Of particular interest in Bolton's analysis is the idea of emotional labour as a 'gift' given for 'philanthropic' reasons by the gynaecology nurses in her study. The nurses described the use of humour in a therapeutic way giving the patients the opportunity to have a laugh in an 'emotionful place' that was a 'woman's world'.

Bolton's analysis also confirms the view that emotion management is shaped by clinical context. A ward sister confirmed: 'The essential basis of nursing is caring. You can't be a nurse if you don't care' (Bolton 2000: 583). Bolton adds a helpful dimension by demonstrating how there may be an interaction between the different levels of emotion management: as individuals they were prepared to give patients extra time if they required it but at the same time worked hard to enact professional feeling rules to present the image of a professional carer.

Theodosius (2006, 2008) claims that emotion management although conceptually innovative in its time has potentially limited the relational aspects of emotion in particular the unconscious processes taking place during patient-nurse interaction. She also reveals that working with emotions is integral to the way in which nurses construct their personal identity which goes beyond external factors to the very reasons why they choose to do nursing in the first place such as ‘unconscious love’ (Theodosius 2006: 899).

Theodosius (2006) decided therefore to apply a methodology that recovered the unconscious emotions by applying an interactive and unconscious approach in the field working with patients, nurses and other health care professionals to capture hidden and invisible emotion processes using diaries, interviews and participant observation. Theodosius was concerned that the emotional labour research undertaken to date had not succeeded in its intention to expose emotion work and make it visible, but rather had marginalised and driven it underground. However it can be argued that at the time when emotions and nursing were first being researched a hidden world of nursing and learning to be a nurse was revealed (James 1989, Smith 1992). In a paper, the Struggle for Effectiveness, Trudi James and colleagues grappled with how to capture emotions as evidence to counterbalance the randomized control trial culture within medicine and health care (James et al 2004). Despite these attempts to capture emotional labour as evidence, the concept may indeed have become ‘normalised’ and part of the everyday language of nursing and care work. For example it was observed at a recent national workshop on compassionate care that ‘emotional labour’ as a term was presented as a ‘given’ without reference or explanation as to its theoretical and empirical origins which may indicate it has been incorporated into the contemporary compassion and dignity discourse.

Theodosius (2008) has extended the analysis of emotional labour to examine the nature of emotions that nurses feel and how they form a part of their social identity which goes beyond the presentational symbolic forms expressed through the emotion management framework first inspired by Hochschild (1983). She also suggests ways that nurses can be supported to learn to incorporate and manage complex, messy emotions as part of who they are in terms of both their personal and professional self. Theodosius demonstrates her approach through a series of powerful vignettes in which she sums up that ‘therapeutic’ emotional labour (which she distinguishes from ‘instrumental’ emotional labour) ‘is still an important component to nursing care’ (Theodosius 2008: 172). In these vignettes Theodosius deals with and describes complex and challenging situations where nurses are working at the extremes: from loving care to complaints; from trust and reciprocity with patients to feeling to be working at ‘half measures’ and being bullied by colleagues. Theodosius’ in-depth analysis highlights the essential nature of two way relationships between nurses, patients and their carers which contribute to the emotional labour process.

Within midwifery, Hunter found that managing the dissonance generated by the co-existence of conflicting ideologies of practice was the key source of emotional labour for students in particular (Hunter, 2004, 2005). The full range of the emotional labour

undertaken by midwives is further documented in a series of collected papers published as *Emotions in Midwifery and Reproduction* (Hunter and Deery [eds.] 2009).

Nicky James who first described the emotional labour of hospice work and care of the dying (James 1989) has since used body work as a lens with which to look at the emotions involved in nursing work (James in press).

Emotional labour and emotional intelligence

Another aspect that has entered the emotions literature since the publication of Hochschild's 1983 study, is the concept of emotional intelligence first described at length by Goleman (1995). Huy (1999) has connected emotional labour and emotional intelligence theoretically and suggests that particularly at times of change, the change process can be facilitated by judicious attention to emotions (Huy 1999). He concludes that emotions are an integral part of adaptation and change and emotionally intelligent individuals are able to recognise and use their own and others' emotional states to solve problems.

Sakiyama (in press) following Fineman (2000, 2001, 2006) argues that emotional intelligence is not about emotions but about judging people's ability to deal with others implying they must only have a 'positive' attitude in their interaction with others achieving this by changing their cognition rather than their emotion. Such intelligence is desired by organisations in order to deal with difficult interactions.

New studies on policy agendas and their influence on education and care: Patient safety and Professional experiences of governance and incentives

I draw on two case studies in which I was recently involved. One study was specifically designed to address student learning and patient safety (Pearson et al 2008) and the other to investigate professionals' experience of governance and incentives in the care of patients with complex long term conditions (Ross et al 2008). This second study revealed that safety and risk were key themes expressed by staff facing huge changes in the way care was delivered to patients. The data for both studies were collected during observation, focus groups and interviews across a range of settings and participants.

There were many examples of the links between patient safety and emotions. A third year student for example described patient safety as 'the prevention of harm, risk management, identification of risks, building trust with public and patients (and) protection of patient wellbeing in physical, social and emotional terms'.

Users interviewed in the same study had strong opinions about the emotional aspect of patient safety stressing how feeling safe was crucial 'right at the start when you come into hospital it's a frightening experience'.

Another user was of the view that 'patient safety is about perceptions and an absolute assurance that your decisions will not be countermanded ... that your wishes will be respected at all times and in all ways and the feeling that you are going to be treated as an individual with the right to decide for yourself'.

For some newly qualified staff the community was perceived to be ‘proper holistic care’ of which patient safety was a key component and integral to the dual notions of quality nursing care and the caring nurse. As one staff nurse observed:

‘If you come across a caring nurse they are more than willing to promote patient safety’

And another:

‘It’s a joint relationship with the patients. They need to be able to trust you’.

In Ross et al’s (2008) study of governance and incentives, keeping individuals safe and free from harm was seen as a fundamental responsibility for community health and social care practitioners and underpinned much of their work in the caring for people with long term conditions.

The data from these illustrative case studies suggest that learning and working at the frontline are associated with a range of emotions and that care and safety are intimately related. Feeling safe involves both physical and emotional dimensions and formal education and supportive leadership to ensure confident practitioners able to give quality care and both assess and take risks. In other words the caring nurse is a safe nurse.

Conclusion

Key to the management of emotion is effective leadership, team working and the management of change against a backdrop of adequate staffing levels, clinical supervision and educational support to increase feelings of competence, wellbeing and job satisfaction among all staff. The capacity of an organisation and its leaders to listen and learn facilitates the recognition and effective management of emotions and is germane to the development of a culture that provides leadership for learning and promotes high standards of patient and worker safety and reduction of risk. The nature of the NHS workforce is changing and responsive systems need to be developed to ensure these standards are attained and sustained by emotionally sensitive leaders to ensure the delivery of quality care that is competent, compassionate and safe. This complex task requires that interdisciplinary research, professional and practice networks come together to set a new emotions agenda for research, education and practice.

An Invitation

WORKING WITH EMOTIONS NETWORK (EMNET)

<http://www2.surrey.ac.uk/fhms/research/centres/crme/expertise/#emotions>

JOURNALS

The International Journal of Work Organisation and Emotion

<https://www.inderscience.com>

Emotion Space and Society

<http://www.elsevier.com/wps/locate/emospa>

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