

ROYAL HOLLOWAY UNIVERSITY OF LONDON  
DEPARTMENT OF GEOGRAPHY

SUBMITTED JULY 2014

# EMOTIONAL GEOGRAPHIES OF CARE WORK IN THE NHS

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**DECLARATION OF AUTHORSHIP**

I, Emma Rowland, hereby declare that this thesis and the work presented in it is entirely my own. Where I have consulted the work of others, this is always clearly stated.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_28<sup>th</sup> July 2014\_\_\_\_\_

**ABSTRACT**

Carescapes, such as the National Health Service (NHS), are highly complex emotional landscapes that engender intense feelings in health care professionals and their patients. Whilst emotions saturate care work they have been given limited consideration. Re-focusing care work through an emotional geographies lens enables greater emphasis on the places and spaces in which care is delivered.

Ethnographic observations and semi-structured interviews were conducted across four NHS Trust sites to explore the emotional care experiences and practices of health professionals. Qualitative data were analysed using thematic analysis, from which five themes emerged: i) geographies of emotional attachment ii) geographies of emotional detachment iii) spatialities of care logistics iv) workplace relationships and v) affective qualities of care work.

Findings emphasise that different carescapes impose discrete challenges to the emotion management of health professionals. The spatial and temporal characteristics of carescapes are fundamental to the construction of emotional care relationships. Carescapes, characterised by slow patient turnover and limited clinical intervention, facilitate the development of emotionally attached care relationships through care practices that encourage proximity and tactile care behaviours. Conversely, carescapes characterised by rapid patient turnover, intensive clinical intervention and / or death may result in emotionally detached care relationships. The mobility of ambulance care work however complicates this mapping of care.

Logistical spaces are used to manage and contain health professionals' emotions. Additionally, logistical decision-making is emotionally exhausting, especially for those working at the interface between private and public care. Finally, workplace relationships mediate between closeness and distance. Working in close proximity encourages emotional talk, reducing the emotional burden of care but may also provoke tensions that challenge professionals' emotional labour.

Understanding the emotional terrain of the NHS may support health professionals to more effectively manage their emotions within different carescapes. This could lead to better emotional and psychological well-being for health professionals.

**ACKNOWLEDGEMENTS**

I would like to express sincere thanks to my academic supervisor Professor Philip Crang and advisor Professor David Gilbert, whose supervision and constructive criticism constantly challenged and enhanced my theoretical thinking throughout the process.

To my former and current employers, Professor Paula Nicolson, Professor Catherine Pope and Professor Alison Metcalfe, I would like to express thanks for all their support and encouragement throughout the process and allowing me the flexibility to work on my thesis alongside my role as a research associate.

Many health professionals contributed to this thesis. I would like to thank them for their time, honest reflections and for allowing me to shadow them as they performed their care work. Without their engagement, interest and support this thesis would not have been possible.

Finally, I am sincerely thankful to my family for their support and patience. I would especially like to thank my father, Trevor, for all his hard work in proof reading the thesis.

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## ABBREVIATIONS AND ACRONYMS

A&E	Accident and emergency
AED	Automated external defibrillator
BM	Boehringer Mannheim test for glucose
BP	Blood pressure
BPS	British Psychological Society
BUHT	Broadwater University Hospital Trust
CAT	Cognitive appraisal theory
CCP	Continuing care panel
CCU	Critical care unit
CRB	Criminal Records Bureau
CS	Clinical supervisor
CT	Computerised tomography
CVA	Cerebral vascular accident
DMT	Dance movement therapy
DNR	Do not resuscitate
DOB	Date of birth
DoH	Department of Health
ECA	Emergency care assistant
ECG	Electrocardiogram
ECP	Emergency care practitioner
ED	Emergency department
ESRC	Economic and Social Research Council
F2	Foundation year 2 (doctor)
GCP	Good clinical practice

## ABBREVIATIONS AND ACRONYMS

HCA	Health care assistant
HDU	High dependency unit
HS&DR	Health Service and Delivery Research
HSJT	Helios and St Josephs Hospital Trust
IBG	Institute of British Geographers
ICU	Intensive care unit
IRAS	Integrated Research Application System
IV	Intravenous
JRCALC	Joint Royal Colleges Ambulance Liaison Committee
LTC	Long term condition
MAU	Medical assessment unit
MDT	Multi-disciplinary team
MDT	Mobile data terminal
MIR	Magnetic resource imaging
NHS	National Health Service
NMC	Nursing and Midwifery Council
NOF	Neck of femur fracture
NRES	National Research Ethics Service
OS	Operational supervisor
OT	Occupational therapist
PCT	Primary Care Trust
PI	Principle investigator
PIS	Patient information sheet
POPS	Proactive care of older people undergoing surgery
PRF	Patient report form

## ABBREVIATIONS AND ACRONYMS

R&D	Research and design
RAT	Rapid assessment triage
RAVT	Royal Alexandra and Victoria Trust
REC	Regional ethics committee
RfPB	Research for Patient Benefit
RGS	Royal Geographical Society
RRV	Rapid response vehicle
RTC	Road traffic collision
SatNav	Satellite navigation
SAU	Surgical assessment unit
SDO	Service and Delivery Organisation
SEAT	South-East Ambulance Service Trust
SHO	Senior house officer
SOB	Short of breath
SSI	Site specific information
TIA	Transient ischemic attack
UTI	Urinary tract infection
WGSG	Women and Geography Study Group
WHO	World Health Organisation

**CHAPTER 1: INTRODUCING EMOTIONAL GEOGRAPHIES OF  
CARE WORK**

Carescapes<sup>1</sup> such as the National Health Service (NHS) are highly complex and dynamic emotional landscapes. The processes and activities surrounding the delivery and consumption of care engender intense sentiments, feelings and emotional reactions in both health professionals and their patients. It is therefore a fertile terrain from which geographers can study the intimate (dis)connections between health professionals and their patients.

Health geographers have explored health and care work emphasising the importance of place, space and temporality to the experiences of care. However, what an emotional geographies lens can bring to this inquiry is a critical engagement with the aspects of care work – feelings, emotions and sentiments – that are often marginalised, suppressed or taken for granted by health geographers and geographers more broadly (Davidson and Smith 2009). The emotional geographies approach therefore enriches and enhances existing health research by placing greater emphasis on the intimate inter-relationships between health professionals, patients and space, transforming our current knowledge and understandings of the emotional lives of health professionals and their patients.

Focusing on the emotional geographies of care work is important because it is becoming increasingly impossible to “separate the experiences of health and health care from the place in which it is experienced” (Andrews 2002:231). This was recently emphasised by the Mid Staffordshire NHS

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<sup>1</sup> The term ‘carescape’ is taken from the carescape /caringscape framework put forward by McKie et al. (2002) and Bowlby et al. (2010 & 2012). The term refers to formal care exchanges provided by formal (paid) carers in care institutions / organisations.

## CHAPTER 1: INTRODUCING EMOTIONAL GEOGRAPHIES OF CARE WORK

Foundation Trust public inquiry (2005-2008) and the resultant Francis Report which found that Mid Staffordshire General Hospital had not provided basic levels of care. In addition, health professionals had failed to recognise the importance of patients' emotions in care delivery. Patient testimonies reported that health professionals had treated them, and their relatives, with "callous indifference" resulting in poor care experiences (Francis Report 2013a). The report also found that the organisational culture was not conducive to creating and maintaining an (emotionally) supportive working environment.

The Francis report (2013) led to 270 recommendations to improve the quality of care, enhance patient care experiences and rejuvenate the organisational climate for NHS employees (Francis Report 2013a). These recommendations reinforce the significance of emotion in care work and the need to further excavate the emotional lives of those health professionals and managers delivering and scheduling patient care within this organisation.

To demonstrate how a focus on emotional geographies contributes to existing theories, concepts, frameworks and research within health geographies, a brief presentation of the literature follows.

## 1.1 HEALTH GEOGRAPHIES

Geography's engagement with health care began in 1940 under the term *medical geography*, a small and niche sub-discipline within human geography (Andrews and Moon 2005; Andrews and Evans 2008). Medical geographers mapped and modelled the spatial determinants of health distribution and the diffusion of disease such as common ailments influenza, measles and cholera (Meade and Earickson 2000) and asthma and eczema (McNally, Williams et al. 2000) as well as rarer diseases such as heart disease (Huff and Gray 2001) and HIV (Gould 1993). More recently, in response to the increased risk of diabetes and an obesity epidemic, the social and cultural determinants of the environment that encourage poor health behaviours (eating and exercise) have also been mapped (Liu, Cunningham et al. 2002; Cummins and Macintyre 2006; Evans, Colls et al. 2011). In addition, the equity of care relating to the provision, accessibility, distribution and utilisation of health services were mapped (Rowles 1978a; Joseph and Philips 1984; Kearns and Moon 2002).

During geography's "cultural turn" the spatial sciences were threatened by a new cultural geography which wanted to "understand, represent and articulate the complex dimensions to and between people, space and place" (Andrews 2002:227). This paradigm shift led to the publication of Kearns' influential paper which, whilst maintaining that geographers should persist with its medical focus, advocated a new complimentary *geography of health* which would focus on the experiences of medicine (Kearns 1993). Kearns' dual stream approach initially polarized geographical opinion (Andrews and Evans 2008). However, over time, health geography began to grow in popularity and relevance for geographers, expanding into areas such as: population health and geographies of care (Milligan 2000; Conradson 2003; Milligan, Gatrell et al. 2004), care of the elderly (Milligan, Gatrell et al. 2004;



Andrews and Philips 2005; Kearns and Andrews 2005), women's health including breast screening (Ross, Rosenberg et al. 1994) and cervical screening (Perkins, Sanson-Fisher et al. 1999), health related behaviours (Poland 2000), mental illness (Parr 1998, 1999, 2003), long term chronic conditions (Dyck 1995; Moss and Dyck 1996; Moss and Dyck 1999) and disability (Butler and Parr 1999; Chouinard 1999).

To explore, explain and examine the experiences of health, well-being and healthcare, health geographers drew on theories from outside the discipline such as life-course theory and rites of passage frameworks. Kenworthy-Teather's (1999) edited book for example, has been hugely influential in observing the embodied experiences of biographical disruptions caused by pregnancy (Longhurst 1999b, 1999a, 2004), childbirth (Sharpe 1999), illness (Moss and Dyck 1999) and death (Yeoh 1999). It demonstrated that biographical disruptions across a person's life-course change their relationships with place, time and other human beings.

Gessler's (1992) concept of "therapeutic landscapes" has also been highly influential, illustrating the "dynamics between landscape, healing and health" (Andrews 2002:230). It paved the way for health geography's engagement with carescapes / caringscapes (McKie, Gregory et al. 2002; Bowlby, McKie et al. 2010; Bowlby 2012:2104). The terms carescape and caringscapes were coined by McKie et al. (2002) who made the distinction between spatialities of care in which formal care is provided by paid health care professionals in institutions such as hospitals and care homes ('carescapes') and informal care provided by, for example, the family in the home ('caringscapes'). Bowlby et al. however, make it clear that the distinction between the two terrains is not "clear cut" (Bowlby 2012:2102); the resources and services provided by carescapes shape the context of caringscapes, for example influencing the provision of care across the life-course or inter-generationally, the logistics and scheduling of (child) care

activities and the availability and access to care. The ideas of carescape and caringscape are therefore bound up with the politics of care.

The terms also engage with wider debates within Geography through the concept of 'landscapes of care' (Milligan and Wiles 2010). More generally applied, this notion illuminates the scales at which care is exchanged. In particular, Geographers have debated the relations between proximate care exchanges between people at the local level and care for distant others (Barnett 2010, Raghuram 2009). In other words, for Geographers the politics of care are in part shaped by issues of space and place and imaginations of proximity and distance.

Research in this area however, predominately focuses on the consumers of health care and informal caregivers (Stables and Smith 1999; Twigg 2000; Milligan 2005). There is a comparative dearth of health geographies research that provides insights into the "day-to-day realities of working life in [formal] health care [institutions]" (Parr 2003; Andrews 2006; Andrews and Evans 2008:761). In 2008, Andrews and Evans began to address this oversight by advocating that more research be conducted focusing on health care providers and their workplaces. Answering his own call, Andrews blurs the boundaries between nursing research and geographies of health to create a geography of nursing, allowing the experiences of healthcare workers and their relationships with the places and spaces of care delivery to be taken more seriously (Andrews 2006; Andrews, Mireskandari et al. 2007). Andrews posits that geographies of nursing offer four benefits to health geographies, as outlined below.

First, it allows researchers to explore different health environments and the inter-relationships between health professionals and their patients. Geographies of nursing however, lacks an explicit engagement with emotion. Combining emotional geographies with geographies of health is

designed to allow the felt worlds and intimate care relationships of health professionals to be more directly explored.

Second, geography's focus on place-person relationships accentuates the importance of place to health care. It is therefore valuable to observe how the spatial characteristics of carescapes influence care delivery. Whilst health geographers have stressed the importance of space and place to care consumption and provision, the significance and impact of time, mobility, proxemics and care politics requires further development. The temporal dynamics of place, for example, are not only important in analysing the daily patterns of care (Wiles 2003) or the biographical disruptions of ill-health across a person's life-course, they are important to the construction and maintenance of emotional care relationships between health professionals and patients. More research is required to explore the inter-relationship between different carescapes and the emotional geographies of care. This thesis looks to address that need.

Third, a geographical lens draws attention to the spatial differences in health care (Andrews and Evans 2008:766). It therefore assists health professionals in making sense of the shifting political and spatial contexts of care, particularly surrounding the responsibilities of care for vulnerable populations such as the elderly. Additionally it illuminates the blurring of boundaries between public and private spaces of care as informal care spaces, such as the home, are increasingly becoming sites of care production and consumption (England 2010; Atkinson, Lawson et al. 2011; Green and Lawson 2011).

Finally, geographies of nursing engages enthusiastically with health care production from the perspective of health workers (Andrews and Evans 2008). Focusing only on the care practices of nurses however may lead to the neglect of the care practices of other health professionals. An engagement with a wider variety of health professionals and hospital managers will offer

new insights into care delivery and enhance geography's relevance to policy and practice for a wider health care community.

In this thesis, health geographies literatures are developed by incorporating theories, concepts and ideas of 'emotional geographies' to the framework. My interest in this field arose from ethnographic engagements within a variety of NHS carescapes. In translating my field notes into ethnographic transcripts, it became apparent that my jottings were saturated with emotional experiences. I felt disgust in smelling rotting flesh, urinary tract infections, faeces and poor bodily hygiene; I was struck with sorrow as I watched stroke patients attempt to walk, talk or complete dexterity tasks and felt pride and elation when these tasks were painstakingly achieved; I felt anxiety in waiting for patients to return from major surgery or when the crash bell sounded, watching wide-eyed as health professionals congregated around a bedside to commence resuscitation. Furthermore, I became haunted by the observed care activities.

Reflecting on these experiences, I began to question why I was affected by the care I witnessed. Why did some patients or care interactions affect me more than others? Are health professionals affected emotionally in the same way? And, if so, does it affect their delivery of care or their relationships with their patients or colleagues? Discussing my reflections in ethnographic interviews I was curious to find out how health professionals (learn to) manage their emotions and additionally to discover whether the places and spaces in which care is delivered impacts on the emotional and intimate experiences of delivering and receiving care.

These early ethnographic experiences led to the research question: What is the contribution of the 'emotional geographies' approach to understanding carescapes and care work in the NHS?

## 1.2 AIMS AND OBJECTIVES

In answering this research question the thesis focuses on the emotional care work of a plethora of health professionals working in the hospital and pre-hospital environment. This dual empirical focus aims to facilitate the exploration of the emotional experiences and care practices of health professionals as they deliver care to their patients. This aim is met through six research objectives. Empirically, the first three objectives are most directly addressed through research of hospital care work, whilst the latter three are most directly addressed in the research on ambulance care work. The six research objectives are:

1. *To explore how and why health professionals engage in emotionally detached care behaviours and the impact of these behaviours on their emotional and psychological well-being.*

Engaging directly with Hochschild's concepts of emotional labour and emotion work (Hochschild 1983b, 2003b), this thesis investigates the role of distance, technologies and organisational rules in helping health professionals to manage their emotions in challenging carescapes such as those in which death is frequent (deathscapes) (Maddrell and Sidaway 2010) and / or where intensive clinical intervention is required (tasksapes) (Urry 2005). It considers how detached care behaviours enable health professionals to provide the most appropriate and effective care for their patients. Furthermore, it explores carescapes in which emotionally detached care behaviours are challenged resulting in geographies of "contested emotions" (Davidson 2005).

2. *To investigate how and why health professionals engage in emotionally attached care behaviours and the impact of these behaviours on their emotional labour.*

The thesis explores the role of emotional labour in the development of emotionally attached care relationships between health professionals and their patients. It specifically examines how bodily proximity, touch and psychoanalytically informed processes help health professionals to gain insights into patients' emotional worlds. Additionally, it examines the role of empathy and emotional gift-giving (Hochschild 1983b, 2003b) on both health professionals' and patients' emotional well-being.

*3. To examine the role of emotional labour and emotion work in the management of patient care.*

Investigating meeting spaces in which patient care is managed, organised and scheduled, the thesis explores the NHS guidelines, procedures and logistical processes that are designed to support health professionals' emotion management. It explores organisational turbulence (Huffington 2005; Cresswell and Martin 2012) and tensions between the delivery and management of patient care and its impact on employees' psychological well-being. Furthermore, it contextualises logistical decision-making through a wider politics of care (Green and Lawson 2011) to illuminate the emotional demands placed on those working at the boundaries of private and public care (England 2010).

*4. To investigate how ambulance crews' mobility affects the development of emotional care relationships with patients.*

The thesis investigates the emotional and logistical challenges of mobile care work. It specifically explores the affect of ambulance crews' mobility on the development of emotional care relationships as a result of the spatial and temporal characteristics of their carescapes (e.g. working in both home and

public spaces). Furthermore, it explores how emotionally detached care behaviours are facilitated through the attachment of medical equipment to patients' bodies (Lapum, Fredericks et al. 2012).

*5. To explore how ambulance crews establish and develop emotional relationships with colleagues on the move.*

Focusing on the relationships between crew mates, in relation to this objective the thesis explores the establishment of intimate and emotionally distant workplace relationships created during the day to day rhythms of mobile care work. It specifically explores the impacts of forced bodily proximity, "emotional talk" (Mehta and Bondi 1999) and well choreographed care routines on the emotional labour of crews. Furthermore, it examines the hierarchy of crew pairings to observe the impact of clinical responsibility and trust on crews' emotion management at scene.

*6. To investigate the affective qualities of emotion in care work.*

In addressing this objective, the thesis investigates the affective nature of care work through ideas such as transference and counter-transference. It also examines the strategies (humour and storytelling) employed by ambulance crews to manage their emotions and affects following emotionally challenging jobs. Engaging with literatures about geographies of affect, spectral geographies and geographies of memory, it explores the haunting nature of mobile care work and the implication to ambulance crews' emotional well-being.

These six objectives structure the thesis (see figure 1). It should be noted however that, whilst each chapter brings to the fore an objective, other

objectives may be present but less fore-grounded illuminating themes that intersect and thread through the thesis.

To achieve these research aims and objectives, qualitative research methods were conducted with a wide range of NHS employees. It is to an outline of the research field that I now turn.

### 1.3 INTRODUCING THE FIELD

Qualitative empirical data were collected from four NHS Trusts in the south of England. Within these Trusts data were collected from three NHS trust hospitals; Broadwater University Hospital Trust (BUHT), Helios and St Joseph's University Trust (HSJT) and Royal Alexandra and Victoria Infirmary Foundation Trust (RAVT) and one NHS ambulance service trust; South-East Ambulance Service Trust (SEAT). All trust and health professionals' names have been anonymised throughout the thesis using pseudonyms.

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#### BROADWATER UNIVERSITY HOSPITALS TRUST (BUHT)

In 1998 two suburban pre-second world war hospitals; Broadwater Hospital and Pilgrim's Hospital merged to become Broadwater University Hospitals Trust (BUHT). Pilgrim's Hospital conducts a wide range of medical and day surgery services, outpatients and specialises in stroke rehabilitation. Broadwater Hospital is a large teaching hospital specialising in maternity services. A new neo-natal intensive care ward was recently opened in addition to a new emergency department (ED) and intensive care unit (ICU). BUHT serves a population of 380,000.



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HELIOS AND ST JOSEPH'S UNIVERSITY TRUST (HSJT)

Helios and St Joseph's University Trust (HSJT) is a large outer-city teaching hospital serving a population of 500,000 and consists of two hospitals Helios General Hospital and St Joseph's Community Hospital. St Joseph's Community Hospital was built in 2008 and specialises in emergency and urgent care, day care and general medicine. Helios General Hospital is a pre-second world war major acute hospital specialising in hyper-acute stroke treatment, maternity and paediatrics services.

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ROYAL ALEXANDRA AND VICTORIA INFIRMARY FOUNDATION TRUST (RAVT)

Whilst consisting of a plethora of care sites, Royal Alexandra and Victoria Infirmary Foundation Trust (RAVT) is most famously known for its two larger inner-city innovative and research lead teaching hospitals, Royal Alexandra University Hospital and Victoria Infirmary, that serve a population of 3.6 million. It gained Foundation status in 2004. Royal Alexandra University Hospital is a major emergency hospital specialising in women's and children's services, acute medicine, care of the elderly, cardiovascular disease, critical care and general and plastic surgeries. Victoria Infirmary is a major elective hospital specialising in dental, renal, urology, orthopaedics and cancer care.

Within these NHS (Foundation) Hospital Trusts data were collected from five hospitals; Broadwater Hospital, Helios General Hospital, St Joseph's Community Hospital, Royal Alexandra University Hospital, Royal Victoria Infirmary. Within these five hospitals, data were collected in five medical departments. These included; cardiology, care of the elderly, obstetrics and gynaecology, general medicine, and emergency care. Access to these hospitals was negotiated through a research project I was working on as a

research assistant and permission was provided to collect ethnographic and interview data with health professionals. Data collection will be explored in more detail in Chapter 3.

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SOUTH-EAST AMBULANCE SERVICE TRUST (SEAT)

Additionally, data were collected within one NHS Ambulance service trust. South-East Ambulance Service Trust (SEAT) was created out of a merger of four ambulance service trusts and serves a total population of 4 million attending 500,000 emergency calls a year. In 2012 SEAT gained foundation status. Within SEAT data were collected from one ambulance station, Hermes, which provides emergency care to a population of 200,000. Due to the mobile nature of ambulance work, ethnographic data were collected in emergency vehicles; rapid response vehicles (RRV) and ambulances; the ambulance station; public spaces such as shopping centres, parks, workplaces, hotels, leisure centres, motorways and roadsides; and private spaces such as homes, sheltered accommodation and care homes.

Access to this ambulance station was negotiated through a research project from which I was working as a research fellow. Ethnographic data were collected with ambulance crews. Data collection will be explored in more detail in Chapter 3.

The thesis structure will now be outlined.

## 1.4 THESIS OUTLINE

The thesis is organised around six chapters (see figure 1).

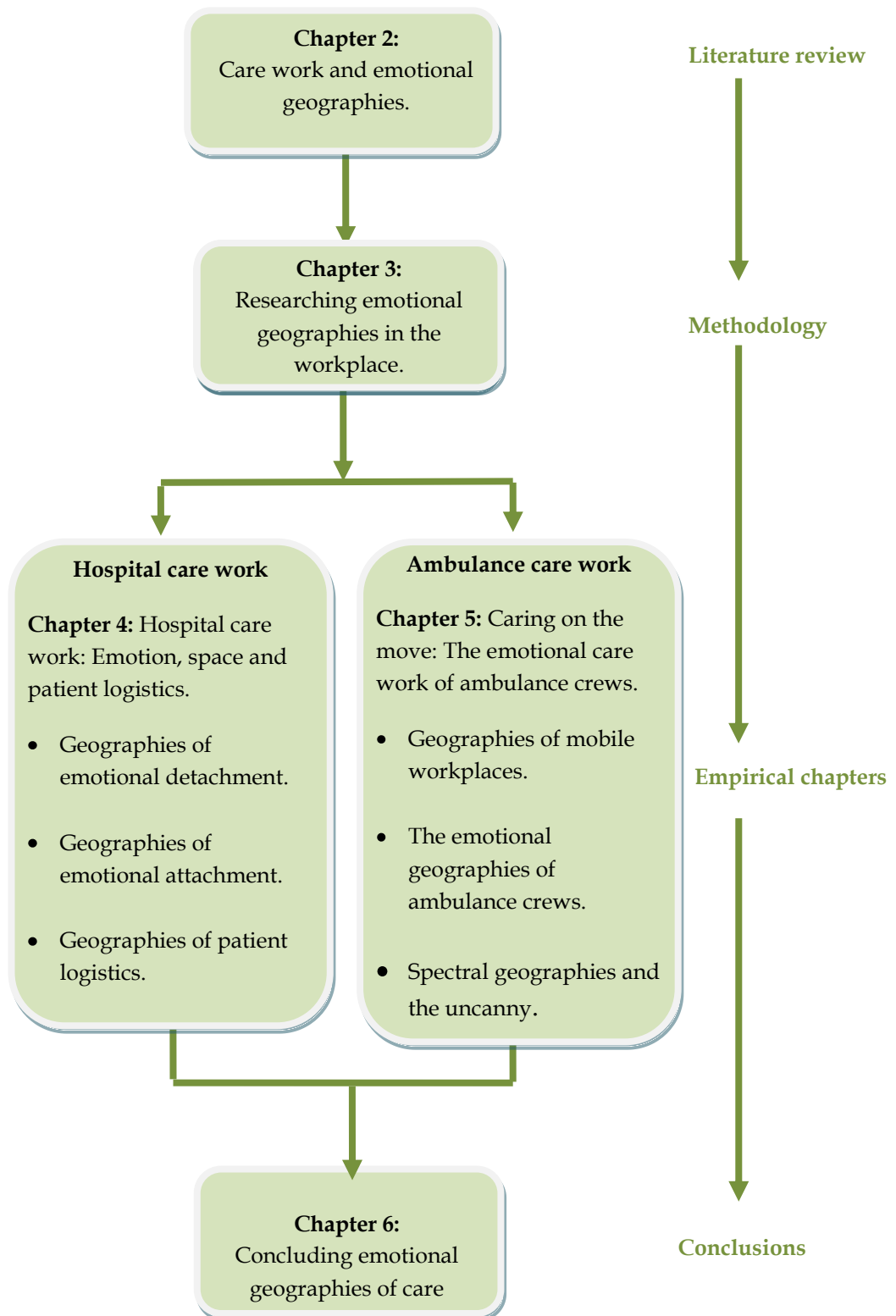


Figure 1: Outline of thesis

*Chapter 2: Care work and emotional geographies* reviews literature that blurs disciplinary boundaries between emotional geographies, the sociology of emotions, emotional organisations and healthcare literatures to articulate and contextualise the emotional landscape from which this thesis is positioned.

Critically engaging with emotional theories, the review explores how emotion has been understood historically from initial biological understandings of emotion (Darwin 1998), psychoanalytical and psychodynamic understandings of emotion (Freud 1937), emotion as a cognitive process (Goleman 1998) and emotion as part of social interaction (Goffman 1990). Combining Freudian and Goffmanesque theories of emotion, Hochschild's work is introduced to demonstrate how emotions are managed in the workplace (Hochschild 1983b, 2003b). Heavily influenced by this work, nursing literatures illustrate how health professionals manage their emotions through emotional labour.

Shifting focus, the literature review maps out the emotional terrain from which geographers have explored emotion. It focuses specifically on the presentation of emotion through; the *emotional turn*, drawing on the work of humanistic and feminist geographers (Widdowfield 2000; Thien 2005), the *affective turn* triumphed by non-representational geographers (Thrift 2004; McCormack 2006) and the *psychoanalytical turn* presented by Pile (2000) which offers a theoretical conduit between emotional and affectual geographies. The review emphasises that by observing care work through a geographical lens we enhance our understanding of emotions in the workplace and develop healthcare literatures by focusing attention on the body heightening the embodied and emplaced experiences of health and illness. A geographical lens also accentuates the importance of time, space and place to the delivery of care and to the construction of emotional care relationships.

*Chapter 3: Researching emotional geographies in the workplace* is divided into two inter-related foci to demonstrate how qualitative methods can be used to explore and analyse the NHS's emotional terrain and the emotional relationships between health professionals and their patients.

Methodological theory dominates the first half of the chapter to illuminate how qualitative methods - ethnography, semi-structured and storytelling interviews - can be used to accentuate health professionals' experiences by facilitating and encouraging "emotional talk" (Mehta and Bondi 1999). In addition, it explores how the ethnographer's body can be used to gain new insights into the emotional, cultural, social and felt worlds of their participants.

Translating theory into practice, the second half of the chapter provides ethically informed discussions about the practicalities of gaining access to the research sites and participants. Furthermore, it describes how data were stored and managed, coded and analysed.

Chapters 4 and 5 present and interpret empirical data. Chapter 4 focuses on the presentation of data collected within three hospital trusts exploring the *emotional geographies of hospital care work*. Chapter 5 centres around data collected within the ambulance service trust focusing on the exploration of the *emotional geographies of ambulance care work*.

*Chapter 4: Hospital Care work: Emotion, Space and Patient Logistics* demonstrates that hospitals are complex emotionally textured spaces. Through an emotional geographies lens it develops the emotion management literature by emphasising the importance of place, space and temporality to the emotional inter-connections between health professionals and their patients. After introductory sections outlining the different carescapes explored, this chapter is organised around three empirical sub-chapters: *Geographies of*

*emotional detachment*, *Geographies of emotional attachment* and *Geographies of patient logistics*.

*Geographies of emotional detachment* (4.4) focuses on the spatialities of care that produce emotional distance between health professionals and their care recipients. Through examples of care provided on a care of the elderly ward, it demonstrates that emotionally detached care behaviours are necessary in emotionally complex spaces of care to protect health professionals emotionally and psychologically from crisis, trauma and death. Constructing emotionally detached care behaviours, health professionals engage in disembodied care practices that reduce bodily proximity and haptic engagements with their patients. This helps them to construct and maintain professional boundaries and enhance clinical decision-making by preventing emotions from contaminating the care process.

Whilst acknowledging that emotionally detached care behaviours are essential in some carescapes, 4.4 also illustrates that some health professionals are becoming disillusioned by care models which advocate emotional detachment. They are therefore turning towards patient centred care that requires “creative altruism” (Bolton 2000b).

*Geographies of emotional attachment* (4.5) focuses on the spatialities and characteristics of the care environment that enhance bodily proximity and create "emotional connections" between health professionals and their patients (Jackson 2010). Focusing on a general medicine ward and a care of the elderly ward, 4.5 demonstrates how care environments characterised by a slow patient turn-over, encourage embodied and emotional care encounters. In these carescapes health professionals get to know their patients on a social and emotional level through verbal exchange and increased bodily proximity (Andrews, Homes et al. 2005). This allows emotional currents to flow between and within bodily interiors and exteriors enhancing clinical decision-making through the disclosure of sensitive

information. Patients may also benefit from the emotional gifts that are given as a consequence of "emotional affiliates" (Wood and Waite 2011).

Finally, through the exploration of a still birth, 4.5 introduces psychoanalytical geographies to demonstrate how health professionals become emotionally and psychologically engaged with their patients.

*Geographies of patient logistics* (4.6) offers a novel approach to the understanding of emotion in care work by combining geographies of logistics with emotional geographies. Presenting three different types of organisational meetings – multi-disciplinary team (MDT), capacity and continuing care panel (CCP) meetings – it demonstrates that logistical spaces are not emotionless terrains.

Lean production techniques are used in the MDT meeting to induce a safe and timely discharge from the ward. However, health professionals struggle to disembody and objectify their patient, posing challenges to the management of care. The capacity meeting focuses on the co-ordination and scheduling of patients through the hospital system to eradicate operational delays that could curtail the movement of patients through the system. Organisational turbulence heightens emotionally exhausting relationships between health professionals and hospital managers that are played out in these spaces.

The logistics of care that operate at the boundaries between private and public space are presented by the CCP meeting. In making decisions about whether additional care should be provided for patients in the community, it raises important considerations for the shifting politics of care, particularly for an ageing population (Lawson 2007; Bowlby, McKie et al. 2010; Atkinson, Lawson et al. 2011).

*Chapter 5: Caring on the move: The emotional care work of ambulance crews* illustrates that ambulance crew work is emotionally demanding due to the

mobile spatialities in which they deliver care. In exploring the emotional topography of ambulance care work, the chapter is divided into three main empirical sub-chapters: *Geographies of mobile workplaces*, *the emotional geographies of ambulance crews* and *Spectral geographies and the uncanny*.

*Geographies of mobile workplaces* (5.3) contributes to geography's "mobility turn" by emphasising that innovations in technology have allowed ambulance crews to become a "truly mobile workforce" (Normark and Esbjornsson 2005) assembling and reassembling their workplace in unpredictable, chaotic, disorganised and risky environments.

Drawing on two diverse carescapes, the home and a public park, 5.3 illuminates how the different spaces in which care is performed have profound impacts on the creation of emotional care relationships between ambulance crews and their patients. In addition, the ambulance, as a place of care, plays an integral role in the deconstruction of these emotional care relationships by transforming people into patients. In being moved to hospital, care recipients begin to lose their personal identifiers through the attachment of medical technology (Lapum, Fredericks et al. 2012). Depersonalisation continues through dis-embodied care practices such as removing dirty linen and wiping down the stretcher.

*The emotional geographies of ambulance crews* (5.4) concentrates on back region behaviours of ambulance crews, particularly focusing on collegial relationships. Exploring the emotional (dis)connections between ambulance crews, it illustrates that working relationships are a combination of proximity and distance (Hargreaves 2001b). Observing the relationships between permanent and non-permanent crew mates it emphasises that the spatial confines of the ambulance forces bodily proximity which creates a close emotional bond between permanent crew mates but conversely tensions between non-permanent crew mates. Emotional bonds create "communities of coping" (Filstad 2010) against the emotional demands of



the job as permanent crews mates learn to engage in emotional talk. Furthermore, intuitive patterns, bodily rhythms and fluid bodily performances which are integral to delivering care are established in the ambulance space.

The emotional relationships between station mates are also observed, specifically looking at the role of dark humour as defence mechanism to break down the emotional tensions allowing crews to come to terms with "intolerable feelings" (Rowe and Regehr 2010) in a therapeutic safe space.

*Spectral geographies and the uncanny* (5.5) draws on the affective nature of care work. Drawing on literatures within geographies of haunting, it explores the role that spectrality, absence and memory plays in delivering care. It observes how "emotional baggage" that ambulance crews carry around with them, as they move across different carescapes, deconstructs linear temporality causing past and present care experiences to collide. Exploring the impact of "spectral casts" (Edensor 2005), 5.5 is divided into three spectral tropes; ghosts, memory and the uncanny.

Focusing on a witnessed suicide and numerous failed cardiac arrests, it illustrates that *ghost stories* are used as cathartic expressions to prevent spectres from becoming trapped in the dark recesses of ambulance crews' minds and impacting negatively on the delivery of care at scene. In contrast, *memory* explores the establishment of "ghostly friends" through positive experiences of care that are preserved in crews' minds inducing satisfaction in their care work.

Finally, uncanny experiences felt in spaces of care that are serendipitous and familiar are explored (Freud 2003). Uncanny experiences demonstrate that visceral beckonings within place herald the nightmarish return of a ghost blurring the boundary between the unconscious and conscious mind; striking fear and anxiety in ambulance crews as their private and public

emotional worlds collide threatening their ability to create emotional distance between themselves and their patients.

*Chapter 6: Concluding geographies of emotional care work* reframes the research findings around five themes: geographies of emotional attachment, geographies of emotional detachment, spatialities of care logistics, workplace relationships and affective qualities of care work. These themes, and their recurring sub-themes – proxemics, temporality, mobility and care politics, emphasise how the spatial and temporal characteristics of carescapes influence, facilitate and support health professionals in managing their emotions to deliver and organise care in the NHS. In addition, they illuminate how different spatialities of care and the care practices performed within them not only affect the establishment and maintenance of emotional care relationships but workplace relationships too. Furthermore, the discussion here reiterates that logistical spaces are not emotionless terrains but complex emotional landscapes in which health professionals and hospital managers draw on organisational rules as defence mechanisms against difficult care management decisions.

Finally, the conclusion presents the strengths and limitations of the research, the potential implications to health care policy and practice in the NHS and provides recommendations for future research.

**CHAPTER 2: CARE WORK AND EMOTIONAL GEOGRAPHIES:  
A CONTEXTUAL REVIEW**

Emotions matter, they help us to understand the world in which we live, our connections, attachments and detachments with place and our interactions, engagements and affective entanglements with others. Since the 1990's geographers have become committed to placing emotion more centrally within research emphasising the spatial and temporal engagements between people and place. This thesis speaks to this commitment by exploring the emotional geographies within care work, specifically analysing the emotion management required by health professionals working in the NHS.

According to Davidson (2003) organisations and workplaces are spatially mediated sites of emotion. The NHS in particular is saturated by emotion as its employees provide care to vulnerable, injured and ill patients who are potentially anxious and distressed. Moreover, as an organisation, the NHS has its emotional topography shaped in part by a shifting politics of care (Milligan 2000; Andrews and Evans 2008). Austerity measures, mergers, closures, employer/employee demands, increased surveillance and targets can cause employees to become anxious and distressed themselves.

Health professionals working within carescapes are required to be skilled emotion managers. They are expected to cope with a variety of different emotional entanglements, not only to support their own and their colleagues' emotional well-being, but to manage, contain and transform the emotional lives of their patients and their relatives (Gesler 2003). The NHS therefore provides a fertile terrain in which to explore how emotions coalesce around and within certain places and spaces.

By blurring disciplinary boundaries, this review attempts to articulate the emotional landscape from which this thesis is positioned. Furthermore, it emphasises Bondi et al.'s supposition that "emotions slip fluidly between

disciplinary borders” (Bondi, Davidson et al. 2005:3). In contextualising this thesis, the review is divided into two sections concerned with: emotional workplaces and emotional geographies.

Commencing with a critical engagement of *emotional workplaces*, it provides an overview of emotional theories which variously casts emotion as: biological, influenced by the work of Charles Darwin (Darwin 1998), psychodynamic and psychoanalytical, influenced by Freud’s psychoanalysis and the “talking cure” (Freud and Rickman 1937), cognitive, leading to the development of ideas of “emotional intelligence” (Goleman 1998), and socially constructed as in the work of social interactionist Erving Goffman (Goffman 1990). More specifically it demonstrates how emotional theories have been used to study feelings and sentiments within organisations through Arlie Russell Hochschild’s work which explores the management of service sector employees’ emotions through emotion work and emotional labour (Hochschild 1983b, 2003b). A critical application of Hochschild’s ideas on emotional labour to health professionals, particularly through nursing research, will be explored (Smith 1992; Bolton 2005; Smith 2012).

Second, *emotional geographies* maps out three theoretical lenses through which geographers have studied emotions: emotional geographies advocated by humanistic and feminist geographers who expound that emotions are socially constructed (Milligan, Bingley et al. 2005; Thien 2005), affective geographies developed by non-representational theorists who recount that affect are unconscious constructs that are always in a state of becoming (McCormack 2003; Thrift 2004) and psycho-analytical geographies which constructs a theoretical bridge between these perspectives, demonstrating that emotions are unconscious constructs but are also relational embodied experiences (Callard 2003; Pile 2010b). The application of these theoretical positions to geographies of health, care disability and illness will be explored.

## CHAPTER 2: CARE WORK AND EMOTIONAL GEOGRAPHIES

Concluding the review, the connections, interconnections, socio-spatial and temporal mediations of emotion, established through a geographical lens, will be emphasised.

## 2.1 EMOTIONAL WORKPLACES

Workplaces are deeply emotional arenas in which "workday frustrations and passions - boredom, envy, fear, love, anger, guilt, infatuation, embarrassment, nostalgia [and] anxiety - are deeply woven into the way roles are enacted and learned, power is exercised, trust is held, commitment formed and decisions made" (Fineman 2007:1). Emotions have therefore become central to the understanding of modern workplaces and to the motivations and interactions of its employees. The value of emotions in the workplace however has not always been recognised. This section aims to present a continuum of emotional perspectives; emotion as biological, emotion as psycho-dynamic and psychoanalytical, emotion as cognitive and emotion as a social construction to demonstrate how emotions within organisations have been analysed. Furthermore, it locates the thesis' theoretical position, between a psychoanalytical and social constructionist perspective by exploring Hochschild's seminal work *The managed heart: The commercialization of the human heart* (Hochschild 1983b, 2003b) and her later work *The commercialization of intimate life* (Hochschild 2003a).

Figure 2 visually presents the theoretical perspectives used to explore emotion and emotions within the workplace. In addition, it demonstrates geography's theoretical engagement with emotion mapping out the emotional landscape from which this thesis is positioned.

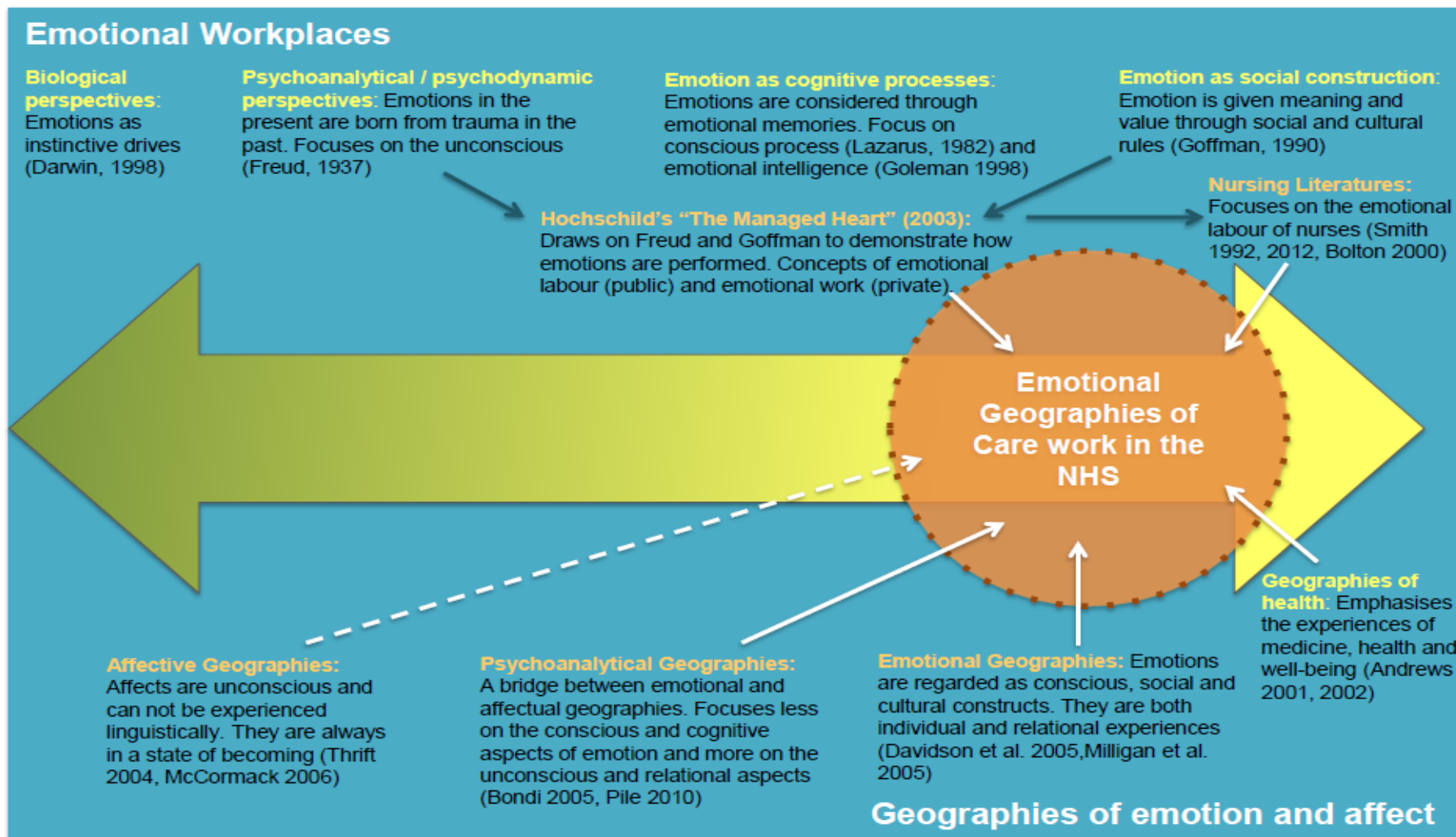


Figure 2: A visual description of the thesis' theoretical positioning arising from the literature review.

## BIOLOGICAL PERSPECTIVES

Charles Darwin argued that humans' emotions and emotional expressions were instinctive, pre-programmed and have evolved from pre-historic survival patterns (Darwin 1998). Our emotions, according to Darwin, not only drive our fight or flight instincts, but have an important communicative function. In his highly influential work, Darwin emphasises that emotions are visual expressions of an underlying state. He therefore established three principles to explore and explain how and why emotions are expressed. These include emotion as: habit, clarification or support for verbal communication and a reflexive response for the nervous system.

In the first principle, emotion as habit, Darwin suggested that emotive facial displays are learnt and genetically inherited by offspring and, at least in the past, had a purposeful function. For example, when shocked or scared the eyes widen to increase the field of vision, allowing us to become more aware of our surroundings. Over time many of these emotional habits have become redundant as we have become dependent on verbal emotional expression. Second, Darwin stated that emotions were expressed to support or clarify what is being verbally communicated for example smiling to show gratitude for a present. Third, Darwin proposed that emotions are (unconscious) reflexes of the nervous system that are used to relieve pent up tensions for example laughing nervously to release unexpressed anxiety or embarrassment. Darwin believed that expressing emotion unconsciously released both physical and psychological tensions.

Central to Darwin's work was his interest in finding out whether emotions are universal or cross-culturally recognisable. After requesting that his colleagues, who lived in various parts of the world, observe the facial expressions of the natives they interacted with (Hess and Thibault 2009), Darwin concluded that emotions were indeed universal. His findings were



later supported by other research which found that a collection of emotions such as fear, sadness, happiness and disgust are displayed, recognised and interpreted universally (Ekman, Friesen et al. 1972; Ekman and Friesen 1986; Ekman 1998). Other emotions however, such as "guilt, humour or embarrassment are not so easily recognisable" (Fineman 2003:10) and may be culturally and socially determined. In addition, Darwin proposed that displayed emotions, such as a smile, could have a social context and an emotional content. In this way, Darwin astutely recognised that a person may outwardly display happiness (smiling) but may internally feel upset or angry; ideas that Goffman (1970) and Hochschild (2003) draw on in their work through the idea of surface acting.

Further to observing emotions in humans, Darwin observed that there was a "continuity between the emotional lives of animals and humans" (Hess and Thibault 2009:125). This continuum was used to demonstrate that humans' emotional displays are part of our genetic legacy and that they are hard wired biological impulses or reflexes (Fineman 2003:10). From this position, Darwin's work influenced evolutionary psychologists who believe that emotional reactions are a result of neurological programmes that have developed for our survival from our prehistoric emotional drives. These allow humans to cope with everyday stresses and crises by allowing us to adapt our emotions through forcing our emotional display, which in turn stimulates the necessary biochemical and physiological changes in the body.

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PSYCHOANALYTICAL AND PSYCHODYNAMIC PERSPECTIVES

Influenced by Darwin's research and the work of evolutionary psychologists, Sigmund Freud, the founding father of psychoanalysis or the "talking cure" believed that emotional responses in the present were established and created out of traumatic emotional events in the past. Freud's most famous work (alongside Carl Jung) focussed on hysteria. Freud noted that hysteria,

which was characterised by excessive anxiety and associated with physical symptoms such as paralysis, ticks and violent physical and verbal outbursts was an emotional reaction to painful repressed childhood memories which unconsciously infiltrated a person's adult life (Pile 2010b).

To release the repressed unconscious emotions, Freud engaged his patients in conversation which brought about a cathartic response allowing unconscious painful memories to come into consciousness bringing enlightenment to the patient. Through psychoanalytical processes Freud also discussed how emotions could be projected and transferred on to others. Freud demonstrates that hysterical patients projected and transferred their anxieties onto the analyst, where they could be analysed and projected back onto the patient through counter-transference. This process helped patients to purge their unconscious emotions.

Freud's psychoanalytical lens has been used by organisational theorists to explore the psychodynamics of every day organisational life (Hirschhorn 1990; Obholzer 1994; Obholzer and Roberts 1994). These theorists focus specifically on toxic organisations that are filled with deep-seated anxieties (Menzies 1970) and created through organisational disruptions such as restructuring and mergers. Organisational disruptions heighten organisational toxicity and anxiety through processes of othering and organisational storytelling (Gabriel 1988, 1999, 2000). Organisation storytelling, in conjunction with employees' own emotions and feelings about the workplace, creates an "organisation-in-the-mind" (Armstrong 2005; Turner, Clavarino et al. 2007). This creates tensions (real or imagined) which increases anxiety, causing employees to construct an emotionally disruptive organisation in which they become psychically imprisoned (Armstrong 2004; Huffington 2005; Morgan 2006).

Confronted with heightened anxieties, organisational groups or employees may resist or rebel against management or organisational rules, thus causing

a process of “splitting” (organisation vs. employees). Whilst this behaviour does not help the organisation it enhances collegial bonding and creates a defence against anxiety (Menzies 1970). Isabel Menzies (1970) demonstrated that nurses created defence mechanisms to protect their own emotional well-being by engaging in routine tasks or only focusing on one body part rather than viewing the patient as a whole (Menzies 1970). Menzies however cautioned against task orientated behaviours because she perceived that they perpetuated anxieties in the workplace. Menzies’s work has been influential in nursing research and will be discussed further in this section.

Whilst psychoanalytical approaches are insightful to the understanding of emotional workplaces they have been criticised for their pre-occupation with anxiety (Fineman 2003). Psychoanalytic perspectives of workplace emotions may therefore be supported by other insights (Craib 1995, 1997, 2001).

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#### A COGNITIVE PROCESS

In contrast, a cognitive approach focuses on the appraisal of conscious emotions and the context in which they are acknowledged and considered through an “emotional memory” (Lazarus 1982, 1991b, 1991a; Lazarus and Lazarus 1994; Lazarus, Cohen-Charash et al. 2001). Emotions are therefore a result of people’s interpretations and explanations of an experience or a situation rather than created through visceral bodily reactions.

Situated within a cognitive approach is “cognitive appraisal theory” (CAT) which has been used to analyse how employees behave emotionally within an organisation. CAT is based on two premises: First, it assesses the impact of emotion on a person in the present or the future. Second, it focuses on adaption, specifically analysing how a person learns to cope or use emotional contexts to their advantage. By combining these two appraisals an employee is able to shape the quality and quantity of the emotional interaction within the workplace. From this perspective cognitive processes

or "head-work" pre-determines the emotional reaction or "heart-work". A nurse for example, may be anxious about helping an aggressive patient because they know that they may be subject to verbal or physical abuse. What is lacking however, from CAT, is recognition of the haptic and bodily sensations that coincide with emotional contexts or interactions. From this perspective the employee's body is emotionally numb.

Highly influential within a cognitive approach research is the notion of the "emotionally intelligent worker". The idea of emotional intelligence became popular in understanding management and leadership skills within organisations (Salovey, Bedell et al. 2000; Fineman 2003). It has subsequently been used in the NHS context to demonstrate how emotionally intelligent health workers can affect the emotional climate of the workplace (Goleman 1998). The term was coined by Mayer and Salovey:

*"The ability to perceive emotions, to access and generate emotions so as to assist thought, to understand emotions and emotional knowledge, and to reflectively regulate emotions so as to promote emotional and intellectual growth"*

(Mayer and Salovey 1997:10).

The term conjoins emotion with rational thinking emphasising how people's emotions might be controlled by cognitive thought processes. It shows that people are aware of their own and others' emotions, how they can manage emotions by knowing what has caused them and how employees can harness their own and others emotions' to make good decisions.

Goleman continued the efforts made by Mayer and Salovey becoming the "leading authority on emotional intelligence" (Hughes 2005:604). Goleman created a set of competencies or skills that defined a person with high emotional intelligence. These characteristics were redefined by George (2000) who proposed four aspects of emotional intelligence: the expression and

appraisal of emotion, the appropriation of emotion to enhance cognitive process and decision-making; knowledge of emotions; and managing emotions (George 2000).

In the NHS emotional intelligence has become a prominent theory with many nursing journals highlighting the importance for health practitioners to be emotionally intelligent, not only to improve staffing relationships but to be able to empathise with their patients (Amendolair 2003; Allan and Barber 2005; Cummings, Hayduk et al. 2005).

In exploring the role of emotions in nursing research from the 1960's, McQueen (2004) showed that health care workers were encouraged to hide their emotions from their patients in order to perform a professional role. In addition they followed procedures rather than using "common sense nursing" and their own emotional intelligence to deliver care. Since the 1960's however, this view of nursing has changed with health professionals being encouraged to display human emotions to illustrate their commitment to patient care (see emotional labour). This paradigm shift has led to greater rapport within patient-nurse relationships allowing nurses to become sensitive to patients' emotions, interpret patients' concerns and ameliorate them through empathy (McQueen 2004).

Drawing on the similarities between emotional intelligence and concepts of emotional labour McQueen states that "emotional labour calls upon and engages" emotional intelligence (2004:103). Hochschild's work on emotional labour will be explored in more detail following a summary of a social constructionist's approach to emotion.

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SOCIAL CONSTRUCTIONIST/ INTERACTIONIST PERSPECTIVES

Sitting between an evolutionary perspective and psychoanalytical perspective a social constructionist / social interactionist perspective of emotion emerges. From this perspective emotion is grounded in a social and

cultural context. Emotion is therefore not purely evolutionary and nor do physiological and bodily sensations simply tell us how we feel. Instead, emotion is given meaning and value through social and cultural rules which are communicated through emotional talk. Emotions are also understood through the experiential, social and cultural contexts from which they are presented, displayed and discussed. The emotions that are verbally communicated or performed indicate the emotional etiquette of a social or cultural grouping.

Emotional etiquette is established and transmitted through “emotional rules” (Fineman 2003:18) or “feeling rules” (Goffman 1990). These direct and control outward expressions of emotion so that people present appropriate emotions and are acceptable within a given context, for example, showing sadness at a funeral or joy on hearing good news. For social constructionists, the outward appropriate display of emotion may be different from what is felt internally, resonating with Darwin’s work.

Our internal emotions however, are not always as we or others expect. Through emotional talk we may be encouraged to feel what is expected or force ourselves to perform what is expected. Drawing on dramaturgical metaphors, Goffman postulates that people perform and present themselves “for the benefit of other people” (Goffman 1990:28).

To present an acceptable self, the actor must consider how convincing their performance is. In some situations however, the actor may unintentionally destroy the performance through an “unmeant gesture” or faux pas (Goffman 1990:203-204). “Dramaturgical discipline” is therefore required to maintain a convincing performance by suppressing and controlling private responses. This is hard work and can breakdown exposing unrehearsed performances.

Emphasising the importance of context to the actor’s performances, Goffman presents back and front region performances. Front region performances are

directed at an audience and actors must perform certain characters and roles. The actor accentuates certain behaviours and suppresses less desirable or socially unacceptable behaviours. Front region performances are therefore exhausting repertoires of actions and characterisations.

In contrast back regions allow the actor to "relax...forgo speaking his lines and step out of character" (Goffman 1990:115). Back regions therefore are often hidden from public gaze allowing the actor to "reliably expect that no member of the audience will intrude" (Goffman 1990:116). Back regions are safe spaces in which improper social and cultural etiquette is excused and actors can "lapse into an associable mood of sullen, silent irritability" (Goffman 1990:133). For Goffman, however, the most interesting space to observe behaviour is the transitory space between front and back regions where the actor creates and loses his/her character. It is in this space that we see actor's "impression management" to maintain front region performances (Goffman 1990:116).

Further to exploring the single actor, Goffman also explored the performance of teams and team work. His work has therefore been used to support organisational theories and to demonstrate how colleagues perform workplace behaviours. Hochschild's work (2003b) uses Goffman's dramaturgical metaphors to explore the emotional performances in organisational life particularly focussing around two analytical devices: emotional labour and emotion work. Hochschild's work was one of the "earliest examples of research into emotional and organisational settings" (Ashkanasy, Hartel et al. 2002:320) and spurred a plethora of literature focussing on the emotion management of employees working in service sector industries. Hochschild specifically explored the airline industry showing how airline cabin crew manage their emotions to deal with difficult passengers and to promote a particular airline image (Hochschild 1983b, 2003b).

## THE MANAGED HEART

Hochschild's interactive account of emotion management is influenced by both Goffman's social constructionist / interactionist perspective and Freud's psychoanalytical perspective of emotion management yet "squares completely with neither" (Hochschild 1979:555). Hochschild affirms that what we can learn from Goffman is the link between social rules and feelings rules. She however criticises Goffman for focussing on only one type of actor, the surface actor.

Hochschild states that whilst Goffman's work illustrates two types of acting, surface and deep acting, he "fails to distinguish the first from the second, and obscures the importance of deep acting" (Hochschild 1979:558). He therefore only presents an actor that is only capable of managing his / her outer self, thus neglecting the management of inner emotions. Hochschild therefore posits that Goffman's actor "does not seem to feel much" and is described as a "black box" (Hochschild 1979:557). For Hochschild then, Goffman's work is valuable to the understanding of the outcome of emotion management but not for articulating acting techniques that are used to achieve emotion management.

In contrast, Hochschild states that what we learn from a psychoanalytical perspective is how people feel unconsciously. Particularly important to Hochschild are Freud's understanding of emotion as secondary to drive and his work on unconscious defence mechanisms, that protect people from painful or unpleasant affects (Hochschild 1979; Hochschild 1983a). Hochschild however criticises Freud's work for not engaging with, or explaining the impact of, social factors on a person's emotional behaviour. From a psychoanalytical perspective, people do not consciously manage their emotions but have a "natural attitude", which often gets them into social trouble because they do not perform emotions that are socially expected or acceptable (Hochschild 1979:560).



Hochschild's emotion management perspective therefore posits actors who are able to consciously manage their external emotional display but are also attuned to their internal emotions. She recognises that unconscious emotions may be affected by social feeling rules. According to Hochschild, there are three types of feeling rules: clinical, moral and social-situational. Clinical feeling rules are the expected expression of emotion by a normal healthy person. Moral appropriateness is the expression of morally legitimate emotions, for example, not getting angry at a child. Social-situational feeling rules are those which are appropriated in certain situations, for example, feeling sad around death. In many situations all three of these feeling rules may interact at once.

Similar to Goffman's feeling rules; Hochschild proposes that managing emotions requires hard work. Due to the effort required, people are not always successful in managing their emotions and this leads to emotional slippages. For Hochschild then, emotion management is synonymous with emotion work: "the act of trying to change in degree or quality an emotion or feeling" (Hochschild 1979:561). Hochschild's emotional worker is therefore different from Goffman's surface actor who superficially controls or suppresses their emotions. Instead, emotion work is aligned with deep acting as it "refers to the act of evoking or shaping, as well as suppressing feeling in oneself" (Hochschild 1979:561). Emotion work therefore has three facets: cognitive, actors think about how they ought to feel and change their feelings appropriately, embodied, the actor attempts to control the physical responses to emotion and, expressive, adopting facial expressions to change internal feelings. Similar to feeling rules, emotional work techniques may operate in conjunction with each other to facilitate altered emotions in a person.

In *Emotion Work, Feeling Rules, and Social-Structure* (1979), Hochschild focussed on the private management of emotions (emotion work). However,

when reading a section in Karl Marx's *Das Kapital*, "The working day", which analysed the emotional cost to manual workers in becoming an instrument of labour many questions were aroused (Hochschild 1983b; 2003b:3). Hochschild wanted to find out the emotional cost to service sector employees in the burgeoning "smile industries" (Talwar 2002; Fineman 2003:33) which had replaced much of the manual labour processes outlined by Braverman (Braverman 1974). Hochschild was concerned that employees of smile industries, remunerated for their emotional performances, would become estranged from their feelings (Hochschild 1983b, 2003b).

In exploring the appropriation and management of emotion for commercial profit, Hochschild coined the term "emotional labour", which she defined as the "publically observable facial and bodily display" of employees' emotions (Hochschild 1983b; 2003b:7). Her argument is that employees within these industries have to suppress their own emotions to perform emotions that are suitable for commercial gain and in alignment with the organisations image. To facilitate this labour, organisations typically provide employees with rules or scripts so that they know what emotions they are expected to display (Crang 1994; McDowell and Court 1994a). Organisations thus standardise their employees' emotions, turning them into part of the commercial product. Employees perform their emotions using two forms of acting: surface acting and deep acting. I will start with the latter.

Employees engaging in deep acting for commercial gain draw on something similar to Stanislavski's method of acting in which they use their "emotional imagination" and draw from a wealth of "emotional memories" (Hochschild 2003b:41) to "deceive themselves as much as others" about how they are feeling (Hochschild 1983b; 2003b:33). Whilst this deep acted performance brings sincerity through a personalised performance it can be detrimental to the employee by causing fatigue. The employee also becomes shocked when

they realise that they have deceived themselves as well as duping their customers during their performance (Hochschild 1983b; 2003b:47).

Service industry employees may also perform surface acted emotional labour, like Goffman's actor, only "deceiving others about how [they] feel, but do not deceive [themselves]" (Hochschild 1983b; 2003b:33). Employees engaging in surface acting thus display a false self through insincere performances. This is perceived to be less stressful for employees, reducing burn out, but poses problems for organisations seeking authentic emotional engagements between staff and customers.

Further to surface and deep acted performances, Hochschild also suggests that employees draw on empathy to assist the management of their emotions. By feeling empathy for a customer, attention is deflected or taken away from the employee (actor), thus preventing them from connecting with their own emotions and resulting in emotional desensitisation (Hochschild 1983b; 2003b:25). On some occasions however, performing empathy does not lead to desensitisation and employees need to find different ways to manage emotions. Employers may engage in back region behaviours, such as talking about customers behind their backs or "thinking about doing something mean like pouring Ex-lax into [their] coffee" (Hochschild 1983b; 2003b:113-114). Organisational fantasies such as these allow employees an outlet for their emotions whilst simultaneously adhering to organisational feeling rules. In other situations service industry employees may display their anger and frustration towards a customer through "mock courtesy" (Hochschild 1983b; 2003b:114). This enables the employee to rebel against the organisation's feeling rules, showing a sense of autonomy over their emotions, and reclaiming "control over their own smile and facial expressions in general" (Hochschild 1983b; 2003b:127).

In researching emotional labour in service industries, Hochschild (2003b) observed the invasion of profit organisations or "mummy industries" into

domestic life (Hochschild 2003a). In her later work, Hochschild analyses the "emotional geography of the workplace and home" (Hochschild 2003a:198). She argues that a new commodity frontier has caused the home and family to become less valued; commodification of domestic care, she suggests, threatens the local culture and social structure of families (Hochschild 2003a).

In exploring this changing ecology of care, Hochschild analyses, for example, the impact of a growing elderly population. In the context of insufficient state funded care, Hochschild argues that two parallel processes are in train. First, the care of elderly dependants has been eroded as care industries in the home have increased. At the same time however families have also been forced to provide more unpaid care for the elderly. Hochschild states that despite women's increased participation in the workplace there is a "stalled gender revolution" as women still take on the majority of emotional care work in the home (Hochschild 2003a:218). In exploring these issues, Hochschild more directly addresses the emotion management required in caring for others and for people who are employed to care. Hochschild's work in this area directly links with wider debates over the politics of care, including within Geography, and has been highly influential in nursing research (Milligan 2000). It is to this work that I now turn.

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EMOTIONAL CARE WORK

Schematically, nursing studies can be divided into two models of care that reflect different theoretical approaches: the traditional (bio-medical) model of care and an emerging contemporary (patient-centred) model of care. Within the traditional model, health professionals are expected to present "respectable emotions" (Milligan 2005:2109), remaining emotionally detached in front of their patients through the presentation of objective and rational behaviour. Creating physical distance is encouraged to increase the

emotional detachment between health professionals and their patients. Health professionals should engage in the minimal physical interactions with the patient needed for medical examinations, and avoid touching for other reasons (e.g. to show empathy or reassurance). From this perspective emotional detachment is considered to aid clinical decision-making by preventing emotions from contaminating the process (Allan 2001a). In addition, emotionally detached care behaviours are perceived to protect health professionals from fatigue created through emotional involvement with a patient. Detachment is therefore thought to enhance health professionals' emotional and psychological well-being, allowing them to "switch off" emotionally (Allen, Smith et al. 1989; James and Huffington 2004; Mackintosh 2007).

The practice of "distil nursing" (emotionally detached nursing care) has been explored in the most emotionally challenging clinical spaces (Malone 2003). Exemplary research includes that on nurses who work in deathscapes (Maddrell and Sidaway 2010; Thompson 2012), i.e. those spatialities of care in which there is a high risk of mortality and health professionals are confronted by death on a regular basis (Greaves 1994; Mann and Cowburn 2005; McCreight 2005; Mackintosh 2007). In delivering distil nursing health professionals protect themselves emotionally from the guilt, anxiety and stress of delivering care to the sick and dying. One way of protecting themselves is through the construction of defence mechanisms. It is here that we see nursing literature engaging directly with psychoanalytical perspectives on emotion. Nursing literature posits two defence mechanisms in particular. One such mechanism is to care for patients through task orientated behaviours or by focusing on body parts rather than the whole patient (Menziez 1970). This enables nurses to objectify and decompartmentalise their care (Menziez 1970; Allen, Smith et al. 1989; Smith 1992). Another technique, suggested by Smith (1992a) in a study of student nurses, is to categorise or label patients so as to objectify them.

The second defence mechanism used by health professionals is to limit the number of emotional care encounters by focusing on organisational time directives, targets and guidelines to distance themselves emotionally from their patients (Smith 1992; Mackintosh 2007; Mackintosh, Berridge et al. 2009). Organisational targets and time directives often discourage emotionally attached care behaviours as they, until recently, have neglected to incorporate time spent with patients for relationship building. By following organisational directives, the guilt and anxiety experienced by many health professionals is removed through processes of splitting; it is not the health professional that don't want to engage with their patient on an emotional level, it is the organisation (Collins 2012).

Nursing research has suggested that such defence mechanisms can be problematic. Studies have found that nurses are becoming cynical and emotionally detached from care behaviours (Smith 1992; Aldridge 1994; Bolton 2001) and frustrated by the lack of time that they are able to spend with their patients (Bolton 2001; Erickson and Grove 2007; Erickson and Grove 2008). Nursing literatures have therefore become more "emotionally aware" (Allan 2001a). A paradigm shift from a traditional model of care to a more contemporary model of care in which emotions are brought more acutely into focus is therefore advocated.

In exploring emotional care behaviours, nursing literatures have engaged with Hochschild's concept of emotional labour to explain and demonstrate how health professionals manage their emotions whilst delivering care to their patients. Notably in 1992, Pam Smith took forward Hochschild's ideas on emotional labour and wrote the *Emotional Labour of Nursing*, which was later up-dated in 2012, *The emotional labour of nursing revisited: Can nurses still care*. In her research Smith explored how student nurses learn to care for patients through deep acted and surface acted emotional labour (Smith 1992). Smith found that the technical and physical care provided by the

nurses was enhanced when it was underpinned by an “explicit caring style” (Smith 1992:941). Emotional labour training therefore was advocated and encouraged amongst nurses (Smith 1992). In this approach carefully managed emotions are perceived to lead to better patient care and greater patient satisfaction (Amendolair 2003; Bolton and Boyd 2003; Lewis 2005).

The literature in this area focuses on three main benefits: the deconstruction of hierarchical nurse-patient relationships, enhanced decision-making, and the creation of a positive emotional climate. First then, emotionally attached care behaviours enhance patient care by breaking down the traditional patient-health professional hierarchies (Evans and Thomas 2009). By breaking down these barriers, health professionals are able to establish rapport with their patients and create personal relationships. Emotional relationships not only increase patient satisfaction, but enhance the health professional’s job satisfaction increasing a sense of pride in care delivery (Bolton 2000a; McCreight 2005).

Frankel (1995) has stated that empathy (deep acted emotion) and sympathy (surface acted emotion) are also integral to the establishment of emotional relationships with patients. Emotional relationships however have a second benefit. Frankel suggests that getting to know patients on a personal and emotional level is fundamental to diagnosis, decision-making and care provision, as patients are more likely to disclose information or talk more openly about their health concerns when they feel that they can trust their health professional. Intimate information about the patient enables health professionals to make more informed decisions.

Further to supporting decision-making, carefully managed emotions also create a positive emotional climate. This third benefit is seen as vital given that the carescapes are saturated with anxiety (Menzies 1970). According to Allan and Smith (2005), many health professionals, especially those in a leadership role such as matrons perceive themselves to be "emotional

sponges" that have the skill to mop up and contain rogue negative emotions that are released by colleagues or patients during emotionally challenging situations, such as death. When death occurs, health professionals often project unconscious emotions such as anxiety (Allan and Smith 2005). By mopping up and containing these negative emotions Allan and Smith's matrons were able to create a positive working environment and prevented nurses from suffering from stress-related illnesses. Unmanaged emotions may cause staffing levels to decrease placing additional pressures on the remaining health professionals. In turn this could lead to medical errors and patient neglect (Murphy 2005).

Additionally, Lewis (2005) demonstrated that health professionals contain their emotions through peer support. Observing nursing staff on a special baby unit, Lewis stated that these health professionals had a strong support network in which they could vent their undesirable emotions such as anger, stress and disappointment in a positive way. They therefore created a spontaneous "community of coping" (Korczynski 2003; Lewis 2005). By talking freely about their emotions these nurses were able to prevent negative emotions from building up and reduced stress and burnout. Drawing on Hochschild and Goffman's work, Lewis stated that the best places for venting their emotions were "back regions", such as the sluice and staff rooms where they could not be observed by patients or their relatives. By demonstrating the need to share rogue emotions, this work draws on broader ideas about the fluidity and movement of emotions within place (James 1992; Ashkanasy, Hartel et al. 2002; Fineman 2003).

James (1993) studied emotional contagion and the emotional labour processes of health professionals working on a cancer ward. Whilst the above studies have demonstrated the circulation of negative emotions that require containing, James emphasised how health professionals carefully manage their emotions to produce positive emotions that can spread across



the ward, dispelling health professionals stress and enhancing staff morale. For James, positive emotions could be manufactured and circulated through deep acted emotional labour. Not all health professionals however are able to perform deep acted emotional labour consistently, as it can be exhausting. They may therefore choose to deliver emotionally empty surface acted performances instead (Bolton and Boyd 2003; Larson and Yao 2005; Brook 2009). The display of empty emotions enables health professionals to appear caring whilst being emotionally disengaged.

Whilst nursing literatures have engaged fervently with Hochschild's work, Bolton (2005) has led a critical reflection on this adoption. She argues that nurses have been too eager to jump on the "emotional labour bandwagon" causing the managed heart to become the "over-managed heart" (Bolton 2005:45). Bolton criticised Hochschild's work in particular for its dichotomy between private (emotion work) and public (emotional labour). She argues that this is too simplistic and that in consequence the concept of emotional labour is unsuited to the display of emotion outside of the service sector, an acknowledgement that Hochschild made in her own work (Hochschild 1983a; Lewis 2005). However, one could argue that the political and organisational changes to the NHS and to the shifting politics of care have seen Hochschild's work becoming more relevant to the NHS. Patients are being increasingly cast as customers or service users and the NHS and health professionals are becoming increasingly accountable for the delivery of good patient care (Smith 1992; Philips 1996; Smith 2012). Organisational and political changes to the NHS are also causing health professionals to perform emotional labour in a similar way to those working within the "smile industries". In recognising the shift in the politics of care, Smith (1992) suggested that nurses were more vulnerable to the demands of the public than retail assistants in the service industry.

Bolton also criticises Hochschild's work by stating that she presents "emotionally anorexic actors" who have no control over their emotions (Bolton 2005:75). In contrast, Bolton argues that health professionals have autonomy over their emotional displays and are not "passive victims of emotional labour" (Andrews, Homes et al. 2005; Lewis 2005:567). They therefore have the ability to create spaces and places in which organisational resistance and workplace misbehaviour can take place producing an "unmanaged organisation" (Gabriel 1995, cited in Bolton 2005: 90).

Building on her criticisms, Bolton seeks other terms that may be more suited to the processes of emotion management in the nursing profession. For example, she looks specifically at the term "sentimental work" (Strauss, Fagerhaugh et al. 1982) and questions why this term did not gain the same popularity as Hochschild's "emotional labour". Bolton appreciates how the idea of sentimental work encompasses both emotional labour and emotional work as it is "not only carried out because of humanistic considerations, but as a means of getting the work done effectively" (Bolton 2005:56). Feeling frustrated with the available terms for nurses' emotional labour, Bolton introduces her own typology. This includes: pecuniary, prescriptive, presentational and philanthropic. These four types of emotion management are developed to demonstrate how health professionals' emotions are implicated in processes of commercial / organisational gain yet allow health professionals to manage their emotions for themselves or to deploy them as emotional gifts to patients.

First, pecuniary emotion management is akin to Hochschild's emotional labour. Pecuniary emotions are performed in line with an organisation's display rules or scripted performance for commercial gain. The employee is therefore emotionally detached from the role they perform. (Bolton and Boyd 2003; Bolton 2005). Like pecuniary emotion management, prescriptive emotion management is performed in line with organisational display rules.

However, this emotion management technique is more complex because they are rules established through membership to a professional body and are connected to social status. These performances are therefore more likely to be more sincere as the rewards are greater than money.

Presentational is compared to Hochschild's emotion work as the employee brings their personal emotional skills into the workplace (Bolton and Boyd 2003:291; Bolton 2005). Finally philanthropic emotion management is aligned with Hochschild's idea of emotion as a gift. It shows that emotions are performed to offer a little extra of their emotional self to the customer and allows employees to gain a sense of themselves (Bolton 2005:97).

Bolton suggested that her four pronged typology of emotion management could have major implications for how we understand emotions in the NHS. Despite Bolton's confidence, her typology has not gained much popularity and I have not utilised Bolton's typology in this thesis. This framework does have some merit in drawing out the complex nuances within the emotion management of nursing work, gradations and shades that I hope are drawn out throughout this thesis. However, Bolton's typology is poorly defined, as she fails to clearly distinguish between presentational and philanthropic emotion management rendering it unhelpful and in need of further theoretical development (see Brook 2009 for other criticisms of Bolton's work). Whilst not using Bolton's typology, I have explored how health professionals' personal emotions are managed in the workplace via emotion work, specifically drawing on ideas such as emotional memory and empathy and the emotional gift. By incorporating and emphasising the role of emotion work within care work I capture the complexity of emotion management and join Bolton in correcting the overly simplistic dichotomisation between emotion work and emotional labour presented by Hochschild.

## SUMMARY

The thesis predominantly focuses on the social constructionist / interactionist and psychoanalytical and psychodynamic approaches to emotion (figure 2). It engages with Goffman's ideas surrounding the performance of emotions and back and front region performances. In addition, Freud's ideas of the unconscious, transference and counter-transference of emotion and experiences of the uncanny are also of value. Drawing on these two approaches, Hochschild's work on the management of emotions in workplaces has also been invaluable, both to nursing studies more generally and more specifically to this thesis in exploring the emotional geographies of health professionals as they deliver care.

Whilst these approaches are the central influences upon the thesis, Darwin's biological perspectives to emotion are not entirely neglected. His ideas surrounding flight and fight reflexes are, for example, useful to the understanding of care work in emergency settings, and his recognition that some emotions are socially determined useful to understanding the management of emotions through surface acting. Finally, from a cognitive perspective, the notion of the "emotional memory" (Lazarus 1991b) is pertinent to the role of empathy in care work.

What follows is a discussion of how these knowledges and understandings of emotion have been further developed through a geographical lens. It will demonstrate that Freud's concepts of transference and counter-transference as well as his ideas about the unconscious have been particularly important in shaping emotions. In addition, Goffman's and later Hochschild's ideas around surface and deep acted emotions are also pertinent to geographers.

In contrast to the nursing literature presented here, geography's engagement with the emotional care work of health professionals is limited. Instead geographers focus on the embodied and emotional experiences of patients

and informal carers. Combining these literatures may therefore provide greater knowledge and understanding of the embodied experiences of care. I now turn to explore geography's engagement with emotion within the field of 'emotional geographies'.

## 2.2 EMOTIONAL GEOGRAPHIES

Emotions matter to geographers because they are intrinsic to our understanding and experiences of the world in which we live, our relationship with place and space and our relationships with other human beings (Davidson and Milligan 2004; Bondi, Davidson et al. 2005). However, despite the centrality of emotions to our everyday lives Geography, as a discipline, for a long time marginalised the significance of emotion (Widdowfield 2000; Anderson and Smith 2001; Davidson and Milligan 2004; Bondi 2005b; Davidson, Bondi et al. 2005; Thien 2005). This disavowal resulted in geographers presenting “an emotionally barren terrain, a world devoid of passion, spaces ordered solely by rational principles and demarcated according to political, economic and technical logics” (Bondi, Davidson et al. 2005:1).

Historically, geographers jettisoned emotion for two reasons. First, for political purposes relating to discourses surrounding gendered knowledge production. Until recently the study of emotion was regarded as the “scandal of reason” (Williams 2001:1). As emotions were deemed unscientific, irrational, subjective and feminine they were perceived to disrupt the objective, masculinist and scientific nature of generating knowledge. Rigorous scholarship therefore “depend[ed] on keeping one’s own emotions under control and...under wraps” (Anderson and Smith 2001:7). Second, like many other disciplines, geographers found communicating, explaining, observing and recording emotions challenging (Anderson and Smith 2001; McCormack 2003; Bondi 2005b; Davidson, Bondi et al. 2005). It was therefore more convenient to “deny, avoid, suppress or downplay its emotional entanglements” (Bondi, Davidson et al. 2005:1).

Humanistic geographers first, together with later currents in cultural and feminist geographies, have taken emotions seriously (Anderson and Smith

2001). In 2000 an emotional geography began to burgeon, gaining credence and respectability in academic literatures. Its increasing relevance to the geographical field was highlighted by the proliferation of emotional research resulting in a plethora of books, a journal (*Emotion, Space and Society*), journal articles, seminars and conferences dedicated to the concept. This surge of interest has been labelled as an *emotional turn* which recognises that the exploration of emotions has an important role to play in “maintaining geography’s critical edge” (Dyck 2007:449).

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#### EMOTIONAL TURN

Geographers associated with the “emotional turn” attempted to contest and disrupt the dominant means of knowledge production through the theorisation of emotion. Through emotional theory, emotional geographers give voice to marginalised bodies (feminised, aged, sexualised, disabled and ill or diseased) who have been oppressed and under-represented by knowledge production that is essentially masculine (Nash 1998; Widdowfield 2000).

Since its conception, the field of emotional geographies has sought to encompass a wide spectrum of geographical themes, shaping key geographical concepts such as place and space in a range of subfields and in research specifically germane to this thesis for example; embodiment and attachment to space and place (Milligan, Bingley et al. 2005; Morris and Thomas 2005; Urry 2005), spatialities of care, carescapes and therapeutic landscapes (Evans and Thomas 2009; Willis 2009; Rose 2012) and workplace geographies (Hubbard 2005; Ditmore 2007; Ducey 2007; Staples 2007; Wissenger 2007)

## A HUMANISTIC GEOGRAPHY PERSPECTIVE

Humanistic geographers were the first to engage with emotion by attempting to escape the dehumanising, technological, Cartesian notions of geography by trying to understand the relationship between humans and the world in which they live. Humanistic geographers believe that emotions are central to what all people do including in their cultural, economic and political activities. They attempt to “attend to the full richness of subjective experiences of place and space” (Bondi 2005b:436).

Within the emotional turn the emotional relationships that we have to place have been explored in a variety of experiential realms. Urry (2005) for example, examined the “place of emotions within place” in relation to the touristic experience. Hubbard (2005) considered the emotional experiences of urban spaces, focussing on differentiations by gender, age, sexuality and disability and on the diurnal nature of modern urban experience.

Similarly, Milligan et al. (2005) explored the embodied and individualistic emotional attachments that elderly people have to their homes and their experiences of fear and anxiety when they have to leave this familiar place to live in an unfamiliar care home. They draw on earlier scholarship in Humanistic Geography and on the inter-relationship between place and emotion by Rowles (1978):

*“Locations ‘live’ by virtue of emotions they invoke within an individual and that [f]eelings about place may reflect sentiments ranging from dread to elation”*

(Rowles 1978, cited in Milligan et al. 2005:51).

Whilst emotional attachments to place are often individual experiences, they can also be experienced collectively creating “emotionally textured spaces” (Milligan 2005:57). Milligan et al. (2005) demonstrated that elderly people



attending a social club shared and validated each other's emotional attachments to place by creating an emotional support network that helped to dispel their fears of the care homes by sharing fond memories of their previous home. The sharing of these emotions was cathartic and integral to their emotional disposition.

Work in this vein has on occasion focussed on questions of health and care directly. For instance, Morris and Thomas analysed how emotions are constructed between palliative cancer care patients and their informal carers in the home. Examining the home as a site of increased care need, dependency and death, they demonstrated that the meaning of "home" is challenged and becomes problematic for terminally ill patients and their informal carers (Williams 2002; Dyck, Kontos et al. 2005; Morris and Thomas 2005).

Whilst the department of health believes that terminally ill patients would prefer to die at home because it is familiar and safe (Department of Health 2000), Morris and Thomas' research refutes this. They showed that for many terminally ill patients, the home becomes a place of fear, anxiety that threatens their safety. Furthermore, many informal carers feel that institutional locations and care provided by health professionals is more preferable, especially in managing emotions such as embarrassment, disgust and distress (Twigg 1999; Morris and Thomas 2005). The location of "terminal care and death...is [therefore] highly emotive" (Morris and Thomas 2005:19) and politically charged (Cartwright and Seale 1990). The politics of care will be discussed later in this thesis.

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### FEMINIST GEOGRAPHY PERSPECTIVE

Following from the work of humanistic geographers, feminist geographers have been "enormously influential in exposing emotional relations in research" (WGSF 1997, cited in Cloke, Crang and Goodwin 2005:477). Whilst

feminist geographies have led the way in understanding emotions from a geographical perspective, it is important to remember that there is nothing “inherently feminist about recognising the influence of emotion in academic research” (Widdowfield 2000:200). The primary goal of feminist geographers is to destabilise the binaries within the western academic world that associates masculinity with rationality, objectivity and the mind, and femininity with the subjective, emotion and the body (Widdowfield 2000; Skelton and Valentine 2003; Bondi 2005c). They therefore challenge the dominant notion that the truth can only be achieved through detached and disembodied research, seeking new ways of understanding and exploring the world through “situational knowledge”, which creates new understandings of the world through personal and relational engagements with others (Haraway 1994; Parr 2005).

Emotions are also the subject of research. Feminist geographers have problematised any easy dismissal of emotions as irrational by demonstrating that they are not only a subjective experience but also inter-subjective and relational. Using what I termed earlier a “social constructionist” perspective, Milligan (2005) demonstrated that emotions are socially and culturally constructed. She notes how people are able to express, understand and relate to each other’s emotions. As emotions are social processes they are mutable, fluid and able to change over time and through an individual’s life experience. This was emphasised by Hepworth (1998) who stated:

*“Emotions are essentially learned ways of responding to social situations, and as such, maybe open to transformation over the life-course in that they change with age and experience”*

(Hepworth 1998, cited in Milligan et al. 2005: 50)

Milligan et al. (2005) proposed two ways of understanding emotional experiences: first the subjective (internal) encounters with emotion and

second, the socially prescribed emotional expectations (external). In our emotional world the two types of emotion are constantly interacting and affecting each other. There is clear resonance here with the work of Hochschild reviewed above. In exploring internal emotional encounters, feminist geographers demonstrate that our bodies are emotional zones and therefore research has paid particular attention to marginalised bodies, with foci including: disability, illness, mental health, health and well-being and the life-course of women (Dyck 1995; Parr and Butler 1999; Morris and Thomas 2005).

This led Davidson and Milligan (2004) to expound that geographies of health and illness are at the “forefront of acknowledging the place of emotion when it comes to re-presenting subjects (embodied) experiences” (Davidson and Milligan 2004:525). Marion Collis (2005) for example explored the emotional well-being of women who underwent a hysterectomy. The women that she studied were all different in terms of their ages and life-stages, and her findings emphasised that the emotional experiences of hysterectomy are not universal but varied and changeable over the life-course. In addition, Robyn Longhurst (1999a, 1999b, 2004) explored how pregnant women feel about their pregnant bodies and the embodied emotions that are created in public spaces. Chouinard (1999) also explored embodied experiences of disability comparing them to her own embodied experiences of being disabled.

In representing marginalised voices and understanding people’s everyday experiences, feminist geographers have invested a considerable amount of time and effort in fieldwork methods (Widdowfield 2000; Bondi 2005b). To represent other people’s emotions qualitative research methods such as in-depth interviews, storytelling and auto-biographical vignettes are favoured, as they enable participants to express themselves in their own words and in their own time (Widdowfield 2000; Bondi, Davidson et al. 2005; Collis 2005). The cathartic and distressing impact of talking about emotions -“emotional

talk"- has been discussed by Mehta and Bondi (1999). I develop my own discussion on methodology in chapter 3.

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#### AFFECTIVE TURN

Not content with the "emotional turn" Geography has also seen the more recent "affective turn", instigated by Nigel Thrift and others working on what he termed "non-representational theory" (NRT). Thrift and other non-representational theorists adapted the theory of affect from psychologists and sociologists. Non-representational geographers argue that an emotional geography is limiting due to its focus on the personal, subjective, conscious, relational and social constructed aspects of emotion (Thrift 2004). Non-representational theorists wanted to broaden the study of emotion to attend to unconscious constructions, the affect that emotion has on the body and to highlight the movement of affects through multiple bodies in proximity.

By emphasising the affective over the emotional, non-representational theorists wanted "to avoid touchy-feely', versions of emotion" (Thrift 2004, cited in Thien 2005:451). Thrift therefore defines affect using masculine language and engineering metaphors:

*"Affect is more and more likely to be actively engineered with the result that it is becoming something more akin to the networks of pipes and cables that are of such importance in providing the basic mechanics and root textures of urban life, a set of constantly performing relays and junctions that are laying down all manner of emotional histories and geographies".*

(Thrift 2004:34).

The performative aspect of affect is important to non-representational theorists because as affects are unconscious they cannot be expressed or given meaning linguistically. Non-representational theorists therefore

challenge themselves to write and research creatively (Bissel 2010; Wylie 2010), a diversity of methodological approaches including variations of ethnography and alternative art-based methodologies such as dance movement therapy (DMT) are implemented (Dewsbury, Harrison et al. 2002; McCormack 2003; Lorimer 2005, 2008).

The study of emotion from a non-representational perspective therefore marks both an ontological and epistemological shift from an emotional geography perspective (Anderson 2004, 2005; McCormack 2005; Anderson and Harrison 2006; McCormack 2006; McCormack 2010). This shift away from emotional geography has continued to grow in popularity through two edited books "The affective turn" by Clough (2007) and "Taking Place: non-representational theories and geographies" by Ben Anderson and Paul Harrison (2010). Anderson and Harrison's book includes a collection of papers that attempt to defend non-representational geographies relevance to the field by articulating its relevance in relation to politics, emotional and ethical research encounters and emotional representation (Boatridge 2011).

From an ontological perspective, non-representational geographers believe that the world is "virtual", constructed in a "realm of potential" (Massumi 1995:91). The world in which we live is therefore always emerging, always being created and always "becoming" (Massumi 2002; McCormack 2003; Thrift 2004; Anderson 2006). This means that "much of what happens in a world of activities and relations happen before it is registered by conscious thought" (Massumi 1995; McCormack 2003:495). It is pre-conscious. This virtual space creates an intermediate state between the body (feeling) and the mind (knowing) which is termed "inhuman" or "transhuman" (beyond being human) (Pile 2010a).

Drawing on the work of philosophers such as Spinoza and Deleuze, non-representational theorists attempt to re-think how the body and mind is understood to gain a new understanding of how affect operates within an

intermediate state. Instead of the traditional view that the mind controls the body, Thrift suggests that the mind and body work together and that the body is constantly changing with its environment, culture and the interaction with other bodies. Affect is therefore not “reducible to affection or personal emotion” (Patterson 2005:164), instead it is produced through the relationship with other bodies. Affects therefore flow through bodies via touch or between bodies within an “affective climate” (Race 2010); they have been described as contagious in so far as affects spread like a virus between people (Pile 2010a). It is through this idea that Freud’s work on transference becomes valuable.

Observing the transference of emotion through touch, Paterson (2005) explores how Reiki masters heal their clients by channelling “cosmic forces” or emotional energies in and out of their bodies. Touch is believed to be crucial in the healing process because “it opens up a deep affective energy pathway” (Patterson 2005:167). McCormack (2003) also demonstrates how the transference of affect through the body or between bodies can be a therapeutic process. Studying Dance Movement Therapy (DMT), in which patients express their unconscious emotions through dance, McCormack found that by allowing people to experiment with new ways of feeling outside of verbal expression they were able to heal the body (McCormack 2003). Therapeutic touch and transference is not only used by alternative medicine practitioners. It has been argued, for example, that patients in hospitals can also benefit from bodily contact from health professionals to aid recovery (Edwards 1998). I argued above that nursing models present different accounts of the role of touch and embodied proximity to practices of health care.

Non-representational theorists believe that the knowledge they produce challenge the dominant ways of understanding the world. This however is a claim strongly refuted by Deborah Thien (2005). She argues that non-

representational geographers continue to contribute to the Western view of knowledge production because they employ the term affect in a masculine, technocratic and distancing way (Bondi 2005b, 2005c; Thien 2005). This, according to Thien, undermines the progress made by feminist and humanistic geographers in destabilising the binaries between emotion and the mind (Thien 2005). In addition non-representational theorists do not take into account that emotional geographers have also studied the movement of emotions through the body and between bodies through transference (Pile 2010a) and ideas such as “emotional contagion” (Davidson and Milligan 2004; Collis 2005).

Despite the terse tone of the exchange between Thien (2005) and McCormack (2006) highlighting wider differences in inspiration between an affective and emotional geography, Thien’s critique highlights some similarities between affects and emotions, insofar as emotions too are fluid, unbounded and move between and within bodies. The differences and similarities between emotional and affectual geographies are further explored in Pile’s paper (2010a). It is to these similarities between the two theoretical perspectives that we now turn.

Within the academic literature the boundaries between affect, emotion, moods and feelings are blurred, with the terms often being used interchangeably (Thrift 2004; Anderson 2006; Dyck 2007). It was therefore no surprise that a request was made to conjoin these concepts to create an “affective/emotional geography” (Tolia-Kelly 2006:216). The movement and transference of emotion between bodies has been labelled both as an “affective pathway” and “emotional contagion”. In addition the concepts of “emotional labour” and “affective economy” also appear to be similar.

Elizabeth Wissenger uses the term “affective economy” to describe how models perform emotions to sell a product. Wissenger's description of an affective economy bears a distinct resemblance to Hochschild’s account of

emotional labour. Wissinger explains that her models, like Hochschild's flight attendants, have to perform and get into character to sell the products. They too have to engage in surface acting to display the emotion demanded by the photographer and discuss the sincerity of their performance. One model, for example, stated "because often you have to smile and you have to find a smile that's not too fake" (Wissinger 2007:242). This undermines the definitions of affect provided by Thrift and McCormack because the model's affective performance does not appear to be a pre-conscious processes, she has thought about her performance and projected a smile to the audience. This emphasises that affective performances are conscious, and allows us to directly compare an "affective economy" with Hochschild's "emotional labour".

More generally, Pile (2010) notes that there are four similarities between emotional and affectual geographies. First, as noted previously, emotions and affects both flow between people and objects; as Pile asserts "emotions move and affects circulate" (Pile 2010a). The second ontological similarity is that emotions and affects are proximate and create intimate knowledge. Third, the study of emotion and affect share a methodological grounding in ethnography (Pile 2010a:11). The fourth shared ground is that both emotional and affectual geographies "privilege the body" (Pile 2010a:11). Whilst there are some subtle differences, for emotional geographers the body is where emotions are expressed and experienced (Longhurst 1999b; Collis 2005), for affective geographers the body challenges the expression of emotion by revealing trans-human pre-cognitive experiences (Thrift 2004; McCormack 2006). Furthermore, emotional and affectual geographies both share Freud's concept of the unconscious (Harrison 2007; Pile 2010a:13). It is through an understanding of the unconscious and psychoanalytical processes that a bridge between an emotional and affectual geography is constructed. It is to geography's "psychoanalytical turn" that we now turn.



## PSYCHOANALYTICAL TURN

A psychoanalytical lens places less emphasis on the cognitive and conscious methods of knowledge production and more on understanding the unconscious and relational, specifically the emotional relationship created between the researcher and the participant. From this vantage point a psychoanalytical geography speaks to both a non-representational theory of affect (Thrift 2004; McCormack 2006) and to a feminist geography of emotion (Milligan, Bingley et al. 2005). It therefore plays a valuable role in developing their conceptual dialogue.

Psychoanalytic geographies have been inspired by the works of great psychotherapists, psychoanalysts and theorists such as Freud, Lacan, Marx, Klein, Winnicott and Kristieva. However, geographers have tended to treat a “psychoanalytic geography as a large unified corpus” (Callard 2003:296). Callard (2003) and Sibley (1995) question why geographers have ignored some aspects of psychoanalytic thought such as Jung and Adler while favouring others such as Freud (particularly his later work), Lacan (Pile 1993; Philo and Parr 2003; Wilton 2003; Bondi 2005b, 2005a, 2007a) and Klein (Sibley 2003). Geographers have paid particularly close attention to Freud’s concepts of the unconscious, fantasy, *unheimlich*, transference, counter-transference and scenic understanding and to Lacan’s mirror theory believing that they are useful in understanding how the social affects the individual (Ahmed 2004b; Ahmed 2004c; Rose 2012), how individuals affect a social corpus (Rose 1993), how people become attached to other people and places (Pile 1996) and processes of ‘othering’ and marginalisation (Sibley 1995; Bondi 1997; Lane 1998; Laurier and Parr 1999; Wilton 2003; Ahmed 2004c).

This interest in psychoanalytic theory is comparatively recent. Prior to the 1990’s geographers treated psychoanalytic concepts with some trepidation. According to Philo and Parr (2003), humanistic geographers were the first to

flirt with Freudian concepts and “embrace elements of the unconscious” (Philo and Parr 2003:285; Pile 2010a). They attempted to use psychoanalysis to analyse the emotional attachments that people held to place (Evans 1978) and to interpret the landscape (Stoddart 1986; Tuan 1997). The majority of geographers however did not begin to engage with such theories until Stephen Pile brought psychoanalysis “within the fold of geography” in 1991 (Pile 1991; Callard 2003:300) initiating what came to be called a “psychoanalytical turn” (Callard 2003; Oliver 2003; Philo and Parr 2003; Sibley 2003). The label may not be entirely helpful; this turn did not mean that the “subject as a whole was somehow ‘turning’ to psychoanalysis but more a simple fact that ‘some people were finding it useful’” (Sibley 2000, personal correspondence cited in Philo and Parr 2003: 283). Nonetheless, the ‘usefulness’ of psychoanalysis to geography was highlighted by the journal *Social and Cultural Geography’s* special issue published in 2003 which dedicated itself to analysing geography’s engagement with psychoanalytic concepts such as transference, counter-transference, projection and congruence.

Many insights from psychoanalytic theory have been directed at the research process itself. Freud’s theories of projection, transferences and counter-transference and Roger’s theory of congruence have however also been applied to a psychoanalytical geography of emotion. Notably, Bondi (2007) demonstrated how women in caring professions manage their emotions and those of their patients in care relationships. In providing care to patients, paradoxical feelings towards the patient such as love and hate, nurture and disgust, patience and impatience and inspiration and oppression are produced. Carers therefore need to carefully manage their emotions through emotional labour and emotion work. According to Bondi emotional labour and emotion work is made easier by adopting the psycho-analytical approach of “congruence”. From this approach the carer must think and work through the negative emotions that they possess turning their uncaring emotions into

caring ones through empathy for the patient. Through empathy the carer attempts to understand how the patient is feeling. Once they think that they know what the patient is feeling then they adopt a caring role suitable for the situation. Congruence prevents negative emotions from being transferred onto the patient.

The carer also has to manage the emotions that the patient has transferred onto them and turn them into positive emotions through empathy. For example, a patient might become increasingly frustrated that they cannot do something for themselves such as fastening a zip on their jacket. This frustration may be passed onto the carer who is in close proximity. Once this frustration is passed onto the carer it is the carer's responsibility not to show her frustration at the patient but to empathise with their plight and remain patient or help them in a way that does not increase their frustration. Bondi (2007) thus demonstrated that emotions can be passed between people who are in close proximity or transferred through bodily contact (Morris and Thomas 2005; Bondi 2007a; Davidson 2007).

It is through bodily contact that Bondi relates to Freud's theories of transference and counter-transference. Freud suggested that when bodily contact occurs the patient is subconsciously reminded of the physical contact that he /she had when they were a child and this affects the emotions that they feel during the caring process and how they respond. For example, a patient who suffered abuse as a child might recoil from the carer's touch and unconsciously feel frightened or nervous. This nervous energy transfers to the carer when she/he touches the patient. The carer is then surprised to feel this emotion (Bondi 2007a).

Ahmed (2004) also demonstrates how emotions can be transferred or, in her terms, have "*contingent attachment*" (Ahmed 2004b:27), which is associated with "proximity...getting close enough to touch another and to be moved by another" (Ahmed 2004b:27). Like Bondi, Ahmed shows that emotions move

between bodies allowing connections or disconnections between people. Ahmed does not believe however that emotions can reside in bodies, as people are not "*emotional containers*" (Ahmed 2004c). Instead, emotions become attached to, but not contained within, people and places through the unconscious (Ahmed 2004b, 2004a; Bondi 2007b). As emotions circulate they collect "*affective value*" and the emotions attached to the person or object can either become intensified or reduced. Ahmed also stresses that not everyone feels the same circulating emotion in the same way. In her essay on the "*contingency of pain*", for example, Ahmed explains that whilst everyone has experienced pain and can relate to being in pain through empathy, pain is a private emotion and therefore no one can know how much pain another person is in (Ahmed 2004c:20; Ahmed 2004b). Understanding experiences of pain are important for health professionals and will be explored in the thesis.

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SUMMARY

Developing earlier sociological understandings of emotion this literature review demonstrates geography's engagement with emotion through three philosophical perspectives: emotional, affectual and psychoanalytical geographies.

A geographical lens brought new insights to this literature by emphasising that emotions and our embodied experiences are intimately tied to place and other people. Pertinent to this thesis was a Feminist Geographer's focus on the embodied experiences of illness and disability which demonstrated how subjective emotional experiences may be shared. In addition, an exploration of how patients become attached to the carers and carescapes in which care is provided is also of importance.

Furthermore, the review illustrated how affectual and psychoanalytical perspectives on emotion and affect have important insights for the study of emotion through its focus on Freud's concepts of transference and counter-

transference and his ideas about the unconscious. These concepts are invaluable in understanding how health professionals establish emotional attachment to their patients and understanding of their emotions through touch and increased bodily proximity.

## 2.3 CONCLUSION

In exploring these literatures the theoretical position of this thesis was presented (figure 2). The thesis is influenced by psychoanalytical and social interactionist theories of emotion, and Hochschild's sociology of emotion in the workplace, however Darwin's biological theories of emotion are not entirely jettisoned. From a geographical perspective, the thesis draws most prominently with emotional and psychoanalytical theories of emotion, yet affectual geographies are not entirely neglected. A definition of emotion is therefore broadly conceived illuminating that emotions slip fluidly between disciplinary boundaries (Bondi, Davidson et al. 2005).

*Emotions are both created and a product of our social and cultural world and the temporalities, spaces and places (including the body) in which they are both contained and fluidly circulate within and between. They are subjective embodied experiences yet also relational and are mutable and malleable to our relationships with others.*

The literature review raised questions about what new insights a geographical perspective could bring to our understanding of emotion, and more specifically to the emotional landscape of the NHS. With this question in mind, I present the key concepts arising from the literature and detail how this thesis will address some of the observed gaps.

The literature converges in four ways; First, both disciplines engage with Freud's, Goffman's and Hochschild's ideas and concepts to develop their understandings of emotion. Specifically focussing on Freud's ideas of transference, it was agreed that emotions move and circulate through and

between proximate bodies allowing people to gain knowledge and understanding of each other's feelings. This is particularly pertinent to care work as health professionals must use transference in conjunction with emotional memory to provide empathy to their patients. In addition, the circulation and containment of emotion can be used to alter the emotional ambiance of a carescape.

Second, Goffman and Hochschild's ideas on surface and deep acted emotion and emotional labour have been influential in exploring how health professionals and informal carers manage their emotions and those of the patients in the delivery of care.

Third, emotions are not just individual embodied experiences, they can also be shared. In the health care setting creating "communities of coping" (Lewis 2005) through shared emotions is invaluable to building relationships with colleagues and supporting health professionals' emotion management.

Finally, focusing on the interface between private and public care, both disciplines explore a politics of care. It was demonstrated that for those receiving care, or working at the boundaries of public / private care provision, emotional demands may be heightened.

In contrast, the literature presented two disparities between nursing studies and emotional geographies. First, nursing literatures focus on the emotions and emotion management of health professionals and the emotional climate of institutionalised carescapes. In contrast, geographical literatures focus on the embodied emotional experiences of patients; the sick, disabled and vulnerable and their emotional attachments to informal carescapes. Research which combines the emotional experiences of patients and health professionals is advocated to provide a holistic perspective of care which will bring new insights in to the care work of the NHS.

Second, nursing literatures engage with Freud's psychoanalytical processes of splitting and projection and Menzies (1970) work on defence against anxieties to explore the unconscious coping mechanisms of health professionals. Geographers have had limited engagement with Menzies work. Incorporating this work into emotional geographies may provide new insights into how people cope with the anxieties surrounding their illness and care provision.

In conducting this review gaps in the literature were observed. I focus here on two omissions, which will be explored in the thesis. First, emotional labour literature demonstrates that health professionals can suffer from burn-out and / or fatigue from both their surface or deep acted emotional performances. The psychological impacts of emotion management are however often neglected. By exploring the affective qualities of care work more rigorously the psychological impacts of care work, for example, being haunted by traumatic incidents and the challenges of emotional (mis)management might be made more explicit.

Second, whilst much of the literature focuses on the emotions and emotional labour surrounding the delivery of patient care or the experience of receiving care, there is limited research which focuses on the emotional costs of managing care. By exploring the logistical aspects of care, new insights into the care work will be exposed offering a new dimension to these literatures.

In the following chapter the methodological and ethical approaches to researching emotions in the NHS will be examined.

**CHAPTER 3: RESEARCHING EMOTIONAL GEOGRAPHIES IN  
THE WORKPLACE**

Capturing the NHS's emotional landscape and exploring the emotional care experiences of health professionals is a complex methodological challenge. Researchers have illuminated the difficulties of recording, understanding, analysing and interpreting participants' emotions (Laurier and Parr 1999; Mehta and Bondi 1999; Widdowfield 2000; Bondi 2005c). Drawing on the research experiences of health, workplace, emotional and feminist geographers and organisational theorists, this chapter demonstrates how qualitative methods can be used to analyse the emotional care work and relationships between health professionals and their patients.

Justifying the methodological approach; this chapter has two inter-related foci. First, it explores how qualitative methods have been used to illuminate "human experience and meaning" (Pile 1991:459) and accentuate health professionals' "experiences of care and caring" (Andrews 2002:226). The chapter therefore specifically analyses the role of semi-structured and storytelling interviews in encouraging "emotional talk", which enable researchers to obtain emotional narratives from their participants (Mehta and Bondi 1999). In addition, it illustrates how ethnography has been used to observe the inter-corporeal, emotional and empathetic relationships between health professionals and their patients (Pile 1991; Allan 2006).

Translating methodological theory into practice, the chapter also details the data collection methods used for this thesis. It also provides ethically informed discussions about field access and gate-keeping, research relationships and rapport with participants, informed consent and reflexivity. Additionally data management and analysis techniques are described.



Addressing these two foci, the chapter is organised around six topics: 1) Re-introducing the field, 2) Access to the research field and gate-keeping, 3) Data collection, 4) Recording data 5) Data analysis and 6) Research relationships re-visited. It concludes by summarising the key aspects of the chapter and emphasises how ethnography and semi-structured and storytelling interviews are conducive to collecting data which is most auspicious for the exploration of emotional geographies in the workplace.

### 3.1 RE-INTRODUCING THE FIELD

The research field consisted of four Primary Care Trusts (PCTs) in the South of England. Within these PCTs data were collected from three NHS trust hospitals and one ambulance NHS trust. Within the NHS hospital trusts data were collected from five hospitals; Broadwater Hospital, Helios General Hospital, St Joseph's Community Hospital, Royal Alexandra University Hospital and Royal Victoria Infirmary. Five medical departments; cardiology, care of the elderly, obstetrics and gynaecology, general medicine, and emergency were the focus. Within the Ambulance service NHS trust, data were collected from one ambulance station. Due to the mobility of ambulance crew work, data were also collected in multiple places including emergency vehicles; rapid response vehicles (RRV) and ambulances, public spaces; shopping centres, parks, places of work, hotels, leisure centres, motorways and roadsides, private spaces; private homes, sheltered accommodation, elderly care homes and psychiatric homes (Figure 3).

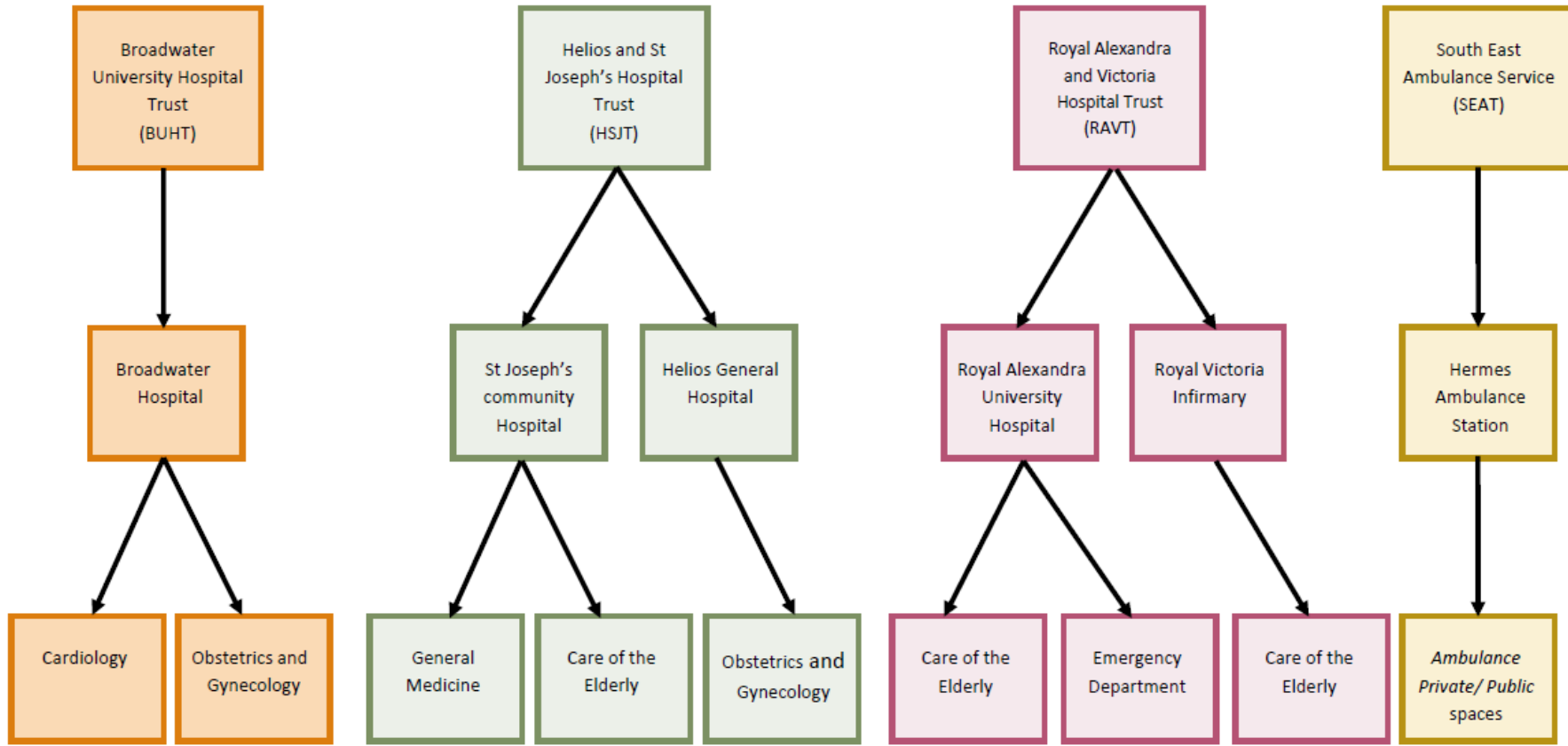


Figure 3: Outline of the research fields

### 3.2 ACCESS TO THE RESEARCH FIELD AND GATE-KEEPING

One of the greatest challenges for researchers is gaining access to the research field and its participants (Keith 1992; DeVerteuil 2004). Negotiating access to NHS carescapes is particularly difficult due to the bureaucracy of ethics committees (Bosk and De Vries 2004; Howard 2004; Hedgecoe 2008) and gatekeepers (Morrill, Buller et al. 1999; Davies 2008; Franklin, Rowland et al. 2012). Researchers willing to share their research experiences have documented the relentless frustration in attempting to gain entrance to the field (Crang and Cook 2007).

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#### GAINING ETHICAL APPROVAL

Acquiring ethical approval to conduct research is a protracted procedure (Mulhall 2003). Researchers must adhere not only to their individual University departments ethical guidelines but also abide by other professional governing bodies such as the Royal Geographical Society (RGS) with Institute of British Geographers (IBG). Researchers conducting research in organisations also have to accept the ethical codes of conduct provided by that organisation.

The NHS has particularly stringent ethical guidance which is required to protect their patients and employees. Researchers wanting to gain access to any carescapes must apply to a Research Ethics Committee (REC) who follow the ethical guidance from the Helsinki agreement and a standardised framework from the Department of Health's (DoH's) health and National Research Ethics Service (NRES) (Howard 2004; Franklin, Rowland et al. 2012).

To apply to a REC, researchers must complete an electronic Integrated Research Application System (IRAS) form attaching all participant information sheets (PIS), consent forms, recruitment letters, posters and

advertisements and data collection schedules. Hard copies of the research proposal, IRAS form and data collection sheets must also be sent to the REC for validation. Once validated, the researcher may make an appointment to meet face-to-face with the REC who will ask questions about the research and the ethical procedures in place. The REC rarely, however, asks the researcher how they may respond to ethical dilemmas that emerge in the field. This has led to REC being criticised for their overemphasis on “ethics-as-substance”, suggesting that there is a unitary way of being ethical rather than “ethics-as-process”, which enables the researcher to constantly monitor the extemporised risks and benefits to participants that occur in the field (Ramcharan and Cutcliffe 2001; Cutcliffe and Ramcharan 2002; Frank 2004). Due to the flexible nature of qualitative research, ethics-as-process was adopted to allow ethical reflection for all ethical challenges confronted in the field.

Qualitative researchers may be additionally critical of RECs as traditionally qualitative research projects were rejected because committee members did not fully understand the flexible nature of qualitative research (Cassell and Young 2002; Tod, Nicolson et al. 2002; Murphy and Dingwall 2007; Coleman and Bouesseau 2008). The proliferation of qualitative methods and the preference for mixed methods projects has however resulted in more qualitative research proposals being accepted and approved (Franklin, Rowland et al. 2012).

In addition to the REC submission, the researcher must also submit, via IRAS, a NHS Research and Development (R&D) form and site specific information (SSI) forms. These forms are sent to the main and subsidiary NHS site for local R&D approval. Supplementing ethical approval researchers must also have a Criminal Records Bureau (CRB) check and attend a “good clinical practice” (GCP) course. Evidence of the CRB check

and attendance to the GCP course must be provided to the local NHS R&D departments before a research passport is granted.

Ethical approval was received from two different local RECs in the south of England, reference numbers 07/Q0806/8<sup>2</sup> and 08/H0502/146 with permission to use data for educational purposes (Appendix 1 & 2).

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#### GATE-KEEPING

Gaining access through the front door does not automatically result in access to the departments or the people within it. Researchers may need to negotiate access via several gatekeepers (Denscombe 1998; Crang and Cook 2007; Madden 2012). Establishing good research relationships with gatekeepers is therefore a prerequisite for aiding access to an organisation and its employees.

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#### ACCESS TO THE FOUR NHS TRUSTS

Access to the three hospital primary care trusts was gained through a research project funded by, what was in 2006 called the Service Delivery Organisation (SDO), now operating under the name Health Services and Delivery Research Program (HS&DR). The research project "Leadership and better patient care: From idea to practice" reference: 08/160/137 was a mixed methods study that implemented qualitative methods; ethnographic observations, semi-structured and storytelling interviews with a quantitative organisational climate survey to analyse the relationship between leadership and patient care.

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<sup>2</sup> A clerical error meant that the IRAS form was not clicked for data to be used for educational purposes. All participants however were all informed that data would be used for publication including the PhD. This is made explicit in the recruitment process.

## CHAPTER 3.2: ACCESS TO THE RESEARCH FIELD AND GATE-KEEPING

As a research assistant on this three year project, access to health professionals and hospitals were appropriated for this research. Following ethical approval, the research team began negotiating access to the three NHS trusts. The following details demonstrate the complexity of gaining access to NHS hospitals and their employees as well as emphasising the role and power of gatekeepers. Challenges that were faced highlight the need to adopt ethics-as-process (Frank 2004; Franklin, Rowland et al. 2012).

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### BROADWATER UNIVERSITY HOSPITAL TRUST (BUHT)

Access to Broadwater University Hospital Trust (BUHT) was negotiated in December 2006 through a member of BUHT's R&D department who provided access to two departments; obstetrics and gynaecology and cardiology. Access to some of the hospital's departments were restricted for political reasons, with access granted to those departments that were performing better i.e. meeting government targets. This may have had implications to the research findings.

The principal investigator (PI) contacted the clinical directors of the two departments via email to arrange an access meeting. Attached to the email were PIS and consent forms. Both clinical directors approved the research and granted access to their departments, providing contact details for the consultants who led the clinical activity on the wards.

The clinical lead for obstetrics and gynaecology informed the research team that they could present the research at a forthcoming departmental meeting which gave the team an opportunity to present in a way that was meaningful to the participants. This enhances participants' knowledge of the project and improves recruitment. The presentation was attended by 15-20 doctors and consultants and lasted for three hours (Franklin, Rowland et al. 2012). Following the presentation, health professionals were given a PIS and contact information was taken from those who expressed interest in

participating. Health professionals were emailed to arrange data collection. Further participants were recruited via a second seminar arranged by a consultant and through snowballing techniques during ethnographic fieldwork (Franklin, Rowland et al. 2012:6).

Whilst the clinical lead in the obstetrics and gynaecology department had given the impression that all health professionals would be attending the seminar, the nursing and midwifery teams were absent (Franklin, Rowland et al. 2012). This caused friction as they were angry that they had not been directly informed of the research. This incident provided an insight into the power dynamics and the organisational culture of this department. An additional meeting was arranged with nursing and midwifery gatekeepers. These meetings were initially challenging due to animosity, every effort was made to re-build their trust and establish a good research relationship.

Gatekeepers in the cardiology department also permitted the research team to present at a departmental seminar which was attended by a variety of health care professions who volunteered to take part in the research.

It should be noted that during access negotiations at BUHT, a proposal to commence the PhD had not yet been submitted. Gatekeepers and participants therefore could not be informed of the PhD research at the point of access. Participants were aware however, via the PIS and consent form, that data collected as part of the funded research may be used in the future or for other research purposes. The PhD was accepted in September 2007 and all participants recruited after this time were notified verbally that data were to be collected for dual purpose. Verbal communication about the PhD thesis included an overview of the research and its methods. Participants were given the opportunity to ask questions about the research. No participants providing verbal and written consent to the funded research declined their consent for the data to be used for the thesis.

HELIOS AND ST JOSEPH'S HOSPITAL TRUST (HSJT)

Access to Helios and St Joseph's Hospital Trust (HSJT) was established through a senior nurse who provided contact details for two clinical directors who worked across the two hospital sites within the Trust: Helios General Hospital and St Joseph's Community Hospital. An access meeting was set up with three gatekeepers to negotiate the departments in which research could be conducted. The gatekeepers provided access to the departments in which they practiced: general medicine, care of the elderly (across the two sites) and obstetrics and gynaecology. Following the meeting, the research team was taken on a guided tour of St Joseph's and were introduced to the health professionals working on the chosen wards. Contact details were exchanged to arrange data collection (Franklin, Rowland et al. 2012:7).

Aware of the gate-keeping challenges at BUHT it was quickly realised that the researchers had again only been provided contact information for the most senior members of the department. This meant that junior members of the team would be either absent from the research or coerced into taking part by their more senior colleagues (Franklin, Rowland et al. 2012). Again it was the nursing teams that were initially not informed or misinformed about the research. A presentation was given to the nursing teams at Helios General Hospital, which was organised by a senior nurse. This seminar permitted nurses to ask questions about both funded and PhD research and to feel that their views and experiences were a valid part of the research (Young and Lee 1996; Young, Kim et al. 2010). Following an explanation of the PhD, nurses were keen to share "emotional narratives" about their experiences of delivering care and how an introduction of a "back to basics" programme was helping them to return to a more emotionally engaged style of patient care that had become buried under targets and paper-pushing exercises.



These stories and discussions were recorded with the nurses' permission and used to inform questions in the field.

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ROYAL ALEXANDRA AND VICTORIA TRUST (RAVT)

Access to Royal Alexandra and Victoria Trust (RAVT) was established through a clinical director of a care of the elderly department at Royal Alexandra University Hospital. A meeting was arranged with the clinical director via email and the research protocol, PIS and consent forms were provided. Following this meeting the research team were invited to present at a multi-disciplinary seminar. An outline of the research was presented alongside some initial research findings from BUHT and HSJT. Information about the PhD was also presented at the seminar. At the end of the presentation the health professionals asked questions and expressed their interest in taking part in both research projects and contact details were exchanged. Ethnographic observations were arranged with two senior consultants. During the ethnographic observations the invitation was extended to observe other departments in which they practiced: the emergency department (ED) at Royal Alexandra University Hospital and the care of the elderly department at Royal Victoria Infirmary. Other research participants were recruited via snowballing techniques and approached during ethnographic shadowings.

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SOUTH-EAST AMBULANCE SERVICE TRUST (SEAT)

Access to South-east Ambulance Service Trust (SEAT) was gained through a research project funded by the Research for Patient Benefit (RfPB). The research project, *Improving the quality of ambulance crew handovers: a qualitative study of knowledge transfer in emergency care teams* reference number: PB-PG-0407-13084 was funded for 18 months between October 2009 and April 2011. The aim of the research was to observe the exchange of patient information between ambulance crew and ED staff en-route and on arrival to hospital.

To inform potential participants of the study, recruitment posters were posted around the ambulance station and in the ED at the main receiving hospital. No participants were recruited through the poster. Instead, a clinical director for SEAT, who was a senior advisor to the project, provided contact details of a person working in the Human Resources (HR) department. Through email and telephone correspondence, HR placed me as a “third man” with a different ambulance crew twice a week over the 12 month data collection period. Keith (1992) comments that having “authorisation for fieldwork [come from] on high makes access that much easier” (Keith 1992:554). Access to board the ambulance however, had to be individually negotiated with the crews.

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#### RECRUITED PARTICIPANTS

In total 278 participants were recruited across the two research projects. This equated to 167 health professionals and 111 patients. Participants participated in one, two or all three of the data collection methods providing both verbal and written consent where appropriate. The data collected for each research project is outlined in figure 4. Only the data collected through my own ethnographic static observations, shadowing and semi-structured and storytelling interviews was used for this thesis. In total 227 participants were included in this research. Data was collected predominately through static ethnographic observations (90 hours), Shadowing (670 hours) and 32 semi-structured and storytelling interviews (table 1 & Appendix 3).

Whilst 227 participants provided consent, the number of participants within this study was much greater. Written consent could not be obtained from “accidental participants” who were “in the same room [and or] were interacting with the fully consented health professional [or patient]” (Mulhall 2003; Franklin, Rowland et al. 2012:8). Where possible accidental

participants were verbally informed about the research and verbal consent sought.

The theoretical underpinnings of the ethnographic method will now be described.



Figure 4: Data collection for the two funded research projects

PCT	Static ethnographic observations (participants)	Static ethnographic observations (total hours)	Ethnographic shadowing (participants)	Ethnographic shadowing (total hours)	Semi-structured and storytelling interviews (participants)	Semi-structured/ storytelling interviews (number)
BUHT	Antenatal gestational diabetes clinic: Antenatal clinic Leader, diabetes nurse, staff nurses (x2), Consultants (x2) (N= 6). Critical Cardiac Unit: Senior staff nurse, staff nurses (x5), Consultant Cardiologist, Capacity Manager (N= 8)	70 hrs	Capacity Manager and Consultant Cardiologist (N=2)	50 hrs	Chief Executive, Consultant Cardiologists (x3), Discharge Manager, Head of Antenatal Clinic, Head of Capacity, Head of Cardiology, Head of Midwifery, Nurses (x3), Nursing director, Registrars (Obstetrics and Gynaecology) (x2), and Senior House Officers (Obstetrics and Gynaecology) (x2).	17
HSJT	General Medicine Wards: Matron and staff nurses (x5) (N= 6)	20 hrs	Care of the Elderly consultants (x2) and General Medicine Matron (N=3)	50 hrs	Care of the Elderly Consultant, Director of Medicine, Discharge Manager, Discharge Co-ordinator, Senior Nurse	5
RAVT	N/A	N/A	Care of the Elderly Consultants (x5) (N=5)	100 hrs	Consultants (x3), Nurses (x2), Physiotherapist	6
SEAT	N/A	N/A	Ambulance crew (x66), Emergency Department staff (x28), patients (x109) (N= 203)	470 hrs	Paramedics (3x), Technician and Emergency Care Assistant (ECA)	4*
TOTAL	20 participants	90 hrs	203 participants	670 hrs	32 participants	32

\*These four interviews were extended ethnographic interviews.

Table 1: Data collected

## 3.3 DATA COLLECTION: QUALITATIVE RESEARCH

By the end of the 1980's discussions surrounding qualitative methods were becoming established within human geography (Eyles and Smith 1988). These discussions reflected geographers' disillusionment with quantitative methods, such as survey and questionnaires, that had dominated geographical research as they failed to provide the experiential and subjective knowledge that geographers now required (Katz 1994; Andrews 2002). This disenchantment led geographers to engage with qualitative methods that had "long been established outside geography" (Pile 1991:459) in other social science disciplines such as anthropology and sociology which were being used to study people in their natural environments (Denzin and Lincoln 1994).

This methodological paradigm shift coincided with the establishment of a "new cultural geography" to which "human experience and meaning" became the focus (Pile 1991:459). These methodological and philosophical shifts led to exciting changes in geographical research "giving voice" to populations that had once been inaccessible or marginalised, by the scientific, objective and masculine rationale of the "quantitative revolution" (McDowell 1992; Katz 1994; Widdowfield 2000).

However, whilst the cultural turn resulted in qualitative research methods being appropriated in most areas of geography, Andrews (2002) demonstrates that the infiltration of qualitative methods into medical geography was much slower due to its affiliations with "hard science". Whilst in other areas of geography human experience was being observed, medical geographers continued to create large statistical data sets. They endeavoured to map the spatial patterns of common and rare diseases correlating them with statistics on environment, risk exposure and poverty so that health care allocation and resources could be increased in disease

dense and poverty stricken locations. It wasn't until a second paradigm shift in the 1990's which "recast" medical geography as health geography that researcher's began to observe the "experiences of care and caring" (Andrews 2002:226; Brown and Duncan 2002).

Aligned with medical sociology and medical studies more broadly (Launer 2002; Hurwitz, Greenhalgh et al. 2004; Allan and Smith 2005), health geography focussed on the experiences of patients who were mentally and / or physically ill and affected by disease or long term condition (LTCs). However, in distinguishing health geography from medical sociology or broader health studies, health geographers emphasised how integral "place [is]...to the overall experience of health and health care" (Kearns 1993; Butler and Parr 1999; Andrews 2002:299). Research therefore focuses on "therapeutic landscapes", places and spaces that focussed on the provision of care, treatment and healing and improving and maintaining people's health and well-being (Gesler 1992:735; Williams 1998; Wilson 2003; Milligan, Gatrell et al. 2004).

Health, emotional and organisational geographers have implemented a wealth of qualitative research methods to obtain subjective, emotional and experiential data. These methods include semi-structured interviews, storytelling interviews, focus groups and ethnography. Whilst all of these research methods could be appropriated to answer the research question, focus groups were not used due to the highly sensitive, personal and emotional nature of the research. Intimate one-to-one and storytelling interviews were deemed more appropriate and conducive for the disclosure of emotive experiences through "emotional talk" (Mehta and Bondi 1999). Semi-structured interviews are also the preferred choice for emotional geographers (Bondi 1997; Pain and Francis 2003; Bondi 2005c), workplace geographers (McDowell and Court 1994a; McDowell and Court 1994b;

McDowell 1997, 2003) and storytelling interviews for organisational theorists (Gabriel 2000; Hurwitz, Greenhalgh et al. 2004).

Ethnographic methods; shadowing (McDonald 2005; Czarniawska 2008) and non-participant and participant static observations (Crang and Cook 2007; Hammersley and Atkinson 2007; Madden 2012) were also implemented to capture the emotional care work of health professionals in the NHS. I now turn to discuss the ethnography in more detail.

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#### ETHNOGRAPHY

Ethnography derives from the Greek to “write about people” (O’Leary 2004; Madden 2012:6). Ethnography however, is not just about writing a narrative about people, it is a critical engagement between the converging points of culture, society, people and place. This critical engagement allows researchers to deconstruct, interpret and explain people’s behaviour within place (Brewer 2000; Davies 2008; Madden 2012). Ethnography adopted and utilised by geographers originated from three theoretical schools of thought; British Social Anthropology drawing on the work of Malinowski, American Cultural Anthropology headed by the work of Mead and the qualitative sociology of the Chicago School drawing on Robert Park’s research. Geography’s ethnographic approach therefore shares many aspects of anthropologic practice (Davies 2008; O’Reilly 2009; Madden 2012).

The main approach of ethnographic practice is to observe people as they live their daily lives through a particular way of seeing termed the “ethnographic gaze” (Madden 2012). This enables ethnographers to observe and describe; the physical structures or settings (buildings, rooms, open/closed spaces, material objects) in which the observations take place, the behaviours of those being observed (the way they converse, their volume and tone, language, bodily deportment, body language, the length and frequency of

interactions or behaviour) and the atmospheric 'vibes' experienced within a geographically defined space (Mulhall 2003; Madden 2012).

In the classic style of ethnography conducted by Bronislaw Malinowski (1922) and Margret Mead (1928) anthropologists inhabited the field for an extended period of time, typically for a year or longer to observe the population and through thick description provide the audience with a "sense of being there" (Geertz 1988, cited in Davies 2008:78; Madden 2012). The research field for anthropologists is a closed "interrogative boundary to map on to a geographical and /or social and or emotional landscape that [was] inhabited by a participant group" (Katz 1994; Madden 2012:39). They therefore lived with and experienced the daily lives of those being observed, gaining a complete understanding of the cultural meanings and social structures of the group and how they inter-relate with each other (Davies 2008; Madden 2012). This practice of observation remains a key feature of ethnographic research. Kearns (1993) for example, asserts that to capture the complex and diverse experiences of health and place, geographers need to be located within a geographically defined space (Kearns 1993; Andrews 2002).

At the same time as Mead and Malinowski's work, Robert Park and colleagues at the Chicago School of Sociology were also observing isolated social and cultural groups within discrete geographically segregated areas. However, unlike the anthropologists observing exotic populations, they observed marginalised cultures in Western societies such as the homeless or gangs (Madden 2012). They therefore sought to create new knowledge and theory by making the mundane and familiar, foreign and mysterious (Katz 1992; Davies 2008). The transition to observing the mundane has led researchers to establish large bodies of work focusing on a range of social institutions such as schools, hospitals and prisons (Goffman 1961; Allan 2001a; Davies 2008).



### CHAPTER 3.3 DATA COLLECTION: QUALITATIVE RESEARCH

The focus on large institutions led ethnographers to move from single site ethnographies to multi-site ethnographies. The term multi-site ethnography has a dual meaning. First, it is used to describe ethnographic research across more than one field site so that different cultural practices and organisational behaviours are compared (Davies 2008; Neyland 2008; Falzon 2009). In line with this definition, this research adopts a multiple field site approach bringing together different health practices, places and spaces into a single ethnographic inquiry.

Second, multi-site ethnography is used to define how the ethnographer may move through and between connected field sites. This may involve the researcher following participants, objects, metaphors, biographies and conflicts across different sites (Marcus 1995; Neyland 2008). This research also falls within this definition as health professionals were followed as they moved from ward to ward, bedside to bedside and between private and public spatialities of care.

Ethnographic research within carescapes, until more recently, has seen limited and sporadic implementation (Mulhall 2003). Where ethnography has been implemented it has been used to: analyse and assess medical practice to prevent “medical mishaps” (Barach and Small 2000; Taxis and Barber 2003; Wirtz, Barber et al. 2003), observe patient safety (Dixon-Woods 2003), observe health professional relationships (Timmons and Tanner 2005), examine how patients manage their health care needs (Savage 2000; Hinder and Greenhalgh 2012), and explore how health professionals and patients experience carescapes and their relationships with one another (Edvardson and Street 2007; Hindmarsh and Pilnick 2007).

Savage (2000) suggested that ethnography is not frequently used in health care research for two reasons. First, funding bodies are not keen to fund ethnographic research because it is deemed “unscientific” as data can’t be generalised to a wider population. Second, ethnography is perceived to carry

greater ethical considerations and risks, especially when conducted in a health care environment.

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#### GEOGRAPHY'S ENGAGEMENT WITH ETHNOGRAPHY

Andrews (2002) and Herbert (2000) advocated that geographers engage more with ethnographic methods (Herbert 2000; Andrews 2002). Geographers, however, like sociologists were slow to respond to this request (Blackman 2007). This was particularly disappointing for emotional and affective research given that feminist, psychoanalytic and emotional geographers and non-representational theorists had demonstrated that participants found it difficult to verbally express their emotions (Widdowfield 2000; Bondi 2003; McCormack 2003). Despite this languid response, the use of ethnography in geographic research has gained momentum, especially in the field of emotional geographies where ethnographic research has been implemented to observe the emotional worlds of teachers (Hargreaves 2000, 2002; Francis and Ingram-Starrs 2005; Kenway and Youdell 2011; Zembylas 2011), feelings of belonging to place and landscape (Kearney and Bradley 2008; Christou 2011; Waite and Cook 2011; Kearns and Collins 2012), (haunted) workplaces (Hockey and Allen-Collinson 2009; Meier 2012), traumatic events and crisis (Lund 2012), cultural practices such as parkour (Saville 2008) and cycling (Spinney 2006) and health care (Allan 2001b; Edvardson and Street 2007).

An initial reluctance to implement ethnography to observe emotions, feelings and sensibilities may have been due to the challenges researchers face in attempting to capture, interpret and explain participant's (unconscious) emotions. Parr (2000) and Pile (1996) have however stated that it is important for researchers to excavate participants' emotions because they are necessary for understanding people's actions as "feelings, impulses and thoughts are [hidden] somewhere in the flesh" (Pile 1996:87). Until recently however, it has been unclear, how participants' emotions should be

uncovered. This has therefore posed a methodological challenge for researchers.

Sarah Pink (2009) has demonstrated that participants' emotions can be explored through sensory ethnography which allows the researcher to attend to all the bodily senses (sight, smell, taste, touch, aural and visceral). An engagement with sensory ethnography reduces "sensory bias" and allows the researcher to understand the emotional world of others through inter-subjective, inter-corporeal, embodied and emplaced knowledge (Porteous 1985; Casey 1996:21; Simmel 1997; Pink 2009). The researcher's body therefore becomes an important tool for capturing and analysing participants' emotions (Moss and Dyck 1996; Parr 1998; Moss 1999).

During ethnographic observations my body was used to interpret emotions experienced in the field. The extract below describes the sensate and visceral reactions recorded during a ward round at Royal Alexandra University hospital.

*... The patient is contagious and is in a side room... The doctors begin putting on red plastic aprons and gloves... Madeline hands me an apron and a pair of gloves...I tie the apron around my waist and quickly pull the gloves on as the group enters the room.*

*...I feel immediately uncomfortable. The room is humid, small and claustrophobic. The infection control precautions only increase a sense of constriction and uneasiness... After a few minutes I begin to feel itchy, dirty, horrible as if little bugs are crawling all over me. I resist the urge to scratch in case it gives away my sense of discomfort. As the itchiness increases I feel disgusted, revolted and repulsed by my seemingly unclean body. Is this feeling my own fear of catching the patient's infectious disease? Or is it the patient's feelings towards his own sick body being projected onto me?*

*In transcribing these notes, the itchiness and the over-whelming feeling to vacate the room is still vivid...*

(Ethnographic shadowing 18: Madeline Marsden, consultant geriatrician, care of the elderly. Royal Victoria Infirmary 17/04/2009)

The sensory experiences bear witness to and explore the emotional and embodied worlds not only of the patient in the side room but of the care experiences of the health professionals. Researchers can therefore use their own sensate experiences to analyse and enrich emotive data (Longhurst 1997; Martin 2002; Edvardson and Street 2007).

In addition to a sensory ethnographic approach, geographers have used other ethnographic methods to explore participants' emotions. McCormack (2003) observed a dance movement therapy (DMT) class stating that dance was one way in which participants repressed inner (unconscious) emotions could be accessed by allowing dancers to "explore new ways of being and feeling... that [could] not be verbalised" (McCormack 2003:492). Within the DMT class, McCormack used participant observation to capture participants' inner most emotional world and explore how they could be interpreted as they transferred through bodies in a "therapeutic landscape" (Gesler 1992). In alignment with McCormack, Ahmed states that ethnographic researchers are able to understand participants' emotions by observing body language, facial expression and emotional cues (Ahmed 2004b:32).

Whilst experiencing participants' emotions, researchers are often challenged by how to translate these emotions into words for dissemination and publication (Rowles 1978b; McCormack 2005; Parr 2005). Demonstrating this challenge, McCormack draws on a task in the DMT, called "witnessing" which involves one dancer performing their emotions to the class. At the end of the performance the class verbally express what feelings and emotions they thought the dancer was trying to convey. The witnesses interpret the

dancer's performance in many ways highlighting the subjective nature of emotions, and thus the methodological challenges for the researcher.

Researchers therefore need to be aware that they may interpret participants' emotions differently from how their participants are feeling. This raises critical questions about the accuracy of ethnography to analyse emotions with Keith (1992) stating that "all ethnographic writing is an act of betrayal" because researchers may misrepresent their participant's behaviour and emotions (Keith 1992:554). To increase accuracy of emotional interpretation, reflexivity is essential. Researchers must think about their own emotional responses to what they have witnessed and draw on their own experiences to understand how participants may be feeling. Pile (1991) emphasises this by declaring that "no-one has the right to analyse anyone else without questioning themselves and their emotional...responses" (Pile 1991:462).

In thinking about how researchers may more accurately record and present participants' emotions, Pile (1991) borrows from Freud's notion of the therapeutic alliance to show that researchers can use their body to absorb participants' emotions through a "research alliance" (Pile 1991). To facilitate a research alliance, it is essential that rapport is established between the participant and the researcher (Rowles 1978b; Pile 1991:461). It is through the research alliance that participants' deep embedded (unconscious) emotions come to the surface and are projected towards the researcher. These projected emotions are then transferred onto the researcher's body through a process of transference which allows the researcher to experience and interpret the participants' emotions (Pile 1991; Laurier and Parr 1999). Counter-transference may be used to expose the researcher's own feelings and emotional responses to the participants' emotions, allowing them to think reflexively about the interpretation (Pile 1991; Widdowfield 2000; Bondi 2005c).

Furthermore, Herbert (2000) proposes, that to improve translational accuracy and to better represent participants' emotions, ethnographers should become embedded in the social practices of the observed, thus making the transition from an "outsider" to an "insider". This transition helps researchers to "comprehend the world from the insider's point of view" (Van Maanen 1988; Headland, Pike et al. 1990; Herbert 2000).

To shift position from an insider and outsider the researcher's body plays a vital role as it enables or disables "interpersonal connections with participants" (Parr 1998:28). In her research with mentally ill patients, Parr describes how she "[manipulated her] body so that it read in a similar way to the other bodies" she was observing (Parr 1998:29). This "body work" (Blood 2005) enabled Parr to limit the 'otherness' of her own body and establish better research relationships with her participants.

Bodily modification was required in the NHS hospital and ambulance trusts in which the research was conducted. Within the hospital I was asked to dress professionally. Whilst conducting ethnographic observations with the ambulance crews I wore, primarily for health and safety reasons, a fluorescent ambulance service "observers" jacket. This jacket however, simultaneously constructed my body as an insider and an outsider. To patients and relatives I was an insider, with some patients mistaking me for a paramedic in training. This mistaken identity was often beneficial as it enabled me to help crews at scene by handing out equipment, fetching the stretcher or aiding with patient lifting and mobility. My true identity as a researcher was always revealed once the patient was clinically stable to prevent any further assumptions. To the ambulance crews themselves however, the observer's jacket was a clear distinguishing marker separating myself as a researcher from them in full ambulance uniform.

Initially my partially modified body affected my ability to assimilate into the service and interact with ambulance crews because they were wary of my

presence, believing that I was a “mole” observing their clinical practice. Over time trust grew and research relationships were established making integration into their organisation culture less demanding. A more in-depth discussion about research relationships will continue in the section - *research relationships revisited*. The ethnographic data collection for this thesis will now be described.

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#### ETHNOGRAPHY IN PRACTICE

Throughout data collection, two ethnographic methods were implemented; non-participant static observations (Crang and Cook 2007; Davies 2008; Madden 2012) and participant observation, including shadowing (McDonald 2005; Czarniawska 2008; Bartkowiak-Theron and Sappery 2012). The methods implemented were dependant on the carescapes in which health professionals were being observed.

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#### NON-PARTICIPANT OBSERVATIONS

Static non-participant ethnographic observations (90 hours) took place on hospital wards, in clinics or in waiting rooms within the three hospital trusts. On the hospital wards, participant observations were predominately conducted from the nurses’ station (figure 5). From this vantage point all patient care activity could be witnessed. This position also allowed observations to take place without being intrusive to the delivery of care and prevented patients from feeling uncomfortable as a result of the researcher’s voyeuristic gaze. The nurses’ station was also a space in which nurses conducted logistical and care management tasks such as filling-in patient records, preparing drugs, organising rotas, completing paperwork and interacting with other health professionals.

The nurses’ station was also a good space from which to conduct static observations as activities were hidden from the patient’s gaze and therefore

back region behaviours could be observed (Goffman 1990; Crang 1994). In these spaces health professionals talked informally, often in lowered tones, about “difficult” patients, exchanged patient care stories, gossiped about other health professionals and discussed personal issues. This space was therefore invaluable to the collection of emotional narratives and to gain insight and understanding about the emotional geographies of ward nurses.

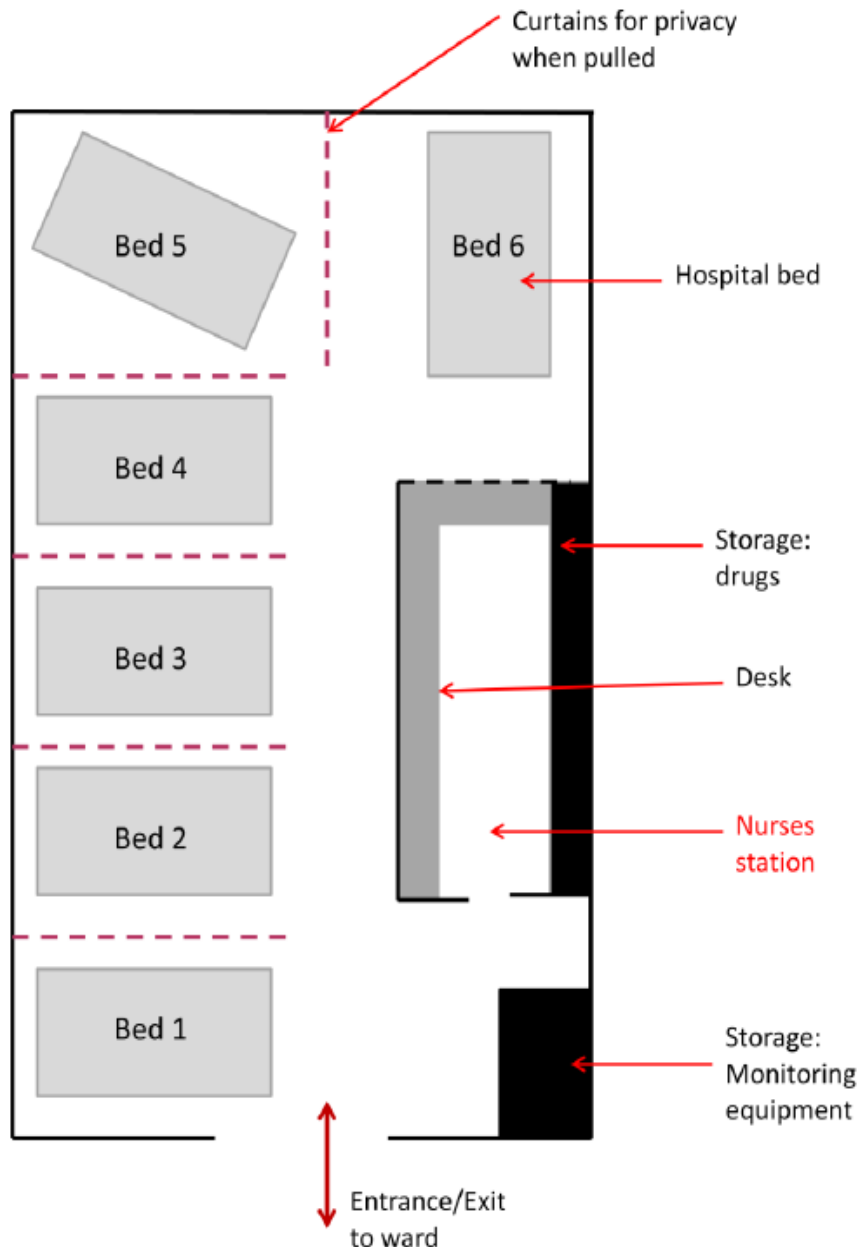


Figure 5: Static observations from a nurse’s station situated on a cardiology ward at BUHT



When the nurses' station was not located directly on the ward, static non-participant observations were taken from a corner of the ward to minimise disruption to patient care (figure 6). Prior to observations all patients were verbally informed of the research taking place and verbal consent was taken from each patient to gain permission to observe care. These static observations were challenging due to the discomfort of sitting on the ward:

*"I walk down the centre of an eerily quiet ward, 4 occupied beds to the right and 3 to the left. I feel the patient's eyes upon me as my heels click across the floor. I take a plastic orange chair from a pile in the corner and place it on the floor and sit down. The patients' eyes are boring into me. I rest my note pad on my lap too afraid to lift it up and begin writing. I feel incredibly uncomfortable, I don't belong here. I shift in my chair a couple of times trying to pluck up the courage to begin making notes. A nurse wheels in a battered wooden drugs trolley and opens its creaking lid and allows it to fall noisily against its wooden backboard. The patients are momentarily distracted by the noise as they look for its origin. I use this distraction as an opportunity to start writing..."*

(Static observation 02: cardiology step down ward, Broadwater University Hospital  
25/06/2008)

In the extract above the patients return a voyeuristic gaze (Hamer 2003). On occasion patients engaged me in conversation about the research which normally prompted the patients to tell stories about their experiences of care. These conversations were not recorded but the interactions raised questions about how much an ethnographer should interact with participants during non-participant observations. The informal conversations however, eased my sense of discomfort and it may have been perceived rude and unethical to ignore patients considering they had provided verbal consent for the observation patient care activity on the ward. Non-participant observations were also taken in the maternity wards waiting room and clinic for

gestational diabetes. In total 90 hours of static observations were conducted across BUHT and HSJT. Static observations lasted between 5-10 hours depending on the location of the hospital and department being observed.

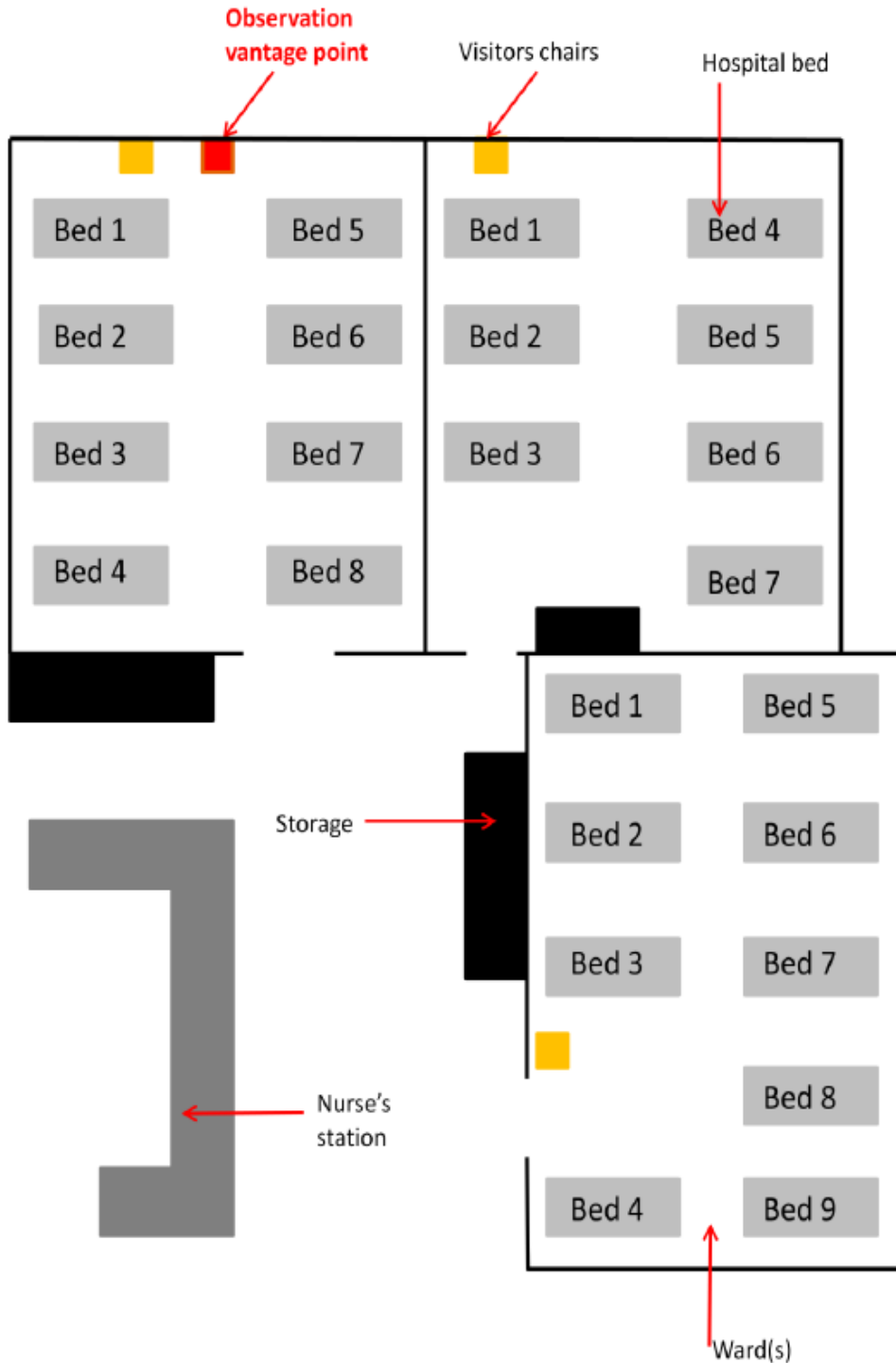


Figure 6: Static observations from a care of the elderly ward at HSJT

## PARTICIPANT OBSERVATION

Shadowing was conducted in all three of the Hospital trusts and the Ambulance Service trust to understand what the world looked like from the point of view of the health professionals being observed. Shadowing is a term used interchangeably for participant observation in organisational research. In this ethnographic method the researcher “shadows” or “follows” an employee over an extended period of time as they move from place to place (Marcus 1995; McDonald 2005; Neyland 2008). Pink (2009) has stated that “sharing in participant’s footsteps, styles and daily rhythms” enables sensory ethnographers, to create an “affinity, empathy and a sense of belonging to their participants” which facilitates a greater embodied understanding of their emotional world (Pink 2009:76).

Verbal and written consent was taken from all those health professionals being observed / shadowed with verbal consent taken from “accidental participants” where possible (Franklin, Rowland et al. 2012). Health professionals were made aware at the beginning and end of each observation that they were able to withdraw their consent at any time without question. No health professionals withdrew their consent.

In the three hospital trusts 10 health professionals were shadowed (see table 1). Participant observation commenced at the beginning and terminated at the end of the health professionals shift (approximately 8-10 hours). This enabled participation in many facets of health care not accessible through static observations. In total 200 hours of participant observations took place.

Within the Ambulance Service Trust (SEAT) 66 crew mates were shadowed, over 470 hours, for the duration of their shift; 12 hours if single-manned in an RRV or 10 hours for a two-man crew in an ambulance. In the ambulance ethnographic observations were taken from the “observer’s chair” which was situated at the head of the stretcher behind the driver’s seat (figure 7).

From this position back and front region behaviours could be observed (Goffman 1980; Crang 1994). When crews were not transporting a patient (at standby or en-route to a job for example), both crew members were sat in the front. From the observer's chair conversations between crew mates could be heard at all times and messages received from the call centre could be clearly seen on the multi-display terminal (MDT) situated on the dashboard. When transporting a patient the attending crew mate would be in the back of the ambulance allowing the observation of care work.

At scene (patient's homes, places of work, public spaces, etc.) observations were taken from a corner of the room or a space that was close enough to the action but not intrusive to the care that the crew needed to provide. The patient was informed of my role as a researcher once they were in a stable condition. Verbal and written consent was taken from the patient en-route to the hospital or once the patient had been safely transferred on to a hospital bed.

Throughout all observations ethnographic interviews took place to clarify behaviours, events and interactions that took place to give understanding and meaning to what was being observed. Ethnographic interviews are characteristically different from the semi-structured and storytelling interviews in that they are ad-hoc and unstructured with questions prompted by what was being observed rather than an interview schedule.

Four extended ethnographic interviews were conducted with five ambulance crew mates following their shifts to gain greater understandings of their emotional experiences of care work. Ethnographic interviews were conducted at the ambulance station or in the home and lasted between 1-3 hours.

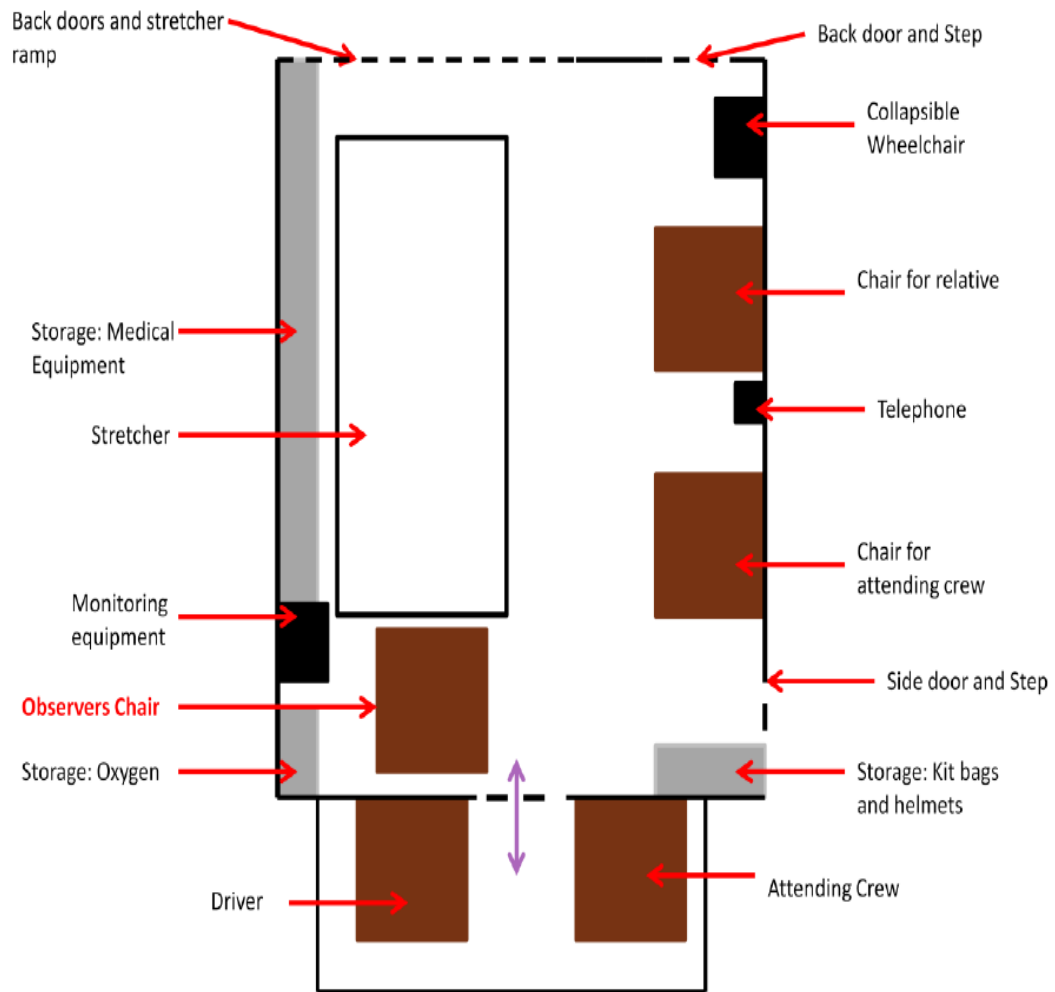
Three ethnographic interviews were conducted individually; one crew pairing, a technician and a paramedic, however wanted to be interviewed

together. This was an interesting dynamic because they were ex-permanent crew mates. These crew mates were therefore very close colleagues and friends who facilitated and prompted a plethora of organisational stories and narratives about their work on the road. This often involved the same story being told from different perspectives, demonstrating multiple storied realities, but also enabled their well choreographed working relationship to be verbally explored, supporting the ethnographic data. The benefits of joint interviews (Valentine 1999:68) or multi-perspective interviews (Kendall, Murray et al. 2009) have been demonstrated by Kendall et al. (2009) who stated that they provide more validated and richer understandings of the experiences of participants than single interviews. Valentine (1999) concurs stating that in joint interviews dyads tend to “corroborate each other’s stories... [or]...jog the other’s memory...[encouraging] them to expand on their version of events, or throw up fresh themes for discussion without the interviewer having to intervene” (Valentine 1999:68). Valentine also emphasises the challenges of conducting joint interviews asserting that dyads can “challenge and modify each other’s account” (Valentine 1999:69). Another challenge is that the interviewer’s question could inadvertently cause tensions or conflicts between dyads and they may ask the interviewer to adjudicate leaving the researcher in a difficult ethical position. During this joint interview no challenges were encountered.

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#### SEMI-STRUCTURED AND STORYTELLING INTERVIEWS

Combining semi-structured interviews and storytelling interviews in an interview process achieves methodological flexibility (Laurier and Parr 1999). It allows the interview to flow naturally in a conversational style permitting the participant to have more control over the interview process. This may encourage participants to share their emotional experiences with the researcher. It is for this reason semi-structured and storytelling interviews were combined.



**Figure 7: Location of the observer’s chair within the ambulance**

SEMI-STRUCTURED INTERVIEWS

In semi-structured interviews the participant takes centre stage having “considerable control over the course of the interview” by directing the topics discussed (Corbin and Morse 2003:339). The role of the researcher is therefore to ask probing questions or request that participants clarify or expand on their answers, without influencing the direction of the interview.

Semi-structured interviews have been used in qualitative research to gather the experiences of employees working in organisations (Gabriel 1988;

McDowell and Court 1994a; Gabriel 2004; Gaglio, Nelson et al. 2006). Leonard (2003) used semi-structured interviews with 60 employees at all levels across two hospitals to gather multiple insights into the organisation by “[underscoring] the different, complex shifting and sometimes ambiguous relationships that...organisational change [has] on the people working with them” (Leonard 2003:219). McDowell and Court (1994a & 1994b) also implemented semi-structured interviews with merchant bankers to analyse how employees resisted, sustained or abided by organisational and societal norms of gendered professional performance.

Semi-structured interviews have also been used by researchers within organisations to gather sensitive and emotive information from participants (Gabriel 2000; Corbin and Morse 2003). Psychoanalytical and health geographers have used interviews to analyse how unconscious emotions are transferred between health professionals / carers and patients (Bondi 2003, 2005c, 2005a, 2007a). For this thesis semi-structured interviews were used to explore how health professionals managed their emotions within the different carescapes and to find out whether organisational rules impacted on their ability to manage their emotions or influenced their relationships with their colleagues and / or patients.

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#### STORYTELLING INTERVIEWS

Whilst interviews may consist of “fragments of stories” (Boje 1991:5) storytelling interviews allow the researcher to “open valuable windows into the emotional, political and symbolic lives” of their participants (Gabriel 2000:2). They therefore gather in-depth stories from an emic point of view, allowing the participant to make sense of and organise their experiences within their many “storied realities” (Wilkins and Thompson 1991:20; Hansen and Kahnweiler 1993; Currie and Brown 2003).

### CHAPTER 3.3 DATA COLLECTION: QUALITATIVE RESEARCH

Whilst stories are never complete, they are characteristically different from semi-structured interviews in that they typically have a “setting, cast of characters and a plot which usually revolves around a crisis” (Hansen and Kahnweiler 1993:1393; Gabriel 1999, 2000). During the storytelling interview the researcher must act as a “fellow-traveller” willing to engage with the participant’s story, “emotionally, displaying interest, empathy, and pleasure in the storytelling process” rather than acquiring detailed facts and sterile information (Gabriel 2000:136). The role of the researcher is to keep the story’s pace by showing their appreciation and engagement in their story.

The Storytelling method has been implemented most widely by organisational theorists (Hansen and Kahnweiler 1993; Frank 1995; Gabriel 1999, 2000; Hurwitz, Greenhalgh et al. 2004; Greenhalgh 2006) to “understand, explain and compare organisational behaviour and interpersonal dynamics within corporate cultures or settings” (Hansen and Kahnweiler 1993:1391). Greenhalgh (2006) and Hurwitz (1994 & 2004) specifically focus on the organisational behaviour within health care settings.

Organisational stories are often told about people or past events to enforce the organisation’s culture and the employee’s identities. While organisational stories serve to structure the norms and values of the workplace, counter narratives are also told by employees or patients (Frank 1995; Launer 2002; Hurwitz, Greenhalgh et al. 2004) to resist organisational norms or to highlight different perspectives; for example medical knowledge vs. patient experiences (Frank 1995; Hurwitz, Greenhalgh et al. 2004), or managerial vs. clinical knowledge (Hansen and Kahnweiler 1993; Currie and Brown 2003). Storied narratives are therefore invaluable in giving meaning and understanding to the way in which these organisations operate and the behaviours, thoughts, feelings and emotions of the employees who work within them. Health researchers have therefore been vehemently engaged with this method.



Milligan et al. (2005) for example, collected written and audio narratives from 20 informal carers of sick and elderly relatives and from formal carers working in care homes. They wanted to analyse the emotional experience of being a carer. Informal and formal carers were asked to record (audio and text) stories based around four issues: the extent of their care giving role, the experiences of care as it shifted from the family to the care home, how much home care was provided and how they integrated such care into the care home and their experiences of this transitional care. By using storied extracts Milligan et al. claimed that they were able to represent the participants in their own words and that their emotions were made visible through their use of language. Unconscious emotions such as guilt, anxiety or fear were also made visible as the story unfolded (Hansen and Kahnweiler 1993; Frank 1995; Hurwitz, Greenhalgh et al. 2004). Unconscious emotions were also felt through the inter-subjectivity between the researcher and participant allowing a bonding process through transference (Pile 1991).

Collecting stories via audio tape or in a written format allows the participant to think about their responses and edit their narratives. Such editing creates neat, tidy and coherent stories and therefore they may lose the raw emotion, ambiguity and complexity that impromptu stories bring. An edited story may also lose subjectivity as participants are able to edit and present themselves and their emotions in a way in which they think is socially acceptable or in a way they think the researcher wants to hear. It is for this reason that the stories requested as part of the interview process were immediate. The participant therefore had less time to think about the presentation of themselves and as a result may have presented a more complex understanding of themselves, their emotions and the dynamics of the carescape and care work.

Susan Halford (2003) used storytelling interviews to gain greater understanding of how a restructuring within the NHS impacted on

employees' workplace identity and performance. Halford found that people typically constructed a sense of their own identity and what was deemed appropriate workplace / organisational identity by comparing or contrasting themselves with fellow colleagues. She asserted that while the stories did not "uncover the true or real self" they offered an insight into the professional constructions of the working self, demonstrating that employees had "multiple identities" (Halford 2003:293). Halford suggests that these insights may not have been uncovered in semi-structured interviews. In addition, a collection of stories from many different participants around the same event or crisis enables the researchers to piece together a single storied reality. This allows greater knowledge of how individuals and groups within an organisation make sense of events and highlights why people perform different organisational behaviours.

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#### SEMI-STRUCTURED AND STORYTELLING INTERVIEWS IN PRACTICE

Health professionals from BUHT, HSJT and RAVT were approached to participate in semi-structured and storytelling interviews. A flexible interview schedule was taken to all interviews which contained a list of semi-structured questions and storytelling questions. The interview schedule focussed around two themes: leadership and patient care (Appendix 4). Only the semi-structured and storytelling questions that focussed on patient care were used for this research as they produced insights into the emotional geographies of care work. Questions included: What does patient care mean to you? With all the priorities that the health service must attend to, how important would you say is patient care? How would you rate the quality of patient care offered by different parts of this hospital? What are the main ways in which you try to offer a high level of patient care in this hospital? Can you think of a time that illuminates the way you or your colleagues try to deliver patient care? And can you think of specific incidents that made

you feel proud/anxious/angry/disappointed about the quality of patient care in this hospital?

The storytelling element allowed health professionals to engage in “emotional talk”, as they narrated their patient care experiences. These care narratives highlighted how “care connects people” emotionally with health professionals demonstrating their emotional attachments to their patients (Lawson 2007; Bondi 2008). Stories also allowed the researcher and the participant to become emotionally connected as the story filled “the imagined space in which they are carried in the mind” (Cross 2009:98).

In total 28 semi-structured and storytelling interviews were conducted in the hospital trusts and gathered a range of experiences and emotional narratives from a variety of health professionals. Interviews were conducted in the hospital and lasted on average 60 minutes. One registrar however, requested the interview to be conducted off site and extended the interview for an additional hour specifically so that he could narrate several stories about the role of emotions in his daily care practice. Thus specifically addressing the aims of the PhD. Following the interview, the registrar stated that he had enjoyed the interview and felt that it had been a cathartic experience, as he rarely got the opportunity to think and talk through some of his experiences of delivering care. Interviews therefore, whilst arousing many emotions, can be empowering (Cotterill 1992; Gilbert 2000).

## 3.4 RECORDING DATA

A description of how the data were recorded will now be the focus.

## ETHNOGRAPHY

Lofland and Lofland (1994) suggest that ethnographic field-notes taken in the field should be “running descriptions of events, people, things heard and overheard conversations around people and conversations with people”. Madden (2010), Emerson, Fretz et al. (2011) and Crang and Cook (2007) also provide some guidance as to what ethnographers should consider when recording ethnographic notes. These centre around three ethnographic gazes: physical structures, behaviours and atmospheric vibes (Madden 2012). Engaging with sensory ethnography, particular attention was paid to what was heard, the sights, smells, textures, and the emotional atmospheres during the delivery of patient care. Personal emotional reactions and responses to events and behaviours in the field were recorded. Whilst some ethnographers have suggested keeping personal reflections in a separate personal diary to prevent ethnographic experiences from becoming “contaminated” (Bernard 2002; Madden 2012:126), the research aims meant that it was appropriate and just personal emotional reflections to be recorded alongside the field notes to provide emotional context.

Traditionally, personal and emotional accounts were omitted from research diaries because they were deemed too subjective (Geertz 1988). However, in the 1960's, sociological ethnographers advocated that personal feelings and emotional reactions be written into research diaries because they add value to the research encounter. First, the researcher's emotional responses in the field may reflect those of their participants, thus gaining first-hand experience of participants' emotions (Lofland and Lofland 1994; Atkinson 2001; Hammersley and Atkinson 2007). Allan (2006) recorded her emotional responses and reactions in the field and stated that it helped her to interpret

and analyse the data (Allan 2006). Second, the researcher's emotional reactions to events or behaviours witnessed in the field may lead to important questions being asked or direct further investigations. Third, by writing their emotional experiences in their research diary, researchers will be able to monitor any changes in their understandings, attitudes and beliefs towards the people / organisation being observed. Rabinow for example, notes how observation "changes the anthropologist and directs him to new observation[s]" and insights (Rabinow 1977, cited in Davies 2008:83).

In recording emotions I witnessed how my emotional reactions to behaviours and experiences changed over time as I became more immersed into the culture and lived experiences of the health professionals. The greatest changes to my emotional reactions occurred during observations with the ambulance crew as I witnessed highly emotive incidents such as cardiac arrest, strokes, labour and death. In observations in the hospital, I was often witnessing the aftermath of these events and therefore the atmosphere was less intense. In recording these events I observed that I was developing my own defence mechanisms in response to these situations.

In addition to recording the array of emotions and emotional experiences encountered in the field, the research diary can also be used to "expose the emotion[s] experienced" during research process and detail the researcher's "achievements, challenges and decision-making processes" (Bennett 2004:416). Widdowfield (2000) and Bennett (2004) are strong advocates of recording research experiences and suggest that they should not be absent from public dissemination. Researchers are perhaps reluctant to disclose their field experiences due to a fear that in expressing their emotions they will become vulnerable and exposed to criticism and their research discredited (Blackman 2007). Bennett (2004), however, perceives that a more open dialogue about research encounters would provide catharsis for researchers enabling them to come to terms with their failings, challenges

and decision-making in the field as well as providing support and guidance for other researchers (Rowles 1978b; Widdowfield 2000; Bennett 2004). Sharing “tales of the field” (Van Maanen 1988) will also expose research as a messy and frustrating process, dispelling the myths presented in published work that the research trajectory is a smooth, linear and formulaic process (Widdowfield 2000; Bennett 2004).

For practical reasons all raw ethnographic notes were recorded in a hard backed note-book which allowed notes to be taken on the move. During ethnographic observations at SEAT, I was occasionally required to help at scene. In these circumstances the back of my latex glove was used as a substitute for my note book (figure 8). The glove was also used if carrying a note-book was insensitive to the patient and their relatives. During fieldwork ambulance crews were observed writing on the back of their gloves to record patient observations and therefore the practice was not out of place. By putting down the note-book I was able to “concentrate more fully on the activity in which [I] was engaged in [and] appreciate the experience of being with other” (Madden 2012:124). This permitted first hand experiential knowledge of the emotional labour required at scene. Focusing intently on my own tasks meant that I excluded the activity and interactions that were occurring around me. It was important to gain a balance of focussed personal insight with wider objective observations.

Contemporaneous field notes were written throughout all participant and non-participant observations to produce vivid and lucid accounts of what was being observed in the field (Atkinson 2001; Hammersley and Atkinson 2007; Emerson, Fretz et al. 2011). It was of great importance that notes were recorded contemporaneously due to the incessant and relentless performance of patient care activities and interactions that were being witnessed. Without these notes trying to accurately recall the observed behaviours, dialogues and events of the day, would have been extremely

challenging. Field notes therefore allow the researcher “a way back into the research encounter” (Pink 2009:124). Ethnographers’ have cautioned against recalling ethnographic events from memory due to inaccuracies and inconsistencies (Hammersley and Atkinson 2007; Emerson, Fretz et al. 2011).



**Figure 8: Writing ethnographic field notes on the back of a medical glove**

Writing contemporaneous field notes requires a skilled and proficient researcher who can efficiently multi-task. Whilst participating in participant activities the researcher is required to focus on the main activities, behaviours and interactions and record them “in real time”, whilst simultaneously recording the activities, behaviours and interactions that occur in the periphery, as these activities often affect or influence the main activities. Concurrently the researcher is required to be reflexive about their emotional experiences or reactions to the activities in the field and think critically about the formulation of questions. Owing to the multiplicity of activities observed the ethnographer must filter and choose which activities, behaviours and interactions that they are going to record (Mulhall 2003; Emerson, Fretz et al. 2011). Ethnographic notes are therefore “selective,



purposed [and] angled” allowing the ethnographer to construct a representation of the event being observed (Emerson, Fretz et al. 2011:106).

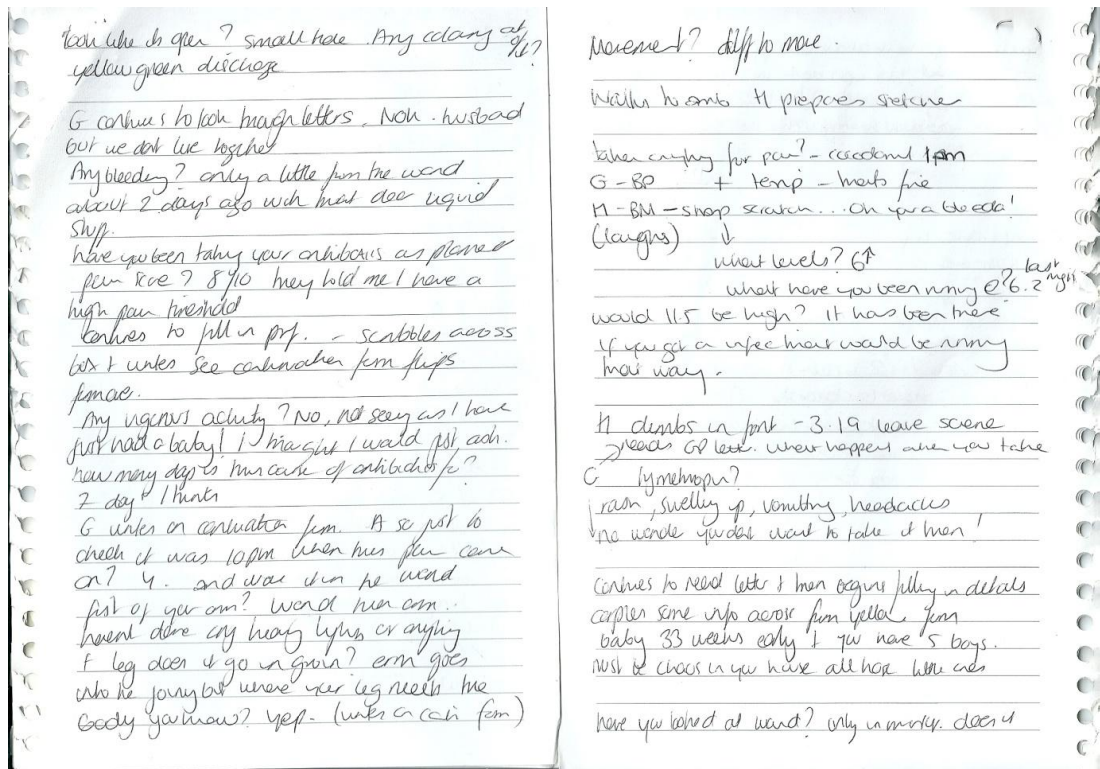
Recording multiple activities and behaviours, even when filtered, is a challenge that forces the ethnographer to make notes at considerable speed. It is for this reason that ethnographic notes are often a series of illegible scribbles, jottings, shorthand abbreviations and symbols (Emerson, Fretz et al. 2011) (figure 9). Loftland and Loftland (1994) state that it is acceptable for ethnographic notes to be “loose” and messy because they are regarded as “behind the scenes documents” and are not supposed to be viewed by anyone except the researcher creating them (Loftland and Loftland 1994; Emerson, Fretz et al. 2011; Madden 2012).

During observations with the ambulance crew, my field notes gained two audience members, a paramedic and a patient’s relative who asked to view the data recorded. These requests filled me with apprehension. Madden (2010) notes how “protective” and “shy” researchers become in “sharing [their notes] with others”, not only because ethnographic data is highly personal but also the fear of how participants might react to the notes (Madden 2012:118). I however felt, ethically obliged to share the data. After viewing the notes both participants appeared to be satisfied by what was written, with the paramedic stating that they “seemed a boring log of what he had just done”.

Writing contemporaneous notes in the field was also challenging because I had to come to terms with the feelings of discomfort in observing people as they went about their daily activities as it felt intrusive, especially in conducting static observations on the wards and in people’s homes. However, after realising the importance of writing contemporaneous notes due to the challenges of inaccurate recall I had to dispense with my discomfort to achieve notes that were “faithful representations of [the] real events” observed (Madden 2012:188). The writing activities of other



professionals during ward rounds and meetings helped to reduce feelings of discomfort because my incessant note-taking was less out of place.



**Figure 9: Field notes written in the research diary**

Whilst contemporaneous notes dominated my style of data recording, there were occasions when notes were made at the end of the day. These are referred to as “consolidated notes” (Madden 2012) or “head notes” (Emerson, Fretz et al. 2011:24). These notes were often prompted by a scribbled list in the back of the note book indicating events or behaviours that needed further explanation.

To prevent loss of content and produce vivid transcripts, ethnographic field-notes were typed electronically the following day forming an ethnographic transcript. Field notes acted as an aide memoir to trigger “flash backs” to the observations, which enabled notes to be fleshed out producing detailed narratives of the data (Pink 2009). In transcribing field notes into ethnographic transcripts, Emerson, Fretz et al. (2011) state that

ethnographers do not “simply recount the tale of something happened, instead [they reconstruct] ‘what happened’ so as to illustrate a pattern or make a point...they construct a version of events” (Emerson, Fretz et al. 2011:245). Researchers therefore need to be explicit about how participant behaviour and emotions were interpreted (Herbert 2000) and to engage in a reflexive dialogue about the impact that their positionality and subjectivity may have on how data were interpreted and meaning and knowledge created. Brewer (2000) therefore states that “reflexivity and interpretation are integrally bound together” (Brewer 2000:120). Without a reflexive dialogue ethnographers may misinterpret or misrepresent their participants or run the risk of presenting a “tidier world than what exists” (Herbert 2000:562).

The process of transcription is extremely time consuming with one days worth of ethnographic field-notes (approximately 20 pages of A5) taking between two-three days to transcribe into approximately 40 pages of A4 typed text. Due to the length of time taken to produce transcripts a backlog of field-notes was created whilst collecting data with SEAT. This resulted in a break from data collection for three weeks until all outstanding field-notes had been transcribed. Despite transcription being a time consuming process, it allows the researcher to get closer to their data re-living their fieldwork experiences and saturating themselves in the lived realities of their participants.

In turning field-notes into transcripts the ethnographer also needs to think about the tone and style in which they are going to write-up their ethnographic tales. Van Mannen (1988) presents three options for researchers: realist tales, in which the ethnographer is absent from the written text and therefore the tale is regarded as objective; Impressionist tales which attempt to provide lucid and luminous descriptions of the field that entice the reader into the story allowing them to interpret the extract; and finally, confessional tales that expose ethnographers personal

experiences within the field descriptions (Van Maanen 1988; Mulhall 2003; Hammersley and Atkinson 2007).

In writing up my research diary, a mixture of impressionist and confessional tales were adopted to bring the field-notes to life. As previously highlighted, researchers such as McCormack (2003) have demonstrated that interpreting other people's emotions is a challenge. It is for this reason that transcripts were partly written in an impressionist style. This style allows the reader, alongside the researcher's own interpretations and analysis of events and behaviours, to interpret the health professional's behaviour, feelings and emotional experiences for themselves. This encourages readers to create an animated dialogue with the data.

Transcripts also contained elements of confessional tales. This was essential given the emotional nature of the research. By presenting my own experiences I was able to convey the NHS' emotional landscape to the reader and offer an insight into the internalised emotional geographies of health professionals as they attempt to manage their emotions and deliver patient care against a torrent of internal and external feelings and organisational rules and regulations.

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#### SEMI-STRUCTURED AND STORYTELLING INTERVIEWS

All interview data were recorded using a digital Dictaphone. Caution, however, should be paid to the "Dictaphone effect" as it influences participants' willingness to disclose information, with participants tending to provide the most interesting pieces of information once the interview has been terminated and the Dictaphone switched off. During some interviews health professionals asked that the Dictaphone be switched off whilst they provided sensitive and confidential information.

To supplement the digital recording hand-written notes were taken. They were taken to sign-post follow-up questions emerging from the participants' narratives so that they were not disrupted. This prevented them from losing their train of thought, or changing the direction of the story. Additionally, notes were taken to record participants' body language or facial expressions. Whilst notes were taken during interviews, I was conscious not to make too many as this may have distracted the participant. Following the interview, retrospective notes were recorded.

Interview data were transcribed into transcripts, allowing me to become immersed in the data.

### 3.5 DATA ANALYSIS

Data were analysed using thematic analysis (Boyatzis 1998; Braun and Clarke 2006; Fereday and Muir-Cochrane 2006). All typed transcripts were read and re-read to become familiar with the data (Strauss and Corbin 1998; Rice and Ezzy 1999; Crang 2005). During initial readings emerging codes were jotted around hard copies of the transcripts (Crang 2005; Fereday and Muir-Cochrane 2006; Saldana 2013:20). These initial codes have been termed "codeable moments" (Boyatzis 1998:117). Codes are described as "researcher generated constructs that symbolise and thus attributes interpreted meaning to each individual datum for later purposes of pattern detection, categorisation, theory building and other analytic processes" (Saldana 2013:4).

Due to the large volume of data produced, all transcripts were input into ATLAS Ti 6.2 for data management (figure 10) (Dohan and Sanchez-Jankowski 1998; Drisko 1998; Basit 2003; Friese 2012). Where codes emerged from the data, transcripts were coded inductively (Glaser and Strauss 1967; Patton 1990; Boyatzis 1998; Strauss and Corbin 1998), and coded deductively where data were influenced by theories of emotion, emotional geographies,

organisational theories and workplace geographies (Crabtree and Miller 1999a, 1999b).

Established codes were placed into ATLAS Ti to create a code list. The codes were then defined to produce an electronic code book within the qualitative software (figure 11) (Crabtree and Miller 1999b; Fereday and Muir-Cochrane 2006; Saldana 2013). The code book provided the name of the codes, a description of the code and an example of when it should or should not be used. Codebooks are typically used when there are more than one researcher coding data so that codes are applied consistently across the data. However, as data were being collected and coded over a long period of time the codebook was a useful reference point for continuing and applying the codes consistently to the data. Code books are also useful to validate the codes used.

The coding process should be repeated several times to organise and reorganise, “corroborate” and “legitimate” the codes (Crabtree and Miller 1999b:170). Different coding styles were applied to the data (figure 10). Some codes were applied to large sections of text for example related paragraphs known as “lumper coding” (Saldana 2013:23). Lumper coding allows the researcher to “grasp [the] basic themes or issues in the data by absorbing them as a whole” (Dey 1993, cited in Saldana 2013:142). It has however been suggested that lumper coding should only be used primarily to allow the researcher to achieve a general sense of what is in the data and as a time saving method (Blazeley 2007 cited in Saldana 2013).

Codes were also applied to small sections of the text using line by line coding (Bernard 2002; Saldana 2013). By using both coding styles I was able to capture both the latent and semantic meanings from the data which allowed the relationships between codes to be more explicitly observed, illuminating the emotional complexity and the richness of qualitative data.

Primary codes were collapsed and consolidated into secondary and tertiary codes until five themes and four recurring sub-themes were produced (Fereday and Muir-Cochrane 2006). The five themes: geographies of emotional attachment, geographies of emotional detachment, spatialities of care logistics, workplace relationships and affective qualities of care work, and their recurring sub-themes - proxemics, temporality, mobility and care politics, were not used to structure the thesis as separating and detangling themes would cause the complexity and relationships between themes to be lost. Instead they can be seen as thematic threads that bring the thesis coherently together. Data however will be discussed and consolidated under these themes as the thesis draws to conclusion.

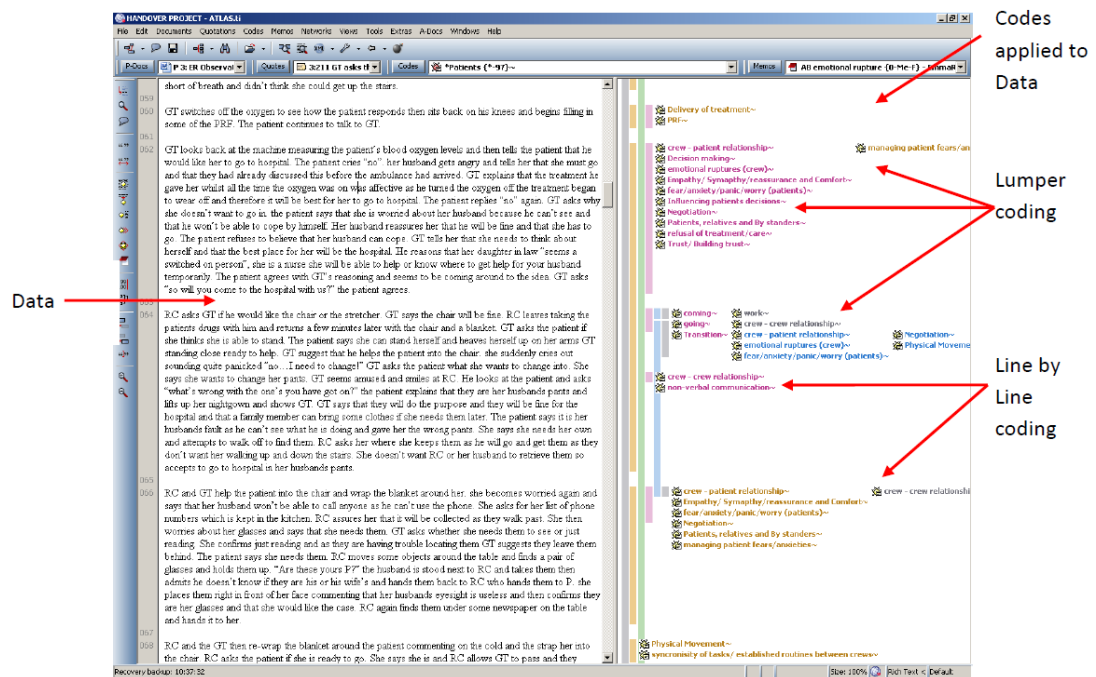


Figure 10: Example of ethnographic transcript coded in ATLAS Ti



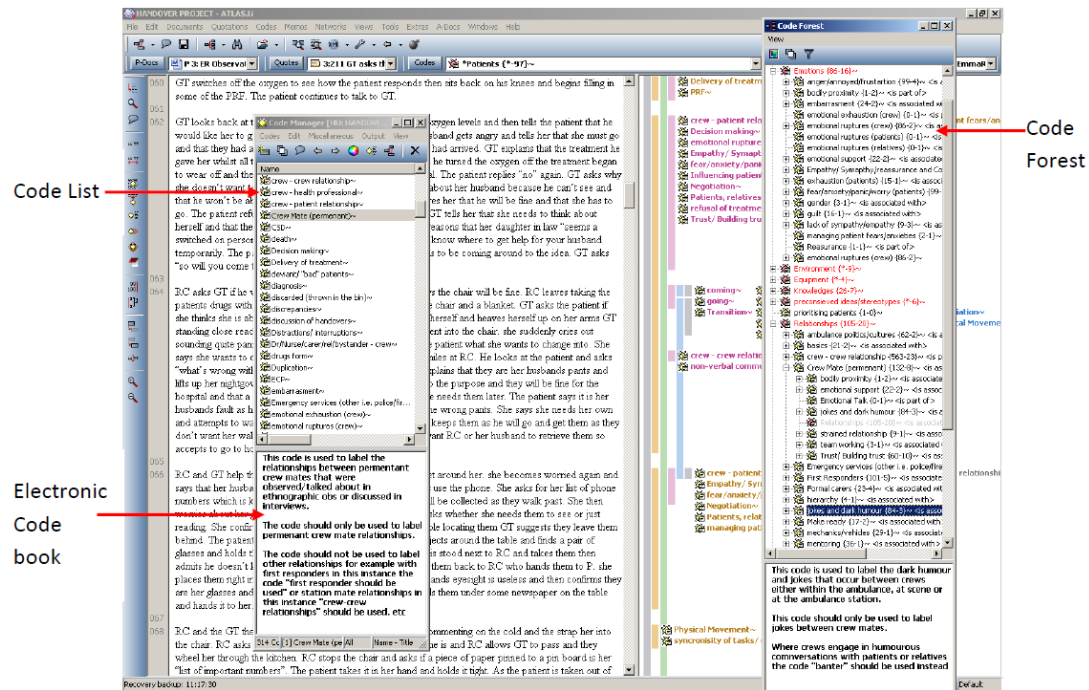


Figure 11: Example of the code list, electronic code book and the code forest used to manage the data.

To aid data analysis queries were run in ATLAS Ti to explore codes or themes in more depth and to look at the relationships between them. To analyse the data, the retrieved query data were placed in a matrix (Pope, Ziebland et al. 2000). Observing the data in a matrix allows the researcher to make initial comments about the data, apply theories to help explain the data and allows the researcher to think analytically about the relationships within the data (figure 12).

Choosing the data to be presented in the thesis was a challenge; first, the vast volumes of data produced through semi-structured and storytelling interviews and ethnographic observations created a plethora of examples. Finding the most representative data was therefore extremely difficult. Second, I had become extremely attached to the data and therefore every utterance, story and observation was perceived as too precious to leave hidden in the pages of the ethnographic transcript. Third, ethnographic observations dominated the data collection. It was however, essential to

provide a balance between the presentation of interview, story and observational data to demonstrate how different qualitative methods can be used to produce emotional data. It was also important that interview and storytelling data were presented to allow health professionals' emotional experiences to be explored in their own words and allow their narratives to illuminate the emotional complexity of their work. Data were therefore selected by its ability to most succinctly represent the events, behaviours and emotional experiences of health professionals working in the NHS as well as being mindful of representing and displaying different research methods.

Extracts chosen had to be edited with caution to prevent the loss of thick description that provides not only context but the luminous details that entices the reader into the prose. Extracts also had to be framed so that it provided a theoretical argument about the emotional geographies observed in care work.

Participant ID	Query	Data	Comments	Theory/Literature	Analysis
P1: E1: C1: 1	Empathy/ sympathy/ care and comfort	It is needed more the younger women is a neighbour. The next guys because she couldn't anything more to help her neighbour she had to help support to anyone care and therefore couldn't get from the way she said it was so painful for her. She felt that she felt guilty and then she said she was going to the ambulance and then the person going to be fine.	It was well guilty that she couldn't do anything to help her neighbor. She felt that she couldn't do anything to help her neighbor. She felt that she couldn't do anything to help her neighbor. She felt that she couldn't do anything to help her neighbor.	Search professionals as an emotion of caring mapping and managing emotions across the day and night (2008, Allen and Smith 2008). The need to manage our people's emotions at work. The need to manage our people's emotions at work.	Search professionals as an emotion of caring mapping and managing emotions across the day and night (2008, Allen and Smith 2008). The need to manage our people's emotions at work. The need to manage our people's emotions at work.
P2: E1: C1: 2	Empathy/ sympathy/ care and comfort	He then moves from kneeling to a propped position and this has to get the patients full attention. He will then take the wheel from the nurse and that he believes that he is going to see the first ambulance crew come to see her and therefore he thinks that will be best for her to go to hospital to get an MRI or to not go to hospital. The patient refuses to go to hospital. It is clear that she is very anxious about the prospect of going to hospital. She says through the tears why she thinks she needs to go and she says that she needs to go to hospital. She says that she needs to go to hospital. She says that she needs to go to hospital.	Building relationships with patients in order to influence them to go to hospital. Building relationships with patients in order to influence them to go to hospital. Building relationships with patients in order to influence them to go to hospital.	Search professionals as an emotion of caring mapping and managing emotions across the day and night (2008, Allen and Smith 2008). The need to manage our people's emotions at work. The need to manage our people's emotions at work.	Search professionals as an emotion of caring mapping and managing emotions across the day and night (2008, Allen and Smith 2008). The need to manage our people's emotions at work. The need to manage our people's emotions at work.
P3: E1: C1: 3	Empathy/ sympathy/ care and comfort	She has been at the machine measuring the patient's blood sugar levels and then tells the patient that she would like her to go to hospital. The patient says 'no' her husband gets angry and she says that she has not already discussed this before the ambulance had arrived. She explains that the equipment he gave her while she was in the hospital was on the machine and she had the sugar off the treatment bag to use off and therefore it will be better for her to go to hospital. She says that she has not already discussed this before the ambulance had arrived. She explains that the equipment he gave her while she was in the hospital was on the machine and she had the sugar off the treatment bag to use off and therefore it will be better for her to go to hospital.	Dealing with patients and husbands and emotions of caring mapping and managing emotions across the day and night (2008, Allen and Smith 2008). The need to manage our people's emotions at work. The need to manage our people's emotions at work.	Search professionals as an emotion of caring mapping and managing emotions across the day and night (2008, Allen and Smith 2008). The need to manage our people's emotions at work. The need to manage our people's emotions at work.	Search professionals as an emotion of caring mapping and managing emotions across the day and night (2008, Allen and Smith 2008). The need to manage our people's emotions at work. The need to manage our people's emotions at work.

Figure 12: Example of the analysis table used to analyse data



## 3.6 RESEARCH RELATIONSHIPS REVISITED

This chapter culminates by re-visiting a previous discussion about research relationships. Whilst the previous exploration of research relationships focussed on gate-keeping and access, this discussion investigates the rapport that researchers build with their participants in the field and refocuses the argument for researchers to engage with ethics-as-process.

Since the “reflexive turn” (Bourdieu and Wacquant 1992) it has become more legitimate for researchers to explore the emotional relationships between the researcher and their participants. This has led to “more realistic fieldwork accounts” about the establishment of research relationships and rapport (Blackman 2007). Establishing rapport with participants is however an exigent process that has been discussed amongst researchers (Van Maanen 1988; Brewer 2000; Hammersley and Atkinson 2007), with many researchers offering advice on how to build research relationships in the field. Gaglio, Nelson et al. (2006) have suggested six ways in which rapport can be created. These include: a) setting clear research expectations, b) interacting with participants face to face especially in arranging research activities, c) continuous contact with research participants throughout the research process even when fieldwork is not taking place, d) being visible, e) adapting research protocols to accommodate participants and f) showing appreciation for participants (Gaglio, Nelson et al. 2006).

Researchers may also build rapport through “impression management” (Hammersley and Atkinson 2007), which was discussed in 3.3 surrounding researchers’ body work (Parr 1998), or through the researcher’s personal characteristics; gender, age, sexuality, or ethnicity (Hammersley and Atkinson 2007). On commencing field work at SEAT, my gender was perceived, by the clinical director, to be an obstacle to establishing research relationships. I was warned that it was an overtly masculine environment

and that their coarse and sexist language may be offensive. On entering the field this warning was unsubstantiated and rapport was quickly and easily established with this group of health professionals.

Gaglio, Nelson et al. (2006) has stated that to build rapport researchers must encompass' positive concepts such as "empathy, friendship, collaboration, trust, loyalty..." (Pile 1991; Pile 1993; Gaglio, Nelson et al. 2006:727). In addition, feminist researchers have advocated reciprocal researcher-participant relationships in which there is "mutual give and take" of information exchange (Pile 1991; Widdowfield 2000; Harrison, MacGibbon et al. 2001:325). This is echoed by Cross (2009) who states that "researchers need to tell their stories to enable participants to tell their emotional stories" (Cross 2009:101). By sharing information, stories and emotions, participants and researchers increase their intimacy and produce "shared worlds" (Bondi 2005c; Pile 2010b:485) and therefore produce greater in-depth data (Wahab 2003).

To gain access and insight to, and understand the emotional geographies of care work, it was imperative that I established good research relationships with my participants. One way in which this was achieved was to share my own thoughts, feelings and emotions in response to events that were observed. After attending traumatic jobs, for example I would express my upset, fear or shock with what I had just witnessed. This not only broke any researcher-participant power relationships down by making myself emotionally vulnerable, it encouraged health professionals to either share their own emotional experiences, provide an anecdote of how they had felt the first time they had witnessed a similar event or provide some advice on how they learnt to manage their emotions.

Whilst researchers are confident in engaging in a dialogue about rapport and how they constructed research relationships in the field there continues to be some aspects of research relationships that remain veiled, for example the

formation of “friendships”. Researchers may conceal the establishment of friendships from their discussions because it may be perceived to distort the boundaries of what is deemed appropriate for research-participant relationships and call into question the legitimacy and credibility of the research (Neyland 2008). The (over)emphasis of qualitative researchers to build intimate research relationships with their participants is also criticised by Pile (2010) who, drawing on the psychoanalytical relationship between Freud and his patients, suggests that researchers need to create a balance between intimacy and distance from their participants. He suggests that a detachment prevents collusion, even through unwitting means, and enables researchers to see the emotional and psychodynamics between themselves and their participant more clearly (Keith 1992; Davies 2008; Pile 2010b).

Powdermaker (1966) disagrees, admitting that “close personal relationships” enhances and intensifies a researcher’s ability to interpret and analyse data. Powdermaker also states that research relationships and friendships impact on both the researcher’s and the participant’s lives. This is particularly the case for relationships formed during ethnographic research due to the concentrated period of time spent together and experiences shared. Of his own research relationships he asserts: “the friendships lasted whether or not we ever saw each other again. They became a permanent part of my life, apparently I of theirs” (Powdermaker 1966, cited in Davies 2008:90). I share some affinity with Powdermaker’s comments as I too have been affected by the participants that I conducted research with. Geertz (1968) however, did not agree with establishing friendships in the field and suggested that such relationships were only “figments of the researcher’s imagination” (Davies 2008:91).

Taking a pragmatic approach Neyland (2008) states that some research relationships will be stronger than others (Neyland 2008). During fieldwork I established different degrees of research relationships, rapport and

friendships with different health professionals. In the hospital settings I found establishing rapport and intimate research relationships more challenging than at SEAT. This may have been due to the types of ethnographic methods implemented. Static non-participant observations for example were not conducive to building research relationships. Ethnographic research in the hospitals was also sporadic, spread over three trusts and this may have resulted in the inability to build meaningful relationships with participants. Despite being more challenging I did establish good rapport and research relationships with a number of health professionals across the hospitals which enabled me to experience their world from their perspectives. Five health professionals particularly stand out as having an influence on my understanding of the emotional worlds of health professionals and for being incredibly accommodating and explicitly opening up to allow me to share in their care work. Whilst I have not seen these health professionals since conducting the research I am often reminded of the time and experiences we shared.

Similarly good research relationships were established with the majority of ambulance crew members at SEAT. Rapport may have flourished in this environment due to the extended periods of time that was spent in the confined space of the ambulance. The observations were also increasingly more participatory in this environment and therefore may have encouraged research relationships to thrive as we were able to co-create and share patient care experiences on the road. Friendships were also formed with a small number of the crew, which have been maintained.

Focusing on “hidden ethnographies”, Blackman (2007) discussed his “research friendships” formed in the field which are normally concealed from dissemination. Through his discussions he highlights the need for researchers to engage in ethics-as-process to negotiate their way through the complex and messy “emotional relations developed between the researcher

and researched” (Blackman 2007:699). In his paper, Blackman details his experiences of establishing relationships with his participants: young women affected by domestic violence and homeless people. To establish relationships with this youth underclass Blackman describes how he went drinking with his participants. He was initially unsure how to explain this behaviour to peers; however this bonding exercise had a “major impact in establishing rapport” with his participants. Blackman however had to think ethically about buying drinks for the youth who were considerably less solvent than himself, as it could have been perceived as bribery to take part in the research.

In conducting research at SEAT I came across a similar ethical consideration. On my first day of observations I took some home baked cakes into the field and left them in the kitchen along with a card. The purpose of this (as explained in the card) was to make the crews aware that I had started observations, as being on the road with a crew meant that I was often invisible to other crew. Throughout the observations baked goods were always brought and left in the kitchen as a “calling card”. This gesture had not been implemented in any way as bribery or to influence recruitment. However, after 6 months into observation and friendships established, a paramedic with whom I had conducted early observations disclosed that he initially did not want me to observe him. He had however, come in to start his shift and ate two slices of cake before reading the card and had felt obliged to allow me into his RRV. In retrospect, this made me question how ethical this seemingly innocent gesture had been.

Like Blackman I also had to think ethically about going for drinks with participants. At BUHT, RAVT and SEAT health professionals invited me to attend social events from birthday celebrations, leaving parties or payday drinks. Ethical considerations had to be made as to how attending such events would affect the research relationship. On receiving an invite for the

first social event, a birthday, the ethical implications were discussed with the PI and research team. It was perceived that not attending the event could offend the health professional who had felt a relationship had been established and therefore could jeopardise the research relationship. This ethical dilemma therefore highlighted the challenges of building rapport with participants and the blurring of boundaries between professional and personal research relationships.

Hammersely et al. (2007) stated that “difficulty in leaving [the research field can]...reflect the quality of the relationships that have been established with participants...the more successful ...the [harder] it can be to extricate oneself from the setting” (Shaffir and Stebbins 1991; Hammersley and Atkinson 2007:). Leaving all four research sites was an emotionally challenging experience demonstrating the quality of rapport and establishment of intimate relationships that I had created in the field. Without such rapport the emotive worlds of my participants could not have been accessed. Whilst Dunscombe and Jessop (2002) suggest that researchers should pretend to form friendships with their participants, forming “fake friendships” would not have been ethical or conducive to the collection of emotional narratives and to the understanding of the emotional geographies in the care work of the NHS.

### 3.7 CONCLUSION

This chapter had a dual purpose: to present the theoretical underpinnings of ethnography and demonstrate the practical application of ethnographic methods for understanding emotional geographies in care work. Achieving this, the chapter explored ethnographic traditions to demonstrate how different schools of thought have influenced the modern day application of ethnographic methods such as participant observations and shadowing to observe the mundane and taken for granted behaviours, cultures and social

practices of employees working in the NHS. It also analysed the theoretical underpinning of interviews and storytelling.

In moving from theory to practice the chapter considered the ethical considerations of gaining access to the field and its participants by examining the role of ethics committees and gatekeepers. Research relationships and rapport were also investigated. Situated within discussions around research practice, the chapter considered the reflexive and subjective researcher and illustrated the importance of these two practices to the interpretation of inter-emotional relationships between health professionals and their patients. In addition, the research methods, participant observation, shadowing, semi-structured and storytelling interviews implemented to collect data were outlined. This included a description of how data were recorded, managed and analysed. Justification of how data were selected for the following two empirical chapters was also explored.

Throughout the chapter the appropriation of qualitative research methods for gaining insight into the emotional world of participants and bring new knowledge, understanding and meaning to the study of emotional geographies in the workplace. It has argued that the embodied and sensate nature of ethnography allows it to be substantially conducive to gathering awareness and an understanding of participants' emotions. By adopting a sensory ethnographic approach which considers the six senses researchers are able to achieve a perspicacious perspective of the research field which includes insight into the complex and nuanced emotional experiences of participants. The researchers' body therefore is an essential research tool for the study of emotion. Bodily experiences and emotions felt in the research field can be used to gather a sense of the emotional climate or context in which the observations are taking place. They can also be used as an experiential reference point in attempting to comprehend how participants are feeling. It demonstrated that visceral feelings experienced in the field can

also be employed to instigate “emotional talk” both in the field and in an interview setting.

Shadowing was an especially useful way of observing emotions in the workplace. Shadowing has been used by organisational theorists and therefore are effective in assembling knowledge and understanding about workplaces and the employees that work within them. This technique permitted the observation of not only how organisational (NHS) rules and regulations impact on participants emotional working lives, but also how it shaped their emotional relationships with colleagues and patients, impacting on their emotional care experiences. Like shadowing, storytelling interviews are used by organisational theorists. Stories collected were helpful in not only exposing workplace culture but also emotive narratives of health professionals. They are therefore advantageous for studying emotional geographies in the care work and organisational and care politics. Semi-structured interviews were also useful in allowing participants to engage in “emotional talk” giving participants the freedom to discuss their emotional encounters in the delivery of care. The success of these methods in collecting, understanding and interpreting and analysing emotions in care work will be demonstrated in the two empirical chapters that follow.

The following chapter, which focuses on hospital care work, illustrates how health professionals carefully manage their emotions to provide patient care. It argues that health professionals, within different carescapes are required to manage their emotions adjusting the balance between emotional attachment and detachment to deliver the most apposite patient care, whilst protecting their own emotional and psychological well-being. In addition it explores patient logistics by focussing on the emotional geographies within the scheduling of care through the NHS system and into the community where it engages with geography’s debates within a shifting care politics.



**CHAPTER 4: HOSPITAL CARE WORK: EMOTION, SPACE AND  
PATIENT LOGISTICS**

Geographies of emotional detachment

Geographies of emotional attachment

Geographies of patient logistics

**4.1 INTRODUCTION**

As an organisation, the NHS places emotional demands on its workers to ensure that patients are satisfied with the level of care provided (Bone 2002; Mark 2005; Erickson and Grove 2008). These demands are most visible within the front regions of the hospital, for example hospital wards, where intimate, inter-relational and emotional care work is performed. Back region activities such as organisational meetings where care work is scheduled and managed are, however, also emotionally demanding for health professionals and hospital managers.

Within the hospital ward the day to day patient care activity is predominately conducted by nurses. It is for this reason that the majority of the literature on emotional care work has been written from their perspective (Smith 1991; Allan 2001a; Bolton 2001; Hunter 2001; Allan and Barber 2005; Allan and Smith 2005; Mackintosh 2007), to the exclusion of doctors, other allied health professionals and hospital managers (Larson and Yao 2005; Beach and Inui 2006; Erickson and Grove 2008). More recently however, this imbalance has begun to be addressed with the role of emotion within doctors' care work building momentum (Hall, Horgan et al. 2002; Montgomery, Panagopolou et al. 2005; Beach and Inui 2006; Roter, Frankel et

al. 2006). The emotional care work of hospital managers continues to be neglected.

Whilst the majority of care work is performed by nurses who are located within the boundaries of the ward other health professionals infiltrate the spatial boundaries to deliver care, for example doctors on their ward rounds, therapists providing rehabilitation, pharmacists stocking up drugs cupboards, capacity managers and discharge co-ordinators organising the transfer of patients between wards or out into the community. These care activities and the inter-personal exchanges between health professionals and patients affect the climate of the ward causing emotions to become entangled resulting in an emotionally intricate terrain.

Drawing on empirical data with a wide range of health professionals, this chapter elucidates that hospitals are extremely complex and “emotionally textured spaces” (Milligan 2005:57). Theoretically underpinned by emotional geographies, this chapter integrates Hochschild’s work on emotion management and psychoanalytical geographies (Callard 2003; Sibley 2003; Bondi 2005b) informed by Freud (1937) and Klein (1975) to deconstruct and analyse the emotional geographies of care work in the NHS. In exploring the processes of hospital care work, it is organised around three sets of geographies: geographies of emotional detachment, geographies of emotional attachment and geographies of patient logistics. This framework will be used to examine how health professionals share, manage, contain and repress their emotions to deliver, schedule and organise care.

*Geographies of emotional detachment* (4.4) focuses on the spatialities of care that produce emotional distance between health care professionals and their care recipients (patients and their relatives). Focussing on these inter-relationships in emotionally challenging carescapes, health professionals elect to perform emotionally detached care behaviours. In performing these behaviours health professionals draw on the traditional medical model of

care. This advocates rational, objective and emotionally distant care encounters over emotional inter-personal interactions and, as a result, helps them to create both physical and emotional distance from their patients. This protects health professionals from the emotional and psychological burden of delivering care in a medical crisis, trauma or in death by preserving important professional boundaries. This not only ensures consistency and equality of care to all their patients, but allows health professionals to provide compassionate, dignified and respectful care to patients at the end of their life-course. Some health professionals are, however, becoming disillusioned and frustrated with the traditional model of care and have attempted to de-construct and resist the organisational rules, i.e. time directives that prevent them from engaging on an emotional level with their patients.

In contrast, 4.5 examines the *geographies of emotional attachment* present in care work by focusing on the spatialities of care work that enhance bodily proximity and create “emotional connections” within the caring process (Jackson 2010). Emotional attachments are influenced by spatio-temporal factors such as the spaces in which care is delivered, the duration of admission and the time that health professionals can give to their patients. Additionally, emotional attachments are created through embodied encounters that enable health professionals to get to know their patients on a social and emotional level. These embodied encounters are not only established through verbal exchanges but through bodily proximity and haptic qualities that allow emotional and affective currents to course between and within the interiors and exteriors of their permeable, porous bodies. This enables psychoanalytical geographies to be incorporated and given credence through an engagement with emotional geographies of care work.

*Geographies of patient logistics* (4.6) focuses on the spatialities of care that operate outside of hospital wards, within organisational meetings. Through the presentation of three different types of meetings: multi-disciplinary team (MDT), capacity and continuing care panel (CCP) meetings, this section demonstrates that managing and organising patient care is emotionally challenging for both health professionals and hospital managers. To assist emotion management, meetings are formally structured to promote emotionally detached care behaviours. Hospital workers however, often struggle to perform detached care due to their "emotional memories" (Hochschild 1979), which enable them to construct empathy through their own personal experiences of the health care system. Their struggle for detachment challenges the idea that the scheduling of patient care operates within an emotionless terrain. Furthermore, geographies of patient logistics engage with a politics of care, specifically in relation to shifting care responsibilities in Western economies.

I now present the carescapes from which the empirical data was collected: The hospital wards and organisational meetings.

#### 4.2 THE HOSPITAL WARDS

The empirical data for sections 4.4 and 4.5 are taken from six different hospital wards across the three NHS trust hospitals; three care of the elderly wards, a cardiac step down ward, a general medicine ward and obstetrics and gynaecology ward (see figure 3). These wards highlight different emotional geographies of care work as they vary in care activities; temporal demands i.e. the length of time health professionals are able to spend with their patients, the duration of patient admission and patients' morbidity and mortality. These spatio-temporal demands affect the emotional climate of the ward, and the emotional demands placed on health professionals.

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**CARE OF THE ELDERLY**

The first care of the elderly ward presented is led by consultant geriatrician, Mr Robert White, and predominantly caters for elderly people requiring palliative and end-of-life care (World Health Organisation 2010). This ward is located in a semi-permanent porta-cabin building abridged to the main hospital building by an enclosed corridor. The environment is therefore uninviting and barren. The positioning of this ward as an appendage to the main hospital may reflect wider social attitudes about the elderly and infirm. Patient turn-over on this ward is predominately dictated by mortality and clinical input is limited making this ward a “deathscape” (Maddrell and Sidaway 2010). It therefore is considered to be an emotionally challenging environment for health professionals.

In contrast, the care of the elderly wards led by consultant geriatricians Mrs Chloe Stanmore and Mrs Madeline Marsden are not deathscapes. These wards contain patients who have been admitted for varying ailments from acute illness to broken bones and therefore the care activities are diverse. Safe discharge from the ward to the home / care home is an expected outcome. These wards are described as “temporally poor” (Urry 2000, 2005) because they are places full of “drudgery” (Sennett 1990:183), slow to change and “heavy with time” (Lash and Urry 1994:250). Patient turnover is slow as many of the elderly patients require complex medical treatments or interventions and / or have to wait for the implementation of a social package before they can be discharged.

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**CARDIOLOGY**

The cardiac step down ward, situated in the cardiology department is led by consultant cardiologist, Mr Alexander Hopper. Patients on this ward have typically been transferred from a high dependency cardiac ward following cardiac surgery and are recovering from their procedures. The environment

on this ward is considered “temporally rich”(Urry 2005) because it is a place “full of time” (Sennett 1990:169), it is busy and fast paced due to high patient turnover and moderate patient care activity. This cardiac ward demonstrates what Elspeth Probyn called "incongruous proximity" (Probyn 2000) as the care activities and spatio-temporal factors challenge health professionals’ ability to become emotionally attached to their patients.

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#### GENERAL MEDICINE

The day to day running of this general medicine is led by matron Judith King. General medicine covers five wards and four side rooms which are linked by a central nurse’s station. The wards are predominately gendered, however during observations there were two male outliers<sup>3</sup>. This ward cares for patients with a range of complex medical conditions and patients are elderly or suffering from long term chronic or genetic conditions. There were however patients recovering from other medical / surgical interventions. Patients admitted to his ward are typically long stay with several patients returning frequently. Due to patient morbidity turnover tends to be slow and patient care activities are varied depending on the patient’s condition. Some patients therefore may require more medical intervention than others. Health professionals on this ward have the time to get to know their patients on an emotional and social level.

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#### OBSTETRICS AND GYNAECOLOGY

Two wards, pre and post-natal wards within an obstetrics and gynaecology department are presented by registrar Dr Nikhil Chopras during a storytelling interview. These wards are characterised by a temporally rich

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<sup>3</sup> Outliers are patients that have been logistically placed on the wrong ward due to the hospital reaching capacity. Outliers may for example include a male patient being placed on a female only ward or a surgical patient being placed on a medical ward.

environment where patient turnover is dictated by the safe delivery of a baby. The emotional climates are typically characterised by anxiety in the pre-natal ward and elation and joy in the post-natal ward. These wards provide a stark contrast to the emotional climate in the care of the elderly wards described above, highlighting the different emotional geographies of care work within the hospital.

### 4.3 THE MEETINGS

The empirical data for section 4.6 is taken from three organisational meetings across the three NHS hospital trusts. These meetings are conducted in logistical spaces of the hospital, back region spaces where the patient's gaze is absent. The meetings include: multi-disciplinary team (MDT), capacity and continuing care panel (CCP) meetings.

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#### MULTI-DISCIPLINARY TEAM MEETING

The multi-disciplinary team meeting (MDT) is taken from observations at the Royal Alexander University Hospital and is attended by a variety of different health professionals intervening in patients' care. Health professionals included: consultant, registrar, ward sister / matron, nurses, speech therapist, occupational therapist (OT), physiotherapists, discharge co-ordinators and social services. MDT meetings within this department are held twice a week and last between 45-90 minutes, depending on the number of patients and the complexity of their care pathways. In this meeting the consultant co-ordinates the discussions and the registrar writes the care plan directly into the patient's notes. Each health professional has the opportunity to present the patients' progress from their perspective and offer a projected care plan. The information is collated by the consultant who presents a management plan and a prospective date for discharge. During these meetings patients are discussed as bed numbers rather than their name to encourage emotionally detached care behaviours.

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**CAPACITY MEETING**

The capacity meeting is taken from Broadwater General Hospital. Capacity meetings at this hospital are held twice a day in the hospital's management suite. They are attended by capacity managers, discharge co-ordinators, nursing staff and business managers. The meetings are short, 15-30 minutes, and are conducted to discuss patient logistics, specifically focussing on the number of beds occupied, the movement of patients across the hospital and imminent discharges. During the meeting, the capacity manager provides the capacity figures for each ward which are recorded in a table drawn on a white board. Capacity managers also present the number of outliers, those about to breach government targets and the number of blocked beds. With this information, logistical decisions are made to mobilise patients through the system.

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**CONTINUING CARE PANEL MEETINGS**

The continuing care panel (CCP) meeting is taken from ethnographic observations at St Joseph's Community Hospital. The meeting is held outside of the hospital, in a proximate trust building. It was attended by health professionals, social services and a county councillor who had not previously had any contact with the patient under discussion. The purpose of the meeting is to discuss whether patients require additional NHS resources in the community. To aid their decision-making, a member of the Trust's social services completes an assessment with the patient / relatives / carers to assess the patient's physical, social and emotional needs. In the meeting the assessment is presented to the panel who discuss the patient's entitlement to additional resources, using "critical care guidelines".

By framing emotional geographies of care work around three discourses: geographies of emotional detachment, geographies of emotional attachment and geographies of patient logistics, this thesis contributes to and develops



the literature on emotion management by explicitly emphasising the spatio-temporal and emotional interconnections between health professionals and their patients. The third discourse, geographies of patient logistics also develops the literature by taking it into new and uncharted terrain through an engagement with geographies of logistics which explores the management and scheduling of care through an emotional lens. These three geographical lenses produce an original analysis of emotional care work in the NHS.

Having outlined the carescapes and logistical spaces in which this thesis focuses. I now turn to explore the carescapes in which emotionally detached behaviours are displayed.

## 4.4 GEOGRAPHIES OF EMOTIONAL DETACHMENT

This section illustrates the spatialities of care that produce physical and emotional distance between health professionals and their care recipients during patient interactions. The first extract is taken from an ethnographic shadowing with respiratory consultant, Mr Robert White, on a care of the elderly ward that specialises in palliative care at St Joseph's Community Hospital. Robert was shadowed for two days (18 hours) and participated in a semi-structured interview. In this extract, Robert visits one of his deteriorating patients during his bi-weekly ward round to discuss the patient's care pathway with their relatives. It emphasises Robert's emotionally disconnected care practices, reflecting the traditional medical model of care. Aligning with this model, Robert limits his bodily proximity and haptic engagements with his patient creating both physical and emotional distance. The patient is also transformed "into a set of esoteric body parts" (Allen, Smith et al. 1989:60). This enables Robert to maintain professional boundaries and prevents him from becoming consumed by the emotional and affective currents that the patient and her relatives are immersed in.

*...Leaving Coleridge ward, Robert says that he needs to quickly visit two patients on Blake and we head down the corridor to the other ward. En-route Robert bumps into one of his registrars, Louise... and asks her if she has time to visit a patient. Louise nods and they head towards Blake to get the patient's files. The nurse's station is situated outside the ward and Robert looks at the white board containing a list of patient names and their bed numbers. Louise opens a paper tray and pulls out two green forms. Robert glances at the forms and comments 'oh will we need two of those today?' and explains that these are DNR (Do Not Resuscitate) forms. Robert states that as the lead clinician he has the overall responsibility in signing these forms even if it is against the relative's*

wishes. He rationalises that everyone would like their relatives to live a day longer but he has to think about what is right for the patient because resuscitation is traumatic<sup>4</sup> and in most cases only prolongs suffering. The decision to resuscitate is therefore **his** and not the patients or their relatives.

Louise takes a red folder from a free standing trolley and begins thumbing through the patient's notes. After a brief conversation, they head onto the ward. The patients on this ward are all very old and frail. The majority are lying lifelessly in their beds; an elderly gentleman is escorted out of the female-only ward by one of the nurses who is loudly explaining that men are not allowed on the ward. One woman, who had been frightened by the gentleman, is sat in a chair with a nurse crouched in front of her trying to console her. Robert asks Louise why the patient is in a side room because she is not infectious and there are free beds on the ward. Louise states that it was the only room available when she arrived and they don't want to move her because she becomes disorientated easily. Robert makes it clear that he is unhappy with their decision to keep her in a side room...

The room is dimly lit, due to the lack of windows and has a strong smell of faeces. The patient's daughter is sat over her mother trying to get her to drink a protein shake out of a carton. As we enter the daughter moves away from her mother and stands by her father's side in the top right-hand corner of the room. Louise walks over to the other side of the room and stands by the patient's daughter and husband hugging the red folder. The patient is lying in her bed with a vacant haunted expression. She is thin and frail and her face is gaunt accentuated by her unkempt afro hair. Robert loudly introduces himself. The patient doesn't respond. Robert tries again. He elevates her arm by taking her wrist and begins to take her

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<sup>4</sup> Physically traumatic for the patient's body and emotionally traumatic for the patient, relatives and the health professionals involved in the resuscitation.

*pulse she moves her head towards him, stimulated by his touch. Louise comments to the daughter that her mother seems to be responding more than she had done this morning. The daughter agrees and says that she thinks it is because the grandchildren were in earlier and that she seems to be more responsive when they are present. She adds that the children even got her to say a few words. Louise smiles "that's wonderful!"*

*As the daughter and Louise talk, the patient's husband watches Robert test his wife's physical abilities. Robert asks loudly 'can you stick out your tongue?' She nods slowly making a grunting sound. 'OK then let's see it!' The patient stares up at Robert. It seems as though she is moving her tongue around the inside of her mouth. Louise leans over Robert's shoulder and rubs the back of the patient's hand to get her attention. With the patient looking at her she says encouragingly 'like this (demonstrates)...stick out your tongue'. The patient continues to struggle. The daughter laughs and stands by her mother's side 'mum do this' (demonstrates) the patient manages to open her mouth but her tongue still does not protrude.*

*Robert looks in her mouth. He then asks whether he can listen to her chest and she slowly nods. He asks Louise if she will help him sit the patient up. Louise steps forward, the husband moves from the corner and helps Louise. Louise rests the patient's body on her forearm as Robert places the stethoscope on the patient's back and then to her chest while Louise holds the patient upright. The husband holds his wife's hand throughout and then helps Louise lay her back down. Robert tells Louise that he can hear 'some crackles' and she draws some x's on the patient notes over a rudimentary picture of a pair of lungs...*

*Robert covers the patient up and then turns to the daughter and asks 'how is she today?' The daughter tells him that she is responding more than she did this morning but she has been denying food and drink. She says everyone has tried to feed her, even the grandchildren, but she won't*

#### CHAPTER 4.4: GEOGRAPHIES OF EMOTIONAL DETACHMENT

open her mouth. Robert asks what they are trying to feed her and she explains that she has not been eating solids for days so they have been giving her nutri-shakes but she won't even drink those today. Robert asks if they have managed to give her any water and the daughter replies 'very little'. He comments that the patient has good skin condition and a good colour in her mouth so he is not worried about the water intake, but he is worried about the amount of food she is consuming. Robert talks directly to the daughter stating that her mother is coming to the natural end to her life and therefore she is giving up, 'withdrawing from life' and tells her that although they will feed her through a tube she should prepare herself and her family for the inevitable. He explains that her mother will start to rip out the feeding tubes to prevent herself from getting the right nourishment. The daughter says that she understands and turns to her father and says 'Dad, do you understand what the doctor is saying?' The husband paces up and down the side of his wife's bed looking lost and agitated. He looks up at Robert and mumbles that his wife is giving up because someone at the nursing home said she was a burden. The daughter scolds her father for saying that in front of her mother. She explains that although she doesn't say anything her mother listens to everything and the more her father says it the more she doesn't eat. Robert says he understands and asks 'how is the family coping?'

The daughter says that her father is finding it very difficult because he is her main carer. She has also taken time off work so she can to support her father. As she speaks about their social circumstances she becomes tearful. Robert listens and occasionally asks questions. The husband continues to potter around the room occasionally touching his wife's head and face. Falling silent the daughter watches her father.

In the silence Robert begins to talk about the deterioration of her mother and what they will be able to do for her. The daughter says 'you're talking about DNR aren't you?' Robert confirms that is correct. The daughter

#### CHAPTER 4.4: GEOGRAPHIES OF EMOTIONAL DETACHMENT

*tells him that she knows about it because her friend's mother recently died and this was discussed with her. The daughter says that she knows what she would prefer but she will have to talk this through with her father. The daughter calls her father over and begins explaining what DNR means. He looks at his daughter, looking lost and scared and she tells him that it is his decision but she thinks that the doctors should not resuscitate her mother because she will be resuscitated to the same state. Robert corrects the daughter stressing that the patient will be 'worse' than what she is currently because she will be a lot weaker. The daughter quietly says that she will have to talk through this with her father. Robert nods and leaves the room. Immediately outside the room Robert snatches the DNR form from Louise and rapidly signs it, thrusting it back in her hands.*

(Ethnographic shadowing 12: Robert White, respiratory consultant, care of the elderly. St Josephs Community Hospital 03/03/2009)

Robert's ethnographic extract highlights three important points for geographies of emotional detachment in care work: professional and workplace feeling rules, bodily proximity, and organisational rules.

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#### PROFESSIONAL AND WORKPLACE FEELING RULES

Robert's detached care behaviour epitomises geographies of emotional detachment. By using workplace feeling rules, Robert constructs an emotional buffer or a "defence mechanism" (Lief and Fox 1963; Menzies 1970) between himself and his patient to protect himself from the emotionally challenging environment and preventing him from becoming emotionally attached to his patient (Lief and Fox 1963; Fabricius 1991; Allan 2001b). Robert's behaviour is typical of health professionals working in "deathscapes" (Maddrell and Sidaway 2010), for example those providing intensive care (Liaschenko, Peden-mcAlpine et al. 2011) or palliative care for patients in hospices (Brown 2003). Research shows that health professionals

#### CHAPTER 4.4: GEOGRAPHIES OF EMOTIONAL DETACHMENT

working in deathscapes, who encounter death on a frequent basis, also become emotionally detached from their own emotions. This enables them to make better care management decisions, as their cognitive thought processes do not become contaminated by emotions, which could lead to medical mistakes (Allen, Smith et al. 1989:56).

In making the decision not to resuscitate his patient, Robert does not want to be motivated by emotion. He therefore separates his emotions from his rational action, making sound clinical judgements by drawing on medical evidence. The ability to separate emotion from rational action is however criticised by Barbalett (2001) who does not believe that the two can be separated. She believes that emotion is integral to rational thought (Barbalett 2001). Despite Barbalett's assertion, geographies of emotional detachment asserts that through careful emotion management health professionals can become detached from their emotions to make rational and objective clinical decisions.

Furthermore, it makes claims to the importance of spatio-temporal factors in aiding health professionals' to distance themselves from their emotions. In this extract, for example, Robert makes his decision whilst the patient is in a stable condition. In an emergency situation, emotions become heightened which could result in anxiety and guilt contaminating the decision-making process. A decision motivated by emotion, could be detrimental causing the patient unnecessary pain and extending their suffering. Additionally it could be harmful to the patient's relatives' emotional and psychological well-being. This was emphasised by Robert in an ethnographic interview;

*"...you learn to distance yourself from the patient otherwise it would be detrimental to your practice...you need a clear head"*

(Ethnographic shadowing 12: Robert White, respiratory consultant, care of the elderly. St Josephs Community Hospital 03/03/2009)

#### CHAPTER 4.4: GEOGRAPHIES OF EMOTIONAL DETACHMENT

Robert's timely decision-making also enables his medical team, who maybe called in an emergency to intervene, to distance themselves from any feelings of guilt that they may experience in not attempting resuscitation. These emotions would already have been contained and consumed by Robert. Robert's decision may also prevent his medical team from experiencing destructive emotions associated with the failure to successfully resuscitate the patient thus reducing work related stress.

The requirement for health professionals to emotionally detach themselves and engage in rational and objective thought is reflected in Robert's acknowledgement of the emotional burden placed on consultants in making difficult clinical decisions and delivering "bad news" (James and Huffington 2004). He states that the emotional responsibilities to deliver bad news falls on consultants "because they have the most experience in dealing with such matters" and have become "hardened to the [emotional] impacts" (Ethnographic shadowing: 3).

The role of temporality within geographies of emotional detachment is again highlighted as Robert's career trajectory and accumulated experiences of delivering patient care has enabled him to learn to successfully contain and repress disruptive emotions to outwardly perform an emotionally composed exterior, delivering bad news in a calm and rational manner. Robert's description of becoming estranged from his emotions reflects Hoschschild's contention that in managing emotions actors become alienated from their own and their client's emotions. This was also argued by Greaves (1994) who, in studying nurses working in a hospice, stated that regular delivery of bad news and exposure to death made health professionals become immune to, or "switch off" from, the emotional consequences (Allen, Smith et al. 1989; Greaves 1994; Mackintosh 2007).

Whilst Robert asserts that he has become hardened to the impacts of his decision-making, the speed in which he signs the DNR and forcibly thrusts it



back into the hands of his registrar intimates that he may harbour some internal guilt or anxiety related to his decision-making. It is here that we witness the psychoanalytical processes of splitting and projection. Moylan (1994) states that splitting occurs when anxiety becomes intolerable.

Choosing between letting patients die or performing aggressive and invasive treatments leaves health professionals with a “frightening anxiety about playing God” (Moylan and Jureidini 1994:232). In this extract we see Robert project his guilt and anxiety onto the DNR form, reducing his intolerable anxieties by symbolically handing over the burden to his registrar. The swift signing of the form provides insight to the performativity of emotion management as we witness the interplay between Robert’s bodily interior and exterior boundaries as he suppresses and contains his emotions.

In this extract we saw Robert emotionally disconnect from his patient by containing his “disruptive emotions” and maintaining a bounded sense of his professional self. However, we also witness Robert showing “emotional awareness” towards the patient’s daughter (Allan 2001a; Mark 2005). This demonstrates the complexities of emotional geographies of care work and emphasises that health professionals are skilled emotion managers as they are able to create emotional detachments and attachments with different patients / relatives in the same spatio-temporal environment. In an ethnographic interview following this observation Robert illustrates his emotional awareness:

*“Did you see the anguish in the daughter’s eyes....the isolation....loss and tenderness in the father...they are the ones that need my help”*

(Ethnographic shadowing 12: Robert White, respiratory consultant, care of the elderly. St Josephs Community Hospital 03/03/2009)

Robert emphasises that emotions are both inter-relational and embodied experiences as he is able to sense, feel and understand the relative’s emotional strains through reading their body language and facial expression.

#### CHAPTER 4.4: GEOGRAPHIES OF EMOTIONAL DETACHMENT

In emotionally connecting with, and managing the relative's emotions, Robert uses "emotional memories" (Hochschild 1979) to draw on his own experiences of being a relative watching the deterioration and ill health of his mother allowing him to become more responsive to the relatives emotional needs.

Robert's experiences as a relative in a similar situation with his own family enable him to connect with the relatives on an emotional level. He is therefore able to support them through this emotionally challenging time, helping them to come to terms with and accept the patient's imminent death through deep acted emotion management. This is succinctly emphasised by Hepworth (2005) who stated "the expression of emotions may involve tensions between awareness of personal feelings and awareness of the expectations of others, which are in turn responsive to situation and place" (Hepworth 2005:178). Robert therefore has to carefully manage his emotional past (emotion work) to enable him to manage and contain the relatives' emotions to help them to cope with the emotional present (emotional labour).

Interestingly however, whilst Robert demonstrates an emotional awareness of the relative's emotions, he only offers an emotionally attached care relationship with the daughter. Emotionally detached care behaviours continue to be performed towards the patient's husband. Robert may have deliberately chosen to become emotionally connected to the daughter, only communicating the bad news about her mother to her, because she appeared to be more capable of managing her emotions. Her father's bodily deportment and anxious pacing clearly indicates his heightened "death anxiety" at the prospect of losing his wife. By directing communication through the daughter, Robert's emotional performance may be less labour intensive:

*"[I need to] judge the most suitable way to tell relatives, and adapt my approach to make it as painless as possible. However, yesterday was easy for me because the daughter was intelligent and knew all about DNR so I didn't really have to go into any detail as she understood and then could explain it to the father".*

(Ethnographic shadowing 13: Robert White, respiratory consultant, care of the elderly. St Josephs Community Hospital 04/03/2009)

It is here that we see Robert relinquishing his responsibility to deliver bad news to the patient's husband by using the daughter as an intermediate interlocutor for the exchange. Using the daughter in this way, Robert shares and distributes the emotional burden reducing the intensity of his emotional labour. He therefore protects his emotional well-being by emotionally detaching himself from the husband's reaction.

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#### LIMITING BODILY PROXIMITY

Robert's limited bodily proximity and physical contact with his patient emphasises his emotional detachment. In creating distance, Robert reduces the haptic qualities of his care interaction. This demonstrates the second analytical discussion point for geographies of emotional detachment.

Throughout the extract Robert spends very little time engaged in physical care activities at the patient's bedside, with the care activities conducted being highly task orientated and for predominately diagnostic purposes, i.e. taking the patient's pulse and listening to her chest. Research conducted with nurses has emphasised that nurses, working in emotionally challenging environments, emotionally detach themselves from their patients to protect their own emotional well-being by being engrossed in task orientated activities (Menziés 1970). Task orientated activities such as taking a pulse enables the nurse to focus on one aspect of the patient's body (Fabricius 1991) reducing their patient to a singular body part, dehumanising them and

#### CHAPTER 4.4: GEOGRAPHIES OF EMOTIONAL DETACHMENT

preventing health professionals from interacting with their patients on a social and emotional level (Walsh and Ford 1989; Fabricius 1991; Mackintosh 2007). This reduces the intensity of emotional labour (Malone 2003).

Limiting physical contact reduces the ability for emotions to be transferred between patients and health professionals' porous bodies, as the affective pathways become disconnected and broken (Bondi 2005c; Patterson 2005; Duffy, Waitt et al. 2011). Without emotional transference, health professionals are less able to understand how patients are feeling as the experiential haptic qualities of care are removed. Without this understanding, it becomes easier for health professionals to implement "detached concern" (Fox and Lief 1963; Allen, Smith et al. 1989; Halpern 2001) or "benign detachment" (Fineman 1993:19) towards their patient.

Duffy et al. (2001) however, has demonstrated that bodily rhythms such as a heart beat or pulse connects people emotionally. Robert is therefore at risk of emotionally connecting with his patient through the two diagnostic tests as the stethoscope becomes a conduit for emotional transference allowing the patient's bodily rhythms to inhabit and become entangled within Robert's bodily rhythms. Limiting bodily proximity is therefore essential for Robert to prevent the transference of emotions and bodily rhythms. The concept of transference will be explored later in this chapter through an engagement with psychoanalytical geographies of care.

In the absence of Robert's physical contact, Louise's bodily contact with the patient increases. The difference in bodily proximity, contact and emotional engagement with the patient between Louise and Robert illustrates the different geographies of care that operate within the space of the ward. We witness how different health professionals are able to engage in different levels of emotional detachment and attachment depending on their professional status and role within the care of their patient. Louise may be more able to provide proximate, tactile and emotionally focussed patient

care because she does not have the same burdens of responsibility as Robert. Louise's more junior status therefore may enable her to become more emotionally connected to the patient through proximate care activities.

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WORKPLACE RULES

Finally, Robert uses workplace rules to emotionally detach himself from his patient. As Robert enters the ward he declares his frustration that the patient is in a side room. Robert may be concerned that other patients and relatives may perceive that this patient is receiving preferential treatment. He therefore wants the patient moved onto the ward to show equality of care. He does not want to become emotionally burdened by other patients /relatives ideas about this patients' care and expectations of their own care (Evans and Thomas 2009).

Additionally, Roberts's displeasure in the decision to keep the patient in the side room may suggest that he is anxious about delivering care in a confined space due to the porous and permeable bodily boundaries that allow emotions and affects to flow fluidly between proximate bodies (Bondi 2005b; Urry 2005; Duffy, Waitt et al. 2011). This analytical argument is derived from my own emotional and affectual experiences of observing care work with several different health professionals in side rooms. Throughout the ethnographic shadowing none of the affective experiences observed in side rooms were pleasant, with negative emotions and bodily sensations heightened in the bounded space. In demonstrating that emotions are intimately tied to place, Urry (2000, 2005) draws on the work of Sennett (1990) and states that places are temporally rich or poor. Hospitals are temporally rich because time and people's mobility moves at speed. This has implications for the emotional attachments and detachments that are established within place.

#### CHAPTER 4.4: GEOGRAPHIES OF EMOTIONAL DETACHMENT

In this extract Robert uses the temporally rich hospital ward and workplace time directives as defence mechanisms to prevent him from becoming emotionally attached to his patient (Mackintosh 2007). NHS time directives (workplace rules and regulations) restrict the time that health professionals are able to interact with their patients, with their time compartmentalised into task orientated activities. Health professionals' day-to-day task based activities (taking diagnostics, monitoring, handing out medications, bathing, dressing, mobilising, etc.) cause them to make several paths across the ward and between wards. These pathways become well trodden cementing health professionals' activities and connecting them with the task-activities performed by past generations of health professionals (Urry 2005:80). Tim Ingold has referred to this as a "taskscape made visible" (Ingold 1993, cited in Urry 2005: 80). These well trodden taskscapes, in addition to the time restrictions placed on health professionals in temporally rich carescapes, result in health professionals feeling that they do not have any time available to interact with their patients on a social or emotional level.

Furthermore, workplace time directives do not allocate time for health professionals to build inter-personal relationships with patients and therefore it is perceived that this activity is under-valued by the NHS (Collins 2012; Smyth 2013; Whipple 2013). As a result emotionally detached care behaviours are encouraged and any guilt experienced by health professionals for not establishing emotionally attached relationships with their patients is absorbed and consumed by the organisation, reducing their emotional burden.

Not all health professionals however, use workplace rules or spatio-temporal constraints as a defence mechanism to reduce their anxiety and guilt. Instead, some health professionals find spatio-temporal constraints increase guilt and anxiety because they prevent them from delivering the emotionally attached care that they desire. The following extract demonstrates how some

health professionals resist the constraints set by organisational rules to deliver emotionally attached care behaviours. These health professionals often deliver emotional care work within a minimal space between emotionally attached and detached care resulting in *geographies of contested emotion* (Davidson 2005).

The extract below is taken from a semi-structured interview with Mr Alexander Hopper, consultant cardiologist at Broadwater General Hospital and demonstrates how he struggles for emotional connections (Jackson 2010).

*ER* ... how do you personally try to provide good patient care?

*AH* Hmm, ((2)) well that's a good question. Erm, ((laughs)) well, I think in terms of care, one needs to listen to people and their problems. If you're not prepared to give people the time to tell you their story you may miss things, erm, experience helps to some extent...I think you've almost got to create [time], erm... I mean sometimes it seems I'm under a bit more pressure, I'm doing a ward round tomorrow at 8am and another one on Friday and the number of people coming in overnight may vary from 3 to 12. So, if I have 12 to see and then the rest of the ward that's already a lot of patients and you feel under more time pressure. But I think you've just got to spend time really and not feel rushed, because if you rush it you're going to miss things and it does take time... we tend to forget that they are individuals in front of us, they are mothers, fathers, husbands, wives, children of people like us and they deserve time spent on them.

*ER* It's interesting there you said individuals and people like us. Do you see them as people when you treat them?

*AH* ...Yes, because they're always different and they're always people. I sit in with the juniors on Monday and a student consulted with

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*a patient and I said to him, and this man's retired and I said to him, what did he do? You know? What was his role, he's 75 now, and he said I don't know. I said well why don't you know? You're meant to be looking at this person as a person, not just some sick body who just came to hospital. You need a holistic view of the individual and that's why we talk to them about their background, and it's trying to create a complete picture of somebody. It's difficult to do that in 10, 15 minutes, but we try.*

(Interview 15: Alexander Hopper, consultant cardiologist, cardiology. Broadwater General Hospital 14/05/2008)

Alexander's interview raises an important exploratory point for the study of emotional geographies of care. He emphasises that, despite temporal challenges, some health professionals want to establish emotional relationships with their patients often leading to internal emotional struggles as personal, organisational and / or professional rules collide.

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#### GEOGRAPHIES OF CONTESTED EMOTION

The fast paced, temporally rich taskscape of this ward is a source of anxiety for Alexander because he is unable to spend the amount of time with his patients that he feels is sufficient to gain holistic (emotional, social and physical) knowledge of his patients' needs. In contrast to Robert, Alexander believes that if the hospital ward environment was temporally poorer (Urry 2005:80) it would allow him more time to establish emotional care relationships with his patients which would lead to more informed decisions about his patients' care pathways. Alexander therefore believes that emotion assists decision-making rather than inhibits it. This is supported by Putnam and Mumby (1992 and 1993) and Ettlinger (2009) who demonstrated that rationality and emotion are inter-related. A degree of emotional connection to patients is therefore crucial to enhancing clinical decisions on the hospital ward. Furthermore, Mayall (2010) demonstrated that gut instinct and emotionally driven motivations were indispensable to traders on the trading



floor who had to make rational and objective decisions about whether to trade.

In agreement with Alexander's feelings of anxiety roused by the spatio-temporal constraints, Bolton (2001) reveals that many health professionals feel increasingly pressured, frustrated and anxious about the amount of time that they are able to spend with their patients due to increasing patient numbers and decreased human resources (Erickson and Grove 2007). In response to the temporary rich environment Bolton (2000) states that health professionals, particularly nurses, are becoming more creative about the time they give to their patients. Bolton (2000) shows that nurses are beginning to offer their time through "creative altruism" by resisting organisational and workplace rules and restrictions (Bolton 2000: 584). Similar to Bolton's nurses, Alexander, like many other health professionals, has learnt to be more creative and efficient with his time. This allows health professionals to provide more holistic patient-centred care to their patients reducing guilt and anxiety. For Alexander however, temporal creativity has not led to personal satisfaction, leaving him feeling frustrated.

The desire to become emotionally attached to patients and to be able to talk to patients on an emotional and social level is becoming increasingly important to health professionals who are becoming disillusioned, burnt-out and dissatisfied with the emotionally disconnected and disembodied medical model of care (Aldridge 1994; Allan 2001a; Bolton 2001). Alexander's motivations and desires for an emotionally connected patient-centred care are aroused by the need to increase patient satisfaction and to increase his own job satisfaction (Redinbaugh, Sullivan et al. 2003). An emotional geographies of care can help health professionals to become emotionally re-connected to their patients by emphasising that care work is an embodied practice and that the hospital ward is a place where emotions should be

expressed and shared but also contained, restrained and repressed where necessary (Milligan 2000; Milligan, Gatrell et al. 2004).

The desire to get to know patients on an emotional and social level was also emphasised by Gillian Bishop, director of nursing at St Joseph's Community Hospital, who, during an interview, revealed an increased need for nurses to return to the basics of care work.

*I think we've let some of the important nursing skills slip off the agenda in our quest to get more technical skills. Nurses nowadays value technical skills such as taking blood and all sorts of other technical things, but originally these things weren't part of the nursing role. I personally think that these skills have possibly been acquired at the expense of other things...like talking to patients, getting to know them on a social level and, erm; I guess an emotional level as well, reassuring people, erm, making them comfortable. You know it is the little things that make a big difference to patient care and to patients' experience. We need to get more involved with our patients.*

(Interview 19: Gillian Bishop, director of nursing, St Josephs Community Hospital 16/12/2008)

Gillian makes some interesting points about the shift in the organisational and cultural identity of nurses. Nurses' professional and workplace feeling rules have shifted from the care work that valued patient-centred care that focussed on emotional connections with patients, known as "primary nursing" (Lawler 1991; Smith 1991; Parker 1992), to a medical model of care valuing "distil nursing" (Malone 2003). This change in professional feeling rules has changed as nurses have gained more technical skills requiring them to focus on more task-orientated activities (Menzies 1970; Fabricius 1991; Bolton 2001). Since this paradigm shift, there have been calls for nurses to become re-established with the traditional emotional feeling rules of their profession. To bring back basic nursing competencies at St Joseph's

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Community Hospital, Gillian was in the processes of developing and implementing a program called "we care" which focussed on the basic nursing skills centred around "three C's of caring...compassion, communication and consistency". Gillian hoped that this programme would realign nursing care with an increasingly more place orientated, patient-centred approach to care work. She also hoped that it would address the guilt that some nurses experienced in struggling for an emotional attachment with their patients against their altered professional feeling rules. This program has since been formulated into the 6 C's (Department of Health 2012) supporting the findings of the Francis Report (Francis Report 2013c, 2013a, 2013b).

Whilst Alexander appeared anxious about his struggle to establish emotionally attached care relationships with his patients, these anxieties appear to be unfounded. Whilst shadowing Alexander over two days he was observed to have a very good rapport with the majority of his patients and was witnessed to perform emotionally attached care behaviours through his emotionally embodied practice as illustrated below.

*The team leave the critical care unit (CCU) and head to Kingfisher, a cardiac step down ward. A Male doctor (F2), John, summarises the patient as he glances over the patient's file. Alexander comments that he thinks that he remembers the patient from a previous admission and asks if this patient has returned. John confirms that Alexander remembers correctly. The group of doctors visit the patient's bedside. On entering the bay the patient calls out 'Dr Hopper! How lovely to see you!' and holds out his hand to shake it. Alexander rapidly walks to the patient and shakes his hand and then sits on the patient's bed 'How are you old chap?'*

(Ethnographic shadowing 05: Alexander Hopper, consultant cardiologist, cardiology. Broadwater General Hospital 27/08/2008)

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This ethnographic observation exemplifies that Alexander has established an emotional attachment with his patient, with their bodily proximity and informality emphasising their emotional care relationship. Unlike Robert, Alexander actively encourages bodily proximity by sitting on the patient's bed and sharing in the patient's personal space. Neither Alexander nor the patient are perturbed by the gesture of physical closeness suggesting that the emotionally connected relationship is reciprocal and desired (Schumann and Matthews 1998; Roter, Frankel et al. 2006; Evans and Thomas 2009). Alexander's act also removes doctor-patient bounded hierarchies, breaking down the power relationships that are created between the health professionals and their care recipients during the delivery of care.

This interaction not only demonstrates that Alexander has become connected to his patient through bodily proximity but also through surface acted emotional labour. Whilst it is evident that the patient believes Alexander's emotional performance, perhaps leading to an enhanced patient care experience, Alexander is unable to convince himself. This leaves him feeling distressed and emotionally ambivalent. This is emphasised in the ethnographic interview below.

*At the end of the ward round Alexander says that he would like a word with me and leads me into his office. Alexander takes a seat and I take one opposite. He says that he wants to talk through what I have seen today. Alexander makes it very clear that he feels very guilty and worried about the time that he spends with his patients. He tells me that he wishes that he could spend more time with his patients and that, if he was a relative, he would like the doctor to spend a lot more time with his loved one than he gets to spend with his patients.*

*Alexander continues that he would like to provide more holistic treatment to his patients. However, talking to patients to find out their social circumstances and well-being takes time, time that he simply does not*

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*have. Therefore he complains that he finds himself only concentrating on the medicine and...the hard facts... He seems worried that in doing this he could potentially miss something important. This predicament leaves Alexander feeling both stressed and guilty.*

(Ethnographic shadowing 05: Alexander Hopper, consultant cardiologist, cardiology. Broadwater General Hospital 27/08/2008)

Alexander blames his inability to establish an emotional connection with his patient on the ward's spatio-temporal constraints and shifting workplace and professionals' feeling rules, which only allow him to collect the "hard facts". This causes Alexander to perform emotional labour through surface-acted emotions. This results in the display of "respectable emotions" in which his "subjective feelings are distanced from his outward expression" (Milligan, Bingley et al. 2005:50). Alexander's internal emotional battle demonstrates that workplace feeling / emotional rules are an "integral feature of emotional geographies because they exist as essential cultural, [organisational and professional] guides or bridges through the complex and difficult pathways" of emotional care work (Hepworth 2005:189). Workplace feeling rules govern subjective emotions however they may be challenged and contested by personal feeling rules about how health professionals should perform care work. This emphasises the complexity of managing emotions in carescapes.

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#### SUMMARY

The section focussed on the spatialities of care that produce emotional distance between health professionals and their care recipients (patients, relatives and loved ones). The practical production of emotionally detached care work was realised through the embodiment of workplace feeling rules that value objectivity and rationality over emotionality (medical model of care). It also explored temporal frameworks which acted as defence mechanisms to reduce the time health professionals spent in care exchanges

with their patients, limiting their bodily proximity and haptic examinations. It rationalised that emotionally detached care work enables health professionals to rise above the emotional and affective fluxes and flows of emotions that patients and their relatives are immersed in. This allows them to maintain an emotionally bounded sense of self and perform professional emotionally detached care work. These emotionally distanced care performances are shown to be necessary not only in protecting the health professional from their patient's disruptive and destructive emotions but from their own disruptive emotions. It therefore preserves their psychological and emotional well-being and professional boundaries. Such emotional care behaviours also ensure consistency and equality of care across all patients. In addition, it illustrated how some health professionals are becoming disillusioned with detached care relationships and seeking ways to deliver more emotionally attached care against the spatio-temporal constraints. This led to contested internal struggles for health professionals as they tried to balance organisational or professional feeling rules against their own personal emotional feeling rules.

## 4.5 GEOGRAPHIES OF EMOTIONAL ATTACHMENT

Refocusing the spatio-temporal lens this section focuses on the embodied practices of care work that create emotionally attached care relationships between health professionals and their patients. In exploring emotionally attached care behaviours, emotional attachment is theoretically and conceptually framed through two lenses: emotional geographies and psychoanalytical geographies which illuminate the emotional and affectual dynamics of care work.

## EMOTIONAL GEOGRAPHIES OF CARE WORK

Focussing first on the emotional geographies of care work the extract below is taken from an ethnographic interview with Judith King, matron of the general medicine ward at St Joseph's Community Hospital during the first day of two ethnographic encounters. It illustrates how hospital wards that are "temporally poor" (Urry 2000, 2005) can facilitate emotional connections between health professionals and their patients. Temporally poor hospital wards are characterised by slow patient turn-over, reduced patient care activities and low patient mortality rates such as some care of the elderly wards or general medicine wards, where patients require limited or no medical intervention and maybe waiting for social packages before they can be discharged.

*Judith collects me from her office and we walk down the corridor to Wordsworth Ward 2 where we stand behind the nurses' station. Judith begins by checking the white board and looks through the files of the new patients that were admitted overnight. Judith talks me through the board commenting on the different types of patients that they have on the ward. She states that she has to read through the new patients' histories to make sure they have been placed on the right ward and get to know her patients. As Judith reads through the files I look at the board and comment that some of the patients have been on the ward a very long*

*time. Judith agrees and informs me it is because many of the patients are elderly with complex medical conditions and therefore their admission is extended. I note that one patient in particular has been here for three months and ask whether she finds herself building relationships with any of the patients. Judith looks up from the file and at the white board says, 'Oh, that's Gloria, mmm has she been here 3 months?...let me check her notes'. Judith leaves the file that she is reading and picks up Gloria's file and looks at the admissions page and then states (sounding surprised) 'three months is correct'. Judith admits that she does find herself getting attached to her patients, especially if they have been here as long as Gloria. She continues that Gloria 'should be elsewhere, but she is ours' explaining that Gloria is really sweet and all the nurses really like her. It would be quite strange if Gloria was no longer on the ward as 'she is a returning patient and it is always nice to have her back'*

*Judith continues to talk about Gloria and I discover that her husband was also in the hospital, but unfortunately had died during his last admission. Following the death of her husband Gloria had come in to see all the nurses with her grandchildren because she had wanted to see some 'friendly faces'. Judith reveals that she was really pleased that she had seen Gloria walk in unaided as it made her proud that her and her nurses had made a difference to Gloria's life so that she could spend some time with her grandchildren at this difficult time. Judith pauses and stares at the board, sighs and then says (sounding disappointed) that they had only managed to make Gloria well for 2 months out of the year and for the other 10 months she has been constantly in and out of the hospital. Although clearly defeated by illness and old age, Judith believes that she and the nurses 'have made a real difference to her life' and hopes that Gloria will get better again as 'she is such a lovely character'. It is evident from Judith's tone that Gloria's prognosis doesn't look good.*

(Ethnographic shadowing 14: Judith King, matron, general medicine. St Josephs Community Hospital 25/03/2009)



This ethnographic interview is illustrative of emotional attachment in care work. It raises an important point for care work informed by an emotional geographies lens; geographies of ownership and belonging.

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#### GEOGRAPHIES OF OWNERSHIP AND BELONGING

The ward's temporally poor environment and Gloria's status as a returning long stay patient has resulted in Judith becoming emotionally attached to her. This has led her to experience a sense of ownership over Gloria, which was emphasised by Judith's comment that "she should be elsewhere but she is ours". Judith's emotional connectivity with Gloria is witnessed not only through Judith's description of their relationship, but with her emotional talk surrounding her relatives; her husband and her grandchildren. This level of emotional attachment in the patient care relationship was advised by Peabody who stated "you must know his family and friends" (Peabody 1927:817).

Setting Gloria within her familial context humanises her, allowing intimate emotional connections to flourish, as patients are regarded as people and not a set of disembodied, dismembered body parts. These emotional connections benefit health professionals through meaningful therapeutic relationships (Schumann and Matthews 1998; Larson and Yao 2005). In talking about her frustration caused by Gloria's increasing ill-health however, Judith's tone begins to change and there is an indication that Gloria's ill-health is causing the nursing team's emotional performances to become more laboured. A change in emotional labour may result in a change in the emotional care relationship offered to Gloria. This relationship may shift between one that is emotionally attached to an increasingly emotionally detached care relationship as Gloria's risk of death increases. The notion of "ownership" therefore may shift over time or as the patient's risk of mortality increases.

Whilst Judith displayed a sense of ownership over Gloria, Judith perceives

that Gloria reciprocated these emotions by feeling an emotional attachment to the ward and the health professionals working within it. This may have resulted in a sense of belonging. Gloria's sense of belonging was established and strengthened through her long admission which enabled her to become emotionally attached to the nurses on the ward. Gloria's sense of belonging or "emotional affiliation" (Wood and Waite 2011:201) to the ward and the nursing team was illuminated through Judith's narrative about Gloria's return to the ward following the death of her husband, in which she returned not as a patient but to "see some friendly faces".

A sense of belonging is regarded as an "affective act" (Probyn 1996; Wood and Waite 2011). Gloria longed and yearned for some emotional support and comfort in a place in which she felt safe and secure, at a time when she felt most vulnerable, isolated and insecure. As Gloria had been admitted to this ward on several occasions in the past, when she was medically and physically vulnerable, she felt that it could provide a "therapeutic retreat" (Armstrong 2005) or an "emotional refuge" (Fields 2011:258) during this emotionally distressing time. The hospital ward therefore has an affective and emotional identification (Caluya 2011:204) for Gloria as a place of emotional care and support.

Gloria's sense of belonging outside of the patient care boundaries demonstrates a wider affective relationship between herself and the nurses. To provide care to Gloria outside of her capacity as a patient the nursing team must employ emotion work to support Gloria, which is not provided as part of their waged labour. By providing care through emotion work Judith's nurses give a part of their emotional selves to Gloria (Bolton 2000b; Erickson and Grove 2008; Deery and Fisher 2010), which strengthens their emotional affiliation. This is emphasised further when Judith is observed to bend the workplace rules to allow Gloria to stay on the ward, even though she should be relocated. In an ethnographic shadowing with consultant geriatrician

Madeline Marsden workplace rules were also bent to allow two elderly patients to remain in her care on the elderly ward.

*...‘Next patient?’ Sam (F2) collects three patient files from the trolley and tells Madeline that they are moving along to Flo and Doris. Madeline turns to me and tells me that these patients have been on the ward for a long time and that they are purely waiting on social packages. They therefore require limited examination. She informs me that the two ladies have become inseparable since they have been admitted and have enjoyed their stay because they have spent all their time chatting and gossiping. She continues that she needs to transfer them to another ward so they can free up some bed space, but they are reluctant to move one without the other, because they have become such great friends, which has meant that for now they will remain on the ward.... Madeline states that they will ‘certainly be missed’ by the nursing staff and herself, as they have been around for so long and have great characters.*

(Ethnographic shadowing 16: Madeline Marsden, consultant geriatrician, care of the elderly. Royal Alexandra University Hospital 30/03/2009)

In both Madeline and Judith's ethnographic examples it is made clear that these patients are logistically “out of place” or “outliers”. A sense of ownership or an “affective affiliation” (Wood and Waite 2011:201) however, has allowed these patients to remain on the wards. It is here that we see a contrast between Robert’s fear that his patient in the side room would be perceived as having preferential treatment and these patients receiving preferential treatment due to their emotionally attached care relationships with the health professionals caring for them.

The emotional attachments were not only established through the length of time that these patients had spent on the ward, but also due to their pleasant characters. Whilst it can be demonstrated that Madeline and Judith provided these patients with emotional gifts through altruistically motivated

behaviours related to their sense of ownership, it could also be suggested that these gifts could have been bestowed due to ulterior motives (Erickson 2005; Erickson and Grove 2007; Erickson and Grove 2008) because “spontaneous goodwill...is [often] an insufficient explanation for emotional gifts” (Cohen 2010b:213). These patients have been allowed to stay on the ward because they were deemed “good patients” and therefore less emotional labour was required to care for them. Zappi and Epstein (2000) however stated that “caring is a charitable act and occurs regardless of liking the patient” (Zappi and Epstein 2000, cited in Larson and Yao 2005:1105) and therefore health professionals should provide equitable care regardless of whether patients are well liked or less challenging.

Due to the emotional demands of caring for challenging patients health professionals were however observed to bend organisational rules to protect themselves from burn-out, fatigue and poor job satisfaction. During static ethnographic observations on Wordsworth Ward 1, for example, a general medicine ward at St Joseph’s Community Hospital, nurses were overheard stating that they did not want a patient to be moved as this would result in another patient occupying the bed. This incoming patient was a well known returning patient and was deemed both “rude” and “ungrateful” by the nursing staff. To care for this patient required intensive emotional labour, with nurses working hard on their emotional performances to display “empty emotions” through surface acting (Bolton and Boyd 2003:301; Larson and Yao 2005).

In her study, Bolton (2001) found that nurses worked harder on their emotional labour with challenging patients (Bolton 2001:94; Hall, Horgan et al. 2002; Roter, Frankel et al. 2006). Bolton and Boyd (2003) also found that cabin crew had to work harder at their emotional performances with “obnoxious” clients, giving vacuous performances which led to dissatisfaction in both cabin crew and clients.

## PSYCHOANALYTICAL GEOGRAPHIES OF CARE WORK

Thus far this chapter has explored the emotional geographies of care work by focusing on the emotional performances of health professionals as they manage their conscious emotions to become emotionally attached or detached from their patients through embodied care practices. The remainder of this section will continue to analyse the emotional connectivity between proximate bodies in care work, however it will be analytically framed by psychoanalytical perspectives (Freud 1937; Klein 1946; Bion 1984; Klein 1997). Psychoanalytical theories will be used to explore how unconscious emotions and affects in care relationships are shared, circulated, concealed and repressed in emotional care work through bodily proximity and touch (Edwards 1998; Parr 2005; Patterson 2005) and transferred between bodies via affective pathways or channels (Patterson 2005; Ticineto-Clough and Halley 2007).

Drawing on the psychoanalytical theories by Freud and Klein the following extracts explore how unconscious emotions and affects have an impact on the connections, exchanges and interactions between health professionals and their patients. A focus on psychodynamic care relationships emphasises that emotions and affects are not placed within the individual but are increasingly more collective and shared experiences within an “affective atmosphere” (Anderson 2009) or “emotional climate” (Stringer 2002). In focussing on the management of unconscious emotions, the role of therapeutic touch and empathy via the psychoanalytical processes of projection, transference and counter-transference are the focus. Additionally, a focus on psychodynamic care relationships emphasises the movement of emotions within a person’s body and between bodies interiors and exteriors (Larson and Yao 2005; Parr, Philo et al. 2005).

Furthermore, a psychoanalytical approach illuminates how unconscious private emotions enter the public sphere of the workplace through "unforced

authentic emotional expression" (McClure and Murphy 2007:104), resulting in health professionals simultaneously managing their emotions through emotion work (private) and emotional labour (public). The infiltration of emotion work was witnessed earlier in Judith and Gloria's extract when Gloria returned to the ward outside of her capacity as a patient. In the extracts that follow emotion work enters the public sphere through both conscious thought and private emotional slippages. This demonstrates the complexity and challenges of emotional care work and how boundaries of private and public emotions can easily become entangled, blurred and less easy to define.

The narrative below is taken from a storytelling interview with Dr Nikhil Chopras, a registrar specialising in obstetrics and gynaecology at Broadwater General Hospital. It emphasises the importance of managing emotions within a therapeutic space (Gesler 1992; Gesler 2003; Milligan, Gattrell et al. 2004) to perform empathy with patients (Larson and Yao 2005; Parr, Philo et al. 2005).

*"...I feel comfortable controlling my emotions, so that it doesn't affect patient care. Obviously if you let your negative emotions get in the way then you are an unsafe doctor...period! But as long as you are there, looking after your patients and empathise with them.... It is very important to empathise Emma, I can't tell you how important that is ... If you don't feel for what they feel you will not be sensitive enough then they will not feel it...you know we talked about positive vibes, we talked about all that affecting the patient...you know it is very contagious..."*

(Interview 01: Nikhil Chopras, consultant obstetrics and gynaecology. Broadwater General Hospital 30/06/2008)

Frankel defines empathy as the "recognition and reflection of the patient's feelings" (Frankel 1995:163), whilst sympathy "more directly involves the [health professionals] own experiences and are more powerful, although are

less open to conscious control” (Frankel 1995:163). Using Frankel’s definitions of empathy and sympathy we observe that health professionals manage patients’ emotional projections through deep-acted emotional labour (Halpern 2001; Larson and Yao 2005). This has been termed as “faking in good faith” (Rafaeli and Sutton 1987). Sympathy in contrast, is a product of health professionals (un)managed private emotions entering the workplace requiring emotion work.

Empathy has been shown to be “fundamental to caring and enhances the therapeutic potential of health professional / patient relationships” (Larson and Yao 2005:110). Health professionals, who display empathetic care, are regarded as more effective carers due to the establishment of affective bonds. These bonds strengthen the emotional connectivity between health professionals and patients within the therapeutic carescape (Larson and Yao 2005; McCreight 2005). This results in “patients being more forthcoming about their symptoms and concerns, thus facilitating medical information gathering, which in turn yields more accurate diagnosis and better patient care” (Halpern 2001; Larson and Yao 2005:110).

For health professionals to perform empathy their bodies need to be receptive to patients’ projections. They must become a blank canvas for patients’ feelings, emotions and affects to be inscribed (transferred) upon. The projection of emotions onto proximate bodies enables health professionals to sense and understand how patients are feeling. Nikhil’s extract indicates that health professionals are aware of the psychoanalytical process of transference and counter-transference within care interactions. It also demonstrates that they are able to use these processes to reassure and emotionally support their patients through physical touch and the movement of affects or “vibes” through the therapeutic space of the hospital ward. Nikhil therefore shows that emotions are not bound within the body, but flow back and forth in an affective dialogue to produce an “affective

ambiance” (Hubbard 2005:124). The body is therefore a “site of spatial orientation” that allows us to experience and understand the world from others perspectives through our “social skin” (Low 2003:10).

The proceeding extract is also taken from a storytelling interview with Dr Nikhil Chopras. In this candid narrative, Nikhil tells a story about the delivery of a still born baby and demonstrates the importance of doctors being emotionally and “psychologically more present” in their interactions with their patients (Hirschhorn 1990:144 ; Kahn 1992). It also emphasises how both health professionals and patients’ unconscious emotions become entangled within place during care work (Bondi 2005b), especially during emotionally traumatic events (Lewis 2005; McCreight 2005; Kenworthy and Kirkham 2011) where “painful emotions” may arise (Willis 2009). This extract therefore emphasises that bodies and emotions and the spaces they inhabit are inseparable (Duffy, Waitt et al. 2011).

*ER “Can you give me an example of when you provided good patient care?”*

*NC “...I think that ...there are a group of patients that... probably need a little more care...not just physically but mentally as well. And I think that one of them was this lady who...came to the labour ward... she told me that she hasn’t felt her baby move in the past one day and she had had some bleeding... obviously there were some concerns on my behalf for the baby. This was a very wanted pregnancy because this was an IVF pregnancy. I examined her a little bit, erm...and on examining her I found that the baby did not have a heart beat... I think...I can only just imagine what that patient must have gone through, erm. I don’t think that there could be anything worse than losing a baby, because it can be exceedingly traumatic. It is not only traumatic for her but her relatives; you can see couples completely shattered by the news that I have just given them. Obviously as a human being I do have emotions as well and*



*it wasn't the best of times at all. Erm, sometimes it does affect you, working on the labour ward there is this one side that is a really huge roller coaster ride where you know you are delivering someone and there are smiles all the way, on the other hand you have certain people who come to the labour ward and unfortunately deliver dead ones, which is not the nicest thing to do, yeah, it gives me the creeps just thinking about it.*

*...I did explain everything to her and obviously, as a doctor responsible for her, I need to follow all the procedures. You know I explained it to her that this is by far something that words cannot express... You can imagine how difficult this situation would be and erm, however, if we could make it the slightest bit better, we would try everything in our power you know to make the situation a lot more comfortable. I ensured that she was given a quiet room with a very good midwife, obviously I had my duties towards the rest of the labour ward as well....*

*We... induced her because we did not want her to go home with a dead baby inside her. It was a very very painful and stressful scenario, it really really was, it was horrible, absolutely and it is very distressing, exceedingly, exceedingly distressing because you know the woman is going through all that pain of labour. And labour is by far one of the worst...I'm glad that I am a man. It is exceedingly painful and I don't know how women take it, and you know at the end of the day still have smiles on their faces. Probably because usually it is a good outcome. But in her case it was even worse, she is going through all that pain knowing that at the end of the labour she is giving birth to something that will not survive...It was very very stressful. So my job was to go in and make sure everything was up to date and that she knew exactly what was happening. I was with her most of the time, but I booked her three-four counselling sessions where she could go down and talk about her emotions and it is nice to get your emotions out at times. I tried to make*

*it a point that I was present, present as much as I possibly, feasibly could be during her emotional outbursts. I wanted her to have all the support that she needed. I did also find that...I did get attached to the patient, being around her, trying to get her care, even if I was out of hours, which means that when I was not meant to be in the hospital. Now I think that some people will argue that, that is a bit over the top, but... I guess that that is medicine for you...It is about lives, and sometimes you have to make that extra effort, to make that person feel that little bit more special.... I thought she would feel a lot more reassured if she saw the same doctor coming in and making sure that she was ok.*

*Well, you know that when things get worse, they get worse!...ultimately what happened with her was that we tried all the induction of labours, we tried everything possible to get that baby out ...it failed!. I can't... tell you how dreadful that scenario was, that she needed a caesarean section to have that baby out....I wanted to make sure that I was present at the caesarean section as well so that she would have a face that she knows...Can you imagine going through a caesarean section, to have a baby...That scar will remind her of her dead baby for the rest of her life!..*

*While she recovered from her caesarean.. I saw her every single day on the post natal ward, obviously she wasn't quite on the post natal ward because of course post natal wards are where women are there with their babies and she didn't have one. So she was in the corner of the labour ward. And I saw her and... made a point not to neglect her, or... her partner because people assume that the only person going through the trauma is the woman... but they are a couple... And he appreciated that quite a lot... They went home. Two weeks later I received a lovely letter, which kind of expressed a lot of gratitude.*

(Interview 01: Nikhil Chopras, consultant obstetrics and gynaecology. Broadwater General Hospital 30/06/2008)

Nikhil's monologue illustrates three important considerations for psychoanalytically informed geographies of emotional care work. First, it demonstrates how emotions are contained during medical crisis. Second, that health professionals are able to communicate emotion and third, that emotional gifts are presented during care work.

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#### GEOGRAPHIES OF EMOTIONAL CONTAINMENT

According to Isabel Menzies' work with nurses, the majority of hospital work contains a "constant sense of impending crisis" (Menzies 1970:26). This results in an environment which is highly stressful and anxiety producing (Allan and Barber 2005). Whilst Menzies' research focussed on nurses, it has been noted that anxiety increases with greater medical responsibility and therefore matrons (Allan and Barber 2005) and doctors, especially consultants and registrars, who have ultimate responsibility for their patients' and medical team's behaviours, may experience the greatest anxiety (James and Huffington 2004).

To cope with anxiety in crisis, health professionals must become an "emotional sponge" (Allan and Barber 2005; Allan and Smith 2005:24) to soak up, contain and manage their own, colleagues' and patients' emotions and "keep them at distance from... their conscious" (Freud 1937; Erwin 2003; Parr 2005:89). This helps them to perform and display a bodily exterior that is "professionally calm" (Allan and Barber 2005:28; Allan and Smith 2005).

As the story commences the patient's anxiety is clearly visible as she relays that she has not felt her baby move and has suffered some bleeding. Nikhil attempts to contain his patient's anxiety by conducting medical examinations that are expected by the patient (McCreight 2005). Following NHS procedures and conducting task orientated activities helps Nikhil to contain his own anxieties within the taskscape. Like Robert, Nikhil also uses the workplace rules and guidelines as a "defence against anxiety" (Menzies

#### CHAPTER 4.5: GEOGRAPHIES OF EMOTIONAL ATTACHMENT

1970; Allan 2001b) to help him repress and contain his emotions. Repression is defined as the process by which an “unacceptable impulse or idea is rendered unconscious” (Parr, Philo et al. 2005:89). Following guidelines and engaging in task orientated behaviours, enable health professionals to focus on other aspects of care work, pushing traumatic emotions to the unconscious. This may cause them to display emotionally detached care behaviours towards their patients as witnessed in Robert’s ethnographic tale.

Whilst Nikhil has a medical responsibility for his patient during this crisis, he also has responsibility for his other patients. In leaving this patient to fulfil his duty of care to his other patients, Nikhil is able to gain "emotional refuge" (Fields 2011) and solace through delivering healthy babies. Engaging in less emotionally strenuous care work, bolsters Nikhil’s emotional spirit and provides an emotional respite from the emotional burden created by this crisis.

Carrying out other care duties however, induces Nikhil’s private emotions (guilt) to enter the public sphere. Klein states that “feelings of guilt drive people towards sacrificing themselves completely to a cause or to their fellow beings” (Klein 1946:259). Nikhil therefore is seen to be sacrificing himself to the patient and her husband, by being increasingly more visible and “psychologically present” (Hirschhorn 1990; Kahn 1992) going beyond his “normal” duty of care (workplace rules) and giving a piece of himself (his time) thus satisfying and containing his guilt. Meier, Back et al. (2001) also witnessed doctors responding to their patient with their own emotions to construct a “sense of their [emotional] self” (Meier, Back et al. 2001:307). Bolton’s research with nurses also demonstrated that health professionals were able to move beyond workplace rules “at their own discretion...to add something extra to the patient / carers relationship” (Bolton 2000b:582).

Nikhil’s behaviour therefore suggests that he is aware of his emotional slippage and that he is attempting to manage it carefully through emotion

work to keep a professional performance. Nikhil therefore illustrates that health professionals are skilled emotion managers who can simultaneously manages both private and public emotions within this care interactions (Meier, Back et al. 2001).

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#### COMMUNICATING EMOTIONS

Second, the psychoanalytical processes of transference and counter-transference demonstrated in Nikhil's narrative illustrates how health professionals communicate emotion during patient interactions. Meier, Back et al. stated that doctors should be aware of these unconsciously projected emotions and manage them carefully, even if the root cause of the patient's emotion is unknown (Meier, Back et al. 2001:302). In this extract, Nikhil has a clear understanding of the root cause of the patient's emotions, which makes interpreting her emotions less challenging.

In the narrative the patient unconsciously projects and transfers her emotions on to Nikhil's body via "projective identification" (Klein 1946) as she desperately tries to rid herself of the terrors related to her still born baby (Moylan and Jureidini 1994). During this transference, Nikhil experiences the patient's emotions and attempts to manage and contain her "disruptive" (Parr, Philo et al. 2005) and painful emotions (Willis 2009) through counter-transference. However, during traumatic events health professional's unconscious emotions can become entangled making it difficult to provide effective empathetic care.

At three junctures in the monologue, emotional entanglements are witnessed as Nikhil's unconscious emotions surface through emotional slippages resulting in the audience wondering whose emotions Nikhil is communicating (see Thomas' debates about geographers use of psychoanalysis in narrative data analysis and "listening for the unconscious" (Thomas 2007:540)). The first two emotional slippages are illustrated when

Nikhil describes the situation as “very painful and stressful” and “horribly distressing”. The audience is unclear whether Nikhil is communicating the patient’s physical pain of labour and her distress in having to deliver her still born baby or his own emotional pain and stress in having to be responsible for the management of his own, his colleagues’ and the patient’s emotions during this medical crisis. Nikhil, it seems is communicating both.

The final emotional slippage is observed when Nikhil states “it’s nice to get your emotions out at times”. Whilst Nikhil is referring to the benefits for the patient in talking to a counsellor he also indicates that talking about emotionally difficult medical situations can also be a cathartic experience for health professionals. This was echoed at the end of the interview when Nikhil expressed his pleasure in taking part in the research because it had allowed him to talk through situations and emotions that he had not discussed before. This statement also connects to discussions made earlier in the methodology chapter by emphasising that emotional geographies (of care work) are “talk-able” (Parr, Philo et al. 2005:99). Nikhil’s admission that he had not communicated this emotional burden to other health professionals also exemplifies the NHS’ organisational and professional culture. Talking to colleagues about emotional experiences are regarded as taboo (Bolton 2000a, 2001).

Whilst Nikhil’s emotional slippages demonstrate the complex emotional entanglements that occur within the emotional topography of the hospital ward, it also provided examples of how health professionals can become interlocutors (communicators) of their patient’s emotions. To become an effective interlocutor health professionals must establish emotional attachments with their patients. These emotional attachments are recreated through deep acted emotional labour where health professionals “force themselves” to imagine and “visualise” the world through their patient’s eyes so that they can better understand what their patient is feeling (Bolton

2000b; Halpern 2001; Larson and Yao 2005). Health professionals can also become interlocutors of emotion through accessing their own personal experiences and emotions through emotion work. The ability to draw on personal emotions to aid emotional connectivity between bodies demonstrates that emotions are inter-relational (Rowles 1978a; Milligan, Gatrell et al. 2004; Duffy, Waitt et al. 2011).

In Nikhil's narrative he illustrates the internalised emotional conflicts described above. Nikhil shows how he uses workplace feelings rules to perform emotional labour and draws on organisational rules and guidelines to protect him from the emotional stresses of the scenario thus demonstrating emotional detachment from the patient. Conversely, Nikhil admits that he became emotionally attached to this patient and therefore this emotional connection forces him to manage both his conscious and unconscious emotions showing the interplay of emotional labour and emotion work within care work.

Moving on from Nikhil's narrative, the following extract is taken from a ward round with consultant geriatrician Chloe Stanmore. It demonstrates how affects in emotional care work are communicated and transferred through affective pathways or channels (Patterson 2005) created by bodily proximity or touch (Edwards 1998; Parr 2005; Patterson 2005) to create empathy. Chloe was shadowed for three days and participated in a semi-structured interview.

*Chloe asks the patient about the pain in his arm. He says it hurts. Chloe asks if he minds her taking a look. She walks round to his right hand side and bends over his arm. His arm is bright red, hugely swollen with angry red lumps all over it. Chloe comments 'oh, that looks sore!' She gently strokes the man's arm with her finger tips and he winces and cries out with pain. Chloe is quick to apologise and sounds sincere and genuine 'oh, I am sorry...yes I can see that hurts'. She continues to touch his arm*



*'oh, it is weeping let's get that cleaned up shall we?'* Chloe asks Richard, her registrar, to get some sterile wipes and he returns several seconds later.

*Chloe apologises in advance that it will hurt him. As she gently wipes the weeping sore the patient's face screws up and he begins to cry, bowing his head tears roll down his face and he makes muffled noises as he tries to prevent himself from crying. Chloe stops wiping his arm and tries to console him by rubbing his shoulders and telling him that she will get him some more pain relief. Seeing this patient cry is really upsetting and I feel my stomach drop and it feels hollow inside, I get an ache in my chest. Chloe looks up to the doctors and asks quietly if they had seen this man cry before. The doctors say that they haven't. The man continues to sob wiping his eyes with the back of his hand. Chloe crouches down in front of the patient and looks directly at his face. She takes his other hand in hers and apologises for hurting him. He mumbles something in-between sobs and Chloe explains he has had an allergic reaction to the IV fluid, needle or the surgical tape. She says she hasn't seen this happen before but they should have the test results soon to find out what he is allergic too. The man continues to sob pointing at his arm. Chloe tells him that she will get something to reduce the pain. She stands, hand resting on his shoulder, and looks around her team with a pained expression.*

*The nurse enters... 'oh...is he alright? What's wrong Mr Thomas?' ...Chloe explains ...She then asks the nurse if she had seen him cry before. The nurse replies 'no'. Chloe and Richard discuss the patient's care pathway, Chloe keeps her hand resting on the patient's shoulder...occasionally rubbing it...Chloe crouches back down to the patient and tells him they will be sorting his pain relief out and that Richard will return when the test results come back. She rubs his shoulder 'are you ok now?' The patient mumbles that he is in pain and*



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*Chloe empathetically says 'I know...I'm sorry...we will sort it out for you...(stands and puts her hand on his shoulder)...I promise... (moves her hand to the top of his head and pats it)...ok?' The patient looks up at Chloe and nods, a tear rolling down his cheek.*

(Ethnographic shadowing 17: Chloe Stanmore, consultant geriatrician, care of the elderly, Royal Alexandra University Hospital 09/04/2009)

Using her body to establish an emotional connection with her patient, Chloe's ethnographic extract details an interesting discussion point for a geographies of emotional attachment which is informed by a psychoanalytical lens. Chloe illustrates that through bodily proximity and touch health professionals can enter into a therapeutic relationship with their patients. This enables health professionals to gain haptic knowledges of their patient's internal feelings as they move between and within body interiors and exteriors.

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#### INTERLOCUTOR OF PAIN

In the previous extract, Nikhil was observed to become an interlocutor of his patient's emotions through bodily proximity. However, in this extract we observe Chloe becoming an interlocutor of her patient's pain through touch and haptic knowledge. Crossley (1996) states that the phenomenon of pain and our relationship to it, whether someone else's or our own, is more immediate than our reflective knowledge; we therefore do not think about pain but react to it (Crossley 1996:37). The sensation of pain is therefore highly inter-subjective. Chloe's exterior bodily reaction (facial expression) in response to her patient's interior sensation demonstrates the porosity of bodily boundaries and that she is able to identify and empathise with the patient due to her own embodied experiences of pain (Low 2003).

Chloe's reaction to her patient also demonstrates a sense of guilt, frustration and responsibility for causing the pain. To absolve her guilt Chloe tries to rectify the medical error as quickly as possible by providing the patient with

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pain relief and rushing his test results through the lab. In an attempt to manage her guilt she also dissolves responsibility for the patient's pain stating that he had an allergic reaction to medical equipment. In externalising the cause of the pain and projecting the blame onto material objects, Chloe is able to transfer her guilt placing the blame outside of her own body and relieving herself from destructive emotions (Klein 1997).

In addition to the medical procedures Chloe also tries to absolve the patient's pain through counter-transference. Chloe is seen throughout the extract to rub the patient's shoulder and pat the patient's head to incite and transfer reassurance in her patient. Holding or resting her hand on the patient's shoulder for extended periods of time allows emotions to mobilise through and between Chloe and her patient's body, enhancing the emotional connections between them. This also extends the therapeutic processes of transference and counter-transference.

Chloe's bodily deportment also displays a mothering role as patting the patient on the head reflects a patient / child relationship. This imagery extends the notion that care work is an inherently gendered occupation (Brooks and MacDonald 2000). This is emphasised by Davies (2003) who states that the health "profession is mothering - grown-up folks when very sick are all babies" (Davies 2003:742). The analogy of a mother and her child is accentuated by the patient's crying.

Similar to Chloe, Madeline Marsden, consultant geriatrician at Royal Alexandra University Hospital demonstrates how emotions are mobilised through the body in proximate care relationships and through therapeutic touch. The extract below is taken from an ethnographic shadowing with Madeline during one of her morning ward rounds across a care of the elderly department.

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*'Hello Mrs Campbell, I'm Dr Marsden, your consultant and these are my doctors and ward sister, we have come to see you this morning'. The patient looks up ...with a blank expression and doesn't respond. The ward sister comments that the patient can't hear very well. Madeline leans her body over the patient's body, with her face close to the patient's and repeats herself in a slower and louder voice.*

*Madeline asks the patient if she is comfortable and the patient shakes her head 'no I didn't think so, let's see if we can move you up the bed shall we?' Madeline asks the Ward Sister, Sarah if they will need to move the patient using the red sheet. Sarah nods and reaches underneath the patient's bed and produces the sheet. Madeline asks Sam, her SHO, to help her move the patient and he walks round to the side of the bed and stands next to her ready to help. Felicity, Madeline's registrar, says that she will help Sarah. Andy, Madeline's SHO (F2), and I stand and watch from the foot of the bed.*

*Sarah uses a remote control to flatten the bed. As the bed lies flat the patient yelps in pain, Sam quickly takes the patient's hand and begins rubbing the back of it and offering some encouraging words...'I know...I'm sorry we will get you comfortable soon'. With the bed flat Madeline looks over the controller and asks where the button for raising the bed is. Sarah walks to the end of the bed and presses a few buttons and the bed rises to waist height.*

*...[With the bed] in position Madeline explains to the patient how they are going to move her and asks the patient if she is ready. The patient nods. Madeline follows Sarah's instruction...Madeline asks Sam what side the patient has her fractured leg on so that they can take extra care of it....As they gently roll the patient she again yelps in pain. Andy winces and moves swiftly around the bed to help the team move the patient, to prevent further pain. Sarah begins roughly pushing the sheet under the patient's body and tells the others that they will need to roll her more on*

*her side so that she can get the sheet under properly. The more they move the patient the more she yelps and it is upsetting. It seems Andy also finds the patient's pain upsetting, as he has a look of anguish and pain across his face. The patient's screams shoot through my body. I momentarily shut my eyes and hunch my shoulders as my body recoils from the noise. Finally the sheet is placed under the patient's body and... they...roll the patient back towards them.*

*...Madeline apologises for putting her through the pain and she lifts her arm and taps Madeline muttering 'it's ok, it's ok'.... Madeline informs the patient that they will be rolling her on the other side now and tells the team to be extra careful as she will be rolling onto her fractured leg and asks Andy if he will concentrate on trying to minimise the pain to the leg. The patient she lets out a blood curdling cry and clings on to the bed sheets. Felicity offers the patient lots of encouragement and reassurance as Sarah and herself hold her in position. Madeline and Sam pull at the red sheet.*

*Once the sheet is in place they roll the patient onto her back. Again she cries out. Madeline takes the patient's hand and begins rubbing the back of it with her hand and offers kind words of reassurance and explains that there is just one more step and then she will be more comfortable....On Sarah's count they shift the patient up the bed. With the sudden movement the patient yelps again and closes her eyes tight with pain. Madeline pats the patient on the head and reassures her that 'all the big movement is done', Andy rubs the patient's legs gently through the bed sheets in reassurance... 'Is that more comfortable?' the patient mumbles 'yes'...Madeline stands back from the bed for a couple of seconds, hands on her hips with a sullen expression.*

*Madeline looks up at Felicity and tells her that the notes written by the other doctor are inaccurate and that she is to write in large print that the patient is in a great deal of pain. As Felicity writes in the patient's notes*

*Madeline asks what pain killers the patient is on and then changes them to a stronger type and dosage. She tells Felicity that orthopaedics need to treat this patient immediately as she cannot stay on the ward without any further treatment. Felicity nods as she follows Madeline's instructions.*

(Ethnographic shadowing 16: Madeline Marsden, consultant geriatrician, care of the elderly. Royal Alexandra University Hospital 30/03/2009)

This extract offers two points of consideration for geographies of emotional attachment in care work. First, it reemphasises the inter-subjectivity of pain and how health professional's bodies can be used as interlocutors of pain. Second, it demonstrates that the psychoanalytical processes of transference and counter-transference are not unidirectional in the therapeutic relationship between health professionals and their patients. Instead the processes are multi-directional. This change in direction is caused when health professionals are unsuccessful in managing their emotions resulting in unconscious emotional slippages between bodies.

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### .....THERAPEUTIC RELATIONSHIP

The inter-subjectivity and affective properties of pain are highlighted in this extract as the whole of the medical team become affected by the patient's internalised pain as it reaches her bodily exterior and is released into the therapeutic space of the hospital ward through her cries which penetrate those bodies in close proximity. Flowing through proximate bodily boundaries the physical reactions to patients' pain are clearly observed on our bodily exteriors; Madeline and Andy wince and screw up their faces and I contract my body. This demonstrates our shared embodied experience of pain and that our bodies have become interlocutors of pain, thus acknowledging an affective connection between health professional and patient. It is this connection that enables health professionals to provide empathy to their patients.

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Whilst the health professionals' reactions demonstrate a shared embodied experience and an affective connection with the patient, other behaviours suggested that they feel guilty for aggravating the patient's pain. To absolve her own guilt and gain reparation Madeline adopts the same defence techniques as Chloe, as she projects her blame onto other objects – the other consultant, who did not provide adequate pain relief. Madeline is also perhaps frustrated with this consultant because his oversight has resulted in her team having to engage in intensive emotion management to cope with the patient's pain and the emotional and physical reactions it provokes.

Through touch emotions are able to flow between bodies in channels through processes of counter-transference helping Madeline to sooth and suppress the patient's pain through an emotional analgesia. It is not only the patient's pain however that is being suppressed and numbed by reassurance. Fabricius (1991) states that health professionals provide reassurance when they refuse to accept their projections; this is elucidated by her quotation:

*'Reassuring the patient was like isolating a fire with a fire blanket, it stopped you catching alight too and left the patient burning alone'*

(Fabricius 1991:102)

Reassurance therefore in many care interactions can act as a defence mechanism to protect health professionals from patient's projected emotions. However, pain appears to transcend these defence mechanisms and does not seem to be able to be halted. The short, sharp fleeting nature of this patient's pain moves too quickly between the patient's and health professionals' bodily interior-exterior for health professionals to erect their defence boundaries. The embodied experiences of pain therefore course through the permeable boundaries of the body, leaving as quickly as it entered. The fleeting nature of this patient's pain may inhibit emotion management, however health professionals providing emotional care work for a patient

with persistent chronic pain may be able to build defence mechanisms, isolating the patient's pain and allowing them to experience it alone.

Due to her inability to manage the embodied sense of pain Madeline's emotional defence mechanisms may have become weakened, allowing her private emotions to enter the workplace. This inadvertent transference suggests that Madeline has inadequately contained her guilt. The patient responds to Madeline's guilt with reciprocated touch allowing the patient's emotional response to pass back between her body through counter-transference. The patient's counter-transferred emotions are accompanied by a verbal reassurance that she is ok. This gesture does not extinguish Madeline's guilt as, like Fabricus' fire blanket, it acts like an empty gesture. Madeline therefore needs to regain control over her emotions which she does by physically distancing herself from the patient and the care activities performed by her medical team. This enables a degree of emotional detachment from her patient allowing her to provide care work through an emotionally balanced performance.

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#### EMOTIONAL GIFTS

Finally, returning to Nikhil's original narrative, the concept of a gift relationship is emphasised. The term "gift relationship" (Titmuss 1970) or "emotional gift" (Bolton 2001) has been regarded as more aligned with the work of the health professional as "there is no expectation of a return on their investment except to make a difference" (Titmuss 1970:245; McQueen 1997; Erickson and Grove 2008) as we saw earlier in Judith and Gloria's extract. However, in this section I analyse the provision of emotional gifts through a psychoanalytical lens by demonstrating that emotional gifts may be motivated by the need for atonement and reparation of guilt (Segal 1988; Klein 1997; Stephen 2000).

McCreight (2005) analysed nurses' emotional responses to termination or still birth on a labour ward and showed that nurses often struggle to cope with the feelings of guilt and anxiety associated with the loss of a dead baby (Lewis 2005; McCreight 2005; Kenworthy and Kirkham 2011) because the "death [of a baby is] regarded as a [medical] failure" (Mander 1994, 2000; Hunter 2001; McCreight 2005:439). Nikhil's narrative reflects this research and demonstrates that such emotions are also experienced by doctors. In response to a series of medical "failures" Nikhil seeks atonement by going beyond his duty of care to provide the patient a wealth of emotional gifts. Drawing on Melanie Klein's object relations theory, gifts are given for reparation to satisfy guilt and sorrow and therefore gift giving is not conducted out of genuine altruism but to satisfy one's emotional needs. Reciprocal gifts are always expected through "gift-exchange" (Hochschild 1983b; Klein 1997: 126; Hochschild 2003b). The motivation for the emotional gift sits uncomfortably against Bolton's work (2001) as she states that emotional gifts by health professionals are not expected to be reciprocated. However, other research has indicated that health professionals may become angry if gifts are not reciprocated (Cohen 2010b:213). At the end of his narrative, Nikhil shows that his emotional gifts were reciprocated via a thank you card which served as reparation for his emotion work.

This demonstrates that gifts have emotional exchange value (Hochschild 1983b, 2003b) and that within care relationships it is important that both health professionals and patients benefit from the gift to protect their emotional and psychological well-being. In seeking atonement for medical failures Nikhil bestows four emotional gifts onto his patient and her husband. First, he ensures that the couple are given a good midwife to look after them. By providing the couple with a good midwife, Nikhil is able to pass on responsibility for the patient in his absence and thus distributing the emotional strain of caring for this patient across the medical team. The distribution of the emotional strain is also indicated throughout the narrative



as Nikhil switches between “I” and “we” when talking about inducing the baby and performing the caesarean thus subconsciously and psychologically spreading the emotional burden of this crisis.

Second, Nikhil gives the couple a side room off the labour ward so that his patient is physically distant from the other new mothers. This distance prevents the patient and husband from being confronted with the emotional pain of losing their baby. Placing the couple on the neo-natal ward would have taunted the couple leading to greater anxiety, distress and other painful emotions. Furthermore, the side room is used to contain the patient’s emotions within a small bounded space preventing their negative emotions from becoming entangled with the “cheerful environment”(Mann and Cowburn 2005) or joyous affective ambiance (Bolton 2000b:585, Hubbard 2003) of the labour and post-natal wards. The containment of the patient’s emotions in this side room also makes it easier for Nikhil to manage. This may have broader implications for hospital design (Penfold and Maben 2013).

Third, Nikhil provides the couple with counselling sessions so that the patient and her husband can talk through their emotions with a professional. This counsellor will contain and manage the couple’s emotional ruptures in an appropriate therapeutic space by absorbing the patient’s projected and transferred emotions and managing them through counter-transference, reassurance and empathy. By providing counselling sessions Nikhil’s emotional labour is reduced.

The final emotional gift provided by Nikhil is that of his time and visibility. Nikhil states that he made a conscious effort to be increasingly more visible and psychologically present with this couple. In a profession where time is very precious and equates to money (Mattingly 1998:121), Nikhil is seen to be going against the social, cultural and organisational norms and defence systems by making himself more available to the patient. Proving extra time

meant that Nikhil stayed extra hours or came into the hospital on his days off. Reflecting on his behaviour Nikhil acknowledges that his behaviour may be in opposition with normal or traditional hospital culture and therefore he may have been criticised by his peers for being too emotionally connected with his patient. Nikhil's behaviour may have been encouraged by "impression management" (Goffman 1990; Hunter 2001) or to "feather his nest"<sup>5</sup>. In showing commitment and professionalism in the face of adversity Nikhil may have hoped to impress his seniors and achieve career progression or may have wanted to set a good example to his junior colleagues, reinforcing the importance of compassion in care (Francis Report 2013c, 2013a, 2013b).

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#### SUMMARY

The section explored on the geographies of emotional attachment within care work, focusing specifically on the spatialities that frame care around emotional connections and attachments between health professionals and their care recipients. It demonstrated that different care environments impact on the emotional attachments that health professionals establish with their patients due to the time that they can spend with their patients. Emotional attachments were also produced through bodily proximity and embodied care encounters, including haptic qualities as emotions moved through the porous bodily boundaries. This led to psychoanalytically informed discussions about the transference and counter-transference of emotions between health professionals and their patients within the therapeutic space of the hospital ward. It specifically looked at how health professionals repressed and contained their unconscious emotions through geographies of containment and boundary maintenance to prevent personal emotions from entering the workplace and disrupting their professional performances.

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<sup>5</sup> Discussion of data with ICU nurse. March 2013

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Finally it analysed the role of emotional gift giving in which health professionals bent workplace rules, provided patients with their time and gave their emotional selves to their patients through extended emotional connections. Emotionally attached care work was realised through shifting workplace feeling rules in which patient centred care and emotional attachments are becoming more valued. Emotional and social understandings of the patient in addition to rational clinical knowledge was believed to enhance clinical decision-making, improve patients' satisfaction and reduce emotional fatigue amongst health professionals.

## 4.6 GEOGRAPHIES OF PATIENT LOGISTICS

In the previous two sections, the geographies of emotional care work within front region hospital wards were the focus. They demonstrated that within different carescapes, health professionals are required to manage their emotions to deliver the most appropriate care for the patient's emotional, social and physical needs. In this final section, geographies of emotional care work are explored within back region, "logistical spaces" such as organisational meetings.

Logistical space refers to the scheduling and management of patient care that is often conducted in back regions, hidden from the patient's gaze. Logistical spaces and the activities within them are designed to encourage emotional detachment. To support health professionals in making rational and objective decisions about the management of care as they mobilise patients through the system. Emotional detachment is encouraged through "depersonalisation and categorization" (Klein 1946:12; Williams 2013a). Health professionals are expected to discuss patients by their bed number, disease or diseased organ rather than by their name to eliminate individual distinctiveness, reduce emotional attachment and aid the careful management of patient care.

In studying the management of patient care, emotional geographies of patient logistics offers a novel and innovative approach to exploring care work by combining two disparate bodies of literature; emotional geographies and geographies of logistics. In combining these lenses the (emotional) interconnections and connections related to the management and organisation of care work within and without the NHS organisation are accentuated. This has implications for the spatialities of care work in the public and private spheres and therefore reframes an emotional geographies of care work more politically through the interaction with the "shifting geographies of care" (Tronto 1993; Sevenhuijsen 2003; England 2010:131;

Green and Lawson 2011) and discourses surrounding the dynamically changing responsibilities of care (Lawson 2007; Atkinson, Lawson et al. 2011).

To illuminate the emotional geographies within the scheduling of care, 4.6 focuses on three organisational meetings; a multi-disciplinary team (MDT), a capacity and a continuing care panel (CCP) meeting. Within these meeting spaces, “the logistics of scheduling care activities” (Bowlby 2012:2107) or *patient logistics* are explored through patient files and discussions surrounding the bureaucracy of patient care. However, the implications of care management are observed to have far reaching impacts to care in the community.

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A MULTI-DISCIPLINARY TEAM MEETING

The first ethnographic extract is taken from a multi-disciplinary team meeting (MDT) on a stroke rehabilitation ward, embedded within a care of the elderly department at the Royal Alexandra University Hospital. The MDT is led by consultant Noah Chapman and is attended by the health professionals (nursing staff, speech therapists, occupational therapists, physiotherapists, doctors, a social worker, and a registrar) responsible for delivering patient care on the ward. The MDT meeting presented below lasted for an hour, which was typical across the hospitals and wards observed. The purpose of this MDT meeting was to discuss the care pathways of the twelve patients admitted to the ward. The extract demonstrates that patient logistics are managed by adopting lean production techniques, similar to those used in commercial industries. These techniques help health professionals to manage their emotions, through emotionally detached behaviours that aid logistical decision-making and enhance the organisation’s logistical efficiency. It also illuminates that meeting spaces are “cathartic spaces” in which health professionals’ emotions can be contained.

*The MDT meeting is held in the patient's lounge off the care of the elderly ward. I am the first to arrive and take a seat at the table made up of several smaller tables pushed together. During hospital meal times this table is used by the stroke patients to share in a communal lunch to prevent isolation on the ward and to encourage those with deteriorated speech to engage with other patients and improve their language skills. This room is therefore multi-functional. The speech therapist Lorna enters and sits next to me. As we talk informally the room begins to fill. Once the table's capacity is exhausted, the latecomers sit on the chairs skirting the perimeter of the room. Noah's registrar Markus arrives pushing the patient file trolley and occupies one of the reserved seats next to Lorna...A few seconds later Noah arrives...*

*Noah opens the meeting by discussing patient 8 and asks Fiona Turnbull, the discharge co-ordinator, if she could update everyone on the patient's imminent discharge. Fiona informs the group that the patient will be going to an interim nursing home while they wait for the rehabilitation centre, the Hobson, to give a decision on whether the patient can convalesce there. Fiona states that the Hobson will probably reject the patient as she cannot mobilise independently and therefore she will stay in the nursing home permanently. She adds we 'are close to discharging this patient appropriately'...Markus writes a commentary in the patient's notes as Noah moves on to the next patient...*

*'I think we should return to some order now. Patient 1?' Markus opens the red patient file labelled 'one' with his pen poised to write the patient's plan. Noah explains the patient's medical history. He tells the MDT that she has been for a MRI (Magnetic Resonance Imaging) scan and they are awaiting the results. He asks the nursing staff to prepare her for a CT (Computerised Tomography) scan. The ward sister makes a note in a hard-backed book...Noah flags this patient up to Lorna and says that she is having difficulty processing words from both English and her mother*

tongue. He informs the physios that not much input is needed from them as her mobility is good, but that she might need input from an OT (Occupational Therapist) due to the use of recreational drugs which induced the stroke. Noah continues that he doesn't think that there is a 'real drug issue' and that drug education might be all she needs.

Noah swiftly moves onto the next patient and asks 'from a nursing point of view how is 2 doing?' Noah listens as each health professional provides information about the patient... he then produces a discharge plan based on the knowledge gathered...Markus writes the plan in the patient's notes.

The discussion of patient 3 commences with an update from a student nurse sat on one of the peripheral chairs. He informs the MDT that the patient is doing really well. Noah thanks him and then looks at the ward sister 'anything you want to add', 'no, I think he has covered everything...(leaning over to the student half whispering) well done!' Noah turns to Lorna 'can we hear from you please?' Lorna states that the patient is also doing very well from her perspective and that she is very pleased with her progress. She tells the MDT that she has given the patient a book and asks the staff to write a short comment in it to say what they have done with the patient that day. Lorna says that it helps with her memory and her language as she is often unable to relay what she has done to her family when they visit. The Physio also says that the patient is progressing well and that she has been writing in the patient's book and that it has been beneficial in demonstrating the patient's progress adding... 'it really helps with her motivation'.

The OT asks the nurses when the IV (intravenous) will be taken out because it is hampering their ability to get the patient to dress herself. Noah says that it can come out and asks the nurses why it is still in. There is no definitive answer and Noah asks for it to be removed as soon as possible.

Noah asks the MDT 'with all this positive feedback should we think about a discharge plan?' Two of the therapists and the nursing staff agree. However, the OT says that she wouldn't be happy with making that decision until next week as they don't think that they have made as much progress as they would have liked. Noah and the rest of the team listen as the OT puts her case forward. Noah is not keen to delay the discharge date further and suggests that some of the issues that the OT has raised should not make an impact on the discharge of the patient. They come to a mutual agreement that they will begin to make referrals in preparation for the discharge so that if she does improve from an OT perspective they can push for an earlier date...

The team discuss patient 4, Lorna... states that the patient's wife is very tearful because her husband is not able to communicate with her... She continues that she is using visual cards with the husband but he is not progressing well. She feels that if she can get the patient to use the cards properly his wife would be less upset. She asks whether anyone has spoken to the wife about stroke recovery. Noah says that had a word with her this morning but was not aware of how upset she was about her husband's slow recovery and says he will make an appointment with her to talk through the challenges of stroke recovery. Noah asks the nurses if any of them have had any communication with the wife. The ward sister says that she has asked the wife if she would like to go to 'stroke education' which she has agreed to and they have given her an information book. However, she agrees with Lorna that the wife is very emotional and explains that when she began to discuss her husband's stroke 'tears were welling up in her eyes so I thought I would leave it, I don't need to upset her any more than she needs to be at this stage...I don't think she is coping well with the shock of her husband's stroke at all...'

(Ethnographic shadowing 24: Noah Chapman, consultant geriatrician, care of the elderly, Royal Alexandra University Hospital 22/07/2009)



This extract demonstrates that lean production or “production line approaches to care” (Hunter 2010:257) are used in the hospital setting to speed up the movement of patients along the care pathway (Kearns and Barnett 2000; Hunter 2010).

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### LEAN PRODUCTION

The purpose of the MDT is to make logistical and organisational decisions about a patient’s care pathway to achieve a safe and timely discharge. Research has shown that an effective and timely discharge can only be achieved if the MDT members work effectively to achieve realistic patient goals along the patient’s care pathway (Taylor, Munro et al. 2010; Taylor, Shewbridge et al. 2013). Patient goals and realistic expectations are visible in this meeting, especially through the negotiation of patient 3’s discharge, which is dependent on the patient being able to meet the OT’s goals for being able to dress themselves. To achieve MDT effectiveness the NHS has provided guidelines on health professionals’ roles within the MDT and protocols for patient management (Taylor, Munro et al. 2010; NICE 2014).

Within this extract the health professionals in this MDT meeting appear to function effectively, with each professional being able to confidently share their perspectives on each patient’s progress, with Noah guiding the discussions. MDT function and effectiveness however was varied across the departments and hospitals observed with some MDT meetings perceived as highly dysfunctional. In these environments MDT members were unable to confidently share their professional input due to power relationships and hierarchies operating within the team. Power relationships often were made visible by consultants dictating the patients’ care pathways to their teams without inter-disciplinary discussions. Dysfunctional MDTs have been shown to affect the effectiveness and efficiency of the patient’s care pathway and discharge plan (Taylor, Munro et al. 2010).

On the contrary an effective and functional MDT can lead to efficient and effective care management through carefully managed patient logistics. There is however a noted absence of geographical literature focussing on the logistics and management of patient care in the NHS (Kearns and Barnett 2000; Atkinson, Lawson et al. 2011). This is not surprising considering that "geographers have paid little attention to the geographies of logistics" (Hesse and Rodrigue 2004:00). Health care logistics however may be studied and have greater implications to the social science disciplines.

Geographers' attention to logistics is however growing due to "the emergence of global production networks, to structural changes in retail or to the commodification of modern consumption" (Hesse and Rodrigue 2004:171). Geographers have therefore explored logistics through corporate and commercial organisational strategies, such as warehousing (Cowen 2010), processes of containerisation (Cresswell and Martin 2012; Martin 2012) and the transportation and commodification of goods (Hesse and Rodrigue 2004; Cresswell and Martin 2012; Martin 2012). Attention however, should also be paid to patient logistics within the NHS to explore the mobility and management of patient care through the system.

Whilst there is a dearth of geographical literature pertaining to patient logistics, concepts within geographies of logistics are applicable to the health care system. Cowen (2010), for example, discusses the "rapid and reliable movement of stuff through space" to meet the supply and demand chains with a commercial organisation (Hesse and Rodrigue 2004; Cowen 2010:601; Shaw and Hesse 2010). In managing these supply chains, tactical and logistical planning is necessary at every level (Cowen 2010). The movement of patients through the NHS system also requires tactical and logistical planning (Kearns and Barnett 2000).

Hesse (2004) notes that modern logistics originated with Taylor (1947) who created fordism to improve the efficiency of factory working through the

development of the task orientated activities along an assembly line known as “scientific management” (Lawrence and Armstrong 1998). The purpose of scientific management was to split up organisational tasks to become more efficient and less emotionally driven as humans were to perform like machines (Lawrence and Armstrong 1998:58). Scientific management introduced temporal dimensions to production such as "sequence, duration, schedule, rhythm, synchronisation and time perspective" all of which are important to the lean management of supply chains (Hesse and Rodrigue 2004:174; Shaw and Hesse 2010).

Traditional logistics functioned around "supply, warehousing, production and distribution" (Hesse and Rodrigue 2004:173) which were independent of each other. In modern logistics, these functions follow a more "integrated approach" to respond to the demand whilst being cost effective (Hesse and Rodrigue 2004:174). Keeping costs down is essential to an organisation's "cost of viability" (Huffington 2005:24) especially in the current climate of "economic and political turbulence" (Sevenhuijsen 2003; Huffington 2005:5; England 2010), which threatens an "organisation's survival" (Huffington 2005:8) and leads to emotional "turbulence within and without the organisation" (Armstrong 2005:22) due to increased anxieties surrounding job security. This is particularly pertinent to the NHS which is perpetually fighting for survival against "continuous government interference and legislation" (Armstrong 2005:22), changing social and economic structures, changing consumption patterns (Kearns and Barnett 2000; Hesse and Rodrigue 2004) and mergers and closures (Armstrong 2005; Adams and O'Mahony 2012; Campbell 2013).

For organisational survival, the NHS needs to adhere to the temporal dimensions of production by mobilising patients through the system in the most efficient and effective way, whilst reducing financial wastage, and enhancing the consistency of patient care (Hesse and Rodrigue 2004).

Consistency of care was highlighted by consultant geriatrician Robert White and director of nursing, Gillian Bishop in 4.3. To support consistency of care and efficient patient logistics, a set of activities dedicated to mobilising patients through the system is required. Within commercial organisations these logistical activities include; "physical distribution" (Hesse and Rodrigue 2004; Cowen 2010; Shaw and Hesse 2010), which "comprises of all the functions of, movement and handling of goods, particularly via transport systems" (Hesse and Rodrigue 2004:172; Shaw and Hesse 2010). Within the NHS, this may include the portering of patients from the ED to the ward, to discharge, and the delivery of care.

The second activity is the management of materials, which entails "production planning, demand forecasting, purchasing and inventory management" (Hesse and Rodrigue 2004:172). In the NHS these activities may include the management of patient logistics that are organised within meetings, organising and managing care pathways, the management and forecasting of the hospital capacity and organising resource allocation. To create efficiency, the boundaries between physical distribution and material management must be blurred and operate as a "reciprocal relationship" (Hesse and Rodrigue 2004:173). Within the hospital setting this means that care delivery and the management, planning and scheduling of care needs are to be integrated effectively to integrate the patient care experience.

In her paper focusing on the logistics in the US military the "spatialisation of cost-benefit analysis", Cowen (2010) emphasises that the movement and effective management of goods through the system has a political and economic function. This is pertinent to the NHS as the management of patients through the system impacts upon and is impacted by political and economic factors. The delivery of patient care is a costly process with an average patient costing £255 to stay overnight (Ward 2012). It is therefore essential that patients are discharged as quickly and efficiently as possible to

reduce the economic burden on the system. Government targets were therefore introduced to streamline and control the movement of patients through the system. This has caused patient stay to be subject to time-compression.

Whilst it is important for health professionals to discharge patients in a timely manner, it is equally important that they do not become too pressured by government targets which may lead to inappropriate or unsafe discharges. This may lead re-admissions that are not cost effective. Re-admission data is collected and analysed at 7 and 30 days. The MDTs' role therefore is to integrate physical distribution with material management to create a balance between a timely and safe discharge and an ineffective early discharge. This was most notable in the discussion of patient 3, where the patient's progress and goals for discharge were negotiated amongst the team.

The next organisational meeting to be discussed focuses on the "management of materials" (Hesse and Rodrigue 2004) through the management and forecasting of hospital capacity figures. Although capacity is the focus of this meeting, knowledge about the "physical distribution" (Hesse and Rodrigue 2004:172) of patients through the system is essential to support logistical decision-making, demonstrating the importance of integrating physical distribution and management of patients. To organise patients through the system, patients are transformed into numbers to assist the management of the fluxes and flows of patients through the system at any one time.

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#### A CAPACITY MEETING

The capacity meeting below was held in a management suite at Broadwater General Hospital, located in a separate building to the main hospital, joined by a single bridge. This geographical positioning was symbolic of the relationship between health care professionals and managers in this hospital

and in the other hospitals observed. In an attempt to reconcile the strained relationship between health professionals and managers, nurses had been invited to attend capacity meetings. The invitation was supposed to reduce the tensions between the professions by establishing a shared goal. This was highlighted in an ethnographic interview with capacity manager, Katherine Baker:

*...“We have only just started inviting nurses to the capacity meetings. It is supposed to improve communication and make nurses understand the role that we capacity managers play in the delivery of care...make them understand the decisions we have to make... Nurses think that we just walk around the hospital writing numbers on clipboards trying to ruin their day and pressuring them to discharge patients or placing patients on their wards when they are short-staffed...we are the most hated people in the hospital... but despite what they think...we do care about the patients...we do realise that behind our numbers there are people...”*

(Ethnographic shadowing 08: Katherine Baker, capacity manager. Broadwater General Hospital 22/10/2008)

Armstrong (2004) stated that being alert to the "emotional undertow of organisational life can be a powerful source of information for...understanding, reviewing performance, foreseeing challenges and opportunities, and guiding decision and action" (Armstrong 2004:11). Recognising the tensions between health professionals and managers and attempting to resolve the conflict may help the scheduling of patient care through a shared and integrated understanding of the logistical and care goals.

The capacity meetings at Broadwater General Hospital occurred twice a day; at 11.00 and 16.00 and lasted approximately 20 minutes. The meeting below was chaired by Jessica Morrison, the business unit manager, and attended by capacity managers, discharge co-ordinators, business managers and nursing

representatives from each ward in the hospital. The attendance of the business unit managers within capacity meetings was unusual. Reflecting on Jessica and Perstephanie's attendance, Katherine sincerely believes that they have attended to monitor her performance, heightening tensions within the managerial sphere and increasing organisational anxieties (Armstrong 2005; Huffington 2005).

*Jessica (business manager) opens the meeting by asking Katherine (capacity manager) for the accumulative figures for the medical and surgical wards across the whole hospital. Katherine reels the figures off the top of her head and Jessica writes numbers in the appropriate boxes in the table marked out with black tape on a white board and then makes her way down the list of wards, asking each representative to provide their numbers... Revealing the figures of the medical assessment unit (MAU) Jessica is angry that they have no vacant beds and no pending discharges and asks why they are not doing more to get patients discharged. The ward representative explains that it is difficult to discharge from this ward because the majority of their patients are elderly and waiting for care packages. Jessica sighs heavily 'let's move on'. Rachel, the ward sister in the emergency department (ED), declares that they had one breeched patient this morning and currently no free beds in majors with trolleys accumulating in front of the nursing station. The senior business manager, Perstephanie, is angered by this news and asks 'how could you have let this happen?' Rachel tries to explain that normally the majority of ED patients would be transferred to MAU but because their beds are blocked there is nowhere for the patients to go. Perstephanie snaps 'this is not good enough...Katherine, I want to talk to you after the meeting...you should have prevented this!' Jessica cuts through the tension and asks 'can we have the figures for surgical assessment unit (SAU) please?' Carol states 'we have no free beds but we will be discharging 1 at 13.00'. Perstephanie asks Carol why they can't discharge the patient now because they are blocking a valuable bed. Carol*



*informs her that they need to administer the patient with a final dose of medication before she can be discharged. Perstephanie in a sharp tone asks why the drugs could not be administered in the discharge lounge. Carol states it is because 'the nurses in the lounge aren't qualified to administer drugs'. Perstephanie seems to ignore Carol and tells that she has to send the patient down to the discharge lounge. Katherine defends Carol stating that this would be in breach of patient safety. Perstephanie reluctantly agrees that the patient can stay on the ward until 13.00...*

*Following the meeting Katherine and I walk back to her office. She is very frustrated by the intrusion of Jessica and Perstephanie and states that they don't understand the difficulty she has in juggling the hospital's numbers. She exhaustedly explains 'that last patient for example, it would not have achieved anything by moving that one patient to the discharge lounge early. We are short of MAU beds, not SAU beds...You can't just place patients anywhere, they have to be in the **appropriate** bed'. She sighs heavily and then continues 'none of them look at the bigger picture...the business managers are only interested in making themselves look good by meeting targets...they are unconcerned with patient care or the patient's experience.....and the nurses are only concerned with what happens on **their** ward'.*

(Ethnographic shadowing 08: Katherine Baker, capacity manager. Broadwater General Hospital 22/10/2008)

The capacity meeting presents two interesting insights for geographies of patient logistics. These include co-ordinating and scheduling movement and the impact of the creation of an organisation-in-the-mind has on patient logistics and emotion management.

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#### CO-ORDINATING AND SCHEDULING MOVEMENT

In the meeting, capacity managers and health professionals are expected to discuss patient logistics in an emotionally detached manner only referring to



patients as numbers for the effective "co-ordination and scheduling of [patient] movement" through the health care system (Martin 2012:360). The movement of patients through the health care system requires "control over the [hospitals] spatial and temporal dynamics" (Martin 2012:360). To manage patient logistics capacity managers must adhere to government targets, such as the four hour waiting time directive (temporal dynamics) and place the patient in the most appropriate ward for their care needs (spatial dynamics). Adhering to these guidelines should reduce or "eradicate delays in [patient] movement" (Martin 2012:360). Controlling the spatial and temporal dynamics within a hospital is a challenge, with patient mobility often curtailed by "operational challenges" (Hesse and Rodrigue 2004; Martin 2012).

Operational challenges were witnessed in the capacity meeting when the figures for the MAU and the SAU revealed no vacant beds or imminent discharges. This resulted in patients breaching government targets in the ED due to "bed blocking" which caused "bottlenecking" in the system (Hesse and Rodrigue 2004; Cresswell and Martin 2012). Bed blocking results in disruptions to the mobility of patients, and it is these disruptions or "organisational turbulence" (Armstrong 2005:22; Cresswell and Martin 2012:520) that causes the "often-invisible [logistical spaces and] networks of mobility" to become visible to patients (Cresswell and Martin 2012:520).

According to Cresswell and Martin (2012) organisational turbulence either presents a threat or an opportunity for an organisation's supply and demand chain. Within the NHS, turbulence is likely to cause a threat to patient safety and patient satisfaction. Additionally it may cause a threat to health professionals' organisational anxiety, as the organisation's survival may be threatened through mergers, closures and job losses as a result of poor performance (Huffington 2005). In response to the organisation's threat, business managers and organisational leaders place pressure on their staff to

meet government targets and deliver better organisational performances. This pressure was witnessed through the attendance of Jessica and Perstephanie at the meeting and the verbal pressure they placed on Rachel and Carol to discharge patients from their wards.

As stated in the introduction, Katherine was highly suspicious of the business managers' attendance, believing that they were there to observe her managerial performance. This induced greater anxiety in Katherine. Through the performance of emotional labour, Katherine delivered a professional performance throughout the meeting. On returning to the private space of her office however, Katherine's professional performance slipped resulting in an emotional rupture in which Katherine's authentic emotions were displayed. Through this emotional rupture the emotional demands placed on Katherine in making logistical decisions and in negotiating between the health professions (delivery of care – physical distribution) and the business managers (meeting government targets – material management), as they struggled to come to a joint understanding regarding capacity. Katherine's role as negotiator causes her to feel drained, exhausted and like the "most hated person in the hospital". Katherine's emotionally demanding role and organisational anxieties causes her to create a defence against her organisational anxieties by creating an image of the NHS, and her role within it, in her mind (Klein 1946; Bion 1984; Hirschhorn 1990).

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### ORGANISATION-IN-THE-MIND

According to Nicolson, Rowland et al. (2011) "organisational members [create and] hold in their mind a fantasy or imagined understanding of the organisation" in which they work (Armstrong 2004, 2005; Morgan 2006; Nicolson, Rowland et al. 2011:118). A fantasy, or "phantasy" (Bion 1984; Lawrence and Armstrong 1998) is described by Klein as "a mental corollary the psychic representative of instinct... it represents the particular content of urges or feelings (for example wishes, fears, anxieties, triumphs, love or

sorrow) dominating the mind at the moment" (Susan Issacs 1952, cited in Klein 1946: 25).

Organisational fantasies indicate the emotional life within organisations are both unconscious and conscious "mental constructs" (Armstrong 2005:7) of the "psychic reality within" (Klein 1946). Organisational fantasies are rarely individual emotional experiences of an organisation but instead are manifested or created in groups (Armstrong 2005), who work within or without the organisation (Shapiro and Carr 1991). It is through organisational fantasies that an "organisation-in-the mind" (Armstrong 2005) or a "work place within" (Hirschhorn 1990) is established.

The concept of the organisation-in-the-mind was first established by Pierre Turquet (1974), who wanted to find out how people's behaviour at a group relations conference was "governed by unconscious assumptions, images and fantasies about the conference" (Armstrong 2005:3). This concept was adapted and adopted over time to work with clients through organisational consultancy, to help organisational clients to "recognise the importance or unconscious factors in the life and destiny of our emotions and to [improve] the functioning, or efficiency of organisations" (Armstrong 2005). It was later defined by Hutton, Bazalgette and Reed (1997) as:

*"'Organisation-in-the-mind' is what the individual perceives in his or her head of how activities and relations are organised, structured and connected internally. It is a model internal to oneself, part of one's inner world, relying upon the inner experiences of interactions, relations and the activities engaged which give rise to images emotions, values and responses..."*

(Hutton, Bazalgette et al. 1997:114)

The concept of an organisation-in-the-mind therefore has insight for emotional geographies of care work and geographies of logistics as it allows

us to delve into the psycho-analytical and emotional experiences of health professionals and their organisational relationships with colleagues and organisational decision-making.

In Katherine's organisational fantasy she focuses on the tensions between nurses and the business managers. Due to these tensions (real or imagined), Katherine perceives her role as intrinsic to the organisation because she, and the other capacity managers, are the only ones in the hospital that understand how the NHS is organised and operates. She is therefore the glue that holds the organisation together. When members of an organisation create an organisational fantasy they attempt to position themselves within the organisation by seeing how well their roles and responsibilities within the organisation fit or do not fit within the organisation's structure and other organisational members' roles. This has been termed the "goodness of fit" (Armstrong 2004:24; 2005; Huffington 2005).

Katherine's role as mediator between the health professionals and business managers allows her to perceive herself as fitting well within the organisation's structure. She feels that she does not fit in well on a personal and professional level with her colleagues and this induces anxiety. Organisational anxieties have a psychic edge in that they produce feelings of dread that, if reality is experienced and acknowledged, it will overwhelm and destroy the individual. Anxiety is therefore profound because it comes with a sense of self annihilation. Given the ever increasing uncertainty of the hospital environment organisational anxieties are not exclusively the products of fantasy. Instead, they have a basis in reality i.e. threat of job losses and hospital closures and therefore reality stimulates fantasy thus feeding and nurturing and organisation-in-the-mind (Armstrong 2005).

An attempt to integrate professional boundaries causes Katherine to feel isolated and misunderstood by both nurses and business managers. This leads her to feel emotionally drained, increasing anxiety and frustration in

the job role. Armstrong states that for people working in hospitals, feelings of isolation and vulnerability are an “occupational hazard”, especially for those in managerial roles due to the emotional “institutional undertow” (Armstrong 2005:49). By institutional undertow, Armstrong refers to the hospital as an organisation that projects a “vulnerable institutional identification”. He explains “to be in a hospital, whether as a patient or as staff – is surely to put oneself, or to be put by others, in a position that exposes oneself to being vulnerable to experiencing ones vulnerability” (Armstrong 2005:49). Katherine’s emotional disruptive organisational fantasy is saturated with vulnerability, isolation and anxiety and is therefore highly “toxic” (Gabriel 2012, 1998, 1999). This toxicity causes Katherine to become tortured creating a "psychic prison" (Morgan 2006:226).

Katherine’s psychic prison exacerbates her sense of guilt and anxiety in the workplace. This increases the emotional labour required to perform her managerial role in the face of the torrent of apathy which she believes she is subjected to during her day to day activities. Katherine's emotionally disruptive and toxic organisational fantasy was emphasised further in another day of ethnographic shadowing:

*I arrive at Katherine’s office at 07.55. Katherine had started work at 07.00. She is wearing a telephonist’s headset and speaking to a staff nurse on the phone, today’s capacity sheet in front of her. As she speaks she scribbles numbers on a scrap piece of paper. She smiles and motions me to sit down.*

*Katherine tells me that ‘it’s all go here this morning’. She explains that she has already had 2 patients, one with chest pains and the other who is short of breath, needing a bed from the ED to a [cardiac step down ward] or a MAU. She says that she needs to find them a bed as soon as possible because they will breach at 09.00. This is a problem because all the beds in the hospital are full because of the weekend and patients cannot be*

*discharged until the doctors do their rounds at 09.00. She informs me that she is going to have to ring CCU (critical care unit) because they have a bed but the patient shouldn't really be placed there due to staffing pressures and because it is a high dependency unit (HDU). However Katherine feels that she has no choice and comments 'just going to have to piss CCU off, they are not going to be happy at all'...*

*'Good morning Julia it's Katherine. I'm afraid I have a patient down in the ED, Mrs Cooper. She will breach at 09.00 and I need one of your beds, can I send her up in about 30 minutes? ...Ok, Thanks Julia, bye'. Katherine turns to face me and says sounding surprised 'now that was easier than I thought!' Katherine explains that staff don't usually give beds up so readily especially over the phone. Katherine states that CCU are particularly bad at disclosing and handing over their beds. She states that Julia usually causes a lot of trouble for her and disagreements often occur. Katherine explains 'I really don't have a good relationship with her, it is always a battle...she has no understanding of the bed situation, if I'm honest none of them do! ...they can't see what I am trying to achieve...they can be so protective of their beds...none of them want to give them up, they don't want outliers...I understand their concerns for the patient's safety, but these patients need beds...but Huh, Emma you should hear the lies!...I have been doing this job for eight years and I know all their tricks, all the silly games they play to protect their beds!...'*

(Ethnographic shadowing 08: Katherine Baker, capacity manager. Broadwater General Hospital 22/10/2008)

Demonstrating her emotionally disruptive organisation-in-the-mind, Katherine talks about the games and deceit that she is confronted with as she manages patient logistics within the hospital. Whilst Katherine presents her organisation-in-her-mind as toxic and full of tension, the ethnographic observation detailing the interaction between Katherine and Julia and in other ethnographic observations demonstrated a different organisation to the

one Katherine perceives. This organisation was less toxic. Katherine's request to place an outlier on CCU was not met with hostility or resistance but with co-operation. This extract therefore demonstrates that there are multiple interpretations of the emotional life of an organisation and thus an organisation may have several contradictory and colluding organisations-in-the-mind.

The short extract below is taken from a static ethnographic observation on a cardiology ward at Broadwater General Hospital. It demonstrates the emotional experiences of nurses in response to the logistical decisions made by capacity managers. It illustrates counter-emotional experiences and the construction of other organisations-in-the-mind and how they interact and relate to each other.

*"I just don't want patients with other problems coming into the ward in case "a critical" comes through the ED... and then they will have to reshuffle the beds to make space...what a nonsense!... I have accommodated enough non-CCU patients on the ward, Mrs Peters for example was not a CCU case... and we have only just got rid of her!"*

(Static observation 04: Critical care unit: Julia Powyers; senior staff nurse. Broadwater General Hospital 20/08/2008)

Julia also constructs an emotionally disruptive organisation-in-the-mind that threatens nursing professional identity and patient safety, as her psychological and physical ward boundaries are threatened by capacity managers' logistical decision-making. In response to the threat to her psychological boundary, Julia creates a defence against the organisational system and against her own anxieties (Klein 1946; Jaques 1955) through a processes of splitting. Julia splits the nurse - manager relationship, positioning the capacity managers as bad and nurses as good. This removes her anxiety related to patient safety aroused by the outlier (Klein 1946; Bion 1984; Morgan 2006).

To maintain her psychological and ward boundaries Julia consciously and unconsciously plays emotional and organisational games with Katherine. Julia's resistance to the perceived threat imposed by Katherine's logistic decision-making however poses a greater destructive threat to Julia's psychological boundary (Bion 1984), as it becomes increasingly more vulnerable to attack from Katherine. Katherine's extensive (8 years) experience of being a capacity manager has resulted in her being wise "to the nurses' games and tricks" and therefore she is already fore-armed to do psychological battle at the boundaries edge to ensure that patients do not breach government targets.

Whilst Julia's psychological and ward boundary is threatened by experienced capacity managers like Katherine, the nurse's defence mechanisms function effectively against the threat from novice and inexperienced capacity managers that do not have the confidence or *emotional stamina* to do battle when confronted with deceit and resistance. This was witnessed during static observations on a cardiac step-down ward.

*At 13.30 the phone rings and Claire (Ward sister) answers it. It is David (capacity manager) looking for free beds. Claire tells him that she has no beds, despite Mrs Smith leaving nearly an hour ago. She also tells him that no patients will be leaving today, despite knowing that Mr Baker will be leaving at 15.00. Off the phone she asks the nursing team to collude with her...*

*At 13.45 David enters the ward. Grace, a staff nurse is sat behind the nurse's station filling in paperwork. David walks towards the desk looking at the patient white board behind her. The discharged patient's names have not been removed giving the illusion of a full ward. The two empty, newly made beds however, tell a different story. David asks 'you're full aren't you?' Grace looks up from her notes and replies simply 'yes'. David looks at the board for a moment longer and then scans the*



*ward before asking 'where is bed 4?' Grace doesn't lift her head from her notes; 'Mrs Martin has gone to surgery'. David nods 'Ah yes, I see'. David doesn't probe Grace any further and leaves the ward clutching his capacity sheet.*

(Static observation 04: Critical care unit. Broadwater General Hospital 20/08/2008)

The organisation-in-the-mind presented in these ethnographic extracts highlighted the emotional geographies and geographies of logistics in the NHS system. They demonstrated that the relationship between capacity managers and nurses in scheduling patient care is emotionally challenging and psychologically distressing as physical distribution (care) and material management (logistics) are integrated to create efficiency along the patient care pathway. In response to organisational anxieties (real or emotional experienced), health professionals and capacity managers work hard at their emotional labour to protect their own emotional well-being. It also emphasises the organisational anxieties created by organisational realities' (mergers, closures, poor performance) and that the creation of disruptive and toxic fantasies can exacerbate organisational anxiety and therefore perpetuates the emotionally disruptive organisation-in-the-mind (Armstrong 2005). The ethnographic extracts from the nurses' perspective of capacity also illustrate that, separate to the NHS' organisational rules, they implement their own logistical measures to avoid over capacity or outliers. This demonstrates patient logistics at a local as well as an organisational level.

The following extract continues to explore the spatialities of emotion in organisational and managerial decision-making. It focuses on logistical decisions made in a continuing care panel (CCP) meeting.

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A CONTINUING CARE PANEL MEETING

The continuing care panel (CCP) meeting was accessed via ethnographic shadowing with care of the elderly consultant and clinical director Andrea

Hutchinson. The CCP meeting was conducted in a council building in close proximity to St Joseph's Community Hospital and was attended by 6 panellists: the chair, Patricia, two members of social services, a district nurse, a local counsellor and Andrea who all serve the local Primary Care Trust (PCT) by making logistical decisions about the provision and allocation of additional patient care resources in the community. The panel have no or very limited previous engagement with the patients being assessed. This limited engagement has led to this panel to be criticised by health professionals such as care of the elderly consultant Madeline Marsden who perceived that patients' emotional and social circumstances are not taken into account during the assessment.

*Madeline provides her thoughts on the CCP stating that she doesn't agree with the process because in her opinion they are unable to make decisions about patients when they haven't met them. She believes that often they do not have the patients' best interests at heart and is based purely on resources and money rather than patient need. It is for this reason that Madeline does not want to join the CCP despite being offered a place*

(Ethnographic shadowing 18: Madeline Marsden, consultant geriatrician, care of the elderly. Royal Victoria Infirmary 17/04/2009)

This demonstrates Madeline's organisation-in-the-mind. It emphasises that people "who are aware of an organisation [group or panel], whether a member of it or not, has a mental image of how it works" (Shapiro and Carr 1991:69). This mental construct however, is not always an accurate representation of the organisation or its activities. The panellists' were observed to take the emotional and social aspects of patient care into consideration when making logistical decisions about resource allocation.

The extract below offers two important insights into the emotional geographies of care work and geographies of patient logistics. First, it highlights that despite the lack of face to face interaction or care relationship

with the patients, decision-making surrounding resource allocation and logistics can be emotionally challenging, requiring careful emotion management from the panel. Second, by focusing on the logistics of care that operate at the boundaries of public and private spheres, geographers are able to access and critically engage with politically-charged care discourses such as the “new politics of care” (Sevenhuijsen 2003) and an “ethics of care” (Tronto 1993, 2001; Lawson 2009) which focus on the shifting geographies of the responsibilities of care (Brown 2003; Atkinson, Lawson et al. 2011).

In this two hour meeting eight patients were assessed and discussed against a “continuing care criteria” (organisational guidelines) to establish whether they qualified for additional care to the care packages already put in place during the patients discharge from hospital (typically organised in a MDT meeting). In this meeting the patients were discussed in alphabetical order by their surname, with only the patient’s demographics; age, gender and their medical history disclosed. This allowed the patient’s care needs to be assessed objectively. Rational decisions about the patient’s medical needs therefore were cast through “depersonalisation and categorisation”, which reduces anxiety (Menzies 1970:96).

*“Ok, shall we start at the top? Patient 1? Who would like to start? (Patricia looks around the panel). The first patient to be discussed is a 96 year old female. The patient’s details are delivered by one of the members of social services. He summarises the patient’s previous medical history, current medical situation, the care she now receives and his observations of the patient according to the continuing care criteria. The continuing care form assesses the patient’s needs by a three tiered criteria of low, medium and high. In discussing the patient’s cognitive ability the assessment is queried by Andrea who asks several probing questions. Andrea changes the patient’s need from ‘moderate’ to ‘low’. The social worker also states that the family are struggling to look after the patient and therefore would like her to be considered for a funded place at a*

nursing home. The panel decide that this patient has low need and therefore will not qualify for additional care. The request for a place at a nursing home is also rejected.

The second patient is discussed by the community nurse. She describes the patient's previous medical history, behaviour, cognition, psychological test results... Again the members of the panel discuss the patient's psychological test results and change the patient's need from high to medium. The nurse tells the panel that the patient would like someone to come in and cook her food. The counsellor asks her 'what is wrong with meals on wheels?' The community nurse states that the patient has complained that she would like more of an input into the food she eats. Patricia suggests a family member help her cook... The nurse argues that the family work and although they buy her food they don't have the time to cook for her as they have small children. The provision of someone to cook food is declined as Patricia feels that the family could do more to help...

The eighth and final patient to be discussed is an appeal. The female social worker leads the discussion... Following a stroke the patient has been left mute and has lost mobility in both her legs, one arm and has facial palsy and therefore dribbles. She is doubly incontinent and uses an aspirator during the day to help her breathe, she is also on medication for motor neurone disease. She currently has a carer who helps the relatives during the day by administering medicine, taking her to the toilet and preparing food, etc. In a previous CCP meeting the team rejected the request for additional care. The family are appealing this decision believing that the patient requires 24 hr care.

Before the son enters the room, the panel re-evaluate the patient and agree that their original decision was correct... The son enters and is introduced to the panel. The meeting between the son and the panellists is filled with tension with the son visibly angry and frustrated by their decision.

*Patricia does not help defuse the situation, remaining authoritative and stern...when the son reads the guidelines for continuing care...she replies 'I am aware of the guidelines...we need to know why we should revoke our decision...and provide your mother with additional care'...*

*Andrea says that she would like to hear about his mother's condition at night and why he thinks that she requires additional care. The man tells a heart wrenching story which leaves me with a lump in my throat. The family are under great strain as he works during the day and his wife in the evening to support the family. When he comes home he takes over the care from his wife and she goes to work. When he goes to sleep he takes a baby monitor with him so that he can hear his mother's cries for help. He gets up 2 / 3x a night to check on her and has, with his own money, hired someone to sit in the room with her.*

*... As soon as the son leaves the room the panel begin to discuss the case coolly. They remain adamant that their first decision was correct. Andrea states that because the patient only has her ventilator for a couple of minutes during the day her need for oxygen is not high and she is only panicking at night because she 'wants attention'.*

*...The meeting finishes 45 minutes after schedule...Patricia asks 'I hope that wasn't too traumatic for you Emma?' I reply that I had found it rather upsetting... and that I was shocked by the continuing care criteria and the positioning patients as low, medium or high need. She tells me that they are working to nation-wide guidelines that they **must** adhere to and that they allow them to offer the best patient care to patients... Patricia asks me to remember that the requests are for **additional care** and that the patients have already got care packages in place that meet their current need. She continues that the NHS does not have an endless pot of money and therefore they have to make very measured decisions about how the care provisions are provided...*

*I ask Patricia how she finds the decision-making process because all of the panellists appeared to be making these decisions very easily and that I had found it quite un-nerving how emotionless they appeared to be. In response Patricia replied 'I'm sorry that you thought that our decisions were emotionless, because that certainly is not the case'... she continues that she finds the processes very emotional and... sometimes 'heart breaking'. However, difficult decisions need to be made...The counsellor agrees with Patricia stating that he finds the decisions he makes 'very difficult' because it is like 'playing God'. Andrea states that she needs to make objective decisions, however, she has found this more difficult since she had to deal with one of her own family members going through this process. She continues that it is a decision that she doesn't take lightly and that sometimes she finds it very emotional and traumatic because she worries about the consequences of her decisions...for this reason she states that she would not put someone junior in this position because she doesn't think that they would be able to cope with the pressures.*

(Ethnographic shadowing 11: Andrea Hutchinson, clinical care director for care of the elderly, care of the elderly. St Josephs Community Hospital 17/12/2008)

The CCP meeting illustrates two important points for emotional geographies of care and patient care logistics: first, it highlights panellist behaviour's and the use of organisational guidelines (continuing care criteria) to manage their emotions while making logistical decision-making. Second, it highlights discourses surrounding the "new politics of care" (Sevenhuijsen 2003) and shifting geographies of care (England 2010).

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#### PANELLIST BEHAVIOURS

Like the managers in the capacity meeting, the continuing care panellists have no direct involvement in the delivery of patient care. Instead, they make material management decisions that impact on the physical distribution of care activities in the community. This means that patients'

additional care needs are based on the results of the assessment and not clouded by any prior personal or emotional care relationships with the patient. Due to the lack of personal engagement, the conversations and decision-making processes appeared, on the surface, to be emotionless, lacking compassion and devoid of any thought to the impact of their decisions to the patients or family members emotional and social needs. This perception made observing this meeting very distressing and at times induced anger at the abandonment of empathy, sympathy or concern for the consequences of their decisions.

Following the meeting however, an ethnographic interview ensued. Through this interview it became apparent that what I had perceived to be emotionless behaviour was a facade, a surface acted performance to enable the panellists to perform emotion management to mask their “authentic emotions” and project confidence, authority and rationality. The emotional labour performed in this meeting is interesting for two reasons: First, it challenges Hochschild’s notion that emotional labour is a function of waged labour that only operates through commercial face to face interactions with customers or patients. The emotional demands and subsequent emotional labour performed by the panellists demonstrates that face to face interaction is not a prerequisite for employees to engage in emotional labour. Second, it contradicts Klein who stated that “the closer and more concentrated the [patient relationship] the more the [health professional are] likely to experience the impact of anxiety and guilt” (Klein 1946:11). In this extract we hear that the professionals experience, manage and contain anxiety and guilt surrounding their decisions, despite having no prior relationship to the patients.

The emotional labour performed by the panellists was described as emotionally “fatiguing”, emotionally strenuous and often “heartbreaking”. This illuminates how demanding panellist behaviours are to perform as they



suppress their guilt, anxiety and frustration. In response to the emotional demands, these panellists used organisational guidelines as a defence against their own anxieties by splitting their decision-making (good) from the guidelines (bad). Obholzer states that “splitting makes it more comfortable for managers to make decisions” (Obholzer 1994:173). Despite engaging with the processes of splitting the panellists’ personal emotions continued to play an integral role in their decision-making due to their "emotional memories" (Hochschild 1983b, 2003b). These memories prevent emotions from being vanquished from unconscious cognitive thought leaving us aware of, or recognising, our own emotional under-currents and emotional experiences in others, thus producing empathy.

Through emotional talk, Andrea disclosed the influence that her emotional memory plays in her decision-making process. She states that the decisions she has had to make for the panel have become more difficult since she went through this process with her own family. Andrea did not reflect on whether her emotional memories hinder or improve her decision-making ability, however she is able to use her emotional imagination to think about how the consequences of her decisions may affect the patient and their family, and is therefore more sympathetic to the continuing care processes (Goleman 1998; Mayall 2010). This illustrates the role of emotion and cognition processes required for decision-making.

Due to emotional and cognitive demands, Andrea says that she would not subject her junior colleagues to the emotional burden of being a panellist because they would not be able to cope with the emotional consequences of their decision-making. She believes that she is able to cope with the emotional burden of her decisions due to her years of experience as a consultant working on the ward and managing the emotions of her colleagues (James and Huffington 2004). These experiences have left Andrea



emotionally desensitised or “hardened” to the emotionally strenuous decision-making required.

The emotional challenges within the CCP meeting are heightened by the presence of the patient’s relative. For the panel this intrusion is quite unorthodox and we see how it disrupts the emotional climate and the organisation of the meeting. Prior to the son’s arrival the panellists ensure that they all agree on the desired outcome for this patient. When the son enters the room he projects his anger and frustration onto the panellists. In adopting a defence mechanism to protect herself emotionally from the relative’s anger, Patricia meets the patient’s anger with an aggressive and confrontational tone which is not conducive to reducing the emotionality of the situation. The confrontational defence perhaps demonstrates that Patricia is struggling to manage her emotions.

The son challenges the panellists further by using the “continuing care criteria” as a weapon against the panellists. Patricia is therefore disarmed, unable to use the guidelines to shield and protect her and the other panellists from the son’s projected emotions. By using the guidelines as a weapon, the son leaves the panellists feeling vulnerable and unprotected as they are exposed to the notion that they are "playing God" with vulnerable people’s lives (Moylan and Jureidini 1994). This exposure enhances the panellists’ feelings of guilt and anxiety as they are forced to accept or reject the burden of their decision-making, resulting in more arduous emotion management.

Containing Patricia’s emotional slippage, Andrea, shifts the focus from Patricia’s emotional rupture and asks the son if he would explain why he thinks that his mother should be the recipient of additional care. It is here that we see Andrea’s skill in communicating with patients which may have come from her years of experience in delivering care on the ward. She is therefore more adept at managing her emotions in emotionally tense climates and in the face of emotional confrontation. Additionally, Andrea

may be more adept at managing her emotions due to her own emotional memories and emotional experiences of being in a similar situation with her own family. She may therefore be more sympathetic to the emotional experiences felt by the son in confronting the panel.

In addition to demonstrating panellist behaviours, the CCP meeting also explores the politics of care.

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### GEOGRAPHIES OF CARE POLITICS

McEwan and Goodman (2010) have highlighted that within advanced economies there is a question mark hanging over who has the responsibility to care for children, vulnerable adults and the elderly and infirm. The question of who cares has arisen due to "the burgeoning resonance given the return of women to the workplace, changing structure and geographical positioning of the family and an increasing ageing population" (Hallman 1999; Hugman 1999; McEwan and Goodman 2010:1043). These "changing social and cultural patterns" (Huffington 2005:5) have resulted in the family taking less responsibility for the care of dependants leading to increased reliance on the state. More recently state services such as the NHS, like many other organisations, have needed to reduce their services, expenditure and resource allocation (Tronto 1993, 2001) due to radically different and shifting external environments creating political and economic turbulence (Huffington 2005:5; Cowen 2010; Cresswell and Martin 2012). This has led to "the boundaries between public and private care [being] re-drawn as governments shift the burden of responsibility for their citizens' well-being [and health] away from state institutions to the private space of the home [and/or] to the private sector of the market" where care is commodified and commercialised (Kearns and Barnett 2000; England 2010:138; Green and Lawson 2011). Social and cultural changes to family structure have resulted in families becoming increasingly reticent to take responsibly for the care of their elderly family members. Families are now consumed by increasingly

high work demands, childcare, austerity measures and live geographically further away from elderly relatives, making caring for them more challenging (Googins 1991; Berman 1996; Lawson 2007; England 2010). These familial challenges were observed not only in the CCP's appeal case, but in an abundance of meetings that the health professionals had with families during ethnographic shadowing.

The extracts below are taken from meetings with relatives on two different elderly care wards at the Royal Alexandra University Hospital and demonstrate the challenges faced by families due to the shifting geographies of the responsibilities of care. The first extract is taken from a meeting between Noah Chapman and patients' relatives on the stroke rehabilitation ward with the care of the elderly department and emphasises the reticence in families to care for their elderly relatives.

*Noah begins the meeting by providing the relatives with their mother's medical history and current medical situation. He emphasises that their mother's stroke a few years ago was smaller - a TIA (Transient Ischemic Attack) and therefore she was able to recover very well. However, the recent stroke has been more severe and that they do not expect her to make...a good recovery.... Noah explains that he thinks that the best place for their mother would be a nursing home as they have the facilities to support her. The daughter sighs loudly and says that their mother would **never** want to go to a nursing home... and states that there must be a way around it... Noah says that there is a solution. The relatives look hopeful... 'You could take on the care yourselves'. The relatives look at Noah with contempt...*

(Ethnographic shadowing 22: Noah Chapman, consultant geriatrician, care of the elderly, Royal Alexandra University Hospital 13/07/2009)

The second extract is taken from a meeting between consultant geriatrician Parvette Patel and her registrar and a patient's son on a care of the elderly

ward and demonstrates the emotional demands and sacrifices that families have to make in order to be responsible for the care of their elderly relatives:

*Parvette asks the patient's son to talk a little more about his mother's mobility and how she copes at home. The son says that he has to do everything for her. He says he doesn't mind doing her shopping, washing or cooking as he has to do all that for himself so it is not an issue. The biggest problem is washing, dressing and changing her pads. He continues 'it sounds awful...but I just can't...I don't want to do it for her...I am her son...it is embarrassing...for both of us...I just can't cope with it!' Parvette empathises with the son and says that she understands how difficult it must have been for him... Lorna tells the son that since the operation his mother has been able to dress herself, give herself a basic wash and with the catheter she no longer has an incontinence problem so there are no issues with keep changing his mother's pads. The son asks 'well who has to change the bag?' Lorna explains that his mother would be entitled to a package of care, at least twice a day to help her get up in the morning, help her dress if she needs it, help her wash and change her catheter bag and then at night to help her undress, have a bath or shower, etc.*

*The son says that he doesn't trust carers. He tells them that carers were supposed to come for his father, but they never turned up...He continues 'my employers were not sympathetic as it was happening every day, so I had to leave... That was about 10 years ago now...I was the full time carer for my dad and now my mum...I want my life back...I need a job...I could just about cope with doing stuff for my dad...but not for my mum...it is stressful... and so embarrassing...I need time off to rest...I haven't had a holiday in 10 years...I am exhausted...I need a break...I can't do this anymore'...*

*Parvette asks the son whether having a care package and carers has made him think differently about sending his mother to a care home... The son*

*looks directly at Parvette and says 'you have twisted me round your little finger...before I came in I was adamant, that she was going to a home...now I am warming to the idea of bringing her back home with me...' Parvette retorts that she is not trying to persuade him either way, 'we both want what is best for your mother!'*

(Ethnographic shadowing 21: Parvette Patel, clinical lead for proactive care of older people undergoing surgery (POPS), Royal Alexandra University Hospital 18/06/2009)

These ethnographic extracts both demonstrate the reluctance and burden that families have in taking responsibility for their elderly relatives due to economic and work-life balance pressures. Many families work long hours, have increasing childcare needs due to having children later in life and the disruption that caring for a relative has to their social, economic and emotional lives. Reluctance to care for family members highlights the shifting geographies and spatialities of care with relatives believing that the responsibility of care should be placed on state services such as the NHS and / or publically funded nursing homes or on private commercialised care providers, where such services can be afforded.

Whilst it is clear that families do not want to take responsibility of the care of the elderly, or other vulnerable family members, state funded organisations cannot afford to support the increasing demands on its resources, especially due to an increased aging population (Hallman 1999). Counter to the families demands, the state therefore redirects care responsibility back to the private spaces of the home causing the boundaries between the state and the home to be renegotiated (Lawson 2007; England 2010; Green and Lawson 2011).

The financial demands on the NHS and the impact that these demands have on the available resources are highlighted by the chair Patricia in this CCP through the reduction of "additional care" in the community. Other cost-saving policies were also highlighted in the MDT and capacity meeting via

the effective management of patient care pathways and the rapid movement of patients through the system. Hospital stays, for example, are shortened to reduce patient expenditure and decrease hospital acquired infections. Increased homecare has helped these health reforms to become cost-effective as it is cheaper for patients to convalesce at home or in a privately funded nursing home than it is to stay in hospital (England 2010). This has caused the home to become an increasingly important part of the care landscape (Milligan 2000; England 2010; Green and Lawson 2011).

The increasing need for families to take responsibility for their dependents has, however, implications for gender politics as women, despite their increasing participation in waged work (Wiles 2003; McDowell 2004; McDowell, Ray et al. 2005; Williams and Crooks 2008), are expected to take responsibility for this burden created by the "care deficit" (Hochschild 2003a; Bone 2009) causing care work to become "invisible work" (England 2010:141). The invisibility of care work is highlighted in the CCP meeting by the appeal case and Parvette's extract. In both extracts the unpaid care work that these families provide for their relatives is un-recognised by the state.

England (2010) has shown that shifting economic responsibility from the state to the home, whilst cost effective for the state, is detrimental to the home, especially for women who may need to reduce their hours at work to meet care demands (Joseph and Hallman 1996; Hallman 1999; Hallman and Joseph 1999). The impact of caring for an elderly relative was highlighted in the ethnographic extracts with the first family juggling care work around their paid employment and the son having to give up full-time employment to be a full time carer for his elderly parents. The impact on the families' social, economic and emotional well-being is explicit through the extracts demonstrating the isolation that informal carers often experience when they exit the workplace to become full-time carers (Wiles 2003). The emotional burden of juggling paid employment with caring for elderly relatives is also

made explicit in the CCP meeting and illustrates the reality faced by many families who cannot afford to place their elderly parents in a private nursing home.

Operating within the "logistical spaces" of the CCP meeting, this meeting has offered two divergent insights into the emotional geographies of care work and geographies of patient logistics. It has highlighted that organisational decision-making surrounding additional resource allocation is emotionally demanding, requiring panellists to perform emotionally laboured behaviours and the use of organisational guidelines as a defence mechanism to protect them from their emotionally challenging decision-making. Second, it illustrated that logistical spaces are highly political and that management decisions within these meeting spaces have powerful social effects, especially in relation to the responsibility of vulnerable populations in the community and shifting politics of care. This section therefore demonstrated the complex integration between emotion and logistics within the delivery of care in the NHS (England 2010).

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### SUMMARY

The final section (4.6) explored the geographies of patient logistics that operate within the "logistical spaces" of the NHS. Focussing on three organisational meetings: a multi-disciplinary team, capacity, and continuing care panel meetings, the section specifically analysed the spatialities that frame the organisations and management of care around the mobilities, fluxes, flows and (emotional) connections and interconnections of patient logistics. It demonstrated that, whilst logistical spaces were constructed to heighten objective and rational decision-making along the patients' care pathways by promoting depersonalisation, categorisation, detachment and the denial of feelings (Menzies 1970; Hochschild 1979; Williams 2013a), organisational meetings were not emotionless terrains. Instead emotions played an integral role in logistical decision-making.

## 4.7 CONCLUSION

*Hospital care work: Emotion, space and logistics* addressed the first three objectives of this thesis by demonstrating how and why health professionals engage in emotionally detached or emotionally attached care behaviours. Furthermore, it explored the impact of these care behaviours on their own and their patient's emotional and psychological well-being. The chapter also explored the back region, meeting spaces to illustrate how logistical spaces and care management decisions are saturated with emotion.

Exploring emotionally detached care behaviours, the ethnographic extracts highlighted the inter-relationships between health professionals and their patients as well as the impact of the spatial and temporal dynamics on care. It therefore brought into focus the interaction between emotional geographies and health geographies. In so doing, it illustrated that for health professionals working in temporally rich carescapes (Urry 2003), decreased bodily proximity and reduced haptic qualities are necessary to make sound clinical decisions that are uncontaminated by emotion. Detached care behaviours therefore benefit patients by providing compassionate, respectful and dignified care to patients, especially to those at the end of their life-course. In addition, disconnected care, advocated by the traditional model of care, also supported and protected health professionals from emotional fatigue, anxiety and guilt. In some tasksapes however, health professionals were becoming disillusioned with detached care behaviours leading to geographies of contested emotions.

Analysing emotionally attached care behaviours, the ethnographic extracts emphasised not only the inter-relationships between care providers and receivers, but also the relationships between place and health professionals / patients through the notion of "belonging" specifically within temporally poor carescapes such as care of the elderly where bodily proximity and tactile care behaviours are practised. Emotionally connected care enhanced health professionals' knowledge and understanding of their patients'



emotional world, leading to greater decision-making, care quality, empathy and emotional gifts. While reducing health professional's emotional labour, anxiety and guilt, emotionally attached care behaviours also enhanced patient's care experiences, thus speaking directly to the needs of the Francis report (Francis Report 2013c, 2013a, 2013b).

The examination of logistical spaces explored the management of care, demonstrating that meeting spaces are not emotionless terrains. Instead they challenge health professionals' emotional labour and emotion work through an engagement of their emotional imaginations. In addition, it also emphasised the spatial diffusions of care through an exploration of care politics as the boundaries between private and public care provision is becoming blurred in the current economic climate, especially surrounding the responsibilities of care for vulnerable populations (Lawson 2007; England 2010). Finally, the exploration of logistical spaces demonstrated how the NHS' organisational climate could be rejuvenated through addressing their employees' organisation-in-the-mind. It emphasised that by combining health care geographies with emotional geographies, geography has an increased relevance for influencing health care policy and practice.

In addition to addressing the first three objectives, the chapter also made connections with the later three objectives, specifically in illustrating how the day to day rhythms of hospital care work and emotional talk within back regions facilitated the construction of emotional relationships between colleagues. Furthermore, the affective qualities of care were emphasised through the emotional story of the still-born baby and the ethnographic observations which championed the communication and transference of emotions and affects, specifically pain, through proximate bodies. The latter three objectives will be fore-grounded and analysed in more detail in the following chapter: *Caring on the move: The emotional care work of ambulance crews* which emphasises the spatialities of care that operate within mobile workplaces.

## CHAPTER 5: CARING ON THE MOVE: THE EMOTIONAL CARE WORK OF AMBULANCE CREWS

Geographies of mobile workplaces

Emotional geographies of ambulance crews

Spectral geographies and the uncanny

### 5.1 INTRODUCTION

Ambulance crews play an integral role in frontline emergency care, “assessing, managing, treating and transporting the public with an extensive range of potential conditions including falls, cardiac arrest, sudden death, severe trauma and social problems” (Department of Health 2005; Craggs and Blaber 2008; Williams 2013b:207; 2013c). The spatialities in which ambulance care is delivered and the attendance to life threatening, “critical incidents” enhances the emotional demands placed on ambulance crews. In attending critical incidents, ambulance crew experience a range of emotions which have to be carefully managed. Additionally they have to manage the emotions of their patients, relatives and bystanders (Caroline 2008; Williams 2012a, 2013c, 2013b; Williams 2013a).

The term “critical incident” was coined by Mitchell (1983) to mean “any situation faced by emergency personnel that [invokes] unusually strong emotional reactions...[to events] which have the potential to interfere with their ability to cope at scene or later” (Mitchell 1983 cited in Halpern, Gurevich et al. 2009:174). Clohessy and Ehler (1999) developed a list of critical incidents which evoked the greatest emotional reactions in ambulance crews. These included: cot death, incidents involving children, dealing with the relatives of patients, burn and mental health patients and handling dead bodies. Alexander and Klein (2001) added to this list to

## CHAPTER 5.1: INTRODUCTION

include: road traffic collisions, medical emergencies, suicides, violent incidents, the victim being known to the ambulance crew and the ambulance crew feeling helpless at the scene. During the ethnographic observations the majority of these incidents were observed.

Despite their important role in the emergency health care system, ambulance crew are under-theorised and under-researched. It is for this reason that the Department of Health (2005) has identified this profession as a research priority. Burgess and Watson et al. (2012) have suggested that limited research with these health professionals may be a result of the ethical and practical challenges in gaining access and obtaining informed consent from the crew and their patients.

Whilst research with ambulance crews is limited, there is a diminutive body of research within this literature which focuses on the emotional aspects of their care work and their emotion management skills in delivering care in the pre-hospital environment. Research focussing on the emotional labour of ambulance crews however is beginning to burgeon under a few key authors (Steen, Næss et al. 1997; Boyle 2005; Mitmansgruber, Beck et al. 2008; Filstad 2010; Brady and Haddow 2011; Brady 2012b; Burges Watson, Sanoff et al. 2012; Brady 2013a). Furthermore, there is a growing body of literature analysing the role of (gallows) humour and storytelling within the emergency services (Tangherlini 2000; Scott 2007a; Roth and Vivona 2010; Rowe and Regehr 2010; Charman 2013; Moran and Roth 2013; Sliter, Kale et al. 2013; Williams 2013b). It specifically analyses how laughter is used as a defence mechanism to cope with trauma. As an emergency service, however, ambulance crew remain marginalised with much of the literature focussing on the police force or fire service.

Notwithstanding small flourishing pockets of literature within health care and organisational literatures, exploration of the emotional labour provided by the ambulance service is noticeably absent from emotional geographies

## CHAPTER 5.1: INTRODUCTION

and workplace geographies literatures. This perhaps is unexpected considering the highly emotive care work undertaken by ambulance crews and their identity as a highly mobile workforce. They therefore provide distinctive, interesting and innovative contributions to both emotional geographies and (mobile) workplace geographies.

Drawing on empirical data within a wide range of ambulance crew, this chapter illuminates that the mobile nature of ambulance work enhances their emotional and affectual geographies of care work. Theoretically underpinned by emotional geographies, it integrates emotion management literatures with mobile geographies informed by the “mobility turn” (Urry 2003) and affectual geographies influenced by Thrift (2004) and McCormack (2006), to deconstruct and explore the emotional geographies of care work in the ambulance service. In examining care work in the pre-hospital environment, this chapter is organised around three sets of geographies: geographies of mobile workplaces, emotional geographies of ambulance crew work and spectral geographies and the uncanny. This framework will be used to examine how the spatial, temporal and mobile nature of this workforce impacts on their ability to manage, suppress, defend and cope with their own and their patients’ emotions during the delivery of (mobile) patient care.

*Geographies of mobile workplaces (5.3)* focuses on the different spatialities of care work delivered by ambulance crews in the community. It emphasises that their mobility offers a distinct and novel perspective to emotional geographies of care work, particularly in relation to the relationships that are established with patients as a result of the spaces, places and temporal dimensions in which care is provided. Care work which is performed in the patient’s home facilitates the construction of emotionally attached care relationships. This is because personal possessions, pictures, objects and relatives that surround crews make it more difficult to split the body as

object from the human subject (Lapum, Fredericks et al. 2012; Scott 2013). Conversely, depersonalised public spaces force crews to emotionally disconnect from their patients. Treating “undesirable patients” (drug addicts, drunks and abusive patients) also results in emotionally detached care behaviours (Stockwell 1972; Kelly and May 1982; Dingwall and Murray 1983; Maben, Adams et al. 2012). Furthermore 5.3 analyses how emotional care relationships between ambulance crews and their patients change during the journey to hospital. It demonstrates that within the ambulance, crews dehumanise their patients, beginning the processes of emotional detachment through the attachment of medical equipment to the patient’s body (Haraway 1994; Lapum, Fredericks et al. 2012) and replacing the patient’s name with a number. Leaving the hospital, crews purge the patient from their mind by changing the bed linen, wiping down the stretcher and removing their gloves.

*The emotional geographies of ambulance crews (5.4)* explores the emotional connections and disconnections between ambulance crew. It demonstrates that crew relationships are established and shaped through the spatial confines of the ambulance. It specifically analyses the bond created between permanent crew mates which enables them to perform care work in intuitive patterns, rhythms and choreographed routines (Hargreaves 2001b, 2001a). These established routines make the emotional challenges of their jobs less demanding. In contrast, the patterns, choreographies and emotional geographies between non-permanent crew mates are also analysed revealing that emotional distance heightens workplace tensions.

In addition, the section also analyses the role of station mates and their role in facilitating and supporting emotion management. It particularly focuses on the role of humour as a defence mechanism to diffuse anxiety and guilt. Additionally, it explores how emotions are managed and contained when

black humour is inappropriate, i.e. death of a child, through the creation of therapeutic safe space.

*Spectral geographies and the uncanny* (5.5) emphasises the affectual qualities of care by illustrating how spectrality, absence and memory plays an integral role within emotional geographies of care work. It highlights that repressed unconscious emotions often unwittingly seep into crews' consciousness during a job throwing linear temporality into disarray as memories or ghosts of past patients collide with the present (Pile 2005a, 2005b; Holloway and Kneale 2008; Holloway 2010). This results in fear, anxiety, terror that can potentially threaten their ability to deliver care. Divided into three spectral tropes: ghosts, memory and the uncanny, this section emphasises the value of incorporating spectral geographies with an emotional geographies of care work. Ghosts focuses on the dark and "hostile forces" (Freud 2003:xliv) that impress upon crews due to inescapable post-memories of "bad jobs" that cause the dead to return (West 2013:4). Memory by contrast focuses on the positive experiences and feelings such as awe and admiration that crews draw strength and confidence from, enhancing their emotional relationships with patients. Finally, the uncanny describes the feelings of familiarity and homeliness (Freud 2003:xliv) felt by crews when they are exposed to patients' materialities in the home.

I now present the care environments from which the empirical data were collected:

## 5.2 THE AMBULANCE SERVICE

The empirical data for this chapter were taken from Hermes ambulance station within the south-east ambulance service (SEAT) (figure 3). Within Hermes ambulance station ethnographic and semi-structured interview data were collected with a range of ambulance crews including: emergency care assistants (ECAs), technicians, paramedics, emergency care practitioners (ECPs), operational supervisors (OS), clinical supervisors (CS) and the station manager. Ethnographic observations were taken at the ambulance station, in the back of ambulances and public and private spaces. To demonstrate the different spaces in which ambulance crews delivered care I provide “arrival scenes” (Geertz 1988) from a variety of ethnographic observations.

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 AMBULANCE STATION

*The taxi pulls off the dual carriage way and into an industrial estate...after winding round the derelict road the ambulance station comes into view, a two story light brick building with a large garage next to it with an electronic sliding iron door... there are some crew standing just outside talking and smoking. Feeling a little nervous I walk towards the group. I spot ECP, Tim Harvey who I have been introduced to. Tim introduces me to the other crew and they joke that I have drawn the short straw working with him today...Tim suggests that we go inside for some coffee.*

*Tim swipes his employee card on the door and it clicks open, we enter a small entrance hall and Tim asks me to sign in pointing to the sign-in book. The toilets are to the right of the front door and we head through a door on the left which leads to the kitchen consisting of two tables and chairs, two fridges and kitchen amenities. Attached to the kitchen (open plan) is a lounge area of approximately 12 blue single and double arm*

*chairs positioned around a flat screen TV. There are three crew in the kitchen drinking hot drinks and in the lounge.*

*Tim suggests that we find me a hi-vis jacket and prepare the rapid response vehicle (RRV). We head up a narrow staircase leading to the station manager's office, a training room and a computer suite. Tim finds a fluorescent observer's jacket and hands it to me saying "xs that should fit!" I try it on over my coat, it comes down past my knees, my hands hidden inside the sleeves. Tim laughs as he begins rolling up the sleeves "sorry, it is the smallest size...it will have to do!"...*

*We head back downstairs and Tim points out the male and female changing rooms, the drugs store, the utility room and the showers... we go through a door which leads into the garage. There is an office to the left and Tim introduces me to the mechanics and operations manager. He hands Tim a pair of keys, who picks up a mobile phone and a radio and we head to the vehicle....*

(Ethnographic shadowing 27: Tim Harvey, emergency care practitioner, Hermes ambulance station 12/11/2009)

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## THE AMBULANCE

*Entering the ambulance through the back door I notice how small but interesting the space is. There are two fold-up chairs strapped to the wall immediately to the right and left of me, to the right the caterpillar chair used to carry patients down stairs and to the left the ordinary collapsible wheel chair.... Along the left hand wall are two emerald green chairs also in a folded position. These chairs are for a relative and crew to sit en-route to hospital. Next to the second green chair a telephone is fixed to the wall. It is used to make pre-alert calls to the hospital. A large sliding door, used to walk patients in and out of the ambulance, takes up the remainder of this side of the ambulance. Facing the back door is a cupboard containing crash helmets, collar and boarding equipment and*



*the kit bags; however the kit bags are predominately left on the floor for ease of access. The cupboard also opens from the outside (once the sliding door is open) and houses the scoop and spinal board.*

*Next to this cupboard is a small recess where crews can climb between the front and back of the ambulance quickly. This recess once had a sliding door however I have been told that I will not find a functioning door on any ambulance because they have been jammed open with medical equipment and/ or taped open with surgical tape. The 'observer's chair is next to this recess allowing me to see in the front and the back of the ambulance at all times (figure 7). In the front of the cab is a mobile data terminal (MDT) which informs crews of their jobs via the call centre and a radio for speaking to the hospital, call centre and other emergency services. Directly in front of my chair is the head of the stretcher. Above this, the telemetry which allows crews to take an electrocardiogram (ECG) reading and send pre-alert messages to the hospital, a blood pressure cuff, Sats probe and an automated external defibrillator (AED)...The affectionately termed 'Pic' n' Mix' boxes containing canulars, needles, bandages, plasters, tourniquets is directly above. Finally, at the foot of the stretcher a large door and ramp that allows the stretcher to be lifted in and out of the ambulance. Oxygen tanks are accessible via a door outside the ambulance in line with the observer's chair.*

(Ethnographic shadowing 26: Tim Harvey, emergency care practitioner, Hermes ambulance station 11/11/2009)

Much of the care work that ambulance crews deliver is conducted in private spaces such as the home, nursing homes or care homes. These private spaces provide crew with an insight into the social and cultural lives of their patients, insights that are not available to health professionals working in the hospital. An awareness of patients' social circumstances is helpful to the care ambulance crews provide.

## HOMES

*The crew arrive at scene. It is a lovely big house with a well kept front garden. Jason Bond comments 'wow...I wouldn't mind living here!' Victoria Dennick rings the door bell and they wait. A middle aged woman opens the door. She has red eyes and a blotchy skin... She informs the crew that they have come for her father. She continues that her mother is exhausted and is having a lie down but will go and get her... We enter a large well decorated entrance hall and climb a wide central staircase with dark wooden banisters... The woman leads the crew into a large bedroom with large windows allowing a lot of natural light to enter the room. The patient is lying asleep in the bed...*

(Ethnographic shadowing 62: Victoria Dennick, Technician, Jason Brand, Student paramedic, Hermes ambulance station 14/06/2010)

*...The front door is opened by a middle aged man wearing ill fitting brown trousers and a dirty half tucked in white shirt and thread bare slippers a cigarette hanging from his mouth. He allows us to walk through and then throws the end of his cigarette into the front garden which is already littered with beer cans, cigarette butts and sweet wrappers. The hallway is dark and narrow saturated with an overwhelming smell of smoke and cluttered with bags and piles of newspapers and un-opened post. The wallpaper tinged yellow and brown from years of cigarette smoke. The patient is sat on a sofa covered in a well stained blanket in the living room. The room is dimly lit and also has tinged yellow peeling wallpaper, the carpet is disgustingly dirty and after standing still for a couple of minutes my shoes become stuck to it. The man sits down in an armchair next to the patient. It is 08.30 and he is drinking alcohol, a pint glass half full of beer and an empty can sitting on the small table in front of him along with an ash-tray overflowing with cigarette butts and ash... crushed beer and cider cans, dirty plates and takeaway boxes surround his feet....flies periodically crawl on my neck*

*and arms, I try and shoo them discreetly as to not offend the patient and her male companion...*

(Ethnographic shadowing 50: Joseph King, paramedic, Adam Hilton, emergency care assistant, Hermes ambulance station 30/03/2010)

In addition to private spaces, ambulance crews deliver care work in public spaces such as shopping centres, workplaces, schools, hotels, leisure centres, road-sides, high streets, recreational spaces. The different spatialities in which care work is delivered emphasises their mobility.

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#### PUBLIC SPACES

*The MDT reads **0850** motorbike vs. car? leg injury. Bobby comments 'ah, another RTC (Road Traffic Collision)...'... There are two ambulances already at scene and one police car. Bobby parks the ambulance in front of the other two ambulances and the police stop the traffic for us to walk safely across the dual carriageway. Underneath the first parked car is the back end of a motorbike with a patient still half on it, he is not trapped under the car but lying in an awkward position on the floor. The CS (clinical supervisor) on scene informs Wilbur Baldwin that the driver of the car and her child are on board the first ambulance. Wilbur climbs on board and slams the door behind him. Bobby attends to the motorbike with the CS and Erica Prawer (paramedic)...The CS brings over scoop...and it is placed underneath the patient and then clipped together. On the CS' count of three the patient is moved away from the bike and onto the grass verge. Bobby asks the patient if he is in any pain. He says that he has a little twinge every so often in his back. Bobby removes the biker's helmet gently and Erica removes the patient's gloves and boots. With these items off Bobby asks the patient if he has any pain again. He says he has a little bit of pain in his arm and in his lower back. Bobby begins assessing the patient's neck by feeling down his spine. Finding no pain, Bobby asks the patient to slowly move his chin towards his chest and then move his ear to his shoulder. The patient says he has a little bit*

*of discomfort in doing this. Erica slightly pinches the patient's toes and asks him if he can feel her. She then asks him to wiggle his toes. She moves onto the fingers....Bobby leaves to get a stretcher.*

*Bobby returns with the stretcher, spinal board and head blocks...The biker is collar and boarded and put onto the stretcher. The policeman stops the traffic as the patient is wheeled across the road to the ambulance...*

(Ethnographic shadowing 65: Bobby King, paramedic, Wilbur Baldwin, emergency care assistant, Hermes ambulance station 28/06/2010)

In framing *caring on the move* around three discourses: geographies of mobile workplaces, geographies of ambulance crews and spectral geographies and the uncanny, this thesis contributes to and develops the emotion management literature by exploring how crew mobility influences the emotional connections and disconnections between patients and colleagues. The third discourse develops health geographies by exploring care work through affective geographies, from which there has been limited engagement (Andrews, Chen et al. 2014). This chapter therefore provides original insights and analysis to care work with ambulance crews.

Whilst the data collected with the ambulance service was largely ethnographic, the chapter seeks to balance interview excerpts with ethnographic extracts. Interview data dominates section 6.5 spectral geographies and the uncanny due to its focus on spectral haunting, memories and feelings of the uncanny that were experienced and expressed through emotional talk (Mehta and Bondi 1999). Hill (2013) and Wylie (2007) have advocated that geographers should become more "sensitive to the ways in which individuals experience memory" (Wylie 2007; Hill 2013:382). It is therefore through the presentation of crews' own voices that this chapter bears witness to, and is sensitive to crews' ghostly experiences, capturing the power of the haunted mind. It advocates that spectral geographies should be taken more seriously within this field.

I now turn to explore the first discourse - geographies of mobile workplaces.

## 5.3 GEOGRAPHIES OF MOBILE WORKPLACES

This section illustrates that the mobility of crew work offers a distinct and novel perspective to emotional geographies of care work particularly in relation to the emotional relationships that are established with patients. It demonstrates that care work which is performed in the patient's home can result in ambulance crews establishing emotionally attached care relationships with their patients due to being surrounded by personal possessions, pictures and objects. In contrast, other spatialities such as public spaces force crews to become emotionally detached. Furthermore, it shows that due to crews mobility, patient care is rarely performed in back regions (Goffman 1990). Instead it is performed in front of an audience (relatives, friends, colleagues or bystanders). This has implications to crews' emotion management (Hochschild 1983b; Goffman 1990; Hochschild 2003b).

## INTRODUCING MOBILE CARE WORK

The first extract is taken from an ethnographic observation with paramedic Christopher Pearce who was single-manned in a rapid response vehicle (RRV). This shift was 12 hours long, commencing at 9am. The extract provides new insights into the connections and relationships between emotional geographies and (mobile) workplace geographies by demonstrating how crew mobility constructs different emotional care demands on ambulance crews in comparison to health professionals working in hospital settings.

*The MDT bleeps 'F SOB' (Short of Breath). As we speed to the location Christopher picks up the radio and asks for some more information. Control informs Christopher that he is going to a lady in sheltered accommodation who is having trouble breathing and has become very confused. Christopher believes the patient has a UTI (urinary tract infection).*

*Arriving at scene Christopher hands me the O2 bag and he takes his orange paramedic bag. Christopher presses the door bell a couple of times, the speaker begins to crackle and a muffled voice says 'hello'. Christopher shouts 'ambulance service' and the door is released. A health care assistant (HCA) approaches us and leads us to the patient's room. Several elderly residents stare as we walk past.*

*Christopher enters the room calling 'ambulance'. A woman returns the calls leading us into the patient's living room. The patient is sat in the centre of the room on a commode. She is naked on her bottom half and slumped over. Christopher crouches in front of the patient and says hello. Christopher introduces himself and tells her he is a paramedic. The patient doesn't respond and Christopher looks at the carer sat in a chair opposite her and asks for her name. The carer says it is Maureen. Crouching down in front of Maureen he asks what the problem is. Maureen says nothing and Christopher turns to the carer for information. The carer says Maureen has not been well, but her breathing has been getting slowly worse and today she seems delirious and confused. Christopher asks Maureen if he can take her blood pressure (BP), Maureen nods. Christopher takes Maureen's hand to lift her arm and she complains that his hands are cold. The nurse laughs and says that the patient always tells her off for touching her with cold hands. Christopher apologises and then attempts to warm his hands by rubbing them together and placing them under his arm pits. He takes her hand again and asks if that is better. She mumbles yes. Christopher warms the BP cuff before wrapping it around Maureen's arm.*

*As the cuff tightens around Maureen's arm, Christopher looks around the room. Pointing at a picture he asks 'are they your grandchildren?' Maureen smiles and looks at Christopher 'yes, I have three...two boys and a girl'. The BP cuff begins to deflate and Christopher writes Maureen's BP on his glove. Christopher asks if he can look in her eyes with his*

*torch...She lifts her head slightly and says 'ok'. Christopher...begins looking into eyes, asking more questions about her grandchildren.*

*...Crouching back on his heels he asks the nurse for the patient's medical history. The carer says she has diabetes which is controlled by drugs, she normally has a high BP, she has osteoarthritis in her knees, feet and elbows, she has had a stroke, she has had breathing difficulties over the past few weeks, her breathing is particularly shallow. Christopher writes this information on his glove. He then looks up and asks me to get the sats probe out of the diagnostic bag, Christopher clips it to her finger. Christopher says her oxygen levels are low (78%) so he will give her some oxygen. Another HCA enters Maureen's room and stands in the corner.*

*Christopher asks if the patient has been diagnosed with a UTI. The carer says that she has and that the doctor has prescribed her drugs. Christopher places the oxygen mask over Maureen's face and switches it on. He then takes her blood sugars. They are high at '13.1'...Christopher takes a mobile phone from his trouser leg pocket and calls control for back up to take the patient to hospital.*

*...Christopher asks Maureen how she is feeling with the oxygen. She mumbles something incoherent and then makes a random comment. The carer laughs and rubs the patient's hand 'Maureen you have been making some funny comments this morning haven't you!' Christopher asks the carer if this confusion is normal. The carer says 'no, she normally sustains good conversation'.*

*Retrieving a PRF (patient report form) from his bag Christopher begins filling it out asking Maureen if her family lives nearby. Maureen says her daughter does. Christopher looks around the room and points at a photograph 'is this your daughter?' Maureen nods. Christopher asks the carer to get him next of kin details and continues to talk to Maureen about her daughter as he fills in the form...*



*Another carer enters the room informing Christopher that the ambulance has arrived...the crew enter and Christopher provides a handover. They write the information on their gloves...Christopher hands the crew the PRF. One crew mate leaves to get the stretcher. Christopher packs away his equipment. The carers leave to get a harness to lift Maureen off the commode. The stretcher arrives and the crew help the carers to get Maureen onto it. Christopher comments 'Maureen has three beautiful grandchildren' and points to the photograph on the shelf. The attending crew ask Maureen questions about her grandchildren. Once on the stretcher the carers leave and the second crew pushes the stretcher out of the room. Other residents have gathered in the communal area to watch...*

(Ethnographic shadowing 32: Christopher Pearce, paramedic Hermes ambulance station 22/01/2010)

Christopher's extract highlights three important points for an emotional geographies of care work and mobile workplace geographies. First, it demonstrates that technology plays an integral role in ambulance crew mobile working. Second, ambulance crew mobility increases the unpredictability of patient care and challenges the emotional labour of crews and third that ambulance crew work is performed in front regions.

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#### MOBILE TECHNOLOGY

Christopher's movement across the city to arrive at the care home in which Maureen lives demonstrates how ambulance crews are a "truly mobile workforce" (Sherry and Salvador 2001; Normark and Esbjornsson 2005:257) because their work is dependent on a particular time and space (Wilberg 2005; Cohen 2010a:69). To enable ambulance crews' mobility, their workplace (ambulance or RRV) must be mobile. Ambulance crews spend the majority of their shift (10-12 hours) in the ambulance or RRV, only returning to the ambulance station for a meal break and to return the vehicle to the garage at the end of their shift.



Despite ambulance crews being a highly mobile workforce and the ambulance a mobile workplace they have been neglected from the "recent explosion [of]... analysis on mobile work" over the last decade (Cohen 2010a:65; 2010b). Instead the "mobility turn" (Urry 2003:155) has focussed on the role of mobile technologies and improvements to motorways and automobiles that have enabled workforces to become more mobile (Laurier 2004; Larsen, Axhausen et al. 2006). Research therefore focuses on the increased use of the car as a mobile office (Eost and Flyte 1998; Laurier 2001; Laurier 2002), or on mobile occupations such as bus drivers and road inspectors (Normark and Esbjornsson 2005), cab and tax drivers (Davis 1959; Psathas and Henslin 1967; Verrips and Meyers 2001; Mmadi 2012), lorry drivers (Hollowell 1968; Agar 1986) process engineers (Bertelsen and Bodker 2001) service technicians (Orr 1996; Ueno and Kawatoko 2003; Wilberg 2005) and mobile hairstylists (Cohen 2010a).

Drawing on a time, space, mobility matrix created by Wilberg (2005), Cohen (2010) demonstrates that there are four different types of mobile workers. Those workers, for example, who can perform tasks independently of time and space such as - accountants, editors and web designers. Second, those that are dependent on place but independent of time, for example employees working on an assembly line. Third, workers who are dependent on time but independent of place, e.g. white collar workers such as IT support or telesales and fourth workers who are dependent on work being performed in a particular space and at a particular time. These workers include teaching, direct- sales and emergency service work.

In addition to this matrix Cohen (2010) also creates a typology of mobile work which was influenced by Felstead et al.'s (2005) home-working study and Green's (2002) analysis of mobile workers. This typology focuses on three relationships between mobility and tasks: first, mobility as work, i.e. lorry drivers, taxi drivers, carriers, pilots and bus drivers, where human

beings are transported. Cohen states that mobility as work is place and time dependent but spatial routes or 'worksapes' may vary (Cohen 2010a:70). Ambulance crews fit into this category as they convey patients to and from the incident to the hospital.

The second mobile type is "mobility for work" (Cohen 2010a:70) which includes construction workers, plumbers, mobile hairdressers, service technicians. Work for these employees is "spatially dispersed" and therefore they have to travel to complete their tasks. This work can typically not be completed in one geographical location or a single workplace and therefore requires mobility. Again ambulance crews fit into this typology because they travel across a city to deliver patient care to patients who are spatially dispersed. Finally, "working while mobile" is the third typology. This work includes accountants, IT consultants and academics. Working whilst mobile for many is a choice, however certain circumstances may constrain this choice, for example workers who have long commutes that may use this time for opportunistic working. Crew work again falls into this category as en-route to the hospital crews complete paperwork such as the patient report form (PRF), check basic observations or, in the case of trauma patients, CPR maybe performed.

Whilst ambulance crews fit with Wilberg's (2005) matrix and Cohen's (2010) mobile workplace typology they have been neglected from research on mobile workforces. Limited research in this area may be due to the challenges of accessing this group of workers and the challenges of gaining ethics (Burges Watson, Sanoff et al. 2012). By neglecting ambulance crews and other emergency workers or community health professionals such as district nurses (Burke 2013), analysis on "truly mobile workers" remains under represented and under theorised.

Where the ambulance service have been studied, research tends to focus on the call handlers despatching the ambulance crews and the technology used

to locate and despatch ambulance crews, rather than focussing on the crews working on the road (Ikeya 2003). The technology used by crews is integral to their mobility. In this extract, Christopher is witnessed using several technologies, both clinical and communicative that enable him to work effectively in the pre-hospital environment. Communicative technologies include the multi-data terminal (MDT), which provides Christopher with information about the patient, taken from the call handler in control centre. Information includes the patient's address, gender, and age, presenting complaint and other relevant symptoms or illnesses raised by the person making the call. The MDT also allows Christopher to communicate with the control centre through the pressing of the "to scene" button, which shows the call centre that the crew has accepted the job. The satellite navigation (Sat Nav) is also linked to the MDT to direct the crew to scene. Christopher also uses the in-car radio to request more information from control and a mobile phone to ask control for "back-up" to convey the patient to hospital.

Laurier (2002), Bardram and Bossen (2003) and Wilberg (2001) have also demonstrated how mobile technologies such as the mobile phone, hands-free kits, laptops and other portable devices have enabled employees to accomplish work on the move by using the car as a modified workplace or a mobile office (Sherry and Salvador 2001; Urry 2003; Laurier 2004). Mobile offices diminish the importance of place, as workers 'assemble' and re-assemble their workplace in third spaces such as petrol stations and cafes (Felstead, Jewson et al. 2005a; Felstead, Jewson et al. 2005b; Cohen 2010a). Ambulance crews' mobile technologies allow them to assemble a workplace upon arrival.

In addition to communicative technologies, mobile clinical equipment is also integral to their mobile care work. In attending a patient, crews take to scene a rucksack containing standard mobile diagnostic tests including BP, blood sugars, oxygen saturation, temperature, basic first aid equipment including:

plasters, bandages, creams, medicines, etc. and an oxygen tank which allows them to assemble a carescape upon arrival. Equipment attached to the ambulance may also be removed and brought to the patient's side such as suction and AED and equipment for mobilising patients such as collar and boards, scoops, stretchers and chairs. Innovations in technology have therefore enabled ambulance crews to treat patients more effectively and efficiently at scene or in the back of the ambulance en-route to hospital.

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#### UNPREDICTABLE SPACES OF CARE WORK

In addition to highlighting how innovations in technology aid ambulance crews mobility, Christopher emphasises how the spatialities of care work in the community are different from the spatialities of care in the hospital. Emergency care work is unpredictable, unknown and often conducted in environments which crews have limited control. The unknown and uncontrollable is highlighted when Christopher is observed calling control to get more information about the patient he is about to attend. During the ethnographic interviews some ambulance crews discussed the information that they received from the MDT. Some crew preferred limited job information because they wanted to go into the job "blind" to prevent assumptions about the job. For these crew this was important for treating what they found and not what they thought they were going to find. Other crew, like Christopher, desired more information so that could begin to think about a possible treatment plan or prepare themselves clinically and / or emotionally for the job.

Furthermore, emergency care work is delivered in "disorganised, chaotic and risky environments" (Burges Watson, Sanoff et al. 2012:648). These spatialities are often ill-equipped to deal with medical situations. Ambulance crews' therefore have to organise space to enable the delivery of care which involves complex "social, temporal and spatial management" (Burges Watson, Sanoff et al. 2012:648). In this extract we witness Christopher

organising the space by moving the coffee table to make room to treat the patient. When the back-up crew arrives further discussions are had about the logistics of extracting the patient from her living room. In this, and forthcoming extracts, the logistics of extracting patients from their home or other spatialities of care are observed to be a challenge. Challenges are not only caused by the size of the space but also the temporality or urgency of removing the patient from the scene.

The unpredictable nature of these carescapes was emphasised in a semi-structured interview with ECA, Dave Tolland.

*It's entirely random, what we do, and it's uncontrolled... If you work in an ED your patients are in bed, they're lined out in front of you, all your equipment's nicely around you, there's plenty of staff to call on. Um, the patient's behaviour tends to be more controlled because they're in [a medical] environment. Obviously in someone's house or on the side of the motorway you've not got that much control. It takes a lot to get control. You really need quite a few people there, someone to control the relatives, someone to give you the equipment, someone to move furniture, or on the side of the motorway police officers to control the traffic. In hospital, you know everything is calm;...if you need any drug, the pharmacist will come.... If you need an X-ray the radiographer will come... If you need their airway sorted, you just make a phone call and the anaesthetist comes. At the side of the roadway it's just you. If a relative visits a relative in hospital, there are a lot of sort of social cues that go with it. You go into the building, you know why you're there, it's a medical facility, all the doctors and nurses are wandering around in their uniforms, relative's in a bed, you know what you're getting. Where as we deal with things that have gone suddenly wrong. The relatives aren't ready for it. They've just been sat at home on a normal day thinking nothing's going to happen, and then something goes wrong. We deal with a lot more raw feeling, especially from relatives, um, which can be*

*very hard to deal with, because all your concentration is on the patient, um, and relatives who don't understand what's happened, aren't accepting it, don't know what's going on, become very alarmed all of a sudden..."*

(Interview 29: Dave Tolland, emergency care assistant, Hermes ambulance station 03/03/2011)

Dave's monologue highlights the lack of control that ambulance crews have over their carescapes. This causes the pre-hospital environment to have different spatial and logistical challenges to the hospital, which may heighten crews' emotional labour and anxiety. Furthermore, Dave also emphasises the isolation and human resource constraints of mobile working. Emergency care often requires several team members to cope with the complexities of care arising in the field. On the road however, there are only two crew in attendance. This means that crews have to juggle logistical, clinical and emotions tasks simultaneously. As a single-manned paramedic, Christopher manages these tasks by himself adding to the challenges of mobile care work. This is in stark contrast to the hospital in which different health professionals can be called upon to treat various aspects of the patient.

Dave also emphasises that emergency events that occur in the home are stressful and shocking for patients and relatives as they are not prepared for such an event (Steen, Næss et al. 1997). Ambulance crews are therefore perceived to be confronted with more raw emotions than hospital staff. Furthermore, Dave comments on the social and cultural rules and expected behaviours that are associated with the hospital setting. These rules do not apply in the home, making treating patients and / or getting them to comply with necessary treatment plans more demanding as crews have to perform care within the patient's social and cultural contexts rather than abiding by the organisation's feeling rules.

## FRONT REGION PERFORMANCES

Finally Christopher's extract emphasises that the majority of ambulance care work is performed in front regions (Goffman 1990). In the extract there are two different types of audiences - the other care home residents and the HCA's. In the majority of jobs however, the audience is typically comprised of the patient's relatives. Whilst the care home residents are bystanders to the activity, the HCA's are participatory audience members, helping the crew to care for Maureen by providing information about her medical history, medication and next of Kin. Providing care work in front of an audience is particularly challenging as there are limited spaces in which back region behaviours can be performed. The emotional labour required to sustain care performances in front regions is therefore exhausting. Continuing the interview with Dave Tolland the emotional challenges of performing mobile care work is emphasised:

*"Um, I've broken the news to families that their relative's deceased before, which is a very hard thing to do. Um, and compared to the hospital staff we have no training in it, and it's not like you can hide in resus for five minutes and prepare your speech... They've seen it in their own living room what you've done, and now you're telling them it's all over. We've had families and young kids screaming at us to keep going. You've got to break that and bring them down to earth. And you have to use quite horrible words. You can't say they've moved on. In denial, people won't accept that. You have to use words like dead, deceased. And you have to be quite firm, at which point you become the bad guy, because you become the focus for their anger, their rage. But you've got to do it"*

(Interview 29: Dave Tolland, emergency care assistant, Hermes ambulance station 03/03/2011)

Dave outlines the emotional pressure experienced in performing CPR in the home as relatives watch, scream and beg them to continue. In contrast CPR



in the hospital is performed in the resus room in the absence of an audience. In the event of unsuccessful resuscitation health professionals have time and space to emotionally prepare themselves before informing relatives. Ambulance crews do not have a back region space in which to collect their thoughts and manage their emotions, nor do they receive training in the delivery of bad news (Steen, Næss et al. 1997:60). The emotional challenges or delivering bad news to relatives within their home is also emphasised by paramedic Matthew Brand:

*"... I think the worst part about that is the family around you and you know you have to tell them that their relative has just died and you know they are going to howl. That's the most difficult thing I think dealing with the howling, I feel sick, not physically sick like I'm going to vomit, but you know you get that sickness in the pit of your stomach, the gut wrenching knots in the stomach that you have to impart bad news and you know the reaction. I don't like the howling, it reminds you of your own mortality, I think that that is what this job does is that it reminds you of your own mortality, I'm no longer 19, death is looming! ...".*

(Interview 31: Matthew Brand, paramedic, Hermes ambulance station 28/03/2011)

Matthew succinctly highlights the "raw feeling" that Dave alludes to but is not keen to express in an emotive way. This indicates the different ways in which ambulance crews deal with their emotions. While Matthew freely expresses himself emotionally, Dave is closed in his emotional expression. The different ways in which ambulance crews express their emotions will be analysed in more depth in 5.4 *geographies of ambulance crews*.

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#### EMOTIONAL ATTACHMENT AND MOBILE CARESCAPES

The majority of the literature with ambulance crews focuses on critical incidents (Steen, Næss et al. 1997; Filstad 2010; Williams 2012a, 2013c, 2013b; Williams 2013a). Critical incidents however only take up 5% of ambulance



crew jobs (Department of Health 2005; Brady 2012a), with the majority of ambulance crews attending less traumatic jobs such as chest pain, to vulnerable or elderly patients or non-life threatening injuries. These jobs are less chaotic and less temporarily demanding which allow crews to establish emotional care relationships with their patients and their relatives.

In response to the absence of research focusing on the mundane and ordinary jobs attended by crews, the following ethnographic extract with paramedic Matthew Brand and ECA Jeff Osborne provides insight to the routine and everyday care work provided by crews. It demonstrates that due to a lack in temporal restraints (non-emergency care) ambulance crews are able to establish emotional care relationships with their patients (Steen, Næss et al. 1997; Filstad 2010; Williams 2012a). The ethnographic observation with Matthew and Jeff took place between 8pm and 6am, and Gordon was their first patient of the evening. Gordon was treated for a suspected neck of femur fracture (NOF) or broken hip, after tripping over his garden hose. This extract emphasises how the spatialities in which care is provided causes not only logistical obstacles but also impacts on the establishment of emotional care relationships with patients.

*At 20.16 the MDT bleeps 'M 81 fallen, hip pain NOF? Age 81'. Jeff comments 'bless him'... Matthew pulls the ambulance out of the ambulance station at 20.19... As they hit the motorway the 999 mode is activated...The crew arrive at scene and are led through the house to the back garden by the patient's wife...she explains that her husband has fallen over whilst watering his vegetables. In the garden the patient is sat on a kitchen chair wrapped in a blanket. His daughter is crouched by his side holding his hand and rubbing his shoulders in what seems an attempt to warm him up. Jeff greets the patient warmly and crouches down in front of him as he introduces himself, Matthew and me. Jeff asks for the patient's name (Gordon) and then asks the patient 'what happened this evening then?' Gordon says that he is a 'silly old fool' who fell over*

*whilst watering his plants. Jeff asks whether he had felt dizzy or whether he had tripped over something.*

*Gordon explains that he was walking around the garden watering his vegetables when the hose pipe got stuck on something. He had tugged hard on the hose pipe and it had freed itself quickly which caused him to lose his balance and step backwards. Unfortunately he had stepped off of a step and tumbled backwards and twisted, falling on his left leg and arm. He says that he has pain in his leg and wrist. His daughter adds that she thinks that her father has broken his hip as they had really struggled to get him up onto the chair and he was in great pain adding that her father doesn't normally complain. Gordon comments that his wife (Sylvia) is always complaining that he is too old to be out doing the entire garden and this fall has proven her right. He whispers to Jeff 'don't tell her I said that'. Jeff smiles at the patient and promises that he won't. Jeff attaches a sats probe to the patient's finger and wraps a BP cuff around his right arm...*

*Jeff asks Gordon if he can look at his leg. Gordon nods and Jeff un-wraps the blanket from around his body and legs leaving it hanging from his shoulders. Jeff comments to Matthew that it looks rotated. Matthew takes a look and agrees...Jeff examines Gordon's wrist commenting that it is very swollen.*

*Matthew stands back on the grass as Jeff examines Gordon further...Sylvia exits the house and stands next to Matthew and provides him with Gordon's previous medical history... Matthew asks Gordon if he would like some pain relief. He would...*

*Matthew informs Jeff that he will nip out to the ambulance to get the morphine and asks him to prepare a flush and the rest of the kit for him. Matthew leaves through the side gate...and props the door open with a plant pot...Jeff opens the rucksack on the grass and begins preparing the*

*needles and syringes and flush and lines them up on the path in front of Gordon. As he does so he checks the dates on the bottles and talks informally to the patient...*

*Matthew returns with the morphine... preparing the canular, Matthew talks to the patient about his vegetables, commenting on good crops and flourishing plants. He asks what his secret is as he has failed miserably to grow anything in his own garden...Matthew checks the date on the morphine and then...as he administers one shot comments 'great shed'. Gordon tells Matthew that every man needs a good shed. Matthew asks what he does in there as he writes the dose and time on his glove (20:46 – 2.5mg)...Gordon says he mostly does potting in there but also he makes wines. Gordon asks Sylvia to get the crew a bottle each to take with them but Matthew graciously declines. Jeff uses the blood from the canular to Gordon's BM (9.5). Matthew asks Gordon what he had been in hospital for and Gordon says that he had cancer... in a break in the conversation Jeff asks Gordon what his pain score is now. Gordon says that it has gone down to 4/10. Matthew slowly administers another shot (5mg) at 20:53...*

*With the pain reducing Matthew and Jeff discuss how they will get Gordon onto a stretcher. The patient is sat on his chair on a narrow path surrounded by a vegetable bed and flower beds. It is a logistical challenge and Matthew returns to the ambulance to retrieve a rotunda (equipment that enables them to pivot patients on the spot). Matthew administers one more shot of morphine at 21.06 and then he and Jeff stand either side of Gordon...on Jeff's count of three they help the patient to his feet...the patient is swivelled 180 degrees so that he has his back to the stretcher...Matthew and Jeff lift the patient up onto it...Gordon winces in pain and lets out a small moan.*

*On the stretcher Jeff and Matthew quickly work around Gordon to make him comfortable...the crew can now see that Gordon's left leg is slightly twisted and extended. Jeff informs Gordon that he probably does have a*

*broken hip... Jeff packs up the rucksack and puts the sharps in the box. Matthew asks the patient whether he thinks that he needs any more morphine. The patient says that he is now comfortable and that the pain score is now 1/10...Gordon is wheeled towards the ambulance.*

(Ethnographic shadowing 60: Matthew Brand, paramedic, Jeff Osborne, emergency care assistant, Hermes ambulance station 06/06/2010)

This ethnographic extract raises three important discussion points for emotional attached mobile care work; the role of labelling and categorising patients, the need to establish rapport and the situated embodied care practices required to facilitate emotionally attached relationships.

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#### LABELLING AND CATEGORISATION

As the extract opens we observe how ambulance crews make judgements about their patients based on the little information that comes through the MDT. Jeff labels Gordon as a “good patient” deserving of their care, emphasised by his comment “bless him” (Stockwell 1972; Kelly and May 1982; Dingwall and Murray 1983; Maben, Adams et al. 2012). In other observations, crews were heard to judge jobs as “a load of tosh / rubbish” or “a waste of time”. Kelly and May (1982) illustrated how a patient’s illness or medical condition, age or social class can affect health professionals’ attitudes towards their patients. Instantaneous judgements tended to affect how crews attend to patients at scene (Williams 2013b; Williams 2013a). This may also affect their ability to build emotional relationships with them.

Building relationships with “good patients” was viewed positively by crews as it offered them some light relief against “bad patients” or traumatic incidents (Steen, Næss et al. 1997). These relationships enabled crews to remember that they are treating people and not patients. Being able to see the patient as a person is important to ambulance crews and they were often heard criticising hospital staff for not doing this. This was emphasised by Paramedic Cheryl Hooper:

*"We're better at dealing with the person and the family than hospital staff. I think it is because they don't see them in their own environment. I think one of the hardest things is when you get to the ED and their [symptoms] are brushed off as nothing. For that person and that family, [being admitted to hospital] is a massive significant thing...I just want to say to them it maybe another CVA (Cerebral Vascular Accident) to you...but this chap was normal yesterday, really independent...this is really going to affect him and his family...they just don't see the bigger picture...it's very frustrating".*

(Interview 30: Cheryl Hooper, paramedic, Hermes ambulance station 08/03/2011)

Through Cheryl's anger, frustration and the belief that hospital staff fail to see patients as people, she illustrates the emotional attachment and emotional investment that crews make to their patients. Cheryl emphasises that the spaces in which ambulance crews deliver care facilitates emotional attachment and therefore because ED staff do not see patients in their home environments they don't see the "bigger picture". Arriving at the ED patient's social and familial circumstances are often deemed irrelevant to ED staff in treating the presenting complaint. This information however becomes integral to the patient's discharge, but is often unrecorded and therefore lost. This is a source of great frustration to ambulance crews because their time and care invested in this patient and their relatives is perceived to be taken for granted and devalued.

The labelling of patients as good or bad was also observed on the hospital ward in section 4.5 *The geographies of emotional attachment* and illustrated how nurses did not want to form emotionally attached care relationships with "bad patients", and bent organisational rules to provide emotional gifts to "good patients" (Hochschild 1983b; Bolton 2000b; Hochschild 2003b). In the extract above Jeff is seen to offer a small emotional gift to the patient by

taking the patient's blood from the canular rather than cause Gordon further pain by extracting blood separately.

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RAPPORT AND EMOTIONAL CARE RELATIONSHIPS

From the first introductions with the patient, Jeff and Matthew try to establish a rapport and an emotional care relationship with Gordon. This is an important aspect of crew work which has been sorely neglected by the literature due to the focus on critical incidents to which emotionally detached behaviours are required (Steen, Næss et al. 1997; Brady 2012b; Williams 2012a, 2013c, 2013b; Williams 2013a). As crews deliver care in the home it is important that they build relationships and become emotionally involved with their patients. Ambulance crews therefore need to be skilled social actors, adapting to different social classes, religions and cultures and putting their patients at ease as soon as they walk into the room.

Building rapport with patients is also integral to mobile working, especially in jobs which are not time-critical or temporally demanding as ambulance crews may be in the patient's home for hours. To keep the interaction with their patients personal, ambulance crews write the name of their patient on their gloves. This was emphasised in an ethnographic interview with student paramedic Jason Brand who stated "the first thing that goes on the glove is the patient's name, you will see I have to keep looking at the glove to remember their name, you know, for the personal touch" (Ethnographic shadowing 62: Jason Brand, Student paramedic).

As Matthew and Jeff treat their patient they extend their relationship by asking him personal questions about his garden. These questions not only fill the time and make the care-interaction less awkward. They also help ambulance crews to build an understanding of the patient's social circumstances which may be important to their care, enabling them to treat the patient more effectively at scene, but also provide the ED with more

holistic information. In the opening ethnographic extract with paramedic Christopher Pearce we also observed Christopher attempting to build rapport with Maureen through the materialities in her room, i.e. photos of her daughter and grand-children. The establishment of ambulance crew-patient relationships is however not always one-way. In the ethnographic observation with Gordon, we witness him attempting to draw the crew into his family unit by asking them to conspire to keep a secret from his wife.

Additionally, establishing relationships with patients' relatives is also important for crews as they can provide vital information that enable crew to treat the patient more effectively. In the extract, for example, Sylvia provides crew with details about Gordon's previous medical history. Whilst the relationship with the relatives is important, current literature fails to report the benefits of relatives at scene. Instead it focuses on the challenges of relatives at scene, especially during critical incidents such as cardiac arrests (Brady 2012b; Williams 2012a, 2013c). Relationships with relatives however can reduce the emotional burden, or anxieties crews face at scene by providing highly relevant medical information that supports their diagnosis and treatment.

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#### SITUATED EMBODIED PRACTICES

Finally this extract highlights the situated embodied care practices performed by ambulance crews in their mobile workplace. It specifically explores how their mobility and different carescapes affect their emotional care work and the emotional relationships with their patients. The delivery of care in the patient's garden poses two challenges to their care practices. First, working in twilight creates temporal demands as the crew need to work quickly before it becomes too dark to provide effective care.

Second, the garden's geography also challenges their care practices due to the uneven surfaces and narrow paths between the flower beds and



vegetable patches that make it difficult for the crew to extract Gordon from his position on the chair to the stretcher. To facilitate and support the crew in mobilising the patient more equipment is needed from their mobile workplace - the rotunda and additional drugs. In mobilising Gordon, the crew and Gordon's bodies are in close proximity, even touching. This strengthens their emotional and affectual relationship as emotions and affects move freely between their body boundaries. Furthermore, in moving Gordon we witness the "body ballet" and well choreographed routines and embodied care practices of well established crew mates. This will be explored in more depth in 5.4 *the emotional geographies of ambulance crews*.

In contrast, the following extract explores how spatial and temporal demands of mobile work supports crews in emotionally detaching themselves from their patients at scene.

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#### EMOTIONAL DETACHMENT IN MOBILE CARESCAPES

Contrary to delivering care work in the home, care work performed in public spaces such as shopping centres, bars and restaurants, hotels, high streets and recreational spaces encourages emotionally detached care relationships between crews and their patients. In public spaces crews do not become immersed in the patient's social and emotional worlds because they are not surrounded by their personal material objects and possessions that allow them to quickly establish rapport with their patients. Furthermore, the types of jobs attended in public spaces also enhance emotionally detached care behaviours as critical incidents (road traffic collisions, suicides, medical emergencies and dealings with drunks and drug abusers) are more likely to occur. These types of jobs are more likely to require crews to engage in task orientated behaviours (Menziés 1970).

In the following extract, with paramedic Bobby King and technician Josh Ledger, we witness the emotional labour required to provide patient care to



those patients who have been labelled deviant, time wasters or "bad patients" for example drunks, drug abusers, abusive patients. In this extract Bobby and Josh spend three and a half hours with a drunken verbally and physically abusive teenage girl.

*We arrive at the edge of park land at 00.11...an RRV is already parked up and an ECP, Steve Blyth, is leaning against his car bonnet, his arms folded across his chest looking unimpressed. Two girls are lying on the floor huddled over each other covered in blankets... Steve walks towards the ambulance and hands over a PRF and... says: 'Fairly pissed, not able to walk. Basically they both just need to go home. I have lost interest (patient vomits loudly on the ground) Oh magic, they are being sick again!'*...

*We walk over to the girls...The blankets are barely covering them, their dresses ridden up to their waists. The larger girl, Kate has huge holes in her tights with a bum cheek protruding. Bobby laughs and shakes his head 'what a view!'*

*Josh crouches down in front of the girls and tries to get their attention...and suggests that they get into the ambulance. Kate tries to drunkenly encourage Zoe (patient) to open her eyes and stand up. There is a lot of giggling and swearing as the patient refuses to get up. Zoe begins retching and Kate pushes her head away and she is sick on the floor. Zoe wipes her mouth with her hand spreading vomit over her face and hair. Josh declares loudly and firmly 'time to get up!' He takes the patient's arm and pulls her to a standing position. Bobby helps Kate to her feet...Zoe swears abusively 'get off me you cunt...you're a twat leave me alone'. Kate laughs and tells her not to be rude but her laughing only encourages Zoe's abusive language. Bobby firmly tells her to stop with the language as he is just trying to help her.*

*In the ambulance...the girls are wrapped in clean blankets the vomit covered blankets are left in a pile on the floor...The patient begins heaving again and Josh quickly gets a vomit bowl from the cupboard above her head and thrusts it in front of her face. She pushes it away but Josh thrusts it under her chin again. Zoe pushes it away again. Bobby takes the bowl from Josh and holds it firmly under Zoe's chin 'you won't be sick on my ambulance floor...or you can clear it up!' The patient laughs 'fuck off you twat!' Kate tells Zoe off 'I'll hold the bowl'. The patient takes the bowl and is sick. Bobby hands Kate tissues and she wipes Zoe's face.*

*Kate asks the crew if they can drive the patient back to her house where she can look after her... Zoe tries to get up. Josh puts his hand firmly on Zoe's shoulder and tells her to sit. Josh asks Zoe where she lives. She gives some vague description of a place opposite a Church. He presses her for a road name. After a lot of giggling and swearing she finally comes out with a name of a road and Bobby looks it up in the AtoZ whilst Josh probes her for a house number...*

*Bobby takes Zoe's BP, BM and attaches the sats probe to her finger which she keeps ripping off and Kate keeps re-attaching... The patient moans that the BP cuff is hurting her and tries to rip it off. Unable to she gives up and slumps over with her head on her friend's lap...Bobby climbs into the front of the ambulance and we leave the scene. Josh and I sit on the stretcher...throughout the journey and Josh tries to coax a story from Kate about how much they had to drink... Zoe talks incoherently and giggles. Josh looks at me and rolls his eyes.. Kate then begins to blow raspberries on Zoe's face and they laugh. Josh and I look at each other, eyebrows raised... Nearing the housing estate...Bobby asks Kate to direct him...Arriving at the flat Bobby opens the back of the ambulance. Kate tries to help Zoe stand but she keeps flopping over and sitting back on the chair with her*

*head slumped onto her chest. Josh asks Kate to sign the PRF to state that the patient has been left in the care of a friend. With the PRF signed Josh hands me the form and asks me to put it in Zoe's handbag so it doesn't get lost....*

*Bobby and Josh help the girls out of the ambulance. Zoe refuses to walk and lies down in the road. Bobby tells her firmly to stand up but she shouts abuse at him. Kate asks her where her key is and she says it is in her purse. I look through the purse but there is no key. Kate snatches it from me and tries to find it herself...The key can't be located. A neighbour comes out of his house and says that he can let them into the main building. The crew thank him. Bobby asks the patient again to stand but she refuses so lifts her up from under her armpits. She continues to shout abuse at him kicking violently. Bobby hauls her to her feet...she lifts her legs like a child that refuses to walk. Bobby tells her abruptly 'walk'. Her verbal abuse towards Bobby continues and he sighs and carries her to her front door. She crawls inside...*

*The crew return to the ambulance. They sit and watch what is going on inside the flat. Kate has disappeared leaving Zoe lying on the entrance mat. They discuss what they should do. Bobby states 'we can't leave her there... Tomorrow we will see in the [paper] 'Ambulance crew leave girl in hallway to die''. They suggest they sit and wait for a couple of minutes to see if her friend comes to get her. After waiting about 5 minutes Kate and the neighbour enter the entrance hall and kneel down in front of Zoe. They are there for a couple of minutes before the neighbour comes out and waves us over...The neighbour says that the patient is fitting.*

*The crew enter the flat, the patient is shaking...There is a wet patch on the carpet where she has wet herself. Bobby asks the friend about the 'fitting'. Kate says that her friend has no history of epilepsy.*

*Bobby tells Kate that he does not think that she has had a fit and she is more likely to be shaking violently because she is not wearing any clothes and it is a cold December night. As Zoe can't get into the flat...she will have to go to hospital...*

*The patient swears at Bobby saying she doesn't want to move...Bobby carries her like a child to the back of the ambulance but she refuses to get in, hitting and kicking Bobby in the vain hope that he will put her down...Josh climbs into the ambulance and tries to coax her inside. Bobby lifts her and tries to hand her to Josh but she kicks out her legs and places them on either side of the door shouting more abuse. Bobby asks her to stop shouting as it is waking up the neighbours she says that she doesn't care and continues shouting. Eventually she is in the back of the ambulance and they strap her into the stretcher her arms and legs flaying violently lashing out at Bobby...*

*...Zoe shouts for Kate...The crew make the decision to leave without her as they think that it will be worse in the ED if they are together. Bobby leaves the scene and we head towards hospital at normal road speed....The patient lays on the stretcher face down with her head leaning over the side pretending to retch and occasionally shouting obscenities...*

*(03.42) We arrive at the hospital and Bobby opens the back door. He tries to take off the straps to allow her to walk into the ED but she screams 'you're a fucking cunt, you fat twat!' and kicks her leg out towards him where it makes violent contact with his stomach. Bobby retorts angrily holding his stomach 'and you're a silly little drunk girl!' Instantly Bobby moves back from the patient and briefly closes his eyes and exhales. He apologises for shouting at her. She tells him she will make a complaint and get him fired and continues to use*

*abusive terms towards him trying to get another reaction. Bobby suggests they just wheel her out on the stretcher....*

*We return to the ambulance where Bobby apologises... and says that he should not have reacted. He is extremely frustrated with himself.*

(Ethnographic shadowing 54: Bobby King, paramedic, Josh Ledger, emergency care assistant, Hermes ambulance station 11/05/2010)

The ethnographic extract has one consideration for how emotional detachment is established in mobile care work.

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#### ESTABLISHING EMOTIONAL DETACHMENT

In treating "unpopular patients" (Stockwell 1972; Kelly and May 1982; Maben, Adams et al. 2012; Williams 2013a:6) or deviant patients, crews adopt coping strategies such as "self-control, distancing and avoidance" (Thompson and Suzuki 1991; Clohessy and Ehlers 1999:252) to become emotionally disengaged in their care work. In response to Zoe's antagonistic and verbally aggressive behaviours, Bobby and Josh carefully manage their emotions. Throughout the extract the crew emotionally detach themselves from Zoe in two ways: first, they create physical distance by limiting their bodily contact and second, personal engagement is limited. Despite careful emotion management however, Zoe's unrelenting deviant behaviour "takes an emotional toil" on Bobby resulting in an emotional rupture (Mitmansgruber, Beck et al. 2008:1359).

The creation of physical distance is observed by all ambulance crew attending Zoe and Kate. As the extract opens we witness ECP Steve Blyth waiting at a distance from the girls. This distance signifies Steve's emotional detachment from the patient and his bodily deportment, arms crossed against his chest, emphasises his lack of interest, anger and frustration. Kelly and May (1982) found that drunken or alcoholic patients evoke negative responses and emotions in crews because they do not allow them to use their

clinical skills. Instead crews are used as a glorified taxi service to convey patients to the ED and this takes them off the road so that they are unavailable to attend deserving patients (Papper 1970; Jeffery 1979; Kelly and May 1982:148). The lack of bodily proximity is continued when Bobby and Josh take responsibility for these patients with both crew members pulling the girls up off the floor by their arms, thrusting a vomit bowel under Zoe's chin asking Kate to clean up Zoe's face. The way in which Bobby carries Zoe also increases bodily distance. This bodily disconnect is observed in stark contrast to the close bodily proximity observed when Matthew and Jeff mobilised Gordon.

In addition, the crew establish emotional detachment through their lack of personal engagement with Zoe and Kate. Unlike Matthew and Jeff, Bobby and Josh do not engage in any personal conversations with their patients. Instead, they only converse with the patients to try and establish what and how much the girls have had to drink and the directions to their house. Furthermore, the crews tone of voice is often assertive and strong with a "sombre demeanour" (Boyle 2005) to demonstrate that they do not think that this behaviour is appropriate nor should be tolerated. Bobby and Josh also make jokes at the patient's expense on numerous occasions throughout the interaction, for example Bobby laughs at the girls lack of dignity. Jokes are a safe way to vent anger directed at patients and act as a defence mechanism against frustrations enabling crews to gain a sense of power and superiority over poorly behaved patients through the "role distancing technique" (Goffman 1990:61; Marra and Holmes 2002; Tracy, Myers et al. 2006). This reduces the possibility of an emotional rupture. Josh's use of humour causes the girls to laugh and be less aggressive and more compliant to his requests. Boyle (2005) states that ambulance crews often use humour with intoxicated behaviour to cajole "irate patients" into compliance (Boyle 2005:51).

Whilst humour and jokes were used to diffuse the frustrations, the interaction with Zoe culminates in an emotional rupture. This emotional slippage is unsurprising considering the length of time that the crew had endured this patient's antagonistic behaviour, abusive language and physical violence. The longevity of their tolerance demonstrates the emotional labour required to manage emotions through surface acted behaviours. It also emphasises how surface acted performances can easily slip exposing authentic emotions (Hochschild 1983b; Goffman 1990; Hochschild 2003b) due to the "pressure cooker syndrome" created through mobile working (Steen, Næss et al. 1997:61).

Immediately following his emotional rupture, Bobby takes a step backwards to increase his physical distance from the patient. In addition he closes his eyes tightly to regain his composure and collect his thoughts so that he can regain control of his emotions. Bobby is however incredibly frustrated and angry with himself for not being able to sustain his emotionally detached professional performance and for allowing Zoe to coax his authentic emotions out of him.

Whilst the extract demonstrated how crews create emotional detachment with deviant patients, interview extracts with ambulance crews illustrated the importance of emotional detachment, especially in life threatening situations (Boyle 2005; Department of Health 2005). ECA Dave Tolland for example, explains how crews emotionally detach themselves from their patients, to deliver "brutal interventions such as ramming tubes down patient's throats, cracking ribs...drilling into bone" (Interview 30 Cheryl Hooper, Paramedic).

*"In those few cases where we've actually really got to intervene... I don't see them as a person. I just see them as various systems that I can fix...We went to a gentleman yesterday who, um, was probably on his last few minutes...his airway was completely obstructed with vomit, and it*



*was like right!... so you just immediately go straight into your system...we just pushed him over, slapped his back, a colleague ran to get the suction, got an airway in, suctioned out loads [of vomit], rolled him on his side, put the oxygen on, and you're just working through...the checklist in your head...[you need to] stabilise, monitor, then get them out of the house... it wasn't until he was on the resus bed ...when we stop and go, ooh, that was a really good job... But when you're on the job you're just thinking what's next? And that's it...focussed on the task...*

(Interview 29: Dave Tolland, emergency care assistant, Hermes ambulance station 03/03/2011)

Dave reveals that for those 5% of life threatening calls made to the ambulance service (Department of Health 2005; Brady 2012a), ambulance crews emotionally detach themselves from the patient by viewing them as a set of body parts that requiring fixing (Palmer 1983; Regehr, Goldberg et al. 2002:510; Scott 2013). This was also discussed by paramedic Matthew Brand who likened delivering medical interventions to a mechanic fixing a vehicle;

*"When I've got a poorly patient that's not quite dead, or might be on their way there, then I'm thinking...no different to how I'd look at an engine...I'm thinking about the treatment...how can I fix this?...once I stop treatment, I try and talk to them and let them become a person again, you know, but for...a little while they are something that just needs fixing and we're trained in that way almost...like cars and motorbikes...an engine...erm, a heart...if that's not working we need to fix it"*

(Interview 31: Matthew Brand, paramedic, Hermes ambulance station 28/03/2011)

Matthew and Dave's experiences of coping with critical incidents demonstrates that ambulance crews get "tunnel vision" (Boyle 2005:54) which allows them to focus on the patient as an object (Filstad 2010; Williams 2012a, 2013b; Williams 2013a). This enables crews to deliver the medical interventions required rather than on the brutality or the pain and injuries



that they may cause the patient. Dave also talks about following processes and checklists in his head that allow him to focus his mind on the task in hand rather than thinking about the emotionality of the incident. William (2013) revealed that paramedics "slavish adherence to established protocols and procedures for example the JRCALC 2006" help them to emotionally detach themselves from the patient (Williams 2013c:516). Following Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines serves as a defence against the anxiety and guilt of treating patients in mobile care-scapes (Scott 2007b). The use of guidelines as a defence mechanism echoes the used of 'continuing care guidelines' in the CCP meeting explored in 4.6 *geographies of patient logistics*.

Observations and interviews have illuminated the emotional detachment initiated in mobile workplaces. Ambulance crews however were also observed to instigate emotional detachment with those patients who they had initially created emotionally attached care relationships with at scene as they convey them to hospital. Creating emotional distance between patients en-route to the hospital was often an unconscious process but was necessary for establishing closure.

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#### TRANSFORMING PEOPLE TO PATIENTS

In the following we return to ethnographic observation with Gordon, Matthew and Jeff to demonstrate how ambulance crews use their mobile workplace to begin the transition from an emotionally attached care relationship to an emotionally detached care relationship.

*Gordon is wheeled onto the ambulance at 21.20...Jeff wraps the ambulance BP cuff around his arm and clips the sats probe to his finger. Jeff looks at the mobimed and says aloud that Gordon's sats are 87% and his pulse is 86. Jeff gets an O2 mask out of the drawer and attaches it to*

*the ambulance's oxygen supply. He puts the mask over Gordon's face. Matthew sits down and begins filling in the PRF...*

*...Matthew hands Jeff the PRF and asks him if he is happy to go. Matthew climbs out the back of the ambulance and slams the back door. Climbing into the cab he calls 21.25 through the hatch. Jeff writes the time directly onto his PRF and then asks Gordon for his surname, address, home contact number, details of his next of Kin, GP, GP surgery...Jeff then talks through the patient's previous medical history with him...*

*...Jeff looks up at the mobimed and states that his sats are now up to 96% so removes the oxygen mask. Jeff continues to fill in the PRF... frequently asking medical questions.*

PF      *You say your shoulder was giving you some pain?*

P        *Not much really, a little*

PF      *Well we will mention it anyway, get it looked at. And all your injuries are down your left hand side*

P        *Yes, that's right*

Pf      *So it looks like you took all your weight on that side...you haven't got any injuries elsewhere*

P        *No, I kind of rolled when I went down but only have pain on the left*

*As Jeff writes in the text box he copies some information across from his glove. He then looks up at the mobimed and says that his oxygen levels have dropped again. He asks 'would you like a bit more oxygen?' Gordon says that he doesn't want any and says that he will breathe a bit more. Jeff looks at the patient a little amused and smiles 'we'll see how that goes shall we?!' Gordon breathes deeply for a couple of breaths and his saturation levels rise from 86% to 91% then to 97%. Jeff laughs and*

sounding surprised says 'well you soon brought those oxygen levels up didn't you!' Gordon laughs. Jeff continues with the questions:

PF      *Any allergies?*

P        *No. I did think at some point that I was allergic to paracetamol as it gives me diarrhoea but then codeine gives me constipation so if I take both they balance each other out so I am alright (laughs)*

PF      *Have you taken any paracetamol today?*

P        *Yes.*

*Jeff examines Gordon's wrist and fingers and comments on the swelling...Gordon tells Jeff a story of how he broke his wrist the second time (trying to help his daughter pump a flat bike tyre when he fell). Jeff nods and responds occasionally with grunts. He then leans over Gordon to take Gordon's BP once more (168/72). Jeff asks whether Gordon hit his head and or had been knocked out. Gordon replies no and Jeff continues to write in the text box. Gordon comments 'I can't get over how stupid I am...all the family will say 'silly old fool shouldn't have been doing it!' But I enjoy the garden you see...' Jeff doesn't respond, stands and asks Gordon if he can have a feel of his shoulder commenting 'we don't want to miss anything do we?' Jeff examines the shoulder and then takes a seat and continues writing.*

*We arrive at hospital at 21.48... the hospital is very busy with a queue of 6 stretchers lined up along the corridor. We join the back of the queue. Jeff apologises to Gordon and says that it looks like it is going to be a long wait.*

*...At the front of the queue Jeff hands over Gordon to Natalie the rapid assessment triage (RAT) nurse*

### CHAPTER 5.3: GEOGRAPHIES OF MOBILE WORKPLACES

- NT     *Name?*
- PF     *Gordon Philips*
- NT     *(spells aloud as he types) DOB?*
- PF     *DOB is provided*
- NT     *(repeats as he types) ok what's wrong?*
- PF     *Our patient was watering his garden with a hose pipe when he fell ? NOF and fractured wrist*
- NT     *Is it short and rotated?*
- PF     *Yes shortened and rotated at ankle*
- NT     *Does he have a pulse there?*
- PF     *Good pulse, suffers from circulation problems. Previous medical history - prostate cancer, arthritis.....*
- NT     *You can go into 1...just need to move that patient out...can you wait a moment?...*

*Patient in bay 1 is removed by two nurses and Gordon is wheeled into the bay. The ward clerk enters the bay and takes the PRF from Jeff and walks over to her desk. A PATslide (patient transfer slide) is used to move Gordon from the stretcher to the hospital bed. Matthew wheels the stretcher out of the bay and removes the linen and throws it in the sluice. He wipes it down with some anti-bacterial wipes and heads to the linen cupboard and places fresh linen on the stretcher... with the stretcher ready for the next patient we leave the hospital.*

*(Ethnographic shadowing 60: Matthew Brand, paramedic, Jeff Osborne, emergency care assistant, Hermes ambulance station 06/06/2010)*

Earlier in this chapter Paramedic Cheryl Hooper expressed her frustrations with the ED staff for not being able to see the bigger picture surrounding

presenting patients and their failure to see their patients as people. The extract however shows how ambulance crews' emotionally attached care behaviours diminish in the ambulance as they mobilise to hospital. In contrast to the care behaviours at scene, Matthew and Jeff begin to transform Gordon from a person into a patient. While for the majority of ambulance crews the process of depersonalisation was unconscious emphasised by Cheryl's disbelief in ED's nurses emotional disengagement with her patients, ECA Dave Tolland was conscious of how his behaviour and clinical procedures inside the ambulance resulted in the depersonalised patient.

*'We see a lot more personal identity [than ED staff], we see their home and we see their pictures, we see their family, we see their pets. Um, we see how they live, we see them I guess at their worst...but by the time they get to hospital we've cleaned them up, wrapped them up [in blankets]...sorted them...packaged them, made them look like a patient...put bandages on them and a set of numbers on them...so yeah, you know, hospitals get presented with patients, we take them from being [John Smith] from [6 Hassock close] and turn them into a patient, a [NHS] number'.*

(Interview 29: Dave Tolland, emergency care assistant, Hermes ambulance station 03/03/2011)

In alignment with Dave's explanation, Jeff's behaviour packages Gordon into a patient. He is wrapped in a blanket and has ambulance diagnostic equipment attached to his body. Through the placement and insertion of medical technologies Gordon's body is turned into a patient cyborg (Haraway 1994; Lapum, Fredericks et al. 2012). In addition, Jeff strips Gordon of his name, by completing the PRF and turning him into an incident number. Furthermore, along the journey we observe how Jeff's interaction begins to change. Jeff becomes more concerned with finding out Gordon's medical history than in engaging with him on a personal level. On two occasions Jeff ignores Gordon's initiations of personal anecdotes turning his

attention to Gordon's blood pressure reading. This disengagement illustrates the process of emotional detachment. Emotional detachment culminates in the hospital when Jeff no longer calls Gordon by his name, other than to book him in. Instead Jeff refers to him as "our patient" signifying the full transition of Gordon into a patient. Matthew and Jeff's emotional detachment is heightened as Gordon is transferred from the ambulance stretcher to the hospital trolley. Gordon is then symbolically eradicated from Matthew and Jeff's memories through the removal of the stretcher's linen and the wiping down of the stretcher with anti-bacterial wipes, before new linen is placed on the stretcher. Finally the crew discard their gloves containing his name, date of birth and other personal information thus removing all traces of him. This echoes activities on the ward in chapter 3: where health professionals were observed to remove gloves and infection control aprons to remove negative emotions from health professional's bodies. The significance of removing gloves was emphasised by student paramedic Jason Brand:

*"The first thing that goes on the glove is the patient's name...the minute the glove is removed the name is forgotten...by the end of the day we might have seen 5-8 patients...I doubt anyone can remember the name of their last patient, let alone the first".*

(Ethnographic shadowing 62: Victoria Dennick, technician, Jason Brand, student paramedic, Hermes ambulance station 14/06/2010)

The transitioning of named people to patients demonstrates how integral the mobile workplace is to crews' emotion management and facilitating emotionally detached care behaviours. In the following section the mobile workplace is also observed to be a space that facilitates the sharing of emotions and feelings.

## SUMMARY

This section focussed on the mobile nature of ambulance work. It demonstrated that due to the different spatio-temporal environments in which crews construct and deconstruct their mobile carescapes, ambulance crews construct very different emotional relationships with their patients than hospital staff. In addition the perpetual performance of front region care behaviours contribute to crews' emotional labour demands.

It argued that certain spatialities such as the home facilitated emotional attachment. Conversely, care delivered other spatio-temporal environments such as public spaces facilitated emotionally detached care behaviours. In the home, emotionally connected care was realised through the establishment of rapport brought about by the materialities and objects. Situated embodied care practices also encouraged bodily proximity and tactile care behaviours that solidified emotional relationships. In dealing with critical incidents and undesirable patients crews adopted strategies to avoid and distance themselves from the patients. Finally, it illustrated how, in mobilising patients to the hospital, crews emotionally disconnect from their patients by connecting them to mobile technologies which transformed people into patient cyborgs. Emotional detachment culminated in the removal of crews' gloves eradicating the patient from memory and protecting crews' emotional well-being.

## 5.4 THE EMOTIONAL GEOGRAPHIES OF AMBULANCE CREWS

This section analyses the emotional geographies of ambulance care work performed in predominately the back regions such as the Ambulance (in the absence of patients) and the ambulance station (McCarroll, Ursano et al. 1993; Filstad 2010; Watson 2012; Williams 2012a, 2013b). It particularly explores the interconnections between workplace geographies and emotional geographies of care work through an analysis of the "emotional connections" (Jackson 2010) and disconnections between crews which take place in the ambulance and ambulance station. In analysing the emotional connections and disconnections between crews, it explores how collegial relationships are a "peculiar combination of closeness and distance" (Hargreaves 2001a:504) and that "the spatial and experiential patterns of closeness and distance in human relationships...help to create, configure and colour the feelings and emotions [ambulance crews] experience" (Hargreaves 2001a:508). Three different types of collegial relationships are observed: permanent crew mates, non-permanent crew mates and station mates.

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 PERMANENT CREW MATES

The emotional connections between permanent crew mates are shaped by the spatial confines of the ambulance as it forces permanent crew mates to work together in close proximity resulting in strong emotional connections (Hargreaves 2001a, 2001b). This enables crews to establish a synchronised routine that reduces stress and the emotional labour performed in delivering emotional care work in the pre-hospital environment. In addition, emotionally close relationships create "communities of coping" (Filstad 2010:380) which enhances crews' emotional well-being through the establishment of trusting and intimate relationships.

The extract below is taken from an ethnographic observation with permanent crew mates, paramedic Richard Cole and technician Jocelyn



Tatum and highlights how permanent crew mates work in well-rehearsed rhythms to deliver efficient patient care work.

*At 18.15 the MDT bleeps 'M 64 years with dizziness and unconsciousness'... The patient's wife opens a side door and leads us to their flat and states that her husband is in the bedroom. Richard leads the way followed by Jocelyn and then myself...Richard asks the patient (Henry) when he began to feel dizzy, whether he had other symptoms and how long that he had the symptoms for. Henry tells Richard that he had suffered similar symptoms a week ago and had attended A&E but they couldn't find anything wrong so he was discharged. Today he went to work, and on returning home felt dizzy and weak... His wife had to catch him and put him into bed...The wife interjects and says that she was incredibly worried when her husband had asked her to call the ambulance because he never usually wants to seek medical help...*

*Richard asks probing questions about Henry's vision, diarrhoea and vomiting...Jocelyn looks through the kit bag and pulls out the BP cuff and stethoscope and leans over the bed asking for his arm and wraps the equipment around his bicep. Jocelyn calls out 'BP is fine 130/170' and Richard writes it on his glove. Jocelyn listens to the patient's chest and pops a disposable thermometer in the patient's mouth making it difficult for Henry to answer Richard's questions. Richard asks the patient's wife if Henry is on any medication. The wife says yes and then leaves to get Henry's medication...She returns carrying four transparent orange bottles with white lids and hands them to Richard writes the names of the drugs on his gloves.*

*Richard asks whether he had changed anything in his routine or medication in the past month which could have contributed to this. Henry says no but his wife says that the doctor had changed her husband's stomach and heart pills in the last few weeks. Jocelyn takes the thermometer out of the patient's mouth and looks at it 'his temperature is*

*perfect'. Richard asks Henry's wife if he had had an ECG since the pills were changed. The wife says no. Richard looks at Jocelyn 'we'll get Henry onto the bus and do an ECG'...*

*On board the ambulance Jocelyn prepares the stretcher. Richard helps Henry aboard. Richard tells Henry that he will be attaching some sticky dots to his body 'you know how this works!' Jocelyn wraps the BP equipment around Henry's arm as Richard reaches up to the 'pick n' mix' and takes out some sticky dots handing half to Jocelyn. Jocelyn sticks the dots to Henry's upper chest and arms and Richard down his leg. Finishing first, Jocelyn unravels the ECG wires and hands Richard the wires for his legs as she attaches the wires to his chest. Richard covers Henry up in two blankets and Jocelyn switches on the ECG....*

*...Jocelyn sits down and begins filling in the PRF while Richard fills in a continuation sheet. Richard asks Henry for his date of birth and he writes the information on his glove. Jocelyn pulls Richard's hand down and copies the date onto her own sheet... Jocelyn stands up and leaves the back of the ambulance and slams the door shut climbing into the front cab...*

(Ethnographic shadowing 30: Richard Cole, paramedic and Jocelyn Tatum, technician, Hermes ambulance station 14/01/2010)

The observation highlights three important points for emotional geographies of ambulance crew care work and mobile workplace geographies. These include: body ballet, trust and increased emotional connection.

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#### BODY BALLET

Throughout the extract Richard and Jocelyn show how permanent crew mates fall into well rehearsed choreographed routines and intuitive patterns and rhythms of working and delivering care to patients. "Body ballet" (Seamon 1980; Meier 2012) is integral to ambulance crews mobile working due to the limited space of the ambulance which forces crews to learn how to

work in close proximity, working around each others' and their patient's body to deliver care.

In demonstrating the well choreographed body ballet, Jocelyn performs a supportive role shaping her care activities (diagnostic tests) around the dialogue between Richard and Henry and packing away the equipment as Richard helps Henry into the ambulance. The intuitive choreography continues in the back of the ambulance where we observe the crew mates working in unison to prepare the patient for an ECG. What is most striking about Richard and Jocelyn's body ballet is that it is done in almost silence and this was common amongst well established crew mate pairings. Verbal communication between Jocelyn and Richard is observed only to share diagnostic results or to signal a change in patient care activity, i.e. the suggestion that Henry needs an ECG. These small and infrequent verbal cues inform Jocelyn which choreographed routine they are about to perform, shaping the patient care activities that follow.

In addition to witnessing permanent crews' body ballet, crews also discussed the importance of establishing routines and patterns of working. The interview extract below was taken with ex-permanent crew mates technician Emily Whybrow and paramedic Jack Philips. Emily and Jack were no longer crew mates because Jack had moved to a different ambulance station, however the strong emotional bond established during their time working together remained strong. Hargreaves (2001), in observing teachers, suggested that they often sought out collegial "soul mates" to help them deal with the emotional strains of the job (Hargreaves 2001a:514). While Jack and Emily did not express their relationship in these terms, they, like the majority of other permanent crew mates at Hermes ambulance station, were emotionally close. This closeness is evident in the transcript:

*JP ...It's about knowing, it's that unseen look at each other when you walk into a room and you think, oh they're poorly and flick a look to [your crew mate] and you just know that everything's going to go up a*

#### CHAPTER 5.4: EMOTIONAL GEOGRAPHIES OF AMBULANCE CREWS

*gear and it's just going to... it'll all be done exactly as it would be but it's just done that little bit quicker and a little bit slicker.*

*EW You don't even have to talk about it...you just know what you've got to do...I find it so much easier working with [permanent crew mates]...because eventually you know; I know exactly how Jack is going to push the stretcher. I know exactly how he's going to carry the chair. It's weird, you get in sync with each other you don't have to talk about it...for example...*

*JP ...One of the last jobs we went to, [the patient] was like 48 or something with chest pains and we'd just been on a run; every job we got was chest pains, chest pains, chest pains and none of them turned out to be anything...Anyway we were on our way to him thinking, you know, it's going to be a load of crap like all the rest of them... We got there... and he's out in the garden... he'd been doing some gardening and he looked well, didn't he? But, you know, we still went with, its chest pain get him to the ambulance and we didn't hang around...I remember, I was sticking ECG dots on him, Em was wiring him up and you'd literally got the limb leads on and... I looked up at Em and thought, oh shit!... We went into free flow and ... things were just firing around all over the place, the line was in the, the dots were on, Mobimed message sent... And I think the whole job time was something like 35 minutes. Ridiculous! And that was one of those jobs... all of a sudden everything goes up; your adrenalin kicks in, your heart rate races.*

*EW And that's the advantage of teamwork and working with someone like Jack and, you know, or myself, you just... we don't even talk. I just know what he's going to do, [and] he knows what I'm going to do. I'm going to do aspirin and he's going to canulate and give morphine. He's going to stay in the back and, I'm going to get in the [front] and drive like, you know, like I've stolen it...*

#### CHAPTER 5.4: EMOTIONAL GEOGRAPHIES OF AMBULANCE CREWS

JP        *You also know that if...I'm canulating over here and we've not done a blood pressure then I just know, I don't even need to ask I know that Em will be doing it. And it's just getting that routine, it's just...*

EW        *...Yeah I'll be looking up and I can see the blood pressure is not on, I can see the stats probe's not on, you know, you're looking at the screen, right the ECG's not working, why? He shouldn't have to worry about that, he's got other things to worry about and that just makes a great day doesn't it?*

(Interview 32: Jack Philips, paramedic and Emily Whybrow, technician, Hermes ambulance station 14/04/2011)

Steen and Naess et al. have stated that there are “negative and positive aspects to paramedics working with the same partner” (Steen, Næss et al. 1997:58). They suggest that permanent crew mates may be dangerous to practice as they may become “too closely knitted together” and may struggle to work with other crew mates or become complacent. Whilst Emily and Jack are very close, demonstrated by their ability to finish each other's sentences, their close-knitted working relationship does not appear to be a danger to their clinical practice. Instead, Emily and Jack's permanent crew status enabled them to work co-operatively, efficiently and seamlessly in an emergency situation.

In establishing an intuitive and well choreographed body ballet, Emily and Jack, like Richard and Jocelyn, had learnt to work with minimal verbal communications and instead work by non-verbal cues such as facial expression and the observation of the care activities of their crew mate. The ability to perform work with minimal verbal communication was observed a crucial skill in managing a critical incident in the back of the ambulance because it prevented patients from becoming anxious, especially if they could not understand the medical terminology (Steen, Næss et al. 1997). Non-verbal cues were also observed between permanent crews to show

frustration with patients that were perceived to be wasting their time, or to indicate something humorous, providing temporary light relief.

In addition, the speed and the fluidity in which crews performed their body ballet increased during critical incidents, as described by Jack in the interview above. However, whilst crew's choreography gathered pace they were able to manage their emotions never showing outward signs of anxiety or stress (Steen, Næss et al. 1997). In the initial observations with crews I, perhaps like the patients they were treating, was oblivious to any medical emergency occurring due to their incredible ability to remain, at least on the surface, calm and collected. It was only after an extended period of observation that I noticed that the subtly elevated pace in care tasks was an indicator of the sickness of their patient. In controlling their emotions, ambulance crews were able to manage their patient's emotions also. This was important to prevent emotions such as anxiety from becoming heightened in the mobile workplace.

Finally, what the observational and interview extracts demonstrate is the need for a demarcation in roles and responsibilities to allow their care work choreography to be fluid and seamless. This highlights the importance of pairing crew mates according to complementary skill levels to enhance effective team work. In working as a team, permanent crew mates support each other, maximising their skills to deliver the most effective and efficient patient care. Understanding and respecting the clinical competencies of each crew pairing facilitates the establishment of mobile working patterns. These rhythms allow crews to focus on the patients' care rather than worrying about who is going to perform tasks or whether their crew mate is clinically competent to do the task. The establishment of a body ballet between crew mates therefore signals that a relationship of trust has been established.

## TRUST

The establishment of trust is a prerequisite for effective permanent crew team working and helps to reduce stress and anxiety (Steen, Næss et al. 1997). This was highlighted in an interview with paramedic Matthew Brand who talked emotionally about his relationship with his permanent crew mate, Jeff and how the mutual trust they had established over time reduced his anxiety at scene:

*“...but I trust Jeff, we work well because we work intuitively, he steps in as much with me as I step in with him. To me he is my right arm...the more we work together...the closer we become...we don't have any boundaries. I know I can trust him in any situation. He has my back, and me his...There are times when I just stand there doing nothing, thinking, and sort of come back into the room, as it were. Jeff has sorted it all out, chatting away [with the patient]...giving me a bit more information. I trust him more than any paramedic...he has great clinical skills and great rapport with the patients...I can trust him on every level... But they [management] don't like permanent crew mates. They say it breed laziness!”*

(Interview 31: Matthew Brand, paramedic, Hermes ambulance station 28/03/2011)

Matthew emphasises the importance of trust between permanent crew mates which allows him to feel clinically supported and less anxious at scene because he knows that he can absolutely trust Jeff. Aligned with Steen' et al.'s research however, Matthew indicates that the ambulance managers are no longer keen on crews working with permanent crew mates because they believe that it causes complacency and laziness (Steen, Næss et al. 1997). Throughout ethnographic observations with different ambulance pairings (permanent and non-permanent), “laziness” was not observed amongst permanent crews. Instead, “positive aspects” (Steen, Næss et al. 1997) were



most visible especially in enhancing patient care and crews' emotional well-being.

The impact that permanent crew mates had on each others' emotional well-being was raised and discussed as an important aspect for the emotional geographies of ambulance crews' mobile care work. The forced proximity in which crews work, as a result of their intimate mobile workplace, facilitates the emotional connections between crew mates.

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#### INCREASED EMOTIONAL CONNECTIONS

Within the ambulance, permanent crew mates forge strong emotional connections with each other. Emotional connections are often established and strengthened through discussions at standby, a time in an ambulance crew's day when they are between jobs and are requested to wait at a specified location within the geographical area covered by the ambulance station. At standby crews often reflected on the clinical and emotional aspects of their jobs as well as engaging in personal conversations.

The importance of being able to reflect on jobs with their crew mate was emphasised by paramedic Cheryl Hooper.

*"Me and Ross always talk about jobs ... in some way or another. Even if it's just a sentence like 'that was a waste of time' or 'that was really challenging' or... 'bless them, what a sweet couple' or... you know just to say something about the job, other times it's a bit more in depth you know... What we could have done better or...that went a lot better than we thought, or that upset me...or that made me angry...sometimes Ross will make jokes...he knows I sometimes get a bit too emotionally involved...you know he might say... 'We got that patient into resus and you didn't cry Cheryl!..How are you managing today? When's it planning on coming out?' It's supportive in a humorous way and I think that helps us deal with the challenges of our work".*

(Interview 30: Cheryl Hooper, paramedic, Hermes ambulance station 08/03/2011)



Cheryl highlights the different ways in which permanent crew mates reflected on and talked about their jobs. Clohessy and Ehlers' (1999) research indicated that crews who were unable to talk openly with each other and suppress their emotions were more likely to suffer from anxiety and stress. Having the opportunity to talk through jobs therefore helps crews to cope, adapt and manage their emotions related to their mobile care work (Tangherlini 2000).

In-depth reflections or debriefing sessions strengthened the emotional bonds and emotional connections between permanent crew mates through "emotional talk". Cheryl demonstrates that Ross is always willing to engage in emotional talk to support her through the emotional demands of their work. Having worked together for a long period of time, Ross knows that following a demanding job, Cheryl will need an outlet for her carefully managed emotions. Ross demonstrates his emotional support by asking in a sarcastic, jovial way, when her emotions are likely to surface. This banter allows Cheryl to recognise that expressing and sharing her emotions with Ross is not only acceptable but expected therefore "consolidating their emotional relationship" (Tracy, Myers et al. 2006:285; Charman 2013).

The use of banter, teasing, jokes and humour between permanent crew mates to facilitate bonding (Tracy, Myers et al. 2006; Scott 2007a; Lynch 2009; Charman 2013), relieve boredom (Charman 2013) and provide light relief in their stressful and emotionally demanding care work was observed frequently and was an important aspect of permanent crew working. The role of humour however, will be analysed in more depth though the emotional connections and relationships forged between station mates later in the section.

Close emotional relationships were observed to be essential because for many ambulance crew, "emotional talk" with their permanent crew mate was the only outlet for expressing and sharing their job related anxieties.

Recent research has shown that emergency service personnel (ambulance crews, police, and fire-fighters) rarely talk to their romantic partners or families about their jobs and prefer to talk to colleagues or other emergency service personnel (Regehr, Goldberg et al. 2002; Lowery and Stokes 2005; Regehr 2005). This research concurs with this finding, as all ambulance crew interviewed stated that unless they had a partner who was a health professional or in the emergency services, they did not disclose or share job related information or their emotions related to their work with their partners or family members. Many ambulance crews expressed the need to protect their partners or family from the emotionality and brutality of their work (Lowery and Stokes 2005; Regehr 2005). They also found their partner's lack of experience and knowledge of their daily work frustrating or their responses to their stories unhelpful to their coping. This was emphasised by Matthew Brand who stated:

*MB "My girlfriend is terrible to talk to about work problems. She really... makes it worse. She just joins in the rant and I'm like, no, no, no... Or she tells me I don't know why you got upset. Yes, thanks! Very helpful!... So, you need someone to...that knows...[who] listens and understands but not there to tell you what to do. They just listen...Um, yes, because we're not... We don't see anyone at work anymore and... That used to be great; have a crap job, come back [to the station], have a chat about it, have the piss taken out of you and then off to the next one feeling refreshed. Mmh...So, now you've just got your crew mate [because] you've only got that little window of time where you're booked clear from a job before the next one comes in."*

(Interview 31: Matthew Brand, paramedic, Hermes ambulance station 28/03/2011)

In highlighting the challenges of trying to talk to his girlfriend about "bad jobs", Matthew illustrates why crews may choose not to talk to their partners or family about their work. Regehr (2002, 2005) has stated that an inability to disclose emotions between partners often causes stress, isolation and conflict

between crews and their partners which can lead to marital breakdown. However, in contrast, they demonstrated that some ambulance crews did talk to their partners about their jobs causing them to become accustomed to hearing the “gruesome and graphic details” (Regehr 2005:111). This often resulted in their partners becoming uncomfortable, distressed, worried about their partner’s emotional well-being and fearful for their safety (Boyle 2005; Williams 2013b).

Horan’s (2012) research with the police supports this finding, by stating that partners of police officers feared for their safety when on duty. In addition, Horan found that the unpredictability of shift work caused partners to feel like a single parent family resulting in marital tensions (Horan, Bochantin et al. 2012). This research illustrates the geographies of community coping and mobile care work has implications for both crews and their partner’s emotional well-being. It is for this reason that the ambulance crews shared their negative job experiences with people who understood how they were feeling such as other emergency services and crew / station mates rather than their family.

Due to the marital tensions caused through crews’ decisions to disclose or not to disclose information about their work, permanent crew mates also became “friends, confidants...and morale boosters” providing, within the intimate space of the ambulance, emotional support to the challenges that each other faced in their personal and / or romantic lives (Palmer 1983:178). In the interview extract below, Emily and Jack highlight that knowing about and sharing each others’ emotional and personal problems allowed them to adjust their mobile care routine to accommodate, compensate or protect each from emotionally challenging jobs.

*JP I’m a big believer in permanent crew mates and I think it’s good. If you’re having a crap time at home and we both, when we worked together weren’t we?*

*EW ..Yeah...*

*JP ...We both went through various things in our personal lives that were really affecting us and, the other one doesn't carry you, but...*

*EW They do slightly, I know what you mean.*

*JP It levels out, you know, so one day, I'd be up here and Em would be down here so I'd be, sort of, doing more work and then the next time it'll be the other way round and, you know, Em sort of protected me from doing too much when things were tough!*

(Interview 32: Jack Philips, paramedic and Emily Whybrow, technician, Hermes ambulance station 14/04/2011)

Emily and Jack were honest about how personal issues impacted on their working lives and how they worked together to manage their emotions to prevent private emotions from affecting or seeping into their public working lives. It is here that we see permanent crew mates giving each other emotional gifts (Hochschild 1983b; Bolton 2000b; Hochschild 2003b) by increasing their emotional labour to reduce the emotional demands on their crew mates, allowing them to focus on the emotion work required to prevent their private emotions from erupting and affecting their delivery of care.

Emily and Jack's close relationship allowed them to alleviate pressure from one another by attending jobs more frequently or taking the lead in increasingly more emotional jobs. For non-permanent crew mates the demands of performing emotional labour are often greater, which may impact on their ability to deliver emotional care work at scene (Alexander and Klein 2001). It may also impact on their emotional well-being, increasing depression, anxiety, burnout and the need to take sick leave (Alexander and Klein 2001).

## NON-PERMANENT CREW MATES

This section illustrates how non-permanent crew mates can cause the routines, patterns or rhythms of mobile care work to become disjointed and fractious, increasing crews' emotional labour at scene. Tensions between non-permanent crew mates are also enhanced by the spatialities and temporalities of their mobile workplace.

The ethnographic extract below is taken from the 24<sup>th</sup> observation at Hermes ambulance station. On this day paramedic Shane Higgins was sent to work at Hermes ambulance station from a neighbouring ambulance station within the SEAT due to staff shortages. Shane had been paired with paramedic Simon Hunter, who I had observed on several occasions with his permanent crew mate technician Christina Blackwell. This extract is interesting because it not only demonstrates the challenges faced by non-permanent crew mates as they try to establish a working relationship or routine but also highlights the difficulties of working with an "outsider" who operates within a different ambulance station culture.

*I meet the crew in the kitchen and then head out to the garage. The crew begin to check through bags. Even though they are both paramedics Shane seems to be taking the stronger more dominant role and it doesn't seem as though this is welcomed by Simon, but this is never expressed verbally... The MDT bleeps...'0178 age 88, unexpected death'...Shane turns to face me and says that they are needed to confirm the death and it could be a possible resus job. The crew arrive at scene at 08.13. As they walk to the patient's bedroom with a care assistant they find out that the patient was found dead at 07.15....Simon quickly moves the screen that the care assistants have put up to shield her dead body from the other care home patients. He collapses it and throws it on to the spare bed and gets quickly into action. AED pads are put onto the patient and a tube is put into her mouth. There is no cardiac rhythm, no breathing and no pulse.*

*Her pupils are unresponsive and her underside is now purple / red, a clear sign that she has been dead for a while.*

*Simon calls the police and requests that they attend to certify the death. Shane begins to fill in a death form. Simon begins a PRF requesting the patient's notes from one of the carers...Simon copies information across from the carers' notes to the PRF Simon occasionally asking for clarification... Simon runs through the events of this morning with the care staff...*

*The police arrive at 08.20 and Shane performs a handover. This is peculiar as Simon is attending this patient and gathering the information from the care assistants. It is therefore his responsibility to perform the handover to the police...Simon finishes the paperwork and asks one of the care assistants to sign it. He then asks the police for their call signs. The PRF is split and the care assistant is given a copy. Simon and Shane discuss the paperwork and swap papers and Simon signs the death form that Shane completed. Simon then excuses himself to 'get some air'. I also leave. Shane stays behind.*

*Out in the ambulance Simon makes it clear that he is not happy that he has been 'lumbered with that wanker' and that he thinks that he is a 'complete knob' for taking over his role in the patient's bedroom. He states that Shane had made him look inferior and pathetic in front of the police because he had taken over his role. Simon is visibly frustrated and angry as he is heavy handed in clearing away the equipment 'fuck this, I need a cigarette...what is that cunt doing in there?...bastard!'. He snatches his jacket from the cupboard slamming the door to a close and heads out of the ambulance... Shane returns 'where's Simon?' I inform him he has gone for a cigarette and he mutters 'slacker!' From his tone I am not sure whether he meant this as a joke or he was serious.*

*Simon returns to the ambulance and Shane begins to tell him that he had spoken to the care staff about their emergency care policy. Simon makes it clear that he is not interested and cuts him dead 'I need food, I'm going to stop at Tesco's. Em, you want anything?' Simon books clear at 09.05 and a message flashes up 'return to base'...the drive to Tesco is in absolute silence and the atmosphere is awkwardly tense...*

(Ethnographic shadowing 49: Simon Hunter, paramedic, Shane Higgins, paramedic, Hermes ambulance station 29/03/2010)

The extract highlights three important discussion points for emotional geographies of ambulance care work and mobile workplaces geographies. These include; Frictions and frustrations, increased anxieties and organisational masculine cultures.

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#### FRICIONS AND FRUSTRATIONS

Throughout the whole day of observations, this crew struggled to find common ground in both their working practice and in their personal lives (supporting rival football teams). This caused the day to be incredibly tense and emotionally draining for the crew and myself.

The greatest challenge for these non-permanent crew mates was their paramedic status, as both crew mates were used to being paired with a technician or ECA, which allowed them to have ultimate responsibility for clinical decision-making at scene. The tensions between the crews commenced from the very first joint activity in the back of the ambulance - checking the kit bags. In a traditional two-man crew, the paramedic checks the orange paramedic's kit bag and the technician or ECA the green kit bag. In this extract, Shane exerts his position of power by taking a responsibility of the paramedic's bag. This causes Simon to feel disgruntled, which was later disclosed in an emotional rupture in the back of the ambulance whilst Shane was replacing morphine at the hospital. These tensions continued throughout the shift with Simon and Shane increasingly being unable to

successfully manage their emotions in the back regions of the ambulance, showing visible anger, frustration and resentment towards each other. This was often expressed through curt exchanges, cutting remarks and an attempt to belittle each other in the presence of other emergency services and health professionals. Whilst these crew mates were unable to successfully manage their emotions in the back regions (ambulance and ambulance station) their emotions were always carefully managed in the front regions. Hargreaves' (2001) research with teachers found that the absence of friendship and emotional closeness between colleagues affected their effectiveness. Shane and Simon's emotional disconnection may therefore have impacted on their ability to deliver effective patient care.

The challenges and emotional demands placed on non-permanent crew mates, especially between two crew of the same rank was emphasised by paramedic Cheryl Hooper:

*"Two paramedics working together is always hard... Because it's, like, who takes the responsibility? It just feels really odd because you just... as a paramedic you're just used to, you know, you're in charge... you do work as a team, but ultimately if something goes wrong it's my responsibility. But if there's two of you it's, like, who's going to cannulate? Who's going to give some morphine? And who's going to do that? And you don't know who's going to do what because... I mean, me and Ross, if I'm going to cannulate he'll put the 12 lead on for instance. Um, or he'll get all my cannulation stuff out ready and I'll cannulate... but there's never any, like, shall I, or do you want to do it, or, you know, and it's really difficult when there's two of you. It's just confusing... Unless you know that paramedic and really get on with them...but some paramedics just have conflicting views on how you should treat people...But when an outsider comes along that no-one has really worked with before, it's not only that there are two paramedics, it's a paramedic and an outsider paramedic, which just makes the whole situation ten*



*times worse...But I do think that depends who the paramedic is as well. Who they both are...I worked with a paramedic a while ago who I didn't really know and I just came in the morning and I said, oh I think we're going to be teamed up because I'm single manned are you single manned? And they said, yes. I went, oh okay, I'm Cheryl...Shall we do it that if you're attending you do all your bits and I'll be your assistant and vice versa?... you know, we just set down the ground rules before we started".*

(Interview 30: Cheryl Hooper, paramedic, Hermes ambulance station 08/03/2011)

Cheryl emphasises that the biggest challenge between a two-manned paramedic crew is negotiating who takes the ultimate responsibility for patient care. In contrast to Shane and Simon, Cheryl acknowledges the possible tensions between herself and her crew mates and overcomes these by engaging in a discussion to negotiate a mobile working pattern that may reduce the conflict caused by hierarchical power struggles.

It is, however, not only hierarchical relationships or power struggles that cause conflict, frictions and frustrations between non-permanent crew mates. In the interview extract below Emily demonstrates that simple tasks such as pushing a stretcher into the ED can cause great frustration when paired with a non-permanent crew mate. Small aggravations caused by fractious choreographies enhance the emotional demands placed on crews making it more emotionally challenging than necessary, thus requiring greater emotional labour from crews to manage their emotions:

*"Permanent crew mates work brilliantly...but then you can go and do your relief week with someone and they push the stretcher a lot harder or they push it and bang it all around and that frustrates me, I'm like, what are you doing? Be gentle with this patient, you know. And, oh hell they slam in and they run around and then there's 150 flipping questions...*

*and I'm like, I can't work like that. It's too much, it's too hectic...Everyone's got their routine".*

(Interview 32: Jack Philips, paramedic and Emily Whybrow, technician, Hermes ambulance station 14/04/2011)

Emily illustrates the disjointed, fragmented and awkward undertakings of working with a crew mate who they have not been able to establish a well crafted body ballet. The stress, anxiety and frustration felt by Emily covering a relief shift is clearly evident in her tone and descriptions of the unsmooth transitions between tasks and the constant questions which slows down the care process. This can affect the emotional well-being of crews, especially in increasing their anxiety by working with someone they don't know or trust.

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#### INCREASED ANXIETIES

In addition, Simon and Shane's ethnographic extract highlights how working with non-permanent crew mates increases stress and anxiety making the shift more emotionally demanding. Whilst Simon and Shane's anxieties arose from their concerns about who would take responsibility for the patient, for other non-permanent crew pairings anxiety arises out of concern for the clinical competency and trustworthiness of their co-worker. This was emphasised by paramedic Matthew Brand:

*"I will not work with people that I don't trust. It increases your stress levels... and your fear. If you're working with someone that you don't feel is suitably competent or trustworthy... you're always thinking I could get struck off if they do something wrong..."*

(Interview 31: Matthew Brand, paramedic, Hermes ambulance station 28/03/2011)

Matthew demonstrates his deep-seated fears that his non-permanent crew mate could provide inappropriate patient care which could cost him his job. This illustrates paramedics' culpability for less qualified crew mates and emphasises the importance of working with a trusted crew mate. Without

trust, Matthew's anxiety and stress levels are elevated causing him to become distracted by his crew mate's clinical competence rather than focussing on the patient's care or rapport building. Concern for a non-permanent crew mate's competency was echoed by paramedic Cheryl Hooper:

*"You don't need to be worrying about your crew mate do you? ... I don't want to work with somebody that I can't rely on to hold it together till we get to hospital. You know, and if that's too much to ask, are you doing the right job?..It is important that we look at ourselves and then our crew mate and then the patient and then the relatives. I mean, that's the order that we're taught how to look after things. But, if you're having to look after your crew mate because they can't hold it together, or you're thinking well they may fall apart, then you're not giving that patient your full attention...so I think you should be well within your rights to say that you don't really want to work with that person".*

(Interview 30: Cheryl Hooper, paramedic, Hermes ambulance station 08/03/2011)

Cheryl emphasises the importance of crews being able to manage their own emotions whilst on a job and the hierarchy of emotion management at scene. A crew mate who is unable to manage their emotions puts pressure on their crew mate who may have to compensate for their inability to successfully manage their emotions, or they are required to work harder on their emotional labour to support their mate. Whilst in a permanent crew mate pairing, crews did not mind carrying each other emotionally, non-permanent crew pairings often resented supporting their crew mate in this way. Crew who were deemed unable to "hold it together" were regarded as a liability and this often had implications to the supporting crew's perceptions of their crew mate's clinical competence (Lowery and Stokes 2005). Those crew members who were deemed poor emotion managers were also deemed to have inadequate clinical skills. As a result crew did not want to be paired with them as they caused greater anxiety and worry at scene.

Paradoxically, whilst Cheryl states that she “shouldn’t have to worry about her crew mate” she also believes that it her responsibility to manage everybody’s (her crew mate’s, patients and their relative’s) emotions at scene. As a paramedic, she needs to be emotionally resilient and supportive of her crew mate and her patient requiring great skill, hard work and emotional toughness, at least on the surface (Lowery and Stokes 2005). Cheryl’s monologue therefore exposes the ambulance service’s masculine culture (Alexander and Klein 2001; Tracy, Myers et al. 2006; Rowe and Regehr 2010; Williams 2012a, 2013b).

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#### ORGANISATIONAL MASCULINE CULTURES

Ambulance crew culture is defined by masculinities (Alexander and Klein 2001; Williams 2012a, 2013b). The masculine culture was emphasised by Simon’s colourful language and Simon and Shane’s inability to reach a compromise due to their macho behaviours. This traditional masculine culture has been shown to limit ambulance crews’ “emotional expression” (Rowe and Regehr 2010; Williams 2013a), with Alexander and Klein suggesting that 80% of ambulance crew keep their emotions to themselves (Alexander and Klein 2001:81) rather than share them with colleagues (Rowe and Regehr 2010) outside of the permanent crew mate pairing, to present themselves as “tough and strong” (Palmer 1983; Lowery and Stokes 2005; Tracy, Myers et al. 2006:291). Steen (1997) referred to this as the “John Wayne syndrome” (Steen 1997, cited in Williams 2013c:515). Crew mates who display their emotions outside of permanent crew pairings are likely to be perceived as emotionally weak or clinically incompetent.

Predominately masculine behaviours prevent crew mates from using formal channels of emotional and psychological support such as counsellors, mentors and clinical supervisors (CS) because they do not want to appear “unable to cut it” (Steen, Næss et al. 1997; Tangherlini 2000:49; Lowery and Stokes 2005). Informal ethnographic interviews revealed that they did not

want to engage in “emotional talk” with formal persons such as the CS or counsellors because they did not know them, trust them and / or had not established a relationship with them on the road. The low up-take of formal channels for ambulance crews to debrief following emotional or stressful jobs is emphasised by Horan et al.’s research which revealed that only 25% of police officers took advantage of the formal services available to them (Davis 1998; Horan, Bochantin et al. 2012). Due to their inability to approach and use formal services, ambulance crew personnel felt emotionally unsupported by the Trust. This sentiment was recounted in an interview with paramedic Jack Philips:

*“You don’t really get a lot of support from the Trust as a whole... If you do get a bad job you’ll get an OS or CS or whatever come and see you. But you don’t really want them...you don’t actually want to bleed your heart out to them”*

(Interview 32: Jack Philips, paramedic and Emily Whybrow, technician, Hermes ambulance station 14/04/2011)

This sentiment was also presented in Steen et al.’s research through a participant who stated “you get very little professional backing here” (Steen, Næss et al. 1997:59). Instead of using these formal channels to manage their emotions, crews established informal emotional support networks. Ethnographic observations showed that station relationships were effective in providing coping mechanisms by breaking down emotional defence barriers predominately through black humour and storytelling (Thorson 1985; Tangherlini 2000; Charman 2013; Sliter, Kale et al. 2013). In-depth discussions however, occurred in private rooms within the station, in crew mate’s homes or over the telephone (Alexander and Klein 2001; Roth and Vivona 2010; Watson 2012). Whilst, as an ethnographer I was aware that these conversations took place, either because crews removed themselves from the station group or retrospectively informed me that a conversation had taken place, I was not granted access to participate in such activity and

respected the crew's wishes to disclose information privately. This coping method appeared to be dependent on the type of job and was typically witnessed with jobs involving children or jobs that reflected their own personal lives (Clohessy and Ehlers 1999; Regehr, Goldberg et al. 2002; Haslam and Mallon 2003).

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STATION MATES

Ambulance crews no longer have the opportunity to return to base following the completion of a job as they are sent to a standby location to meet "to scene" time targets or are sent immediately to the next job after "booking clear". There is therefore "insufficient time to recover [emotionally] between events" (Alexander and Klein 2001:80). Ambulance crews therefore only have the opportunity to talk to station mates during their meal break or in their down time before and after shift (Tracy, Myers et al. 2006).

In the limited time that station mates spend together, they build friendships and establish important emotional connections through the sharing of humorous stories about jobs that they have attended. Sharing and swapping stories has five functions. First, to build, establish and sustain ambulance station culture (Tangherlini 2000; Tracy, Myers et al. 2006; Lynch 2009). Second, they have a "cohesive function to solidify [station mate] relationships" (Mayer and Salovey 1997; Garrick 2006; Richman 2006; Tracy, Myers et al. 2006; Roth and Vivona 2010). Third, to learn from each other's experiences on the road by "[exploring] a range of actions" to see if something could be done to "improve patient care" (Tangherlini 2000; Williams 2013b). Fourth, to relieve boredom through an elaborate and entertaining way of "recounting the day's events" (Tangherlini 2000:47; Tracy, Myers et al. 2006) and finally, to provide a "psychological outlet for the emotions engendered by encountering human suffering on a daily basis" (Tangherlini 2000:48; Wanzer, Booth-Butterfield et al. 2005) through dark

humour, or gallows humour (Palmer 1983; Young 1995; Alexander and Klein 2001; Roth and Vivona 2010; Watson 2011; Moran and Roth 2013).

Whilst storytelling and "emotional talk" between station mates has been reported to have five functions, their role as a defence mechanism (Freud 1960; Roth and Vivona 2010) to help crew to establish "closure" (Tangherlini 2000) following an emotionally challenging job will be the focus here. The ethnographic observation below was recorded following down time.

*...Paramedic Cheryl Hooper and ECA Ross Carpenter enter the kitchen. Cheryl heads straight to the kettle 'anyone want some tea?' technicians Sophie Albright and Gail Henderson don't look up from their magazines but mumble a barely audible 'no', paramedic Robin Clarke and ECP James Taylor say that they will have one. Ross slumps down in one of the spare chairs at the head of the table, his hands in his pockets looking down at his feet. James states in between mouthfuls of food 'what's up with you? You got a face like a slapped arse' Ross looks up 'dead'.*

*Cheryl places a cup of tea in front of Ross and Robin then fetches her own and James' tea and sits down 'you gonna tell it or am I?' (big grin on her face). Ross says that Cheryl can tell the story. The girls look up from their magazines and James (the station joker) already looks amused. Cheryl sets the scene, they had been sent to an old woman's home, the patient had died in her bed and her daughter had found her when she came round to check on her that morning. Cheryl says that the patient had been dead for some while as rigamortis had set in and they (Ross, her and paramedic James Fielding, the first responder) were trying to gently move the patient's arms down by her side because they were in an odd position. The daughter was standing in the corner of the room watching...*

*Ross had looked up and the old lady had a figurine of a dog standing on its hind legs in a begging position on the bedside table. On seeing the similarity between the figurine and the old lady's position, Ross had*



*started to chuckle to himself his shoulders rising and falling as he tried to suppress his laughter. Harry had looked at him with a quizzical look and Ross signalled with his head and eyes to look at the bedside table. Harry and Ross were now both trying really hard to stifle their laughter, but were now bouncing off each other with small noises escaping from Harry as containing his laughter almost become unbearable...Cheryl is left wondering what they are laughing at and wants to be let in on the joke...Cheryl suggests that the daughter go and make a cup of tea downstairs and they will be with her in a few minutes to talk about her mother and fill in some paperwork... The daughter leaves and Ross and Harry let Cheryl in on the joke, they are all now laughing in silence. As Cheryl tells the story she and Ross laugh hard at the memory. On cue Harry enters the station kitchen arms in front of him tongue hanging out and panting like a dog. James quips 'you old dog you!' and everybody laughs...*

(Ethnographic shadowing 48: Robin Clarke, Paramedic, Sophie Albright, Emergency care assistant, Hermes ambulance station 23/03/2010)

The extract above demonstrates that humour can be “long engaging stories, sight gages, one-liners, facial expressions or amusing noises” (Thorson 1985:201). Within the ambulance service humour is used to “highlight the way [in which ambulance] work is incongruous, chaotic and threatening” to their emotional well-being (Tracy, Myers et al. 2006:293). Humour therefore provides a non-threatening, playful way in which crews can “trivialise” and make death “mundane” (Tangherlini 2000:49; Tracy, Myers et al. 2006), thus ameliorating the adverse emotional effects of their job (Brady 2013b). The role of humour and storytelling is analysed below.

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#### HUMOUR AND STORYTELLING

Ambulance crews use humour, especially dark humour or gallows humour, within storytelling as a coping strategy or defence mechanism (Freud 1960; Roth and Vivona 2010) to breakdown crews’ emotional barriers allowing



them to cope with the emotionally challenging jobs attended at scene through desensitisation (Palmer 1983; Thorson 1985; Alexander and Klein 2001; Watson 2011).

Rowe and Regehr described gallows humour as humour that “involves the juxtaposition of morbid and farcical elements, it is a humorous response that appears inappropriate or illogical in the face of hopeless situations” (Rowe and Regehr 2010:449). As an outsider, the jokes and stories told were therefore initially perceived as inappropriate, perverse and shocking as they were often “socially unacceptable” (Tracy, Myers et al. 2006; Lynch 2009; Rowe and Regehr 2010:450). After being immersed in the activities and culture of the ambulance service, the cathartic effect (Freud 1960) of these stories and jokes as a release for the stress, horror and intolerable feelings felt by crew mates (Rowe and Regehr 2010) became apparent. I became accustomed to this coping mechanism, with jokes and stories losing their shock value. Lynch’s (2009) research with kitchen staff emphasises this point by stating that people outside of a cultural group often do not find “in-group humour” or jokes funny (Tracy, Myers et al. 2006; Lynch 2009:448). Humour can therefore bring people together as well as isolate them (Hopfl 2007; Lynch 2009). Being a part of the joke, or understanding the joke enables people to feel like insiders and accepted by the cultural group therefore establishing a cultural identity (Rowe and Regehr 2010).

In Cheryl’s narrative we see how crews deal with the sombre and emotionally challenging experience of death by finding humour in the situation. In his research with funeral directors, Thorson (1985) demonstrates that people who deal with death on a regular basis “[poke] fun at others who have died or who must die” to free themselves from the emotional burden that dealing with death on a regular basis presents (Thorson 1985:207). To prevent the crews’ humour from being observed as disrespectful to the patient and her daughter, Cheryl sends the daughter away and in doing so

transforms the space into a back region, where gallows humour is acceptable (Filstad 2010; Roth and Vivona 2010; Watson 2012; Williams 2012a). The need to engage in black humour as a coping mechanism is outlined by Cheryl Hooper:

*“We have a very black sense of humour in the ambulance service, because it’s our way of dealing with it. We use humour to control our emotions...that’s the thing...a lot of the time we will have a laugh about something that isn’t...well wouldn’t be particularly funny to anyone else, but it’s our way of dealing with it. And it’s not because we find it funny, we just try and find the humour in a situation to make it light-hearted...and it does work most of the time”*

(Interview 30: Cheryl Hooper, paramedic, Hermes ambulance station 08/03/2011)

Cheryl illustrates that implementation of humour is tactical (Tangherlini 2000; Roth and Vivona 2010), an “emotional break to strengthen clarity in the face of overwhelming stress” (Staff 1993, cited in Roth 2010:319). Reinforcing the notion of inside / outside humour Cheryl acknowledges that their jokes and stories wouldn’t be funny to those outside the ambulance service, emergency services, or health care setting thus emphasising their cultural identity. The “insider” experience and the use of storytelling and jokes as a coping mechanism was also emphasised by Matthew Brand:

**ER** *Could you say something more about your use of humour and jokes?*

**MB** .... *I remember it was a secondary school teacher said to me, once you’ve laughed at something... it’s hard to take them serious. Um, James tells the best stories... has he told you about the one on the high street where someone was hit by a truck?*

**ER** *No.*

**MB** *He says it all very solemn and [it was] a really horrible RTC and a seagull swooped down and picked up a bit of brain and flew off with it*

*and...You're looking for something funny...something...anything to laugh at you know, almost anywhere and it's... Um, we quite often have inappropriate humour we'll just come out with something sick and wrong. And we do it with each other... James [is] a great one for just saying something, and you just think, you bastard! But now you've just cheered me up, so, yes, cheers for that. But, yes, um... Yes, I think it's a way of just saying, well, you can't get down about it, just laugh about it sort of thing, yes. Um...It's just a case of if you're laughing about it, you can't cry about it and if you tell a story...[and] it's a funny story and it's not a sad story... Okay, some poor devil's had some horrific tragedy but it's not my tragedy... I don't want it to become my tragedy by bottling it up and ruining my life. Um, mmh, yes, you see, luckily my friend's a policeman, my closest friend, and, yes, he's just as sick. And I think you do start getting friends... With every job you start getting friends within your job.*

*I think [this job] does distance you from other parts of society because some people just think you're a sick fuck! Um, and people ask you when you're out socialising, what do you do? I tell people I'm a van driver quite a lot of the time because as soon as you say paramedic, [they are like] oh, you people are great and want to talk about a gory job.... I don't want to talk to them [I could just] stare through them and say, dead babies, um... I wonder how much of that I had... I know I've always had a sick sense of humour. I wonder how much of that... I can do the job because of that humour or whether the job brings a lot of it out more...I don't think I'd ever dreamt of laughing about a seagull picking up... bits of someone's brain and flying off with it. I just... Yes, James is a great story teller; he always says he's too busy having a laugh to get stressed... He's lying likely.*

(Interview 31: Matthew Brand, paramedic, Hermes ambulance station 28/03/2011)

Like Cheryl, Matthew demonstrates that crews use jokes as an outlet for the psychological tensions associated with death, tragedy and danger (Freud 1960; Tracy, Myers et al. 2006; Roth and Vivona 2010). In providing a

psychological outlet, crews are able to shut out the emotionality of the immediate situation and focus on the task in hand (Regehr, Goldberg et al. 2002; Roth and Vivona 2010), therefore diffusing anxiety provoking situations (Bruxman 2008). Humour also prevents crews from bottling up negative emotions, or taking negative emotions home with them (Rowe and Regehr 2010), which may result in greater anxiety, depression, burnout and absenteeism (Young and Cooper 1999; Lowery and Stokes 2005; Sliter, Kale et al. 2013). Furthermore, dark humour helps crews to keep the “sentimental order” (Glaser and Strauss 1967) by separating the patient and their relatives’ grief from their own through emotional detachment (Regehr, Goldberg et al. 2002; Scott 2007a; Rowe and Regehr 2010).

Dark humours ability to induce emotional detachment is reflected in the story Matthew re-tells from James, a fellow Paramedic, who is revered for being a great story teller. In the story the patient is reduced to a single body part, the brain, causing disassociation between an organ and a person. The seagull in the story also provides a distraction from the patient and the traumatic RTC scene witnessed by the crews as it shifts the audience’s attention from the road accident skyward. Through the humorous visual image, with the seagull flying off with a piece of brain, the audience (and the storyteller) is prevented from recalling any information about the carnage of the collision on the ground. In alliance with James’ story, Tracy et al. (2006) recounts similar gruesome stories with fire-fighters who “regularly joked about the many gory episodes that peppered their work...for instance...body parts splattered across the pavement” (Tracy, Myers et al. 2006:293). These stories emphasise the importance of humour in dehumanising and emotionally detaching their work from the gruesome reality of death.

Matthew concurs with Cheryl that their use of black humour and stories are often inappropriate to those outside the service, yet it is integral to the way in which they cope and manage their emotions. In discussing the role of

humour, Matthew becomes reflective questioning whether the ambulance service brings out his dark humour or whether he can do the job because he already had a dark sense of humour. Matthew does not reach a conclusion from his musing but recognises how his use of dark humour influences his social interactions outside the job and the friends he chooses to keep.

Furthermore, Matthew's monologue emphasises his sense of isolation from the rest of society as a result of his dark sense of humour and his unwillingness to engage in conversation about his profession with those outside the service because it sparks great interest in the traumatic events. Events that Matthew and his colleagues are perpetually trying to forget. To prevent questions about his job Matthew pretends to be a van driver because he doesn't want to be confronted by questions that may result in him not being able to manage his emotions correctly resulting in an emotional rupture or displaying inappropriate behaviour. Matthew also demonstrates that lying about his profession is also about protecting wider society from the trauma and emotional challenges of his job as nobody really wants to hear tragic stories.

For Matthew, like many other ambulance crew, the majority of his friends are either inside the ambulance service, health professionals or in other emergency services because they understand the emotional challenges of performing their job. They are therefore more likely to indulge in the same humour and dark stories (Horan, Bochantin et al. 2012). In addition, Matthew demonstrates how stories have a cathartic purpose, providing crews with an outlet to share in their grief and anxiety with the rest of the station.

It is interesting to note the frequency in which these stories were told. Jobs that ambulance crews struggled to deal with were told much more frequently than events that had a minor impact on their emotional well-being. The repetition of stories therefore acts as a cathartic process allowing

crew mates to understand the events and cope with their anxiety and guilt (Freud 1960). Whilst Matthew admits that storytelling and dark humour offers great relief his last comments about James are very revealing. Matthew states “James is a great storyteller he always says he’s too busy having a laugh to get stressed. He’s lying likely”. In conjunction with Cheryl’s comments previously, Matthew’s comment indicates that storytelling and dark humour only go so far in protecting crews emotionally from the emotional implications of their job. Crews therefore need to engage in other defence mechanisms and relationships to cope and manage their emotions. Such mechanisms include “emotional talk” with close station mates (Alexander and Klein 2001).

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### EMOTIONAL TALK

Whilst dark humour was used as a defence mechanism or coping strategy for the majority of clinical incidents or emotionally challenging jobs, there were some jobs where gallows humour was “out of bounds” (Rowe and Regehr 2010). Jobs resulting in the death of babies and young children and the terminally ill were often cited as the jobs in which gallows humour was highly inappropriate and in bad taste (Alexander and Klein 2001; Haslam and Mallon 2003; Boyle 2005; Filstad 2010; Williams 2013b) because they “penetrated the emotional armour of the emergency worker” (Filstad 2010:372). In addition other jobs, which had personal significance to the crew could also be deemed poor taste (Williams 2013b). Faced with these events ambulance crews rejected the use of jokes and humour and instead shared their experiences with station mates through “emotional talk”. The fine line between knowing when jokes and humour was appropriate and engaging in emotional talk was expressed by Emily Whybrow:

*“...You say I’ve had this type of job and it isn’t a pleasant job and someone will come out with a quip, you know and you can take offense to it and you’re like, hang on a minute I’m trying to talk about this...”*

#### CHAPTER 5.4: EMOTIONAL GEOGRAPHIES OF AMBULANCE CREWS

(Interview 32: Jack Philips, paramedic and Emily Whybrow, technician, Hermes ambulance station 14/04/2011)

Emily illustrates that the use of humour as a defence mechanism has its limits (Rowe and Regehr 2010) with some ambulance crew becoming frustrated by the dominant coping mechanism available to them. In response, they may seek out station mates who they know they can confide in and who will listen rather than make jokes (Steen, Næss et al. 1997). Citing Robison's research, Lowery notes that only 37% of paramedics "talked the trauma out" with fellow colleagues (Lowery and Stokes 2005:172), however Alexander and Klein (2001) stated that for those paramedics that did talk over incidents with colleagues, found "emotional talk" very helpful. This was emphasised by Jack Philips who described a situation where he phoned a colleague to discuss and reflect on a paediatric arrest.

*"When I had my paed arrest I was still fairly new, you know, I was only six months, seven months out on the road, um, but luckily, um, I knew that [Samantha] was off, she finished at midnight or something and I spent two and a half hours on the phone to her. I couldn't...didn't want to talk to my crew mate...we had both gone through that horrific incident together...erm I guess it was too raw for both of us..."*

*At the time I was with somebody who wasn't in the service, um, and although she could empathise as to why I was upset she didn't understand why I was **so** upset. And, I mean, Sam in particular with that job...she fully knew all the emotions and everything else that I'd been through, um, and it was just, it was the nicest thing in the world to actually talk through with somebody who genuinely understood how I felt, um...A couple of years later when Sam [had] another paed arrest she rang me up and we were on the phone for a couple of hours just talking it all through... and it is a horrible thing to say but people that aren't in the service and haven't experienced all the different kind of... it's just a massive clash of emotions...And it's weird because, I mean it probably*



#### CHAPTER 5.4: EMOTIONAL GEOGRAPHIES OF AMBULANCE CREWS

*sounds really callous but, you know, somebody who is 80, 90 years of age they've had a really good life, you know, they've lived for 80 odd years and I can deal with that, you know, it's their time and all that kind of stuff. But a kiddie, you know, I mean, mine [was] 15 months old, it's nothing and it's really weird because you've never met the kid, you've never met the family, you've got no real emotional ties to it but it really upsets you... yeah I find that a really hard one to get over...*

(Interview 32: Jack Philips, paramedic and Emily Whybrow, technician, Hermes ambulance station 14/04/2011)

Jack echoes Matthew's sentiments about not being able to talk to his wife / partner about the job because they do not fully understand the emotional labour that comes with a stressful job. Instead Jack chooses to speak to a close station mate. Jack shows the need for in-depth emotional talk by revealing the length of time that he was on the phone to Samantha. The time spent discussing the job indicates the emotional struggle and critical reflection required to cope with the outcome of the paediatric arrest. Following his discussion he was able to repay the support to Samantha after she suffered her own paed arrest thus engaging in emotional gift-exchange (Titmuss 1970; Bolton 2000b; Hochschild 2003b).

Research with emergency services has shown that "incidents involving children were rated as the most stressful and were among the most common events leading to intrusive memories" (Clohessy and Ehlers 1999:260). Jack's memory of the event demonstrates the emotional attachment that crews feel towards their patients and the associated guilt with not being able to save the child. Emotional connections between Jack and the child's parents are formed through their united grief. The emotional affect on Jack and the emotional attachment that Jack still has with the baby is demonstrated through his "intrusive memory" that enables him to recall details about the child such as its age years after the event. Jack, like many of his colleagues, has become "haunted" by these events. The role of haunting will be further



developed in section 5.5 through an analysis of the spectral geographies of mobile care work.

The importance of disclosing and debriefing with a station mate to reduce intrusive memories and prevent pent-up emotions from affecting his practice is explored in the rest of Jack's interview.

*"...It would still upset me and, you know, I have no problem with saying it would still make me cry afterwards, um, and I think if you don't have that feeling there's something not right with you,. And you do become hardened to, you know, people getting injured and people dying and things like that but if you don't get affected by a paed arrest then there's something...seriously wrong with you...I've known guys that have been in the job 25, 30 years and they have paed arrests, like James the other week, and, um, you see them on the job, he's back at work the next day because he knows it's the best thing for him and you've just got to keep going, but you talk to him about it, are you all right, and a bloke who's been in the job 30 [years], even he started, got frustrated and started welling up. And I said, sorry, and he said, no, and he had to talk about it... he needed to offload there and then ... he probably started the shift at seven it had got to ten o'clock at night, he's not seen anybody because he's in the car on his own. I told him, I'd heard about it and even he wells up and you just think, you know, he's been in the job all that time and you'd think he be hardened but it's really tough. [After my paed arrest] I made the foolish mistake of doing my shift the next day. And I had been sent to another station and I thought, well [this place is in the countryside, so it is going to be] a sleepy hollow day... I was still upset, I was still crying and stuff in the morning over it, and I thought well it's a late [shift], I'll go and pick a few grannies up off the floor... but I had the most horrendous shift going, um... so by the end of that day, I was so physically and mentally drained.*

## CHAPTER 5.4: EMOTIONAL GEOGRAPHIES OF AMBULANCE CREWS

(Interview 32: Jack Philips, paramedic and Emily Whybrow, technician, Hermes ambulance station 14/04/2011)

Jack continues to emphasise that jobs containing children, especially the death of children, are more emotionally demanding than other jobs (Clohessy and Ehlers 1999). Jack's monologue emphasises that unlike most jobs the length of time in the service can't harden or prepare crews for the emotional turmoil that crews will face as a result of child mortality. Instead, it is expected and accepted that crews will return immediately to work so that they can engage in emotional talk and display their emotions in front of colleagues where they can be contained and managed. Unmanaged emotions can result in "intrusive memories" which leads crews to become haunted. This is analysed in the following section through an analysis of spectral geographies and the uncanny.

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### SUMMARY

Exploring the emotional geographies of care work performed in the back regions of the ambulance and ambulance station this section analysed the emotional connections and disconnections within collegial relationships. It argued that the mobile workplace forces crews to work together in close proximity resulting in strong emotional connections for permanent crew mates. These communities of coping (Filstad 2010) facilitated not only emotional talk but encouraged crews to work in well choreographed body ballets which reduced the emotional demands on crews. In contrast, for non-permanent crew mates, the mobile workplace exaggerated emotional disconnections and disjointed care routines. This increased their emotional labour due to increasing frictions and frustrations and heightened their anxieties surrounding their crew mates' clinical and emotional competency.

Finally, it analysed the construction of emotional relationships between station mates, particularly focussing on the role of humour and storytelling in supporting crews' emotion management following traumatic jobs. It also

#### CHAPTER 5.4: EMOTIONAL GEOGRAPHIES OF AMBULANCE CREWS

showed that for some jobs, such as pead arrests, black humour was not regarded as an appropriate defence mechanism and instead emotional talk was advocated.

## 5.5 SPECTRAL GEOGRAPHIES AND THE UNCANNY

This section makes a novel contribution to emotional geographies of care work by demonstrating that ambulance crews and other health professionals become haunted by spectres, ghosts and unwelcome visitors whilst delivering care. The affective quality of care work is therefore emphasised by recognising that ghostly beings have an impact on health professionals' emotional and psychological well-being.

Ignited by geography's "spectral turn", the twenty-first century, according to Maddern and Adey (2008), has been a century of haunting with the exploration of ghosts and ghost stories becoming popular in recent years (Mayerfeld Bell 1997; Buse and Stott 1999; Pinder 2001; Luckhurst 2002; Pile 2004; Holloway 2006; Holloway and Kneale 2008; Holloway 2010; Frers 2013). The spectral turn has predominantly focussed on the relationship between space, time and memory within the city or urban landscape (Pile 1996). This research has demonstrated that hauntings cause space and time to fold or collapse allowing "distant and present events, people and objects to become more intimate" (Maddern and Adey 2008:292).

Drawing on the "slippages and porous boundaries between different types or categories of spectres" (Maddern 2008:364), this section explores how ambulance crews become haunted by past patients, memories or uncanny experiences on the road. According to Maddern and Adey (2008) ghosts exist in the "liminal spaces" between life and death (Maddern and Adey 2008:29; Roberts 2013) and are kept alive through crews' (negative and positive) memories (Gibas 2012) of past patients. Ghostly experiences therefore may have an impact on the delivery of patient care as past and present collide, unsettling crews' ability to deliver care in the present (Pile 2005a ; Holloway 2010; McCormack 2010; Jones, Robinson et al. 2012).

To demonstrate the spectral-geographies within the emotional geographies of care work *spectral geographies and the uncanny* focuses on three spectral tropes: ghosts, memory and the uncanny. As spectral experiences are subjective, causing the unconscious to become externalised (Matless 2008) and recognised by the conscious, this section focuses on predominantly interview extracts with ambulance crew. Interview excerpts illustrate how previous emotional care work erupts, interferes and threatens the establishment of emotionally attached care relationships and the delivery of care work through haunted ruptures and discontinuities in the haunted self. The significance of allowing subjective ghost stories to be told in the participant's own words is emphasised by Hill (2013) and Wylie (2007) who are both sceptical of "writing styles that focus almost exclusively on the authors, thoughts, feelings and memories" (Hill 2013:383). It is therefore advocated that methodologies that "...allow other voices to be heard...[are] sensitive to the ways in which individuals experience memory as embodied acts of remembering...[and] develop[s] literacy techniques that allow us not just to reveal the haunting spectre of the past in the present but to do so from the vantage point of the other" (Hill 2013:383).

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## GHOSTS

Spectral narratives were often told and re-told over the duration of the data collection process and appeared to perform a cathartic role for the crews. Paramedic Christopher Pearce for example recounted on several occasions a ghost story about a recent hanging that he attended. On each account told, Christopher emphasised a different aspect of the story or reflected on how he or his crew mate reacted or coped with this incident. Research has shown that if ghosts are not talked about then they remain in the "dark interiority of their memories" (Ginn 2013:13). The retelling of ghost stories was therefore a coping strategy for dealing with the inescapable "traces of the dead" (Ginn 2013:11). The repetition of ghost stories illustrates that crews are haunted

souls, who are continually visited by "unwelcome trespassers" (Cameron 2008). For some crew, their haunting becomes inescapable persistent and disturbing as ghosts linger around the edges of everyday care work (Ginn 2013). This demonstrates the complex everyday battle between the unconscious and conscious mind in delivering emotional care work.

Matthew Brand, with whom I established a close relationship over the duration of the ethnography was very articulate, honest and open in divulging his experiences and affects associated with being haunted at work. Over several informal conversations he expressed his "temporal turmoil" (Wylie 2007:176) created by his own guilt, anxiety and a sense of failure at not being able to bring his patients back following a cardiac arrest. These patients (along with other poignant patients) became part of Matthew's ghostly entourage or "spectral cast" (Edensor 2005), accompanying him to incidents requiring resuscitation. Whilst Matthew did not consciously allow these ghosts to interfere with his practice, his spectral baggage subconsciously weighed him down (Gibas 2012). This may have impacted on his practice by increasing his feelings of guilt, anxiety and self doubt in his ability to successfully resuscitate his next patient.

The following extract is taken from a semi-structured interview with Matthew and demonstrates how crews become haunted by ghosts, through repressed negative memories of previous patients (Wylie 2007). These memories were often related to bad or traumatic critical incidents, that lie dormant, but always in a state of becoming in ambulance crews' unconscious (Wylie 2007; Meier 2012). They are often called into present consciousness by a trigger, for example a job description provided by the mobile data terminal (MDT), which releases them from their unconscious prison allowing them to "disturb and haunt" the mind (Wylie 2007; Gibas 2012).

*"I kind of have... sort of traces from previous jobs. I know it sounds...  
mmm, you know but I have sort of what I call ghosts.*

*...My first one, she's dead. I know her name, but I won't say... Anyway, I ended up bagging her on the way in. I was new, **very, very new**. I was with, Chris Wills um, who was my mentor, and I didn't quite realise how poorly she was, um, because I was **new**, um, and, ah, the daughter was distressed and I think I said something like it's not as bad as it looks as I'm bagging away and I did not know how to deal with that. Um, you're not given training in that sort of thing. That was a... Yes, that always sticks in my mind... The real emotional one [that gave] me a lump in my throat for hours afterwards... This chap, similar age to my dad, maybe a bit younger, the daughter, a bit younger than me. Um, he was a drinker... anyway he seemed like... you know, he was improving. All the way in [to hospital] he's getting better and talking more and you're just thinking, yay, this is going well. I can't remember, but, um, I was chatting away to the daughter, he's still improving, you know, getting some words out. He then went into respiratory arrest going up Cheyne Road and then cardiac arrest getting him out the back [of the ambulance].*

*So we got him to resus... they tried a few things. Then I think they called her in to say goodbye and watch them stop [the machines]... And I just stood there and I thought I've got to stand here and see this. I need to... You know... Because I wasn't too involved I need to be able to see how people react. Just for next time, a learning experience because, you know, you're not trained and I don't know how you would train someone... And, yes, I was so close to crying my eyes out, um, and, yes, I had that sort of sore throat for hours afterwards... And you're sort of rubbing your throat and tipping your head up to try and stretch the muscles out. I have never forgotten that day.*

(Interview 31: Matthew Brand, paramedic, Hermes ambulance station 28/03/2011)

Matthew demonstrates an important point for emotional geographies of care work viewed through a spectral geographical lens; that ghostly entourages

induce fear and anxiety, but in facing death, crews train themselves to cope with their emotions.

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#### EMOTIONAL TRAINING

Matthew interestingly refers to his ghosts as traces, which signifies an affectual connection to the past that has left an imprint on his (unconscious) mind. The emotional connections between Matthew and his spectral being manifested due to the emotional affiliations constructed with his previous patients when he originally attended the job. Matthew demonstrates his emotional connection in two ways, first by noticing and affirming similarities between his own life and that of the patient. Research with ambulance crews show that jobs which draw parallels between themselves and their patients are the most distressing (Clohessy and Ehlers 1999; Filstad 2010; Williams 2012b).

Second, Matthew demonstrates his attachment to the patient by being able to recall the patient's name. The ability to recall names or other human traits or characteristics suggests that the crews are unable to successfully split the patient as body from patient as person heightening feelings of guilt and anxiety. These anxieties become projected and attached to the patient, creating and embedding the spectral being in their mind. Ghosts therefore become "psychic invasions" (Holloway and Kneale 2008:301) inducing a "sense of horror, anxiety and punishment" onto ambulance crews, reminding them of their clinical failings and wrong doings (Cameron 2008:390). Ghosts therefore "uncover and interrogate the [activities] of the past in the ongoing present" and therefore have an educative purpose (Cameron 2008:383; Coddington 2011).

In addition, the ghostly entourage provides Matthew with the emotional training required to cope with the emotional demands of the job. In the description of his first ghost, Matthew's guilt is created not only out of his



failure to successfully resuscitate his patient but his guilt in poorly handling the daughter's fears and anxieties surrounding her father's health. Matthew feels foolish for reassuring her that his medical intervention (bagging) was not as bad as it looked. In hindsight, Matthew realises that he should not have said this and therefore this ghostly apparition reminds him to be more careful in disclosing information to relatives which may build false hope. By learning from their ghosts, crews are able to cope with their mistakes and live with the uncertainty of their job. This is emphasised by Cameron (2008) who stated "only by living with, talking with and accepting our ghosts that we might learn to live" (Cameron 2008:383).

Matthew's second ghost story teaches him to manage his emotions in the face of death and gives him experience in how to deliver bad news to relatives, both of which crews do not get any formal training in. This ghost story is interesting due to discussions surrounding Matthew's attachment to the patient. Despite his original preoccupation with the similarities between the patient and his daughter, and himself and his own father, Matthew proclaims that he was sufficiently emotionally detached from the patient and therefore able to stay in the room while the resuscitation team switched off the machines and delivered the bad news to the daughter.

Matthew recounts the emotional and affectual challenges of dealing with death, describing his visceral and physical instincts at watching this scene. Matthew admits that he carried the visceral impacts of witnessing these events for hours after, illustrating the immediate and short term affective impact of this patient's death on his body. The longer-term affective quality of what Matthew witnessed continues to haunt him as he relives the scene in his mind. This haunting may suggest that Matthew was not as emotionally detached from the patient as he thought, illustrating the fine line between emotionally attached and detached care relationships. It also heightens the importance of crews being reflexive about the relationships created with

patients, and the need to realise the impact that patient care has on their emotional well-being to prevent the construction of spectres in the future.

Engaging in emotional talk with crew mates or station mates may support crews to realise the emotional impact of a job and prevent the creation of ghosts through the suppression, for example Cameron (2008) stated that “ghosts allude to the presence of that which has been excluded, marginalised and expelled” (Cameron 2008:383). However, as previously demonstrated, emotional talk does not always prevent a haunted mind.

Reflection and emotional talk does go some way to appease the guilt and anxiety harboured by the ambulance crews following critical incidents. In the interview extract that follows, Paramedic Cheryl Hooper demonstrates the importance of being able to reflect on jobs to cope with their own emotions. Without reflection ambulance crews find themselves mentally and psychologically unable to move onto the next job.

*CH Me and Ross had a real run of properly poorly patients, about a year ago actually. And, um, for the first six months we worked together it was constant, it was really poorly patient after really poorly patient and, um, I think I got to the point where... I was just an emotional wreck in my head. Not so much outwardly, I wasn't really... I guess I hadn't... you, kind of, don't really have a chance to, get over one before you've got another one...*

*And anyway, I went to handover in the ED one day and I knew that I was going to cry. So I just... and I said to Ross I'm really sorry but I've got to get out of here and I just gave him the clipboard. It was probably not the right thing to do, but then it wasn't right for me to stand in resus trying to give a handover with tears streaming down my face either. And, um, I went off to the toilet and had a good old cry and it ... it just built up, you know and sometimes it just hits you when you're least expecting it I think.*

*ER Was there something that triggered that...*

CF ...It was just another person going to resus and I think I just got... I can't even remember what the job was actually. ... I think it had just got to the point where it was, um...[in a previous job] I'd had to make a couple of decisions [that were difficult] ... I decided to stop CPR on this lady... We'd got her into the ambulance and normally that would be an occasion where people just continue CPR to hospital, you know. But I couldn't get an airway and I...it's always airway. If you can't get an airway then you don't move on. What's the point in doing anything else because if you can't get a good airway you're not going to... and, um... but she was so full of fluid and that was the first job that I had as a paramedic, because it was a couple of months after I qualified, and I, kind of, had to make a really difficult decision. Excuse me [clears throat].

And, um, she was alive when we got to the house; I think that's probably... I don't know, because I kind... I keep going... I go back over it even... every now and then it just gets into my mind... I can see it replaying. I just, sort of, think maybe I should have done this, or maybe I should have done that, blah, blah.... But, we were doing CPR in the back of the ambulance and I just said to Ross, I said, look I don't... I can't get an airway I don't think we're going to get anywhere with this. We couldn't bag or anything. So I said, I'm going to go and talk to the husband and you know, keep going for now and I'll go and speak to him.

So I went and spoke to him and I said... I said, I'm really sorry sir but your wife's, um, heart has stopped and she's not breathing at the moment. I said, um, I'm sure that you could probably tell she was very poorly... I said have you and your wife spoken about what your wishes would be and he said, um, it's funny you should say that but three months ago we had a consultant appointment and he told her that she was living on borrowed time. And he said to her, you know, um, I... there's nothing else we can do for you, you know, your heart is failing, and he said to me we'd spoke about it not long after that and she'd said that whatever happened, when it happened, that

*was it... she didn't want to end up in a hospital bed not being able to do anything, that kind of thing.*

*I came back out and said what had happened and that I'd spoken to him and what he'd said and we agreed, you know, we'd stop. And then, um, the husband came and knocked on the door, he said, can I see her? I said, yes that's fine, just give us two minutes and we'll just, you know, make her a bit more presentable if that's ok. And he was like, yes that's fine. Next thing we know, um, we get her all, you know, covered up with a blanket and that kind of thing, and I stepped out to go and get him and there's him stood there with a priest...*

**ER** *...Oh goodness...*

**CF** *...Anyway, so the priest said to me, he said...if you don't mind, I'd like to do a little bit of a prayer for her while he's with her if that was ok. And we were like, erm ok?...*

**ER** *...hmmm really unusual circumstances....*

**CF** *...I mean, firstly I'd done something that...you wouldn't even normally consider and that's to call a cardiac arrest in the ambulance...That was a bit odd anyway because I was just kept going over it, should I be doing this? Should I not be doing this? Can I do this?, um, is it right, am I going by my morals or am I going by what they want, or am I forcing my opinion on them or I don't know? And, um, yes bizarre...totally bizarre...But that started off our trend of bad jobs and I don't think I ever put that one to bed properly because it, it just, it's always stuck in my mind. But I think it's just some jobs do, some jobs always will do.*

*And after that I said to control I've got to go and get a cup of tea, I need to calm down and I can't go and deal with anyone else at the moment. Because that's the trouble, it then impacts on your other patients when jobs go like that. That's what's difficult about our job I think, it's not carrying*

*something on for the rest of your shift... Erm because [it's such a quick turn-around] we literally rock up, pick [a patient] up, chuck them in the back, do a few bits, get rid of them, and that's it. And that's it over and done with...next patient... and sometimes that's not enough, sometimes you need to follow that on a bit.*

(Interview 30: Cheryl Hooper, paramedic, Hermes ambulance station 08/03/2011)

Cheryl's interview emphasises two important points for emotional geographies of care work observed through a spectral lens: first that the ambulance crews' mobile workplace influences the construction of phantoms and ghost stories and second that psychic invasions and eerie undercurrents destabilise crews' self-confidence and professional judgements.

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#### CONSTRUCTING PHANTOMS AND THE PSYCHIC INVASION

Cheryl indicates that the temporally rich environments in which emergency care work is provided impact on crews' ability to perform emotional labour and manage their emotions following critical incidents because they have very little time to reflect before being sent to the next patient. Their heightened mobility therefore facilitates the construction of ghosts, demons and phantoms because it prevents them from engaging in emotional talk which may help crews to release ghouls and spectral beings before they become trapped in the dark recesses of their minds (Ginn 2013).

Having an opportunity for emotional talk starts a cathartic process which enabling crews to reflect and understand what had produced the ghost in the first place (Gordon 1997:22). An understanding of spectral beings can result in exorcism, reducing the haunted mind. Instead the mobile, temporally rich environment is, conducive to the suppression of emotions which cause patients and critical incidents to "[reincarnate] in a haunting sense" (Meier 2012:3) and erupt without warning into the present (Hill 2013).

The immediacy and involuntary sense of haunting is emphasised by Cheryl on two occasions in the extract. First, her impromptu need to cry in resus and second, the clearing of her throat as the "emotional weight" (Gibas 2012) of the spectral narrative returns to haunt Cheryl once again, causing her emotions to resurface. The resurgence of emotions highlights the continual emotional labour required to manage her emotions in the present as she had in the past when she felt like an "emotional wreck" on the inside but presented an emotionally collected professional exterior. This demonstrates psychological invasions caused by ghosts waiting in the wings to disrupt and disturb linear temporality causing the past and present to collide (Wylie 2007; Gibas 2012). Furthermore, eerie undercurrents destabilise Cheryl's self confidence and professional judgements causing her to question whether, in hindsight, she should have called time on the resuscitation process. These anxieties may impact on Cheryl's decision-making in the future.

The hauntings thus far have been produced through deep-rooted negative emotions such as anxiety, fear, horror and guilt following critical incidents. The following spectral trope, *memory*, emphasises that ambulance crews can conjure "ghostly friends" (Maddern 2008:359; Matless 2008) through positive memories induced by emotions such as pride, amazement and awe for past patients.

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MEMORY

Bergson (1939) has stated that "pure memory" is the survival of personal memories in the subconscious that returns to the conscious spontaneously with a faithful preservation of the past. Like haunting, the construction of pure memories can be voluntary causing aspects of the past to erupt into the present through physical sensations or engagements with the world (Bergson 1939 cited in Hill 2013). Unlike the horrific feelings of terror associated with haunting (Cameron 2008) the eruption of pure memory

induces happiness and satisfaction. The following interview extract with Cheryl Hooper emphasises the positive affectual impact on memory.

*"...there are odd occasions... I'm thinking of particular um, brain cancer lady who'd beaten it so many times and I just thought she was just so brave and... she was just being so positive despite all the things that were against her, you know, and, um, she was amazing. [In the back of the ambulance]... she just suddenly went, I'm really sorry but I think I need to have a cry, and I went, that's ok. And I was just, like, can I have a cry with you then? And we were actually laughing but crying and it was just really one of those really bizarre situations. And all the way to hospital we were just in a right old state.*

*And we got to the other end... I can't even remember who I was working with...we went, ah, I think we both just need a minute. And, um, we sat in the back for a minute and we just had a good old chuckle about it and, um, you know, she was the sort of lady that I almost, sort of toyed with following up and checking up on her and then I thought, do you know what, it will upset me more if I find out she never made it out of hospital. So I decided not to, you know. And as much as I wanted to know what happened to her, it... at some point she probably died because she did have brain cancer... it's not something you're going to live for ages with. But her positive attitude was amazing... she just blew me away... you know, even now it just makes me well up a bit because it's just a wonderful memory.*

(Interview 30: Cheryl Hooper, paramedic, Hermes ambulance station 08/03/2011)

Cheryl's memory of this patient demonstrates that ambulance crews' spectral casts do not have to cause terror or distress. Instead, they can be "ghostly friends" (Maddern 2008; Matless 2008) that provide crew with feelings of comfort, pride, awe and admiration from which they can draw strength and inspiration from when their care work becomes emotionally challenging.



## GHOSTLY FRIENDS

Cheryl's memory demonstrates that an emotional connection with her patient was established in the intimate space of the ambulance. As witnessed previously, the ambulance is usually used to begin the processes of emotional detachment by turning patients into cyborgs (Haraway 1994; Lapum, Fredericks et al. 2012). Cheryl however uses the space to build an emotionally attached relationship with her patient.

Cheryl's pure memory reveals a tender and touching scene between patient and health professional heightening their emotional connection as they share in back region behaviours. Cheryl and her patient's emotional ruptures demonstrate that neither are able to successfully manage their emotions. In contrast to Cheryl's emotional rupture previously witnessed in the section, Cheryl does not perceive this emotional rupture to be unacceptable. Instead, she indicates that her emotional display was within acceptable limits of patient care because it enabled her to share in an "emotional moment" with her patient, creating a positive emotional experience towards the end of her patient's life. This echoes research which shows that ambulance crews believe that it is appropriate to display their true emotions with terminally ill patients and children (Williams 2012b).

The mismanagement of Cheryl's emotions therefore acted as a bonding experience cementing this patient firmly into her memory. The companionate of their emotional outburst was further emphasised by the shared giggling and chuckling about their behaviour. This laughter acknowledges, on some level, the inappropriateness of the emotional outburst and the crossing of patient / health professional boundaries and indicates a sense of emotional relief in being able to express and share their true emotions with one another. It is unclear however, whether Cheryl and the patient are crying for the same reason. Cheryl is emotional because she recognises her patient's bravery and courage in the face of death. This leads



her to think about her own mortality resulting in her experiencing her own "death anxiety" (Brady 2013b). In contrast, the patient is perhaps crying due to the acknowledgement that her life is about to become extinct and the relief of no longer having to fight for survival. Regardless of the reason for the emotional rupture, it is the bonding and emotional impact that fixes this job in Cheryl's memory. Whilst this memory is one of awe and admiration, it also harbours some anxieties for Cheryl, as there is an element of doubt about whether she should have allowed herself to display or indulge in her emotions, as it could be perceived as unprofessional.

Divulging her pure memory, Cheryl's narrative provides light relief and emotional strength in a job predominately haunted by unwelcome trespassers, ghouls and demons resulting in this inscribed representation of the past to become a treasured memory. This memory may have positive implications for Cheryl's emotional well-being and as a consequence may have a positive effect on the delivery of care. It is not however just the personal connections established with patients that lead to haunting by ghostly friends. Hauntings can also involve aspects of the uncanny (Freud 2003; Hook 2005; Roberts 2013). In this final section the spectral trope of the uncanny analyses how personal memories and feelings of the familiar emerge in spaces of the unfamiliar causing unsettling and terrifying experiences.

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#### THE UNCANNY

The geographies of mobile care work is analysed through Freud's notion of the uncanny (Freud 2003) to explore how ambulance crews' personal relationships and experiences can persistently haunt their everyday care work through feelings, connections and experiences of the serendipitous, "familiar and homely" or "das heimlich" (Freud 2003:xliv) in "unfamiliar territory" or "unheimlich" (Freud 2003:xliv) through the intertwining of materialities and "post memory" (West 2013).

It is through a sense of the uncanny that different temporalities "generating a series of double translations between past and present, real and artificial, psychological and supernatural" (Freud 2003:xlvi). The merging of the past and present causes feelings of anxiety, terror, fear and foreboding forcing crew to engage in emotion work to suppress the "nightmarish return" (Freud 2003:liv) of the "departed, or departing" (Freud 2003:l) to be deliver care to their patients.

The ethnographic observation below is taken with permanent crew mates Bob Hatcher and Nancy Taylor and illustrates how uncanny experiences, suppressed during the delivery of care, returns and erupts into consciousness causing a sense of dread, discomfort and fear, as the realisation that their lives are mirrored in their patient's life.

*I arrive at the ambulance station just before 16.00. Bob arrives at the same time and we head into the kitchen. Bob asks the two crew mates sat at the table if they have seen Nancy. They say they haven't. Bob leaves to change into his uniform...*

*Nancy arrives at the station at 16.05 and Emily Whybrow attempts to leave the kitchen to warn her that Gavin (the station manager) is 'on the war path'... However Gavin appears in the corridor, and immediately begins shouting at Nancy for being late. His shouting can be heard through to the kitchen. After a minute or so the shouting stops and it falls silent. The station mates look amongst themselves with concerned expressions.*

*Bob enters the kitchen area clutching a box of drugs and asks if Nancy has arrived yet. Emily says that she has but Gavin has confronted her in the corridor for being late. Bob is visibly anxious and asks 'where is she?' Emily says that she didn't come into the kitchen. Bob says he will go and find her. Emily says she will go as she is probably in the ladies. She stands to leave as Nancy walks in through the kitchen door and dumps*

*her bags by a table. Emily asks 'you want a cup of tea?' Nancy nods clearly fighting back the tears. Bob walks towards her and she holds her hand up to stop him coming any further 'no don't'. She puts her hand to her head and takes a breath and then drops into a crouched position and pulls roughly on her laces trying to tie up her boots. All eyes are on Nancy. Another crew mate walks into the kitchen with a big smile on his face and is about to say something when he senses the atmosphere and stops...*

*Yanking at her shoe laces Nancy talks angrily, tears falling down her face, 'I have enough to deal with without him shouting his mouth off in my face...his big fat red angry face....I am five minutes late...I am never late...he said I am always late...what does he know...comes in at 9, goes home at 4...never around for the whole day...launching into attack me' Nancy continues with her angry rant, tears streaming down her face. She talks about all the problems she has had to face over the last few weeks (her husband's father dying of cancer with only a few weeks to live and having to care for him, her husband and her three young children under the age of 6) and that she hasn't let it affect work. She talks about the support that her husband has had from his work, offering him paid leave. The service has offered her limited support in comparison.*

*Emily hands Nancy a cup of tea and brings her to stand. Nancy puts it on the side and Emily gives her a hug. Bob asks Nancy is she wants to go and talk. She nods and they leave the kitchen. The kitchen is silent for a few minutes and then becomes overly animated as the station mates discuss Gavin's increasingly bad mood...*

*Bob and Nancy return to the kitchen just before 17.00 and we head out into the ambulance... The MDT whirs with the crew's first job - a female chest pain. Nancy is in the attending seat and Bob driving...*

*[The patient is placed in the back of the ambulance] Nancy touches the patient's shoulder and tells her that they can see nothing wrong with her ECG. The patient sighs with relief. Nancy asks if there are stressful things going on in her life at the moment. The patient discloses that her mother-in-law is very ill at the moment and she is trying to look after her, make sure her husband is coping, her children, although they are old enough to be able to deal with it, and hold down her job. She talks at length about how stressed she has become especially in having to continue working. The situation mirrors Nancy's and yet she does not appear to have acknowledged the reflection. Or perhaps she is an incredibly skilled emotion manager being able to empathise with the patient without showing any of her own emotions?*

(Ethnographic shadowing 64: Nancy Taylor, technician, Bob Hatcher, paramedic, Hermes ambulance station 24/06/2010)

The ethnographic extract emphasises important aspects of caring on the move that have already been presented and discussed in the chapter. These include a depiction of the ambulance services organisational behaviour and the masculine and hierarchical relationships between the station manager and his crews; the lack of perceived formal support felt by crews in the service and the dynamics and relationships between permanent crew mates and station mates and their role in emotion management. Whilst these discussion points are noteworthy, the notion of the uncanny is the focus here.

Following the job neither Nancy nor Bob acknowledged the uncanny experience. I was therefore left perplexed as to why the crew had not acknowledged the similarities between Nancy and her patient. It was only later, sat at a standby location that Nancy spontaneously began to cry as the reflection dawned on her. Through the concept of the uncanny, this final section reveals the challenges faced by ambulance crews in managing their

emotions on the road, especially in delivering care to patients in which serendipitous and mirrored experiences exist.

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#### MIRRORED EXPERIENCES

In "The Uncanny", Freud discusses the creation of a double (the doppelganger) (Freud 2003:141) which is created by the ego to "ensure against the extinction of the self" (Freud 2003:142). To protect oneself from self-annihilation people identify themselves with others to forget or substitute their true self for the other, therefore protecting themselves from self destruction (Freud 2003). However, in this extract it is Nancy's ability to dismiss or temporarily reject the creation of the double (the patient) that enables Nancy to protect herself from the emotional burden and anxiety of delivering care to the patient. Freud states that the function of the mirror image is to create self-observation thus bringing suppressed knowledge to the conscious. Nancy's realisation of the mirroring process induces terror and anxiety because what was once alien is now familiar causing Nancy to feel highly unsettled and disturbed as she comes to "understand the extraordinary degree of uncanniness" between herself and her patient (Freud 2003:143). It is the feeling of the unheimlich, the imbalance between the familiar, which causes Nancy to become distressed as she is forced to engage in self-observation or self-reflection through her doppelganger and realises the emotional burden she is under.

Whilst the delayed realisation of the mirror image causes Nancy to become distressed, it is the suppression of the feelings of the uncanny experienced on the road that allow crews to manage their emotions successfully to deliver professional patient care in the pre-hospital environment. Nancy's emotional rupture however indicates that the sense of the uncanny is inescapable as it is always returning (De Certeau 1998; Freud 2003:144; Cameron 2008). In the following interview extract paramedic Cheryl Hooper demonstrates how her unconscious suppressed experiences of the uncanny create cognitive

dissonance, which prevents and protects crews from the conscious haunting affect of the “uncanny”. It specifically describes how uncanny experiences often emerge from material objects in the patient’s home.

*...I think most of us when we’re... with a patient that’s, you know, in similar circumstance or is, you know, there’s something that reminds us about somebody we love or somebody we know, or whatever. I don’t think that you recognise that factor in that until... you finish that with that patient. I think you learn to just put your feelings aside a bit. I mean, it’s always there isn’t it? ...*

*I went to something that caught me out of the blue... I went to this guy who, um, who’d died the night before. So, you know, it was recognition of life extinct... we were waiting for the police and I was talking to his neighbour downstairs and, um, I was on the car (RRV) so I [was on my own]. I’d done all the paperwork and me and the neighbour were just sat there waiting for the police and I was chatting to him about this guy. And, um, I walked out into the kitchen to look for his medication and it... struck me how similar he was to my granddad. Um, bearing in mind my granddad had died about five years earlier so it wasn’t a recent thing, but... I just thought... and you know how that shiver goes down your spine and you just, sort of, think oh my god... this is so weird!*

*...I went and sat back [down with the neighbour] and I just, kind of... put it to the back of my mind... Anyway, so the police turned up, I handed over to them, left them with him [patient], started back to base um, and I got to... [some] traffic lights and I was sat at a red light and I just started crying. Randomly. And I was just, like, I don’t even know what I’m crying about and I had to pull over. I pulled over and phoned up control and Darren answered and he... said, um, hello Cheryl. I went, hello, I can barely talk, he went, are you alright? I went, I’m a bit upset..., I’ve just been to the most bizarre job because it was just so much like [my*

*grandfather]... and I assume, that that was what it was, that it just hit me that, you know, I wasn't going to see him again.*

*This guy, you know, he was so active, same age as my granddad he had a proper butter thing, you know, like they do, the little silver ones, ah, with the little knife next to it and he had his plate set up for the next morning for his breakfast and...he had a little loaf, you know... my granddad always used to buy it because he loved uncut bread, he never liked sliced bread, he was really against sliced bread. So he would always buy one of the little loaves and, you know, there was always a couple of slices gone and I always used to love that, going over and having a slice of that with some butter on because we never were allowed butter at home and, um, you know. And a proper teapot and you could just see that he'd set it all up ready for the next day, it was all clean and tidy and all the towels were folded in half and hung over the cooker and it was just all these little things that just... and it was like someone had just crept up and slapped me round the face. Really bizarre.*

*...At the time, in the house, I recognised that it was a reminder, but you just put it to the back of your mind... you're just not in a place where you can... it wouldn't have been appropriate... more important things to do at that point in time and so you just put it away don't you? ... and then a bit later it will just hit you...I don't think it's a conscious thing... I think subconsciously... I think consciously I recognised that it was familiar and that there were all these little things and I, kind of... had a little smile when I saw and thought oh, you know, it's just like granddad's house, how weird and I did, that was the way I thought about it.... I don't think I even really acknowledged that it had affected me...*

(Interview 30: Cheryl Hooper, paramedic, Hermes ambulance station 08/03/2011)

The interview extract highlights an important point for emotional geographies of care work framed through a spectral lens; it illustrates that



feelings of the uncanny are "sensed remotely" (McCormack 2010) only moving into the conscious through visceral signals brought about through material objects.

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MATERIAL OBJECTS AND THE UNCANNY GHOST

Emery (2003) states that the source of uncanny experiences is often unlocatable within the person sensing that something is wrong, bizarre, eerie or familiar. Instead a feeling of the uncanny is experienced in the body through fluttering in the stomach. This was emphasised by Cheryl as she describes her uncanny experience which was summoned to her consciousness through visceral reactions (Anderson 2006; Maddern 2008; Holloway 2010) or "affective electricity" (Maddern 2008:293) which was triggered by the material objects on the patient's kitchen table. Emery (2002) called his "visceral beckoning" (Emery 2002:170) as it highlights how affective, sensual relations waiting beneath the "conscious register" rise to the body's surface to signal the return of the uncanny ghost.

Holloway and Kneale (2008) have demonstrated in their analysis of the hauntings within film, literature and life that "objects somehow hold or store emotions, memories or even consciousness" (Holloway and Kneale 2008:299). Cheryl describes how, on seeing the patient's butter dish, knife and tea pot, she experienced an eerie sensations as her grandfather's spectral presence begins to emerge from these objects resurrecting unsettling visceral experiences (Maddern 2008). Hill (2013) has suggested that people and things resonate temporally in relation to each other because material objects endure where people change and because material objects have the power to affect us through a "material echo of the past" (Hill 2013:381). For Cheryl the patient's material objects (butter dish and tea pot) and the recognition of ritual and habit (tea towel hanging over the oven door and the preparation of tomorrow's breakfast) forced memories of her grandfather, that had become trapped in her subconscious through emotional dissonance, to



surface allowing mirroring between her grandfather and her patient. In addition, the death of the patient may have also resurrected Cheryl's spectral grandfather by drawing her attention to a "life extinct". The uncanny ghost resurfaces to demonstrate a delayed understanding of loss (Dolar 1991).

The delay in this understanding is witnessed in Cheryl's narrative when she reveals her emotional rupture in the RRV on her way back to base. This rupture emphasises that the return of the uncanny ghost are "irreverent" (Emery 2002:377) and that there is no good time to be haunted, especially in mobile care work where there are limited back regions for emotional expression. In both extracts, Cheryl and Nancy illustrated that feelings of the uncanny are "disquieting experiences" (Madden 2008) and catch ambulance crews by surprise, "springing up at the most awkward time" as a highly unpleasant experience" (Dolar 1991) before disappearing as quickly as it came, into the unconscious. Throughout this section, uncanny experiences, spectres, ghosts and memories have caught ambulance crews by surprise, often disrupting their mobile care work and illustrating that there is "no good time for ghosts" (Matless 2008:338). Ghosts and experiences of the uncanny catch ambulance crews unaware because they work so hard at managing their emotions in interactions with patients through surface-acted emotional labour that they don't address, or sufficiently manage, their deep-rooted emotions. The ability to manage their emotions and cope with the emotional demands of their job, as we have seen throughout the chapter, are hampered by the temporal constraints of their mobile care work and the masculine culture which inhibits emotional talk. Unmanaged emotions and the uncanny ghost therefore return - but always at the least opportune moments.

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SUMMARY

Drawing on three spectral tropes: ghosts, memory and the uncanny, this section explored the affective quality of care work by demonstrating how

crews' mobility encourages unwelcome visitors, spectres and ghosts to haunt their minds, affecting their ability to deliver patient care at scene and their emotional and psychological well-being.

Focussing on unwelcome trespassers, it argued that crews narrate ghost stories to cope with the inescapable traces of the dead that haunt their minds following bad or traumatic jobs. Due to their mobility and the temporally and spatially rich care environments in which they work, crews struggle to escape disturbing memories trapping them in the dark recesses of their minds. In contrast "memories" focuses on the construction of "ghostly friends" that induce happiness and satisfaction in crews' care work. It argues that pure memories constructed through emotional connections and affiliations with patients provide light relief in a job predominately haunted by trauma thus supporting crews' emotional and psychological well-being. Both ghosts and memories provide emotional training that teaches crews important lessons about emotional care work for future patients.

Finally, the uncanny explores crews' emotion work as personal emotions, connections and experiences enter the mobile workplace through processes of mirroring or material triggers in a patient's home that induce visceral reactions and feelings of the familiar in an unfamiliar place. To prevent an emotional rupture at scene, crews suppress these unconscious feelings only to re-surface in the conscious mind where they must be managed and contained.

## 5.6 CONCLUSIONS

Caring on the move: the emotional care work of ambulance crews addressed the last three objectives of the thesis by demonstrating how crews' mobility and their mobile workplace impacts on their emotional care work and the relationships that they establish with both their patients and their colleagues. Furthermore, it explored the affective qualities of mobile care work by focussing on the haunting and spectral dimensions of their work.

In exploring how crews' mobility effects the development of emotional care relationships with their patients, the chapter demonstrated that the different spatial and temporal dynamics of mobile carescapes influences the relationships that crews are likely to establish. Private spaces such as the home for example were observed to induce emotionally attached care relationships as care work was performed amongst the patient's personal possessions (photographs and material objects) which forced crews to view patients as people and establish greater rapport with them. This attachment reduces crews' emotional labour at scene as they are able to gain greater social and emotional information from their patients to aid their clinical decision making. In addition rapport enhances the patient care experience which is encouraged by the Francis Report.

In contrast, critical incidents attended in public spaces were observed to encourage emotionally detached care relationships. This was because incidents that happened in public spaces were more likely to be critical incidents such as RCT's which required crews to perform task orientated behaviours, observing patients as body parts and enabling crews to focus on their clinical skill in an emergency. Temporality also affected the establishment of emotional care relationships with the day of the week and time of day influencing the types of jobs and patients attended. Shifts conducted on a Friday and Saturday night for example were more likely to incur "undesirable patients" which resulted in crews constructing

emotionally detached care relationships to protect themselves from the frustration of this care work, which could induce burnout and fatigue. Patients however receiving emotionally detached care may perceive poorer patient satisfaction.

Finally, the mobile workplace also facilitated crews' emotional detachment from their patients en-route to the hospital via the placement of medical equipment to their bodies which created a patient cyborg. This coping mechanism protected ambulance crews' emotional and psychological well-being enabling them to move onto the next job.

Crews' mobility also affected the construction of emotional relationships with colleagues. For permanent crew mates the spatial confines of their mobile workplace and forced proximity resulted in the creation of intimate emotional affiliations as they learnt to engage in emotional talk to support each other following emotionally challenging jobs. They also learnt to work in well choreographed care routines which reduced their anxieties and emotional labour at scene due to effective and efficient body ballets. In contrast non-permanent crew mates worked in disjointed care routines which added to crews' emotional demands. This was exacerbated when crew pairings were of the same hierarchical rank as the responsibility of care was challenged. Furthermore, it was demonstrated that station mates helped crews to manage their emotions on the road through the use of dark humour and storytelling. Emotional talk was also used following jobs where humour was inappropriate. Due to crews' mobility there are limited spaces in which crews can express, contain and manage their emotions. Being able to return to the station following a traumatic job may be beneficial in helping crews to manage their emotions and be supported by their peers.

The final section investigated the affective qualities of emotional care work by focusing on the spectres, ghosts and un-welcome trespassers that haunt crews' minds and affect their ability to deliver care at scene. Drawing on

crews' spectral baggage it was demonstrated that crews' ghostly entourages increased their emotional labour as they attempted to manage anxieties and emotions from previous jobs in the present. Memories in contrast focussed on the welcome trespassers that supported crews' emotional labour giving them hope and pride in their care work. In addition, crews' ghosts and memories were regarded as crews' emotional training on the road, teaching them to manage their emotions predominately in death that can't be taught in the classroom. This may have implications for new student crews who spend the majority of their time learning their clinical skills in the classroom with limited road experience. This generation of ambulance crew may therefore not be as able to manage their emotions as those who learnt on the job. Finally, experiences of the uncanny demonstrated how crews managed their personal emotional memories that unconsciously enter the workplace and require managing through emotion work. It therefore demonstrated that crews are skilled emotion managers. To prevent a haunted mind crews could be better supported by the organisation. This may be achieved through the provision of a fixed therapeutic / cathartic spaces in which they can have their emotions managed. This is important because their hyper-mobility currently restricts their ability to effectively manage their private and work-related emotions.

**CHAPTER 6: CONCLUDING EMOTIONAL GEOGRAPHIES OF  
CARE WORK**

This thesis has explored the emotional landscape of the NHS illuminating the complexity of health professionals care practices and emotional experiences of delivering care. By re-casting the study of emotion management (emotional labour and emotion work) through an emotional geographies lens it emphasised the contribution that geography can bring to the understanding of care work in the NHS.

In concluding this thesis this chapter refocuses the research findings around five themes identified through thematic analysis: geographies of emotional attachment, geographies of emotional detachment, spatialities of care logistics, workplace relationships and the affective qualities of care work and their recurring sub-themes: proxemics, temporality, mobility and care politics. These themes speak to the thesis' aims and objectives (box 1), emphasising the emotional and affective care practices of health professionals as they deliver, manage and schedule patient care in the hospital and pre-hospital setting.

**Aim:**

To explore the embodied emotional experiences and care practices of health professionals as they deliver care to their patients.

**Objectives:**

1. To investigate how and why health professionals engage in emotionally attached care behaviours and the impact of these behaviours on their emotional labour.
2. To explore how and why health professionals engage in emotionally detached care behaviours and the impact of these behaviours on their emotional and psychological well-being.
3. To examine the role of emotional labour and emotional work in the management of patient care.
4. To investigate how ambulance crews' mobility affects the development of emotional care relationships with patients.
5. To explore how ambulance crews establish and develop emotional relationships with colleagues on the move.
6. To investigate the affective qualities of emotion in care work.

**Box 1: Aims and objectives**

## 6.1 GEOGRAPHIES OF EMOTIONAL ATTACHMENT

Enhancing existing knowledge and understandings of emotional labour within care work, an emotional geographies perspective demonstrated that emotions are intrinsically linked to the places in which they are felt, contained and managed. It therefore emphasised that the spatial and temporal characteristics of carescapes and notions of proximity and distance are fundamental to the construction of emotional relationships between health professionals and their patients.

Spatialities of care which facilitate emotionally attached care relationships were characterised by slow patient turn over and/or less intensive clinical intervention. These carescapes permitted health professionals to spend more time getting to know their patients (and their relatives) on an emotional and social level. Building rapport with patients' and understanding their emotional and social worlds facilitated clinical decision-making. Patients, who trusted and felt an emotional affiliation to their care provider, were more likely to disclose sensitive and intimate information. Additional information about the patient's emotional and social world may aid or speed up diagnosis, leading to more effective and efficient care pathways. In addition patients benefitted from emotionally attached care relationships through emotional gift exchange (Hochschild 2003b) or by gaining psychological and emotional support during a challenging biographical disruption (illness / death). For some patients, care relationships led them to perceive the ward as an "emotional refuge" (Fields 2001) from wider social and personal challenges. This illustrated their positive patient care experience as well as demonstrating that they believed their care provider's emotional performances.

For ambulance crews, the mobile nature of their crew work facilitated and enhanced the construction of emotionally attached care relationships. This



was particularly evident through the delivery of care in private spaces such as the home. Establishing rapport in the home aided diagnosis and enabled crews to encourage resistant patients to attend hospital, reducing their anxieties and supporting their emotional labour at scene.

Emotionally attached care relationships in both the hospital and pre-hospital setting were also achieved through the performance of care practices that encouraged bodily proximity and tactile behaviours. Increased proximity allowed emotions to flow fluidly between and through health professionals' and their patient's porous bodily boundaries via psychoanalytical processes such as transference and counter-transference. This strengthened the emotional bonds between health professionals and their patients enabling them to gain insight and perspective into their patient's felt and emotional worlds through empathy. Empathetic care performances benefit both health professionals and patients. For health professionals, the display of authentic emotions prevented burn out and fatigue and gave health professionals a sense of pride in their care delivery which bolstered their emotional and psychological well-being (Bolton 2001, 2005). For patients, being in receipt of empathetic behaviours enhances their emotional care experience.

### 6.2 GEOGRAPHIES OF EMOTIONAL DETACHMENT

In contrast, emotional disconnections within carescapes resulted in the establishment of emotionally detached care relationships. Carescapes which facilitated emotionally detached care behaviours were observed in both the hospital and pre-hospital environments. These environments were distinguished by transient and rapid patient turnover, high or intensive clinical interventions requiring task orientated behaviours and / or spaces in which death was frequent. In these spaces health professionals were temporally constrained, preventing them from engaging with their patients on an emotional and social level. In addition, in these environments, patients

## CHAPTER 6.2: GEOGRAPHIES OF EMOTIONAL DETACHMENT

were often viewed as body parts requiring fixing rather than a person and therefore disembodied care practices that discouraged intimacy, tactile care behaviours and bodily proximity protected health professionals from the emotional intensity of their work.

Health professionals, in both hospital and pre-hospital settings, often become estranged from their emotions in these carescapes through surface-acted emotionless performances. This not only supported rational, decisive and objective clinical decision-making, but also protected them from the anxieties, guilt, frustrations and other emotional demands of their work. In these carescapes psychoanalytical processes such as splitting and projection were frequently used to construct defence mechanisms against negative emotions such as anxiety and guilt. Organisational guidelines and targets for example were used to rationalise and justify emotionally disconnected behaviours towards patients, thus relieving health professionals from the guilt and frustrations of their care behaviours.

Patients (and their relatives) however also benefitted from emotionally detached care relationships. Clinical decision making, made in the absence of emotion, allowed health professionals to make difficult decisions in the best interests of their patients for example “Do not resuscitate” (DNR) which allowed patients to die with dignity and not subjected to the physical pain of resuscitation. Removing the decision from the relative or the patient prevents emotions from contaminating the decision making process and reduces feelings of guilt in not intervening at the end of life.

In addition the micro-geographies within carescapes also challenged health professionals’ emotion management. This was observed, for example, in single occupancy rooms and in the back of the ambulance, where the small confined spaces prevented emotions from circulating and dispersing, intensifying the emotional climate (Stringer 2002) or affective ambience (Hubbard 2005) which increased health professional’s emotional labour. The

emotional rupture witnessed by paramedic Bobby King, whilst attending a drunken teenager, demonstrated how contained emotions challenge health professionals' emotion management often leading to emotional slippages. Conversely, however the ethnographic observation with registrar Nikhil Chopras, and his patient who miscarried her baby, demonstrated that the micro-geographies of carescapes can be used to enhance the patient care experience and support health professionals' emotional well-being by preventing negative emotions from circulating and affecting the emotional climate on the ward.

Whilst some spatialities of care encouraged emotionally detached care relationships, in other carescapes emotionally connected and disconnected care behaviours and relationships fluctuated creating geographies of contested emotions (Davidson 2005). In these spaces, health professionals became disillusioned by their empty care performances and attempted to construct emotionally attached care against the temporal and organisational demands of their care work. They hoped that creating emotionally attached care relationships would relieve feelings of guilt, anxiety and frustration. However, this was not always successful, with many health professionals feeling dissatisfied by their emotional care performances.

### 6.3 SPATIALITIES OF CARE LOGISTICS

The logistical spaces in which patient care is managed, demonstrated the emotional complexity and emotional labour required by health professionals, hospital managers and panel members in making decisions about the management of patient care.

Distinguishing between the management of care and the delivery of care, logistical spaces encourage emotionally detached care behaviours, for example meetings are conducted at a distance from the hospital ward to increase physical (and emotional) distance from patients. Organisational

protocols and guidelines are also used to enhance the disconnection between patient care and care management, facilitating objective and rational decision-making. Logistical spaces were however not emotionless terrains, with health professionals and managers carefully managing their emotions through both emotional labour and emotion work to make difficult logistical decisions.

Emotional geographies, combined with geographies of logistics, created new insights into the ways in which emotions infiltrate and effect decision-making and logistical care processes. Exploring the lean production techniques, used to co-ordinate and schedule patients' movement through the health care system against the temporal (waiting times) and spatial (right bed, right ward) systemic constraints, the multi-disciplinary team (MDT) and capacity meetings illuminated how health professionals and managers' emotions become entangled in logistical processes. Failure to affectively schedule patients' movement was observed to lead to organisational turbulence (bed blocking) (Cresswell and Martin 2012), which forced invisible logistical processes to become visible to patients and relatives, threatening not only their safety but their satisfaction in the care provided. Furthermore, organisational turbulence and workplace pressures induced by organisational targets increased NHS workers anxiety and guilt as they attempted to restore a balance between effective and efficient patient care. Organisational turbulence also heightened already strained relationships between health professionals and hospital managers and affected their emotional and psychological well-being.

The continuing care panel (CCP) epitomised the notion that logistical spaces are ostensibly emotionless landscapes, as they are bound by stringent guidelines, finite financial and human resources and formed of a decision-making panel that have no emotional affiliations to the patients under review. The CCP meeting however was abundantly emotional, with surface

acted panellists' behaviours creating fatigue. Panellists emphasised the emotion work required to suppress and contain their emotional imaginations to prevent their personal emotions from contaminating the decision-making process. To assist their emotion management panellists used continuing care guidelines as a defence mechanism to justify rejecting additional care requests and protect themselves from the consequence or impact of their decisions on the patient and their family.

Furthermore, working at the boundaries between private and public care, the CCP meeting raised important concerns for geographies of care politics. It particularly highlighted implications to an ethics of care as a result of current social and cultural transformations to family structures and the health care system. Health reforms have raised questions about who should take responsibility for caring of vulnerable populations. The emotional impact of these changes on patients and their relatives was exposed not only through the CCP observation but also through ethnographic extracts from care of the elderly wards. These observations highlighted the economic and social burden for relatives in caring for vulnerable family members. They also emphasised the emotional weight placed on health professionals as they attempted to reconcile these two opposing forces to establish a compromise about where the responsibility of care lies. Reaching conciliation often involved protracted negotiations with relatives, in small logistical meeting spaces where emotions were intensified and therefore were emotionally exhausting for both health professional and relative. This could lead to poor emotional and physical well-being for both resulting in increased absenteeism and deterioration in the emotional and psychological health of the health professionals. In addition relatives may need to access additional NHS services to support their emotional well-being.

### 6.4 WORKPLACE RELATIONSHIPS

Workplace relationships are a combination of closeness and distance (Hargreaves 2001a). The mobile workplace (ambulance) forced crews to work in close proximity. This facilitated the establishment of emotionally attached relationships between permanent crew mates. Emotional connectivity led crews to work in intuitive patterns, bodily rhythms and well choreographed routines that not only enhanced the delivery of patient care but placed less emotional demands on crews. Working together in close proximity additionally fostered trust facilitating the construction of a therapeutic landscape in which they could engage in “emotional talk” (Mehta and Bondi 1999). Emotional talk provided a coping mechanism for dealing with critical and traumatic incidents on the road.

The ambulance station was also observed to be an important therapeutic space following “bad” jobs. Station mates contributed to and supported each other’s emotion management through jokes and black humour. However, despite this space being perceived as a “therapeutic landscape”, crews rarely had the opportunity to return to the station as they were sent to standby locations to meet government targets. This was observed to have a detrimental impact on crews’ emotional well-being with many crews becoming haunted and affected by unmanaged past jobs, which may have implications to the delivery of care at scene.

In the hospital environment, back region spaces such as meeting rooms acted as cathartic and therapeutic landscapes for health professionals to project and share their emotional care experiences, and for them to be contained, managed and soaked up like a sponge by colleagues, supporting emotional labour on the ward (Allan and Smith 2005). The value of therapeutic spaces for health professionals is limited in emotional labour literatures. An emotional geographies lens therefore draws focus to this space

demonstrating its importance and function in emotionally and psychologically supporting health professionals to manage their emotions especially in response to challenging patients, death and trauma. The importance and value of therapeutic back region spaces in assisting emotional labour therefore requires further examination.

Conversely, detached and emotionally empty workplace relationships were also explored. Ethnographic observations demonstrated the tensions created by forcing bodily proximity within the mobile workplace. Disconnected and incompatible body ballets, that are common between non-permanent crew pairings, emphasised the challenges in delivering effective and efficient patient care which led to increased anxiety and emotional ruptures.

Within the hospital, emotionally detached workplace relationships between hospital managers and nursing staff were illuminated through the establishment of an organisation-in-the-mind (Armstrong 2005). Tense workplace relationships were heightened existing workplace anxieties as a result of the unrelenting threat of redundancy, hospital mergers and closures caused by failures to meet government targets. Detached relationships between NHS staff were therefore not only affected by the micro-spatialities of care delivery but also by macro-political spaces of care that manifested at ward level. Fractious relationships added to the burden of delivering and managing care, impacting on the emotional and psychological well-being of health professionals and managers. More research needs to be undertaken to explore these emotionally political geographies of care work.

### 6.5 AFFECTIVE QUALITIES OF CARE WORK

The spaces in which care work is delivered cause emotions to emerge as affects. In the hospital environment we observed how affects move through and between patients' and health professionals' porous bodies through the transference of pain. Experiencing transferred pain allowed health

professionals to understand and empathise with their patients. In addition, Nikhil's narrative about a still born baby also demonstrated how affects circulate within space affecting the ambiance of the ward.

Within the pre-hospital environment, the idea of mirroring processes (Freud 2003; Rose 2012) was used to demonstrate how pre-conscious affects are suppressed to prevent personal emotions from interfering with care work, especially during incidents where there is symmetry between health professionals' and their patients' emotional lives. Transferring to the conscious, these pre-conscious affects cause emotional ruptures that require emotion work to prevent them from impacting on their care work.

In addition, the research demonstrated that affects emerged through interactions between health professionals and their patients during every day, mundane care situations. These affects created impressionable emotional memories through the sharing of highly emotive and affective trans-human experiences with their patients (Andrews, Chen et al. 2014). This enabled crews to experience care in an intensely emotional way, experiencing feelings such as awe and admiration for patients and pride in their care work. These mobile affective energies can be re-called to support health professionals' emotional well-being when attending emotionally and clinically unfulfilling jobs.

Affects also emerged through interactions with material objects that reignited ghost stories and notions of the haunted mind. For example, job information emanating from the mobile data terminal caused ghostly entourages to re-group in crews' unconscious minds, increasing feelings of anxiety and affecting their emotional well-being and care performances at scene. In addition, patients' material objects in the home also gave rise to mobile energies and intensities through experiences of the uncanny (Freud 2003). In these instances, material objects forced pre-conscious visceral reactions or "feeling states" (Andrews, Chen et al. 2014) in health



professionals which later led to the conscious recognition of an uncanny emotional experience. Arising to the conscious, these affects led to emotional ruptures as they forced health professionals to make sense of and manage these intense feelings.

Further research is required to explore the affective qualities of care work to better understand the importance of managing emotions in the present to prevent negative affects and ghosts from instantly emerging during care interactions and affecting patient care experiences. It is also essential to understand how health professionals manage affects in the hospital environment. In addition it is important to explore how patients are affected by immediate intense feelings and how these feelings may affect their patient care experience and the construction of care relationships with their health care providers.

I now turn to discuss the possible implications for policy and practice.

### 6.6 IMPLICATION FOR POLICY AND PRACTICE

The findings and conclusions presented here demonstrate the relevance and timely nature of this thesis. The recent publication of the Francis report (Francis report 2013a,b,c) and other health professional guidelines such as the Nursing and Midwifery (NMC) code of conduct and “Compassion in our practice: Nursing, Midwifery and care staff” (Nursing and Midwifery Council 2013) emphasises the importance for health professionals to enhance overall care performance through their delivery of compassionate care to increase patient satisfaction. In addition, the Francis report seeks to instil a sense of pride in care delivery and to recognise that better support should be provided to enhance the emotional and psychological well-being of health professionals and managers so that they are able facilitate and engender a culture of emotional care work. Data were collected prior to the publication of the report thus highlighting that emotional (compassionate) care has long

been an important part of care delivery and management for those practicing at ward level. The renewed significance and attention that policy makers are giving to emotion in care work is encouraging.

There are several ways in which an emotional geographies perspective to care work may influence policy and practice. First, in focusing on the temporal and spatial characteristics of carescapes, the establishment of emotional care relationships between health professionals and their patients is accentuated. In understanding and recognising that different carescapes impose different emotional challenges to the health professionals working within them, policy makers may be able to implement tailored emotional labour training that specifically addresses the emotional demands and challenges within each carescape. Currently, limited formal emotional labour training is provided for health professionals (Smith 1992; Smith 2012). Specific training may extend and support the repertoire of emotion management skills and tools already possessed by health professionals, providing effective coping strategies to support their emotional care work. Greater proficiency in emotional labour techniques may assist health professionals in protecting their own and their colleagues' emotional and psychological well-being, reducing emotional fatigue and burn-out, which in turn may reduce absenteeism (Hochschild 2003b; Allan and Barber 2005).

Furthermore, understanding and recognising that different carescapes pose different emotional challenges for health professionals can also lead to the establishment of new care directives that could provide guidance and support to health professionals in delivering care at ward level. New directives could allocate time within practice for building emotional and social relationships with patients in relevant spaces of care. This would not only demonstrate that policy makers are taking the role of emotion in care work seriously and showing that emotional care is equally as important as the physical care provided, but will also convey a clear message to those

already forming emotional connections with their patients (and their relatives) that their work is valued and the organisation supports them in this endeavour. Time for relationship building may reduce feelings of guilt and anxiety, especially for those health professionals working within contested spaces of care, and will also enhance consistency of care across the organisation.

Third, in exploring the spatialities of emotional care work, an emotional geographies lens demonstrated that emotions can become contained or circulate within different carescapes. Health professionals may use this knowledge as an effective emotion management tool to change the emotional climate or affective ambiance of the carescape in which they are working to ease their emotional labour. This knowledge may also be pertinent to hospital designers and policy makers. Recent research has shown that the nightingale ward is increasingly being replaced by single occupancy rooms to reduce the spread of infection and enhance patient satisfaction (Penfold and Maben 2013). Single occupancy rooms however are not favoured by all patients or health professionals. It has been demonstrated that some patients, especially elderly patients, do not like single occupancy rooms as they incite feelings of isolation. In addition, single occupancy rooms may increase health professionals' anxieties due to fears about patient safety. The emotional and psychological consequences for both patients and health professionals' well-being as a result of hospital design should be explored further.

Fourth, in recognising that logistical spaces are highly complex emotional terrains, this thesis suggests that health professionals and managers could be better supported in these spaces. Currently there is limited recognition of the emotional demands of those managing care, with limited formal training to support decision making surrounding the managing and scheduling of care. Training would enhance the emotional and psychological well-being of

health professionals, especially for those working at the boundaries of private and public care where the shifting politics of care create additional emotional challenges.

Policy makers may also benefit from an awareness of the emotional burden placed on both recipients and providers of care at the edge of care boundaries when creating care guidelines. A more considered approach could have implications for service use in the longer term. Better support for health professionals in managing patients' and relatives' emotions at the boundaries of private and public care may result in less anxiety and emotional strain. In addition, health professionals may be in a better position to empathise, support and encourage relatives in caring for their elderly and / or vulnerable relatives in the home. This may reduce the burden on NHS resources in caring for elderly / vulnerable patients but may also prevent relatives from accessing additional NHS resources as a result of their own stresses caused by the care burden.

The thesis also highlighted implications for the ambulance service's policy and practice. The importance of emotionally connected workplace relationships in supporting coping strategies following challenging jobs was emphasised. However, due to their mobility, ambulance crews rarely have the opportunity to spend time at the station outside of meal breaks to build relationships with a wider network of crew. Policy makers should recognise the value of the ambulance station as a cathartic and therapeutic space and allow crews to return to base, especially following bad jobs, to assist coping. Being isolated at standby causes negative thoughts, feelings and affects to manifest leading to a haunted mind which may be detrimental to crews' emotional and psychological well-being if unmanaged.

Unmanaged emotions may lead to emotional slippages in front of patients or relatives, displaying unprofessional or inappropriate behaviours which may negatively impact on the patient care experience. In addition, unmanaged

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emotions and affects such as anxiety may impede or undermine health professionals' confidence or clinical competency. Recognising the therapeutic value of back region spaces in supporting health professionals to manage their emotions is essential in fostering an emotional resilient care workforce.

Finally, the value of well paired crew mates not only for supporting and facilitating "emotional talk" but for delivering effective and efficient care through well choreographed care routines and trusting partnerships was emphasised. Policy makers should be encouraged to consider the implications to crews' emotional and psychological well-being as a result of being placed with a crew mate that they do not feel that they can trust or that they can confide in.

This knowledge and understanding may also have lessons for health professionals working in the hospital environment. Due to staff shortages, health professionals often have to work with bank staff or colleagues that they have not established a trusting relationship with. This may increase health professionals' emotional labour on the ward, adding to the emotional burden of care work. Being aware of the emotional costs of disconnected workplace relationships may be as important to those managing staff rotas.

### 6.7 STRENGTHS, LIMITATIONS AND FUTURE RESEARCH

In moving away from the implications of the research to policy and practice, I now turn to reflect on its strengths and limitations. The data for this thesis were collected through two different research projects, each with their own research questions and protocols. This may have posed limitations for the thesis. First, the aims and objectives for each project were separate from the aims and objectives of the thesis. This could be perceived as a challenge for the researcher and could raise questions about the researcher's ability to effectively interrogate the field and collect adequate evidence to support and

answer both research questions simultaneously without jeopardising the quality and rigour of data for both research projects.

The distinct lines of inquiry between the research projects however was a strength, as it enabled the data to be easily separated and demarcated into thesis and research project data, research tasks and ideas could therefore be decompartmentalised and separated. In addition, for many researchers collecting data for their thesis as part of a larger research project is often fraught with anxieties and challenges about knowing how to separate the data which will form their independent research questions from the wider research project. Having very different research questions negated this challenge as the research inquiries were theoretically and ideologically different.

Second, the thesis' data were dependant on data collection tools and procedures for the other two studies. This may have constrained the data collected for the thesis as interview schedules are often tailored to specific research questions. However, both research projects were predominately ethnographic. An inductive ethnographic approach does not debilitate the data collected as the researcher is not restricted in their exploration of the social, cultural and emotional worlds of their participants. Furthermore, interview schedules included storytelling, which allowed health professionals to take the researcher on an emotional journey allowing the independent research aims and objectives to be explored. The methods of data collection therefore did not impede the independent research needs of the thesis; instead they encouraged and facilitated greater exploration of the emotional worlds of participants.

Third, due to ethical approval, the perspectives and embodied emotional experiences of care delivery and management focussed on health professionals, with limited engagement with the emotional experiences of the patients receiving care. Focusing solely on the emotional experiences of

health professionals, however, was a strength due to the dearth of research within emotional geography literatures that focuses on the experiences of care workers. In addition, nursing research and health geographies also focus on the care work of nurses. Exploring the emotional experiences of care work with a variety of health professionals therefore encouraged a novel line of enquiry surrounding the inter-relationships between place, emotion and care and gaining insight into the wider emotional landscape of the NHS.

Collecting data through two research projects provided two additional opportunities and strengths for the thesis. First, the projects facilitated and secured access to two research sites that are challenging and difficult to infiltrate due to strict ethical procedures and stringent gate-keeping activities (Denscombe 1998; Madden 2012). Access to these sites may not have been granted through my own independent research. This access contributed to the collection of a wealth of rich and invaluable qualitative data.

Second, the academic and clinical research teams I worked within were highly inter-disciplinary and incorporated academic leaders in the fields of health psychology, medical sociology, health leadership, organisational theory and organisational storytelling. Working in these teams exposed me to a plethora of different insights, knowledge, perspectives, theories and literatures that aided and supported the development of my research ideas, methods and theories which encouraged and inspired my intellectual development and could be implemented alongside my own understandings of social and cultural geography. This enabled me to produce a thesis inspired and grounded by a bricolage of different academic disciplines and ideas, which enhanced and informed its critical engagement with the emotional geographies of care work.

Following this evaluation of the strengths and weaknesses of the thesis, the possible avenues of future research are now considered. As noted above, the thesis focuses on the emotional experiences of care from the health

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professionals' perspective to the exclusion of patients and relatives'. An obvious trajectory for future research is therefore to explore the emotional geographies of patients' experiences of care in the NHS. This might include the exploration of how patients and relatives recognise the emotional labour of health professionals and how emotion management techniques impact on patients experience of care.

In addition, such research may also explore patients' and relatives' experiences of receiving care in the NHS and the emotion work required by patients and relatives to deal with the emotional burden of illness and disease. For example, a research bid was submitted by the author and collaborators in December 2013 to the Economic Social Research Council (ESRC). Drawing on both Hochschild's theories of emotion work and emotion as gift (Hochschild 1983b, 2003b) and life-course theories (Kenworthy Teather 1999), specifically in relation to biographical disruptions caused by illness, the proposal is to research male partners' experiences of their spouse's altered body image following (prophylactic) mastectomy and breast reconstruction as a result of the presence of a BRCA gene mutation. It is hoped that this research will provide new knowledges and understandings about how couples manage their emotions surrounding heightened risk of illness and disease and altered body image. It will also generate greater understanding of men's experiences of their partners' breast cancer risk and support men to be more involved in their partners' patient care experience, from which they are often excluded due to the female centric clinical environment. Research focusing on the emotional experiences of patients and relatives suffering from other diseases and illnesses may also be explored.

It is hoped that the findings and conclusions from this thesis have enhanced our knowledge and understanding of the emotional landscape of the NHS and the emotional care experiences of a variety of health professionals and



managers. This knowledge may be used to support the requests of the Francis report to engender the six C's of care – care, compassion, competence, communication, commitment, courage – enhancing the NHS for patients and the health professionals working within it. However, the thesis demonstrates that a simple blanket return to compassionate care is not possible due to the complex and nuanced emotional landscapes of the NHS. The spatial and temporal characteristics of different carescapes therefore need to be considered to better support health professionals in delivering and managing emotional care work and undertaking their emotion management.

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## APPENDICES

## APPENDIX 1: REC APPROVAL FOR PROJECT 07/Q0806/8

07/Q0806/8

Page 1

**London - Surrey Borders Research Ethics Committee**

St George's University of London  
 South London REC office 1  
 Room 1.13,  
 1st Floor, Jenner Wing  
 Tooting  
 London  
 SW17 0QT

Telephone: 020 8725 0262  
 Facsimile: 020 8725 1897

24 January 2007

Professor Paula Nicolson  
 Head of Department of Health and Social Care  
 Royal Holloway, University of London  
 Egham Hill,  
 Egham, Surrey  
 TW20 0EX

Dear Professor Nicolson

**Full title of study:** Leadership and Better Patient Care: From Idea to Practice  
**REC reference number:** 07/Q0806/8

Thank you for your letter of , responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered by the members of the Sub-Committee of the REC.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

**Conditions of approval**

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

**Approved documents**

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application		15 December 2006
Investigator CV		
Protocol		
Covering Letter		
Interview Schedules/Topic Guides: Clinical, managerial and other staff		



Interview Schedules/Topic Guides: Patients		
Questionnaire: Organisational Climate Survey - Patients		
Questionnaire: Organisational Climate Survey - Staff		
Participant Information Sheet: Ethnographic Observation		
Participant Information Sheet: Focus Groups		
Participant Information Sheet: Interview - Patient		
Participant Information Sheet: Interview - Staff		
Participant Consent Form: Generic		
Response to Request for Further Information		
Focus Group Questions - Staff		
Focus Group Questions - Patients		

#### Research governance approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

#### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

07/Q0806/8	Please quote this number on all correspondence
------------	--

With the Committee's best wishes for the success of this project

Yours sincerely

**Mrs Sheree Manson**  
Committee Co-ordinator

Email: [sheree.manson@stgeorges.nhs.uk](mailto:sheree.manson@stgeorges.nhs.uk)

Enclosures:                      *Standard approval conditions*  
   *Site approval form*

## APPENDIX 2: REC APPROVAL FOR PROJECT 08/H0502/146



**National Research Ethics Service**  
**SOUTHAMPTON & SOUTH WEST HAMPSHIRE**  
**RESEARCH ETHICS COMMITTEE (A)**

EJC/STA/hph

22 December 2008

Dr Robert Crouch  
 Consultant Nurse/Senior Lecturer  
 Southampton University Hospitals NHS Trust  
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 Southampton University Hospitals  
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Dear Dr Crouch

**Full title of study:** Improving the quality of ambulance crew handovers: a qualitative study of knowledge transfer in emergency care teams.  
**REC reference number:** 08/H0502/146

Thank you for your letter of 18 December 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

#### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

#### Mental Capacity Act 2005

I confirm that the committee has approved this research project for the purposes of the Mental Capacity Act 2005. The committee is satisfied that the requirements of section 31 of the Act will be met in relation to research carried out as part of this project on, or in relation to, a person who lacks capacity to consent to taking part in the project.

#### Ethical review of research sites

The Committee has not yet been notified of the outcome of any site-specific assessment (SSA) for the research site(s) taking part in this study. The favourable opinion does not therefore apply to any site at present. We will write to you again as soon as one Research Ethics Committee has notified the outcome of a SSA. In the meantime no study procedures should be initiated at sites requiring SSA.

#### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

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Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering Letter		07 October 2008
Application		02 September 2008
Patient Interview Reply Card	1	
Participant Consent Form: Patient	3	05 September 2008
Participant Consent Form: Nursing/Medical Staff	3	05 September 2008
Participant Consent Form: Interviewee	3	05 September 2008
Participant Consent Form: Ambulance Staff	3	05 September 2008
Interview Schedules/Topic Guides: Patients & Carer	1	
Interview Schedules/Topic Guides: Staff/Other Stakeholders	1	
Southampton University Hospitals NHS Trust - Consent Policy & Video Consent		
South Central Ambulance Service NHS Trust Hampshire Division - Observer Policy	Appendix 11	
Diagram of procedure for anonymising data	Appendix 8	
Ambulance Seating Plan	Appendix 7	
Proforma for Analyzing Documentation	Appendix 10	
Letter from Sponsor		13 September 2007
Protocol	1	
Investigator CV		
Response to Request for Further Information		18 December 2008
Participant Information Sheet: Patient	3	16 December 2008
Participant Information Sheet: Nursing/Medical Staff	3	16 December 2008
Participant Information Sheet: Ambulance Staff/Interviewees	3	16 December 2008
Advertisement	2	16 December 2008

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review –guidance for researchers" gives detailed

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guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email [referencegroup@nres.npsa.nhs.uk](mailto:referencegroup@nres.npsa.nhs.uk).

**08/H0502/146** **Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

  
Mr Edward Carter  
Chair

Email: [scsha.SWHRECA@nhs.net](mailto:scsha.SWHRECA@nhs.net)

Enclosures: "After ethical review – guidance for researchers" SL- AR2 for other studies

Copy to: Mrs Christine McGrath  
Southampton University Hospital NHS Trust

APPENDIX 3: LIST OF OBSERVATIONS AND SEMI-STRUCTURED AND STORY-TELLING INTERVIEWS

INTERVIEWS

BROADWATER UNIVERSITY HOSPITAL TRUST (BUHT)

- Interview 01: **Nikhil Chopras**, consultant obstetrics and gynaecology. Broadwater University Hospital 30/06/2008
- Interview 02: **Simba Bhattesa**, consultant obstetrics and gynaecology. Broadwater University Hospital 18/09/2008
- Interview 03: **Lewis Williams**, doctor (F2) obstetrics and gynaecology. Broadwater University Hospital 19/10/2008
- Interview 04: **Benjamin Bennett**, doctor (F2) obstetrics and gynaecology. Broadwater University Hospital 25/10/2008
- Interview 05: **Adam Devon**, doctor (F2) obstetrics and gynaecology. Broadwater University Hospital 12/11/2008
- Interview 06: **Emilia Napier**, associate director of maternity services, obstetrics and gynaecology. Broadwater University Hospital 19/11/2008
- Interview 07: **Siobhan Naughton**, antenatal clinic team leader, obstetrics and gynaecology. Broadwater University Hospital 06/12/2008
- Interview 08: **Gavin Hibbert**, doctor (F2), obstetrics and gynaecology. Broadwater University Hospital 06/12/2008
- Interview 09: **Deborah Harrison**, maternity nurse, obstetrics and gynaecology. Broadwater University Hospital 19/12/2008
- Interview 10: **Sophia Willow**, cardiology nurse, cardiology. Broadwater University Hospital 27/02/2008
- Interview 11: **Daisy Lowe**, Cardiology cardiology nurse, cardiology. Broadwater University Hospital 18/03/2008
- Interview 12: **Tracey Bradshaw**, cardiology nurse, cardiology. Broadwater University Hospital 20/03/2008
- Interview 13: **Christine Ollier**, capacity Leader, capacity. Broadwater University Hospital 14/05/2008
- Interview 14: **Robert King**, cardiology nurse, cardiology. Broadwater University Hospital 07/05/2008

### APPENDIX 3: LIST OF OBSERVATIONS AND INTERVIEWS

Interview 15: **Alexander Hopper**, consultant cardiologist, cardiology. Broadwater University Hospital 14/05/2008

Interview 16: **Vince Peters**, consultant cardiologist, cardiology. Broadwater University Hospital 11/06/2008

Interview 17: **Pablo Bittern**, chief executive. BUHT 03/06/2008

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#### HELIOS AND ST JOSEPH'S TRUST (HSJT)

Interview 18: **Robert White**, clinical director Helios General Hospital and consultant care of the elderly St Joseph's Community Hospital and Helios General Hospital 28/11/2008

Interview 19: **Gillian Bishop**, director of nursing, St Josephs Community Hospital 16/12/2008

Interview 20: **Monica Binns**, discharge co-ordinator, St Josephs Community Hospital 16/12/2008

Interview 21: **Darren Cowell**, director of strategy. HSJT 19/03/2009

Interview 22: **Lucinda Randall**, director of nursing, Helios General Hospital 19/06/2009

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#### ROYAL ALEXANDER AND VICTORIA HOSPITAL TRUST

Interview 23: **Noah Chapman**, consultant geriatrician, care of the elderly, Royal Alexandra Hospital 02/04/2009

Interview 24: **Lottie Popper**, head of occupational therapies, Royal Alexandra hospital 07/04/2009

Interview 25: **Dimi Dhesi**, Clinical lead for proactive care of older people undergoing surgery (POPS), Royal Alexandra Hospital 22/04/2009

Interview 26: **Sue Walters**, clinical director of therapies, Royal Alexandra Hospital 09/06/2009

Interview 27: **Madeline Marsden**, consultant geriatrician, care of the elderly, Royal Alexandra Hospital 29/05/2009

Interview 28: **Jim Crabbs**, nurse specialist, care of the elderly, Royal Alexandra Hospital 24/07/2009

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#### SOUTH EAST AMBULANCE SERVICE (SEAT)

Interview 29: **Dave Tolland**, emergency care assistant, Hermes Ambulance Station 03/03/2011

Interview 30: **Cheryl Hooper**, paramedic, Hermes Ambulance Station 08/03/2011



### APPENDIX 3: LIST OF OBSERVATIONS AND INTERVIEWS

Interview 31: **Matthew Brand**, paramedic, Hermes Ambulance Station 28/03/2011  
Interview 31:

Interview 32: **Jack Philips**, paramedic and **Emily Whybrow**, technician, Hermes Ambulance Station 14/04/2011

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#### ETHNOGRAPHIC OBSERVATIONS AND SHADOWING

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##### BROADWATER UNIVERSITY HOSPITAL TRUST (BUHT)

Static observation 01: cardiology step down ward: **Julia Powyers**; senior staff nurse, **Claire Dhan**, staff nurse; **Grace Chapman**, staff nurse, **Tim Howard**, consultant cardiologist. Broadwater University Hospital 24/06/2008

Static observation 02: cardiology step down ward: **Julia Powyers**; senior staff nurse, **Claire Dhan**, staff nurse; **Grace Chapman**, staff nurse, **Tim Howard**, consultant cardiologist. Broadwater University Hospital 25/06/2008

Ethnographic shadowing 03: **Sid Olsen**, consultant obstetrics, obstetrics and gynaecology. Broadwater University Hospital 30/06/2007

Static observation 04: critical care unit: **Julia Powyers**; senior staff nurse, **Claire Dhan**, staff nurse; **Grace Chapman**, staff nurse, **Tim Howard**, consultant cardiologist; cleaner 1; cleaner 2; **David Phelps** capacity manager. Broadwater Hospital 20/08/2008

Ethnographic shadowing 05: **Alexander Hopper**, consultant cardiologist, cardiology. Broadwater University Hospital 27/08/2008

Ethnographic shadowing 06: **Andrew Matthews**, consultant gynaecology, obstetrics and gynaecology. Broadwater University Hospital 18/09/2008

Ethnographic shadowing 07: **Katherine Baker**, Capacity Manager. Broadwater General Hospital 15/10/2008

Ethnographic shadowing 08: **Katherine Baker**, capacity manager. Broadwater General Hospital 22/10/2008

Static observation 09: antenatal clinic: **Sian Lang**, antenatal team leader; **Andrea McGraw**, diabetes nurse; **Jessica Crisp**, receptionist; **Philipa Portman**, nurse; **David Briant**, consultant obstetrics and gynaecology; **Gillian Whitbread**, consultant obstetrics and gynaecology Broadwater General Hospital 27/10/2008

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##### HELIOS AND ST JOSEPH'S TRUST (HSJT)

Ethnographic shadowing 10: **Bill Craven**, associate medical director and clinical care director for care of the elderly, Care of the elderly. Helios general hospital 16/12/2008

### APPENDIX 3: LIST OF OBSERVATIONS AND INTERVIEWS

Ethnographic shadowing 11: **Andrea Hutchinson**, clinical care director for care of the elderly, care of the elderly. St Josephs Community Hospital 17/12/2008

Ethnographic shadowing 12: **Robert White**, clinical care director for care of the elderly and respiratory consultant, care of the elderly. St Josephs Community Hospital 03/03/2009

Ethnographic shadowing 13: **Robert White**, clinical care director for care of the elderly and respiratory consultant, care of the elderly. St Josephs Community Hospital 04/03/2009

Ethnographic shadowing 14: **Judith King**, matron, general medicine. St Josephs Community Hospital 25/03/2009

Ethnographic shadowing 15: **Judith King**, matron, general medicine. St Josephs Community Hospital 26/03/2009

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#### ROYAL ALEXANDER AND VICTORIA HOSPITAL TRUST

Ethnographic shadowing 16: **Madeline Marsden**, consultant geriatrician, care of the elderly. Royal Alexandra Hospital 30/03/2009

Ethnographic shadowing 17: **Chloe Stanmore**, consultant geriatrician, care of the elderly, Royal Alexandra Hospital 09/04/2009

Ethnographic shadowing 18: **Madeline Marsden**, consultant geriatrician, care of the elderly. Royal Victoria Infirmary 17/04/2009

Ethnographic shadowing 19: **Parvette Patel**, clinical lead for proactive care of older people undergoing surgery (POPS), Royal Alexandra Hospital 16/06/2009

Ethnographic shadowing 20: **Parvette Patel**, clinical lead for proactive care of older people undergoing surgery (POPS), Royal Alexandra Hospital 17/06/2009

Ethnographic shadowing 21: **Parvette Patel**, Clinical lead for proactive care of older people undergoing surgery (POPS), Royal Alexandra hospital 18/06/2009

Ethnographic shadowing 22: **Noah Chapman**, consultant geriatrician, care of the elderly, Royal Alexandra Hospital 13/07/2009

Ethnographic shadowing 23: **Thomas Evans**, consultant geriatrician, care of the elderly and emergency department, Royal Alexandra Hospital 20/07/2009

Ethnographic shadowing 24: **Noah Chapman**, consultant geriatrician, care of the elderly, Royal Alexandra Hospital 22/07/2009

Ethnographic shadowing 25: **Thomas Evans**, consultant geriatrician, care of the elderly, Royal Alexandra Hospital 23/07/2009



### APPENDIX 3: LIST OF OBSERVATIONS AND INTERVIEWS

#### SOUTH EAST AMBULANCE SERVICE (SEAT)

- Ethnographic shadowing 26: **Tim Harvey**, emergency care practitioner, Hermes Ambulance Station 11/11/2009
- Ethnographic shadowing 27: **Tim Harvey**, emergency care practitioner, Hermes Ambulance Station 12/11/2009
- Ethnographic shadowing 28: **James Fielding**, Paramedic and **Graham Taylor**, Emergency care practitioner Hermes ambulance station 04/01/2010
- Ethnographic shadowing 29: **Miles Freda**, paramedic and **Tina Day**, technician, Hermes Ambulance Station 12/01/2010
- Ethnographic shadowing 30: **Richard Cole**, paramedic and **Jocelyn Tatum**, technician, Hermes Ambulance Station 14/01/2010
- Ethnographic shadowing 31: **James Fielding**, paramedic and **Susan Street**, technician, Hermes Ambulance Station 20/01/2010
- Ethnographic shadowing 32: **Christopher Pearce**, paramedic and **Susan Street**, technician, Hermes Ambulance Station 22/01/2010
- Ethnographic shadowing 33: **James Fielding**, paramedic and **Jason Cross** student paramedic, Hermes Ambulance Station 27/01/2010
- Ethnographic shadowing 34: **Matthew Brand**, Paramedic and **Jeff Osbourne** Emergency care assistant, Hermes ambulance station 29/01/2010
- Ethnographic shadowing 35: **Clarissa Penny**, Clinical supervisor and **Dave Tolland** Emergency care assistant, Hermes ambulance station 03/02/2010
- Ethnographic shadowing 36: **Clarissa Penny**, clinical supervisor and **Tina Day**, technician, Hermes Ambulance Station 05/02/2010
- Ethnographic shadowing 37: **Clarissa Penny**, clinical supervisor and **Kim Masters**, emergency care assistant, Hermes Ambulance Station 10/02/2010
- Ethnographic shadowing 38: **Clarissa Penny**, clinical supervisor and **Dave Tolland** emergency care assistant, Hermes Ambulance Station 11/02/2010
- Ethnographic shadowing 39: **Vanessa Martin**, technician and **Chloe Duggan** emergency care assistant, Hermes Ambulance Station 15/02/2010
- Ethnographic shadowing 40: **James Fielding**, paramedic and **Cheryl Hopper**, paramedic Hermes Ambulance Station 16/02/2010
- Ethnographic shadowing 41: **Clarissa Penny**, clinical supervisor and **Si Grant**, paramedic, Hermes Ambulance Station 26/02/2010
- Ethnographic shadowing 42: **Alex Crane**, paramedic and **Tina Day**, technician, Hermes Ambulance Station 01/03/2010

### APPENDIX 3: LIST OF OBSERVATIONS AND INTERVIEWS

- Ethnographic shadowing 43: **Matthew Brand**, Paramedic and **Paul Wilkins**, Emergency care assistant, Hermes ambulance station 03/03/2010
- Ethnographic shadowing 44: **Robert Greene**, technician and **Dana Long**, emergency care assistant, Hermes Ambulance Station 10/03/2010
- Ethnographic shadowing 45: **Graham Taylor**, emergency care practitioner, **Dana Long**, paramedic, **Chrissy Field**, emergency care assistant Hermes Ambulance Station 17/03/2010
- Ethnographic shadowing 46: **Hayley Tripp**, paramedic, **Dana Long**, paramedic, Hermes Ambulance Station 18/03/2010
- Static Observations 47: emergency department 24/03/2010
- Ethnographic shadowing 48: **Robin Clarke**, paramedic, **Sophie Albright**, emergency care assistant, Hermes Ambulance Station 23/03/2010
- Ethnographic shadowing 49: **Simon Hunter**, paramedic, **Shane Higgins**, paramedic, Hermes Ambulance Station 29/03/2010
- Ethnographic shadowing 50: **Joseph King**, paramedic , **Adam Hilton**, emergency care assistant, Hermes Ambulance Station 30/03/2010
- Ethnographic shadowing 51: **Adrian Might**, paramedic , **Hannah Topps**, student paramedic, Hermes Ambulance Station 04/05/2010
- Ethnographic shadowing 52: **Adrian Might**, paramedic , **Hannah Topps**, student paramedic, Hermes Ambulance Station 04/05/2010
- Ethnographic shadowing 53: **Jack Philips**, paramedic , **Emily Whybrow**, technician, Hermes Ambulance Station 10/05/2010
- Ethnographic shadowing 54: **Bobby King**, paramedic , **Josh Ledger**, emergency care assistant, Hermes Ambulance Station 11/05/2010
- Ethnographic shadowing 55: **James Fielding**, paramedic , **Frances Flint**, technician, Hermes Ambulance Station 18/05/2010
- Ethnographic shadowing 56: **James Fielding**, paramedic , **Frances Flint**, technician, Hermes Ambulance Station 19/05/2010
- Ethnographic shadowing 57: **Susan Street**, paramedic , **Michael Adams**, emergency care assistant, Hermes Ambulance Station 25/05/2010
- Ethnographic shadowing 58: **Matthew Brand**, paramedic , **Jeff Osborne**, emergency care assistant, Hermes Ambulance Station 27/05/2010
- Ethnographic shadowing 59: **Matthew Brand**, paramedic , **Jeff Osborne**, emergency care assistant, Hermes Ambulance Station 05/06/2010

### APPENDIX 3: LIST OF OBSERVATIONS AND INTERVIEWS

- Ethnographic shadowing 60: **Matthew Brand**, paramedic, **Jeff Osborne**, emergency care assistant, Hermes Ambulance Station 06/06/2010
- Ethnographic shadowing 61: **Jonas Burns**, clinical supervisor, **Jeff Osborne**, emergency care assistant, Hermes Ambulance Station 09/06/2010
- Ethnographic shadowing 62: **Victoria Dennick**, Technician, **Jason Brand**, Student paramedic, Hermes ambulance station 14/06/2010
- Ethnographic shadowing 63: **Nancy Taylor**, technician, **Bob Hatcher**, paramedic, Hermes Ambulance Station 23/06/2010
- Ethnographic shadowing 64: **Nancy Taylor**, technician, **Bob Hatcher**, paramedic, Hermes Ambulance Station 24/06/2010
- Ethnographic shadowing 65: **Bobby King**, paramedic, **Wilbur Baldwin**, emergency care assistant, Hermes Ambulance Station 28/06/2010
- Ethnographic shadowing 67: **Elena Match**, technician, **Chrissy Field**, emergency care assistant, Hermes Ambulance Station 10/07/2010
- Ethnographic shadowing 68: **Call Centre**, SEAT 28/07/2010
- Ethnographic shadowing 69: **Mitch Halse**, emergency care practitioner, Hermes Ambulance Station 09/10/2010
- Ethnographic shadowing 70: **Mitch Halse**, emergency care practitioner, Hermes Ambulance Station 10/10/2010
- Ethnographic shadowing 71: **Mitch Halse**, emergency care practitioner, Hermes Ambulance Station 11/10/2010
- Ethnographic shadowing 72: **Bobby King**, paramedic and **Wilbur Baldwin**, emergency care assistant, Hermes Ambulance Station 26/10/2010
- Ethnographic shadowing 73: **Graham Taylor**, emergency care practitioner and **Wilbur Baldwin**, emergency care assistant, Hermes Ambulance Station 26/11/2010
- Ethnographic shadowing 74: **Cheryl Hopper**, paramedic and **Ross Smith**, technician, Hermes Ambulance Station 28/11/2010
- Ethnographic shadowing 75: **Cheryl Hopper**, paramedic and **Ross Smith**, technician, Hermes Ambulance Station 29/11/2010
- Ethnographic shadowing 76: **Cheryl Hopper**, paramedic and **Ross Smith**, technician, Hermes Ambulance Station 09/12/2010
- Ethnographic shadowing 77: **Victoria Dennick**, technician and **Jason Bond**, student paramedic, Hermes Ambulance Station 11/12/2010
- Ethnographic shadowing 78: **Emily Whybrow**, technician and **Jason Bond**, student paramedic, Hermes Ambulance Station 18/12/2010

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Ethnographic shadowing 79: **Emily Whybrow**, technician and **Ross Smith**, technician,  
Hermes Ambulance Station 14/01/2011

Ethnographic shadowing 80: **Emily Whybrow**, technician and **Jason Bond**, student  
paramedic, Hermes Ambulance Station 15/01/2010

Ethnographic shadowing 81: **Nancy Taylor**, technician and **Dave Tolland**, Emergency care  
assistant, Hermes ambulance station 21/01/2010

Ethnographic shadowing 82: **Victoria Dennick**, Technician and **Ross Smith**, technician,  
Hermes Ambulance Station 23/01/2010

Ethnographic shadowing 82: **Victoria Dennick**, technician and **Ross Smith**, technician,  
Hermes Ambulance Station 24/01/2010

APPENDIX 4: INTERVIEW SCHEDULE: LEADERSHIP AND BETTER PATIENT CARE: FROM IDEA TO PRACTICE



*The talk that introduces the study can be viewed as an 'active, consequential part of the interviewing process... such talk clearly provides precedence and direction' (Holstein & Gubrium, 1995: 41). The introduction 'positions the respondent in relation to the questions that are about to be asked' (ibid. 42).*

**A) Revised introduction to the 'Participant Information Sheet: Staff Interviews'**

You are being invited to take part in an interview study about leadership and patient care in three different hospital settings. The purpose of this study is to identify how leadership can improve patient care.

We know that leadership can motivate people, and that health care workers are committed to providing good patient care. But, we also know that leadership, and patient care can mean different things to different people.

To understand if leadership can improve patient care, we want to learn how nurses, doctors, other medical professionals, and managers and patients define and understand leadership and patient care. To do this, we want you to answer specific questions, but we also would like you to tell us about everyday occasions of leadership and patient care.

We'll be asking you to tell us stories about leadership and patient care at certain points in the interview. But please feel free to tell us stories, or give us examples, whenever you feel this would help us understand how you feel about any of the issues we raise.

**B) Interview**

\*Introductions, background and experience in relation to patient care and leadership in the organization

**1. Leadership**

'Leadership' means different things to different people.

**a. How would you define it?**

- Do you see that kind of leadership at this hospital? Why/not?
- What about in this unit?
- What makes someone a good leader? Can you give me an example?
- Who here at work do you see as providing leadership to you personally? Why?

**b. Do you see yourself as someone who could be a leader?**

#### APPENDIX 4: INTERVIEW SCHEDULE FROM LEADERSHIP PROJECT

- Why/not?
- Under what circumstances?

c. Can you give me an example of leadership in this hospital? (Note for the interviewer – encourage to tell stories from everyday life, to describe incidents)

### 2. Patient care

a. Like leadership, '**patient care**' means different things to different people.

- How would you define it?

b. Tell me about patient care in this hospital. How is it defined?

- Are there differences between units? Tell me about them. Why do you think this is?
- How would you improve patient care in the hospital?
- How would you improve patient care in this unit?

c. How do you [as a hospital worker, nurse, etc.] try to deliver good patient care?

d. What do you think are some obstacles to delivering the sort of patient care you'd like to see? How could these obstacles be removed?

e. Do you think leadership could improve patient care in this hospital?

- Why/not?
- Do you think that better leadership would improve patient care? Why/not?
- Has the leadership in this hospital improved patient care since you've been a member of staff? How so? Or why not?

### 3. Stories

a. Could you tell me about a time that made you feel **proud** of patient care in this hospital?

- In this unit?

b. Could you tell me about a time that made you feel **disappointed** with patient care in this hospital?

- In this unit?

c. Could you tell me about a time that made you feel **proud** of the quality of leadership in this hospital?

- In this unit?

d. Could you tell me about a time that made you feel **disappointed** with leadership in this hospital?

- In this unit?