Emotional labour: clinicians’ attitudes to death and dying

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Abstract

Purpose – This paper aims to understand the impact of emotional labour in specific health care settings and its potential effect on patient care.

Design/methodology/approach – Multi-method qualitative ethnographic study undertaken in a large ICU in Sydney, Australia using observations from patient case studies, ward rounds and family conferences, open ended interviews with medical and nursing clinicians and managers and focus groups with nurses.

Findings – Clinician attitudes to death and dying and clinicians’ capacity to engage with the human needs of patients influenced how emotional labour was experienced. Negative effects were not formally acknowledged in clinical workplaces and institutional mechanisms to support clinicians did not exist.

Research limitations/implications – The potential effects of clinician attitudes on performance are hypothesised from clinician-reported data; no evaluation was undertaken of patient care.

Practical implications – Health service providers must openly acknowledge the effect of emotional labour on the care of dying people. By sharing their experiences, multidisciplinary clinicians become aware of the personal, professional and organisational impact of emotional labour as a core element of health care so as to explicitly and practically respond to it.

Originality/value – The effect of care on clinicians, particularly care of dying people, not only affects the wellbeing of clinicians themselves, but also the quality of care that patients receive. The affective aspect of clinical work must be factored in as an essential element of quality and quality improvement.

Keywords Patient care, Death, Health services, Australia

Paper type Research paper

Introduction

The term emotional labour encapsulates the affective aspects of work. Prominent in organisations with client contact, it is fundamental to the work of health professionals (James, 2004; Hochschild, 1983). Health professionals must not only understand and interpret the physical needs of those for whom they care, they must also respond to their emotional needs (Staden, 1998). This conception enforces all direct caregivers, but it can run counter to a conception of health care as principally task-based work. Clearly, the personal and professional skills of health care professionals are important.

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attributes in health care, but their capacity to cope with their work cannot be separated
from the content of the work itself. Specific types of health care, for instance cancer
care and intensive care, are personally challenging, stressful and anxiety-provoking
(Delvaux et al., 1988; Rooda et al., 1999). Much of the discussion of the effect of
managing serial death that characterises these clinical specialties is contained in the
nursing literature, but its effect is as profound on medical clinicians’ performance and
emotional life (Arnetz, 2001). For doctors, anxiety can attach to the effect that failure to
rescue can have on their perception of their own clinical competencies and can manifest
as feelings of guilt about letting the patient down (Meier et al., 2001). For nurses,
anxiety can attach to their connection to individual patients and the powerlessness
they feel in bearing witness to often futile treatment, especially if it impedes comfort
care (Yang and McIlfatrick, 2001). In this paper, we examine clinicians’ attitudes to
dying and death and conclude that to survive the assaults of their work, clinicians
must openly acknowledge and talk about the effect of witnessing serial death so as to
effectively engage with the affective intensity of the work they do.

Dealing with illness and death is taxing for individuals at the best of times, but we
assert that it becomes a risk to patient and clinician safety if its negative side effects
are not recognised and moderated. Obholzer (2005) describes the side effects that can
arise in organisations dealing with loss and bereavement as “emotional toxins”, for
example anxiety and stress. We follow Robb in describing anxiety as a feeling of
apprehension caused by a threat to a person or their values that can manifest as an
exaggerated feeling of impending doom, dread, or uneasiness (Robb, 1983). Stress, on
the other hand, can be described as the consequence of anxiety – the excessive and
deleterious effect of a taxing environment and demanding circumstances on a person’s
ability to cope (Marks et al., 2005). Clearly, not all emotional labour causes anxiety, and
not all anxiety is stressful. Where stress does occur, Obholzer (2005) maintains that
health care workers seek to defend themselves, often by denial, and that institutions do
the same. Feelings of anxiety and stress are normal and natural, and “it is not the
defensive process per se that is the problem – it is the defensive process that is fallen
into in an unspoken, unthought-about and unconscious way that is the problem”
(Obholzer, 2005, p. 298). Thus, where organisations fail to help health care workers to
bring defensive behaviours to the surface and to acknowledge and counteract their
effect, their negative consequences can be deleterious for both patients and clinicians
alike.

Stress that affects people’s capacity to do their job is a recurring theme in the health
literature, and, for our purposes, our selected review leads us to group it broadly into
three main themes. First, is the stress of working in large organisations, where the
impersonal routines necessary to manage complex health services can overwhelm the
needs of individuals (James, 2004). Second, is the stress that comes from the type of
work itself as clinicians regularly witness the distressing effects of disease on the
patients for whom they care (Rooda et al., 1999). Closely associated with this is a third
form, not widely recognised in the literature that clinicians experience when they “give
of themselves” to support vulnerable and dying people. In the case of end-of-life care,
clinicians run the risk of identifying too closely with the vulnerability of others that can
cause them to confront their own mortality and that of their close family. Continually
confronting death in this way can affect clinicians’ well being, their attitudes to dying
people and, potentially, the type of care they provide, especially if clinicians and the
clinical units in which they work deny its existence, fail to acknowledge its risks or avoid discussions about how best to handle it (Meier et al., 2001; Rubin, 2000). We contend that this third type of stress is a risk to the emotional health of doctors and nurses and is largely hidden in health care organisations, notwithstanding stress-related burnout, absenteeism and resignation.

The first two types of stress, those from working in large organisations and the content of work, are arguably more amenable to identification and amelioration (Brilli et al., 2001) where they are relatively common and have their origins in the external organisational environment (Mularski et al., 2001). However, stress from emotional labour may not be as readily identifiable or amenable to technical solutions where it is bound up in caregivers’ personal anxieties that challenge their self-concept and confidence (Barnard, 1988). Conscious fears can be readily recognised and resolved, but if unconscious fears mask defensive personal and social behaviours they can be confronting to address and difficult to remedy (Hinshelwood and Skogstad, 2000). In this paper we examine the anxieties of doctors and nurses who care for people as they die and situate our study in a large intensive care unit. First, we describe our method; next we present extracts from the data and interpret them within the context of clinician-reported anxiety; we then discuss its implications for clinicians and its potential effect on patients and on the organisation. We conclude that both personal and organisational sources of stress prevail in end-of-life care and need to be practically acknowledged and counterbalanced to remedy its effects. We position our examination within a review of the literature on emotional labour to which we now turn.

Background

Emotional labour in health care

Emotional labour is defined as the effort involved when employees “regulate their emotional display in an attempt to meet organisationally-based expectations specific to their roles” (Brotheridge and Lee, 2003, p. 365). James (2004) regards it as one of three main components of health care, together with the organisation and physical tasks of care. It is thought to serve a functional purpose in regulating the receiver’s emotions and affectual life, is often regarded as synonymous with empathy, and can involve “surface acting” where appropriate responses are elicited to patient circumstances in the absence of a personal connection (Larson and Yao, 2005). When seen in this way, it becomes an instrument detached from its object and designed to elicit the active and conscious manufacture of feeling (Hochschild, 1983). It can also involve “deep acting” where a personal exchange takes place, as the health professional connects with the patient to feel the emotion that they wish to display (Mann, 2005). In either form, emotional labour is not formally recognised as an element or competency in health care and is absent from ideal models of care and from workforce development strategies.

In Western countries, death has moved out of the home and into health care institutions where professional carers substitute for the family (Seale, 2000). These professional carers can experience anxiety and stress from the emotional labour of caring for dying patients and their relatives, especially where it involves the withdrawal of active medical treatment (Miedema, 1993). Extrinsic pressures can overlay and exacerbate emotional labour if organisational demands conflict with clinicians’ personal and professional standards, for instance if clinicians take on too
much responsibility, if they cannot keep up to date with knowledge, if they are left to take difficult decisions alone or if conflict arises between stakeholders about what constitutes appropriate patient care (Watson and Feld, 1996). However, what constitutes emotional labour is not clear because the types of tasks involved and who performs them is not well known – it is not described in official records, its component skills are difficult to name, its acquisition is not well understood, nor is its alleviation (Staden, 1998). As well, the ease with which physical, concrete tasks can be done can push aside difficult emotional work. Added to this is the traditional location of emotional labour in the sphere of women and of nurses that denies its effect on men and on physicians (Kalvemark et al., 2004). This suggests that the stress that many clinicians feel even after they cease emotional work, and the connections between emotional labour, anxiety and stress on the one hand and clinicians’ quality of life, patients’ quality of care and organisational effectiveness on the other have not yet been fully drawn (Feldstein and Gemma, 1995).

Much of the discussion around emotional labour concerns its commodified nature of surface acting, and the implications and consequences of deep acting are less well developed. Positive attitudes to death and dying appear to be inherent in deep acting, and some clinicians are better able than others to manage its distressing effects. These attributes appear to be spread across individuals and groups and do not lie in identifiable genders and professions (Rooda et al., 1999). Age, experience and psychosocial maturity are thought to be positively associated with reduced anxiety in women and less apprehension about communicating with dying patients, although in oncology, researchers have found that older and more senior nurses have difficulty recognising patients’ emotional needs, and their own (Rooda et al., 1999). Death anxiety is higher in women than in men in some instances (Rooda et al., 1999) and junior staff generally feel anxious about the adequacy of their care (Servaty et al., 1996). Significantly, negative attitudes to death and dying correlate with anxiety about one’s own aging and death (Rooda et al., 1999). Notably, palliative care regimes of care that allow for holistic and psychosocial agendas to take root appear to encourage open attitudes to death and dying that other specialties may not (Hibbert et al., 2003). The reported positive attitudes of hospice and palliative care nurses to death and dying may therefore represent a conscious career selection, not present in intensive care doctors for example who report distress and dissatisfaction with their career choice (Coomber et al., 2002).

This selected discussion of the literature suggests that emotional labour is inherent in the work of both medical and nursing disciplines, and assumptions that it affects particular genders and professions are misguided. Both intensive care doctors and nurses report distress in their work. Nurses experience helplessness, inadequacy and depression if they identify too closely with patients, and doctors can experience distress and withdraw from patients and colleagues if their attempts to save patients fail (Feldstein and Gemma, 1995). Neither group communicates well about their experiences (Costello, 2001). This denial and avoidance of the topic is problematic if there is no personal growth for those affected and if skills to appropriately respond to the emotional needs of others and of self are not fostered. Thus, retained anxiety and unresolved stress can affect clinicians’ emotional, psychological and physical state manifesting as irritability, headaches and tiredness and possibly suicidal tendencies and substance abuse (Coomber et al., 2002). We conclude that emotional labour is a
Caregiver stress as an element of quality
A growing literature is developing on the relationship between clinicians’ attitudes to their work and the quality of care they provide (Larson and Yao, 2005; Mann, 2005; Mark, 2005). In the case of caring for dying people, emotional labour is often intense because it is the clinician who accompanies the patient and their family through the success and failure of medical treatment, and their emotional shifts from hope to disappointment and ultimately to death and to mourning (Sorensen and Iedema, 2007). Particular skills and organisational supports systems are needed to accomplish these tasks and to not leave the carer physically and emotionally depleted (Mann, 2005). The literature suggests that neither clinicians nor the organisations in which they work are well equipped to do so (James, 1989; Chally, 1995). Thus, if, as we contend, the quality of clinical practice is influenced by clinicians’ attitudes, negative attitudes to death will be associated with negative attitudes to care (Rooda et al., 1999). Hence, poor quality of care can result if the values of the patient and their family have not been identified, if care goals are not coherent, if clinical technology is inappropriately used to assuage patient/family anxiety and if clinicians fail to engage in time-consuming decision processes that can culminate in patient and family mistrust of the system and of professions, if omitted (Meier et al., 2001). Thus, where attitudes to death and dying are shown to be multidimensional and complex, originating from personal, professional and organisational sources, strategies to address them will also be multidimensional (Rooda et al., 1999).

Strategies to ameliorate caregiver stress
Few studies are described in the literature about how to recognise and alleviate the stress of emotional labour, and there is a limited awareness in the clinical literature that it is an issue requiring attention. In some cases, caregiver stress is attributed to administrative managers’ confusion about what constitutes the primary work tasks of clinical teams (Hinshelwood and Skogstad, 2000). If strategies focus solely on extrinsic causes they may not be effective if they miss the intrinsic nature of stress. Being aware of its deep psychological nature will help to shift remedies from enumerating its symptoms to understanding the types and levels of stress that health professionals encounter, the anxieties that underlie them and the defenses that mask them (Hinshelwood and Skogstad, 2000).

In this regard, both nurses and doctors engage in defensive behaviours. For nurses, depersonalisation, detachment and denial are common; for doctors, detached concern, a learned response to avoid emotional involvement, is a similar defensive mechanism (Leiderman and Grisso, 1985; Lief and Fox, 1963). Organisational arrangements can reinforce and entrench these behaviours and thus they can become problematic for constructively managing anxiety and for effectively organising work tasks (Menzies, 1960). Burying anxieties in personal and social defense mechanisms may hide them from view, but their effect will continue to be felt in interpersonal and organisational fractures. For instance, the defensive behaviours that individuals and groups produce as responses to particular environmental stimuli can become accepted as norms in collective settings and
reproduced as negative workplace cultures (Hinshelwood and Skogstad, 2000; Menzies, 1960). Yet the possibility of change exists, contained in the coexistence of groups that can perpetuate unconscious anxieties and defenses on the one hand, and those that actively work to address underlying problems on the other (Hinshelwood and Skogstad, 2000). Nevertheless, the clinical literature is relatively silent on the implication for practice arising from the negative effects of emotional labour in specific health care settings, how they impact on performance and how they can be ameliorated (Mann, 2005). To flesh out possible responses to these dilemmas, we turn next to outline our method for examining the relationship between emotional labour and its potential effect on clinician performance within a specific regime of care.

**Method**

We undertook a qualitative study to gauge the effect of clinician attitudes and practices on end-of-life care in a large intensive care unit (ICU) in an acute public tertiary hospital in Sydney, Australia. We chose a unit that fulfilled the requirements of a critical case study site (Flyvbjerg, 2001) acknowledged in the field as progressive in intensive care practice and research, and likely to be representative of Australian tertiary hospital ICUs in general and those of other countries with similar health systems. Ethics approval was gained from the hospital in which the study was conducted, and data were collected between 2000 and June 2002. Table I outlines the project’s modes of data gathering, participants and study sessions.

<table>
<thead>
<tr>
<th>Type of method</th>
<th>Description of participants</th>
<th>No. of participants</th>
<th>No. of sessions</th>
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<tbody>
<tr>
<td>Patient case studies</td>
<td>Patients within the ICU</td>
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<td>16</td>
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<tr>
<td>Family conferences (by request)</td>
<td>Within the ICU</td>
<td>15</td>
<td>6</td>
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<tr>
<td>Interviews with medical managers</td>
<td>Divisional medical director</td>
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<td>(by request)</td>
<td>Departmental medical director</td>
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<tr>
<td>Interviews with intensivists</td>
<td>Intensive care consultants (staff specialists)</td>
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<td>(by request)</td>
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<tr>
<td>Ward rounds (by request)</td>
<td>Senior and junior medical personnel</td>
<td>11</td>
<td>3</td>
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<tr>
<td>Interviews with nurses</td>
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<td>(by request)</td>
<td>Nurse educator</td>
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<tr>
<td>Focus groups with nurses</td>
<td>Less experienced nurses (up to 2 years)</td>
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<td>1</td>
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<td>(voluntary participation by invitation)</td>
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<td>Intermediate nurses (2-5 years)</td>
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<td>Experienced nurses (5-17 years)</td>
<td>9</td>
<td>1</td>
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<tr>
<td>Interviews with palliative care</td>
<td>External to but servicing the unit</td>
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<td>1</td>
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<td>specialists (by request)</td>
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<td>Interviews with chaplain</td>
<td>External to but servicing the unit</td>
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<td>(by request)</td>
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**Table I.** Data collection methods

| Total                                  | 89 | 46 |
Interviews and focus groups were conducted and tape recorded by a social scientist and transcribed by a professional service; case notes were taken of observations in family conferences, clinician interactions with patients and ward rounds. Over 240,000 words of transcript were produced. The data gathered were analysed by a social scientist, a policy analyst and an organisational behaviourist using grounded theory techniques and categorised using open coding methods (Glaser and Strauss, 1968). Themes and patterns that emerged were analysed using the constant comparative method from which tentative theories were generated that were further contextualised using specific literature reviews. Each of the participants of our study was asked in varying ways how their work with dying people affected them. We have selected statements from a small group of clinicians that are particularly emblematic and representative of the theme under scrutiny here.

Limitations
Our study findings are limited to the specific site of the research, although we believe that the emotional labour is problematic in those institutions where people die. They are offered as a foundation for further research, particularly where directed to developing organisational mechanisms to counter the negative effects of emotional labour. The theme of this paper, the attitudes and practices of clinicians in end-of-life care, is discussed in the section following; other themes emerging from this study are reported elsewhere (Iedema et al., 2005; Iedema et al., 2004; Sorensen and Iedema, 2006; Sorensen and Iedema, 2007; Sorensen and Iedema, 2008).

Analysis and interpretation
Our data attest to the challenging environment that ICUs present for clinicians. For the most part, clinicians spoke openly and at length about their work and about their attitudes to care for dying people. Nurses appeared to engage more with the human consequences of serious illness and death than did doctors. However, the different professional orientations of these two professions emerged as a fracture line that separated the experience of nurses and of doctors about caring for dying people and from finding opportunities for common ground on which to illuminate and develop mutually satisfying team-based support (Iedema et al., 2004). Organisational arrangements overlaid these differences and exacerbated clinicians’ attempts to ameliorate the stress of their work. We present excerpts of discussions pertinent to the theme of this paper and interpret them under three main headings: anxiety about death, anxiety about professional relationships, and anxiety about the systems of care.

Anxiety about death
Nurses and doctors both experience anxiety when they first encounter death. Typically, they are “thrown in at the deep end” to manage as best they can. Few are prepared for their experiences. For most, their initiation is traumatic and these early experiences can set attitudes and practices that are carried on well into the future. Nurses’ first experience of death tended to be described as definitive and negative, exemplified by the nurse speaking in the excerpt below. Her first experience of death and her fear at managing it unprepared were almost unspeakable, and laid the foundation for future responses. Her detachment from the dead person and her
avoidance of the tasks involved have shaped her attitudes to dying patients and, in turn, her practices:

I'm becoming detached. I just probably don't want to deal with it. The first time I had a death on the ward I nearly – what the hell are we supposed to do? And it wasn't a good experience, because it wasn't a very nice death. But that sort of laid the foundation for how I deal with that sort of thing (Less experienced nurse, 5.02.02).

The nurse’s retained anxiety from her first experience of death appears to have impeded her emotional growth and skill development, and the stress of her experience raises questions about her ability to relate and respond appropriately to dying people and their family. Many nurses expressed ambivalence about showing emotion to family members in the face of death and reported a range of responses including denial of feelings, suppression of emotion and open display of feelings. One nurse believed that showing emotion to family members was unprofessional (13.03.02); a different nurse disagreed, believing that while crying was an acceptable response, her fear of the judgment of others stifled these emotions (15.02.02). These reactions suggest that display rules modified nurses’ behaviour contrary to their inner emotions (Grandey, 2003). In contrast, the nurse speaking in the next excerpt appeared to have worked through these dilemmas to accept that expressing emotion was appropriate, rejecting disciplinary display conventions and the negative judgments of others. Precisely why crying is perceived as weak, and why restraint is seen as a strong and appropriate response to despair is not clear. The crux to resolving the dilemma for this nurse centred on identifying with her own personal circumstances:

[...]

but I've got to the point now, I just don’t care. I don’t care if someone thinks that I'm weak or whatever. The other day we had a young girl in here and her mother just burst into tears and all I could do was hug her. And I was crying too because I was thinking, I'm a mum too now and if that was my baby I'd be devastated (Intermediate nurse, 12.02.02)

Engaging with patients and families in this way may be therapeutic for the family and important for clinicians’ skills development. The therapeutic effect for family members in avoiding suppressed, anticipatory grief (Youll, 1989) emerges in the next excerpt. The nurse speaking empathises with family members. By expressing her emotions she signals their acceptance and legitimises them in others. The family’s expectation of being pushed away is replaced by a “caring about” experience as the nurse acknowledges and responds to their pain:

This lady passed away and her sons were really nice and they were so thankful for the care that we were giving her and [I] started crying with the – because these were like big bikey guys you know? Tattoos and long hair and everything, and they’re crying and we started to cry and the student was absolutely bawling, and they said thank you, you actually feel what we feel, it’s good to see that; you're not pushing us away and ignoring our grief (Less experienced nurse, 5.02.02).

The responses of each of the three different nurses featured above – both negative and positive – influenced the experiences of family members. The ability of the nurses to express feelings and to respond to the emotion of others with their own, as described in the last two excerpts above, represents a means of working through and coming to terms with their attitudes to death and dying, and accepting the realities of work in regimes of care where emotional labour is central, compared to the response of the
nurse in the first excerpt above where discomfort with and rejection of this reality were evident. Significant in such a regime of care where emotional labour is intense, was the absence of institutional mechanisms through which clinicians could talk about their experiences, gain relief from its intensity, or reflect on the personal and professional skills necessary to respond to the situations presented to them:

I think too, what they need up here is someone – a social worker or someone you can go and talk to like once a week, where you have a de-briefing in private, where you can just de-brief. Especially after you’ve had a really sick patient and something might have happened and that. I think you really need someone there to be able to go to. And I don’t think there’s anyone here, is there really? (Less experienced nurse, 2.5.02).

Nurses’ capacity to translate their own personal attributes into clinical skills to manage the myriad emotional needs within the unit emerges in the next excerpt. Nurses accepted the limitations of cure and the importance of helping families to also accept this reality. The nurse speaking next takes pride in her skill in this regard, not as a detached, distanced task, but as one in which she was fully engaged:

Like I had a patient – same thing – she was going to die suddenly and in this instance the family didn’t want it to happen. The doctors tried but it didn’t work with the doctors, so I had to try and go through the process of trying to persuade the family that it is better for the patient to let her go. So that whole thing took two days and then when they finally accepted it – that’s it – they all broke and I nearly broke with them. I think I got like a big connection with the family while it was happening as well (Less experienced nurse, 13.03.02).

Doctors, in contrast, appeared not to be as comfortable as these nurses in working through their responses to the emotional needs of others and of themselves and tended to avoid it (Sorensen and Iedema, 2007). The anxiety that doctors experience confronting the reality of disclosing a poor prognosis to a patient emerges in the next set of excerpts spoken by a senior staff specialist. In the first excerpt below detached concern appears to be the doctor’s preferred response. It helps doctors to do the work they must do, but it can also lead them into an emotional cul-de-sac. The doctor admits that becoming emotionally involved is stressful; suppression of feeling is easier. Openly acknowledging the prognosis and discussing the person’s death with them invites vulnerability and risks the doctor’s ability to control the encounter. In the second excerpt below the doctor acknowledges that being confident in her interpersonal skills has extended her emotional range, presumably to one more aligned with the presenting situation:

The work is too hard . . . It is hard and there’s constant dealing with dying and sickness and illness and distress and stuff. It’s not easy.

I remember when I was first starting as a consultant, about once a month you would have a patient that really got under your skin and you became emotionally involved about the family or about the patient and it makes it very stressful when it’s like that. And then what you tend to do is, you tend to clamp down I think on your emotions, at least when you start because that makes it easier to deal with.

And then when you’ve been an ICU (consultant) for a reasonable length of time you can afford to let it go a little bit more and let the family see, or have a bigger range of emotions to deal with them because your basic self is more secure than it was when you started (Senior staff specialist doctor, 11.04.02).
In the next excerpt the risk for the doctor in talking to a patient about their impending death becomes clear. Once the prognosis has been given, the doctor does not know where to take the conversation. There is nothing that the patient can do about his impending death, and there is nothing that the doctor can do, or knows to do. For this doctor, the medical skill repertoire remains bounded within a narrow curative role:

It is just too daunting to go up to the patient and say look I’m sorry Joe but tough luck mate you’ve had it. It’s not easy to do that. What if Joe says, well stuff you, I don’t want to die. What are you going to say then? Tough luck, you are. I mean there is nothing they can do about it (Senior staff specialist doctor, 11.04.02).

This excerpt suggests that this doctor believes that patients expect doctors to save them, regardless of their condition; it also suggests that the doctor expects this of herself. It confirms what we have argued elsewhere, that doctors’ failure to test this assumption prevents them from engaging with the patient about their immediate wellbeing and care, including their psychological wellbeing (Iedema et al., 2005). Thus, the difficulty of admitting the limits of medicine makes the shift from curative to comfort care equally difficult. Neither the patient nor the doctor benefits from this lack of moral courage, and the speedy relinquishing of the patient to nurses once a diagnosis of dying has been made impacts negatively on the care of the patient and on nursing colleagues. It is to this dilemma that we turn next.

Anxiety about professional relationships
The apparently sudden withdrawal of doctors once a diagnosis of dying was made distressed nurses. Nurses interpreted this action as abandonment, of the patient and of themselves. The trust embedded in doctor-patient relationships, important in both medical and nursing ethics and in developing the types of therapeutic relationship discussed earlier, suffered when patients lost their worth as objects of salvage and medical effort was withdrawn. The nurse speaking in the next excerpt feels the withdrawal personally and professionally:

I feel like I’m really letting them down and their family down. Because they’ve built that trust up with you and you’ve worked really hard to save the – try to get something good out of it and then suddenly, it’s almost like you turn around and say to them, they’re no good anymore, I haven’t the time for them (Intermediate nurse, 12.02.02).

The priorities of medical clinicians differed markedly from those of nurses. The pressure on thinly spread medical staff with responsibility for a substantial patient load can evince management strategies not in accord with nurses’ views about appropriate patient care. A different senior staff specialist speaking in the excerpt below bluntly emphasises medical priorities that clearly distinguish the object body of interest to medicine and the lived body of interest to nursing in highly divergent terms:

I would put the other hypothesis that at the end of the day our work is to salvage people and when they’re dying I’ve finished with that one . . . Bed 4 is dying, don’t even worry about it because I’ve got 24 other people and I’m going home with this complex set of things I’ve got to remember and I’ve got to analyse and I’m thinking of the whole night then and I’m going home and it’s always running around in my head (Senior staff specialist doctor, 3.10.01).

Doctors’ burden of responsibility was not lost on nurses, nor was their isolation. Nurses spoke at length of ways they supported each other in the absence of formal debriefing
and feedback mechanisms, using humour, personal support and cooperation, and, at
times, the unit social worker (less experienced nurse 05.05.02), but no one, including
presumably other medical colleagues, appeared to support doctors. This collegial
concern was not reciprocated. In speaking of the relationships between medicine and
nursing, the senior staff specialist featured first in this analysis speaks about the
pressure of the job, her anxiety and the stress of the work, and projects her feelings on
to nurses:

Sometimes we get irritated with them when they’re not thinking about what they’re doing. I
think that’s the thing that makes me the crossest. When something is screamingly blindingly
obvious and they just haven’t thought about why it’s there. That’s the thing that really gets to
me. You know you’re not here to – anyway that really annoys me. So that’s all I ask of them
(Senior staff specialist doctor, 11.4.02).

These comments suggest that neither nurses nor doctors took advantage of their
shared experiences to voice their anxieties, to discuss the consequences and to offer
mutual support. Multidisciplinary forums for practice improvement were not evident
and opportunities to bridge these professional fractures were lost. Yet, as a work
group, nurses openly reflected upon the quality of care patients received and how it
could be improved, and it is to this that we next turn.

Anxiety about the systems of care
Inadequate unit resources at times translated into a lack of on-the-job guidance to
clinicians about how to manage difficult issues and difficult cases. This lack of
guidance allowed problematic interpersonal interactions to persist, and for negative
feedback about performance to sap clinician motivation and coping capacities. The
demand for ICU beds meant that little time was available for staff to mourn and to
recover from the death of a patient for whom they had cared that went against nurses’
ethical and moral values. The nurse speaking in the next excerpt is confronted by the
lack of respect paid to the personhood of patients when they die, quickly becoming just
another dead body for disposal to free up a bed:

A lot of time when a patient’s dying or dead it’s “get the patient downstairs and get the bed
cleaned because there’s a patient in A&E (accident and emergency) that’s got to come in” . . .
The bed’s not even cold and there’s someone else in that bed and that really disgusts me (Less
experienced nurse, 5.02.02).

Nurses spoke about their anxiety caring for very ill people without support,
particularly at night (night nurse 23.03.02), and the high level of accountability
expected of them (intermediate nurse 12.02.02). This pressure was exacerbated when
nurses’ efforts in difficult circumstances were not acknowledged, as the nurse speaking
next indicates:

My second day here I started as a casual and being a casual starting here you don’t get the
orientation. You just walk in the door, there’s your patient, off you go. . . . And then a couple of
weeks later one of the management came to me and said how did you think you did? I was
quite surprised this person was even interested. And I said, well I thought I did quite well
actually. [She said] Oh that patient was too sick for you; you shouldn’t have had that patient. I
was so upset. . . . I was really upset. I didn’t say anything to her. I didn’t cry. I didn’t say
anything back, I just went home and I just thought, I don’t like it here anymore. I mean you
want people to come and help you to understand things, but also you don’t need someone to
managers must become skilled in good management practices, including how to motivate staff to reflect on their own performance and to improve their skills. The clinical nurse educator speaking next discusses performance in less personal terms, describing good patient care as not just about having the right attitudes, but also about having the right organisation. Unit practices require regular and constant rotation of staff between patients, but such rotation cuts across the therapeutic connection between the carer and the patient. The nurse speaking regards this as counterproductive to producing good quality care that relies on continuity of the carer and on a progressive patient care plan, because without such continuity, responsibility for the patient and accountability for patient outcomes is weakened. In her view, where outcomes cannot be attributed to the work of any one clinician, accountability is relinquished because the therapeutic connection is lost and there is no clinician investment in the outcome:

I've been thinking about this for a long, long time, and been talking to N [named nurse] or anyone who will listen about uhm what the problems in our Intensive Care Unit are, and the fact that we rotate every three minutes and part of our critical decision making process is actually knowing the patients, and if they (nurses) are having a time management [problem] or they feel that their accountability is less than what it would normally be had you known that patient, then they won't implement care in the long term because they are no longer accountable (Clinical nurse educator, 31.5.01).

Not all deaths are traumatic. Experiences of death can be positive when they are anticipated and appropriately prepared for, as the description below illustrates of a death observed by the researcher:

They've put blankets over J [named patient] so she looks tucked in and warm. We sit and wait. N [named nurse] adjusts things, patting the blanket. Sits on bed talking to family. Tissues on bed. Husband has arm around wife (Field notes, 5.06.01).

In the end, achieving a good death may lie in the attitudes of the staff that work in the unit feeling positive about death, including their own, and being comfortable about working with people who are dying, expressed this way by a nurse:

You've got to start with yourself first in one respect. You've got to be happy to be here. You've got to be able to say I'll come here every day and feel good about it (Less experienced nurse, 5.02.02).

Appropriate end-of-life care may involve accepting attitudes to death and dying, but acquiring them and the practices that sustain them appear to be serendipitous. The environment of the ICU studied here was relatively uncritical of unit attitudes and practices on how they affected the therapeutic relationship between clinicians and patients, and organisational demands pushed inconvenient and less urgent issues aside. In the absence of engaged unit managers and strong multidisciplinary team processes to expose and discuss common issues, the attitudes and practices of clinicians remained a neglected component of quality in end-of-life care. We go on to discuss these issues in more detail.
Discussion

Clinicians in our study cared for people who were dying; they cared about particular individuals; and their caring roles were hampered by organisational systems that as often exacerbated stress as alleviated it. Our analysis demonstrated that clinicians experienced anxiety about death, but that professional relationships and organisational systems did not support clinicians to moderate the effects of their work. Many of the experiences reported in our study were negative, yet some nurses and doctors were reflective about their practice and displayed an ability to work through the fear of negotiating emotion and engaging with the distress of others on both a personal and human level. Nurses’ reaction to their work ranged from disassociation to resignation, engagement and resolution, and the self-efficacy evident in some nurses enriched their caring roles and their satisfaction with their work. Doctors, on the other hand, appeared to uncritically accept their independent and single-minded approaches to their jobs, and the isolation from colleagues and disengagement from patients that followed. They remained “stuck” in cure roles without a broader repertoire of patient and personal support once their cure role was at an end. This single-mindedness translated into a group norm that separated the dying body from the dying person and sharply defined the goals of medicine from those of nursing (Zussman, 1992; Good, 1994).

Defensive practices protected clinicians from confronting the discomfort of death, but they also impeded the articulation of practice limitations. It has been suggested that differentiating work groups into those that perpetuate defensive behaviours and those that work to address underlying problems is a useful diagnostic and strategic tool (Hinshelwood and Skogstad, 2000). If this is so, the gap between reactive and proactive responses to death may represent a measure of the divergent attitudes and practices of each group, and in turn may become a means for revealing discomfort and stress, discussing alternative ways of acting and learning how to constructively modulate anxiety. However, the absence of the routine contours for analysing, planning and preparing patients for care paralleled its absence in clinicians’ own adjustment to their work. Overall, opportunities for clinicians to come to terms with their own attitudes to death were denied by unit norms that elided patient, family and caregiver need. It is here that the significance of our analysis most clearly registers: our findings suggest that the way caregivers manage their professional roles and the effect that it has on them personally has implications for the effectiveness of their clinical practice, for the type of care they are able to give to patients and families and ultimately for their own wellbeing.

While the significance of emotional labour for nursing was borne out in our study, no particular model of care collectively guided nurses in this work. Our study revealed that emotional labour was also central to medicine, but that the extent to which it was recognised as an inherent component of care requiring a particular set of attitudes and skills was minimal. Doctors were isolated in the way they managed the deaths of patients and contained in their own reactions to them, in contrast to nurses who demonstrated individual instances of personal adjustment and social support. When confronted by challenging events, medical clinicians tended to retreat to the safety of their professional roles and to display a strong disassociative response to the psychological and emotional needs of patients, and of themselves (Iedema et al., 2004). These responses included detachment from the patient as a person, denial of and...
reluctance to engage with the feelings of others, and projection of anxiety on to others. Doctors’ seeming control of their feelings may mask a lack of confidence in their clinical and interpersonal skills to confront death and to manage the consequences of revealing the feelings and emotions that accompany it (Harvey, 1996). The absence of a social support system for doctors condemned them to remain locked within their own negative judgements of their skill adequacy and precluded the type of personal development experienced by some nurses and essential if clinicians are to survive their experience in end-of-life care.

As discussed above, organisational systems designed to regulate resource allocation, unit staffing, care continuity and clinician training exacerbated rather than ameliorated the stress of work. Bodies were quickly disposed of, emotions were suspended, or harshly judged, to contain the consequences of a poor prognosis and nurses were shielded from continuing contact with patients. Neither patients nor families, nor arguably doctors and nurses, gained from these strategies. Within the defensive and cost conscious environment operating in the ICU, the skills needed to manage the shift in goals from cure to comfort risked becoming an automatic and superficial response to the distress of others to avoid the spilling over of grief and the need to deal with its attendant emotions. The discomfort of nurses in not honouring the personhood of patients who had died and for whom they have cared and with whom they had become attached further compounded the stress of intensive care and its organisational environment. Unreflective taken-as-given attitudes to death and dying precluded an assessment of the adequacy of existing systems of care, of developing a set of higher level personal and team-based skills, of supporting doctors and nurses to collectively reconcile their own attitudes to death and dying and of assessing the capacity and competency of individuals to work effectively in emotionally intense regimes of care.

The absence of such skills in intensive care contrasts with their presence in palliative care, where openness in discussing dilemmas around death and dying, responding to patient’s fears in this regard and assisting patients and families to accept the inevitability of death is evident (Iedema et al., 2005). As intensive care moves to incorporate similar practices, doctors and nurses will need to analyse and reflect upon their responses to the emotional demands that face them, to collaborate and to come to a consensus about the diagnosis and prognosis of individual patients and to accept this information as unique for each patient, to collectively and explicitly articulate moral dilemmas, and to manage both the medical and human needs of dying people as treatment benefit diminishes. In doing so, clinicians must come to terms with their own emotional responses, to understand the repercussions of their care roles on their own physical and emotional wellbeing, to articulate feelings of anxiety and stress, to debrief, to seek relief and to accept emotional responses to death and dying as normal and natural. Only by developing a set of coherent practices related to the care of dying patients based on this knowledge can clinicians become aware of the standards of care required, to consciously engage with the dilemmas of dying and to ameliorate their negative effects.

**Conclusion**

There is an important body of work on the affective dimension of caring for the dying, particularly in the context of palliative care, but we were unable to locate work on how
to resolve the tensions of emotional labour around death and dying in the context of intensive care. This paper addresses this shortcoming. Our work reveals that the impact of emotional labour implicit in fractured organisational, professional and personal relationships goes largely unrecognised because there are no mechanisms through which these issues can be routinely discussed. We conceive of emotional labour as having both intrinsic and extrinsic origins. Anxiety about one's personal capacity to manage the confronting experiences of death and dying within an environment of conflicting values can combine in a stress reaction that affects clinicians and patients alike. While extrinsic organisational stress is well recognised in the literature, the psychological capacity of clinicians to manage their own vulnerability and the vulnerability of others is less evident. Although replete with descriptions of emotional labour and distress, the nursing literature has little follow through to clinical practice. Even less is written about emotional labour in medicine, and our data show still less attention is given in practice.

Intrinsic stress emerges as a critical element in the care of people who die in institutions. We believe that the present construction of emotional labour, as women’s and nurses’ work, devalued and marginalised, is unhelpful, outdated and not reflective of the needs of modern institutionalised health care. Our study brought forth examples of enforced emotional display that served to regulate the intensity of end-of-life care and to modulate the expression of feeling and regard. These modulated displays suppressed and contained the behaviour of patients, families and colleagues within acceptable unit norms. What emerged was the sense of injustice imposed on the feelings of others to unreasonably constrain the strong emotions that accompany death. In this context, the link between the defensive behaviours of individuals as a response to anxiety and their embodiment in a collective workplace culture offers an understanding of the problem, its pervasiveness and its seeming intractability.

Our analysis allows us to reconceptualise emotional labour as inevitably inherent in health care, particularly in the care of dying people. Not all emotional labour is stressful, but the fear, anxiety and stress that does occur is indicative of the lack of fit between clinicians’ attitudes to death and dying and the environment of intensive care in which they work. Hence, the quality of patient care will rest upon clinicians acknowledging the essence of emotional labour in health care, incorporating it as a clinical competency in end-of-life care and supporting trainee health professionals in their early encounters with death. It will also rest on organisations acknowledging emotionality as a legitimate and necessary activity in end of life care. Emotional labour does have negative connotations (Hochschild, 1983) and organisational support is essential in helping clinicians to anticipate and respond to the emotional needs of their patients and of themselves, and to practically incorporate the role into staffing policies and unit resources. Without support to reveal and discuss feelings within the context of their patient care work, clinicians may not tap into and confront the deep-seated fears and anxieties that underlie destructive defensive behaviours. Only through purposeful collective workplace strategies can clinicians ameliorate the stressful effects of emotional labour on their patients and on themselves.

References


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