Exploring the experiences of female nurses on emotional labour and the labour process in the public healthcare sector in eThekwini municipality, KwaZulu-Natal.

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Contents

Abstract

The dissertation explores female nurses' experiences of emotional labour and labour process concerning their interactions and relationships with management, doctors, and patients at their workplace. This paper introduces some key concepts of the labour process theory in exploring emotional labour in the workplace contributing to the emotional labour process. Moreover, the study was conducted in KwaZulu-Natal's public healthcare sector, focusing on female nurses with a working experience of four years and above. The dissertation used a qualitative method, semi-structured in-depth interviews, and a schedule technique to gather data. The research was analysed using thematic analysis and was assessed in line with the objectives of the dissertation. The nursing profession requires positive displays of emotions and characteristics such as smiling, compassion, being kind and caring. The findings show that gender plays a role in the nurse-patient interaction and nurses feel undermined by some professional doctors and respected by student doctors. Whilst the nurse-nurse manager relationship is viewed positively. Further findings show that nurses experience harsh working conditions such as long working hours and low wages that leave them dissatisfied. However, nurses are motivated by their contribution to improving their patients' health, which keeps them committed to their jobs and produces good performance. In addition, nurses experience managerial control and concerns of power dynamics are revealed but they have also had agency to resist through strikes and individually. Although emotional labour is a requirement in the nursing profession, nurses are found to experience consequences such as stress and anxiety.

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Chapter 1: Introductory chapter

1.1 Introduction

Hochschild (1983: 7) first defined emotional labour as maintaining the outward visage that creates the appropriate state of mind in others – in this case, the impression of being cared for in a convivial and safe place where one must either induce or repress feelings. In addition, symbolic interactionism is sourced by emotional labour to examine individual's interactions, displays, and experiences as they constantly reconstruct their feelings to fit in with societal norms (Blumer, 1969: 82). Consequently, individuals frequently improvise, and don various masks based on the situation (Goffman, 1957; Hochschild, 1983). People who engage in emotional labour are forced to repress their feelings to put on "different masks". Furthermore, Hochschild employs the dramaturgy approach of Goffman (1959: 10) in emotional labour as it uses theatre to describe social interactions that mould an individual's performance to conform to societal standards.

Moreover, individuals engage in both deep and surface acting as forms of emotional labour. Surface acting entails an individual who expresses fake emotions to align with the expected displays (Ashforth & Humphrey, 1993; Grandey, 2003). As a result, individuals tend to feel caught between their true selves and the idealised version of themselves because of being perceived as playing several per their workplace responsibilities (Prati, 2004: 48). Additionally, deep acting is when people alter their emotions for necessary public presentation (Goldberg & Grandey, 2007; Thwala, 2021). According to Hochschild (1983: 136), people who engage in deep acting during their service labour process feel content and cheerful.

Thus, emotional labour can also be considered a positive skill that involves workers putting effort on "privately felt emotions" to align with the organisationally expected emotions to better relationships in the workplace (Hochschild, 1983; Wharton, 2009). Rules and regulations in an organisation are seen as social norms that are intended to mould and steer employees' feelings, physical labour, and professional abilities (Wharton, 2009: 147-148). According to Hochschild (1983: 162-163), women are trained to master emotions, such as turning rage into kindness, through the specialism of emotions. Further, some professions are only appropriate for women as there is a requirement placed on women to elicit typically feminine feelings (Hochschild,

1983: 163). Hence, women are deemed to be exposed to emotional labour. Further, nurses fall part of the service sector, and it is seen as a women's career because they are deemed to be more prone to care and nurture (Bosch & Lehendorff, 2017: 44).

Furthermore, nurses' goal is to provide a service to the patients with whom they interact with. This brings up Hochschild's (1983: 98) claim that while service positions do not generate concrete commodities, nurses, or service workers supply 'good services' - which means that organisations require service workers to market their emotional condition, both in themselves and others. Emotional labour is considered as a labour product since workers must smile, feel, and seem in a certain way as directed by managers and organisations (Brook, 2009; Hochschild, 1983). James (1989: 16-20) describes emotional labour as hard productive work because female nurses must manage their emotions while being placed in a situation where there are dictators (management) who dictate how emotions should be managed as part of the nurse's role in the workplace. Thompson (2009: 5) views emotional labour as the organisation and management's use of "value-based practices to shape employee identities" through direct and indirect control tactics (Grossman, 2012: 65-67). Consequently, workers become alienated from themselves, the product or service, human nature, and the labour process (Brook, 2009: 80-86). Although workers may seem to be passive, they have the agency to resist the control and interests of management. Workers can produce resistance through trade unions by striking or by refusing emotional labour (Brook, 2009: 24) and providing empty performance that does not align with organisational norms (Bolton & Boyd, 2003: 301).

Moreover, ever since democracy, the South African government has been funding the public healthcare sector as a means of creating access and availability for 80% of the population (Von Holdt & Murphy, 2007: 314). However, due to the growth of the population over the years, the public healthcare sector has been faced with several challenges such as being underfunded and understaffed. In KwaZulu-Natal's strategic plan conducted by the Department of health in 2010-2016 (cited in Jili and Nkosi, 2015: 80) suggests that the province is in demand for placements of staff and necessary skills for resources to be utilised. According to Jili and Nkosi (2015: 80), healthcare providers such as nurses go through increases in workload due to the constant and increased demand for the utilisation of public healthcare facilities (also see Von Holdt & Murphy, 2007: 315). Thus, resulting in the deterioration of the quality of care, a decrease in nurse productivity and the inability of medical resources (Von Holdt & Murphy, 2007: 316).

Therefore, this research seeks to understand how nurses use emotional labour to work through their nurse-manager, nurse-doctor, and nurse-patient relationships - even during challenges of lack of medication, medical equipment, short staffed. Thus, this addresses how emotional labour is used during the day-to-day workplace duties of female nurses which influences their interactions, relationships, and experiences. Whilst also understanding the effects and impact that emotional labour has on the nurse's mental health and how they can cope with them. As much as emotional labour may positively help nurses during their interactions, it can also create negative consequences such as burnout and emotional fatigue.

In addition to these challenges and emotional labour, nurses must keep to the control and power strategies of nurse managers and doctors. This suggests that nurse managers and doctors have some degree of control over the labour process of nurses through their workplace duties, shifts and orders received. Despite the challenges and workplace control faced by nurses in the public healthcare sector, nurses use emotional labour to hide their true emotions. In this regard, the research seeks to understand the extent nurse managers and doctors control nurses' labour process. As well as how this control affects the nurse-nurse manager and the nurse-doctor relationships.

1.2 Research objectives

The primary objective was to explore the emotional labour and the labour process experienced by nurses in the public health sector in eThekwini municipality, KwaZulu Natal.

Subsidiary objectives:

1. To explore the gendered nature of emotional labour experienced by female nurses concerning patients and doctors.
2. To understand the working conditions of nurses working in public hospitals.
3. To understand the experiences of nurses in relation to control and power exercised by management and doctors.
4. To explore the display, effects, and experiences of emotional labour (deep acting and surface acting) of female nurses in the workplace concerning managers, doctors, and patients.

1.3. Research methods and methodology

Research methodology is used to describe the procedures, and techniques used to analyse data based on a research topic. According to Denscombe (2010: 4), the qualitative method is used for exploratory and descriptive studies whereby the researcher seeks to understand their research topic by using different techniques to analyse participants' perspectives. Tenny et al. (2022: 1) further explain that the qualitative method gathers the experiences, perceptions, and behaviours of participants. Hence, the qualitative method brought insight into the research through lived experiences of nurses' emotional labour process and their labour process. Furthermore, a semi-structured in-depth interview schedule was utilised as a technique of gathering data that was guided by research questions aimed at answering the objectives. Semistructured in-depth interviews are flexible as they allow for the comfortability of participants through conversations, open-ended questions, and unrestricted responses. Whilst a guideline or schedule instrument was used.

Furthermore, a snowball sampling technique was utilised. This technique was helpful because the researcher had already been in contact with 4 future participants, and they were able to refer other participants that fall under the required category: female nurses who have worked at least two years in the eThekwini municipality public healthcare sector. There was a sample size of 10 black African female nurses because of the time constraints to complete the dissertation as well as a sample size made it easier to conduct interviews as the participants all worked in different shifts. Further, some nurses worked in the urban parts of KZN's public healthcare facilities while others in the rural parts. In addition, all ethical requirements stated by the university were adhered to by the researcher. Ethical approval was obtained from Rhodes University, the research was voluntary as verbal and written consent was acquired from participants. The researcher was aware of the positionality of the research as some nurses did not know what emotional labour is. Therefore, the researcher ensured that participants were well informed on what the research is about, what the research aims to achieve and the research process.

Interviews took place in an environment chosen by the participants for their comfort and privacy sharing information. Each interview's duration was approximately two hours. The responses of the participants were transcribed and analysed using thematic analysis. According to Maguire and Delahunt (2017: 3352), thematic analysis is "a process of identifying patterns or themes within qualitative data" (also see Braun & Clarke, 2006). Thematic analysis is more

than simply summarising data, it involves interpreting and understanding the data at hand. In addition to this, Braun and Clarke (2006: 86) suggest that the process of thematic analysis includes - becoming familiar with the transcribed qualitative data, generating codes, looking for themes, reviewing and defining those themes and finally doing a write-up. Therefore, the participants transcribed responses was coded according to themes, and analysed to allow for a reflection on what the findings means for the literature. Also, the recordings were safely stored on Google Drive for the researcher to access. Additionally, this analysis tool allows for the researcher to provide rich and detailed data as it can include various perspectives and understanding.

Chapter 2: Contextualising emotional labour and the labour process

2.1. Introduction

Hochschild (1983: 7) introduces emotional labour as the suppression or management of feelings as a means of creating a public display which can be seen through deep acting or surface acting. Workers experience emotional labour because of the commodification of emotions which results in workers conforming to the expectations of employers in exchange for wages. Therefore, the working conditions and managerial control strategies such as surveillance and supervision, ensure that workers abide by the rules of the workplace and act accordingly in their performance of physical, mental, and emotional labour. Consequently, workers become alienated in the workplace but even through that, agency is reflected in the different mechanisms of resistance whereby workers resist the control and power of management. This section will discuss emotional labour which is embodied from the symbolic interactionism and dramaturgical perspective. Further, the labour process theory will be conceptualised as a means of borrowing concepts such as labour power, control, consent, alienation, and resistance.

2.2. Emotional labour and symbolic interactionism

Arlie Hochschild (1983) is recognized for coining the term emotional labour in her book, 'The Managed Heart', to explain how employees manage their emotions through rules and restrictions imposed on them. Hochschild (1983: 7) uses flight attendants as an example of emotional labour as she argues that the staff are frequently encouraged to always be smiling, polite, and friendly to passengers. Even if the flight attendants are in a foul mood, they are expected to put in emotional labour to ensure that they present themselves nicely or reassuringly to the passengers. Hence, emotional labour refers to the act of transferring emotion management from the private to the public realm of work (Wharton, 2009: 150). In addition, the service sector has been growing in numbers with the wider inclusion of female workers (Bosch & Lehendorff, 2017: 37; Wharton, 2022: 47) and most positions demanding emotional labour are largely handled by women (Hochschild, 1983: 162).

These tasks mainly require instilling sentiments of well-being or validation in others, which are typically assigned to women (Abbott et al., 2006: 51). Service employment, hospitality, and healthcare are examples of jobs that are assumed to use the abilities that women are thought to use in the private sphere such as traditionally feminine emotions which furthers the idea that

certain occupations are for women (Abbott et al, 2006: 53; Hochschild, 1983: 163). However, both women's work and emotional labour are important components in the labour process for female workers. Any work that involves interactions with recipients such as in the service sector, is regarded to need some level of emotional labour for workers to gain the ability to interpret interactions of others and act according to the displayed rules (Wharton, 2009: 153; Wharton, 2022: 48). Hence, social interaction is a crucial element of creating meanings of the world and experiences which are shaped by humans' self-reflection (Wharton, 2009: 154).

Emotional labour is embodied in symbolic interactionism which focuses on individuals' subjective viewpoints and how they make sense of the world from their own perspective (Carter & Fuller, 2015: 10). Symbolic interactionism becomes useful in this dissertation because it allows for the exploration of participants experiences of emotional labour and workplace interactions that are governed by behavioural rules and expectations. As a result, this often results to individuals constantly having to deal with the view of self as well as how others perceive them during interactions (Goffman, 1955: 5). The presentation of self becomes important during interactions as emotions and feelings become attached (Goffman, 1957: 6). The dramaturgical perspective suggests that emotions and displays change according to the situation at hand. Hence, Goffman (1959: 4) shows two types of settings through the analogy of theatre: the front stage and the backstage. The backstage looks at the actor when they are away from the audience when they display their true selves (Goffman, 1959: 5). While the front stage suggests that emotional and behavioural displays become observed by other individuals while the actor or in this case, the worker acts according to societal expectations and rules (Goffman, 1959: 5). Emotional labour in the interactive service sector focuses on the front stage of an individual's performance, and this could be seen through deep acting and surface acting.

Hochschild (1983: 134) distinguished two types of workplace emotional expressions: surface acting and deep acting. The focus of surface acting is on public displays of emotional expressiveness. When employees adjust their external emotional expressions but do not seek to feel the feelings they are exhibiting (Humphrey et al., 2008: 751), and this can also be referred to as a presentation of emotion. Hence, an individual's emotional expressions on the outside may differ from how they are feeling on the inside. For instance, when a service employee-recipient interaction takes place and the recipient (patient, customer, etc) is rude towards the service employee, a common kind of surface acting is when a service worker accentuates or fakes a grin. Even in instances when the service employee is required to show

positive displays of smiling, looking happy and being kind but may not feel like smiling, they will frequently do so to make the recipient feel more at ease or pleasant. Furthermore, Hochschild (1983: 134) proposed that conducting emotional labour can cause emotional dissonance. She stated that this is the time when employees are forced to portray emotions, regardless of whether they match their genuine feelings (Hochschild, 1983: 135). Hochschild (1983: 135) argues that workers may develop a sense of anguish as well as a variety of identityrelated concerns that impair psychological well-being (Hochschild, 1983: 136). In addition, Grandey (2003: 87) has shown that surface acting adds to emotional exhaustion, while deep acting does not.

Deep acting is defined as an effort to truly feel the emotions one is expected to display (Hochschild, 1983: 136; Wharton, 2009: 161). This goes beyond simply displaying surfacelevel emotions. Individuals instead strive to adjust their privately felt emotions to truly feel what they want to display. (Humphrey et al., 2015: 758). Workers have benefited from deep acting by boosting their sense of personal success (Brotheridge & Grandey, 2002: 29). While management often encourages emotional workers to internalize their emotions, to enhance the quality and reduce emotive dissonance, increase job satisfaction, organisational commitment, and job performance (Brook, 2009: 10; Humphrey et al., 2015: 760). In addition, some organizations, and institutions, like the care sector, avoid explicit display requirements and instead offer encouragement to 'be yourself' or 'display autonomy' (Goldberg & Grandey, 2007: 308) – in the case of the nurse-patient, nurses can deny partaking in emotional labour for a natural setting of showing care. Also, nurses can provide an exchange of gifts whereby they act beyond the required or expected script with no intended reward to be received.

2.3. The labour process theory and the incorporation of concepts: Skills, consent, control, and resistance

The labour process theory is used to denote the ways in which labour and capital are integrated in means of producing services and goods. Nowadays, the economy is filled with workers that are qualified, physically, and emotionally skilled, and trained - physically and emotionally trained workers. According to Grugulis & Lloyd, (2010: 93-94), upskilling has resulted in the need for managerial and professional jobs which require workers with qualifications and skills. Moreover, managerial control begins from the time managers recruit workers to pursue their preferences of employer-friendly identities when selecting workers (Sturdy et al., 2010: 124129). Then, when a worker signs an employment contract, they consent to the rules of the

workplace, workplace expectations, and the working conditions of the workplace. In addition, according to Grugulis and Lloyd (2010: 91), the "labour process are subject to ongoing pressures for change, as organizations seek to cut costs, adjust quality standards or introduce new products and services". Hence, managers are constantly going through continuous pressure to restructure operations and cut down labour costs. As a result, management produces control strategies such as physical and emotional training, normative control, electronic surveillance, and managerial supervision to ensure that goals are met (Belanger & Thuderoz, 2010; Brook, 2010; Brook, 2013; Goldberg & Grandey, 2007; Hall, 2010; Marx, 1973; Sturdy et al., 2010).

Furthermore, according to Sturdy et al (2010: 114-115), different forms of managerial control are masked behind workers' "participation, autonomy and shared interest" and to act as one's true self. These forms of control make workers feel part of the organisation, workers to continue being motivated, execute tasks, gain self-discipline, and have several identities which help them with their job performance (Sturdy et al., 2010: 131). Further, the employment relationship between capitalist/employer and worker is set on antagonist structures that even the agency that employers give to their workers is shaped by production and labour power control (Belanger & Thuderoz, 2010: 147). Although, these control tactics and strategies may seem like workers have no choice but to comply with management, this is not always the case – workers can still find the space and the agency to misbehave and resist managerial control (Belanger & Thuderoz, 2010: 137). Therefore, the misbehaviours of workers reveal their discontentment with their jobs which allows workers to show resistance through low work commitment and job performance, stoppages of work and strikes (Belanger & Thuderoz, 2010: 143). These behaviours tend to go against the interests of employers such as slowing down production and are recognized as misbehaviours.

2.4. Labour process theory and the incorporation of the emotional labour process

Emotional labour forms part of the labour process as workers do not only experience physical and mental labour but also emotional labour. The labour process theory focuses on employees' experiences during the transformation of labour power (Brook, 2010: 327; Grugulis & Lloyd, 2010: 91). Marx (1976:1103) argues that the labour process consists of capitalists, in this case of the research - management, taking control of the "means of production and labour power". Further, the labour process theory emphasizes the contradictory nature of the labour process due to labour power's indeterminacy and unequal employment relationships (Belanger &

Thuderoz, 2010: 143; Brook, 2013: 85). An employer purchases labour power as wage-labour, thus converting the worker's physical, intellectual, and emotional entity into a commodity (Belanger & Thuderoz, 2010: 140; Brook, 2013: 91). Managers utilise their knowledge and control strategies to gradually alter work processes to reach goals that align with the interests of the firm or institution and capital (Ackroyd & Thompson, 1999; Sturdy et al., 2010; Thompson, 2003; Vicent, 2011).

Moreover, organisations have endeavoured to control this process, making emotional labour a legal job requirement, because service industries such as nursing rely on workers' capacity to manage their emotions (Vincent, 2011: 1372). Thus, the economy of emotions is moulded by the managerial design and control systems intended to shape the display of workers' emotions towards higher organisational purposes, such as enhancing productivity, profitability, and performance (Hochschild, 1983: 99; Vincent, 2011: 1370). At first, individuals maintain a stable sense of self by conforming to recognised emotional conventions, such as those linked with professional practices (Vincent, 2011: 1372). Then, individuals engage in emotional gifts and sincere performances in the existential service of customers, clients, and colleagues perceived emotional needs (Vincent, 2011: 1372).

However, the exchange of emotions for wages in turn, leads to workers becoming alienated from themself, product or service, human nature, and the labour process (Brook, 2009: 80-86; Grossman, 2012: 65-67; Hochschild, 1983: 101). The labour process alienation is closely related to product alienation, where workers lack control over production processes, work conditions, and health effects (Brook, 2009: 10). Furthermore, Hochschild (1983: 110), like Marx (1976: 42), sees this estrangement from the product of labour as having a human cost for emotional labourers (also see Brook, 2009: 10). Hochschild highlights the alienation that derives from the progressive devaluing of a worker's creative contribution through the increasing rationalization of the labour process (Brook, 2009: 12). Human nature alienation addresses the damaging effects of capitalist society on our species being (Brook, 2009: 14).

The alienating conditions created by capitalism, lead to the workers losing control of their labour power and emotions, which are consequently 'owned' by employers and directed as part of the service provided (Vincent, 2011: 1372; Hochschild, 1983: 57). As a result, employees grow disengaged from their own displays and thus affects the workers' interactions with others (Vincent, 2011: 1372). Therefore, workers become estranged or alienated from aspects of themselves used to perform the work (Brook, 2009: 10). However, workers eventually

recognise their different interests and actively reject the alienated conditions of their work (Vincent, 2011: 1374). While also recognising the morally questionable nature of the emotional displays and normative commitments demanded by their employer (Vincent, 2011: 1374).

According to Brook (2010: 14), Hochschild's resistance theory suggests that workers can challenge managerial control by questioning feelings of alienation from self. Thus, workers exercise their agency to pursue goals that are known to be diametrically opposed to those of their employer (Vincent, 2011: 1373). Hence, workers can individually show resistance in the workplace through misbehaving and not complying with the rules of the workplace, not being productive in the workplace, etc (Belanger & Thuderoz, 2010: 145).

Moreover, there are debates about emotional labourers being passive, allowing management to exert partial or near-complete control through the successful transmutation of their feelings (Brook, 2010: 13; Brook, 2013: 90). However, according to Brook (2013: 104), some scholars reject the possibility of a successful transmutation, arguing that the managerial control of emotional labour is often contested and the nature of the service labour process results in continuous negotiation and re-negotiation over labour power transformation (also see Brook, 2010: 13; Callaghan & Thompson, 2002: 251). In addition, trade unionism is an alternative to workers agency and resistance as they express workers' accumulated resentment and discontent – resulting to trade unions and workers collectively incorporating resistance around emotions and newer dimensions of work through collective bargaining and strikes in the workplace (Thompson, 2010: 12; Thompson, 2010: 339; Vincent, 2011: 1375).

2.5. Conclusion

In conclusion, the management or suppression of workers' emotions occurs through workplace interactions as explained using symbolic interactionism and the dramaturgical perspective. Thus, emotional labour becomes an expectation to be utilised in organisations because of the need for workers to undergo emotional management during their workplace tasks, duties, and responsibilities. Hence, the labour process concepts were borrowed in this study to show the link between the emotional labour process taking place during workers' labour process through consent, managerial control, alienation, and resistance.

Chapter 3: Emotional labour and the labour process in the nursing profession

3.1. Introduction

Nurses worldwide must be qualified to provide high-quality care to patients (Bolton & Boyd, 2003: 298). The nursing profession is seen as both feminine and stressful, thus requiring a balance of physical work whilst also considering other people's emotions through emotional management (Bolton & Boyd, 2003: 298). Hence, nursing is a physically and emotionally demanding job, with female nurses playing a crucial role as mothers and caregivers in healthcare facilities (Cavalheiro et al., 2008: 30; Staden, 1998: 150). Furthermore, managers enforce rules to shape nurses' workplace interactions and relationships (Smith & Gray, 2000: 7; Wharton & Erickson, 1993: 157). These workplace rules are made explicit to encourage emotional labour and good job performance (Adeniji, 2015: 6793; Wharton & Erickson, 1993: 157). This chapter discusses emotional labour and borrows some key concepts from the labour process theory such as control and resistance in nursing, the nursing sector in South Africa, and nursing in KwaZulu-Natal (KZN). Further, this section focuses on studies conducted based on issues such as the challenges faced by nurses both in a global and local spectrum.

3.2. Emotional labour and the labour process experienced by nurses worldwide in public hospitals

Huynh et al. (2008) conducted a comparative study on nurses' emotional labour. According to Huynh et al. (2008: 197), emotional labour is a process in which nurses establish a professional persona to express either surface, or deep acting during work-related encounters. This study supports the notion that the consequence of emotional labour includes long-term health issues such as anxiety and stress, which may influence nurses' productivity in healthcare facilities (Huynh et al., 2008: 197). Furthermore, emotional labour requires an individual to have some influence over the emotional activities of the labour, which commodifies the employee's

sentiments (Huynh et al., 2008: 200; Smith & Lorentzon, 2007: 47). Grey (2009: 7) argues that emotional labour is intended to highlight both the parallels and distinctions between emotional and physical labour, with both being hard, skilled work that requires expertise, affected by immediate conditions, external controls, and subject to divisions of labour.

In addition, emotional labour necessitates an individualised but trained reaction that aids in the management of patients' emotions in the day-to-day operations of health organisations (Smith & Lorentzon, 2007: 46). Smith and Lorentzon (2007) applied the concept of emotional labour to a study of student nurses at one of United States nursing schools. According to the findings, emotional labour made nurse-patient contact easier (Smith & Lorentzon, 2007: 50). As a result, emotional labour is an almost imperceptible link that the nurse develops with the patient. Although it is tacit and unrecognised by records, emotional labour is acknowledged by the nurse-patient and is believed to aid in the administration of daily life on the ward (Smith and Lorentzon, 200: 50; also see Smith, 2011). Therefore, the use of emotional labour by nurses' aides with managing emotional disclosures, which promotes information exchange, patientcentred, democratic practice, and the creation of comprehensive care plans that take the patient's opinions into account (Smith & Lorentzon, 2007: 51).

Further, Smith and Lorentzon (2007: 52) also highlight the image of nurses as a natural carer which was seen to put patients at ease with a familiar mother figure. Their findings suggest that some student nurses linked the nursing of patients to a mother nursing her child (Smith & Lorentzon, 2007: 52). The image of nurses as natural carers was said to be an automatic help in 'breaking down emotional barriers' between nurse and patient and to assist in establishing informal relations necessary to nursing (Smith & Lorentzon, 2007: 53). However, on this study they found that nurses do not clearly show the factors that lead to their impatience when they work with different kinds of patients. They conclude that impatience leads to tiredness and ineffectiveness at work (Smith & Lorentzon, 2007: 54). This study suggests that characteristics that make it harder for nurses to hide their emotions, particularly while working with demanding patients, have a negative impact on the nurse's performance (Smith & Lorentzon, 2007: 54).

According to Funk et al. (2017: 2213), "Paid care for dying people and their family combines commodified emotion work and attachments to two frequently opposing role identities: caring

person and professional". A study was carried out in Canada's healthcare institution which investigated how healthcare workers understand personal grief in the aftermath of a patient's death (Funk et al., 2017: 2211). Employees frequently struggled to find the time and space to deal with loss, and encountered normative limits on grief expression at work, according to the findings (Funk et al., 2017: 2217). Participants advised against crying in front of patients and were hesitant to share their emotions with colleagues (Funk et al., 2017: 2217). Grief was displayed in limited ways, in secret and for brief periods (Funk et al., 2017: 2217). Participants not only suppress and contain sadness, but they additionally avoid it from happening by taking an emotionally detached attitude regarding their jobs and interactions with patients and families (Funk et al., 2017: 2218). Respondents also expressed anger and irritation when they were unable to aid patients due to understaffing and heavy workloads (Funk et al., 2017: 2218).

In addition, Garon's (2006: 249) study concentrated on the experiences of nurses who engaged in resistance acts in America. The nurses stated that they performed acts of resistance in response to unfair treatment, abuse of authority, or ethical concerns (Garon, 2006: 253). Resistance occurred in the form of protests, slow production and not following orders that they do not agree with (Garon, 2006: 253). Nurses emphasised coherence among coworkers, thus there were no power differentials in the nurse-nurse interaction (Garon, 2006: 253). Furthermore, the healthcare institution acquired power inequalities, complicating the nursedoctor connection (Garon, 2006: 254-255). Doctors appeared to have more backing from persons in positions of power than nurses, resulting in unequal treatment (Garon, 2006: 255). Furthermore, power imbalances were shown when nurses struggled to approach doctors (Garon, 2006: 255).

Furthermore, Grey (2010) conducted their research in an urban region in East London in the United Kingdom. The purpose of this exploratory qualitative study was to examine nurses' narratives on emotional labour and to investigate the gendered character of emotional labour (Gray, 2010: 351). According to nurse replies, traditional images of nursing shape patient expectations (Gray, 2010: 351). Nursing was portrayed as the labour of an 'angel', 'Florence Nightingale', and part of the domestic work of 'mothering the sick till they feel better,' so nurses felt obligated to inject emotions into their profession (Gray, 2010: 352). Certainly, the imagery linked with emotional labour in nurses are overwhelmingly female. Hence, emotional labour was thought to be primarily the responsibility of women. Women were viewed as necessary in

nursing activities such as cleaning, bathing, pregnancy, and obstetrics (Gray, 2010: 355). Thus, emotional labour divisions undoubtedly influence perceptions of emotional labour performed by nurses, doctors, and other healthcare personnel. In the preceding extract, the idea of the primary healthcare team as a functioning family is used (Gray, 2010: 355).

The picture of a family may be utilised to reinforce the gender stereotype of the subjective female (nurse) and objective male (doctor) that is prevalent in society. To be sure, there are constraints placed on both doctors and nurses in terms of how these professions are expected to labour emotionally and the perceived appropriateness of physical and emotional interaction. This has a direct impact on how professionals consult with patients and attend to their emotional needs during medical encounters (Gray, 2010: 356). Emotional labour is gained via experience and the ability to speak reflectively about nursing experiences with staff and colleagues and thus reflective learning was viewed as an emotional effort (Gray, 2010: 356). Difficult concerns and problems with others were discussed and worked through using shared experiences of the emotional labour involved with nursing (Gray, 2010: 356). However, nurses' commitment to emotional work with patients, their families, and colleagues demonstrates the therapeutic value that nurses place on their emotional labour (Gray, 2010: 356).

Nevertheless, Selberg et al.'s (2022) study looks at working conditions in Sweden hospitals and how they have changed the experiences of female nurses working in the public sector. Nurse participants stated that the nursing profession has a high workload intensity, making it impossible to complete the full-time working hours assigned to nurses (Selberg, 2022: 85). On the other hand, understaffing has made nurses' tasks in healthcare institutions more difficult, and this problem was left for nurses to tackle through techniques such as overtime (Selberg, 2022: 86). Nurses are perceived to be frustrated by management's inability to hear their requests for healthcare improvements - according to the participants, managers lack knowledge to manage healthcare facilities (Selberg, 2022: 88). When nurses communicate this knowledge to managers, they believe management is uninterested (Selberg, 2022: 88-89). As a result, nurses expressed dissatisfaction with their professions because their care work was not recognised or valued (Selberg, 2022: 90).

Moreover, Pandey and Singh (2015: 555) investigated the relationship between surface and deep acting emotional labour, burnout, and job satisfaction in Indian women community health workers. The research on community healthcare nurses demonstrates that the detachment of

nurses is connected with surface acting and supports their effectiveness and sound judgement - in which healthcare workers appear worried while remaining aloof (Pandey & Singh, 2015: 556). Whereas a high level of emotional engagement relates to deep acting, which may render nurses unable to do their duties since deep emotional labour is associated with an emotional connection with the suffering of patients and may lead to increased burnout (Pandey & Singh, 2015: 556). Furthermore, nurses who have gone through deep acting, lacked the adequate training to maintain the proper emotional distance with the patient's condition (Pandey & Singh, 2015: 557). Not only may deep acting exhaust the nurses emotionally, but it can also prevent them from expressing the required confidence and comfort to patients (Pandey & Singh, 2015: 558).

Kumar and Jin's (2022: 2622) study investigates Pakistan nurses' emotional labour and stress in health care emergencies, specifically their emotional tiredness and the availability of organisational and management assistance to mitigate the impacts. As the COVID-19 pandemic was declared a global outbreak and many countries proclaimed medical emergencies, job demands and desired emotional reactions from frontline workers were intensified (Kumar & Jin, 2022: 2622). Therefore, nurses had a variety of stress reactions because of such high levels of job demand (Kumar & Jin, 2022: 2623). According to the findings, job stress fully mediates the association between surface-acting and emotional exhaustion (Kumar & Jin, 2022: 2623). The challenge in Pakistan's public health system is that the healthcare workers, in addition to the risk of contracting the virus in COVID or isolation wards, are experiencing anxiety and exhaustion because of their long shifts, a lack of support, and a lack of social companionship from direct supervisors (Kumar & Jin, 2022: 2630).

A Chinese study by Bai et al (2022) on work alienation among nurses due to a high risk of infection, a demanding workload, and high levels of chronic stress. According to the research, nurses exhibit a moderate level of job alienation (Bai et al., 2022: 21). High-educated nurses with low professionals titles, shorter work hours, and poor salaries, and ICU nurses were shown to experience high levels of job alienation (Bai et al., 2022: 21). Additionally, work alienation has a detrimental influence on the nursing profession and may damage the professional nursing development (Alfuqaha et al., 2023: 1). Therefore, the study of Alfuqaha et al. (2023: 2), investigated Jordanian nurses' regarding their levels of professional development, motivation to learn, and job alienation during the Covid 19 pandemic (Alfuqaha et al., 2023: 2). The results

of the study revealed that the levels of job alienation were high, as work alienation was negatively connected with preparedness for professional development (Alfuqaha., 2023: 14).

Additionally, a study was carried out at Benha University Hospital in Egypt to determine the relationship between organisational justice, work alienation, and deviant behaviour among staff nurses (Abd-Elrhman 2020: 1). According to the data, nurses experienced occupational alienation, deviant behaviour, and impotence due to their lack of influence over their working environment and decision-making (Abd-Elrhman, 2020: 24-25). Furthermore, the nurses who were alienated showed higher levels of stress (Abd-Elrhman, 2020: 25). Nurses were discovered to exhibit negative work deviance behaviours, which nurse managers ignored (Abd-Elrhman, 2020: 25).

Furthermore, Ogbimi and Adebamowo (2006) used questionnaire surveys to conduct a study on the nurse-doctor relationship in Nigerian healthcare facilities. The findings on the nursedoctor connection revealed that nurses had higher opinions of doctors' work than doctors had of nurses' work (Ogbimi & Adebamowo, 2006: 3). Staff shortages harmed the nurse-doctor connection. However, it was discovered that nurses were the ones to report nurse staff shortages since doctors would frequently leave patients in the care of nurses, causing nurses to experience the pressure of understaffing more (Ogbimi & Adebamowo, 2006: 3-5). As a result of the shortage of nurse staff, emotional labour escalated, resulting in nurses experiencing emotional exhaustion, stress, or burnout (Ogbimi & Adebamowo, 2006: 5). In addition, according to one report, the single greatest threat to providing HIV/AIDS treatment in Sub-Saharan Africa is nurse shortage, and nurses in the developing world face: increased workloads, HIV infection, and low morale (Zelnick & O'Donnell, 2005: 165). As a result of a scarcity of beds and other resources such as medication and medical supplies, patients are treated in inconvenient settings such as hospital floors or are sent home untreated (Zelnick & O'Donnell, 2005: 166).

3.3. South Africa's public healthcare then and now and the challenges of the nursing sector

Although there have been several research conducted worldwide concerning nurses, the South African context of the public sector nurses dates to the legacy of apartheid. Any assessment of

South Africa's situation, as well as any attempt to recover from its past, must recognise the weight of its history – as discrimination, segregation, and unjust laws dominated South Africa's history. According to Wells (1974: 32-33), the country had one medical school that would admit African medical students, and only 15 Africans were certified as doctors in 1972, compared to 440 whites. Even if all medical institutions were open to black African students, the numbers would be limited due to Africans' low educational opportunities. Further, few blacks were allowed to practise medicine and those who were approved were forced to attend schools with minimal resources (Brauns, 2016: 48). And when the blacks were admitted to white institutions, they were exposed to practices such as a ban on black medical students wearing white coats and stethoscopes in white hospitals (Brauns, 2016: 48). Therefore, in Cape Town, "there was one doctor for every 308-white people during this period, compared to one doctor for every 22 000 people in Zululand and one doctor for every 30 000 people in the Northern Transvaal" (Brauns, 2016: 50; Wells 1974: 34). Furthermore, black nurses were denied necessary training resources and the opportunity to apply their talents appropriately (Brauns, 2016: 48; see also Schneider et al., 2007).

According to Seedat (1984: 64-66, reported in Brauns, 2016: 58), a 1983 inquiry by journalists who visited Baragwanath Hospital in Johannesburg revealed that "89 women occupied 40 beds in one ward". Also, the only means for doctors to identify urgent cases, doctors slapped stickers labelled urgent on the foreheads of dangerously ill patients (Brauns, 2016: 58). Other hospitals have similar problems, in 1977, the Livingstone Hospital in Port Elizabeth displayed horrific circumstances in which black women in labour were subjected to sleep two on a hospital bed, on mattresses on the floor, and carts in the halls (Brauns, 2016: 60). Whilst in King Edward Hospital in Natal was designed to service the whole black population of the region (Brauns, 2016: 59). According to statistics (cited in Brauns, 2016: 59), "the hospital saw approximately 600,000 out-patients per year". Therefore, during apartheid, the practice of providing healthcare in a racially discriminatory way resulted in a society where the standard of healthcare and healthcare facilities remained highly deficient (Brauns, 2016: 50; BaldwinRagaven et al., 1999: 9). Black African nurses faced challenges of harsh working conditions during apartheid, long working hours, and poor pay (Esterhuizen, 2012: 47). Apart from caring for patients, nurses also had to perform domestic labour duties such as scrubbing the floors (Esterhuizen, 2012: 48).

Moreover, the newly democratic South Africa inherited a highly fragmented and bureaucratic system that offered inequitable healthcare services (Brauns, 2016: 50 also see Aikman, 2019). Aside from the issues of high child and maternal mortality, rising levels of tuberculosis and HIV/AIDS, and inept administration, the country is facing shortages of qualified doctors and nurses. According to Brauns, 2016: 51), "more than 80% of South Africans rely on public healthcare" and the majority of them are black Africans. However, patients face barriers to care – and despite South Africa's extensive social security system, which includes disability, care dependency, and old-age subsidies, major hurdles to getting treatment exist, especially in the context of free public healthcare in the public health sector – with struggles of accessing facilities and lack of resources (Brauns, 2016: 51). Rural communities, for example, face more access challenges than metropolitan communities, such as distance, time, and expense of accessing health services, including emergency transportation.

Moreover, according to Aikman (2019: 20), public healthcare facilities have numerous flaws, including long waiting times, poor quality healthcare delivery, outdated and poorly maintained infrastructure, and poor disease control and prevention practices (Aikman, 2019; Fikani, 2021; Coodvadia et al., 2009). According to the TimesLive (2018), health institutions experienced issues such as poor waste management, a lack of sanitation, and poor grounds and equipment upkeep. Patients and staff verified that several departments had an undesirable physical environment such as dirty toilets for providing effective health treatment (TimesLive, 2018). Hence, as mentioned in the TimesLive (2018), certain members of the public have expressed worry about a lack of equipment in hospitals, which has resulted in fatal delays in urgent surgery.

According to Bianchi and Milkie (2010: 708), "the growing number of patients and decreasing number of nurses has resulted in a degradation of the work environment, implying that the South African nursing profession is in desperate need of a sense of work-life balance". In addition, the intensification of work has caused protracted delays for some patients seeking treatment, such as cancer patients who are hampered by a lack of oncology specialists and equipment, as well as extensive waiting lists for surgery or diagnostics, which are also hampered by a lack of equipment (Maphumulo & Bhengu, 2019: 2). According to Maphumulo and Bhengu (2019: 3) study done through the analysis of several South African articles from 1996-2018, shortages of material resources, equipment, and supplies (for example, glucometers

for measuring blood glucose) resulted in a prolonged stay of patients in the hospital. Further, the articles also reported that the scanning equipment was not in proper working order, therefore patients were continuously referred to other institutions for investigations or had to wait until the medical equipment was repaired, resulting in delayed diagnosis and treatment

(Maphumulo & Bhengu, 2019: 5).

Moreover, the South African public healthcare system is understaffed, and as a result, nurses are forced to adapt and deal with shortages by learning new skills, increasing their competencies, and taking on additional responsibilities, among other coping mechanisms (Khamisa, 2019: 7; also see Mutshatshi et al., 2015 and Di Paola & Vale, 2019). Clark et al (2006:38) suggest shortages of nurses create the inability of nurses to meet the demands of patients in public healthcare facilities. According to Sovold et al. (2021: 4), nurses have been reported to have higher levels of negative outcomes, such as depression and PTSD, than doctors. The study of nurses and the concept of emotional labour has taken on even more significance.

Nurses are currently confronted with unfamiliar issues such as patient overflow, which necessitates more resources that the healthcare industry lacks, extended working hours, and operating new working equipment that necessitates abilities (Bolo and Yako, 2014: 6). Working shifts and having constant high emotional interactions with patients, according to Vermaak et al. (2017: 37), are two very prevalent job stressor aspects of the daily work environment for nursing personnel. As a result, significant levels of work-related stress, burnout, and poor health are widespread among nurses (Vermaak et al. 2017: 37). This could be attributed to the long working hours and frequent direct, intimate, and emotional interaction with many patients that characterise nursing job (Vermaak et al., 2017: 37; Khamisa et al., 2013: 6). Furthermore, nurses face high risk of infection with limited access to protective equipment and may be forced to adapt as best they can to ensure the continuation of their obligations and services (Svold et al., 2021: 4).

Bolo and Yako (2014: 4) discovered that higher job pressure predisposes both orthopaedic nurses and patients to work-related difficulties in a study conducted at an East London public hospital on nurses' psychological requirements. These issues include failure to attend to their own psychosocial needs and changes in attitudes that diminish work performance and nursing

care quality (Bolo and Yako, 2014: 4). This could explain why nurses are often seen as grumpy, rude and with negative attitudes. In their study, Bolo and Yako (2014: 9) concluded that if the healthcare facility does not foster a culture of recognition for employees, nurses' self-esteem may suffer, and they may need to shift employment to grow professionally. Working long hours under adverse conditions, such as a lack of medication, mattresses, and work equipment, is demotivating enough that their effort goes unnoticed. Furthermore, the study of Segnon (2014: 78) has revealed that shortages of staff and lack of medical equipment have resulted in high rates of absenteeism and fatigue by nurses working in one of Johannesburg's public hospitals.

Additionally, the nurses' working conditions have been recognized as unfavourable and a hazard to the health of nurses – thus nurses experience work-related stress and trauma due to the nature of nurse's work (Segnon, 2014: 80). However, there are traumatic counselling and the employee wellness programme that is meant to assist nurses with stress management and trauma – which has been reported to be helpful (Segnon, 2014: 81). In addition, Raliphaswa et al. (2021) conducted a study on nurses in Limpopo state hospitals to investigate job satisfaction. According to the study, nurses are unsatisfied because of a lack of resources and bad infrastructure, which makes it difficult for them to conduct their jobs and provide high-quality patient care (Raliphaswa et al., 2021: 50). The North-West healthcare facilities have been encountering working conditions problems such as long working hours, low wages, high demand of patients, decomposing bodies due to not enough mortuary beds, loadshedding, water shortages and more (TimesLive, 2018).

Conversely, nursing is frequently portrayed as having feminine characteristics related to childcare and nursing (also see Maluleka, 2020). According to Matousova et al. (2020: 843), a woman's position is primarily that of a working mother whose desire is not to succeed or lead others in her occupation, but rather to balance the dual responsibilities of employment and the household. To begin, boys and girls are taught from an early age whether jobs are masculine or feminine, and their aspirations are accordingly formed (Matousova et al., 2020: 844). This explains why nursing is regarded as a feminine occupation. Nurses must be highly organised, submissive, self-controlled, perform flawlessly, and endure adverse working conditions such as low pay and nearly endless hours (Matousova et al., 2020: 844).

According to Batisai (2016a: 6 cited in Matousova et al., 2020: 845), the cause for low compensation is strongly established in women's traditional unpaid responsibilities as wives,

mothers, and carers. In addition, nurses are required to perform non-nursing tasks such as cleaning patients' rooms and equipment (Bekker, 2013: 31). According to Bekker's (2013) study, professional nurses revealed that they perform non-nursing duties, whilst also comforting patients, educating patients and their families. Further, nurses working in the public sector are found to be dissatisfied with their jobs – and the inability to complete nursing tasks due to having to do non-nursing duties (Bekker, 2013: 47). As a result, nurses have become accustomed to performing non-nursing tasks as part of their workload. However, nurses find doing nursing duties to be more satisfactory than non-nursing tasks (Bekker, 2013: 47)

Concerning the nurse-doctor relationship, a study was conducted by Qolohle et al. (2006: 1) in KwaNobuhle, Uitenhage. The findings showed that a challenge of seniority was recognized whereby hierarchal attitudes and dominance of doctors were felt by nurses (Qolohle et al., 2006: 13). Furthermore, both negative and positive interactions were reported whereby nurses and doctors showed mutual respect (Qolohle et al., 2006: 13). However, some interactions compromised of inconsistent doctors' visits and lack of communication. According to the participants, conflict was resolved through track recording the nurse-doctor relationship and interactions (Qolohle et al., 2006: 14). Furthermore, Palacio (2022: 335) conducted a study on conflict between nurses and nurse managers in Johannesburg.

The findings showed that majority of nurses and nurse managers were female – and nurses experienced low levels of conflict with nurse managers as collaboration was used as a strategy of compromising during conflicts (Palancio, 2022: 341). Moreover, nurse managers are the centrality of conflict resolution and management especially in a diversified workplace. Koesnell et al. (2019: 4) did research on conflict management used by nurse managers in the context of having a diverse working staff in a military hospital. The findings showed that nurses experience conflict daily of which nurse managers need to resolve due to the diversity in the organisational culture of the hospital (Koesnell et al., 2019: 27). In Moeta and du Rand's (2019) study was based on three public hospitals of Johannesburg, an emphasis is suggested on the importance of reducing conflict in the workplace to avoid consequences such as decreased productivity which will adversely affect patients' quality of care.

Another way of which conflict is resolved is through striking. According to Rensburg and Rensburg (2013), the public sector undergone a national strike due to wage negotiations in 2007 and 2010 – of which nurses had also participated. The 2007 strike broke down because of the

agreement that renegotiations will take part three years later which was in 2010. The strike went through for six weeks as trade unions collectively worked together to represent the workers during collective bargaining with the government. The strike was based on increase of wages of which in 2007 the trade unions and government could not agree to the demanded percentage increase. Consequently, the longer the negotiations took place, the Rensburg and Rensburg's (2013: 4) article has noted that during the 2010 strike, replacement nurses were kidnapped by nurses striking in means of intimidation, hospital entrances were barricaded so that non-striking nurses and workers could not enter the premises of the hospitals. Also, the military veterans, medical students, and the public started assisting in hospitals due to staff shortages – further, some hospitals closed resulting in patients being transferred into other hospitals (Rensburg & Rensburg, 2013: 7). After some time of striking, agreements were reached whereby the government agreed to pay workers thus leading to nurses going back to work (Rensburg & Rensburg, 2013: 7).

Furthermore, a most recent strike took place in March 2023 across the country regarding nurses affiliated with the South African National Education Health and Allied Workers (NEHAWU) seeking a "10% salary increase" for their affiliated nurses and other health workers (Peoples health dispatch, 2023). The strike occurred over a period of 10 days whereby the government resorted into a collective bargaining with the trade union whereby the "government wanted to provide healthcare workers with 5% increase" (Peoples health dispatch, 2023). However, the trade union's main argument was that workers are faced with concerns of inflation increases and rejected the government's settlement (Peoples health dispatch, 2023). According to Khumalo's (2023) article, this strike led to inadequate care in hospitals as many patients died because the NEHAWU affiliated nurses stopped other nurses from entering the hospitals premises through intimidation tactics and forcefully removing them. And as a result, the government deployed the army to provide care for patients as well as the police force had to intervene.

Consequently, the trade union received a court order to stop the strike and nurses returned to work without a settlement agreement. Therefore, nurses and staff members as reported by the Spotlight (2023) online newspaper returned to work but refused to do their daily responsibilities and duties. Nehawu continued to bargain with the government until a settlement was reached whereby an agreement of "7% was reached" (Mahlaka, 2023). In addition, during this period,

other trade unions from the public sector such as the Democratic Nursing Organisation of South Africa (DENOSA) and the Public Servants Association (PSA) were getting ready to “strike for a 10% increase for their affiliated workers, the government decided to provide all public servants workers with a 7% increase including other benefits such as an incentive scheme and monthly bonuses of R1000” in means of avoiding further strikes (Mahlaka, 2023).

3.4. Nursing in KZN’s public healthcare

Nurse training is an essential aspect of nursing education and guarantees the development of knowledgeable nurse staff with the necessary competencies to respond to current and changing healthcare needs of a diverse population (Beddoe & Murphy, 2004: 307; Mathias & Wentzel, 2017: 1; Marques da Silva et al., 2014: 1; Michalec et al., 2013: 316). According to Mathias and Wentzel (2017: 4-5 also see Mekhatha, 2021: 23), nurse students experience a lot of stress because of their academic workload, training hours, mastering skills, having to cope with traumatic situations, the pressure of avoiding making mistakes, and bad relationships with patients. Fortunately, the clinical staff support and assist students during their training term by negotiating students' responsibilities (Mathias & Wentzel, 2017: 5). Furthermore, experts such as Michalec et al. (2013: 314) argue that including mandatory training and exposure to healthcare activities and obligations with the assistance of nurse professionals in nursing education makes nurse students more confident, competent, and induce compassion fatigue.

Moreover, a study conducted on nurses at King Edward VIII Hospital by Phatela (2021: 55) revealed that emotional labour is the unhealthiest work since it impacts people's life in a variety of ways (Phatela, 2021: 86). The study states that emotional labour influences the physical, psychological, and stimulating feelings of humans. To substantiate this principle, the study focused on the two basic components of emotional labour, namely surface and deep acting (Phatela, 2021: 86). Surface acting is a strategy used by the study's participants (nursing staff) to ensure that they follow the hospital's rules and regulations. To that end, this study suggests that nurses at King Edward VIII Hospital, like any other service worker, are unable to express themselves freely at work since they repress their emotions to offer good care to patients. This means they must respond appropriately even if they are furious with the patients because they are unable to articulate their sentiments (Phatela, 2021: 60). In essence, nurses participate in emotional labour throughout their careers because they deal with a wide range of people in the

hospital setting, including colleagues, patients, relatives, and friends of patients. Hence, nurses manage their emotions in various ways such as performing surface acting to fulfil their various responsibilities.

The unproductive consequences addressed in Phathela's (2021) study invariably reflect the effects of such emotional labour. This includes the impacts of emotional labour on their bodies, such as excessive physical and emotional exhaustion, tension, soreness in the arms and shoulders, swollen feet, and headaches from working too many workloads (Phatela, 2021: 87). As much as nurses adapt effectively at work due to their grasp of their job, they also face several hurdles and problems that impede their work. The primary complaints found were a lack of staff at King Edward VIII Hospital, a lack of materials and resources to work with, working with patients who do not listen to their instructions, smelling environments where sewage flows next to the offices they work in, and management always promising to improve the working conditions they complain about but never following through (Phatela, 2021: 87). Further, nurses allege that nurse managers are aware of their bad working conditions, but they always complain about the department of health's budget (Phatela, 2021: 61).

In this regard, the study proves that job intensification is distressing and exorbitant in the sense that stressed nurses experience emotional and psychological disorders because of high workloads (Phatela, 2021: 85-86). However, no nurses in the study required assistance with emotional or psychological disorders during the interviews (Phatela, 2021: 86). According to Phathela (2021: 86-87), nurses become detached or indifferent with patients. Mlaba et al. (2023: 5412) conducted a study in three of Durban's public hospitals on the experiences of nurses in oncology department regarding compassion fatigue. Compassion fatigue is seen in many professional healthcare workers whereby professional healthcare workers start getting tired of showing compassion because of the chronic exposure to people suffering in the hospitals (Mlaba et al., 2023: 5412). The findings were that the participants scored "an average score of 56.2%" which showed that more than half of the participants experience compassion fatigue (Mlaba et al., 2023: 5413). The female participants had a higher mean score compared to the male participants due to female nurses being placed in areas of the healthcare facilities whereby they are intensely exposed to patients and must continuously partake in emotional labour (Mlaba et al., 2023: 5413).

Nevertheless, if good quality care is to be provided, nurses must have favourable attitudes towards patient care (Haskins et al. 2014: 32). Haskins et al. (2014) study investigated nurses' attitudes towards providing care to patients in one rural district hospital in KZN through the perspectives of nurses and patients. Most nurses despised nursing due of staff shortages, heavy patient loads, absenteeism, and poor interpersonal interactions (Haskins et al., 2014: 38). Poor patient care and deliberate neglect of patients' basic requirements were reported by nurses and patients (Haskins et al. 2014: 39). Further findings showed that nurses criticised poor nursing care on patients', as well as a lack of management support (Haskins et al. 2014: 40). Additionally, Bam and Naidoo (2014: 2) conducted a study on the understanding of the notions 'caring' and terminal patient – and documented the experiences of nurses caring for terminally ill HIV patients, as well as how these experiences influence the nature of care provided. The nurses perceived the caring concept as altering the patient's quality of life via supportive care and hope for life (Bam & Naidoo, 2014: 5). Palliative care made nurses aware of their own mortality, allowing them to be more sensitive, empathetic, and committed to their patients' care (Bam & Naidoo, 2014: 5).

In addition, the findings have revealed that social networking enables nurses to cooperate with colleagues in interdisciplinary teams and share knowledge, skills, and support within the palliative care team to improve patient outcomes (Bam & Naidoo, 2014: 6-7). Nurses who spent a long time caring for terminally ill HIV patients reported feelings of powerlessness and emotional stress with no professional counselling or stress management programmes to help nurses (Bam & Naidoo, 2014: 7-8). Moreover, Hlongwane's (2015: 4) study focuses on the association between compassion fatigue, emotional work, and medical and surgical wards in KZN public hospitals. Findings indicated that nurses had moderate degrees of compassion fatigue, emotional work, and workplace stress (Hlongwane, 2015: 34). Compassion fatigue was positively connected with the presentation of negative and neutral emotions and interactions, while positive emotions and emotional control were negatively correlated (Hlongwane, 2015: 34).

Overall workplace stress was positively connected with compassion fatigue, but emotional work and job stress were negatively correlated with compassion fatigue due to emotional demands and a difficult work environment (Hlongwane, 2015: 49-53). Furthermore, Mhlongo et al. (2016: 162) conducted a study to investigate midwives' (midwives are registered or

certified nurses that have midwifery educational level – hence, they are employed in the hospital and may work at the maternity, gynaecologist etc ward as they have extensive knowledge on female healthcare) experiences with practice breakdown in maternity units at a public hospital in KZN to improve the quality of care in maternity units. Patients have specific expectations of the midwife, yet midwives who attended to pregnant women during antenatal care did not adhere to set protocols and norms, resulting in problems following delivery (Mhlongo et al., 2016: 170-171). Further, midwives are stated to face problems such as performing non-nursing related responsibilities such as searching for patients' files, which should be performed by a clerk or administrator, and this causes them to lose concentration on their patients (Mhlongo et al., 2016: 174).

Furthermore, Minaar's (2003: 37) study, which is a component of a larger investigation carried out in KwaZulu-Natal, describes workplace compassion in a few different health services. The opinions of nurses and nurse managers on providing care at work are discussed in this study (Minaar, 2003: 37). Caring is centred on human competence, healing, and recuperation. It is crucial for nurse managers to provide a safe and nurturing work environment for nurses to guarantee the treatment and recovery of patients in health services (Minaar, 2003: 38). Nurses are more equipped to provide compassionate nursing practices in the patient care setting when there is a caring culture in the workplace (Minaar, 2003: 38). It is evident that receiving loving treatment is necessary for one to develop compassion, and that compassion may be hampered or strengthened by the working environment (Minaar, 2003: 39).

The results of this study showed that care and a human culture were not sufficiently prevalent in nursing settings (Minaar, 2003: 39). The examination of nurses' workplaces revealed that nurse managers did not treat nurses with human decency or with consideration for their cultural needs (Minaar, 2003: 39). It found that throughout their routine nursing duties in the hospital, nurses did not feel that their nurse managers were as considerate of their comfort and wellbeing (Minaar, 2003: 40). Most nurses did not get enough assistance to carry out their duties. They did not find their employment to be fulfilling (Minaar, 2003: 40). The issue of poor communication and interaction between nurse managers and nurses in hospitals persisted (Minaar, 2003: 40). In addition, Dawood et al. (2022) conducted a study on the assessment of employer support, anxiety, stress, and depression experienced by nurses during Covid19. The findings revealed that participants were not supported emotionally and physically by nurse

managers, they expressed concerns of not being heard or cared for by management – especially since they revealed high levels of trauma, stress, anxiety, and depression (Dawood et al., 2022: 19). Further, nurses revealed that they had to continue working, put their emotions aside even during time of hardships in their personal lives – such as the loss and grief of a loved one during the pandemic (Dawood et al., 2022: 19).

Hull's (2009) thesis investigated how a deeply entrenched nursing hierarchy is being reconfigured and challenged, as well as how nurses' position is being transformed, in relation to larger political and social processes in the post-apartheid context. It is an ethnographic examination of nurses at Bethesda Hospital, a rural government hospital in northern KwaZuluNatal. The countrywide government servant strike in 2007 lasted a month, and union activists toured throughout KwaZulu-Natal to encourage workers to join the strike in demand of increases of wages. No one did at Bethesda Hospital (Hull, 2009: 13). Nobody came to work in uniform for the duration of the strike for fear of being identified by trade unionists and compelled to strike, or worse (Hull, 2009: 13). For several nurses, the walkout marked the beginning of new developments. The strikes created a sense of abnormality in the hospital's daily interactions, blurring the patient-nurse interface, while also reinforcing the hospital's physical separation from the outside world through the reinforcement of its physical boundaries as a form of resistance (Hull, 2009: 15).

Nurse training reflected comparable concepts and typically comprised a harsh set of regulations by which nurses were supposed to behave, in accordance with the views of their senior matrons (nurse managers are also called matrons as per the apartheid times), who played a variety of roles, both gentle and maternal as well as that of a firm superior (Hull, 2009: 63). The interaction between doctors, nurses, and patients, as well as between white and black nurses at different levels of the professional hierarchy, is one of the most visible manifestations of larger political and cultural discourses within the hospital and in the attitudes of its employees (Hull, 2009: 63). Nurses' perceived status is maintained by several factors, including their security as permanent and highly demanded employees in a context of severe unemployment, and their symbolic position as state representatives, informed by an image of the state as the dominant nexus of wealth (jobs, medicine, grants) to which people try to gain access, but which is symbolically separated as 'above' society (Hull, 2009: 112). The hospital's missionary history, which instilled the concept of nurses as respectable Christian elite, also influences nurse

prestige. (Hull, 2009: 113). Service failure is perceived as being caused by human motivations, in this case of junior nurses, rather than being entrenched in the system's greater structural inefficiencies or the level of financial commitment and political will of the higher-ups (Hull, 2009: 133).

Jili and Nkosi's (2015 also see Pillay et al., 2022) study states that working conditions, increased workloads, resource shortages, congested wards, and a sense of being ignored by management are among the difficulties faced by nurses in Ngwelezana's hospital (Jili & Nkosi, 2015: 89). Additionally, the unfavourable working conditions for nurses eventually have an impact on how well they do their jobs (Jili & Nkosi, 2015: 89). According to the study, nurses deal with a lot of patients, however others are turned away since there aren't enough resources available to aid in their recovery (Jili & Nkosi, 2015: 89). Because of this, nurses are said to suffer from burnout and occupational stress, particularly considering staffing shortages in the workplace (Jili & Nkosi, 2015: 89). Furthermore, because the wards are crowded with both contagious and non-infectious patients, they are perceived as being extremely chaotic (Jili & Nkosi, 2015: 90). Additionally, the laboratories run slowly, which postpones the treatment of the patients (Jili & Nkosi, 2015: 90). According to Mclntosh and Stellenberg (2009: 1), the scarcity of qualified nurses and inadequate nursing staffing are two problems plaguing the South African healthcare sector.

To address the nursing shortage and preserve high-quality patient care, a staffing strategy was put in place at the hospital that was the subject of the study in KwaZulu-natality (Mclntosh & Stellenberg, 2009: 5). The newly implemented plan urged nurses to take on an extra 10 hours of paid labour per week on a voluntary basis. Regrettably, this tactic caused the quality of care provided in the wards to decline (Mclntosh & Stellenberg, 2009: 5). In addition, Naranjee et al (2019) conducted a study on nurse managers in KZN's public healthcare and how the nurse managers must take the role of a financial manager and nurse manager at the same time. Although this study looks at nurse managers and the research will be focusing on nurses, this shows that there are shortages of staff in the public healthcare facilities of Durban which then leaves nurses to fulfil jobs that they do not have the skills for. The results shows that nurse managers do not have necessary skills for the role of a financial manager, and this could also result to the mismanagement of funds which leaves healthcare facilities with a lack of resources and human resources (Naranjee et al, 2019:156).

Furthermore, another study was conducted by Nkosi (2014: 2) focused on health professionals' perspectives of service delivery issues at Ngwelezana hospital. The study's goal was to identify the problems that health professionals (nurses and doctors) confront in the course of their employment and how these challenges affect service delivery at the hospital (Nkosi, 2014: 2). The study found that the challenges these health professionals confront prohibit them from providing appropriate care to those who seek medical attention daily (Nkosi, 2014: 6). The study's findings also indicated that health professionals were dissatisfied with their working conditions such as low wages, long working hours and were under a lot of pressure (Nosi, 2014: 6). According to the findings, health professionals feel neglected by management, and there is a persistent lack of resources as a necessity during their work (Nkosi, 2014: 7). Furthermore, the study recommended that Ngwelezana hospital reassess its work environment and make it as favourable as possible to reduce burnout, absenteeism, and unproductiveness among health professionals (Nkosi, 2014: 7). The study also indicated that the hospital should reward and incentivize staff based on their performance to keep these employees satisfied and motivated to do well in their employment (Nkosi, 2014: 8).

Retaining qualified healthcare workers to provide services in remote locations is a major difficulty facing the South African healthcare sector (Du Plessis et al., 2019 also see Tawana 2018). Du Plessis et al. (2019: 1) study aimed to conduct a comparative analysis of the factors that influence employee satisfaction among healthcare professionals working in urban and rural locations. The results showed that there were notable differences between the sample groups from the urban and rural areas regarding work-related happiness, pay, career advancement, service quality, and intention to leave (Du Plessis et al., 2019: 8). Due to several factors, including tribalism, family responsibilities, geography, and communalism of which was found to have a significant impact on the retention and calibre of healthcare practitioners in rural settings, healthcare workers in these places were reasonably content with their jobs (Du Plessis et al., 2019: 12).

3.5. Conclusion

This chapter has emphasized on the requirement of emotional labour in nursing which poses both negative and positive outcomes. Nurses around the world have seemed to experience emotional labour through either deep acting or surface acting which has aided in workplace

interactions. Further, emotional management becomes a bigger burden as nurses work in harsh working conditions and environments which affects nurses process labour and quality of care received by patients. Consequently, the above-mentioned studies have brought on issues of nurses finding difficulties to balance work life and personal life due to the long working hours but also nurses are found to be physically and emotionally exhausted and fatigued. In most cases, nurses have revealed that no amount of complaint has changed these working conditions, they do not receive any support from management, nor do they attend any support programmes (if present in the healthcare facilities). However, nurses find support in the co-workers through the shared experiences of emotional labour and the labour process.

In addition, the labour process concepts have been revealed through the above literature whereby commodification of labour and emotions is recognized in the nursing profession. Further, the literature has shown extensively the working conditions of the public healthcare facilities of which nurses are faced with whilst having to continue with their work duties. Nurses become alienated due to the intensified workload, increases in patient demands, and within their wards. As a result, to these working conditions, commodification, alienation, and control – nurses experience consequences such as emotional and physical exhaustion, stress, and burnout. Nevertheless, resistance is detailed through individual misbehaviours or trade unionism strikes as nurses fight for their rights, wage increases and better working conditions.

Chapter 4: The experiences of female nurses as 'emotional managers' through managerial control during their labour process in KZNs Public Healthcare sector

4.1. Introduction

This chapter examines the experiences of ten black African female nurses working in KwaZuluNatal's (KZN) public healthcare sector – Nkonjeni Hospital, Mshiyeni Hospital, Addington Hospital, Clairwood Hospital and St Aidens Hospital. The nurses interviewed have different specialisations such as two registered nurses, two orthopaedic nurses, two neonatal (NICU) nurses, two intensive care unit (ICU) nurses, one radiography nurse, and one labour and delivery nurse. The nurses' ages range between 25-55, and have undergone compulsory educational study and hospital training. Their experience spans from 4 years to 34 years, and they are primarily female, reflecting the expectations placed on them by management, doctors, and patients. The literature aims to understand the professional and feminine qualities of these nurses. Moreover, this chapter's discussion follows in line with the previously mentioned dissertation objectives in the introductory section – whilst is also interpreted through the emotional labour and the labour process theories.

Moreover, the first theme is the gendered nature of emotional labour which focuses on the nurse-doctor and nurse-patient relationships, and the experiences and perceptions of female nurses regarding gender and treatment; the second theme is the study identified four themes: the working conditions of female nurses, including employment contracts, physical training, workplace experiences, challenges, and wages. The third theme explores the experiences of female nurses concerning power and control exercised by nurse managers and doctors, workplace conflict, autonomy, and resistance. The fourth theme explores their emotional displays and emotional labour, focusing on training, patient interactions, and the effects of emotional labour and supportive structures for nurses experiencing mental health issues.

4.2. The gendered nature of emotional labour.

Acker (1990) analysed gendering in the labour market, workplace, and jobs, focusing on the division of labour and hierarchies. Gendering is evident in symbols, imagery, and interaction patterns as it is an active process where jobs are associated with either gender, solidifying masculine, or feminine identities as workplaces are crucial sites of identity formation. Further, nursing is considered a feminist profession in general, with emotional labour expected to be present in female nurses (Simpson, 2007: 58). Therefore, the nurses must use emotional labour

to put patients at ease, provide the right kind of emotional support, and reassure them. Nurses must learn to control and manage their own emotions to accomplish this, which essentially means putting on a false self. However, emotions are often overlooked which results in gender stereotypes and the assumption that female nurses excel in emotional labour due to their natural qualities (Gray, 2010: 349). Most of the time emotions have been reduced to women's work which occurs as invisible in the nursing profession (Simpson, 2007:58). Therefore, the presence of emotional division of labour in nursing is grounded on gender stereotypes which results in management assuming that female nurses are better at emotional labour than men because of their natural qualities (Gray 2010:349, Simpson 2007:70).

According to Matousova et al. (2020: 844), nurses must perform flawlessly, be strictly wellorganized, submissive, and self-controlled, and tolerate adverse working conditions including poor pay and almost endless hours. These gender expectations were ingrained in a woman's thinking and influenced her life; they were fashioned by patriarchal norms in a patriarchal culture (Matousova et al, 2020: 845). Nurses are faced with juggling between the demands of management, the doctors, and patients. Concerning the research data, it has been found that nurse participants must find the balance between behaving professionally, undergoing emotional labour and women's work. Thus, emphasizing the capacity of nurses to manage emotions during workplace interactions. According to the nurses, the nurse-management relationships and interactions are influenced by mutual obligations, commonalities of goals, and workplace expectations. Further, this could be viewed as normative control whereby nurses are indoctrinated by management with shared interests, beliefs, and values as means of gaining high performance (Hochschild, 1983: 99; Sturdy et al., 2010: 116; Vincent, 2011: 1370). In addition, since nurse managers are mostly women, the nurses find it easier to interact with them as they are expressed as more understanding than the male nurse managers.

Additionally, nurse participants report that they are expected by nurse managers to dress and behave professionally and provide optimal patient care – thus agreeing with Hull's (2009: 63) thesis in stating that the healthcare system is presented with harsh regulations whereby nurses are supposed to behave and dress in accordance with the nurse manager. Further, Vincent (2022: 1372 also see Hochschild, 1983: 99) emphasizes on the requirement for workers to manage emotions as a part of a control tactic whereby emotions are moulded by the rules of the workplace. In this case, nurses are required to be empathetic, kind, caring and sensitive –

showing positive emotions whilst suppressing negative emotions such as frustration and anger. However, some nurses have shown that when they experience emotional exhaustion, they tend to show their frustration towards patients, which could initially seem like nurses are rude or unapproached. Furthermore, nurse managers ensure complaints are resolved promptly, and nurses are aware of the issues to avoid recurrent surfaces of complaints – suggesting that nurse managers play various roles of gentleness and maternal but also as firm superiors (Hull, 2009: 63). A radiology nurse (aged 51, 30 years of experience) stated:

> *"a patient once complained to my manager that I am not doing my job because the line was moving slowly. My manager apologised to the patient for the inconveniences that were present. But my manager did not reprimand me because they already know the difficulties that we face with having to manage files, care for patients and communicate with doctors*.

Furthermore, in relation to the nurse-doctor relationship, nurses provided an overview of the doctors they work with. They were described as predominantly males with some being student doctors and others professional doctors. The majority of the participants view professional doctors as co-workers or colleagues and were found to have positive interactions. Although there are positive interactions with professional doctors, they are still viewed as authoritarian and expect nurses to be professional, independent, and take orders – as agreeable with Qolohle et al. (2006) study that stated hierarchal attitudes and dominance are felt by nurses whilst experiences of both negative and positive nurse-doctor interactions occur. In addition to the nurse-doctor relationship, it tends to be harmed by the harsh working conditions that are experienced by nurses as also stated in Ogbimi and Adelbamowo (2006) study suggesting that shortages of staff harmed the nurse-doctor relationship. The examples that participants mentioned during the interviews are related mostly to medical supplies – when the hospital lacks resources and nurses are unable to care adequately for patients, doctors assume they are lazy and do not want to do their jobs. Furthermore, medical students are reported to be assigned to a doctor who will be responsible for training the student. During this process, providing instant medical care to a patient may take long because the professional doctor will want to educate the student doctor about the patient's condition, or test if the student doctor has any knowledge of the patient's condition. This then takes up time for nurses to receive their tasks from the doctor and delays patient care:

> "*Student doctors are allowed to work alone only under the permission of the doctor or through their supervision. Some students come to me and ask me questions about patients and the hospital. Student doctors do make mistakes sometimes and as nurses we are allowed to assist wherever we can. When this happens, I must remain understanding and treat the student doctor like my student nurses in being the source of information since I am the patients advocate*" (registered nurse aged 28, 6 years of experience).

Further, female nurses have expressed that they receive a lot of more respect from student doctors than professional doctors mostly because they are recognized as mothers or older than them. Over 44-year-olds report some respectful doctors, like being called "Mom", "Granny", or "Sister", being given food or treats by doctors and having supportive ones due to shared care for patients – An ICU nurse (aged 38, 17 years of experience) responded that *"when my patient died, we all cried with the doctor and shared a few words of encouragement".* Thus, doctors and nurses in the healthcare sector often engage in professional interactions, focusing on patient discussions. Hence, this is the most enjoyable interaction according to two participants as doctors are found to create meaningful relationships and provide guidance. This sense of security was attributed to the fact that nurses and doctors worked together and cared for patients in the same ward. The young nurses from the ages of 25 to 35 have stated that they created friendships with some student doctors while others tend to undermine them because of the weight these two professions have in the healthcare sector. On the other hand, all nurses expect respect from doctors, but often face belittlement and undermining:

> "*I once worked with a doctor who dropped a paper and told me to pick up a paper that he had dropped on the floor on his feet. The doctor stood there not occupied with anything but still said that. I was very annoyed, but I did it anyway even if it is not under my job description*" (orthopaedic nurse aged 44, 30 years of experience).

Moreover, the majority of the surrounding population of public healthcare facilities is subject to low income and some to no income at all (also see Van der Berg, 2002; Van Rensburg, 2014; Von Holdt & Murphy, 2007). Hence, the initial reason for developing the public healthcare sector was to ensure that disadvantaged people get access to free healthcare services (Von Holdt & Murphy, 2007: 313). In stating this, it can be debatable whether accessing public healthcare services is free as people pay for other expenses such as transportation services and food. Furthermore, the nurse-patient relationship is influenced by the situation and character of

patients. Female nurse participants are found to judge the patient's character with aim of improving their interactions. The majority of patients are described as submissive to the instructions of the nurses. Further, respectful, quiet, and grateful patients are propense to receive better care, as nurses are seen as mothers or sisters, it can be a sense of complicity between nurses and doctors. However, some patients tend to be troublesome in terms of being rude, and disrespectful, and becomes difficult to give instructions when taking medications, if the nurse is a female. Female nurses are seen by some patients as fragile, weak, and defenceless sex, thus easier to take advantage of and benefit from their softness -

> *"I once encountered a drunk patient, and he was so rude towards me that I needed to call male nurses to have a word with him. I was very angry when he was rude, I had to remain calm and not say anything back to him but continue to do my work"* (registered nurse aged 25, 4 years of experience).

Further, South Africa consists of a multilingual and multicultural population with different religious and cultural beliefs and customs (Matthews & Van Wyk, 2018: 3). Nurses often encounter male patients who prefer male nurses due to cultural and comfortability reasons and patients are described as more comfortable with nurses of the same race and language. In cases where there is no male nurse in the ward, nurses have reported to calm patients down and reason with them to receive care. Further, most of the patients received are reported to be Indians and black Africans. Therefore, some Indian patients are said to want to be cared for by Indian nurses which becomes difficult when there are no Indian nurses during the shift. Thus, these patients tend to become rude and undermine the black female nurses by testing their knowledge of their medical condition and medication:

> An orthopaedic nurse (aged 44, 23 years of experience) stated that "*an Indian nurse was admitted to the hospital and started asking me questions on their diabetic pills that they've been taking for months. I felt very tested, and I asked her why she was suddenly asking me these questions, but she didn't reply. So, I answered her questions to show them that I know what I am doing*".

In addition, according to Matthews and Van Wyk (2018: 7), the KZN's dominant language is IsiZulu and English which are also used by the nurses to communicate and inform their patients about their conditions and treatments. Hence the black African nurses, who speak IsiZulu,

become helpful to doctors during language barriers whereby black African patients cannot speak English:

> A general registered nurse (aged 28, 6 years of experience) shares one of her experiences: *"A 9-year-old patient was sent to me because the doctor didn't understand her because she was Zulu and as I was examining her, she told me that she was raped by a sangoma so I had to inform the doctor and we called the police. She was going with her granny, but we suspected that the granny knew and would try to prevent the police getting involved so we didn't tell her until the man got arrested on the same day".*

Also, the above statement suggests that patients become comfortable towards female nurses rather than male doctors. Thus, making patients able to openly discuss sensitive matters regarding their health.

Further, when nurses move beyond the rules of their nurse-patient relationship and choose to add extra emotional work, this is regarded as the exchange of gifts (Hochschild 1983: 300). The exchange of gifts done by nurses becomes a very special gesture because it does not require any gift in return (Bolton, 2000: 582). Bolton's (2000) study shows the aspect of agency in nurses' relationship with patients whereby nurses can give out extra emotional work even when confined to management and doctors' control and power. Hence, the participants have shown that they do provide gifts to respectful patients but also those patients whom they have been emotionally attached to through caring for them. Further, nurses such as the NICU and ICU nurses who care for critical patients are found to convey the exchange of gifts by ensuring beds and the working environment are clean, constantly checking up on patients when during shifts, comforting patients, and motivating patients for recovery. NICU nurses form strong relationships with the children's parents, providing sensitivity and support during their critical conditions.

These interactions require intense suppression of emotions, especially for nurses who have built bonds with these families. Female nurses, who are mothers themselves, can resonate with their patients' families by empathizing, and showing humility and gentleness. In addition, nurses have described themselves as passionate hard workers who have become perfectionists in mastering their work and gaining knowledge to ensure patient care. Also, they view themselves as kind, calm, and reserved during interactions and this makes nurse-patient interactions easier. Nurses play a significant role in patient-patient relationships as they show "motherly love" by

ensuring patient comfort and providing necessary care. Despite being limited to positive traits, nurses still enjoy caring for patients who show gratitude after recovery.

Moreover, all interviewed nurses reported not being involved in abusive patient treatment but being stern towards patients, which can be confused with abusive treatment. However, 3 nurse participants have witnessed co-workers giving patients abusive treatment, but incidents not being reported to management - this lack of resolution has led to co-workers reprimanding each other as "*nurses often don't realize their treatment until they are told by a third party. They understand that nurses are human with feelings and should not show their frustrations to patients*" (orthopaedic nurse aged 44, 30 years of experience). Unfortunately, nurse participants seemed uncomfortable speaking about this topic of abusive nurses which was seen through countlessly repeating the question, facial expressions, and body language. Although nurse participants may have reported that they have never given patients abusive treatments, there is a possibility that is not the case.

4.3. The working conditions of female nurses

Working conditions refer to the terms and conditions of an employee's employment, including their working environment, mental and physical demands, and job description (Fusheini et al, 2017: 3). These conditions are stipulated through an employment contract, which a future employee needs to agree and consent upon (Fusheini et al, 2017: 3). An employment contract suggests that the employee's emotional and physical entities are commodified as they give away their physical and emotional labour power for wages and benefits (Belanger & Thuderoz, 2010: 140). In stating that, the nurses have all reported to be permanent workers with various social security benefits such as pension fund, medical aid, sick leave, responsibility leave, uniform allowance, and annual leave. In addition, two nurses work in the rural areas of KZN public healthcare sector and receive rural allowance as part of their employment agreement (NICU nurse aged 38, 17 years of experience; labour and delivery nurse aged 55, 34 years of experience).

Drucker (1999) suggests that workers possess a blend of formal education, training and skills development which are essential for organizational performance (also see Davenport, 1999). Hence, nurses are required to gain education and training to enter the profession, which typically takes approximately four years (depending on the type of nurse) - including three years of study and one year of compulsory hospital work experience. Further, nurses have

reported to be trained by nurse managers who were referred in various ways due to the differences of educational times: *"matrons"*, *"supervisors"*, *"nurse managers"*, and *"managers"*. According to Thompson (2010: 27), managers utilise their knowledge during the labour process to reach the objectives that are in line with the goals of the workplace. Hence, training for nurses consisted of being assisted by a nurse manager and assigned to a professional nurse to provide guidance on the interactions with patients, management, and doctors through completing administrative tasks, overseeing wards, and putting theory into practice by providing patients with medical analysis, medication, or injections and manage equipment and instruments. Additionally, organisations rely on knowledgeable workers as their intellectual capital can have an impact on workplace performance.

Thus, physical training aims for nurse students to gain confidence and trust to produce optimal performance as a means of achieving organizational goals and objectives when they become registered nurses. During training, nurses are exposed to the hospital settings and wards, different kinds of patients, and experience the working conditions of a nurse. In this period nurses have expressed that they experienced being in the morgue, learning how to inject a patient, and being in different wards under unpleasant conditions such as lack of medical equipment – and this is congruent with studies such as Mathias and Wentzel (2017), and Mekhetha's (2021) in suggesting that nurse students experience a lot of pressure intensified workload, cope with traumatic situations, juggle their school work and to learn new skills. Further, nurses reported to have gone through traumatic experiences during the stage as some nurses fainted at the sight of seeing a dead body. After completing training as a general registered nurse, options are present in continuing with further studies to acquire titles like neonatal nurse (NICU) and others. In addition, ward allocation is determined by human resource management which is stated in the employment contract. General registered nurses can transfer to any department that does not require further qualifications given that there is communication with their nurse manager and the human resource manager.

Also, if a nurse wants to be transferred into a particular department shortage needs to be recognized in the department the nurse wants to be transferred into; an intensive care unit (ICU) nurse (aged 38, 17 years of experience) reported that, *"I was working as an orthopaedic nurse because I was assigned to that department when I first started working and then I later asked to be assigned in the ICU department".* The participants have reported that they receive training for approximately 2 weeks to a month depending on the experience that the nurse has (whether

they have worked in that department or not) when they transfer into a new department. Furthermore, nurses have stated that the majority of nurse managers are women. The role of nurse managers in public healthcare facilities is to supervise nurses, create rosters, and act as a 'middleman' between nurses and doctors also between nurses and higher management. Through this, nurse managers try to ensure nurses perform their duties effectively and patients are cared for appropriately. Therefore, during everyday meetings and constant nurse-nurse manager communication, nurses are given details of where to work during their shifts and what duties are to be completed.

Moreover, nurse managers in public healthcare facilities face constant pressure to restructure operations and cut down labour costs, which affects nurses working hours (Aiken et al, 2002: 30). Female nurses work 40 hours a week, as required by the government. However, the distribution of these hours depends on the schedule produced by the nurse manager. According to Aiken et al (2002: 37) study, their nurse participants are found to be dissatisfied because they are unable to have control over their labour process. This is congruent with this research as several nurses expressed their unhappiness with their working schedules of which they do report to the nurse manager and in some cases, changes occur. In addition, seven nurses work 14 hours per shift, starting from 10 am until 8 pm and then the night shift from 8 pm to 10 am. While three nurses work 12 hours per shift starting from 7 am to 7 pm and night shifts start from 7 pm to 7 am. Night shifts are compulsory for 4 months annually, and to compensate for the 40 hours, nurses are required to take unpaid days off. Overtime is not available in public healthcare facilities unless an emergency requires multiple nurses.

In this case, nurses receive extra days off to compensate for overtime. Nurses often work both day and night shifts, with two nurses preferring the night shift due to personal errands and the ability to rest. However, the majority prefer the day shift because the night shift disrupts their sleeping routine and causes increased fatigue, *"since I am usually sleeping at night, by the time it gets to 4 am I am very tired and all I want is to go home but the patients are still coming in and I have to work"* (registered nurse 25 years old, 4 years of experience). While also participants reported a high workload per shift. Furthermore, Brook (2009: 10) touches on the labour process alienation whereby workers lose their control over their work and as a result, become estranged from their work. Hochschild (cited in Brook, 2009: 12 also see Vincent, 2011: 1374), states that the labour process alienation devalues the creativity of workers and

thus workers become disengaged from their work due to the increased rationalization of the labour process.

In this case, the nurse participants have shown levels of alienation which is also congruent with the study of Abd-Elrman (2020) suggesting that occupational alienation is experienced by staff nurse participants in their research due to the inability to gain control over their working environment and decision-making in the workplace. Thus, results in the misbehaviour of workers – which according to Belanger and Thederoz (2010: 143), is another way of resistance against the interests of employers due to dissatisfaction. Hence, nurses in this research have revealed that they experience alienation because of the limited decision-making, working hours and intensified workload during shifts. And as a result, some nurses go against the rules of the workplace such as leave the hospital during working hours to attend personal errands and the nurse managers do not take note of such behaviours.

The nurses have different duties to assists the facilities such as the orthopaedic nurses takes care of any bone related issues of patients in the orthopaedic ward - the NICU nurses cares for children in critical conditions at the neonatal ward - the delivery and labour nurse care for patients who are pregnant at the maternity ward - the ICU nurses care for patients in critical conditions in the ICU ward - the registered nurses work in the general ward and care for patients with various illness - the radiology nurse assist in taking x-rays, MRI, CT scans and ultrasound scans of patients. In addition, nurses have reported doing other duties such as administrative duties, and preparing beds for patients – thus aligning with Bekker's (2013) study that states professional nurses performed non-nursing duties such as cleaning patients but also performed other tasks such as caring for patients:

> "*When my dad was admitted, I made sure that his bed was made extra special so he could be comfortable. All my co-workers know which areas in the ward I work in because I am always cleaning and making sure I work in a clean environment*." (ICU nurse aged 47, 23 years of experience).

Further, it has been found that nurses play a common role in assisting doctors during the process of a patient's surgery in the theatre room. Nurses are allocated by nurse managers as part of their tasks to work at the theatre assisting doctors during surgery or taking patients to the theatre. In addition, the fragmentation of tasks results in the reduction of skills level required in the workplace – whilst also lessening the control that the workers have on their labour

process (Thompson, 2003: 14). Consequently, the high stratification in the work of nurses which consists of specialization and numerous tasks, has led to the fragmentation of tasks. Therefore, this study has found that nurses experience fragmentation of tasks and deskilling within wards through being assigned daily duties and tasks by the nurse manager.

Moreover, staff shortages have been a challenge that hinders the quality of care of nurse participants to patients. Therefore, the study has found that when a nurse retires or leaves their job they are not replaced, thus this burdens nurses with more job intensification. According to Khamisa (2019: 7), understaffing and intensification of work have led to nurses learning new skills in means of taking on more responsibilities in the workplace. Hence, this unbalanced shift between patient care and administrative work results in nurses having to leave caring for patients to attend to files:

> *"Others would want their files back and after you have given them, they tell you that they change their minds they are not leaving anymore. At that time, I have left doing my job to attend to these patients because we don't have enough staff, so we must juggle through everything doing files and admin but also doing x-rays."* (radiology nurse aged 51, 30 years of experience).

The shortages of staff intensify the demand for emotional labour and as a result, nurses are left feeling stressed, overwhelmed and physically and emotionally exhausted. In addition, according to the participants, the increased demand for patients is caused by patients not going to the primary healthcare facilities (clinics) first for care. In South Africa, a clinic is the first step of seeking medical attention and then when the medical condition of a patient requires more attention, they are referred to the public hospitals (Brannigan, 2007: 38). However, several people have avoided or jumped this step and have gone straight into seeking medical care from public healthcare facilities. Also, Brannigan (2007:38) highlights that the South African population is continuously increasing but consequently, the public healthcare infrastructures are not being upgraded or increased, thus placing a strain on medical professionals such as nurses.

According to Brannigan (2007: 39), the South African Nursing Council (SANC) has seen an increase in registered nurses, but this has not kept up with the overall population growth. The general shortage of nurses is "over 50 000, and the public sector is financially constrained, employing 58.9% of the nursing workforce in South Africa" (Brannigan, 2007: 41). Moreover,

South Africa's healthcare sector faces financial constraints due to increased funding cuts, "requiring nurse managers to provide efficient quality care while reducing costs and expenditure, despite contributing 40% of total healthcare spending" (Naranjee et al., 2019: 1). Additionally, two female nurses, one NICU nurse and one labour and delivery nurse, are provided with rural allowances due to a shortage of nurses in rural areas of KZN. The great shortage of nurses in rural areas of KZN is due to the migration of nurses to urban areas. The rural allowance is a government strategy to attract more healthcare workers to rural areas. Due to the staff shortage in rural areas, these nurses are found to not only work in public healthcare hospitals but also in clinics during their days off – as 3 nurses have also reported that they used to work in private hospitals during their days off as part-time nurses as a way of making extra money.

However, negative effects on the nurses' workplace performance such as lack of good quality of care provided by participants are recognized as they are seen to neglect their public healthcare duties because "*patients do not know their rights like those in the private hospitals as it is common for patients to sue the private hospital for not doing my job than in the public*" (orthopaedic nurse aged 44, 23 years of experience), and also expressing feelings of physical, mental and emotional exhaustion. Further challenges include shortages of medical equipment, medication, and surgical stock, affecting nurses' performance and patients' well-being; "*we don't give good quality patient care because of the difficulties we face in wards that make it hard for us to prevent certain things from happening and complications to patients' health*" (registered nurse aged 27, 6 years of experience). However, some nurses sought help from other hospitals to use equipment or receive medication for emergency patients. Thus, these findings are seen to align with Von Holdt and Murphy's (2007: 312) study in suggesting that South African public healthcare hospitals do not provide adequate healthcare to patients. However, this can be recognized as managerial failure to create solutions as nurses are left by management to face the consequences of staff shortages medical equipment, and unmanageable workload – like Jili and Nkosi's (2015: 90) study suggesting that the South African healthcare sector is plagued by problems of the scarcity of qualified nurses which initially results to crowded wards and experiences of burnout and occupational stress for their participants.

In addition, there have been negative perceptions of nurses' wages as young nurses from the ages of 25-35 have reported that they are: *"paid very low wages compared to the amount of job we do at the hospital"* (registered nurse aged 25, 4 years of experience). However, nurses

between the ages of 35 and above are seen to be used to the amount of their wages because: *"I have learned to work around what we earn and budget"* (NICU nurse aged 38, 17 years of experience). In stating this, nurses receive annual bonus packages, such as a 13th cheque, on their birthdays, which contributes to their job performance and commitment. Fortunately, the nurses expressed that they feel happy during their birth month and are encouraged by the positive feelings to provide optimal care for patients. Job satisfaction is a key factor affecting employee motivation and performance, particularly in nurses who have a positive affective orientation towards their job. The study has found that working conditions and job design contribute to the job dissatisfaction, which is unique in their role of constant patient contact. However, nurses have reported to be motivated by the appreciation that patients show, through simple gestures such as, "thank you's" and receiving "gifts". This motivation drives them to be committed to their job, provide good quality of patient care to those patients, and perform well at work.

4.4. The experiences of female nurses of control and power exercised by management and doctors

According to Pillay (2011: 12), management is defined as the process by which sources are integrated with directing, planning, organising, controlling, and coordinating workplace activities. Therefore, management conveys control strategies to ensure that employees create optimal performance while satisfying workplace objectives. Thus, according to the participants, nurse managers use control structures to monitor compliance, improve the quality of nursing services, find solutions to workplace problems, and aim for nurses' development and growth. Nurse managers play a common role in overseeing nurses, assigning nurses responsibilities for the day, scheduling shifts, and ensuring nurses do their workplace duties. Managerial control is reported to be through the nurse manager's physical check-ups during the nurses' shifts, auditing and evaluating patients' files, and nurses having to put their initials on work-related paperwork to state what they have done for the day's shift. Although nurse managers are recognized as the most helpful, they face skills deficit which makes them incompetent.

Pillay (2011) suggests that South African nurse managers lack skills and knowledge on organizing and control tactics. Also, nurses reported that the public healthcare facilities they work at do not have electronic surveillance such as cameras, which leaves surveillance to be in a physical form. In addition, because each shift has a nurse manager, it has been found that

those nurse managers who work during the day shift have less managerial control, largely performing fewer rounds to monitor nurses – than those who work during the night shift as they are found to portray more control, performing rounds approximately every hour, to ensure nurses do their job and do not fall asleep. Hence, these control strategies are described as very helpful and not overwhelming by the participants as they can actively be engaged with their workplace duties and be alert during their shifts. Furthermore, some nurses have claimed that supervision by nurse managers occurs solely to guarantee that nurses accomplish their job of caring for patients, that patients are content with the care provided, and that complaints are avoided.

As a result, because managerial control has become a part of their profession, nurses can easily agree to the workplace's expectations of their performance because *"everyone is just doing their job"* (general registered nurse aged 28, 7 years of experience). Further, the nurse managers are reported to have opened an environment for nurses to be able to communicate their frustrations or complaints during their shifts and daily meetings. Also, nurses have expressed that nurse managers are transparent and communicate effectively – according to Fana and Goudge (2021: 6-8), managers who intensify their communication with staff have a resilient and better functioning environment. According to Sturdy et al. (2010: 114-115), managerial control tends to be masked by "participation" as a means of helping workers with their job performance. Hence, in this study, about 6 nurses expressed that their nurse managers help them in wards when there is an unmanageable number of patients in wards – evidently showing that these nurse managers have participation skills. Then one nurse whose nurse manager is also doing their nurse duties has reported that,

> "*My nurse manager already has a lot of work because she has to be a nurse, attend management meetings, do paperwork and more so already we become extremely shortstaffed because she does her nurse duties only for a short period of time.*" (General registered nurse aged 25, 4 years of experience).

Whilst the other 4 nurses receive no help from nurse managers in wards in relation to the increase in patients. According to these participants, their nurse managers are always in their offices except for meetings with nurses, when they require something from the nurses or when they do their rounds. In addition, the nurse participants have reported having a certain level of autonomy such as nurses are able to make decisions regarding medication or treatment plans to stabilize patient's condition, autonomy in determining the quality of care rendered, autonomy

during meetings in expressing their opinions on medical matters and situations that need their input. However, autonomy becomes limited due to the control strategies of nurse managers and through doctors' orders. The ICU and NICU nurses are found to have lesser autonomy than the other participants.

Moreover, the nurse-nurse manager relationship is not always as positive as resistance does occur which shows the discontentment of nurses in the workplace. This of course affects their job performance as some nurses have shown to misbehave by providing less care to patients, or by approaching the nurse manager: *"I complained to the manager that why is she always making me work on Saturdays and she had to change my shifts"* (NICU nurse aged 38, 17 years of experience). According to Belanger and Thuderoz (2010: 143), workers misbehave in their workplace due to the discontentment with their duties which makes them show resistance through low job performance, low levels of work commitment and strikes – thus slowing down production. Furthermore, the majority of conflict that arises between nurse-nurse manager is related to workplace rosters, broken equipment, and shortages of resources. In addition, the antagonistic employment relationship provides workers with an agency that is shaped by their labour power and production (Belanger & Thunderoz, 2010: 147). Therefore, the nurse participants have shown that they have some agency to approach their nurse manager and verbalize on issues that arise, but they have little agency to resist the nurse manager's orders or control as,

> *"I still go to work even if I don't like our shifts"* (labour and delivery nurse aged 55, 30 years of experience)*, "I clean my working space and make the bed properly and working environment clean for patients even if it is not part of my job description to clean"* (ICU nurse aged 49, 28 years of experience), "*I work in the theatre because I am assigned there by my nurse manager but I don't enjoy working there*" (radiographer nurse aged 51, 30 years of experience).

Moreover, in terms of the nurse-doctor relationship, nurses have reported having certain autonomy in wards, implying that nurses can act autonomously and beyond doctors' directives to maintain patients' critical conditions or make patients comfortable. According to the nurses, the only control that doctors have is to provide nurses with instructions or orders on, *"which medications to give to the patient"*, and *"whether patients need surgery and when"*. Thus, doctors give directions or tasks to nurse participants regarding their patients, which are either communicated during doctors' rounds, in writing or during meetings before shifts start by nurse

managers. Therefore, in such cases, the nurses have reported to have never resisted or rejected a doctor's order because, *"it would be me refusing to do my job"* (registered nurse aged 25, 4 years of experience). Hence, doctor's orders for nurses are viewed as part of their job of caring for patients to achieve a mutual goal.

Furthermore, the nurse participants under the age of 44 have indicated that they have had no disputes with doctors since they adhere to the doctors' orders without hesitation, queries, or arguments, giving legitimacy and authority to doctors' professional knowledge. The older nurse participants, aged 44 and upwards, are seen to query about a doctor's decision due to their expertise and experience. However, some doctors may view this as disrespectful because of power imbalance and professions while others may be impressed by the way nurses are knowledgeable which makes their opinions heard. Nevertheless, the choice of what medication the nurse should provide is always in the hands of the doctor. However, the nurses have emphasised the significance of writing everything down so that if doctors make mistakes, especially student doctors, or do not accept nurses' ideas and a patient's condition worsens, they may provide proof in circumstances when doctors may blame nurses. Additionally, this is not to state that nurses are doctors, or they know everything but their experience of nurses enables them to advise doctors on medications that may produce fewer side effects or that they know are suitable for the patient.

Moreover, nurse managers are conflict managers as they are in an emotional environment whereby there are different interests and cultures among co-workers. In stating this, when conflict between nurses and doctors occurs, nurse managers become the first point of contact and mediator. Therefore, the nurse managers are notified and get involved in resolving the conflict through communication with parties to find a solution. Nurses have expressed that doctors listen to nurse managers more than them which reveals the different power dynamics present in these relationships. Hence, according to Garon's (2006: 254-255) study, power inequalities within healthcare institutions tend to complicate the nurse-doctor relationship thus resulting in unequal treatment and power imbalances. Furthermore, nurse participants reported that they have been through conflict with doctors, are those participants from the ages of 4455 years old. Most conflict is reported to be concerning patients' health and shortages of resources which make it seem like nurses are *"lazy"* or are not doing their job. Hence, this study is in alignment with Ogbimi and Adebamowo's (2006) study in suggesting that the participants findings revealed that the shortages of staff harm the nurse-doctor relationship and nurses

experience the pressures of understaffing more than doctors. Further, participants have noted that they feel stressed out when for instance, *"a doctor accuses me of giving a patient the wrong medication which they have prescribed for us to give the patient"* (ICU nurse aged 49, 28 years of experience). However, the nurse participants also feel a sense of safety in knowing that they can provide the necessary proof to the doctor and nurse manager.

The nurse manager is not the only mediator of conflict. When conflict is beyond the control of the nurse manager, the matter is taken to higher management such as the human resource management and the nurses go to their trade union representatives for assistance. All of the nurse participants are either affiliated to National Education Health and Allied Workers Union (NEHAWU), Democratic nursing organisation of South Africa (DENOSA), or the Public servants association of South Africa (PSA). Whether trade unions are successful through striking and collective bargaining has been very controversial. Individual bargaining is considered as ineffectual by trade unions due to the representatives' lack of understanding, especially as some representatives are not nurses but may work in other public healthcare facilities:

> *"I resigned with immediate effect at my previous nursing job at a hospital, but I was supposed to receive money on the month I had resigned which I didn't get. So, I consulted with a trade union representative who I went with to management for me to get my money. But it was unsuccessful because the representative was not educated enough on bargaining and agreements which made me lose and I left the issue like that"* (orthopaedic nurse aged 44, 23 years of experience).

Three registered nurses were discovered to have participated in previous strikes. Although nurses are permitted to strike with the support of a trade union, the government always seeks to solve the nurses' demands so that patients are not disadvantaged. This research shows a similar situation to Sidley's (2007) research. According to Sidley (2007), South Africa's public hospitals went through a two-week strike which was largely about wages and working conditions. Most nurse participants recognised that strikes have been over wages, government policy and working conditions, which the government has not been able to agree on, resulting in unfavourable developments for those who are members of a trade union. As reported by the participants, strikes normally occur for a week or more because the government never agrees to the percentage of wage increase or to the demands of the nurses. Therefore, in most cases, strikes end not because the nurses have received all their demands from the government but

because of the different power dynamics between trade unions or nurses and the government. An instance of this is the recent strike that occurred in March 2023 whereby NEHAWU wanted a “10% increase, but the government offered 4.7%” which then made nurses to continue striking (Al jazeera, 2023). When the trade unions and the government cannot reach an agreement, the government tends to look towards the South African Labour Appeal Court so that strikes can end (Al jazeera, 2023). Hence, in some instances, strikes are seen to stop and the percentage that the government offers is taken by the trade unions.

Additionally, during strikes the army medics is normally deployed to the hospitals affected so that patients do not suffer with the absence of nurses (Al jazeera, 2023). In 2007, patients in critical conditions were transferred to the private hospitals for care because of a national strike that had taken place in the public healthcare sector (Sidley, 2007). While nurses that continued with their work in the hospital, dressed in their casual clothes so that to avoid being recognized by those striking. Nurses working in ICU and NICU wards have struggled to participate in strikes due to the critical nature of their duties, which makes abandonment hard. These nurses, along with radiography and orthopaedic nurses, are found not to join in any strikes - as they continue to work even if it puts their lives in danger because they may be viewed as *"traitors"* (NICU nurses aged 38, 17 years of experience). Smith (2010) in The Guardian newspaper has reported that South African nurses who do not participate in a strike but instead opt to continue working, go through violence and intimidation which has resulted in several nurses in the past being beaten and violently attacked. The nurses have expressed that when those nurses that strike enter the hospitals, they lock themselves in the management’s offices to avoid being harmed as security guards are found to be of no help in such circumstances. Also, the nurses who did not partake in strikes do get the same benefits as those who participated in the strikes because of their affiliation with trade unions.

4.5. The display, experiences and effects of deep acting and surface acting by the female nurses

Social interactions are understood through a variety of negative or positive emotions (Dormann & Zapf, 2004; Holman et al., 2008). Emotions are transformed as labour through the rise of service work and the automatization of the intensive labour process (Kim, 2018: 1085). Nurses do not only care for patients but also sell their smiles in return for wages thus hiding their troubles and true emotions behind smiles. Nursing is classified as one of the highest professions partaking in emotional labour as it also carries the burden of burnout, fatigue, and exhaustion

(Kim, 2018: 1087). However, emotional labour is also viewed positively as it increases job satisfaction and patient satisfaction. Further, nurses sustain intense contact with patients who require compassionate care through challenging conditions – as they are not only required to regulate their emotions but also suppress the fear and distress of their patients (Kinman & Leggetter, 2016: 5). According to Bolton (2001: 12).

Thus, nurses are emotional jugglers who as a result change faces due to emotional requirements in the healthcare. Individuals have structured social interactions through display rules and expectations that oversee the degree of emotional display and job performance. Nurses are expected to show positive emotional displays such as smiling, joy, laughing and show interest in their job. Hence, nurse managers expect nurses to have these qualities of emotional labour to ensure patient satisfaction. Further, nurses have expressed that nurse managers and doctors have the same workplace expectations towards nurses which include ethical and professional behaviours, being presentable, working independently without a doctor, good listener, taking orders, having good working performance, coping with unpredictable situations, and be emotionally stable throughout their shift.

When the nurses describe their relationship with nurse managers, they all act according to the expectations in maintaining professionalism through dress code or nurse uniform, attending required meetings, and keeping up with administrative work:

> *"I remember when I started working and we would have to stand against the wall every time a matron passed us you know because that was expected of us, but the times have changed and that is not done anymore"* (orthopaedic nurse aged 47, 26 years of experience).

Also, respect is seen to be an important factor with nurses above the age of 35 because of their days of training when nurse managers were recognized as superior to nurses. Hence, the nurses report being more reserved in their interactions with nurse managers and certain doctors – as they interact with nurse managers and doctors with respect and kindness but also keep their interactions professional. These nurses do not show their true emotions towards nurse managers and certain doctors and would use surface acting during interactions. However, nurses have recalled instances whereby when they are exhausted and burned out, they find it impossible to be kind or express positive emotions such as smiling which leads them to avoid or detach from interactions with co-workers by isolating themselves or taking longer breaks from their work.

Therefore, surface acting has been helpful during the nurse-doctor and nurse-manager relationships.

Moreover, the expectations of patients towards nurse participants are reported as having nurses who are unjudgmental, approachable, understanding, kind, respectful and caring. The nurses find this expectation the basis of making patients feel comfortable, safely cared for and able to seek assistance without any fear. Hence, this making some nurse-patient interactions enjoyable because nurses can show a portion of their true sides whilst having to maintain professionality and emotional management. In stating this, nurses show empathy when they feel empathetic or show genuine happiness when a patient recovers. However, when it comes to patients who seem to be worried about their medical conditions, nurses are said to "*lie*" or "*pretend*" as if everything will be fine so that the patients will not lose hope. This has helped the nurse-patient relationship and interactions as nurses are able to provide immediate care, and nurses are able to comfort and motivate patients. Additionally, just as actors show pretentious or artificial appearances, nurses display fake emotions to regulate and control their emotions (Kim, 2018: 1086). Hence, nurses find surface acting to be more helpful than deep acting in providing hope, and comfortability and lessening their stress about the critical condition at hand.

Therefore, here nurses are seen to go through surface acting because they suppress their concerns of the patient and try to give them comfort. However, this can result in emotional dissonance whereby nurses are stuck between true feelings and expected feelings. In addition, 6 nurses stated that they are naturally bubbly, outspoken, and people person thus they are naturally adaptable to their line of work. Further, these nurses experience a great demand of patients because of the wards they are situated in which tends to make them feel overwhelmed, annoyed, and exhausted. This does affect their job performance in that when they are tired, they tend to focus on completing their job instead of partaking in emotional labour which then results in true emotions being revealed. Nurses are said to show their frustrations by shouting at the patients. This could be recognized as burnout in the sense that nurses get physically, emotionally, and mentally exhausted – consequently absenteeism, lack of job commitment and delays in completing tasks are experienced.

In addition, approximately 4 nurses (2 ICU nurses and 2 NICU) have suggested that they are naturally shy people but are able to be confident and adapt to their line of work. Especially since the nursing profession requires people who can communicate, are outspoken and confident. Hence these nurses have emphasized the multiple identities individuals create

through emotional labour. Nurses can be their true selves at home or with certain co-workers, but they must change into another identity of a nurse so that they can adhere to the job expectations and emotional management. Ashforth and Humphrey (1993) explore the identities of workers in the interactive service sector, and they suggest that emotional labour stimulates pressure for workers to identify themselves in the interactive service role thus creating different identities for themselves. In addition, the NICU and ICU nurses care for patients who are in various critical conditions and are always faced with two options either death or recovery for a patient. Hence, the participants have expressed that when a patient dies, they feel very sad, distressed, and self-critical especially when it was experienced for the first time. The nurses used to blame themselves when a patient died as some patients died in their presence and they started crying about leaving their loved ones before death. So, this has been one of the emotional difficulties that these nurses face.

The NICU nurses care for infants and children and their sadness mostly stems from the families of the patients that must bear the bad news. All four nurses have revealed that they do cry for in isolation in the bathrooms and then afterwards have to comfort themselves and continue working. While some nurses have had the experience of being comforted by the doctors that they have been working with to care for the deceased patient. Further, these ICU and NICU nurses have shown that they experience deep acting more than surface acting because they have been shown to internalise their emotions and prepare themselves before going to work – in cases where they might encounter difficulties with a patient. Thus, when it happens, they are already mentally prepared for anything. Additionally, these nurses have revealed that they usually talk to themselves saying, *"I have tried my best to save them. I did all I could and now I have to work"* (ICU nurse aged 44, 23 years of experience) in means of comforting themselves to aim for managing their outward displays of emotions. Therefore, deep acting in this case has been revealed to be a coping mechanism for nurses to be confident in their work and to acknowledge their efforts in their patient's well-being. Although true emotions are not expressed in front of patients, the nurses are able to deal with their true emotions after the encounter. This is deemed by several scholars as a better way of partaking in emotional labour because individuals can positively go about their emotions. This also leads to lesser consequences because feelings are dealt with through either crying or expressing their feelings afterwards.

The presentation of self becomes vitally important in organisations that have made emotional labour a legal job requirement (Vincent, 2011: 1372). Thus, this is dependent on the extent in which nurses can manage their emotions. Emotional training includes obtaining emotional skills such as the skill of managing emotions (Bolton, 2000: 580). In most cases, as found in the research data, nurses are not emotionally trained but are expected to manage their emotions on their own: *"None of the nursing courses I took taught me how to deal with emotions"* (NICU nurse aged 35, 14 years of experience). In addition, one of the nurses had an opportunity to be a nursing lecturer at one of the nursing institutions. The nurse participants stated that they would always tell their students to *"be calm in every situation"* (orthopaedic nurse aged 44, 23 years of experience) that they encounter. This shows that nurse students are not necessarily taught how to manage emotions in depth, but it is something that does come up from time to time as a means of preparing nurse students for physical training. Therefore, nurse participants have recalled that during their physical training, they looked up to their assigned professional nurses because that was where they had to learn the practicality of their profession for both physical training and emotional management – as during training they encountered several patients, doctors, and management of which they saw from their assigned professional nurses on how to behave emotionally and physically.

Further, nurses have reported that emotional management comes with experiences of having to interact with different kinds of people – and with the help of professional nurses, they are able to learn how to emotionally behave during interactions. Another nurse has stated that *"experience does help us a lot in coping with our emotions and being able to remain calm even after interacting with a rude patient"* (radiography nurse aged 51, 30 years of experience). This emphasizes that emotional labour is as hard work as physical labour as both require a lot of effort and attention. Also, the very experienced nurses – from 7 years of experience – have expressed to detach themselves from their patients which makes them manage their emotions better: *"immune or detached from all those interactions over time"* (delivery and labour nurse aged 55, 34 years of experience).

However, nurses have shown factors of compassion fatigue whereby continuous interaction has resulted in nurses being tired of showing care and compassion. Nurses will stop greeting patients, show less smiling, stop being friendly towards patients and turn cold towards patients whilst doing their job. This reduces the fact that nursing is all about compassion and care and without these things, nurses may be seen as rude, scary to be comfortable with and abusive

towards patients. Alienation from self as Hochschild (1979: 27) and Bolton (2000: 9) have described is the sense of being estranged from one's feelings because of the consequences of emotional labour. These nurses have been found to detach or be immune to the negative interactions or challenges faced at work because of the consistent exposure. Also, alienation from the self is shown through the continuous use of emotional labour whereby nurses must constantly smile, be kind, and act happy even through the challenges they face both at work and at home.

Furthermore, the ICU nurses have approximately three to five patients during their shifts because of the critical state that these patients are in which requires special and individualised care. These nurses have reported that they become attached to their patients because some patients tend to stay in the healthcare facilities for months before being fully recovered. Hence, when a patient fully recovers, they feel very happy that they were able to contribute to their journey of recovery. However, these two ICU nurses expressed that days are different and sometimes patients do not recover. Thus, the way they feel after a shift is dependent on how their day went:

> *"It depends on how hectic my day was. If I work at ICU then all my patients' conditions are maintained, then I would go home happy because there is nothing to be sad about. if I lose a patient, be it a baby or an adult of course I become sad and I talk about it at home. Then if I had to work at another ward because of a crisis, I come back very tired because that required a lot of my energy especially if there is a major accident"* (ICU nurse aged 49, 28 years of experience).

Additionally, receiving a lot of patients is recognized as emotionally and physically draining, exhausting, and overwhelming.

Other nurses (excluding the ICU nurses) are placed in different departments of the healthcare facilities and the number of patients that come in for assistance is always high whether it is at night or during the day. This has made nurses find it difficult to interact with different kinds of people, listen to medical problems, find solutions, and comfort them. Hence, these nurses find themselves very excited to go home after their shifts because of their exhausted bodies and minds and all they think about is relaxing at home. An orthopaedic nurse (aged 47, 7 years of experience) stated that, *"my children laugh at me every day because I fall asleep on the couch while watching tv when I get home because I become very tired at the end of my shift"*.

However, the nurses are found to find coping mechanisms such as talking to co-workers and talking to loved ones about any interaction or situation that affects them negatively such as a patient that has passed on in their care or experiences of a rude patient or doctor.

Furthermore, mental health-related issues in the nurse have been linked to stress, anxiety, and trauma. According to the World Health Organisation (WHO, 2023), stress is defined as "a state of worry or mental tension caused by a difficult situation", anxiety is "excessive fear and worry and related behavioural disturbances" (WHO, 2023) and trauma is the result of the "exposure to an incident or series of events that are emotionally disturbing or life-threatening" (Trauma informed care, 2021). The nurses have found themselves not only stressed about a patient's well-being but also stressed about their own health is at risk, especially during the time of COVID-19. Most of the participants have reported that during the time of COVID-19, they had so much fear of contracting the disease whilst having to go home after their shift to their families. Also, some nurses expressed having to stress about contracting illnesses from public healthcare patients such as tuberculosis (TB). Additionally, the stress also stirs from the demanding profession that these nurse participants are in – whereby the nurse participants must focus on their workload whilst having to smile and be kind throughout their shift no matter how they really feel. Consequently, nurses' job satisfaction tends to decline when working with patients that will pose a harm to their health and end up gaining avoidance strategies such as emotional disconnection. Nurses have shown to be cautious, irritable, concerned, and grumpy when caring for these patients.

Further, the anxiety is found to stir from the fear of having a patient pass away in the care of the nurses and the fear of making a mistake when caring for a patient. Nurses are found to experience severe anxiety during training, the first 2 years of working as nurses and during the outburst of COVID-19. Nurses still recall their traumatic experiences such as the first time they saw a knife inside a patient's head during an x-ray scan (radiography nurse aged 51, 30 years of experience), the first time a patient passed away (ICU nurse aged 49, 28 years of experience), the first time a patient's bone was detached from their arm (orthopaedic nurse aged 44, 23 years of experience). This also created mild trauma which the nurses seemed to suppress and continue with their job. Thus, making these mental health issues manageable for the nurses. In addition, all the nurses have mentioned that their workplace has support structures which allow nurses to seek help if needed. The support structures consist of an employee assistance programme which includes psychologists, therapists, and doctors that are available in the public healthcare

facilities free of charge for the nurses to visit in cases of distress. However, none of the nurses have taken the initiative to visit these support structures because they have not seen the need to seek any support for their stress, trauma and/or anxiety or this programme has been viewed as not helpful. Nevertheless, nurses' families, nurse managers and some doctors are viewed as another support structure in which nurse participants can communicate with them if they have any problems or any help that is needed.

Further, the point of communication for doctors does not end when they leave the patient in the nurses' care, but the nurses are still able to receive guidance and support from doctors even though they are expected to work independently from the doctor:

> *"We as nurses can still call doctors if there are any changes in the patient's condition if we require clarity or if we need guidance. So yes, the doctors do guide us and in terms of support, I think it depends yet again on the doctor you are working with. Some do provide support while others don't and support could be in the form of asking how you feel after a patient has died or calling a few hours after I had called in to ask guidance for something"* (NICU nurse aged 35, 14 years of experience).

Nurses are also obliged to look for doctors in public healthcare facilities if needed. Although nurses may seek for doctors' guidance nurse managers are present during shifts and also avail themselves to the nurses in cases where they need assistance or guidance.

4.6. Conclusion

Nurses work under strenuous working conditions with some challenges which have made nurses to be seen as resilient, supported by nurse managers, and working around the resources they have available. However, nurses are forced to work long hours with limited resources which causes work-related stress, burnout, and physical exhaustion. Further, nurses have shown dissatisfaction with their working conditions, but their experience has made them be used to their working environment. The nurse participants have shown to experience alienation whilst job satisfaction occurs the most when nurses see the impact of their contribution to their patient's health. Nurse managers do not only ensure that nurses go about their workplace duties and responsibilities as stated by the employment contract, but also ensure that emotional labour is maintained by nurses. Therefore, emotional labour is a tool that reflects in the nurse's performance of workplace duties and behaviours. In addition, nurses are found to use their femineity and emotional labour in their nurse-patient relationships and interactions – deep

acting and surface acting – has assisted in the workplace interactions and relationships. Moreover, emotional labour helps nurses to cope with the power differentials which is seen using surface acting during their interactions. Likewise, with the interactions of nurse-nurse managers, nurse managers convey control tactics in the workplace and surface acting is used to make this relationship and interaction smooth. Furthermore, the NICU and ICU nurses partake in deep acting whilst the other nurses use surface acting during their interactions with patients and their families. Consequently, to emotional labour, nurses experience mental health problems such as work-related stress, burnout, emotional and physical exhaustion, PTSD, and anxiety. These have been coped through support structures such as nurses' families, coworkers, and management. Nonetheless, resistance has taken place in the form of misbehaviour and strikes whereby nurses resist their working conditions and wages.

Chapter 5: Conclusion

5.1 Introduction

The purpose of this dissertation was to explore the experiences of female nurses working at KZN's public healthcare sector regarding their emotional labour process and labour process. Therefore, certain aspects were explored such as the gendered nature of female nurses, the working conditions of nurses, their experiences with doctors and management control and power, and lastly, the experiences and effects of nurses' emotional labour process concerning deep and surface acting. Furthermore, this chapter discussion will be based on an entire dissertation reflection, with a brief outline and summary of the previously mentioned chapters.

5.2 Reflection on the Dissertation

Emotional management occurs in the interactive service work such as with nurses, waitresses and more. Hence, it is one of the skills that nurses require during their workplace interactions. This study adds to knowledgeable sources as there are not many studies that investigate emotional labour and the labour process experienced by nurses specifically in KZN's public healthcare sector. In stating this, the dissertation found that female nurse participants were aware of their emotional management especially since they interact with all kinds of different people with various injuries and fears. Therefore, emotional labour becomes important to ensure smooth interactions, and comfortability of patients, to ensure patients can trust nurses, and bring hope to patients. However, emotional labour is also recognized in the nursemanagement and nurse-doctor relationship – whereby nurses suppress and management their emotions through imbalanced power relations and control. Furthermore, nurses do get to a point of emotional fatigue whereby they get detached from individuals. Also, effects such as stress, anxiety and PSTD have been found in participants.

Moreover, the first chapter includes the objectives of the dissertation whereby the purpose, aims and overall process of the research is introduced. The second chapter compromises the contextualisation of emotional labour which consists of a discussion of emotional labour using Hochschild (1983). In addition, symbolic interactionism, and the dramaturgical perspective from the viewpoint of Goffman (1959) are included in the chapter in focusing on workers' interactions and performance in the workplace in relation to emotional labour. Lastly, the chapter consists of some borrowed concepts from the labour process theory such as consent,

commodification, alienation, agency, and resistance. The discussion in the second chapter was done to put an understanding of emotional labour and the labour process.

The third chapter addressed the emotional labour and the labour process of nurses. The discussion began with an overview of the experiences of nurses' emotional labour process and labour process globally. Followed by an extensive discussion on South African nurses starting from the apartheid era until the present. Then lastly, the KZN's nursing sector was discussed whereby issues of working conditions, experiences of emotional labour, agency and resistance were discussed. This chapter comprised various literature on both global and local levels in means of bringing about a perspective of the nursing sector in the public healthcare sector. Further, the discussion shows that emotional labour is required to perform workplace tasks and duties but also the state of the nursing sector and the way emotional labour is used to curb these conditions.

The fourth chapter addresses the dissertation's objectives mentioned previously and discovers themes which have contributed to the understanding of this study. The first objective showed that the nurses' gender influences the nurse-patient relationship – both negatively and positively. Female nurses are found to be portrayed as mothers, sisters, or daughters by patients (dependent on age differences) and this has played a role in nurse-patient interactions and relationships. In addition, the gender of nurses did not influence the nurse-doctor and nursenurse manager relationships. Nurses were treated respectfully by student doctors rather than some professional doctors because of the different medical titles which caused some doctors to belittle the nursing profession than others. However, the nurse-nurse manager relationship was recognized positively, as nurse managers are seen as helpful.

The second objective highlighted the working conditions of nurses. It was found that nurses undergo long working hours and are dissatisfied with their wages. However those who work in the rural parts of KZN earn incentives and most of the nurse participants have been found to have worked in either primary healthcare or the private healthcare sector whilst working in the public healthcare sector in means of getting additional income. Of course, this has tampered with their ability to provide good quality of care to patients and produce good performance in the wards. Furthermore, nurses work under strenuous working conditions such as shortages of staff, shortages of medical equipment and medication. whilst also having to do unrelated duties to their profession such as cleaning and administrative work. Therefore, nurses are recognized to be left to work under these conditions without the intervention of management. However,

nurses are found to be very skilful in their workplace, juggling emotions and their physical work as there is no fragmentation of tasks.

The third objective addressed the power and control doctors, and nurse managers possess, and the findings showed that nurse managers conduct control tactics as a means of ensuring that nurses perform their duties during their shifts. Whilst doctors portray control through the orders they give to nurses concerning patients. However, nurses have autonomy but become limited because of the control nurses and doctors have. Also, nurses are not passive beings as they have agency and have been found to resist these different power dynamics and control through strikes and individual grievances which require a trade union representative. Further, nurses bring forth their concerns during daily meetings with colleagues and nurse managers.

In the last objective, the discussion was based on the emotional labour process in finding out that ICU and NICU nurses undergo deep acting while the other nurses perform surface acting. In stating this, nurses are found to experience a lot of emotional management and suppression not only through nurse-patient interactions, but also through the interactions they have with patient's families. In this objective, it is recognised that nursing is a very complex and hard job that requires a lot of physical and emotional work. Nurses are found to be "numb" from feeling, have compassion fatigue, burnout, emotional distress, stress, anxiety, and PTSD due to the complexity this profession comes with. In addition, everyone has their own idea of nurses in the public healthcare sector, some nurses may be regarded as rude, impatient, and unkind – which are qualities opposite to what nurses should have. However, this study has given a bit of insight into this by suggesting that nurses experience emotional labour which eventually depletes their duties to be kind, caring and patient. In this study the participants have stated such instances and have stated that the kind of patient they interact with distinguishes the quality of care they will be provided. In stating this, the study does not try to reveal the positive aspects of nursing but also tries to view the negative side of it.

5.3 Suggestions and recommendations

The findings of this study suggest that emotional labour is important in the performance of nurses' daily workplace duties and tasks. This may not be stated in the employment contract, but emotional management is required and remains a skill that nurses learn through experience. However, a suggestion this study should make is emotional support mainly from management with regards to the effects of emotional labour. Although the healthcare sector has made

provisions for which nurses do not want to attend, nurse managers should create an environment whereby emotional difficulties are expressed by nurses. Hence, nurse managers to be aware of emotional labour and its effects so that they are able to gather a better understanding of nurses' emotional experiences in wards – thus creating workshops that focus on emotional skills and the importance of mental health care for better performance. Lastly, nurse managers and the government should intervene in the working conditions of nurses mainly those that affect the quality of care.

5.4 Areas for further study

As mentioned earlier, there is not much literature conducted on the KZN's nurses concerning emotional labour and their labour process. Therefore, additional research should be contributed into this, however, also including the views of patients, nurse managers and doctors regarding their experiences with nurses' quality of care.

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Appendices

Appendix A

Semi-structured in-depth interview guideline/schedule:

Objective 1: Explore the gendered nature of emotional labour experienced by female nurses in relation to patients and doctors

1. How is your relationship with doctors and with patients in general? Please explain.
2. Can you please describe the way in which doctors, and patients normally treat you as a female nurse and how that makes you feel? Do you think that it is different with male nurses? Please explain.
3. How does your position as a female nurse affect the way you interact with patients, doctors, and management in the workplace? Please explain.
4. Have you ever felt undermined or not respected by doctors or patients because you are a female? Please explain. What do you think are the main expectations from patients and doctors in relation to your work? Explain.

5. How would you describe yourself as a female nurse – are you for example patient/impatient, understanding or not, go beyond the management expectations to make patients happy, passionate about your job, work just to gain a living, etc? what do you enjoy about your job? Please explain.
6. How has being a female helped you cope with being a nurse – for instance being able to display nurturing characteristics with patients and be professional with doctors? Please explain.
7. Has your experience as a female nurse affected the wards you are placed in? if so, do your responsibilities increase or decrease and how does that make you feel? Please explain.
8. Has the public hospital you work at ever had issues with female nurses giving abusive treatment towards patients? If so, how did management resolve the issue?

Objective 2: Explore the working conditions of nurses working in public hospitals

9. What employment contract do you have – permanent, part-time, temporal, etc? Does your employment contract include any social protection such as medical aid, sick leave, or insurance? Please explain.
10. Who was responsible for training you when you first got the job – management or senior nurse or other? What did your training include and how has it helped you with your job? Please, explain.
11. How long have you been working in public healthcare? Can you please describe your experience and the main tasks you perform in this sector in general?
12. What challenges and barriers do you face to do your daily job tasks - does your workplace experience any staff shortages, or shortages of medical equipment and resources? Please explain.
13. Who assigns you to work in a certain ward – what wards have you worked in and what were your responsibilities in each ward? Please explain. Do you choose to work there or is

it part of your contract? Do you feel prepared to work in this ward (do you have the necessary skills?).

14. Are you working different shifts during the week and how many working hours does each shift have? If yes, which shifts do you enjoy working – day shift or night shift and why? How does the workload differ between each shift? Please explain.
15. Do you receive overtime and how many working hours is that? Do you receive wages for overtime as well? please explain.
16. How do your perceptions of wages and compensation packages (thirteen check) affect your overall job satisfaction, job performance, quality of patient care and your commitment to the healthcare facility?

Objective 3: Study the experiences of nurses in relation to control and power exercised by management and doctors

17. Who is responsible for supervising you: management, senior nurse or others? What are the ways in which supervision or surveillance occurs (cameras, reviewing of documentation and patient records, performance evaluation, etc)? How has the supervision of management helped you to do your work – do you find it helpful, overwhelming, or not needed, or other? Please explain.
18. How has the control and power strategies of management such as surveillance, influenced your perception of consent in relation to your performance expectations, job roles and job satisfaction? Please explain.
19. Do doctors have control or power over what you do during your shift at work? Have you resisted the control or orders of a doctor in relation to your work? Please explain.
20. Have you ever experienced instances whereby the views of a doctor and yours regarding a patient are in conflict? If so, how did that make you feel and how were you able to resolve the situation?
21. In relation to the above question, do doctors allow you to make your own decisions regarding patients outside of their orders? – for instance, a patient suddenly gets worse, and the doctor is not there to let you know what to do. How do you handle sudden situations and how has this made you feel?

22. Do you experience alienation? Has job autonomy, decision-making and opportunities for professional growth influenced you to experience alienation and how has this impacted on the quality of your job performance? Please explain.
23. Do you experience any conflict at work with managers, supervisors, or senior staff? If so, with whom and what do you do to resolve it? Explain. Who do you go to when you have individual grievances at your workplace and how has this helped you? Please explain.
24. Have you spoken with your superiors on behalf of your co-workers or the collective regarding grievances or complaints? Do you receive support from your co-workers? Please explain.
25. Are you aware of the trade unions for nurses? Are you part of a trade union? If so, has your trade union succeeded in fighting for your grievances in the past? If not, why are you not part of a trade union? Please, explain.
26. Have you heard about nurses' strikes in your workplace? Have you participated in a strike at your workplace before? If so, what was the strike about, and did it result in positive changes? Please explain.

<u>Objective 4: To study the display, effects and experiences of deep acting and surface acting of female nurses in the workplace in relation to managers, doctors, and patients.</u>

27. Is there any expectation from management, doctors, or patients for you to behave in a particular way? Do the regulations or code of conduct explain the expected behaviours that nurses should display when interacting with doctors, managers, or patients?
28. How would you describe your relationship with your manager, other nurses, patients, and doctors? Please, explain. Which interaction do you feel most comfortable and excited to experience – manager, patients, or doctors? And why?
29. Are you normally a people person or a shy person? If so, how has this helped you to interact with patients? If not, what has helped you to be able to interact with patients? Please explain.

30. Do ever find yourself expressing your true emotions and how you feel in the workplace with management and doctors? What emotions do you display? Please, provide a few cases of when this happened.
31. What emotions do you experience and display with patients when you have lots of them to attend? Please explain how you feel on such occasions and what are patients' reactions. Please explain.
32. How do you feel when you care for patients in critical conditions? Explain. How is your relationship with these patients? Explain.
33. How have you been able to put your emotions aside and focus on helping a patient in critical condition – do you mentally prepare yourself before going to work, do you meditate before work/encountering each patient, do you help the patient and deal with your emotions later, etc? Please explain.
34. How do you handle a difficult patient e.g. does not want to take their medication? And how does this make you feel – neutral, worried, unbothered, or other? Are you expressing your true emotions or do you fake them to satisfy the patient? Explain.
35. Have you had access to training in which you can train your emotions in all situations? Please explain.
36. Does the continuous interaction with patients with all kinds of medical problems affect you emotionally? Please explain. Please describe the emotions you normally feel after your shift – happy, sad, excited to go home, etc. Please explain.
37. Do you think that experience eventually makes a nurse separated from their roles as a female nurse and hence are able to cope with negative interactions? Please explain. Can you please describe how you felt after you first encountered negative interactions with a rude patient, or a doctor compared to how you feel now with the experience you have gained?
38. Knowing that your job is very demanding, have you ever experienced work-related stress, anxiety, panic attacks, trauma, or depression? If so, how has that affected your work? Please, explain. Has management been able to be supportive when you or any other nurses experience difficulties of stress etc? Please explain.
39. Are there any structures such as a workplace psychologist that is put in place for nurses to freely seek when experiencing work-related trauma, stress, anxiety, etc? Please explain.

40. Do you receive enough guidance and support from the doctors you work with - given the fact that they only see the patient for check-ups, and you are then left with taking care of the patient? Please explain.

Appendix B: Consent form

PARTICIPANT INFORMED CONSENT DECLARATION

(To be signed by research participant/s)

Project Title: ***Exploring the experiences of female nurses in emotional labour and the labour process in the public healthcare sector in eThekwini municipality, KwaZulu-Natal.***

Kinnie Plaatjies from the Department of Sociology, Rhodes University has requested my permission to participate in the above-mentioned research project.

The nature and the purpose of the research project and of this informed consent declaration have been explained to me in a language that I understand.

I am aware that:

1. The purpose of the research project is to explore emotional labour and the labour process experienced by nurses in the public healthcare sector situated in eThekwini municipality, KwaZulu Natal.

2. Rhodes University has given ethical clearance to this research project 7396 ***(Ethics Approval Number)*** and I have seen/may request to see the clearance certificate by contacting the Ethics Coordinator (ethics-committee@ru.ac.za)

3. By participating in this research project, I will be producing awareness of emotional labour. Participants will benefit through being aware of the emotional labour that they experience. The participants will gain understanding of their emotions and interactions with doctors, management, and patients.

4. I will participate in the project by participating in an interview.

5. My participation is entirely voluntary and should I at any stage wish to withdraw from participating further, I may do so without any negative consequences.

6. I will not be compensated for participating in the research, but my out-of-pocket expenses will be reimbursed.

7. The following risks are associated with my participation: there is the risk of not feeling comfortable or having feelings of distress to respond to certain questions which might tamper with the quality of information that will be provided.
8. The Researcher intends to publish the research results in the form of ***a scholarly journal. Publications in scholarly journals have the benefit of having a wide audience reach. The publication through scholarly journals will also enrich the university's research publications.*** However, confidentiality and anonymity of

records will be maintained, and my name and identity will not be revealed to anyone who has not been involved in the conducting of the research, ***unless I indicate to the contrary/recognize that as a public figure my identity will inevitably be/become known, in which case I agree to accept the loss of anonymity.***

9. In terms of the Protection of Personal Information Act (No. 4 of 2013) it remains my right to request the Researcher to provide me with a detailed explanation of exactly how confidentiality and anonymity of the data I provide will be achieved. I may also request to know exactly how my personal information will be stored securely, for how long it will be stored.

10. If any data collected from me for this research project is to be used by the Researcher for any further study, I am to be informed in writing and my written consent requested again. I need not give consent for the new research if it is incompatible with the initial purpose of the present study (POPIA, s15(3)). Equally, I can simply reject the request. In such cases, a formal request needs to be made to me by the researcher via the Ethics Coordinator (ethics-committee@ru.ac.za).

11. In terms of the POPI Act, I possess the right to receive feedback about this research. This will take the form of email, text messages and hard copy print outs. The participants will choose in which manner they want to receive their feedback unless ***I elect not to receive this feedback.***

12. Any further questions that I might have regarding the nature of the research and/or my participation in it will be answered by

13. By signing this informed consent declaration, I am not waiving any legal claims, rights, or remedies. A copy of this informed consent declaration will be given to me, and the original will be kept on record by the Researcher.

14. I ***agree/disagree*** (delete inapplicable) to the Researcher's request to take photographs, or videoing me as part of this research project, recognizing that agreement here is likely to raise the risk of compromising my anonymity and that steps will be taken to ensure this will not happen it my consent is given.

15. I ***agree/disagree*** (delete inapplicable) to the Researcher's use of voice recording of my comments and opinions during interviews, the purpose of which is to ensure the accurate recording of my views/responses. Furthermore, I have the right to request a copy of the interview transcriptions to confirm that my opinions are accurately recorded.

I, ……., have read the above information / confirm that the above information has been explained to me in a language that I understand, and I am aware of this document's contents. I have asked all questions that I wished to ask, and these have been answered to my satisfaction. I fully understand what is expected of me during the research.

I have not been pressurised in any way and I voluntarily agree to participate in the abovementioned project.

……. …… …….

Participants signature **Witness** **Date**