

**The Interface between Nurse and Patient in Health Care: Exploring the Use of  
Emotional Labour among Nurses in Mthatha**

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# ABSTRACT

In exploring the use of emotional labour among nurses within the nurse/patient relationship, this study employed the conceptual framework of ‘emotional labour’ associated with Arlie Hochschild-as a means of examining the “nature” of the nurse patient interface, including the dynamics, challenges and intricacies that shape this relationship of care. The portrayal of emotional care offered to patients dealing with suffering and illness by nurses as an entirely natural activity for women is related to the devaluation of emotional labour. The focus of this study is *how* nurses manage their emotional involvement with patients to provide quality services.

The study was conducted in Mthatha in the former Transkei in the Eastern Cape Province with nurses who worked St Mary’s Life Group and the Nelson Mandela Academic Hospital. A qualitative research design and qualitative ethnographic research methodology was chosen as suitable for answering the research question. Data was collected using semi-structured interviews and a focus group, and transcribed verbatim. Data analysis included identifying consistent emotional labour themes in the responses.

The study’s main findings revealed that emotional labour strategies of surface acting and deep acting were utilised as a means of meeting organisational rules established by management of the two health care institutions that were investigated. Nurses understood that only desirable traits like include friendliness, smiling and proving a calming environment for patients should be exhibited. It was revealed that nurses often used sentimental work and emotion work in performing their tasks as this made their work easier. Lastly, the research revealed that external factors like overcrowding and shortages in personnel, accompanied by the emotional demands on nurses’ work has adverse effect on nurses work environment. The dissertation has contributed to the limited body of knowledge about emotional labour in the South African context and the lived experiences of nurses deploying their labour to patients.

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# INTRODUCTION

The impact of emotions on organisations and more especially, on nursing has found interested amongst researchers in recent years (Mann, 2005; Staden, 1998; Wolkomir and Powers, 2007; Zapf, 2002; Fisher, 2009; Hayward and Tuckey, 2011; Bolton 2001; Allan and Barber, 2005, Wharton and Erickson, 1993). The use of Emotional labour is an attempt by workers to fulfil organisational behavioural norms and expectations. Emotional labour attempts to recognise the manner in which one displays feelings and how this has a strong impact on the quality of service transactions between employees and customers and in the light of this research nurses and patients. New strategies of control have placed Emotional labour at the forefront of the paradigm shift in labour process theories (Ackroyd and Thompson, 1999; Vincent, 2011; Warhurst et al, 2011). These managerial control strategies are intended to manipulate emotions displayed towards organisational interests, such as increasing productivity, profitability and performance. According to Warhurst et al (2011: 124), having a ‘good’ attitude is regarded as a prerequisite for employees by employers, helps them to appropriately manage their own emotions in the workplace and express desirable emotions to clients. In the case of nurses within their labour process, performing Emotional labour is a method of managing their own emotions to ensure that quality service is delivered to the patient.

The term “emotional labour” was coined by Arlie Hochschild (1979; 1983; 2003), based on the experiences of flight attendants and the ways in which they are trained to comply with organisational expectations (feeling rules) so as to express desirable emotions to passengers (Brown, 2010:7). Emotional labour is the “management of feelings to create publicly observable facial and bodily display; emotional labour is sold for a wage” (Hochschild, 2003:7). Emotional labour is typified by three characteristics: face-to-face or voice contact with the public; it requires the worker to produce an emotional state in another, and it allows the employer to regulate some degree of control over the emotional activities of workers through training and supervision. In the nursing labour process, nursing could be understood from an emotional labour perspective as face-to-face and front line contact with patients, managing their emotions

for the benefit of the patient and in accordance with the organisation's rules that they are taught during training.

Hochschild's (2003) emotional labour thesis drew upon Goffman's "dramaturgy" to reinforce the performance element in all interactions. This emphasises that people play roles and try to create certain impressions in the audience for whom the performance is intended. Within the workplace, employees in trying to execute tasks at work and in doing this play multiple roles especially as investigated in nursing emotions at work (e.g. Bolton, 2001; Hayward and Tuckey, 2011; Fisher, 2009). The manipulation of emotions is a requirement of the job as management implements display rules in many organisations. According to Hochschild (2003), these display rules were created by management with a profit motive in mind. Hochschild (2003), however, realised the far-reaching effects of emotional labour like emotional exhaustion and dissociation with true feelings which she termed "emotive dissonance".

In accordance with display rules, nurses are expected to depict desirable traits when interacting with patients. These desirable traits include friendliness, smiling and calming down the fears of patients. These desirable traits are achieved by performing emotion work. Emotion work, according to Zapf (2002: 238), refers to the quality of interactions between customers and clients. The nurse-patient interface is the most pertinent point within the service transaction. The nurse is seen by the patient as a representative of the hospital. The nurse's service or treatment of the patient is, in turn, seen as a representation of the hospital. Emotion work that nurses perform was conceptualised by Strauss, Fagerhuag, Suczek and Wiener (1982) as 'sentimental' work. For example, a nurse working in the paediatric ward may choose to put on a funny voice when addressing children to coax them into taking their medication. As Zapf (2002: 240) states, sentimental work is a secondary task which works hand in hand with the primary task of medical diagnosis and treatment. Emotion work performed in this instance is a means of making the work easier for the nurse and achieves its purpose with regard to the patient.

The performance of emotion work is done during face-to-face interaction or through voice interaction where many employees are required to express suitable emotions as the job requires. Examples of this include the service industry statements for example, that the customer is always considered to be right. Employers change their interaction acumen when dealing with customers in order to always ensure that the client is happy by manipulating their own feelings (surface

acting and deep acting). Through interaction with customers, employees (including nurses) must remain poised and calm even when dealing with aggressive and arrogant patients. The emotions that are expressed during emotion work are meant to influence other people's attitudes and behaviours.

The gendered nature of nursing – involving women doing a ‘woman’s job’ by carrying out ‘women’s work’ – has been widely reported (Bolton, 2005; James, 1992; Lupton, 1998). This dates back to the gendering of emotion and the role that women play in the domestic sphere. The portrayal of emotional care offered by nurses as an entirely natural activity for women is related to the devaluation of emotional labour. Characteristics such loving, nurturing, sentimentality and kindness form the basis of what it is to be a woman in the domestic sphere and form the basis for private reproductive labour. Lupton states that “these ‘feminine’ emotional attributes are often seen as desirable, appropriate and demonstrating a women’s capacity for emotional sensitivity and caring for others” (1998:107). Whilst these ‘womanly virtues’ are seen in private reproductive labour, when commodified in the nursing labour process they form the basis for public reproductive labour as well. Public reproductive labour within the nursing profession is the day-to-day, face-to-face work of caring for the ill and injured. While these tasks are considered to be common knowledge, the unacknowledged and emotional dimension to work includes listening to patients, comforting frightened patients who are about to undergo surgery and providing an essential form of human contact (Nakano, 1992:32). It is no surprise that jobs such as nursing, which hinge on caring and tenderness, are associated with women’s work in a patriarchal society. Yeates points out that “it is this insistence on care as labour, the strong connections between productive and reproductive labour and gendered social relations of welfare that have particular resonance for political economy” (2005:228). This gendering of the nursing profession is reinforced by the images of nursing that still reverberate with that of the caring female, particularly with the prototype of Florence Nightingale.

Within the South Africa context, there has been great fixation on the declining quality standards within the nursing profession. Writers such as Breier (2009:112) argue that the lack of “care” exhibited by nurses is at the centre of the problem. The South African government exerts a great deal of pressure on its workers to adopt Batho Pele (People First) principles to change perceptions of uncaring staff in public hospitals. The White Paper on Public Service of 1997

seeks to introduce a new approach to service delivery, an approach that will put pressure on systems, procedures, attitudes and behaviour within the public service and re-orientate service delivery in the customer's favour (South Africa 1997:12). The image of nurses has changed dramatically, particularly with reference to incidents of patient abuse by nurses and the shortage of nurses in South Africa. This is due to insufficient nurses being trained which has thrust health workers to the forefront of the policy agenda. This said, the nature of services offered in health care in South Africa must be investigated. The focus of this study is on **how** nurses manage their emotional involvement with patients in order to provide quality services.

The present study has four research objectives. The first research objective is to examine the perceptions of emotional labour by nurses. This research objective looks at the way in which emotional labour is understood and interpreted within the nurse-patient interface by nurses. The second research objective is to investigate the nature of expressions of emotional labour at the interface of nurse-patient relationships. This research objective investigates the nature of emotion labour within the nurse-patient relationship and also the intricacies and dynamics that underpin this relationship. The third research objective investigates the training mechanisms that equip nurses in executing emotional labour. This theme examines the training mechanisms that equip nurses to perform their jobs. The fourth research objective explores the effects of emotional labour on nurses' work organisation and their relationship with their patients. This research objective explores the effects of emotional deployment on job satisfaction, fatigue and overall work organisation.

This research hopes to contribute to the limited but growing literature on health workers in the South African context. According to the South African Nursing Council, the nurse-patient ratio is 443:1 in the Eastern Cape, which is of particular interest to this study as it is where the study was conducted. The ratio has a negative impact on the nurse's ability to perform their work and speaks to a greater problem facing this sector such as staff shortages and the condition of public hospitals and the global conditions of work for nurses. The nature of services offered in the private and public healthcare in South Africa are distinctly different and those who offer services in both sectors feel different about the work they perform. Having said that, to get a clearer picture of the nature of emotional labour offered to patients, it is necessary to interview workers from both the private and public health sectors.

The thesis will examine the nurse-patient interface in health care and the use of emotional labour by nurses in the Eastern Cape. *Chapter 1* discusses pertinent theories and concepts that encompass emotional labour and the connection between nursing and emotional labour. *Chapter 2*, provides the perspective in which nurses, who, are the subject of this study, the history of their profession, the legislative framework and the current working conditions. *Chapter 3* discusses the research design. This chapter sets out the aims of the research and the research location. Qualitative, ethnographic research design is identified as the most appropriate in meeting the aims and objectives of the study. Details regarding the sampling methods and the participants are included, the latter in the form of a comprehensive table. The chapter also provides details regarding the semi-structured interviews and the focus group used as data collection methods. *Chapter 4* discusses the findings relating to research objective one and presents the demographic information collected. Chapter 5 presents and discusses the findings relating to research objectives two, three and four. This chapter outlines the intricacies of training nurses, how nurses feel about their work organisation and the nurse-patient interface. These are pertinent areas in the study of the work of nurses and highlight the impact of emotional labour on nurses. *Chapter 6* discusses the research findings of the research in relation to the research objectives and provides recommendations for future research and the nursing profession.

# **CHAPTER 1**

## **EMOTIONAL LABOUR AND NURSING**

### **1.1 INTRODUCTION**

By its nature, health care work is characterised by emotions and is, therefore, a suitable context for an exploration of emotional labour. Emotional labour studies have contributed to an understanding of the crucial role that emotional management plays in healthcare. One of the most researched areas in emotional labour has been the health sector and in particular nursing, in which emotional management is a crucial aspect of their role (Mann, 2005). As caregivers, nurses are expected to provide support to their patients who face difficult and sometimes sorrowful circumstances.

Thus, it is appropriate to begin by setting out exactly what “emotional labour” means. This chapter attempts to provide a clearer picture of the emotional labour concept and all key areas of development in theorising about this concept. The chapter attempts to investigate the manipulation of feelings by nurses in response to their occupational norms in their interaction with patients. It begins by providing a definition and conceptualisation of emotional labour. It then provides a synopsis of the emotional labour argument, briefly covering all pertinent arguments and concepts. This chapter provides all critical concepts to this study.

### **1.2 EMOTIONAL LABOUR: A PORTRAIT OF CURRENT THEORETICAL PERSPECTIVE**

While the idea of emotional labour originated from Hochschild (1979; 1983; 2003), since then researchers have differed on the conceptualisation of emotional labour in attempting to provide a

fundamental understanding of how emotions are regulated and managed in response to organisational rules. A general distinction exists between two distinct theoretical approaches of emotional labour, one being job-focused and the other being employee focused (Brotheridge and Grandey, 2002; Zapf, 2002). According to Brotheridge and Grandey (2002:18), job-focused emotional labour represents the level of emotional demand. The second, employee-focused emotional labour represents the employee process or experience of managing emotions to meet work demands. Job-focused emotional labour looks at the emotion regulation process when one attempts to modify expressions to meet work demands (Hochschild, 1983; Grandey, 2000; Brotheridge and Grandey, 2000). In exploring the use of emotional labour among nurses within the nurse/patient relationship, this study adopts an employee focused emotional labour theoretical framework to propose how employees modify expressions to meet organisational demands.

### **1.2.1 HOSCHSCHILD'S CONCEPTUALISATION OF EMOTIONAL LABOUR**

The term 'emotional labour' was coined by Arlie Hochschild (1979; 1983; 2003) in her groundbreaking dramaturgical perspective on the emotional interchange between flight attendants and passengers. Emotional labour is the "management of feelings to create publicly observable facial and bodily display; emotional labour is sold for a wage" (Hochschild, 2003:7). Emotional labour is typified by three characteristics: face-to-face or voice contact with the public; it requires the worker to produce an emotional state in another; and it allows the employer to regulate a degree of control over the emotional activities of workers through training and supervision (Hochschild, 2003; Smith, 1992). Hochschild (2003) subscribes to a broad definition of emotional labour as most jobs might include aspects of emotional labour:

But most of us have jobs that require some handling of other people's feelings and our own, and in this sense, we are all partly flight attendants. The secretary who creates a cheerful office. The waitress or waiter who creates an atmosphere of pleasant dining, the tour guide or hotel receptionist who makes us feel welcome, the social worker whose look of solicitous concern makes the client feel cared for, the salesman who creates the sense of a hot commodity, the bill collector who inspires fear, the funeral parlour director who makes the bereaved feel understood, the minister who creates a sense of protective outreach but even-handed warmth –

all of them must confront in some way or another the requirements of emotional labour (Hochschild, 2003:36)

While Hochschild (1979; 1983; 2003) admits that most jobs and functions, whether classified as paid or unpaid labour, have emotional labour requirements as shown by the quote above, she does offer some distinction between paid work and unpaid work, stating that emotional labour is for wages and, therefore, has an exchange value. This paid work is what Hochschild calls emotion work. She uses the synonymous terms 'emotion work' or 'emotion management' to refer to these acts which are done in the private context where they have use value. Emotion work in this context is defined as the process of managing and presenting emotions in the private sphere. The emotional work performed by nurses has been conceptualised by Strauss, Fagerhuag, Suczek and Wiener (1982) as 'sentimental' work. Sentimental work, according to Strauss et al (1982: 254), is an element in any kind of work where the object being worked is alive, emotional and the work may be a central feature of that work. Strauss et al (cited in Bolton, 2000: 581) compares "sentimental work" to tender loving care, but stresses that it is not only performed out of humanistic considerations, but also as a means of getting the work done effectively.

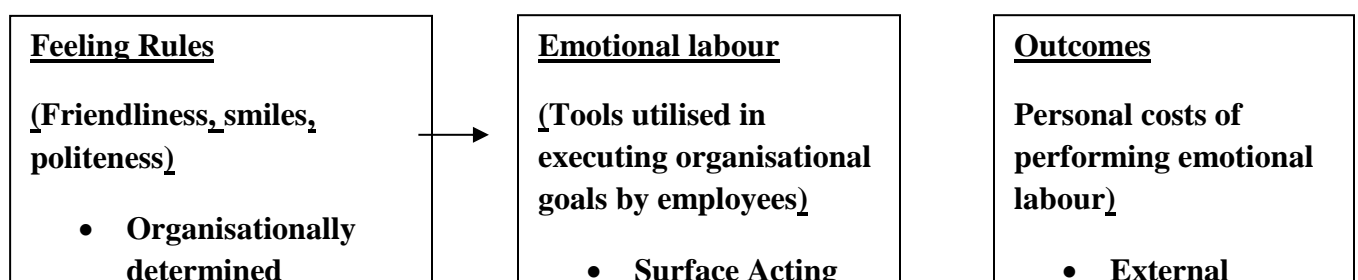
As discussed earlier, Hochschild's (1979; 1983; 2003) emotional labour thesis is based on the experiences of flight attendants and the ways in which they are trained to comply with organisational expectations (feeling rules) so as to express desirable emotions to passengers (Brown, 2010:7). During face-to-face interaction with customers, employees are expected to present appropriate emotions as part of their job. In the nursing labour process, a nurse's work could be understood from an emotional labour perspective as face-to-face and front line contact with patients, managing their emotions for the benefit of the patient and in accordance with the organisation's rules (feeling rules) that they are taught during training. In accordance with display rules, nurses are expected to depict desirable traits when interacting with patients. These desirable traits include friendliness, smiling and calming down the fears of patients in times of anxiety. These desirable traits were achieved by performing emotion work

The theoretical framework that underpins emotional labour comes from Goffman's (1959) dramaturgy (a framework in which any face-to-face interaction can be interpreted as a theoretical

performance) perspective. Goffman (1959) expands the idea of Kenneth Burke – the pioneer of the dramatic approach – and portrays actors as performers enacting rehearsed lines and roles. Goffman’s (1959) analysis of social interaction provides a sociological understanding of emotions and assumes that emotions are actively managed by people according to the rules of a particular situation (cited in Bolton, 2001: 87). Goffman (1959) shows that people in face-to-face interaction do not switch themselves on and off, but glide from one performance to the next, sometimes matching feeling and face with the situation (a sincere face), and others merely maintaining a face (a cynical face), but with an element of their true self present at all times. Within a performance, Goffman (1959) suggests that actors use what is called “traffic rules interaction”, which ensures that actors constantly monitor not only their own conduct but also the conduct of others, thereby sustaining the predictability of everyday life. These traffic rules interactions as mentioned by Goffman (1959) are similar to what Hochschild (2003) terms “feeling rules” that actors use in social interactions with clients.

Hochschild (2003) makes an important comparison between emotional labour and physical labour with the analogy of Marx’s young boy working in the factory and the contemporary flight attendant. The comparison is on the physical effort deployed by the factory worker in undertaking his work and emotional manipulation that the flight attendant utilises in performing her job. Whilst this comparison reflects opposite ends of the labour spectrum, Hochschild (2003) states that “beneath the difference between physical and emotional labour lies a similarity in the possible cost of doing work: the worker can become estranged or alienated from an aspect of self, either the body or the margins of the soul, that is “used” to the work” (Hochschild, 2003: 7). This illustrates that irrespective of the type of labour, the work that workers engage in – be it physical or emotional – is plagued by a form of estrangement from the self. Underlying Hochschild’s (2003) emotional labour thesis is Marx’s concept of alienation as the effect of the emotional labour process on frontline or service sector employees because of management exerting control over labour power. The diagram below explains the process of emotional labour and its outcome.

Figure 1.1 Hoschild’s perspective of emotional labour model



Source: Brown (2010:8).

Hochschild's emotional labour thesis is not without criticism. Hochschild (2003) is criticised by Brook (2009) who states that Hochschild presents an absolutist analysis, whereby all emotions in the workplace are captured for commercial use and that Hochschild conflates emotional labour with physical labour and fails to recognise that workers retain the means of producing emotional labour. By this Brook (2009) means that human agency is unacknowledged and workers, according to Hochschild (2003), are simply rendered powerless. Bolton and Boyd (2003: 293) take this further by stating that Hochschild (2003) over-emphasises the divide between public and private performances of emotional self-management and tends to use the term 'public' and 'commercial' interchangeably, creating an over-simplified dichotomy.

Brook and Boyd's (2003: 293) second criticism of Hochschild's (2003) emotional labour concept are that she equates the physical labour process with the emotional labour process. Hochschild (2003) states that just as workers may become alienated from their physical labour, they may also become alienated from their emotional labour. However, differences emerge in the extent of alienation. Brook and Boyd (2003: 293) compare a factory worker to Hochschild's (2003) flight attendant. They state that the flight attendant, unlike the factory worker, owns the means of production. That this to say that while management determines what 'good service' is by creating customer interaction scripts, it is up to the worker to decide how much feeling is invested in the performance. Hochschild's emotional labour thesis undervalues the spaces of resistance and misbehaviour that the worker can exercise (Thompson and Ackroyd, 1995; Brook, 2009; Bolton and Boyd, 2003).

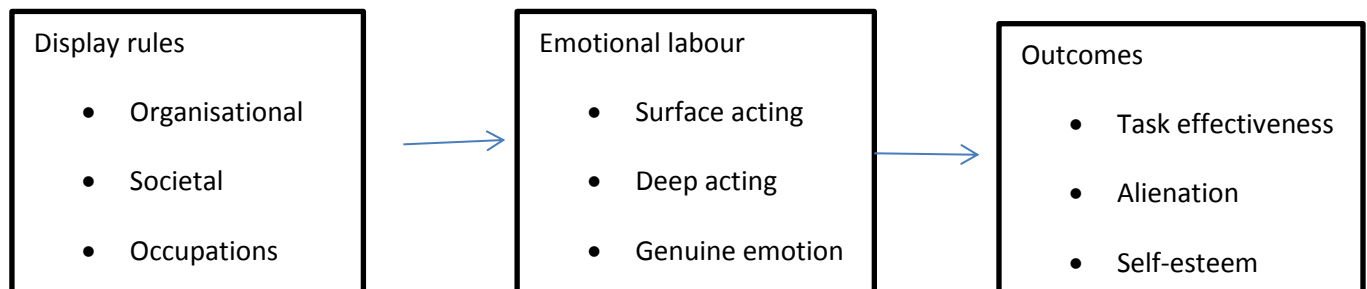
There have been a number of researchers who have tried to develop the concept of emotional labour further, namely Ashforth and Humphrey's (1993) who see emotional labour as observable behaviour, Morris and Feldman's (1996) interactionist model of emotional labour, Grandey's (2000) emotional regulation model of emotional labour and the labour process theory and emotional labour which attempts to explain the emotional labour concept from a Marxist framework. These theories will be discussed below.

### **1.2.2 EMOTIONAL LABOUR AS OBSERVABLE BEHAVIOUR PERSPECTIVE**

Ashforth and Humphrey (1993:90) define emotion labour as “the act of displaying appropriate emotions” with the goal to engaging in the form of impression management. In comparison to Hochschild's (1979; 1983; 2003) perspective, Ashforth and Humphrey (1993) are concerned with emotional labour as an observable behaviour rather than as the management of feelings. Unlike Hochschild (1983) who uses the term 'feeling rules', they use the term 'display rules'. Feeling rules, according to them, refer to what emotions should be publicly expressed rather than what emotions are actually felt. “Because display rules refer to behaviour rather than to internal states, it is relatively easy for customers, managers and peers to observe one's level of compliance with the rules” (Ashforth and Humphrey, 1993: 90). According to Zapf (2000: 243), Ashforth and Humphrey (1993) point out that Hochschild's (1983) definition of emotional labour implicitly presumes that performing emotion work necessarily means applying either surface acting or deep acting. They argue, however, that there are instances where emotions are spontaneous and genuinely experienced by the employee and propose that “a nurse who feels sympathy at the sight of an injured child has no need to act” (Ashforth and Humphrey, 1993: 94). Thus, Ashforth and Humphrey (1993) view the genuine experience and expression of expected emotion as a means of accomplishing emotional labour. Ashforth and Humphrey (1993: 94) believe that emotional labour can increase self-efficacy, that is, that one can successfully fulfil task requirements and task effectiveness. Ashforth and Humphrey (1993) argue that a pertinent consideration should be whether or not emotional labour results are positive or negative on the well-being of the labourer. This rests on the social and personal identity of the employee and how closely they align themselves with the role. Ashforth and Humphrey (1993) see the outcomes of emotional labour as either positive or negative depending on how well the employee

is able to align their identity with their role and conform to display rules. According to Grandey (2000: 96) as well as Ashforth and Humphrey (1993), the emotional labour theory downplays the importance of the internal management of emotions through surface acting and deep acting. They suggest that a broad array of factors effects emotional expression. Grandey (2000:96) further states that Ashforth and Humphrey (1993) focus mainly on the relationship between observable expression and task effectiveness or performance.

Figure 1.2: Model based on Ashforth and Humphrey’s (1993) theory of emotional labour



Source: Santo (2012:35).

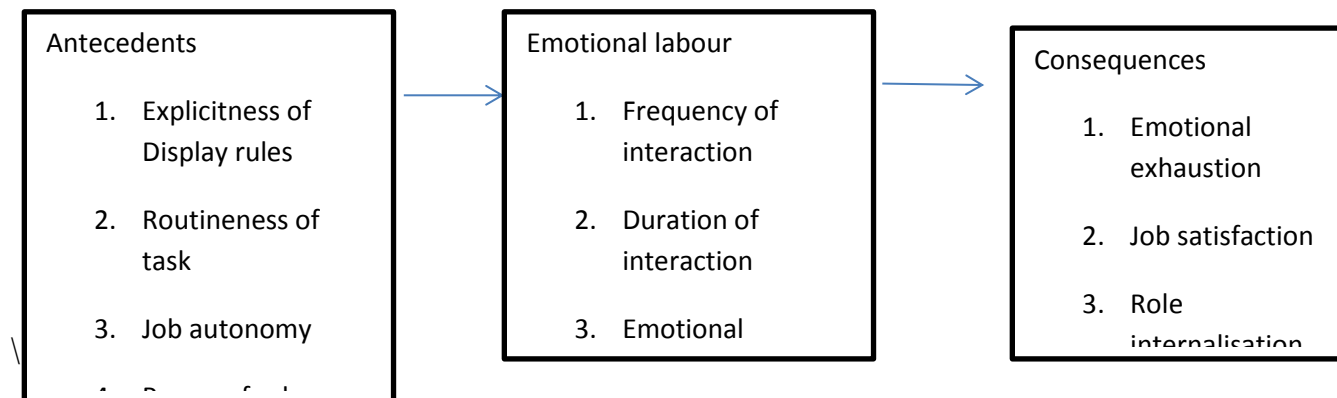
### 1.2.3 INTERACTIONIST MODEL OF EMOTIONAL LABOUR

Following Ashforth and Humphrey (1996), Morris and Feldman published their theory of emotional labour in 1996. Morris and Feldman define emotional labour “as the effort, planning, and control needed to express organizationally desired emotions during interpersonal transactions” (1996:987). Morris and Feldman (1996) argue that emotional labour is multi-faceted and is based on the interactionist model. This theory is focused on expressive behaviour rather than the management of emotions. The definition has four tenets. Firstly, it is embedded in the interactionist model of emotion. “This perspective suggests that individuals make sense of emotions through an understanding of the social environment in which the emotions are experienced: this approach, then suggests that emotion is at least partly socially constructed” (Morris and Fieldman, 1996: 988). Secondly, they argue that in every situation whether there is congruence between felt emotions and organizationally desired emotions, individuals will always exert some effort required in expressing emotions. “Thus, we argue that Wal-Mart greeters who experience emotional congruence between their own felt emotions and

the emotions required by the job still have to expend some effort ensuring that the felt positive emotion is actually displayed in a desirable form.” (Morris and Feldman, 1996:988). Thirdly, they also see the commercialisation of emotional labour as being consistent with Hochschild’s (2003) original notion of emotional labour. Unlike Hochschild’s (2003) focus on the management of feeling, this theory focuses on expressive behaviour because it is appropriate expressive behaviour that is organizationally desired (Morris and Feldman, 1996: 988). Lastly, this definition proposes standards or rules that dictate how and when emotions should be expressed. This emotional labour construct has four constructions: frequency of appropriate displays, attentiveness to required display rules, the variety of emotions to be displayed and emotional dissonance.

This theory does not specifically address surface acting or deep acting, although they acknowledge both surface acting and deep acting as ways in which people could manage their emotions. These researchers believe that the main focus should be on appropriate expressive behaviour because that is what organisations desire. Morris and Fieldman (1996) argued that emotional dissonance should be considered a dimension of emotional labour because it is the mismatch between felt and displayed emotion that requires greater control, effort and skill for people to display the required emotion. Morris and Feldman’s (1996) emotional labour model depicts emotional labour as a multi-dimensional construct and provides additional ways to measure emotional labour other than simply measuring frequency in displays. Below is their model of emotional labour

Figure 1.3: Model-based Morris and Feldman (1996) interactionist model



Source: Morris and Feldman (1996:260)

#### **1.2.4 EMOTIONAL REGULATION MODEL OF EMOTIONAL LABOUR**

Grandey (2000) seek to combine the situational focus of Morris and Feldman(1996) experiences of emotional labour together with central views of surface acting and deep acting (Ashforth and Humphrey,1993; Hochschild, 2003) as emotional labour mechanisms by which emotional labour display rules demands are met. Emotional regulation, according to Grandey (1998:275), refers to the process by which individuals influence the emotions they have, when they have them and how they experience and express these emotions. Grandey (2000) that that Gross (1998b) model for emotional labour may be useful as an emotional labour subject. “In this input-output model, individuals receive stimulation from one situation and respond with emotions” (Grandey, 2000:98), Grandey’s (1998:275) theory says that emotional regulation may be automatic or controlled, conscious or unconscious. Grandey (2000:98) states that with Gross (1998) model of emotion regulation, which emotion regulation can occur at two points: antecedent-focused and response focused.

With antecedent-focused emotion regulation, the individual can regulate emotions at two points. The first entails participating and preparing for an emotionally stimulating events prior to exposure. Conversely, response-focused regulation entails the individuals suppressing or modifying their emotional response once the stimulus has been received. Gross (1998) further divides antecedent-focused emotion regulation into four categories: situation selection, modification, attention development and cognitive change.

Grandey (2000) sees that emotional labour process as being contingent upon antecedent variables such as frequency, duration, and the variety of interactions. Grandey’s (2000) model suggests individual and organisational factors as having a direct impact on whether surface acting or deep acting are utilised as emotional labour strategies. The individual factors considered are gender, emotional expressivity, emotional intelligence and the effective tendency of the individual. Organisational factors include sources of social support and the level of job autonomy. Grandey (2000) sees that individual outcomes such as burnout and job satisfaction as being closely dependent on whether surface or deep acting are used as emotional labour strategy.

#### **1.2.5 LABOUR PROCESS THEORY AND EMOTIONAL LABOUR**

Braverman's (1974) *Labour and Monopoly Capital* serves as the basis for the labour process theory. Like Marx, Braverman (1974) argues that since workers cannot be relied upon to work in the interest of capital, then control is necessary for capital to realise the full potential of the labour it employs. "Specifically, Braverman (1974) argues that the desire for profit determines the organisation of a capitalist labour process, and in particular the tendency for labour to become progressively fragmented and deskilled, and for the work of conception (mental labour) to be separated off from the work of execution (manual labour)"(Reid, 2003:560). This idea of the separation of manual labour and execution became what is known as scientific management, the distinction between design and execution of tasks.

The labour process theory stems from the idea that human effort is essentially indeterminate; therefore, managers are faced with the problem of reducing these uncertainties to secure continued profitability (Vincent, 2011: 1374). Many have pointed to new employment strategies of control that have placed emotional labour at the forefront of a paradigm shift in labour process theories (Warhurst, Van der Broek, Nickson and Hall, 2011; Vincent, 2011). The control imperative suggests that managers use authority to redefine work processes in an effort to achieve "higher interests" (Ackroyd and Thompson, 1999; Vincent, 2011; Warhurst et al, 2011). These managerial control strategies are intended to manipulate emotions displayed towards organisational interests such as increasing productivity, profitability, and performance. According to Warhurst et al (2011: 124), having a good attitude is regarded as a prerequisite of employees appropriately managing their own, as well as the customer's emotions. The Labour process theory highlights some constant control and surveillance by management of the work process and worker. According to Chong (2009:30), control of emotional labour by management is achieved through a display of emotional regulation strategies such as deep acting. Hochschild (2003:89) states that

*When rules about how to feel and how to express feeling are set by management, when workers have weaker rights to courtesy than customers do, when deep acting and surface acting are forms of labour sold, when private capacities for empathy and warmth are put to corporate use, what happens to the way a person relates to her feelings or to her face? When worked-up warmth becomes instrument of service*

*work, what can a person learn about herself from her feelings? And when a worker abandons her work smile, what kind of tie remains between her smile and herself*

Hochschild (2003) in this instance points out how emotion work, as use value enters the marketplace and is transformed into exchange value and sold for a wage in the form of emotional labour (Mclure, 2007:106; Marx (1976). He suggests that all commodities have what is known as a use-value and an exchange value. “Objects produced by oneself or by other people in an immediate environment, which are personally controlled and consumed to sustain life have use value” (Mclure, 2007:106). In contrast, objects created for someone else rather than oneself or enters the market and is used for monetary gain, have an exchange value. In the section titled *Hochschild conceptualisation of emotional labour* the dichotomy that exists between emotion work (unpaid labour) and emotion labour (paid work) is clarified. This has created an illusionary dichotomy of private and public use of emotional labour as the distinguishing characteristics; yet there is Marx’s conceptualisation of emotional labour having exchange value.

Bearing this in mind, Chong (2009:30) states that, emotional labour needs to be understood within the production process. It is the function of management, through its hierarchy of control, to turn the workers’ capacity to work into actual productive activity and facilitate the extraction of surplus value (Reid, 2003:564). Chong (2009:26) found that in Hochschild’s emotional labour thesis, workers’ identity is produced and consumed as part of the production of surplus value. Also that is it not just the production of the worker as “woman” that is being consumed in the nursing labour process , but what is perceived to be consumer desire for performance of “traditional” feminine traits. This is achieved through the performance of emotional labour.

Marx (1844: 88) states that “labour not only produces commodities, it produces itself and the worker as a commodity and it does so in the same proportion in which it produces commodities in general”. The process of commodification is the building block on which the worker’s alienation starts, and the worker is not only alienated from the product he or she produces, but also from his or her labour. Through this process of alienation, the object that labour produces stands opposed to the labourer like something alien to him or her. The labourer, through the production process, is embodied and made material some material object. Marx (1844:88) states that ”in the sphere of political economy, this realisation of labour appears as a loss of reality for

the worker, objectification as a loss of and bondage to the object, and the appropriation as estrangement, as alienation”.

By understanding emotional labour from a Marxist framework that studies the processes that leads to commodification— whereby labour power in the form of one’s emotions is sold for wages in the public sphere – emotions come under the control of the purchaser. According to Hochschild (2003: 118), the process of the work of labourers being sold to management is termed “transmutation”, “The commercialisation of emotions is dependent on three elements according to Hochschild (2003:118): emotion work, feeling rules and social exchange. Firstly, emotion work is no longer a private act but a public act, which is bought and sold. The display work within emotion work is managed and directed by managerial manuals and staff handbooks that employees are taught during entry into the organisation. This is done so that the employers can be assimilated to the culture of the organisation. “Thus, control is disbursed through teams, work-related ‘self-empowerment’ schemes, organisational norms, etc. with the goal of having worker seemingly identify with the customer, when the real goal is to have the workers identify with the company’s interest” (Chong, 2009:30-31). Secondly, feeling rules are no longer simply matters of personal discretion, negotiated with another person in private, but are spelt out publicly in training programmes and in the discourse of supervisors at all levels (Hochschild, 2003:118). Thirdly, ”social exchange is forced into narrow channels; there may be hiding places along the shore, but there is much less room for individual navigation of the emotional waters” (Hochschild, 2003:118).When feeling rules are not negotiated by private partners, but are instead negotiated through company manuals within the public domain of work this affects worker. The cost, however, of the commercialisation is on the workers’ identity. The worker, through the acceptance of display rules dictated by management, gives up control over *how* the work is done. Essentially the worker loses expressive control of how the work is done and is restricted to implementing standard procedure.

Thus having set out the emotional labour framework and theories that build on the theory in the sections above, it is important to mention the dimensions of emotional labour namely, feeling rules, surface acting, deep acting and nursing. The next section deals with that.

### **1.3 DIMENSIONS OF EMOTIONAL LABOUR**

### **1.3.1 NURSES AND FEELING RULES**

The concern in the emotional labour thesis is to show that emotions are subject to acts of personal management, acting in accordance with implicit “feeling rules”. The latter, as defined by Hochschild (2003:268), are “a set of shared, albeit often latent, rules” or situational guidelines that help match the expected emotion of a particular situation in carrying out emotion work. According to Erickson and Wharton (1993:461), display rules may be explicit or these rules may be informal in norms that have been learnt through socialisation and are common practice in society. Highly formal display rules can be seen in the service industry where it is explicitly known that friendliness and smiles are part of the job and these are outlined in training manuals by management. In Hochschild’s (2003) emotional labour thesis, flight attendants learn implicit display rules during training. These feeling rules are imposed by management on emotional labourers to ensure the delivery of the necessary quality of customer service. The rules, according to Brook (2009: 12), dictate the form, content and appropriateness of emotional displays, thereby separating workers from the design and the control of the labour process, since both design and control are informed by management practices.

Feeling rules or display rules set by management are part of the employers’ effort to shape workers’ emotions and emotional displays. The control by management of the feeling rules manifests in demanding behavioural compliance from emotion labourers in the form of surface acting and deep surface acting (Hochschild 2003:35). This often entails reinforced statements like “don’t bring your problems to work” echoed by management to staff. These statements reinforce a culture of emotional manipulation so as to ensure that implicit feeling rules are followed. Acts of emotion management are not simply private acts; they are used in exchanges under the guidance of feeling rules in organisations. In manipulating their emotions, workers are forced to engage in surface acting and deep acting where they mask or hide their feelings so as to sustain an outward impression to meet the organisational behavioural norms. In nursing, there are organisational policies of how to behave with patients, there are also societal norms and expectations of how professionals should behave. Being gentle with a patient could improve his/her compliance with treatments, reassuring an anxious patient may reduce the risk of pain from complications.

In dealing with pain and suffering on a daily basis nurses need to manage the intimate and emotional nature of their relations with patients (Allan and Barber, 2005; Sloan, 2012; Wharton and Erickson, 1993). “These emotions and the nature of intimacy may be different depending on the context of the clinical encounter” (Allan and Barber, 2005:392). Nurses in these instances use emotional management strategies. Wharton and Erickson (1993:458) define emotional management “as the self-regulation of emotional exhibition for the purpose of producing intended effects on others’ minds”. The nature of the task often dictates the level of emotional management that nurses need to utilise. Some clinical areas require greater emotional deployment than others due to the nature of patients being serviced. For example, a nurse who works in a paediatric unit may deploy more emotions into her service than a nurse working in the surgical unit. The emotion management strategies that nurses utilise are referred to as surface acting and deep acting, in the subject of the next section.

### **1.3.2 NURSES: SURFACE ACTING AND DEEP ACTING**

Hochschild (2003) argues that service employees perform emotional labour in trying to meet organisational demands in one of two ways: surface acting and deep acting. First, he or she (the emotional labourer) must comply with display rules through surface acting. Surface acting involves managing the expression behaviour rather than feelings, and by this is meant managing facial expressions and bodily displays that may give away the true feelings of the labourer rather than the feeling they intend to foster in the other. This is accomplished by the careful presentation of verbal and non-verbal cues such as facial expressions, gestures and tone of voice in such a way that the customer/person knows that employees are only acting (Ashforth and Humphrey, 1993: 92). The flight attendant uses surface acting by being polite and smiling to calm down the anxiety of first-time flyers or even when the flight experiences turbulence and some passengers are scared.

However, Ashforth and Humphrey (1993:92-93) state that discrepancies may exist between what is genuinely felt and what is displayed. “Such discrepancies may occur because various facts may impede the agent from feeling the emotions that he or she genuinely wants to display” (Ashforth and Humphrey, 1993:93). However, according to Zapf (2002: 243), there are instances that while these discrepancies exist, emotions are spontaneous and genuinely felt. He terms this automatic emotion regulation. If an emotion is genuinely felt, then the expression of it is

automatic and without thought. For example, when nurses feel sympathy for a patient whom might be ill or on their deathbed, the expression of this emotion will not be rehearsed or acted out.

When nurses perform emotion work, the desire to feel certain emotions does not automatically mean the performance of emotional labour will always be successful since there may be many occasions where people are unable to genuinely feel certain emotions. The negative consequences of emotional labour manifest in themselves instances. Hochschild (2003) describes various psychological consequences of emotion work and posit that emotion work is a special far-reaching form of human exploitation which even affects the workers' personality. In these cases, the performance of emotional labour or employees who play multiple emotional roles has negative consequences and could lead to emotional dissonance (Mann, 2005; Wharton, 1993). According to Zapf, "Underlying was a one-dimensional concept in emotion work: the more interaction with clients, the higher the frequency of emotional display, the more often emotions have to be shown which are not felt and consequently the most negative are health outcomes"(2002: 241). Hochschild (2003) maintains that showing emotions not felt in a given moment would lead to the alienation of one's true feelings. This will be discussed in a later section.

Different to the work offered by Zapf (2002), is the notion derived from Goffman's (1959: 139) work is on the self's ability to be multiple selves. This refers to the ability of the self to manage different roles during interactions. Multiple selves as created by the performer can lead to problems (tensions between different selves), a dynamic shift between roles, or a multiple presentations of selves (as well as coping mechanisms to deal with these discrepancies). Under normal circumstances, however, people are capable of handling these multiple, fluctuating, situational selves. The multiplicity of selves is also clear from the use of role-distance. Role-distance refers to the degree to which people separate themselves from the role they play (while they are playing it) (Goffman, 1959:140). People play roles in a double fashion: they enact the role and distance themselves from it.

The second means of complying with display rules is through deep acting, where the actor attempts to experience the emotion displayed. Ashforth and Humphrey (1993, 93) state that this is when an individual uses their imagination in experiencing the desired emotion. Hochschild

(2003) discusses two methods for deep acting: firstly, through exhorting feeling, whereby one actively attempts to evoke or suppress an emotion and secondly through trained imagination, whereby one actively invokes thoughts, images, and memories to induce the associated emotion (for example, thinking of a death to make you feel sad). According to Hochschild (2003:28), the distinguishing feature of these two approaches is that one is directly exhorting feelings while the other is making indirect use of trained imagination.

Emotional labour in the health settings involves assessing strategies of emotional regulation available to nurses. This includes analysing how nurses manage their own and their patients' emotions, and how nurses come to terms with difficult processes – such as delivering bad news and dealing with fatalities – that are often an unavoidable part of the nurse-patient interface.

#### **1.4 EMOTIONAL LABOUR AND NURSING**

Emotional labour is an important part of the healthcare profession, and more so within nursing (Mann, 2005; Bolton, 2005). The emotional labour concept attempts to acknowledge the tremendous emotional effort and human flexibility of nurses in their daily encounters with the patients they care for (Huynh et al, 2008: 196). Some writers, such as Bolton (2000), Brotheridge and Grandey (2002) and Mann (2005), have highlighted the importance of emotional labour in the delivery of healthcare and its importance to the patients who receive it. Due to the precarious nature of the healthcare system, nurses sometimes feel that they need to engage in emotional labour to ensure that their emotional displays match patient or social expectation (Mann, 2005). For example, interactions with angry, hostile or uncooperative patients, who are emotionally charged, demand for nurses to suppress or alter their emotions.

Various studies highlight the importance of a nurse's ability to manage emotion and to present the desired demeanour in healthcare settings. For example, Bolton (2001: 86) describes nurses as “emotional jugglers”, who are able to match their emotions with their appropriate situations, and who, through emotional juggling, are able to elicit feelings of safety and comfort in patients. Gray and Smith (2008: 259), in their study of emotional labour and clinical settings in nursing care, found that emotional labour was stereotypically portrayed as feminine, and wrapped up as part and parcel of “women's” work. Emotional labour performed by women – such as nursing – has traditionally been identified as women's work and the mother's role in the family (Gray,

2009; Bolton, 2000; James, 1992). The portrayal of emotional care as an entirely natural activity for women is related to the devaluation of emotional labour in cultural, gender, and economic terms. The natural “feminine” emotional attributes are often seen as desirable and appropriate, demonstrating a women’s capacity for emotional sensitivity and ability to care for others (Lupton, 1998:107).

It is no surprise that jobs such as nursing, which hinge on caring and tenderness, are associated with ‘women’s work’. In his study of nursing the terminally ill, James (1989: 20) concludes that emotional labour could be productive, hard work and at times even sorrowful, but that this is a vital part of nursing work which nonetheless remains undefined and undervalued due to its link with women’s natural domestic caring roles. Similarly, Bolton (2000: 580) states that the term “labour” used in conjunction with emotion emphasises the caring aspect of nurses’ roles, which can be hard and productive work, similar to physical labour, and, therefore, should be equally valued.

The emotion work performed by nurses was reported by Gray’s (2008) participants in his study as making contact easier within the nurse-patient interface. Emotion work that nurses perform was conceptualised by Strauss, Fagerhuag, Suczek and Wiener (1982) as ‘sentimental’ work. Sentimental work, according to Strauss et al (1982: 254), is an element in any kind of work where the object being worked on is alive and where sentiment and people’s reaction to that sentiment and labour may be a central feature of that work. Strauss et al (cited in Bolton, 2000: 581) compare “sentimental work” to tender loving care, but stress that it is not only performed out of humanistic considerations, but also as a means of getting the work done effectively. This emotion work helps the patient manage disclosures of a sensitive or emotional nature (Gray, 2008:170). Therefore, emotion work increases information sharing as well facilitating in creation a symbiotic relationship between nurse and patient. This symbiotic relationship facilitated by emotion work speaks to the need to treat patients as “individuals”, who deserve dignity and respect, as emphasised by the law and Batho Pele initiative in the South African legal context and contributes to a more liberal and enlightened form of patient care, in which individuals are treated in a “holistic manner” rather than being constituted as objects or “things” specified in terms of a clinical identity (May, 1992:482). According to Gray (2008:169), the therapeutic potential of nurses’ interpersonal involvement with patients is certainly a central feature of

nursing. In Gray's (2008:170) study of emotional labour of nursing, the emotion work was reported by nurses as a chief part of the nurse's role in making patients feel "safe", "comfortable" and "at home". Based on these assertions, there is an acknowledgement of the importance of emotional labour in providing care to patients. According to Mann (2005:307), nurses perform emotional labour within the nurse-patient interface, not because of prescribed display rules but rather to offer authentic caring behaviour because they feel that it is a desirable skill for their job/role and because they derive satisfaction from doing so.

## **1.5 NURSE-PATIENT INTERFACE**

The nurse is a pivotal figure in patient care and provides most of the care that are needed. McQueen (2000: 724) states that the provision of care demands good interpersonal skills to form a therapeutic relationship with patients and to communicate effectively with relatives and other health professionals. This relationship involves work and skills on the part of the nurse. Importantly, one of these skills involves emotional management. Emotional management is a vital and necessary skill in the nursing profession, and this is because emotional management is the regulation of feelings in order to modify emotional expression. According to McQueen, "the main aim of emotion management is to facilitate the best possible outcome for patients" (2004:104). Generally, emotions are managed in response to the display rules for the organisation or job (Goffman, 1959; Hoschild 2003). The shift in a patient and nurse relationship can be categorised as a move away from a directive approach of "caring" for patients to a wide interpretation, embracing the concepts of caring for and caring about patients. This new perspective is known as the new nursing approach (Savage, 1995; McQueen, 2000)

Nurse-patient interaction can be conceptualised through Goffman's (1959) theory of dramaturgy. Goffman's (1959) analogy of social action as performance is a useful way of describing how actors manage themselves as social actors and more especially for this research, how nurses according to Bolton (2001:89), work hard to manage their emotions in administering care to patients. Using a Goffmanesque analysis, Bolton (2001), in her study of nurses as emotional jugglers, presents what is called the 'professional face'. "The presentation of the professional face requires a combination of contradictory elements – caring whilst remaining distant" (Bolton 2001: 90). The idea of caring whilst remaining distant is necessary for the nurse in administering care as this is a method for the nurse to come across as professional but not getting personally

involved. The nurse creates distance between herself/himself as means of not losing control in the relationship as she/he must exhibit superiority and professionalism. The nurses' need to distance herself/himself from the patient has created a debate about whether or not nurses form relationships with their patients, some believing that nurse-patient relationships are dangerous to this position of power that the nurse holds. With this in mind, Shattel found in "patients nurse-patient relationships believed that these relationships were therapeutic, nurses frequently expressed doubt about the value of their relationship with patient" (2004:717).

The idea of caring whilst remaining distant is similar to what Goffman (1959) describes as role distancing. Role-distance refers to the degree to which people separate themselves from the role they play (while they are playing it). People play roles in a double fashion: they enact the role and distance themselves from it. Role-distance is a function of social status: people in low-status roles are more defensive in their role-distance (ashamed of their role). To achieve role distancing the nurse utilises surface acting and deep acting by masking feelings to remain unattached and, as Bolton (2001: 92) found in his study, nurses are aware that they must actively work on their emotions in the name of professionalism. The idea of remaining professional by distancing oneself from the patient, as articulated by Bolton (2001), is a barrier that fosters the view that the nurse is unemotional, cold and authoritative. Opposed to this view, writers such as McQueen (2000) and Shattel (2003) state that this view of distancing oneself from the patient does not encourage open communication between nurse and patient and, as a result, patients' psychological and emotional needs are not met or catered for. McQueen (2000: 724) states that a closer relationship is encouraged between professionals and patients.

Much of the research on nurse-patient interaction focuses on the nurse's manner of communication when interacting with patients and the nurse's role of power in the relationship (Shattel, 2004; McQueen, 2000). The patient freely gives up power to the nursing professional because he or she has specialised knowledge that the patient does not; and the professional, in this instance the nurse, is willing to accept power. The assumption can be made that within this context, the patient is viewed as being without autonomy or agency. However, Shattel (2004:716), disagreeing with this model of viewing the patient as lacking autonomy or agency asserts that, in an act of agency or resistance, the patient might interrupt the nurse by actively wanting more attention or care than is given. Jewkes, Abrahams and Mvo (1998:175), in their

research on why South African nurses abuse patients, found that the method of resistance used by patients to challenge power relations in the health setting was used by patients to restore a sense of self-respect and personhood. One respondent in the study was quoted as saying: “we are supposed to accept it because that is beneficial to us ... if a person can be cheeky to the nurses and go home (refusing to attend again) she would be digging her own grave, not the nurses”. Ultimately, what might be inferred from this passage is that resistance was ultimately not beneficial. In such acts, the passive, accepted role adopted by patients in previous years is replaced by a more active, questioning approach, reflecting social change and a greater awareness of health issues (Shattel, 2004:716).

## **1.6 GENDER, SEX AND NURSING**

In many different cultures, being female is associated with the care of others (Lupton, 1998; Ceci, 2004; Badgett and Folbre, 1999). This may fall within the private realm or within the public realm of work. It is essential to provide a definition of sex and gender. “Sex’ is a word that refers to the biological differences between male and female, this includes visible difference in genitalia, the related difference in procreative function” (Oakley, 1985:16). Simply put, sex is the biological genitalia that one is born with. “Gender, however, is a matter of culture, it refers to the social classification into “masculine” and “feminine” (Oakley, 1985:16). An example to illustrate this is, you can be a male but have feminine traits or you can be female and have masculine traits like body language and a general masculine disposition. According to Delphy (1993, 3), psychological differences between the sexes are due to social conditioning. “Gender norms governing interpretation of appropriate behaviour for women and men are closely linked to socially constructed conception of familial altruism and individual self” (Badgett and Folbre, 1999:311). According to Lupton (1998: 105), gender is performative in nature. That is to say, that gender is linked to one’s socialisation and goes beyond one’s inscribed sex: “it is not simply a matter of adopting male or female ‘sex role’ and adhering to it throughout one’s life span, but rather that of a project constantly taking up different masculinities and femininities” (Lupton,1998: 105). The performative nature of gender reveals itself in the manner in which we dress, walk and speak. The gendering of self-has also brought about discussions around the gendered notions of emotions. Discussions has centred on the way in which women feel and express emotions in comparison to men. This has created a binary discussion between what is

called “the emotional woman” and the “unemotional man”. This notion of men being less emotional than women has always been at the centre of the discussion between these labouring individuals when it comes to care and about who is better suited for its provision and administration. The image of women as better suited for caring has permeated most organisations with regard to what they consider to be better emotion managers. This leaves women in the bottom of hierarchical structures as they are only considered for jobs where they can care for people .Acker (1990: 143) states that this is due to masculine rationality of managers. In the early image of managers a ‘masculine ethic’ of rationality and reason can be identified. This masculine ethic elevates the traits assumed to belong to men with education advantages. It requires a tough-minded approach to problems, the ability to abstract and plan, a capacity to set aside personal, emotional considerations in the interests of task accomplishment and a cognitive superiority in problem solving and decision making (Kanter, 1997, cited in Acker, 1990: 143). With men, traits such as being seen as "tough" are considered attractive while for women these emotions are considered unattractive.

Feminist scholars have often emphasised that caring and nurturing is an integral part of women’s identity and that women undertake these roles, whether in the private or public sphere, to fulfil their true feminine essence (Poole and Isaacs, 1997; Yeates, 2005). These professions often hinge on the supply of social reproduction duties like care and nurturing and the demand for is reproduction, in nurses (which are often female) and the ability to deploy these skills in helping the sick. Seen in this lens, it is no wonder that caring in general and nursing, in particular, are devalued and merely seen as women’s work as these professions are linked to women’s social reproduction in the private sphere. Feminist scholars have also emphasised social reproduction in capitalist societies, where women are segregated into lower paid jobs in the services industry, where their ‘true womanly virtues and skills’ might be used. Feminists, according to Yeates (2005: 228), have emphasised a close relationship between non-wage and waged labour: the work women undertake in the public sphere often mirrors that which they undertake within the private sphere and it is no wonder that there is a large concentration of women in childcare and work with the disabled.

In the dramaturgical perspective of emotional interchange between flight attendants and passengers, Hochschild (2003) points out that the majority of flight attendants are women who

are more involved in emotion work than their male counterparts, in which they are expected 'to enact two leading roles of womanhood: the loving wife and mother (serving food and tending to the needs of others) and the glamorous "career women"' (dressed to be seen, in contact with strange men, exhibiting a professional and controlled manner) (Hochschild, 2003: 175). The dichotomy that exists for the flight attendant may also exist in nurses, who not only enact the loving mother (by tending to the needs of the sick) but also the firm, unemotional nurse who does not flinch when faced with emotional cases. This is linked to the perceived idea of gendered emotions. Socially it is perceived as typical and more appropriate for women to show emotions rather than men to express emotions such as grief, fear, sentimentality and vulnerability, envy and jealousy (Lupton, 1998; Badgett and Folbre, 1999). These feminine emotional attributes are seen as demonstrating woman's capacity for emotional sensitivity and caring for others.

One cannot begin to discuss gendered emotions without looking at sexual division of labour as this is integral to the discussion of gendered emotions.

### **1.6.1 SEXUAL DIVISION OF LABOUR**

The work that women do in the sexual division of labour is domestic. Domestic work contributes to reproduction of the labour force and daily maintenance (Katz, 2001; Beneria and Sen, 1981). "It is linked with the market both by way of what it purchases and by what it provides the commodity of labour power that is exchanged for wages" (Beneria and Sen, 1981: 292). In most households the work done by women is unpaid. According to Katz (2001: 711), social reproduction encompasses daily activities that add to the means of production and the labour-power to make society work. "At its most basic, it hinges upon the biological reproduction of the labour force, both generationally and on a daily basis, through the acquisition and distribution of the means of existence, including, food, shelter, clothing, and healthcare" (Katz, 2001: 711). This means that the activities that take place at home (domestic work) in the form of general upkeep of the home contribute to the reproduction of the labour force. Social reproduction attempts to provide links between the household and the state. It also attempts to value the activities of unpaid domestic labour at the forefront of the reproduction of labour power in a capitalist society.

This means that reproduction, which refers to those activities that reproduce people over time, particularly caring and nurturing activities performed by women, has the ability to produce healthy, social, adept labouring bodies who contribute to the accumulation of profit in the capitalist society (Beneria and Sen, 1981: 292). This means that there exists a connection between the spheres of production (the domestic sphere and the work undertaken by women) and reproduction (which is the public sphere -where men are typically seen as wage labourers). This connection calls into question the position of women in the labour market.

Women's precarious position in the labour market is bound with the gender division of labour in the family. Women's subordinate position within the family and the sphere of reproduction position can be seen as both cause and effect of this gender division of labour. Within the gender division of labour in the nuclear family structure, a male breadwinner and female homemaker are used as the gender roles that each sex must fulfil, based on the idea that a woman's place is in the home and is economically dependent on the male breadwinner without acknowledging domestic labour (performed by women) and how greatly this contributes to the supply of labour in the labour market. Social reproduction and production in the labour market depend on women's unpaid labour in the home. "The separation between the process of production and that of social reproduction of labour implied that the division of labour between men and women took new forms and shaped new power relationships within the traditional context of women's subordination" (Picchio, 1992: 11). Women's subordinate position in the sexual division of labour is further devalued when they become employees in caring occupations like nursing that are typically pay less than most jobs. Acker (1990: 70) says that this is due to the gendered concept of work and jobs. "The concept of 'a job' is thus implicitly a gendered concept, even though organisational logic presents it as gendered neutrality. 'A job' already contains the gendered-based division of labour and the separation between public and private spheres. The concept of 'a job' assumes a particular gender organisation of domestic life and social reproduction. This reveals how gender is now constructed in part through work (Chong, 2009: 15). It is important to discuss the idea of care and the links to the sexual division of labour.

### **1.6.2 CARE AND THE SEXUAL DIVISION OF LABOUR**

Care, as performed by women, takes place in the domestic sphere in the form of domestic care. Care has both a paid and unpaid countenance to it. According to James (1992:490), "domestic

care combines “caring for” with “caring about” and caring as part of women’s activity and identity in a way which differentiates them from men, affecting how women enter the social world and social relations in the employment arena”. James (1992) reiterates the same points that are made about gender and females – these being that it is in a woman’s identity to be caring and is reinforced by domestic duties. Domestic care is unpaid labour as it falls under the gender division of labour within household duties.

It is impossible to speak about emotional labour and nursing without talking about the notion of care. Caring is the valued essence of the nursing profession (Bolton, 2005; Huynh, Alderson and Thompson, 2008; Watson, 2005), involving more than the technical aspects of work, but, more importantly, constructing the “emotional climate” conducive to patient care. Nurses are confronted with human suffering on a daily basis and are expected to provide genuine caring to alleviate the suffering of patients rather than offer a simple task-orientated response (Bolton, 2005). Caring within the nursing labour process performed mostly by women has been commercialised and sold for wages. It is in providing this care that nurses often utilise emotional labour strategies like surfacing acting and deep acting.

Although the notion of ‘care’ is problematic and difficult to define, there has nonetheless been an interest in the literature on the importance of caring in nursing (James, 1992; Poole and Isaacs, 1997; Staden, 1997; Rivonski and Price- Glynn, 2010; Yeates, 2005). Caring labour performed by nurses, which fuses labour and love, is defined by Davies (1995: 18) as “attending, physical, mental and emotional needs of another and giving a commitment to nurturance, growth and healing of that other”. Rakovski and Price-Glynn (210: 402) make a clear distinction between emotional labour and care labour, stating that while emotional labour refers to jobs requiring short-term emotional displays of an impersonal nature to impersonal clients, caring labour refers to jobs requiring emotional and physical caring in personal, enduring and constructive relationships with clients. These jobs may be hospice care and caregivers in comparison to nursing. According to James (1992: 488), the main components of care work involve organisation + physical labour + emotional labour, and that it is only through the amalgamation of these components that work can be achieved. Physical labour within care labour involves “caring for” and distinguished from emotional labour as this involves “caring about”. Caring

labour involves activities ranging from highly intimate to less intimate tasks such as cooking, cleaning and ironing (Yeates, 2005; Rivonski and Price-Glynn, 2010).

Whether or not it is undertaken as a commodified exchange value, care is marked by its association with woman's work. A distinction must be made, however, of the locations where care presents itself in the public (workplace) and the private (domestic care) domain. Care, as performed by women, takes place in the domestic sphere in the form of domestic care, and similarly in the workplace in the form of workplace healthcare. Based on the former, care has both a paid and unpaid dimension to it. Paid caring work is constructed as "women's work" (Dyer, McDowell and Batnitzky, 2008; Yeates, 2005; Baines, Evans and Neysmith, 1998) and organised and undervalued as if it were in the unpaid domestic sphere.

According to Baines et al (1998:4), the use of the term 'care' signals the frequently invisible and unvalued work that women perform and which encompasses obligation and responsibility. This is because the economic revenue from nurses, who provide care, is undervalued and unseen and is not weighed as greatly as the returns it generates. The concept of an uncaring woman is often seen as inconceivable, as if to care were the essence of being a woman. This is reflected in societies' reactions to female nurses who abuse patients or as Bains et al (1998:5) assert, in a neglectful mother. This dichotomy of care being both love and labour has far-reaching implications for nurses and calls into question why they decided to become nurses in the first place. Describing gynaecology nurses' commitment to the "femaleness" of their work, Bolton (2005:173) explains how nurses interviewed in her study "sought to confirm to underlying expectation that nursing is a vocation, involving altruism and overwhelming drive to "care" for people, rather than offering a career involving choice and skills". Bolton (2005:173) reveals this problematic construction of labour and love, that while nurses in the gynaecology field provide a strong professional identity, the perception of caring is that of a "calling" or the overwhelming drive to "care" for people and linked to love, rather than a strong profession which is linked to labour contributes to the devaluing of this work and the attribution of this as an unskilled and naturally female profession (Dyer et al, 2008:2031).

According to Beneria and Sen (1981:313), care labour is often squeezed into its own category and considered for use rather than for exchange. The assumption is based on the idea that care only takes place within the family as "unpaid work" and not in capitalist society as paid work.

Hochschild (1983:7), however views care labour in its close association to emotional labour performed by flight attendants in the form of emotional labour having an exchange value. Emotional labour also has detrimental effects on the worker.

## **1.7 CONSEQUENCES OF EMOTION WORK**

Studies on emotion work in healthcare mostly focus on the performance of emotional labour by nurses (Bolton, 2000; Brotheridge and Grandey 2002; Mann, 2005). Recently, authors have tried to investigate the effects of prolonged emotion work by nurses (Wharton and Erickson, 1993; Smith, 1999; Zapf, 2002; McVicar, 2002; Martinez-Indigo, Totterdell, Alcover and Holman, 2007). Research shows that working with people, especially when they are suffering or ill, requires a great deal of emotional labour. This requires deep acting strategies (changing inner feeling states in order to display an appropriate emotional display) and surface acting (displaying emotions that are not experienced). Nurses not only manage their emotions but also their patients through providing reassurance and comfort in times of fear. According to Brook and Boyd (2003: 293), emotional labour carries with it the greatest personal cost to the worker as compared to physical labour, as the factory worker does not have to “love the factory wallpaper” whereas the air stewardess has to invest the product of passenger satisfaction with feeling. The same can be said with the amount of care the nurse must deploy to the patient in achieving quality care. The very fact that employees regulate their feelings in exchange for a wage has been regarded as a risk to a worker’s well-being (Brotheridge and Grandey, 2002:18). The sustained performance of emotional labour which requires people to people display, may leave people struggling for authenticity in interactions in which they have little control and creating pressure for the worker. Hochschild (2003:187) states that such distress emerges in workers’ inability to distinguish self from the job role in one of three ways. Firstly, some workers can over-identify with the job and are unable to “depersonalise” themselves and work-related hostilities, thereby increasing stress and risking burnout. This is the creation of the boundary between work and the self. Secondly, others do separate self from the job but feel bad about doing so. Thus, separation can create a sense of a lack inauthenticity and make work unrewarding. Finally, some workers so effectively separate self and job role that they risk becoming estranged from work. In attempting to resolve these problems, Hochschild states that the problem “is how to adjust one’s self to the role in a

way that allows some flow of self into the role but minimises the stress the role puts on the self” (2003:188).

A key concern in the emotional labour thesis is the idea of authenticity and how the performance of emotional labour hinders or enhances authenticity portrayed in the performance. The idea of emotional dissonance explores this further. “Emotional dissonance occurs when an employee is required to express emotions which are not genuinely felt in a particular situation” (Zapf, 2002:245). Emotional dissonance may also be considered a form of person conflict or multiple person conflicts. Emotional dissonance may originate from when an employee feels nothing when a certain display rule is required or the display rule may require the suppression of feeling and the person is unable to. “Emotional dissonance may originate from ‘faking in good faith’ when the employee accepts the underlying display rule or from ‘faking in bad faith’ when the display rule is not accepted” (Zapf, 2000:245). Emotional dissonance is a mismatch between felt emotions and organizationally desired expression of these emotions. There are varying degrees to which emotional dissonance may be felt, for example, if a nurse spontaneously feels emotions, emotional dissonance is low, if he or she feels nothing or the opposite emotion, emotional dissonance is high. Zapf (2002:245) identifies a significant relationship between emotional dissonance and burnout dimensions of emotional exhaustion depersonalisation amongst employees. The nurse may experience emotion dissonance if they are not able to feel what they should feel.

### **1.7.1 BURNOUT AND EMOTIONAL EXHAUSTION**

Burnout, according to Zapf (2002:255), was first investigated with observations of personal relationships with patients, clients or children, and how these are sometimes emotionally demanding and require high degrees of empathy and emotional involvement. Excessive identification with emotional requirements often leads to burnout. Studies by Ashforth and Humphrey (1993) saw the outcomes of emotional labour as either positive or negative depending on how well the employee are able to align their identity with their role and conform to display rules. The more the employee identifies with the role the higher the chance of burnout. The burnout syndrome, according to Brotheridge and Grandey (2002:17), entails three distinct states in which employees feel emotional “spent” (emotionally exhausted), display a detached attitude towards others (depersonalisation) and experience a low sense of efficiency at work (diminished

personal accomplishment). Emotional exhaustion refers to the depletion or draining of emotional resources. People who feel emotionally exhausted often feel that their energy is lost and they are at the end of the tether. Zapf (2002:256) proposes that frequent face-to-face interactions, which are intense, emotionally charged and of a longer duration are associated with higher levels of emotional exhaustion. Depersonalisation points to the development of negative attitudes towards clients. Emotional labour demands are stressful because they create the need to manage emotional states for organisational goals, and this emotion work is a more proximal prediction of stress and burnout (Brotheridge and Grandey, 2002:20). Surface acting and deep acting – the two processes of emotional labour – are the mechanisms that employees use in managing their emotions to meet work demands. The constant enhancement or suppression of feelings in dealing with patients within the nurse-patient interface may lead to what Hochschild (2003) details as inauthentic feelings being displayed. This may also result in feeling detached not only from one's true feeling but also from other people's feelings, suggesting a relationship with the dimension of depersonalisation.

Continuous surface acting, according to Brotheridge and Grandey (2002:22), leads to dimensions of burnout. Hochschild (2003) argues that doing "emotion work" is was a way of decreasing a state of emotional dissonance and may result in a feeling of accomplishment if the performance is effective. According to Brotheridge and Grandey (2002:22), deep acting can relate to lower depersonalisation and more personal accomplishment because deep acting involves treating the customer/patient as someone who is deserving of authentic expression. Acting in inauthentic over time may result may result in feeling detached not only from one's true feelings but also from other people's feelings.

## **1.8 CONCLUSION**

The nurse is a pivotal figure in patient care and provides most of the care that are needed by patients. Nurses, according to Bolton (2001:89), work hard to manage their emotions in administering care to patients. The emotion work that nurses perform is integral to the nurse-patient relationship of care. The relationship between nurse and patient often allows for grasping

the complexity of the work that nurses do. It is pertinent to the goals of this study to understand the emotional labour concept. To this end, this chapter provided the theoretical framework which is an employee-focused emotional labour theory, to propose how employees (the nurse in this context) modify expressions to meet organisational demands. This chapter has also attempted to outline recent developments in theorising about emotional labour. In keeping with the aim of this study of exploring the use of emotional labour among nurses, this chapter has provided the ground-work in analysing the dimensions of the emotional labour concept in relation to the work that nurses do within the nurse-patient interface (like feeling rules, surface acting and deep acting) and looking at the nurse/patient relationship. This is done to paint a clearer picture of emotional labour strategies and the work that nurses do. This chapter also looked at the gendered nature of nursing work and at the relationship between nursing work and the sexual division of labour. The intersectional nature of women's position in the labour market and the position that they occupy within the sexual division of labour in the private realm needs to be unpacked when looking at the nursing profession as mostly women occupy it and in society undervalues it. The same is said in this chapter, about the devalued nature of emotional labour that nurses perform. Lastly, this chapter has looked at consequences of prolonged emotion work by nurses namely, leading to burnout and exhaustion. In this way, this study hopes to add to the limited the research on emotional labour in the South African nursing industry. What this work will accomplish is a set of results that are important in terms of insights gained in the normative and the lived experience of emotional labourers in contemporary care.

The next chapter provides a looks at the nursing profession in South Africa in order to draw a clearer picture of the subject of this thesis.

## **CHAPTER 2**

# **NURSING IN SOUTH AFRICA**

## **2.1 INTRODUCTION**

This chapter outlines the milestones in South African nursing history, drawing on how the racial division of the country's past translated into the profession. Furthermore presenting the current nurse's scope of practice comprised in South Africa's legal framework that regulates the nursing practice and government policy (such as The Strategic Plan for Nurse Education, Training and Practice). This chapter also provides recent figures of the number of nurses trained in all provinces in South Africa. This attempts to outline the current workforce that is trying to meet the service demands. This chapter also sketches the legislative framework that governs health care in South Africa, as well as Batho Pele initiative and the Patient Rights Charter that looks at alternative ways in which services should be administered to patients.

This chapter outlines the landscape in which the subjects of the research, their history, the legislative framework and current working conditions in an effort to provide a deeper understanding of nursing in South Africa.

## **2.2 A BRIEF HISTORY OF NURSING IN SOUTH AFRICA**

The broader context of the nursing profession in South Africa cannot be adequately understood without a consideration of the intertwined histories of apartheid and the nursing profession in the country. In June 1820, the Reverend John Brownlee established a mission station at Chumie near, what is presently known as King Williams Town. This mission school cemented the centres of education for black men and women that made possible the eventual education of black nurses (Mellish, Oosthuizen and Paton, 2010:43). According to Marks (1994, cited in Breier, Wildschut and Mqgqolozana, 2009), the first trained nurses were nuns of the religious orders and English "ladies and God-fearing women", and eventually black middle-class women. The first African professional nurse qualified in 1907, but even so, only a few black nurses were trained afterwards (Jewkes, Abrahams and Cersa, 1998:1782). By the mid-19th century, nursing as a profession had become a prestigious occupation for many black women. Nevertheless, accessibility into this profession continued to be limited. The first black woman to pass the nursing certificate of the Cape Colonial Medical Council was Cecilia Makiwane. She became the country's first African professional nurse in 1908 (Breier, Wildschut and Mqgqolozana, 2009:8).

During the 19th century, there were a number of key developments in the history of nursing. South Africa became the first country in the world to grant state registration to trained nurses. Nurses and midwives that could provide proof of training to the Colonial Medical Council were registered. Due to this, there was growing recognition of nurses and over eighteen hospitals in South Africa started the training of nurses. Another key development in nursing history was the formation of the South African Medical Council (SAMC) after the passing of the Medical, Dentist and Pharmacy Act (Act 13 of 1928). This Act, according to Mellish et al (1995:48), provided for the recognition by the Medical Council of the certificates issued and the registration granted to nurses by the previous medical council. This body became the registering body for midwives and nurses, with disciplinary powers and powers to approve training schools, to conduct examinations and to grant certificates. This council also meant the representation of nurses as this body regulated nursing education, entry requirements, training requirements and examinations of all racial groups as stipulated by the SAMC.

With the beginning of the 20th century, due to developments in the 19th century, the training of black nurses began at Victoria Hospital, Lovedale in the Cape Colony. Those trained at Lovedale Hospital as general nurses were admitted to the register of Colonial Medical Council. The training of black nurses started in 1909 at the McCord Nursing Home in Durban. By the end of the 20th Century, the demographic of nursing had been transformed into a profession dominated by black women (Jewkes et al, 1998:1782).

Prior to 1994, race influenced access to health services (Coovadia et al, cited in Burford, 2012:34). Racial discrimination has since been removed from the health care system and the public health system has been transformed. Through redirecting the funding to previously disadvantaged areas, the government aimed to improve and deliver better health care for all races (Burford, 2012: 34). Within the South African context, the structure of health care industry within which the nursing professionals operate, consists of the private and public sector (Burford, 2012; Geyer, Naude and Sithole, 2002). The public sector is funded with taxpayer money and is usually under-resourced and over-utilised as this caters for about 80 percent of the population while the private sector only caters for approximately 20 percent of the population (Coovadia et al, cited in Burford, 2012:34). The private sector is a profit sector where patients

have medical aid or medical insurance, which makes provision for the payment of services rendered by providers (Geyer et al, 2002:11).

Health care providers consist of single health practitioners providing services to individual patients, hospitals, clinics and occupational health care services. The nursing profession mainly provides mother and child health services, general care and wound care (Geyer et al, 2002:11). Nurses and midwives are involved in all levels of healthcare delivery; these being the national government, the provincial government, and lastly, district or local authority services (Geyer et al, 2002:11, Burford, 2012:34; Coovadia et al, cited in Burford, 2012:34).

The South African health system is organised into a three-tiered system consisting of national government, the provincial governments, and regional, local or district services. The national government is responsible for overall legislation and policy formulation. Provincial governments are responsible for shared functions as well as abattoirs (slaughterhouses), ambulances, archives and museums, libraries, liquor licenses, veterinary services and all provincial matters such as planning, cultural matters, recreational amenities, sport, roads and traffic. The third level of the system is comprised of region or district and local authority services. Each of the nine provinces in South Africa is demarcated into regions and districts that are responsible for certain health services, provided they are financially able to do so. In the case of the third level of government not being able to deliver the required health services, it then becomes the responsibility of the provincial government. Local authorities are management structures in metropolitan areas that make provision for all the services that the particular area requires, including health. The government's health policy is based on the principle that the nurse will be the public's first contact with the health service where preventative health and minor ailments are addressed. Where necessary, the patient will be referred to a secondary or district health service and hospital where medical practitioners are available (Geyer et al, 2002:11; Burford, 2012:34; Coovadia et al, cited in Burford, 2012:34).

Health care is differentiated from other sectors due to the main work objective being human-centred. This female-dominated profession requires a variety of tasks to be performed throughout the workday, with the majority of these being patient-centred (Gurses and Carayon, cited in Burford, 2012:34). The main goal of nursing is to provide the patient with care and treatment. This is done through a range of tasks that vary from low intensity (such as taking blood pressure

and administrative work) all the way to intensive tasks which involve patient care and working with doctors (Hignett, cited in Burford, 2012:34). Administrative tasks include updating patient files and the related paperwork needed for discharging or admitting patients (Gurses and Carayon, cited in Burford, 2012:34). The more intense work tasks include washing and feeding the patient, gathering information from the patient, and administering medication. Nursing staff need to be able to follow rigid procedures as well as use their own discretion for tasks where decisions regarding treatment and courses of action are required (Shepard, 2001 cited in Burford, 2012: 34). The concept of the “nursing process” excludes medical diagnosis but provides holistic patient care and meticulous written records (Rispel and Schneider, cited in Breier et al, 2009). This is a four-step process which includes determining the client’s problem, called the assessment phase, and secondly making plans to solve the problem (planning phase). Thirdly, the execution of the plans (implementation phase) and lastly, evaluating to what degree the actions were effective in solving the identified problem (evaluation phase).

Interpersonal and social skills are required to interact not only with the patient but also with various members of the health care team, as well as the patient’s visitors. In addition, to the above-mentioned skills, teamwork and good communication skills in the nursing staff are required (Shepard, cited in Burford, 2012: 34). This is necessary, as patients require continuous care and nursing staff need to work as a team and liaise with other staff in terms of shift changes (Shepard, cited in Burford, 2012: 34). Nurses also need to collaborate with doctors and other staff in the health care environment in order to treat the patient. Hignett and Richardson (1995) state that, due to these various subsystems working together to provide healthcare to the patient, the potential for communication errors always exist. Nursing work is often classified as demanding, highly repetitive and physically exhausting due to the emotional and psychological component of caring for patients. Nursing is associated with high levels of work stress,

### **2.3 SOUTH AFRICAN NURSING PROFESSION: SCOPE OF PRACTICE**

The nursing profession in South Africa is regulated by the Nursing Act (Act 30 of 2005), which provides for the registration of professional nurses and the enrolment of nurses and nursing

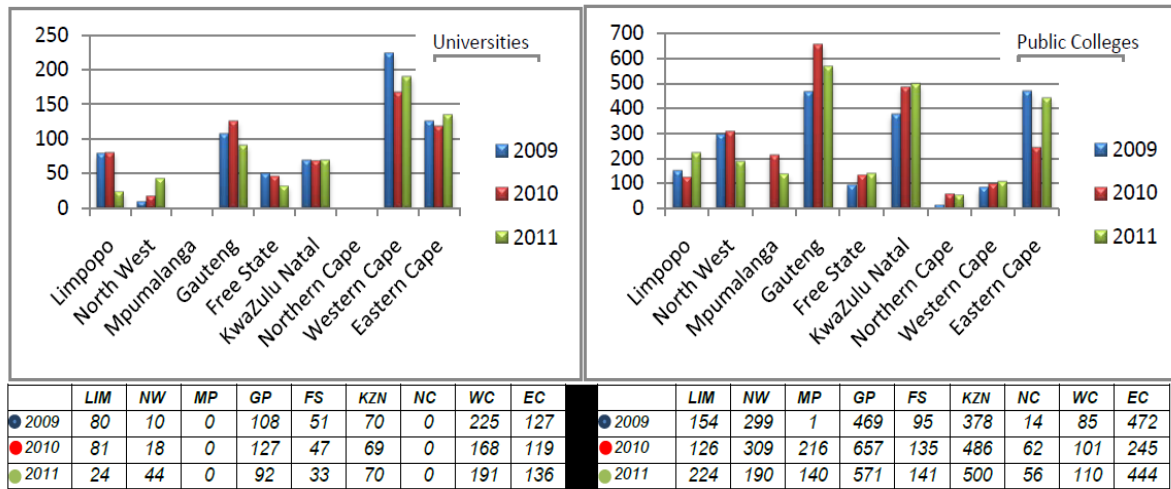
auxiliaries. There are four basic categories of nurses, who are educated and trained in South Africa: the professional nurses, midwives, staff nurses and enrolled nursing auxiliaries (South African Nursing Council 2005:25). Section 30 of the act highlights the scope of profession and practice of the different categories of nurses. According to this section, a professional nurse “is a person who is qualified and competent to independently practise comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice” (South African Nursing Council, 2005:25). A midwife is a person who “is qualified and competent to independently practise midwifery in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice” (South African Nursing Council 2005: 25). An auxiliary nurse or an auxiliary midwife is a person “who is educated to provide elementary nursing care in the manner and to the level prescribed” (South African Nursing Council 2005:25).

The South African Nursing Council, in terms of the Nursing Act, keeps a register of professional nurses and nursing auxiliaries eligible to practice in South Africa. In South Africa, two avenues are offered where nurses may be trained and educated: namely, nursing colleges and universities. According to Subedar (2005:92), public sector nursing colleges, most of which are funded by the provincial Departments of Health, train all the professional nurses completing the four-year training course. The training of professional nurses at universities is a four-year degree that also leads to the registration of a professional nurse in general nursing, midwifery, and mental and community health with the SANC. All nursing programmes offered should, apart from being approved by the Senate of the University or College, be accredited by the SANC, the South African Qualification Authority (SAQA) and the Higher Educational Quality committee. Nursing students enrolled at universities for a degree programme, receive bursaries from the Department of Health. Since 1989, the SANC has permitted enrolled nurses and nursing auxiliaries to qualify as professional nurses through a two-year bridging programme that allows nurses in the enrolled nurse category to “upgrade” to the professional nursing category (Subedar, 2005:100). As part of nursing education, all student nurses undertake practical components in public hospitals under the jurisdiction of the Department of Health. According to Jooste (2012:62) that there is demand amongst nurse educators for the rationalisation and transformation of the current nursing college into tertiary institutions, as has happened in many countries around the world.

According to the Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17, South Africa's health care system is predominantly nurse based and requires nurses to have the competence and expertise to manage the country's burden of disease and to meet South Africa's health care needs (Department of Health, 2013: 4). Globally, there is a recognition of a crisis regarding shortages in the health workforce, which are characterised by critical shortages, imbalanced skill mix, migration and uneven distribution of health professionals (Department of Health, 2013: 9). The shortage of nurses undermines the effectiveness of health systems and the delivery of healthcare systems. Another key area that is highlighted by The Strategic Plan for Nurse Education, Training and Practice is the inclusion of modules where caring are compulsory modules at all levels of nursing and midwifery training in order to address the images of nurses and nursing (Department of health 2013:11). As highlighted in Chapter One, caring is the valued essence in nursing and it is imperative for the education and training of nurses to facilitate the education of nurses in this regard, in restoring dignity back to the profession. Some of the recommendations to restore professionalism as stated by the document is a "comprehensive programme should be in place to promote the nursing profession at the school level to attract a good cadre of nurses" (Department of Health 2013:11).

The Strategic Plan for Nurse Education, Training and Practice document launched by the SANC in Figure 2.1 displayed that nursing education institutions output of nurses did not match the service demand for nurses and midwives. The SANC, according to Wildschut and Mqolozana (2008:12), has identified a shortage of nurses in South Africa due to insufficient nurses being trained, particularly in specialised services, with declining production over the last few years.

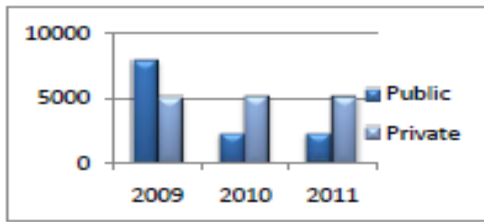
Figure 2.1: University and nursing college output in four-year programme



Source: South African Nursing Council (2008:12)

Figure 2.1 shows that Limpopo and North West have the smallest population of nurses being produced in four-year programmes at a university level and in public nursing colleges. This shortage in the population of nurses might be located within the number of universities that offer four-year programmes to nurses such as those seen in Mpumalanga and the Northern Cape, where there are no universities. The Western Cape and the Eastern Cape have the highest number of nurses educated in universities. In public colleges, however, Gauteng has the highest number of nurses and midwives trained and the Northern Cape the least number of nurses and midwives

Figure 2.2: Production of enrolled and auxiliary nurses in nurse programme, 2009-2011

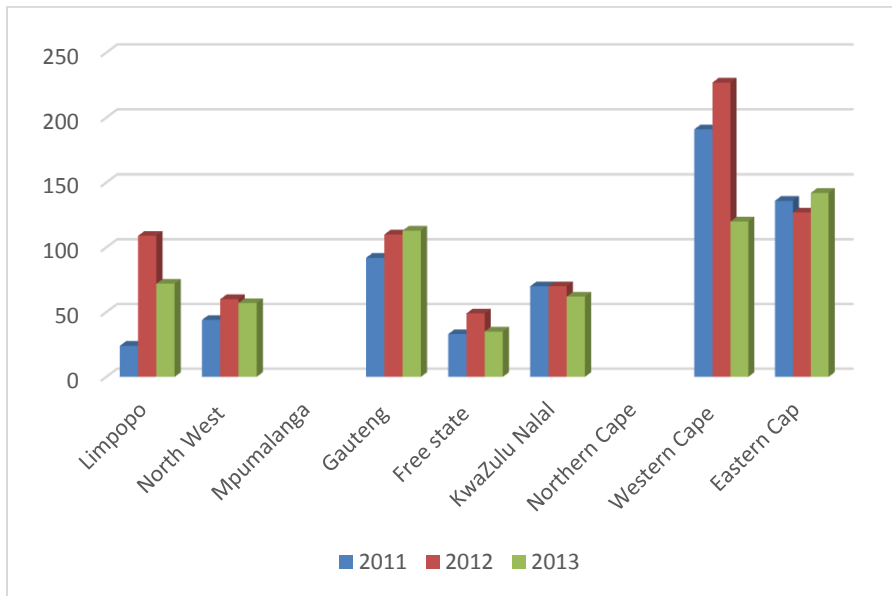


Source: South African Nursing Council (2008:13)

Figure 2.2 shows a decline in the number of nurses trained between 2009 and 2011. This is a particular concern for service delivery and improving the status of the South African health care system. The graphs also show that the production of enrolled nurses in the public sector was higher than the production of auxiliary nurses in the public sector.

The South African Nursing Council's recent statistics on the production of nurses in nursing colleges and universities between 2011- 2013 has shown that the North West, KwaZulu-Natal and Free State did not produce over a 100 graduates amid 2011 to 2013. The decrease in the number of nurses produced in these areas means that the growing populations need for health care workers is not being met. The highest number of nurses produced can be found in the Eastern Cape and Western Cape. This is particularly admirable for the Eastern Cape as it is one of the provinces in South Africa with the poorest health care facilities. Mpumalanga and the Western Cape had no data recorded for the number of nurses produced in their universities. This could be attributed to the fact that no four-year programmes are offered for nurses. While the North West and Free State recorded the lowest numbers in the output of nurses in 2009 to 2011, there was a great improvement in both these provinces in the figures represented in 2011 to 2013. These figures can be found in figure 2.3 below.

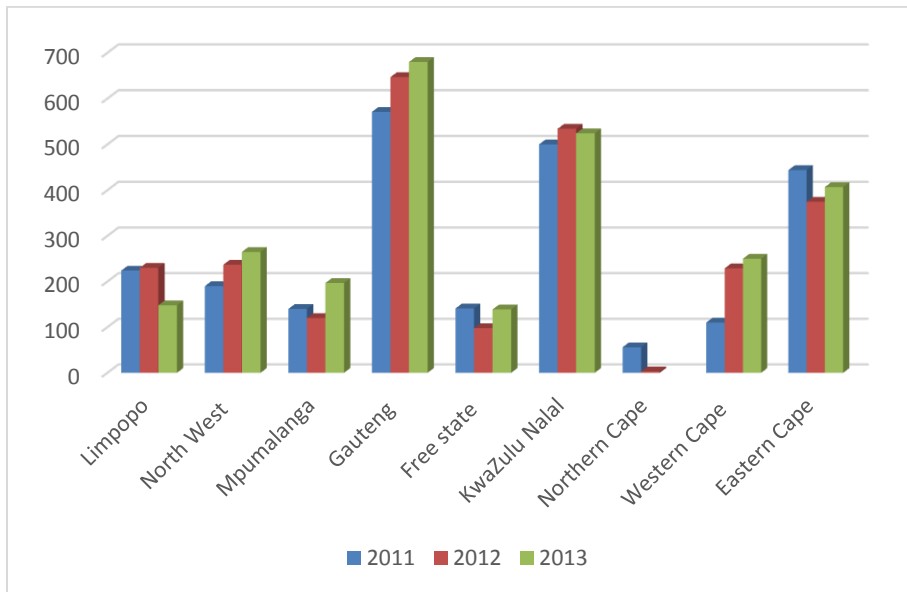
Figure 2.3: University output in four-year nursing programme, 2011-2013



Source: South African Nursing Council (2013)

The South African Nursing Council also released data on the number of nurses being produced in nursing colleges between 2011 and 2013 (as shown by figure 2.3). Limpopo, the Free State and Northern Cape exhibited the lowest number of nurses produced in the public colleges. Gauteng has the highest recorded number of graduates produced in nursing colleges; this is unlike the number of graduates this province produces in universities. Within both institutions of learning, the only provinces that have a steady growth are the North West, Gauteng and the Eastern Cape. Every year these three provinces are trying to meet the growing demand for health care practitioners. These figures can be found in the figure below.

Figure 2.4: Nursing College output in four-year nursing programme, 2011-2013



Source: South African Nursing Council (2013)

With the number of health practitioners produced in the nursing colleges and Universities, it is helpful to look at the number of nurses produced compared to the growing population. The SANC has released a provincial distribution of nursing workforce in South Africa. In the table below, the nursing workforce is drastically small when compared to the population that it serves. The highest population can be found in Gauteng with 12 728 400 million people and a nursing workforce of only 66 866 nurses, as seen in table 2.1. The larger implication of this is that nursing institutions are not producing enough nurses. The profession, which was once prestigious, is not attracting as many people. The North West, Gauteng and Eastern Cape, which were pinpointed as the provinces with the highest graduate rates in both nursing colleges and universities, have a small nursing workforce in comparison to their populations (as seen in Table 2.1). The Northern Cape has the smallest nursing workforce in comparison to all the other provinces and with a population of one million people. The Eastern Cape, which is particularly relevant to this research, has a staff complements of 26 686 in comparison to its 6 million population.

Table 2.1: Provincial distribution of nursing workforce versus the population of South Africa

	Population	Nursing workforce as at 2013/12/31			
	2013	Registered	Enrolled	Auxiliaries	Total
<b>Limpopo</b>					
Female	29 340 400	9312	4976	8352	22 640
Male	2 583 600	1224	515	868	5607
Total	5 518 000	10 536	5 491	9 220	25 247
<b>North West</b>					
female	1 769 900	7859	2693	4372	14 924
male	1 827 700	1051	283	577	1 911
Total	30 597 600	8910	2976	4949	16 835
<b>Mpumalanga</b>					
Female	2 105 100	6 015	2628	3792	12435
male	2 022 900	685	263	309	1257
Total	4 128 000	6700	2891	4101	13692
<b>Gauteng</b>					
Females	6 296 400	31498	14679	16294	62471
Males	6 432 000	2099	1174	1122	4395
Total	12 728 400	33597	15853	17416	66866
<b>Free State</b>					
Females	1 420 300	6973	1763	2944	11680
Males	1 332 800	973	331	374	1678
Total	2 753 100	7946	2094	3318	13358
<b>KwaZulu-Natal</b>					
Females	5 482 600	25 838	20702	11127	57667
Males	4 974 300	2320	2309	1109	5738
Total	10 456 900	28158	23011	12236	63405
<b>Northern Cape</b>					
Females	588 700	2020	404	1089	3513
Males	574 200	179	45	107	331
Total	1 162	2199	449	1196	3844
<b>Western Cape</b>					

Females	3 059 300	15016		5891	7927	28834
Males	2 957 600	1015		357	559	1931
Total	60 160 900	16031		6248	8486	30765
<b>Eastern Cape</b>						
females	3 502 000	13667		4192	5977	23836
Males	3 118 200	1271		583	996	2850
Total	6 620 200	14938		4775	6973	26686

Source: South Africa Nursing Council (2014)

The SANC also released the provincial nurse to patient ratio in South Africa. This ratio, as pointed out earlier, is influenced by the nursing workforce in relation to the South African population. The highest nurse to patient ratio is in Mpumalanga, with a ratio of 616 to 1 registered nurse as shown in figure 2.2. Mpumalanga has a population of 4 128 000 and only 6700 registered nurses. When analysing service delivery in the healthcare sector, nurse to patient ratio is a key criterion, as one of the key problems in this sector is a lack of workforce. The greater implication of having a larger population in comparison to the workforce is it degrades and erodes the level of service that can be offered and places stress on the hospital staff. Immigrants from neighbouring countries put further strain on the nursing workforce. The outbreak of diseases and the high HIV and AIDS rate also places great pressure on the personnel of this staff to work even harder. The provincial nurse to patient ratios can be found in the table below.

*Table 2.2: Provincial nurse to patient ratio in South Africa*

Province	Registered Nurses
Limpopo	524:1
North West	404:1
Mpumalanga	616:1
Gauteng	379:1
Free State	346:1
KwaZulu-Natal	371:1
Northern Cape	529:1
Western Cape	375:1
Eastern Cape	443:1

Source: South African Nursing Council (2014)

The SANC figures on the differentials between male and female nurses are reflected in Figure 2.5. These figures represent the total number of nurses registered, enrolled and nursing auxiliaries by the end of 2013. On close inspection, there is a far greater number of females across all categories and this shows how nursing is female dominated. The figure below speaks volumes about the stereotype that women are ‘naturally’ better nurses and that nursing is women’s work. The notion of sex, gender and nursing were discussed in Chapter One.

Figure 2.5: Male and female nurses in South Africa



Source: South African Nursing Council (2014)

Adding to the problems of this sector is the scarcity of skills in the South African labour market (Wildschut and Mqolozana, 2008: 14). The migration of nursing professionals to developed countries has also added to the challenges in the health care system. Wildschut and Mqolozana (2008) further state that the adverse effects of the flows of skilled professions from developing countries have thrust the migration of health workers to the forefront of the policy agenda. According to Egerdahl (2009:1), South Africa has been the target for developed countries active recruitment of nurses and other health care professionals in their health care system for almost fifteen years. The migration of nurses exacerbates the problems of an already broken system. As seen in a report published by SANC, the shortage of nurses is due to the supply and demand of nurses is not being met. This is due to the number of nurses being trained in the country does not match the high demand for nurses that are needed. Adding to the burden is nurses that are trained and are moving away to other developing countries. The result of this being that the health care system is being crippled. The loss of nurses through migration usually results in a reduction of the capacity of the healthcare system in developing countries like South Africa to deliver efficient healthcare to its citizens (Egerdahl, 2009:2). It must also be added that poor working conditions, low salaries, limited benefits, and a lack of proper medical equipment and facilities, make the migration to developed countries seem favourable to nurses

There has been great fixation about the declining quality standards within the nursing profession in South Africa, with writers such as Breier (2009: 112) arguing that the lack of “care” exhibited

by nurses is at the centre of the problem. The South African government places a great deal of pressure on public sector workers to adopt Batho Pele (people first) to change perceptions of uncaring staff in public hospitals. The White Paper on Public Service of 1997 seeks to introduce a new approach to service delivery, an approach that will put pressure on systems, procedures, attitudes and behaviour within the public service and re-orientate service delivery in the customer's favour (Department of Public Service and Administration, 1997:12). The image of nurses has changed dramatically, particularly with reference to incidences of patient abuse by nurses. According to Meiring (2010:14), the image of nurses and nursing held by the general public in South Africa, as currently portrayed in the open press, is one of extreme negativity. This image of the nursing profession is based on stereotypes. Lack of resources – staffing, medication, equipment and infrastructural problems – together with industrial action, such as nursing strikes that have often plagued South Africa, have had a detrimental effect on health services (Meiring, 2010: 16).

The shortage of professional nurses in the public and the private sector in South Africa constitute a major crisis in the health care industry and may, in part, be attributed to the poor image of nursing as a profession. Adding to the poor image of nursing, is that men are often discouraged from choosing nursing as a profession because of the public image that nursing is a profession mainly suited to women. The image of the nurse is influenced not only by the stereotypical views of the public but also by both their own self-image and their professional image as perceived by other health care professionals (Meiring, 2010: 27). The self-image of the nurse drives the social value of nursing and, if enough nurses were able to enhance their self-images, then the image of the entire profession may improve. The self-image of nurses working in the private and public sector may be very different as working conditions and status were given to nurses in these sectors differ completely (Meiring, 2010: 27).

## **2.4 LEGISLATIVE FRAMEWORK OF SOUTH AFRICAN HEALTH CARE SYSTEM**

This section outlines the broad policy and legislative framework governing health care in South Africa. The Nursing Act (33 of 2005) created the legislative framework for the review of scopes of practice for different categories of nurses to ensure that nursing and midwifery practice in South Africa is aligned to the needs of the health care system (SANC, 2010: 14). A nursing strategy for South Africa was launched in 2008 to articulate how nursing education and training,

practice, resources, social position, regulation and leadership would unite to support the nation's health system. This section is important to this research as it provides context for understanding the health-related law that governs the practice of nurses in South Africa.

(i) The National Health Act (Act 63 of 2003) which provides for guidelines for service delivery in South Africa and allows for the Department of Health to publish regulations on education and training of Health workers after consultation with the minister of Education.

(ii) The Nursing Act of 2005 and its related regulations allow for the review of the scopes and practices for different categories and related to education and training programmes.

(iii) Another health service related legislation, for example, the Medicines and Related Substances Act (Act 101 of 1966); Mental Healthcare Act (Act 17 of 2002); Occupational Health and Safety Act (Act 85 of 1993); Births and Deaths Registration Act (Act 51 of 1992); etc.

(iv) Education legislation, including the National Qualifications Act, 2008 (Act 67 of 2008), Higher education Act, 1997 (Act 101 of 1997) and the Higher Education Amendment Act (Act 39 of 2008) which defines higher education as a national competence of the Department of Higher Education and Training (DHET) and National Education Institutions based on compliance with higher education criteria for registration.

(v) Promotion of Equality and Prevention of Discrimination Act (Act 4 of 2000); Choice of Termination of Pregnancy Act (Act 92 of 1992); Children's Act (Act 38 of 2005); etc.

## **2.5 BATHO PELE INITIATIVE**

Before 1994, patients were regarded as passive recipients of care and decision-making regarding health and illness as this was viewed as the domain of doctors (McQueen, 2000; Per and Tonder, 1996). However, after 1994, democracy brought about a number of modifications to the socio-economic climate in South Africa, and one of these changes was the Reconstruction and Development Programme (RDP). This programme addresses, amongst others, the reform of the healthcare system in South Africa. The aim of this document was to ensure that all South

Africans received better value for money spent on health services and to increase a quality of life (ANC, 1994b:43). In terms of service delivery, the document highlighted “the introduction of management practises should promote efficient and compassionate delivery of services that ensure respect for human rights and accountability to users, clients, and the public at large” (ANC, 1994b: 46). The RDP document serves as the basis for many of the national policies that were developed as a result, and this framework document plays an important role in the delivery of public servers in South Africa.

The White Paper on the transformation of Public services was published in October 1997 (Department of Public Service and Administration, 1997). The White Paper on Public Service of 1997 sought to introduce a new approach to service delivery, an approach that would put pressure on systems, procedures, attitudes and behaviours within the public service and re-orientate service delivery in the customer’s favour (Department of Public Service and Administration, 1997:12). The White Paper set out eight national priorities intended for the transformation of service delivery in healthcare. The key criterion in these national priorities was its effectiveness in the delivery of services, which met the basic needs of all South African citizens (Department of Public Service and Administration, 1997:9).

The purpose of the White Paper was to provide a policy framework and practical implementation strategy for the transformation of the public service delivery. The White Paper is primarily about how public services are provided and specifically about improving the efficiency and effectiveness of the way in which services are delivered (Department of Public Service and Administration, 1997:9). The White Paper hinges upon the principles of the South African Constitution on public administration. The Constitution stipulates that public administration should adhere to following principles: namely, “a high standard of profession ethics be promoted and maintained; services are provided impartially, fairly and equitably and without bias, peoples’ needs be responded to” ((Department of Public Service and Administration, 1997:9).

The White Paper has eight principles for transforming public service delivery. These are expressed in broad terms in order to enable national and provincial departments to apply them in accordance with their own needs and circumstances (Department of Public Service and Administration, 1997:14). The eight principles of Batho Pele are consulting, service standards, increasing access, and ensuring courtesy, providing information, increasing openness,

transparency, redress and value for money. For the purpose of this dissertation, only principals that relate to the topic will be discussed namely consulting, service standards, increasing access, ensuring courtesy, providing information, redress and value for money will be discussed below.

### **2.5.1 CONSULTING**

Consultation, according to the national initiative, stipulates that “citizens should be consulted about the level and quality of public services they receive and, wherever possible, should be given a choice about the services that are offered” (Department of Public Service and Administration, 1997: 16). The intended implication for patients upon implementation is to give citizens the opportunity to influence decisions about public services, by providing objective evidence that will determine service delivery priorities (Department of Public Service and Administration, 1997:17).

### **2.5.2 SERVICE STANDARDS**

The second priority is service standards. This states that “citizens should be told the level and quality of public services they will receive so that they are aware of what to expect” (Department of Public Service and Administration, 1997:16). The intended practice of this principle is that all national and provincial departments publish standards for the level and quality of services they will provide, including the introduction of new services to those who have previously been denied access to them. Some of the standards cover an array of issues such as the maximum time a patient should have to wait at a primary healthcare clinic (Department of Public Service and Administration, 1997:17).

### **2.5.3 INCREASING ACCESS**

This priority looks at access: “all citizens should have equal access to the services to which they are entitled” (Department of Public Service and Administration, 1997: 6). This priority follows the parameters set out by GEAR to rectify the inequalities in the distribution of existing services. What this entails is that all national departments and provincial departments set targets to increase access to their services for those who were previously denied (Department of Public Service and Administration, 1997: 17).

### **2.5.4 ENSURING COURTESY**

The fourth priority is courtesy and this states that all citizens should be treated with courtesy and consideration (Department of Public Service and Administration, 1997: 17). The concept of courtesy as outlined by the White Paper goes beyond asking public servants to give a polite smile and to say “please” and “thank you”, but hinges of the Code of Conduct for public servants issued by the Public Service Commission. This principle details the behaviour of public servants when interacting with paying patients, and advocates that all citizens should be treated with courtesy and consideration. The departmental codes of conduct should cover at least:

- How to greet and address customers
- Identification of healthcare workers
- Principles for conducting interviews
- The timeframe within which to respond to enquiries
- Procedure for dealing with complaints
- Language (Department of Public Service and Administration, 1997:19)

This principle believes that patients are to be treated as individuals, with fairness, in an unhurried manner, with empathy and understanding, as well as with consideration and respect. Discourtesy must not be tolerated. Staff performance should be monitored and managers are expected to set an example of behavioural norms to the junior healthcare workers.

### **2.5.5 PROVIDING INFORMATION**

This principle states that “citizens should be given full, accurate information about the public services they are entitled to receive” (Department of Public Service and Administration, 1997: 15). It aims to empower patients and create a better understanding of health services that they are entitled to receive, their illness, diagnosis and treatment. The White Paper (Department of Public Service and Administration, 1997: 19) states that health care providers should determine what patients need to know and then decide on the best way to provide the information in an understandable language and free from jargon. Implementing Batho Pele will require a complete transformation of communication with the public and will require providing information in a variety of media and languages that meet the different needs of different customers.

### **2.5.6 REMEDYING MISTAKES AND FAILURES/REDRESS**

The last principle states that “if the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; and when complaints are made, citizens should receive sympathetic, positive response” (Department of Public Service and Administration, 1997:15). The principle of redress deals with the proper and effective approach to handling complaints. The complaints system should be accessible in writing, face-to-face or by telephone. This principle will not be discussed further as it is not directly related to this study.

### **2.5.7 VALUE FOR MONEY**

This principle states that “public services should be provided economically and efficiently in order to give citizens the best possible value for money” (Department of Public Service and Administration, 1997:15). The White Paper states that services should be cost effective and delivered within the departmental resource allocations. Procedures should be simplified and waste effectively with inefficiency eliminated (Department of Public Service and Administration, 1997:22). This principle is of importance for unit managers to plan, organise and control all resources in such a way that cost-effective patient care can be rendered.

## **2.6 THE NATIONAL PATIENTS’ RIGHTS CHARTER**

The Patients’ Rights Charter of South Africa is a charter by the National Department of Health, which promotes and protects the rights of patients in the health care sector (Department of health, 1999). The Charter also endeavours to bring into effect the principles of the Batho Pele initiative. The Charter was launched in 1999 and lays out the rights and responsibilities, which patients have when they receive treatment at medical health facilities. The Charter outlines the rights to good quality healthcare and raises awareness about human rights in the health sector while putting the Constitution of South Africa and the Bill of Rights into practice by promoting access to healthcare, equity and patient rights (Department of Health, 1999:2). At the launch of the National Patient’s Rights Charter in 1999, the then Minister of Health, Dr Manto Tshabalala-Msimang, expressed the government’s commitment to the fundamental values of the National Health System. These fundamental values consisted of a comprehensive service that is available to all, responsive to the expressed needs of the people as well, and, above all, a service that is

delivered with respect and compassion while preserving the dignity of the recipient of the service at all times. The undertakings of the Charter are to foster a change in attitudes of health workers, and ultimately to strengthen the partnership between patient and health workers.

The Charter outlines the following patient's rights: a healthy and safe environment, participation in decision making, access to healthcare, knowledge of one's health insurance/medical aid scheme, choice of health services, be treated by a named health care provider, confidentiality and privacy, informed consent, refusal of treatment, a second opinion, community care, complaints about health services (Department of Health, 1999: 1). The most relevant to this study is participation in decision-making, access to healthcare, and complaints about health services. Under the participation in decision-making, the Charter stipulates: "every citizen has the right to participate in the development of health policies, whereas everyone has the right to participate in the decision-making on matters affecting one's own death" (Department of Health 1999: 1). Furthermore, with the third principle regarding access to healthcare, the Charter states the following: "Everyone has the right to the provision for special needs in the case of new-born infants, children, and pregnant women, the aged, disabled persons, patients in pain, and persons living with HIV or AIDS" (Department of Health 1999: 1). Under the broad umbrella of access to healthcare, the Charter states: "Everyone has the right to a positive disposition displayed by healthcare providers that demonstrates courtesy, human dignity, patience, empathy, and tolerance". Lastly, complaints about health services (third principle) state: "Everyone has the right to complain about healthcare services, to have such complaints investigated, and to receive a full response on such investigations" (Department of Health, 1999: 3). It is hoped that this Charter will improve service delivery and allow the recipients of services to put pressure on the providers to ensure that customers, who are patients, are key in the setting of priorities, which in turn determine the nature and the level of services to be provided.

## **2.7 CONCLUSION**

This chapter provided a synopsis of the South African health care system, outlining the complexities and challenges that this sector faces, including the shortage of personnel, lack of skills in the labour market, and insufficient nurses trained at nursing colleges and universities. It

is important for this study, to provide the greater perimeter to which these nurses work including all important legislation and laws that regulate this sector. The shortage of nurses is not uniquely a South African problem as many countries struggle with this but this does affect the functioning of this system. This chapter lies the foundation for the deeper investigation on the use of emotional labour by nurses.

# CHAPTER 3

## RESEARCH DESIGN

### 3.1 INTRODUCTION

This chapter presents the research methodology adopted in this study. The aims of the study will be introduced along with the research location. It also outlines the suitability of the chosen research methodology for achieving the research goals. The chosen research methodology is ethnography as this is the most suitable for this research as it attempts to describe and explain how nurses perceive working with patients. The research methodology that underpins the research also speaks to the sampling technique that is used in the study. The sampling methods utilised in this study were purposive sampling and snowballing. All problems encountered during field work are clarified in the section entitled, *Challenges Experienced during Fieldwork*. This chapter also outlines both the data collection methods (interviews and focus groups) and the data analysis methods used in this research. Finally, it outlines the ethical considerations that this study adhered to in gathering the data.

### 3.2 RESEARCH AIMS

This paper endeavours to explore the nature of the nurse-patient interface, including the dynamics, challenges and intricacies that shape this relationship of care. This means the way in which nurses describe and experience their work, along with their perceptions of their patients and how this shapes their performance of work. Thereafter, it explores nurses' perceptions of quality care, as well the effects of emotional labour on their ability to perform their work. It is hoped that this project would add to the limited body of knowledge about the understanding of how nurses are deploying emotional labour within the nurse-patient interface. The research has the following objectives:

- Examine the perceptions of emotional labour by nurses

- Investigate the nature of expressions of emotional labour at the interface of the nurse-patient relationship
- Investigate the training mechanisms to equip nurses in executing emotional labour
- Explore the effects of emotional labour on nurses' work environment

### **3.3 RESEARCH LOCATION**

The study was conducted in Mthatha in the former Transkei in the Eastern Cape Province. According to the Health Systems Trust, the Mthatha provincial health care system is in crisis, largely due to the shortage of staff and resources. Rod Allen, the CEO of the Umtata Complex that oversees four hospitals, describes conditions at Umtata Hospitals as “pathetic and unacceptable” (Health Systems Trust, 2013). According to Treasury figures for February 2003, the Eastern Cape Province has the greatest shortages of nurses and doctors. There is one doctor per 8,825 people (the national average is 3,928) and one professional nurse per 1,278 people (national average is 916) (Health Systems Trust, 2013). The Eastern Cape spends R91 per capita on primary health, the second lowest in the country after Limpopo and way below the national average of R158 (Health Systems Trust, 2013).

Mthatha, which is located within the OR Tambo district, is one of six districts in the Eastern Cape. The district is mainly rural with approximately 1.9 million people. “The functional literacy rate is 52%, and about 70% of the economical population is unemployed” (Eastern Cape Department of Health, 2012-13:4). This implies that a large part of the population in this area is highly dependent on public health services. This area is also one of the key areas in South Africa that have been chosen as a key pilot site for the introduction of the National Health Insurance.

### **3.4 METHODOLOGY**

Qualitative methods were chosen because, while there was qualitative research that exists in this field mostly abroad, there is little research in South Africa about emotional labour within nursing. Thus, this research is aimed at contributing to a limited body of research on emotional labour performed by nurses in South Africa. A qualitative research design was chosen because it allows one to research and view events and the social world through the eyes of the people being studied (Bryman, 2012:399). Taking the view of the people that are studied as a point of

departure, it allows the researcher to gain insight into the way people attribute meaning to their environment and their experiences. Qualitative research concerns itself with an explanation, description and the emphasis is on context (Bryman, 2012:401). By this, we mean that qualitative research attempts to explain phenomena by asking “why” in the setting being investigated. Qualitative research design also allows for flexibility and unstructured method of data collection (Bryman, 2012:403). This seemed more favourable when wanting to view the world or social phenomena through the eyes of those being studied. This unstructured and flexible method allows the researcher to adapt to all unforeseen problems that he or she may encounter in the field.

### **3.4.1 QUALITATIVE RESEARCH METHODOLOGY: ETHNOGRAPHY**

Qualitative research was chosen as the most suitable methodology for this research because it enables the researcher to be seen as an active learner in the process, who can tell the story of the participants, rather than an 'expert' who passes judgment (Cresswell, 1998:20). According to Reeves, Kuper and Hodges (2008: 512), ethnography is the study of social interactions, behaviours, and perceptions that occur within groups, teams and organisations. The central aim of ethnography is to provide rich, holistic insights into people's views and actions, as well as the nature of the location they inhabit, through the collection of detailed observations and interviews. Ethnography provides a truthful account of people's stories in their own words (Higginbottom, 2013:37). Ethnographic data analysis involves explicit interpretation of the meanings and functions of human actions; the product of this analysis primarily takes the form of verbal descriptions and explanations (Reeves et al, 2008:513). Ethnography is a useful methodology for addressing a range of research questions within the health profession. In particular, it can generate rich and detailed accounts of clinicians' professionals and their approaches to delivering health care, as well as in-depth accounts of their experiences. Due to this, this methodology is vital in answering the research question of how nurses use emotional labour within the nurse-patient in Mthatha.

The study draws on the traditions of qualitative data collection and ethnography, which look at how people make sense of the world around them, their experiences of social relationships and other people (Garfinkel, 1967). The study attempts to explain how nurses experience and describe working with patients. The research takes an in-depth look at how the deployment of

emotions by nurses made in the context of the nurse-patient interface affected nurses. Using this approach enabled the researcher to get in-depth information based on the nurses' experiences. Participants were chosen using purposeful sampling strategies because of their extensive knowledge of nursing. The participants were gathered through snowballing and purposive sampling.

### **3.5 SAMPLING METHOD AND PARTICIPANTS**

“To achieve a systemic approach to data in qualitative studies, two conditions must be fulfilled: first, there must be clear idea of the case investigated, and secondly, there must be a documentation of feasible techniques in the taking of samples of individuals, events or activities” (Flick et al, 2004; 167). The sampling techniques that were used to achieve the objectives of this study were purposive sampling and snowballing and are discussed in detail below.

#### **3.5.1 PURPOSIVE SAMPLING**

Purposive sampling was used, since as Bryman (2012:202) recognises, that purposive sampling is strategic so that those sampled are relevant to the research questions being posed. Within this research, the categories of nurses interviewed were professional nurses and enrolled nursing assistants. The nurses targeted in this research worked at Nelson Mandela Academic and St Marys Life Group in Mthatha. The sample was based on knowledge of the population and the subjects shared characteristics like their experiences of nursing. The sample group had all gone through training and were qualified registered nurses.

#### **3.5.2 SNOWBALLING SAMPLING**

Snowball sampling refers to asking participants who have been interviewed to invite other people who might be interested in the research (Bryman, 2012:202). Snowballing is one of the useful sampling strategies that are used in ethnographic research. Snowball sampling was used in this research through referrals and word of mouth to recruit participants. Snowballing was also used because it was less time-consuming and easier to conduct. Participants were recruited due to research difficulties of access by referrals and word of mouth. Once the researcher had recruited enough participants, they were contacted for a suitable time and date was arranged for interviews. It was also made clear that participation was voluntary and, prior to interviewing, all

nurses were informed about the nature and procedure of the research. Participants were also asked to sign a consent form ensuring they understood and agreed to participate in the research.

### 3.6 DATA COLLECTION METHOD

The following techniques were used to acquire the research data: semi-structured interviews and focus group discussions. The data was collected using English and Xhosa as mediums of communication and, in the case of the latter, translated into English.

#### 3.6.1 INTERVIEWS

Interviews were conducted with the respondents in this study, which included enrolled nurses, nursing assistants and professional nurses at Nelson Mandela Academic hospital and St Mary’s Life Group Hospital in Mthatha. Figure 3.1 below details the biographic information of all the nurses that were interviewed in this study. Individual biographic information can be found attached. These nurses were chosen from different clinical areas based on their availability. To protect the identity of the respondents, all interviews were conducted in private, at a place and time of the participants’ convenience. Most were conducted during the lunch break or tea break at their place of employment (n=13) or at their residence (n=10). Below is a list of all the nurses interviewed in this study that stipulates the name, title, workplace, gender, years employed, ward and date of the interview. To protect the identity of the participant’s pseudonyms were used. An individual biographical information sheet can be found in Appendix 3.

*Table 3.1 Profile of nurses interviewed*

Name	Title	Workplace	Sex	Years employed	Ward	Date of interview
<b>Bongi*</b>	Professional nurse	Nelson Mandela Academic	Female	20 years +	Psychiatry ward	12/09/2014
<b>Siphokazi*</b>	Professional nurse	Nelson Mandela Academic	Female	39 years	Operating theatre	12.09.2014

<b>Sally*</b>	Professional nurse	Nelson Mandela Academic	Female	20 years +	HIV/AIDS counsellor	12.09.2014
<b>Nancy*</b>	Enrolled nursing assistant	Nelson Mandela Academic	Female	3-5 years	Eye ward	28.06.2014
<b>Angie*</b>	Enrolled nursing assistant	Nelson Mandela Academic	Female	3 years	Eye ward	12.09.2014
<b>Anelisa*</b>	Professional nurses	Nelson Mandela Academic	Female	20 years +	Women's health clinic	01.07.2014
<b>Ncumisa*</b>	Professional nurse	Nelson Mandela Academic	Female	5-10 years	Women's Health clinic	01.07.2014
<b>Zanele*</b>	Professional nurse	Nelson Mandela Academic	Female	44 years	Women's health clinic	01.07.2014
<b>Odwa*</b>	Professional nurse	Nelson Mandela Academic	Female	5-10 years	Women's Health clinic	01.067.2014
<b>Zandile*</b>	Professional nurse	Nelson Mandela Academic	Female	5-10 years	HIV/AIDS counsellor	25.06.2014
<b>Sanele*</b>	Professional nurse	Nelson Mandela Academic	Female	1-2 years	Eye ward	28. 06.2014
<b>Nozi*</b>	Professional nurse	Nelson Mandela Academic	Female	20 years +	HIV/AIDS counsellor	26.062014
<b>Lindi*</b>	Professional nurse	Nelson Mandela Academic	Female	1-2 years	Infection control	01.07.2014

<b>Lynn*</b>	Professional nurse	Diocesan School for Girls'	Female	20 years +	School nurse	18.08.2014
<b>Wendy*</b>	Professional nurse	Nelson Mandela Academic	Female	1-2 years	Infection control	01.07.2014
<b>Zintle*</b>	Enrolled nursing assistant	Nelson Mandela Academic	Female	20 years +	Cardio/ neuro	28.06.2014
<b>Asanda*</b>	Professional nurse	St Mary's Life Hospital	Female	5-10 years	Surgical ward	03.29.2015
<b>Olona*</b>	Professional nurse	St Mary's Life Hospital	Female	5-10 years	Surgical ward	03.29.2015
<b>Mfundo*</b>	Enrolled nursing assistant	St Mary's Life Hospital	Male	1-2 years	Medical ward	03.28.2015
<b>Lunga*</b>	Enrolled nursing assistance	St Mary's Life Hospital	Male	1-2 years	Medical ward	03.28.2015
<b>Thandi*</b>	Professional nurse	St Mary's Life Group	Female	20 years +	Medical ward	03.28.2015
<b>Afrika*</b>	Professional nurse	St Mary's Life Group	Female	20 years +	Medical ward	03.28.2015
<b>Lundi*</b>	Professional nurse	St Mary's Life Group	Female	20 years +	Medical ward	03.28.2015

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The interviews averaged 30 to 45 minutes and the focus group lasted 1 hour and 20 minutes. The focus group was conducted with the women who worked in the Women's Health Clinic. This information on focus groups will be discussed further in the subsection titled *focus group* in 3.6.2. The taped interviews were transcribed verbatim. The interview schedule drew on the

research aims and focused on questions that might reveal emotion regulation strategies that nurses employ, scenarios that might reveal the level of emotional attachment (which aroused strong emotions or could prove to be traumatic) that nurses have with their patients, and the outcomes or consequences of their work.

The overall research question in exploring the use of emotional labour by nurses in Mthatha. Simply put, the research remains interested in how nurses deploy their emotional labour in the nurse-patient interface. What the research sought to ascertain is the presence of emotional labour implicit to care work that nurses provide to patients. The discussion pertaining to emotional labour has demonstrated the complexities involved in trying to answer the research question. As a result, the interview schedule was formulated under set categories and sub-questions:

1 Examined the perceptions of emotional labour by nurses

- Do you try changing your feelings to match the feelings you must express to the patient? (Instances where you have delivered bad news to the patient or you gave fake sincerity)?
- How true is the statement “when working with patients, do you attempt to create certain emotions in yourself that present the image that your patient’s desire?

The questions posed in this theme were designed to examine the respondents’ perceptions of emotional labour. The questions investigated how they felt about feeling rules at work, the degree to which they felt they can express emotions at work, the type of emotions that they can show at work and their level of attachment to their patients.

2 Investigate the nature of expressions of emotional labour at the interface of the nurse-patient relationship

- How would you describe your relationship with patients?
- Do the illnesses and misfortunes of your patients affect you in any way? How badly would you say they affect you?

These questions investigate the nature of emotion labour within the nurse-patient relationship and the intricacies and dynamics that underlay this relationship. The questions speak to the rationale of the treatment of patients.

### 3 Investigate the training mechanisms to equip nurses in executing emotional labour

- What form of training to do you receive to perform your job?
- Do you feel supported by your supervisors when dealing with emotionally stressful elements of your job?

This theme examines the training mechanisms that equip nurses to perform their jobs.

### 4 Explore the effects of emotional labour on nurses' work organisation

- Do you feel satisfied with the kind of work you do?
- Does working with people cause strain and leave you fatigued?

This theme and its questions explore the effects of emotional labour on nurses' work organisation. The questions are aimed at exposing the effects of emotional deployment on job satisfaction and fatigue. It is apparent that each of these sub-questions is linked to overall goals of this study.

## **3.6.2 FOCUS GROUP**

A focus group contains elements of two methods: the group interview, in which several people discuss a number of topics, and a focused interview, for which interviewees are selected because they are known to have been involved in a particular situation and are asked about their involvement (Bryman, 2012:502). In focus groups, participants are able to bring to the fore issues in relation to a topic that they deem to be important and significant. The focus group was also used as a method of data collection whereby the researcher sat with a group of participants in an organised venue and asked open ended questions that were prepared for the interviews. As stated by Reeves et al (2008), one of the strengths of using a focus group as method of data collection lies in its ability to mobilize participants into responding and commenting on each other's contributions, a practice that allows statements to be challenged, extended or developed in ways that produce rich data for the researcher. Similarly, Brink (1996) defines a focus group as a discussion based interview that produces qualitative data for the researcher. The aim of the focus group is to gain clarity about participants' understanding and perspectives on various issues. According to Creswel (1998), focus groups are valuable when the interaction among

participants is similar and cooperative and generate rich data. “The focus group offers the researcher the opportunity to study the ways in which individuals collectively make sense of phenomena and construct meaning” (Bryman, 2012:504). The issues raised by the research allowed for discussions between the participants to develop and for a more realistic account of how the nurses feel about their work to come to the fore. In this research, participants would debate and question each other about the opinions which allowed for a more comprehensive understanding of how nurses experience their work.

A focus group was conducted at the Nelson Mandela Academic Hospital with nurses from the Women’s Health Clinic. The focus group was done during their lunch break where the facility was not full and the women had time to answer the research questions. The focus group method was chosen with the participants for two reasons. Firstly, because of time constraints as the participants were too busy to do one-on-one interviews. Secondly, a focus group allowed for the free flow of information and sparked a conversation amongst this group. It also allowed the women to be honest about the issues that they face. The women were more comfortable speaking as a group as opposed to one-on-one interviews. This method was appropriate for this research as it allowed for greater knowledge to be drawn from these discussions.

### **3.7 DATA ANALYSIS METHOD**

Data analysis consisted of identifying consistent themes in the participant’s responses. Analysis of the data was undertaken in a thematic manner where data is examined to identify and to categorise the themes and key issues that emerge. Initially, all interviews were transcribed from Xhosa into English and each interview was examined from two points of view and then written up. Firstly, a biographical narrative was constructed and filled out by all participants, summarising the participants’ sex, age, the number of years employed as a nurse, the sector they worked in, and their daily routine within the hospital. Secondly, an analysis of the information gathered from the interviews, in the light of the conceptual framework outlined in the literature review to ascertain the extent to which this framework provides insights into the narratives offered by the nurses.

### **3.8 ETHICAL CONSIDERATIONS**

Ethical considerations aim to determine what approval will be needed, checking the guidelines regarding the consent of the respondents and possibly anticipating the questions and potential hazards, confidentiality and other risk factors that may occur during the research (Flick et al, 2004; Bryman, 2012, Brink, 1996). The ethics that were applied in this research include ensuring the protection of participants. Protection of the participants will be in the form of anonymity for all those participating. This will ensure that all participants feel they can freely share their views and feelings without prejudice. Furthermore, consent was established with all research participants. No racial, cultural or religious group were discriminated or alienated during the research. The research will also abide by the research code of conduct provided by Rhodes University.

All participants in this study signed consent forms, which outlined the goals of the study and their contribution towards achieving them (see Appendix 2). All respondents were informed that no personal information would be used in the research and information gained during the interviews would be treated as confidential. To this end, pseudonyms were used to conceal the identity of the nurses. Ethical approval was received from the Rhodes University Higher Degrees Committee and from the Eastern Cape Department of Health.

### **3.9 CHALLENGES FACED DURING FIELD WORK**

The fieldwork was undertaken in Mthatha in the former Transkei. Pre-arranged meetings were scheduled with the CEO of Nelson Mandela Academic and St. Mary's Hospital. The largest problem encountered was gaining access to the hospital. Different levels in the hospital hierarchy are involved in the regulation of access. Firstly, is the person responsible for authorizing the research project. In the case of difficulties, they are held responsible for this authorisation by the external authorities. Secondly, the level of those interviewed or observed, who will invest their time and willingness.

Both hospitals that were approached had their own internal bureaucratic problems that meant further delays in executing the field work within the first quarter of 2014. The nurses working at St Mary's hospital were on strike during the first quarter of 2014 against the management of the hospital for a pay increase. On the other hand, Nelson Mandela Academic was without a CEO and the acting CEO did not agree to any research projects taking place in the hospital. These

barriers to entry meant that field work was pushed into the second and third quarter of 2014 and beginning of 2015.

The second problem that was encountered was that of access. Both hospitals possessed their own internal ethical review committees for researchers. The Nelson Mandela Academic Hospital review committee was tied to the Walter Sisulu University's Department of Medical Science in Mthatha and St Marys Hospital was tied to Life Group in East London. This meant that any research that could be conducted would have to wait until a standing committee was in session. This meant that approval would only be received in the second and third quarter of 2014. To avoid further delays, I utilised the help of family who worked at the Nelson Mandela Academic Hospital, who helped find participants and interviews were done outside of the hospital. Referrals and word of mouth were also used as means of finding more participants.

At St Marys Life Group Hospital a request on formal hospital forms was submitted via email to their head of Education in East London. This request included the research proposal, research questions, methods and time needed to do research. Accompanying documents were endorsements from Rhodes University Sociology Department. Approval to conduct research at St Marys Life Group in Mthatha was only received in September of 2014. This can be found attached under addendum 1. These methods all meant that the gatekeeper problem was bypassed. Approval to conduct this study was granted by the Eastern Cape Department of Health and can be found attached at Appendix 1.

The third problem was that of time. The most common problem at both facilities was that of time, in trying to see participants for interviews and scheduling interviews with nurses. With nurses who worked at Nelson Mandela, interviews had to be organised outside of the hospital and at the nurse's convenience. This often meant that interviews took place when nurses were not working and in their homes. After research consent was received from St Marys Life group, a formal introduction by Hospital CEO was arranged between myself and all heads of the nine clinical areas that the hospital has. After familiarity had been established by heads of clinical areas, a formal introduction was made by myself to all nurses working in the different clinical areas. Thereafter scheduled times had to be made with Heads of clinical areas on appropriate times that their hospital wards could be visited. Times also had to be establish with nurses who worked at the different wards. This meant that interviews took place during nurse's teatime and

when they were free. The issue of time impacted on interview style, interviews could only take place for as long as nurses were not busy. This meant that some interviews could involve two or three nurses at a time to try to minimize time. Grouping nurses in this unorthodox fashion helped to bypass the issue of time constraints.

### **3.10 CONCLUSION**

This chapter outlines the research design used to achieve the research goals and the difficulties experienced in gaining access to the facilities. The study draws on the traditions of qualitative data collection and ethnography, which look at how people make sense of the world around them. Using this approach enabled the researcher to get in-depth information based on the nurses' experiences. The study was conducted in Mthatha in the former Transkei in the Eastern Cape Province, with nurses chosen from Nelson Mandela Academic and St Marys Life Group Hospital. The nurses, who were the participants in this study included enrolled nurses, nursing assistants and professional nurses at Nelson Mandela Academic hospital and St Mary's Life Group Hospital in Mthatha. To collect data, purposive and snowballing were used as these proved to be the best methods for the study and in line with qualitative ethnographic research that was chosen. Data collection methods were in the form of semi-structured interviews and a focus group discussion. Analysis of the data was undertaken in a thematic manner where data is examined to identify and to categorise the themes and key issues that emerge in answering the research question. The methods that were used to collect data were chosen to accommodate the research problems that were experienced during fieldwork. The main problems that were experienced were that of access and time constraints in conducting interviews. The problems in access were overcome by means of referrals and word of mouth, all respondents in this study signed consent forms indicating their consensual participation in the research. All ethical considerations were adhered to and approval to conduct research was received from Rhodes University Higher Degrees Committee and from the Eastern Cape Department of Health. All the information collected in during this process is aided in answering the research question and this can be found in the proceeding Chapter 4 and 5.

# **CHAPTER 4**

## **PERCEPTIONS OF EMOTIONAL LABOUR BY NURSES**

### **4.1 INTRODUCTION**

This chapter presents and discusses the findings relating to research objective one and presents biographical information collected from all the nurses interviewed. The research objective aimed to examine the perceptions of emotional labour by nurses using Hochschild's (2003) view of emotional labour. Qualitative data was collected through structured and semi-structured interviews so as to address this research objective. Data was coded under the under Hochschild's emotional labour themes of feeling rules, surface and deep acting, masking one's true emotions: nurses as chameleons: the many hats that nurses wear, emotional manipulation and emotional boundaries.

### **4.2 BIOGRAPHIC ANALYSIS**

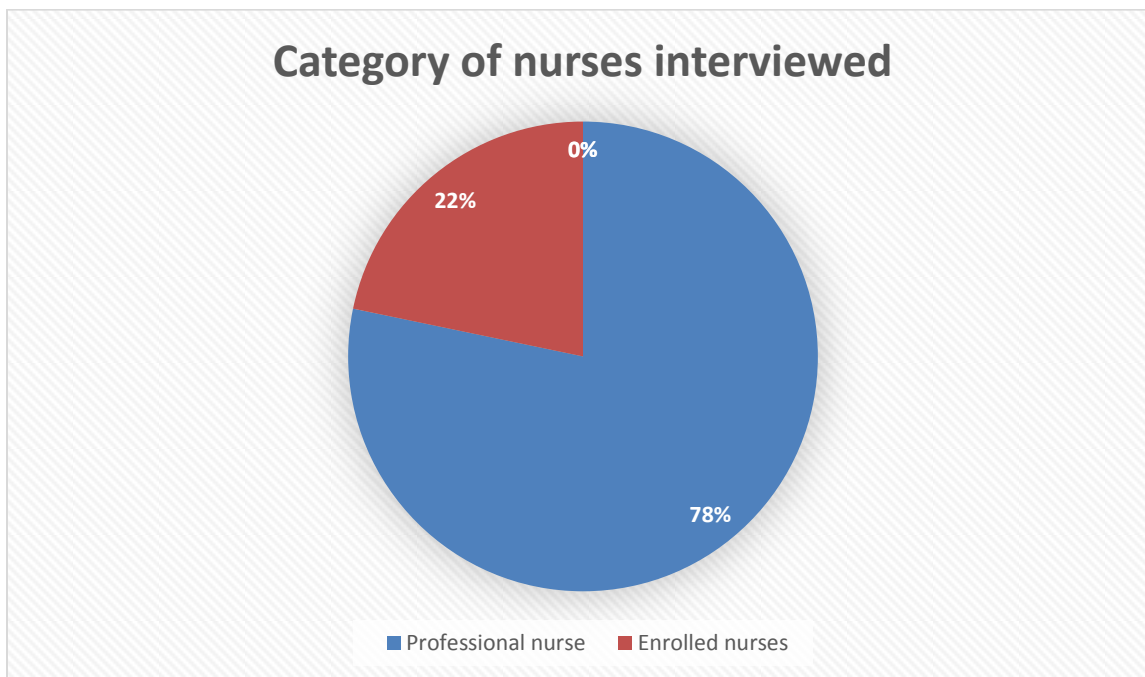
This subsection provides a summary and discussion of the biographical information collected in this study to develop a profile of nurses interviewed. Creating such a profile is important in order

to obtain insight into the characteristics of the group of people being studied, who in this case are nurses employed in private and public hospitals.

#### 4.2.1 Profile of Nurses Interviewed

The categories of nurses interviewed were professional nurses and enrolled nursing assistants. In Chapter Two, a contextual framework of nursing outlines the different responsibilities that come with the different roles. The work organisation, uniform and duties of the different categories of nurses are distinctly different and this is done as a hierarchical distinction feature in and amongst the nurses. The figure 4.2.1 below represents the number of professional and enrolled nurses interviewed in this study:

*Figure 4.2.1: The category of nurses interviewed*



78% of the nurses interviewed in this study were professional nurses and 22 % of the nurses interviewed were enrolled nurses. The classification of nurses entails different responsibilities and different levels of care. As part of biographic sheet nurses listed their duties, one for the enrolled nurses working in eye ward stated that her duties included:

*bed making, observations, eye swabbing, assessments, wound dressing, changing draining bottles, writing up a care plan, attend to bed that needs to change and feeding helpless patients (Eye ward, Sanela, enrolled nursing assistant, 2014).*

According to Mellish et al (2010:37) and as seen from Sanele's duties and other nurses like her, enrolled nursing assistants provide elementary care and this such as bed making, feeding of patients and observations. The more intense work tasks include washing, feeding, gathering information, and administering medication were also duties that were done by nursing assistants. One must also add that both enrolled assistant nurses and professional nurses' duties change according to the ward in which they work. For example, the duties of Zandile, a professional nurse who works as an HIV/AIDS counsellor, included

*HIV testing, counselling on HIV, preparation of clients for initiation of anti-retrovirals (ARVs), counselling on treatment compliance and adherence (HIV/AIDS Counsellor, Zandile, Professional nurse, 2014).*

Professional nurses provide comprehensive nursing care and perform administrative tasks which include updating patient files and updating the related paperwork needed for discharging or admitting patients (Gurses and Carayon, 2009 cited in Burford, 2012: 34). A professional nurse who worked in the operating theatre shared the following duties:

*identification of patients, assisting doctors with operating patients, nursing patients post-operation and before going to the surgical ward, teaching student nurses" (Operating theatre nurse, Siphokazi, Professional nurse, 2014)*

A professional nurse working in the psychiatric ward also shared her duties:

*I have four-fold functions as a professional nurse, namely, patient care and this means assisting patients and support them, physically, socially and emotionally and relatives as well. Administration tasks as a professional nurse are to manage the unit, take charge of the colleagues including junior personnel like student nurses and lower category of nurses. Work hand in hand with doctors so as to be able to satisfy patient needs, making sure those patients are satisfied with care using*

*patient centred approach, education and research (Psychiatry ward nurse, Bongi, professional nurse, 2014).*

Apart from the duties that nurses perform as seen from the responses given by nurses, other distinctive features amongst nurses vary from hospital to hospital. At St Marys Life Group Hospital, there were a number of distinguishing features such as some nurses wearing white uniforms while others wore a navy blue Life Hospital Group uniform. The explanation given was that nurses in white were those who were recruited by an independent recruiter outside of the hospital and were non-permanent staff. Those in the blue and red uniform were permanent staff. The most common distinguishing feature on nurses uniforms are the shoulder pads or what are commonly known as epaulettes and badges that adorn nurses uniform. These signify hierarchical rank amongst nurses. For example, when a nurse passes the nursing diploma and becomes an enrolled nursing assistance, they receive a plain red epaulette. As the nurse furthers her/his studies, badges and bars adorn the epaulette in courses like midwifery, education, community, psychiatry, family planning, administration. These bars and badges on the epaulette dictate the specialisation and the duties that a specific nurse may undertake in the hospital.

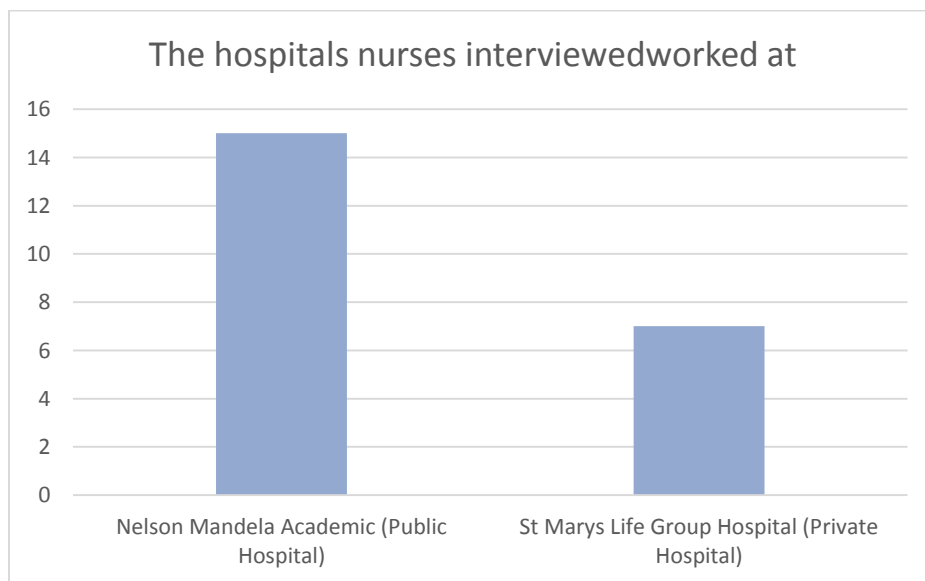
The hospital hierarchy also dictates the duties and responsibilities that are allocated to each position. Professional nursing duties are more comprehensive in that they go beyond just bed-making and feeding patients and the professional nurses delegate duties to assistant nurses. The professional nurse is usually the sister in charge of the ward and part of her duties is to manage the overall running of the ward, with the assistant nurse who reports to the professional nurse. The nurses interviewed in this study worked in both private and public hospitals.

Within the South African context, the structure of healthcare industry within which the nursing professionals operate consists of the private and public sector. The public sector is funded with taxpayer money and is usually under-resourced and over-utilised as this caters for about 80 percent of the population while the private sector only caters for approximately 20 percent of the population. The majority of the nurses who were interviewed in this study were from Nelson Mandela Academic Hospital, which is a public hospital. The nurses complained of overcrowding in their wards and the large volume of patients that they catered for. This hospital often caters for referral patients from surrounding areas in Mthatha, which adds to the increase in number of patients that nurses attend to. The issue of workload seems to have a direct impact on the

emotional labour that nurses utilise and on their overall organisation of work like fatigue and job satisfaction. This issues will be detailed in much greater detail in Chapter 5.

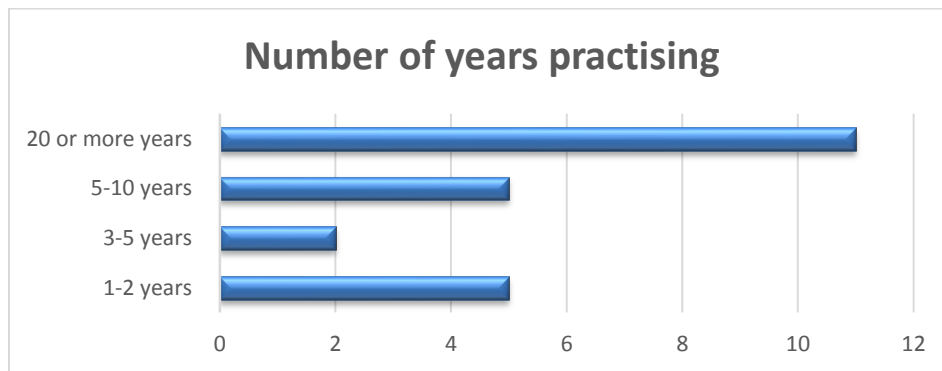
The other nurses who were interviewed in this study worked at St Marys Life Group Hospital, which is a private hospital in Mthatha. The private sector is a profit sector where patients have medical aid or medical insurance, which makes provision for the payment of services rendered by providers (Geyer et al, 2002:11). This hospital in comparison to Nelson Mandela Academic hospital was less crowded with fewer patients. The nurses at St Life Marys Life group hospital there used an electronic system all throughout the hospital that monitored patient’s records and updated prognosis of patients. The admitting and releasing of patients was also electronic. This electronic system according to the nurses made work much more efficient. Nurses however still complained about how poorly paid they were, and one admitted to moonlighting in another hospital during the night to make more money. Figure 4.2.2 below details the respondents who worked at Nelson Mandela Academic and those who worked at St Mary’s Life Group Hospital.

*Figure 4.2.2: The hospitals that nurses interviewed worked at*



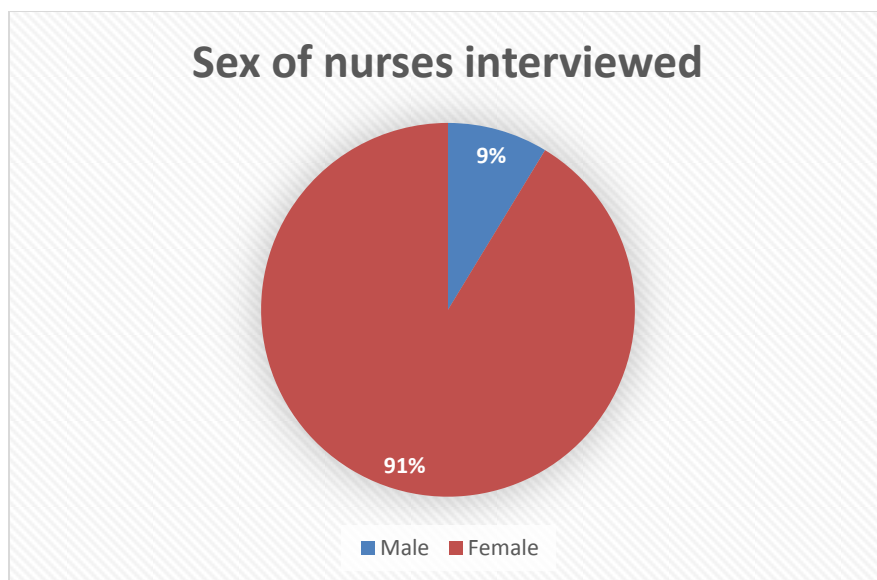
The nurses in their biographic sheet were also asked to detail the number of years they had been working as nurses. The majority of the nurses interviewed as illustrated in figure 4.2.3 below were nurses who had been practising for 20 years and more. The smallest demographic of nurses interviewed had been working for 3-5 years. The emotional labour strategies of those who had been practising for a long time was evident in their answers. Siphokazi, an operating theatre nurse who has been nursing for 39 years revealed that leaving her problems at home was something that she encouraged nurses who were just starting out. She believed that her years of experience had enabled her to compartmentalise her feelings and emotions so that they never got in the way of her work. The nurses who had been nursing for 20 years and more also revealed how nursing was a calling for them and nurses who had only been practising for less than 5 years saw nursing as a career due to issues of unemployment.

*Figure 4.2.3: Number of years practising*



The biographical analysis also asked nurses to indicate whether they were male or female. The pie chart Figure 4.2.4 below illustrates that 91 % of nurses interviewed were female. This confirms notions of nursing in Chapter one and figures released by the SANC of nursing being a female dominated profession and often described as “women’s work”. 9 % of the nurses interviewed were male. When asked whether they thought that woman were better nurses than men, they said yes as they believed that women were more caring than men.

*Figure 4.2.4: Sex of nurses interviewed*



### **4.3 DIMENSION OF HOCHSCHILD’S EMOTIONAL LABOUR**

In the nursing labour process, nurses’ work could be understood from an emotional labour perspective as face to face contact and front line contact with patients, managing their emotions for the benefit of the patient and in accordance with organisational rules (feeling rules) that they are taught during training. The concern in the emotional labour theses is to show that emotions are subject to acts of personal management, acting in accordance with implicit “feeling rules”. The sections below, look at the dimensions of emotional labour in relation to the answers offered by the respondents in this study.

#### **4.3.1 FEELING RULES**

Feeling rules, as defined by Hochschild (2003: 68), are “a set of shared albeit often latent, rules” or situational guidelines that help match the expected emotion of a particular situation in carrying out emotion work. These feeling rules may be explicit or informal in nature. There is great expectation according to Bolton (2000: 583) that centre on the way nurses manage their emotions as they must appear kind and caring but also detached. These, according to Hochschild (2003), are known as “feeling rules” that are used by organisations as a discipline measure to ensure that adequate service is given to patients or clients as nurses refer to them. Goffman (1959), like Hochschild (2003), suggests that actors use what is called “traffic rules interaction”, which

ensures that actors constantly monitor not only their own conduct but also the conduct of others, thereby sustaining the predictability of everyday life. These traffic rules interactions are used by the actor to foster a desired projection of identity. In Hochschild's (2003) emotional labour thesis, the flight attendant is taught the implicit feeling rules or Goffman's (1959) traffic rules interaction that they must comply with them as early as recruitment and selection. Nurses, like flight attendants, learn these implicit feeling rules during their training and education. When asked about what emotions she could and could not show at work, a nurse stated that:

*As a nurse, we are taught that when you are here at work interacting with patients you cannot show pity for patients but you must always be supportive. Here at work, you find that no matter how affected or hurt you feel about a patient's situation or condition you must be strong for the patient. There are instances however, that while you try to be strong for the patient, you end up showing what you feel, that you show empathy for what the patient is going through and this happens naturally but as nurses we try very hard to endure the pain, if sometimes the pain is too much to endure, we sometimes just go to the bathroom and hide there (Nancy, eye ward nurse, 2014).*

Nancy reemphasised the need to remain calm and poised in front of the patient because it is something that they have been taught as early as training in nursing education. Nurses like Medical students learn what Ashforth and Humphrey (1993) call the art of "detached concern", where they convey concern but remain sufficiently aloof to retain their impartiality. The nurse also revealed that this is done for the benefit of the patient when she says: "you must be strong for the patient", even if it means that she must suppresses her own feelings. Nancy reveals that she often shows empathy for her patients, as this happens naturally. The concept of empathy according to Hayward and Turkey (2011:1512) is linked to the manipulation of emotional boundaries. "Empathy involves both cognitive (recognising and communicating an understanding of the others feelings) and effective (engaging with and experiencing the feelings of the other person) process" (Hayward and Turkey, 2011:1512). This is an example of informal feeling rules that have been taught through socialisation. This further reveals the need to feel in control of the patient/nurse relationship and indicates how nurses are willing to work that much

harder on their emotions in order to maintain the professionalism and integrity of their profession.

Nancy's account can also be analysed from Goffman (1959) view of social interaction as performance. During a performance, the manner in which the actor conveys the information to their audience is what Goffman describes as a "front". Goffman (1959: 13) explains a front as the expressive equipment of a standard performance and the front constitutes the setting in which the performance takes place. There are, however, different parts that constitute the front, and the first part that Goffman mentions is the "setting", which includes furniture, décor, physical layout (1959:13), and physical objects which communicate or reinforce the identity the individual wishes to perform. This being said the performer has what Goffman (1959: 4) calls the "personal front". The "personal front" refers to 'the other items of expressive equipment, the items that we most intimately identify with the performer himself or herself, and that we naturally expect will follow the performer wherever he or she goes' (Goffman, 1959:14). These items may include clothing, sex, age, racial characteristics, size, as well as looks. In the case of the nurse, the "setting" in which the performance takes place would be the hospital or a hospital ward. The personal front would refer to the particular nurse in question, but also the nurse's uniform and things such as the manner in which the nurse carries herself or himself when speaking to patients. In order to maintain a convincing performance, there must be consistency between the setting, appearance and manner of the individual (Goffman, 1959: 15). Nancy's front is where the performance is taking place with the patient. In not wanting to give away the performance, she moves to the back (bathroom) where feels she can show her true feelings. Away from the patient (front), Nancy can reveal her true self where her performance is not subject to feeling rules.

Siphokazi, an operating theatre nurse who has been nursing for 39 years also revealed the feeling rules she had been taught during training. Siphokazi spoke on the importance of empathy as highlighted by Hayward and Turkey (2011). She said that nurses are taught two key principals that they were to adhere to:

*Sometimes you put yourself into their (patient) shoes and you show what is called empathy. And you think that they (patient) have this condition that cannot be reversed and when you get home you almost want to pray for them. When we are doing nursing training us say that we (nurses) are there to assist the patient with two*

*things: to recovery and to assist a patient to a peaceful death, so that someone doesn't die never having been cared for. These are our duties as nurses (Siphokazi, Operating theatre nurse, 2014)*

To achieve the feeling rules that Nancy is aware of, she utilises surface acting. Surface acting, according to the definition presented in Chapter One, involves the managing of expressional behaviour rather than the feeling. By this, we mean managing the facial expressions and bodily display. Nancy is cognisant of the supportive role that she must play, suppresses her feelings and changes her facial expressions not to show how deeply affected she is. She complies with the display rules set by management and taught to her during training. Nancy detaches herself from her true feelings. The idea of detachment and maintaining strength by not revealing one's true feelings is a coping mechanism for Nancy so as to comply with feeling rules in the hospital. Bolton (2000: 58) found in her study of nurses working in a gynaecology unit that nurses work hard on making sure that they “mask” their feelings in order to help the mother come to terms with the difficult decision of having to terminate a pregnancy whilst also maintaining their professional face. The nurse in such tough situations has to maintain the integrity and strength of her profession. In the same way, Nancy ‘masks’ her true feelings as a protective shield in order not to lose face with the patient as this would alter the power relationship between patient and nurse. Hugman (cited in Bolton, 2001:91) states: “by failing to construct and defend clear boundaries the professional becomes too closely linked with the service user and the idealised image of the calm, collected professional would become tarnished”. The nurse only feels comfortable with revealing her emotions out of the prying eye of the patient and her staff in the bathroom so as to maintain professionalism.

A clear example of implicit feeling rules is the “gentle method” that nurses working at St Marys Life Group hospital were taught during training and have to adhere to. The gentle method is St Mary’s Life Group hospitals very own method of ensuring quality service is given to patients. The gentle method states that:

*Greet all patients*

*Engage your patients and their families/significant others*

*Nurse every patient with pride*

*Teach your patients about their condition, their progress and their treatment programme*

*Lead nursing care all the time*

*Embrace all patients of all groups, irrespective of race, religion and status (St Marys Life Group, 2014)*

The “gentle method” is very similar to Batho Pele and the Patients’ Rights Charter, which are outlined in Chapter Two. This principle states: “patients should be treated as individuals, with fairness, in an unhurried manner, with empathy and understanding, as well as with consideration and respect. Discourtesy must not be tolerated”. The Patients’ Rights Charter under the broad umbrella of access to health care states: “Everyone has the right to a positive disposition displayed by healthcare providers that demonstrate courtesy, human dignity, patience, empathy, and tolerance”. These implicit feeling rules are hung all around hospitals and can be seen by those who use these facilities. The punishment according to the nurses for not following these rules, entail warnings for misconduct, as their conduct went against the ethos that the hospital was fostering. Feeling rules in the hospital also covered what they deemed to be desirable and undesirable emotions. Pity, according to Nancy and other nurses interviewed in this study, is an emotion that is considered undesirable by hospital management. Emotions such as anger and pity are all negative emotions that should not be expressed by nurses to patients.

Another nurse, when asked about the emotions she could and could not show at work, likened the feeling rules implicit to cashiers in the service industry:

*Just like cashiers, you need to be polite. You need to smile because when you smile you bring hope to someone who is ill and cannot do anything for themselves... You are not allowed to come with your problems or show them. You must be cool and polite. You must be someone who can show great empathy for someone else (Sally, HIV/AIDS counsellor, 2014).*

Two other nurses shared the same sentiments:

*I have emotions/feelings but when it comes to work I know that I must control my temper and change my attitude. I must fix my attitude towards the client because the client is not aware that when I left home I was upset or not feeling well. When I get*

*here (work) I need to make sure that I fix and change my feelings because I am going to deal with clients now and they must feel happy” (Anna, Women’s Health Clinic nurse, 2014).*

*In all the years that I have worked as a nurse, I always tell my young nurses that if you have a problem at home you have left it at the gate. You have to constantly work on your emotions and you cannot bring your home emotions to work because you could argue with nurses, argue with patients. That could just cause chaos. You could cry and do all the things you shouldn’t do at work. If you try to as a young nurse at the start of your career to teach yourself to suppress your problems so that other people don’t see your true feelings. You need to handle your problems within yourself so that when you encounter patients it is as if you have no problems at all (Siphokazi, Operating theatre nurse, 2014)*

Sally, an HIV and AIDS counsellor, recognises the desirable traits that she must display of which being polite and smiling are part of them. She knows these desirable traits must include friendliness, smiling and providing a calming environment for her patient. This is in accordance with the feeling rules that she has to display and also these desirable traits, according to her, foster the performance “which is that of giving hope to the patient by smiling”. Anna and Siphokazi talk about what they know and what they have to do. These are called informal display rules and are informal because these are norms that have been learned through socialisation and are common practice in society and the workplace (Ashforth and Humphrey, 1993; Zapf, 2002). Siphokazi, an older nurse, who has been nursing for more than 39 years states that:

*In all the years that I have worked as a nurse, I always tell my young nurses that if you have a problem at home you have left it at the gate.... If you try to a young nurse at the start of your career to teach yourself to suppress your problems so that other people don’t see your true feeling.*

She recognises the need to suppress her own feelings in order to get the work done and display feelings that are expected of her. As Anna states: “I am going to deal with clients now and they must feel happy”. Anna, like Siphokazi, realises that she must suppress her feelings for the benefit of the patient so that they can feel happy. All the nurses interviewed shared the same

sentiments of the nurses quoted above, recognising implicit feeling rules at work. This realisation expands to emotional boundaries as well - emotions felt and experienced at home and those felt and experienced at work need to be separated. Sally, the HIV and AIDS counsellor, realises that she has to move outside of her own problems and show empathy for her patients. The need to be polite and friendly is done for the benefit of the patient. The nurses in this study understand that their performance of emotion work as Zapf (2002: 238) shares, “is done to influence people’s behaviour and attitude” and in this particular instance is done in order to bring hope to ill patients. The nurses understand that their job is to provide support and hope. This is done by being strong for the patient, as highlighted by Sally, and in this instance, it is done by being friendly and polite. Writers like Bolton (2010: 350) highlight the therapeutic value of performing emotional labour as nurses in this study point out that her behaviour and disposition brings hope to the patient. Feeling rules, according to Hochschild (2003), are situational guidelines and the nurses in this study understand by following formal and informal feelings rules. They understand that being polite and friendly is a means of making work easier and providing hope to patients. To meet feeling rules and standards nurses utilise surface acting and deep acting.

#### **4.3.2 SURFACE ACTING AND DEEP ACTING**

In attempting to manage emotions, actors use surface acting and deep acting during face-to-face work. Surface acting involves managing the expression behaviour rather than feelings. This means managing facial expressions and bodily displays that may give away the true feelings of the labourer rather than the feeling they intend to foster in the other. This is accomplished by careful presentation of verbal and non-verbal cues such as facial expressions, gestures, and tone of voice in such a way that the customer/person knows that they (employees) are only acting. Deep acting, on the other hand, involves the actor attempting to experience the emotion displayed. According to Hochschild (2003: 28), the distinguishing feature of these two approaches is that one is directly exhorting feelings while the other is making indirect use of trained imagination. Nurses sometimes feel they need to engage in emotional labour to ensure that their emotional displays match the patients’ social expectations and organisational rules (feeling rules) (Mann, 2005).

As shown in the section above on feeling rules, when nurses try to fulfil organisational rules they utilise surface acting and deep acting. Prime examples of this are Nancy, who works in the eye

ward, and Siphokazi, the surgical nurse, who tell new nurses that they must learn to suppress (surface acting) their feelings. All the nurses interviewed in the study (except for Zanele) tried to comply with organisational rules by performing surface acting and deep acting. According to Hochschild (2003), nurses utilise surface acting and deep acting. Surface acting and deep acting are tools utilised to achieve organisational goals. Nurses' responses when asked if they actually felt the emotions that they display at work to patients:

*Yes, absolutely. Yes, I do feel the emotions ...not all of them all the time ... there are empathy and sympathy that I show that is genuinely felt. There are times however when one is at the end of their tether, that you will say "enough", "no more". "What do you need" but generally speaking, yes (Lynn, School nurse, 2014).*

*Sometimes, the feelings that I show at work are feelings that I genuinely feel. When dealing with patients I even have that feeling that I should do something about their problems because you find that even after you have left work that feeling stays with you, "that had I done everything for that client who had that problem or behaviour (Zandile, HIV and AIDS Counselling nurse, 2014)*

Another nurse had a contrary response:

*No. I actually don't feel the emotions that I show but I put on a smile even when I don't particularly feel happy. But this (putting on a smile) makes me irritable and one wrong comment could set me off. You don't actually feel that emotion (happiness-related to the smile) that you have displayed because there are things that are eating you up in the background of all that. Even when dealing with a client you find that they will do something that will irritate you and you find that you quickly have to adjust your feelings not to show that irritation or when you say something wrong (fuelled by your emotions) you quickly apologize to the client (Zanele, Women's Health Clinic nurse, 2014).*

Lynn's and Zandile's responses show that emotions are genuinely felt. This is what Zapf (2002: 243) refers to as automatic emotion regulation. These emotions are automatic and spontaneous, without thought. Lynn states that these emotions are those of empathy and sympathy. However, there exist discrepancies. This was looked at in Chapter One by Ashforth and Humphrey (1939:

92-93) as highlighted in the section of feeling rules by Zanele and also reemphasised in her response about how she does not feel the emotions that she shows at work. She says “I put on a smile even when I don’t feel happy...do not actually feel the emotion (happiness- related to the smile) that you have displayed because there are things that are eating you up in the background of it all”. The passage shows Zanele, having performed emotional labour by putting on a smile, realises that this does not match with how she really feels. The discrepancy in making the performance authentic is ruined by what she may be going through outside of the performance, influencing her immediate performance. This discrepancy in Zanele’s performance reveals what Hochschild (2003) stated, how many people struggle with authenticity in interactions in which they have little control and creating pressure in workers to conform with emotional rules. Emotional dissonance may also be considered a form of person conflict or multiple person conflicts. It may originate when an employee feels nothing when a certain display rule is required or the display rule may require the suppression of feeling and the person is unable to. There is a discrepancy of multiple selves in Zanele’s performance. She realises that she has put on a smile on her face as she is a nurse in this facility and the patients expect it from her, but she cannot seem to do so because she does not feel these emotions. The performance is unsuccessful for her because pretending to feel a certain way irritates her authentic self. Zanele’s performance reveals a mismatch between felt emotions and organizationally desired expression of emotions.

When discrepancies occur it raises the question of the authenticity of the felt emotions. The question of whether the emotions expressed during the performance are real or fake. Out of all the nurses interviewed the nurses at the Women’s Health Clinic admitted to feigning their feelings more than all the nurses interviewed. Most of the nurses who were working at the clinic had been professional nurses for more than five years. Some of their responses when asked whether they feign their feelings when interacting with patients were:

*I do fake my feelings but this happens when I have to deal with a client who might possibly be the same age as your child and you feel that you are getting angry, your feeling with this child is that you are getting angrier with thoughts of how can a child this age be aborting/terminating a pregnancy. But you know that you need to hide your feelings so that the client/child can feel free since they have a choice now of whether or not to terminate a pregnancy and I know that need to make her feel*

*comfortable and not to make her feel guilty. Because once I show my true feelings she will find that she isn't happy and like she is doing something that is against the law but in actual fact she is doing something that by law is allowed to do (Anelisa, Women's Health Clinic, 2014).*

Another nurse in the same women's clinic had the same attitude:

*We do fake our feelings because if you do not fake your feelings it will seem like you are judgemental or you are discriminating or you violating someone's rights because as they come to the clinic to terminate a pregnancy they have certain problems ...you have to fake because it could be the first, second or third time but there are personal reasons there. You have to fake because at the end of the day you have to deliver a service to a paying client excellently (Ncumisa, Women's Health Clinic, 2014).*

These nurses in the Women's Health Clinic shared these feelings in the focus group, all admitting to the false portrayal of feelings. They presented in their accounts of a dichotomy between authentic versus inauthentic emotions, the real versus the fake. However, these false portrayals could be linked to the type of work that nurses in this facility do. The constant enhancement or suppression of feelings in dealing with patients within the nurse-patient interface may lead to what Hochschild (2003) detailed as inauthentic feelings being displayed. This may also result in feeling detached not only from one's true feeling but also from other people's feelings, suggesting a relationship with the dimension of depersonalisation. The delicate nature and moral issues associated with terminating pregnancies form part of the reasons why the nurses in this facility displayed and presented disingenuous emotions that were not what they felt. The nurses highlighted the danger of their jobs. As seen by Anelisa's response:

*Your feeling with this child is that you are getting angrier with thoughts of how can a child this age be aborting/terminating a pregnancy. But you know that you need to hide your feelings so that the client/child can feel free since they have a choice now of whether or not to terminate a pregnancy and I know that need to make her feel comfortable and not to make her feel guilty. (Anelisa, Women's Health Clinic, 2014)*

Nurses felt upset with clients who did not listen when advised on family planning and contraceptive alternatives. The nurses faked their feelings and put smiles on their faces (surface acting) because they realised that had to deliver a service to clients and comply with organisational set feelings rules of “service with a smile’ and not discriminate against patients as this went against the Choice of Termination of Pregnancy Act of 92 of 1996. Ncumisa states that no matter how agitated she may be, she hides her feelings so that the client can feel comfortable and not make her feel guilty.

To further unpack and investigate the discrepancies that exist for what is experienced and what is really felt, nurses were asked whether they try changing their actual feelings to match the feelings they were expected to express. Some of their responses were:

*I don't try to change my feelings to match the feelings that I have to express. When I express an emotion, it comes from a genuine place. I have never expressed an emotion involuntary due to me knowing what is expected of me. My feelings always come from a true and genuine place. For example, when I'm breaking bad news, I have that feeling that I'm breaking bad news and this going to hurt someone. It's never a case of “oh well the patient has AIDS and that's that”. It's always a genuine feeling (Sibongile, HIV and AIDS Counsellor, 2014).*

Another shared the same sentiments:

*Yes, I have to change because if I don't change my feelings...wait let me see...let me make an example, if you are dealing with mentally ill patients and then you show anger, too much anger. Let me make an example if a patient was supposed to come on such and such a date and they didn't come and that interferes normally with the treatment, the concentration of that medication in their body. Now it's not good because it hasn't been continued and that's wrong but if I become so angry, the patient can leave me like that and go back home because he cannot handle me and by so doing it's not good for the patient because he has defaulted already. So I have to try and compromise. If I show my attitude and I'm shouting, the patient won't tolerate me and he will leave me. My only option is to go down to his level and try and explain the importance of taking regular medication. If I become too angry and*

*shout, it could even result in the patient hitting me. By shouting I am just exacerbating the situation (Bongi, Psychiatry ward, 2014).*

Lynn the school nurse also said:

*“It is true. But again it isn’t insincere. You know this girl is coming in and she expects this of me of me now, it is in her best interest that I can give her what she is expecting. When I say it is insincere I mean it is never forced, it is almost natural. I think I have been in the game for a long time so that switch that I’m talking about happens (Lynn, school nurse 2014).*

Sibongile revealed that when interacting with patients, all her emotional responses were genuine and they were not involuntary. Wendy admitted that she changed her actual feelings to match the feelings that patients expected them to portray and to fulfil organisational display rules. In the case of Bongi, the nurse who worked in the psychiatry ward, the change of emotions was merely a changing of one’s attitude (surface acting) in order not to reveal their true irritation or frustration with the client/patients because they know the type of patient they are dealing with. The nurses agreed that anger and frustration were negative emotions that they were aware would interfere with their work. They are aware of the display rules and utilise surface acting and deep acting to fulfil these rules as well as to get the work done. They often have to mask their feelings in order to foster credibility to their performance. To fully understand emotional labour, it is pertinent that the masking of emotions by nurses be looked into. Lynn, a school nurse, also stated that she changed her actual feelings but added that this was not in any way disingenuous or insincere. She mentioned that her experiences, or as she put it “being in the game”, has meant that she was aware of the feelings that she must express for the performance to be successful. The idea of surface acting and the discrepancies that occur in the performance of emotional labour lead to the idea of masking of feelings that nurses undertake.

#### **4.4 MASKING TRUE FEELINGS AND EMOTIONS**

Nurses describe how they have to “mask” their feelings in order to express the right emotion or sometimes to present the professionalism and the image of the nurse who is composed and caring. These nurses perform hard emotion work and offer patients comfort and empathy whilst

remaining detached from any turmoil or dispute that they may face at home or in the private realm. Lynn admitted to masking her emotions when asked and stating the following:

*Yes, I do, if you come in and you're not feeling great, you have to put on a mask. If it has been turmoil at home, you come in and you put on a mask and you get on with it. You grow, you grow into that persona. It's a switching on and a switching off ... You leave your feelings behind and you put on a new mask but that mask isn't insincere, it's a switch (Lynn, school nurse, 2014).*

Another nurse shared her experience:

*Yes, sometime because I am a human being who is sometimes affected by things. From time to time I will find that something happened at home that hurt or bothered me but when I get to work, I have to put on a mask because here I am bringing hope to someone who is ill so I have no choice but I have to put on that mask (Sally, HIV and AIDS counselling nurse, 2014).*

Lynn, when asked if she put on a mask in order to express the right emotions at work, described how she put on the mask in order not to be affected by things that happened at home. She also described how the mask was like putting on a “persona”. The persona of the kind, caring nurse who is expected by those who are visiting the facility. The persona is like impression management that the nurse is aware of. Goffman (1959) suggests that actors are knowledgeable agents that “give” and “unwillingly” give off impressions about themselves and the performance to the audience.

The transition from one role to another was like a switch that she turns on and turns off, this shows emotional manipulation of feelings during the transitions of roles. Lynn's persona management is similar to what Goffman (1959) describes as an act whereby during face to face interaction, people do not switch themselves on and off but glide from one performance to the next. The particular role that the nurse transitions from is that of the mother in the domestic sphere and that of the school nurse in the public sphere. According to Bolton (2001: 88), the former provides the necessary conceptual connection between the private and public worlds of emotion management, thus emphasising actors' multiple identities. It is the acting that the nurse has to do as she moves from private unpaid labour to public paid labour. She knows that upon

her arrival at work she must fit a role or persona. As she describes it “you grow into that persona”. In her case, it’s that of the studious, caring nurse that she is expected to be. She masks her emotions in order to detach herself from the private unpaid role of the mother and wife to her family and leaves the problems that come with that in order to fulfil the role of the nurse in paid public realm. A nurse working in the surgical ward explained the split between emotions felt in the domestic sphere and the public sphere:

*We mask our emotions for the benefit of the patient. You have emotions for work and you have emotions for home. It almost happens automatically now. You could fight with your husband and leave home irritated and get into your car and immediately you forget all those problems at work (Siphokazi, Surgical nurse, 2014).*

*Sometimes you have to because I am dealing with mentally ill patient and I have to sometimes because they look at your approach. If your mood is not ok, you will find that you will get negative answers from them and sometimes you have to mask your emotions to get positive answers (Wendy, psychiatric ward nurse, 2014).*

In his study, Bolton (2001:91-92) found that nurses working in the National Health Service Trust Hospital would use terms such as “face”, “mask” or “act” when discussing their professional roles. “This signifies how nurses are very aware that they must actively work on their emotions in order to present the recognisable face of the professional career” (Bolton, 2001:91-92). The nurses insist that the acting or switching on and off emotions was a means of getting the job done or a coping mechanism cognisant of the dual roles they are expected to play. Siphokazi shared the same sentiment as Lynn. She stated that the switching from home emotions and work emotions was automatic, and it was not something that she thought about but something that happened on its own. The switching from the persona of a mother/wife to that of the nurse and the display rules that she must adhere to happen automatically and without thought. This was also the finding made by Hayward and Tuckey (2011:1510), that emotions were an important function and something that nurses were not consciously aware of. The dichotomy that exists for the flight attendant may also exist in nurses, who not only enact the loving mother (by tending to the needs of the sick) but also the firm, unemotional nurse who does not flinch when faced with emotional cases.

Due to the nature of working with mentally ill patients, Wendy explains that it is beneficial in her job to mask her feelings or not presenting her actual feelings. This is done because mentally ill patients often look at the approach of the nurse, and if they feel like the nurse is particularly rude or aggressive, this might elicit negative emotions in them. One might go as far as to say that there is a transference of energy or mood based on the type of patient. The nurse says that you treat mentally ill patients as normal as possible but during your conversation with them, you have to accommodate mental incapacity. In his study, Gray (2009:257) found that nurses working with mentally ill patients had varied emotional distances according to what they saw as “good” and “bad” patients. “In the case of “bad patients”, an emotional distance was encouraged. With “good patients”, the reverse was true and informal intimacies were said to be acceptable and encouraged. The idea of masking one’s feelings is very pertinent in mental health service delivery as a study was done by Nxasana and Thupayagale-Tshweneagae (2014:89) shows that in South Africa there are high rates of psychiatric readmissions. These re-admissions overload the available mental health team especially in the case of Nelson Mandela Hospital, which is the only hospital in the region that has a mental health clinic. All patients from surrounding areas are transferred to this hospital. In such cases, it important for nurses to be mindful of the way in which they interact with patients.

Masking of emotions is a means of convincing the audience of the authenticity of the nurse’s emotions during social interaction. These emotions, usually positive, (smiling, friendly demeanour), are means of confirming to the display rules set out by management but also as a means of the nurse separating the emotions felt and experienced at home and those at work. Masking of one’s emotions could be seen as a form of surface acting, where one is concerned about managing the expression or behaviour rather than the feelings (for example, managing facial expressions and bodily display). Through the masking of emotions, the nurses put on a persona that satisfied management display rules and the expectations of patients. Managing of emotions through masking could draw our attention to skills of emotional manipulation that nurses have.

#### **4.4.1 EMOTIONAL MANIPULATION**

The emotional manipulation that these nurses exhibit in this study is similar to Bolton (2001:86) who saw nurses as emotional jugglers who are able to match their emotions with the appropriate

situation. By doing this, they elicit feelings of safety and comfort in patients. In order to elicit these emotions, the nurse realises that she has to leave her problems at home because organisational norms and standards dictate this. These norms and standards are taught as early as nursing school. Nurses used emotional boundary between emotions felt and experienced at home and those felt and experienced at work. One nurse described this emotional boundary as “work emotions” versus “home emotions”:

*When I am emotional at home, I cannot come to work and apply the same feelings that I felt at home. I should have different emotions when I come to work. I should not be affected by what happened at my home at work. If I left home and I was angry, I cannot come here (work) and still be angry at my colleagues when they do not know what happened at home. So the emotions that I felt or showed at home. I must leave them at home when I come to work and I must resolve those feelings (Odwa, Women’s Health Clinic nurse, 2014).*

Nancy shared the same sentiments when whether she subscribed to the statement “leave your problems at home”:

*Yes, I do... once I enter the hospital ward I forgot all the problems I had at home and focus on work and when I get home later, I will deal with those emotions all over again (Nancy, eye ward nurse, 2014).*

One nurse, however, pointed out the difficulty of juggling and separating what she felt at home and what she experienced at work.

*Personally at times, the emotions that I felt at home, I often bring them to work. Sometimes I can feel that I am not okay but I try my best to work on myself not show what I really feel those emotions. I sometimes find however that if someone walks into the door and they say something that evokes those emotions in me and I quickly get irritable (Zanele, Women’s Health Clinic nurse, 2014).*

The respondents in the study all pointed out how important it was to leave all negative feelings and emotions at home. Any emotion that they perceived would hinder them from providing the

best service to the client should not be brought to work. That it was important to not let any negative emotions or feelings that were experienced at home affect their work. The nurses constantly referred to adjusting their personal feelings to match the feelings that they were expected to portray at work. The constant need to adjust one's inner feelings (deep acting) in order to deliver the best service to the client was the motto and ethos that all the nurses in this study subscribed to. All nurses in this study all agreed that they believed in the statement of leaving their problems at home.

It appeared as though showing one's truest emotions or baggage of "home" emotions would interfere with the work they had to do and if seen in the Goffman's (1959) social interaction view, would discredit the authenticity of the emotions displayed during the performance. Goffman (1959) sees social interaction as a performance, the main performance of which is taking place between the patient and nurse. This is referred to as the front (ward where the patient is inside). In this performance, the nurse remains poised and calm when dealing with a stressful situation. She suppresses her own feelings (surface acting) to remain strong for the patient. The actor (nurse) exits the stage away from where the performance is taking place (to the bathroom), where she is able to reveal her true feelings and be her true self away from the performance and audience (patient). She reveals her true feelings away from the patient so as to ensure that she does not discredit her performance by acting in a particular way. Away from audience (patient), the nurse (actor) has to de-role the character that she has presented (unaffected by what the patient is going through) to the patient and move away from the character that she has created to convince the patient of authenticity of her performance

One nurse, however, pointed out that at times she could not restrain herself or manage her emotions at work. This is what Ashforth and Humphrey (1993:92-93) refer to as discrepancies that may exist between what is genuinely felt and what is on display. Zanele states that "Sometimes I can feel that I am not okay but I try my best to work on myself not show what I really feel". Zanele points out that what she genuinely feels (which is influenced by what happened at home) is not what she displays when she is at work. However, she constantly works on her emotions (using surface acting and deep acting). The success of the performance is not always achieved. As Zanele points that, one hindrance of what she tries to display sets her back into what she genuinely feels. The "feeling rules" that are implicit and set by management for

work (such as “don’t bring you problems to work”) often cause a binary division for nurses between emotions that can be shown at work, which are usually positive (smile and be friendly) and those that cannot be shown at work (anger, irritation and frustration). As shown by Zanela’s answer, sometimes feeling rules are not always successful and employees sometimes do not follow them. This speaks to Hochschild’s (2003) criticism by Brook and Boyd (2003:203) that while management determines “good service”, it is up to the worker to decide how much feeling is invested in the performance. Due to emotional manipulation that nurses utilise in matching their feelings to a particular situation, nurses can be seen as chameleons.

#### **4.4.2 NURSES AS CHAMELEONS: THE MANY HATS THAT NURSES WEAR**

It is possible for organisational actors to have multiple identities (Goffman, 1959; Bolton, 2001; Wharton and Erickson, 1993). Goffman (1959: 139) emphasise the actor’s ability to be many things to many people, stating that “while actively participating in an activity system, he or she is, nevertheless, also obliged to engage in other matters, in relationships, in multi-situated systems of activity, and in sustaining norms of conduct that crosscut many particular activity systems”. This draws our attention to the multiple roles that nurses' play during their performance. One nurse when asked whether she believes in the statement of leaving your problems at work mentioned the roles she must play:

*Yes, I subscribe to the statement leave your problems at work. Because even when I get home, I cannot be 'wearing' the problems that I had at work. I need to be a mother when I get home and not sister so and so. I have to be a mother to my kids, a wife to my husband (Sally, HIV and AIDS Counsellor, 2014).*

Two other nurses shared the same sentiment:

*I sometimes find that I am now a social worker, a psychologist and the work that you are doing is beyond the nursing work that you were trained to do. When you listen to their (patients) problems, they even tell you problems that are outside of why they are at the facility (Ziyanda, Women’s health clinic, 2014).*

*You find that you now have a lot of children that aren’t your own because you care for some of the patients that come into this facility. You solve problems and you end*

*up saying “oh I was social worker today, oh I was a parent today, or I was a psychologist today (Ncumisa, Women’s health clinic, 2014).*

The nurses responses show that the nurses realised that the work that they did usually went beyond just nursing work but required them to wear many hats, that of the mother, a social worker and even a psychologist on some days. As stated by Sally, an HIV and AIDS counsellor that “I cannot be ‘wearing’ the problems that I had at work. I need to be a mother when I get home and not sister so and so. I have to be a mother to my kids, a wife to my husband”. Sally in her own words realises she cannot be the same person she was at work as a nurse, but realises that she must be a wife and a mother. She also realises what is expected of her in the different roles that she must play. Ziyanda in her responses details more clearly the multiple roles that she plays, when she says “I sometimes find that, I am now a social worker, a psychologist and the work that you are doing is beyond the nursing work that you were trained to do.” The work that she does goes beyond putting on a smile but calls on the nurse to provide empathy to patients. The nurses realise that they are able to present a variety of faces according to the situation at hand. This speaks to Goffman’s (1959) notion of the self’s ability to be multiple selves and the ability to manage different roles during interactions. Multiple selves as created by the performer can lead to problems (tensions between different selves), a dynamic shift between roles, or a multiple presentations of selves (as well as coping mechanisms to deal with these discrepancies). These discrepancies and problems may lead to emotional dissonance as discussed in chapter one. Emotional dissonance is a mismatch between felt emotions and organizationally desired expression of these emotions. “Emotional dissonance may originate from ‘faking in good faith’ when the employee accepts the underlying display rule or from ‘faking in bad faith’ when the display rule is not accepted” (Zapf, 2000:245). Emotional dissonance may also be considered a form of person conflict or multiple person conflicts. Under normal circumstances, however, people are capable of handling these multiple, fluctuating, and situational selves. Seen in this light, one would agree with Bolton (2001: 97) that nurses are emotional jugglers, able to navigate different situations and matching the appropriate face with a particular situation. Bolton (2001) describes these as “the professional face”, the “smiley face” and the “humorous face”. The emotional work that nurses perform sometimes goes beyond wearing a hat and mask but creates attachment between the nurse and patient. When asked about attachment, these were some of the responses from nurses:

*You end up end being a parent and everything to this one patient. Like, for example, there was this one patient, who was poor and lost both her parents and the only family member she had was her brother. She was studying at WSU (Walter Sisulu University Mthatha campus) and she was here to terminate a pregnancy. She was telling me that she doesn't even have any money. I ended up so attached to that child and we swapped contact details. I would call her when I am at Spar and I would buy her groceries and things (Anelisa, Women's Health Clinic, 2014).*

The nurse above describes how one of the roles that she played to one of her patients manifested into an attachment between her and a patient. The multiple roles that nurses play reveal how nurses are a never ending storage bag, taking on other people's emotions. A similar idea was expressed by James (1989:40) when referring to women as "society's emotional sponges". This can be seen in the responses of nurses interviewed who literally took on the roles of being more than just nurses to their patients. The ability to manoeuvre from role to role shows how skilled nurses are being emotional labourers. James (1989:26) identifies the emotional labourer's skills: (1) being able to understand and interpret the needs of others; (2) being able to provide a personal response to these needs; (3) being able to juggle the delicate balance of each individual and that individual within a group; and (4) being able to pace work, taking into account other responsibilities. While nursing work is considered invisible and undervalued and the skills that nurses deploy into their work disguise themselves as womanly virtues, it is clear that nurses are very skilled emotional labourers, able to juggle delicate situations by matching their desired role organisational rules and the face.

Attachment is not advised to nurses as part of their training. The nurse's ability to play multiple roles raises the question, how does one play many roles, without forming an intimate emotional relationship with a patient? The answer lies in the emotional boundary tools that nurses utilise in order to maintain the professionalism of their position whilst performing emotion work.

#### **4.4.3 EMOTIONAL BOUNDARIES**

The use of emotional boundaries underpins the efforts that nurses undertake in trying to fulfil management organisational rules and mitigating the private-public duality that exists for nurses. "The distancing and connecting mechanism can be viewed as the processes that link emotional

demands inherent in client-orientated occupations to both negative and positive outcomes in terms of well-being, development, and performance” (Hayward and Tuckey, 2011:1518). According to Hayward and Tuckey (2011:1511), emotion boundaries are used by nurses to regulate anticipated or felt emotions. These emotional boundaries are not attached to single interaction but are used in the broader approach to work. “It was described as a mechanism that supported the nurses’ need for professionalism in their work” (Hayward and Tuckey, 2011:1511). Goffman (1959) also talks about emotional boundaries by referring to it as role-distancing. Role-distance refers to the degree to which people separate themselves from the role they play (while they are playing it). People play roles in a double fashion: they enact the role and distance themselves from it. Role-distance is a function of social status: people in low-status roles are more defensive in their role-distance (ashamed of their role). One nurse revealed the difficulty that comes with creating emotional boundaries:

*You never get too affected... you never distance yourself because you are scared of getting affected. I would say that you become too close to a patient because day by day you get to know them. You have to be close to them and you get to know each and every one of them like what they eat, like what medication they take and what procedure to do to them. There is nothing that you don't know about a patient (Siphokazi, Operating theatre, 2014).*

Siphokazi, an operating theatre nurse, indicated that distancing is something that is impossible because you grow close to the patient with the day to today procedures that you must do and the general interaction with the patients. However, she also said: “you never get too affected”. This indicates that nurses distance themselves to maintain an emotional boundary. Creating an emotional boundary speaks to the training that nurses undergo. As Nancy says: “you cannot show pity for the patient but you must empathise”. Seen in this light, an emotional boundary is created by nurses to fulfil management set display rules and maintain professionalism in their jobs. The professional distance exists because nurses have to do their job adequately but the distance is how much the nurse gets emotionally involved with the patient. Through the interviews conducted and responses given, the researcher concluded that emotional boundaries became part of nurses’ professional persona, akin to masking one’s emotions:

*Mostly it depends on me. I often have to distance myself. I constantly have to tell myself that at the end of the day, as much as I have to empathise with the patient, my ultimate role is to advise the patient by saying that “you have to go there to seek help”, that I don’t have to carry the burden of the patient. I ultimately have to distance myself so that I am able to do the job properly so that it does not affect me too much (Ziyanda, Women’s Health Clinic, 2014).*

The language used by the nurses such as, “I often have to distance myself” and “I have to constantly tell myself” reveals active emotional management done through creating emotional boundaries in trying to distance themselves so that they can do the work well. Hayward and Tuckey (2011:1513) revealed that distancing was meant to produce the professional face, which was described as both caring and distant. “The ‘professional face’ was described in two ways: (1) representing emotional neutrality, where emotion was prevented from being elicited, and (2) akin to expressive suppression, where the professional face acted to suppress the expression of the nurse’s feelings” (Hayward and Tuckey, 2011:1513). In this case, the nurse uses deep acting to actually try to change her emotional state. The nurse distances herself from the patient so that she is able to perform her job and does this by reinforcing her role of being a nurse and the professionalism that comes with her position. Distancing is a form of control for nurses that nurses use in managing their own and others emotions during interactions.

Another nurse shared:

*I am not able to distance myself from my patient because the patient has got a belief in me, the patient trusts me. I cannot distance myself but the patient has put all their trust and hope in me. When she comes here she knows that I will be able to solve all her problems, so for that reason, I cannot distance myself. I try everything in my power to help them by giving them all the services available to me (Sibongile, Women’s Health Clinic, 2014).*

Other nurses who worked in the women’s health clinic were asked if they sometimes felt great worry for their patients. This can be attributed to the delicate nature of their work.

*Yes, it happens because sometimes you find...you sometimes just make it personal and think “what if this was my child, what If she was the one who had to perform an*

*abortion because she was raped” or a neighbour or relative. In that case, you have to understand and put yourself in her shoes (Ziyanda, Women’s Health Clinic, 2014).*

*It affects you, especially if it is the product of a rape and you try very hard to assist the client as much as possible. Even the person who raped them, you want the case to follow a process that the perpetrator gets arrested. Sometimes we even take to social workers and then to the police. Sometimes you will find that a 30-year-old will rape a 15-year-old or that they had agreed to sleep together and you find that, that’s statutory rape even if they agreed (Zanele, Women’s Health Clinic, 2014).*

The statements made highlight the dynamic and complex nature of emotional regulation. It reflects the difficult and often unsuccessful emotion regulation that nurses go through. The nurses in the Women’s Clinic place the burden of their patient’s problems on their shoulders, they find that if there is a problem, they feel that it is their duty to solve it. The nurses kept on saying that they are their patient’s last hope and it is their duty and responsibility to help the patient. Duty is one of the key areas that drive nurses to help patients, even extending beyond their jurisdiction as nurses.

#### **4.5 CONCLUSION**

This chapter has argued the use of emotional labour by nurses interviewed at St Mary’s life Group hospital and Nelson Mandela Academic Hospital in Mthatha. In answering the research objective, data was coded under the Hoschild’s emotional labour thesis of feeling rules, surface and deep acting, masking one’s true emotions, nurses as chameleons: the many hats that nurses wear, emotional boundary and sentimental work. The questions posed in this research were designed to examine the respondents’ perceptions of emotional labour. The questions investigated how nurses felt about feeling rules at work, the degree to which they felt they can express emotions at work, the type of emotions that they can show at work and their level of attachment to their patients.

In looking at the aim of research objective one, nurses in this study revealed how vital emotional labour strategies were in maintaining the organisational rule set by management. Nurses learn these implicit feeling rules during their training and education. A clear example of implicit

feeling rules is the “gentle method” that nurses working at St Marys Life Group were taught during training and have to adhere to. In adhering to the feeling rules, all the nurses interviewed in this study believed that nurses should not bring their problems to work. Nurses understood that only desirable traits like friendliness, smiling and providing a calming environment for their patients should be exhibited. In displaying these desirable traits, nurses in this study utilise surface acting and deep acting in trying to achieve feeling rules. There were some discrepancies in their performance, where some feelings were faked (as seen with the nurses working in the Women’s Health Clinic). The idea of professionalism is at the centre of nurses’ work, and in trying to maintain professionalism, emotional boundaries are set up to maintain power in the nurse/patient relationship. In adhering to feeling rules, nurses described how they have to “mask” their feelings in order to express the right emotions or sometimes to present the professionalism and the image of the nurse who is composed and caring. The masking of feelings in conjunction with the multiple roles that nurses play reveal the emotional manipulation of feelings by nurses. The emotional management and emotional manipulation revealed how nurses were emotional labourers. This was done to adhere to organisation rules and nurses own self-image.

# **CHAPTER 5**

## **THE ORGANISATION OF NURSING WORK**

### **5.1 INTRODUCTION**

This chapter presents and discusses the findings relating to research objective two, three and four. Research objective two aimed at investigating the nature of expressions of emotional labour at the interface of nurse-patient relationship. This research objective investigates the nature of emotion labour within the nurse-patient relationship as well as the intricacies and dynamics that underlay this relationship. Research objective three investigates the training mechanisms to equip nurses in executing emotional labour. This theme examines the training mechanisms that equip nurses to perform their jobs. The fourth research objective explores the effects of emotional labour on nurses' work organisation and their relationship with patients. This research objective explores the effects of emotional labour on nurses, as well as their patients. It also exposes the effects of emotional deployment on job satisfaction, fatigue and overall work organisation. Qualitative data was collected through structured and semi-structured interviews to address these research objectives.

### **5.2 EMOTION WORK AND NURSING**

By examining the work of nurses, we see that their work involved more than manual labour. Broadly speaking, nurses were required to perform two duties of attending to their patients

through manual tasks like doing rounds, administering medication and caring for their patients. In the latter role, women faced enormous of pressure to replicate the loving and nurturing role that they exhibited in the domestic sphere.

The emotion work performed by nurses is referred to as sentimental work. Sentimental work, according to Strauss et al (1982: 254), is an element in any kind of work where the object being worked is alive, where sentiment and people's reaction to that sentiment and work may be a central feature of that work. Strauss *et al* (cited in Bolton, 2000: 581) compares "sentimental work" to tender loving care, but stresses that it is not only performed out of humanistic considerations, but also as a means of getting the work done effectively. This helps the patient manage with disclosures of a sensitive or emotional nature. For example, interactions with angry, hostile or uncooperative patients, who are emotionally charged, pose a great demand for nurses to suppress or alter their emotions.

Emotional labour in the health setting involves assessing strategies of emotional regulation available to nurses. This includes analysing how nurses manage their own and their patients' emotions, and how nurses come to terms with difficult situations – such as delivering bad news and dealing with fatalities – that are often an unavoidable part of the nurse-patient interface. In Gray (2008) study of emotional labour of nursing, the emotion work was reported by nurses as a chief part of the nurse's role in making patients feel "safe", "comfortable" and "at home". Based on these assertions, there is an acknowledgement of the importance of emotional labour in providing care to patients. Nurses who worked in the HIV and AIDS and the psychiatric ward performed more sentimental work than any of the nurses who were interviewed and this is due to nature of work that these nurses perform. Nurses were asked in this study whether their work included the calm of patients' anxieties and fears.

*Yes it does. As an HIV counsellor, I have a lot of patients that are anxious and fearful especially when it comes to HIV. As we know there is a stigma attached to HIV and that stigma still exists. So whenever someone finds out that they are HIV positive, they have those fears that "yho, tomorrow I am dying or next week". So it is my duty to ally the anxiety and try to show them that "fear not we have treatment and everything will be ok". So I bring hope and calm down the fear and anxiety that the patient has" (Sally, HIV and AIDS counselling nurse, 2014)*

Another nurse who worked as a counsellor shared the same sentiment:

*You have to calm down the patient ... That's the one thing I do a lot of especially in counselling HIV and AIDS. It's almost the trademark of my department. Sometimes you will find that the if you have to break bad news to a patient, you have to wipe their tears and give them water and make sure that they are calm (Nozi, HIV and AIDS counselling nurse, 2014).*

A nurse working in a different ward also shared the importance of calming down the fears of patients:

*That's one of my jobs to calm down the anxiety of patients. For example, if I have to inject my patient, the mentally ill patient, some people they don't want to be injected. I have to allay the fears of the patient by telling them that the pain won't last for too long and it will be just a slight pain and it will be over in a few minutes. Some patients can become so scared that they literally run away from you and the injection. I have to calm them down by telling them how useful the injection is, that there will be no harm to them and that it won't hurt them and there will be no side effects. There is a lot of calming down because of the type of patient that I deal with on a daily basis because they might act violently or cause me bodily harm. The manner in which you say things, your approach goes a long way when dealing with patients. It shouldn't be too difficult for the patient to understand (Bongi, psychiatry ward nurse, 2014).*

The emotion work that nurses perform as revealed by their responses, helps the patient manage with the disclosure of a sensitive or emotional nature. This can be seen especially in cases with HIV and AIDS where nurses know that there is a stigma attached to HIV and AIDS. As Sally says, it is also important that patients do not take the news badly. It is through allaying the fears of patients that nurses are able to do their jobs. In Wendy's case, she realises that performing sentimental work increases information sharing, when she says "*I have to calm them (patients) down by telling them how useful the injection is, that there will be no harm to them and that it won't hurt them and there will be no side effects*". This creates a symbiotic relationship between nurse and patient, where the patient trusts the nurse and allows them to do the job that they need

to do. Bongi, realising the type of patient she is dealing with, needs to treat patients as “individuals”, who deserve dignity and respect, as emphasised by the law and the *Batho Pele* initiative that contributes to a more liberal and enlightened form of patient care, in which individuals are treated in “holistic manner” rather than being constituted as objects or “things” specified in terms of a clinical identity according to May (1992:482). The emotion work that nurses perform is what Strauss defined as sentimental work and as seen in the extracts above, was a means of getting the work done. The nurses in these two wards stress the importance of emotion work and being compassionate and kind to their patients as this is an integral part of their work. Emotion work is less work than it is the natural activity that workers do in providing a service to paying patients.

The emotion work revealed by these responses was in the action of repression of emotional action. The respondents moved from surface to deep acting over time. The nurses are constantly aware of adjusting their emotions to situational guidelines and this is evident in Bongi’s response when she says “*There is a lot of calming down because of the type of patient that I deal with on a daily basis because they might act violently or cause me bodily harm. The manner in which you say things, your approach goes a long way when dealing with patients*”. The responses revealed that nurses were emotional labourers and utilise emotional management strategies.

### **5.3 NURSING AS GENDERED WORK AND THE SEXUAL DIVISION OF LABOUR**

Gray and Smith (2008; 259) found that nursing is predominantly a gendered profession. They found in their study of emotional labour and clinical settings, where emotional labour was stereotypically portrayed as feminine, and wrapped up as part and parcel of women’s work. A large part of nursing involves providing care to patients and care is provided by women. Care, as performed by women, takes place in the domestic sphere in the form of domestic care. Care has both a paid and unpaid countenance to it. James (1992) reiterates the same points that are made about gender and females – that it is a woman’s identity to be caring. This is often reinforced by domestic duties. Domestic care is unpaid labour as it falls under the gender division of labour within household duties. The SANC figures on the gender differentials between male and female nurses have also been released in figure 2.3 found in Chapter Two. This reveals that there is a far greater number of females across all categories and this shows how nursing is female dominated. Nurses in this study also revealed that there were predominantly female nurses that can be found

in their clinical areas with the exception of the eye ward, surgical and psychiatry. The nurses were asked whether they believed women were better nurses than men and these were some of their responses:

*I still say that nursing is a profession for women because men mostly are not happy to be there. I think male nurses give us a lot of problems. Men are men and I don't think they were meant to be nurses but due to a lack of jobs they find themselves in the profession but we can't say their performance is zero per cent but some of them are really excellent at their job and you think this one has the skill and has the passion but they drink (Siphokazi, surgical ward nurse, 2014).*

Another nurse shared the same sentiments:

*Yes because female nurses are more sympathetic and show great empathy towards the patient unlike men. Men are more on the surface and others find that they aren't as supportive as women and this is just their naturally state if one could say (Sally, HIV and AIDS Counselling nurse, 2014)*

*I would say yes. I would say being a woman is a gift from God. Women have the ability to care for children from birth to adulthood at home. Think nursing needs someone who will be able to care for people. I don't think that men have the ability to care for people, even just small things like changing a baby's nappy. So now can you imagine when men have to wipe the bum of an adult, I don't think men will be able to do this. I just think women are suited for this profession. I think women have the ability to care more than men. This not to say that men are emotionless. (Thandi, Medical ward, 2015)*

The view that women are better nurses than men is still one of the dominant narratives amongst nurses who were interviewed in this study. The quote shown above by both Siphokazi and Sally reveal that nursing is informed by gender ideologies of women's role in care work and in providing emotional labour to others. Sally reveals how female nurses are "more sympathetic and show greater empathy" and how it is a natural state of women being more supportive than men. These ideologies or beliefs viewed in this context of nursing where being a woman is associated with a positive identity. When men demonstrated nurturing tendencies, these were

seen as a few men or seen as unusual and special. Women were seen as natural carers and more feeling, possess social and emotional capital that men don't have. This social capital afforded them the status of better nurses. These responses also show the stereotypical view that nursing is feminine work and this view also implies that men due to inability to care or feel could not be considered emotional labourers. Unlike women, men's motivation to be nurses did not have a clear and pronounced motivation like the drive to care for others seen from Siphokazi's vantage point. While women's reasons for becoming nurses was constructed in helping others and was linked to their feminine attributes of caring and loving. The participants also revealed the gendered nature of emotions present in their accounts like "women having the ability to care for children, from birth to adulthood". This response by Thandi reveals links between women and their roles at home. Women at home are viewed as carers for children and when women's roles in the labour market mirror that position, this is. Women as nurses and their position as mothers in the private reproductive labour constituted a source of value and expertise for women that men were not privy too. Women's emotion work was also attributed more value to their ability to provide services to patients.

Acker (1990: 70) stipulates that this is due to the gendered concept of work and jobs. "The concept of "a job" is thus implicitly a gendered concept, even though organisational logic presents it as gendered neutrality. In the case of nursing, the femininity that is associated with this job as presented by the nurses interviewed. "A job" already contains the gendered-based division of labour and the separation between public and private sphere. The sexual division of labour that places women as caregivers in the private realm and presents itself in the nursing labour process, where caregiving at work is better suited for women than men. This reveals how gender is now constructed in part through work (Chong, 2009: 15). Lynn was an exception to this rule; she believed that there are men who make good nurses. The responses centred on the idea that women were more emotional than men, that they were better carers. The nurses were speaking to the gendering of emotions. The idea of the unemotional man still exists, with the view that men are less emotional than women. Another nurse working in the medical ward reiterated the idea that women were better at nursing stating that:

*Yes I think woman are better because they are more caring. I don't believe that men would be able to do the work that lets say women do in paediatrics of neonatal*

*even. Because women are parents are used to this and I don't think men would be able to do the same"* (Asanda, Medical ward, 2015)

One of the male nurses who was interviewed also reiterated the idea that women were better at nursing than men:

*Yes, I think they are better because women are just more caring than men. We come as men and woman come as mothers and they care too much. Even if someone cannot walk they are the first one to approach* (Lunga, medical ward, 2015)

Asanda, the medical ward nurse believes that there are hospital wards like paediatrics and neonatal where men wouldn't be good at their jobs by virtue of being men. This is an essentialist view of men's capabilities as nurses. The common thread in all the nurses responses are that women are caring than men seems to form the foundation of why women are better nurses. The common assumption in these responses is that men do not possess the right emotions to be nurses. Underlying the caring narrative of women, is the position that they hold in the home as mothers, the carers of the family. Yeates (2005: 228) emphasised a close relationship between non-wage and waged labour: the work women undertake in the public sphere often mirrors that which they undertake within the private sphere. It is no wonder that there is a large concentration of women in childcare and those who work with the disabled. A distinction must be made between the locations where care presents itself: in the public (workplace health care) and the private (domestic care) domain. Speaking on this distinction, nurses were asked if there were any similarities between the work that they performed at home and the work that they did at work. The nurses interviewed were asked whether the work (caring for people) is similar to do the work that women do at home (caring for their husband/partners/families/children). This question also highlights the invisibility of emotional labour due to its close association with family care. This question was posed in order to explore the contribution of social reproduction, which is unpaid domestic work and its contribution to reproduction in capitalist society. Social reproduction, in the case of nurses, includes cleaning, washing and providing care. This is also similar to work which is performed by females in the domestic sphere. This is similar to work done by registered nursing assistants. This was highlighted in Chapter Four. Their responses included the following:

*I think it is the same and it has to be the same. If I do not have compassion or caring at home, I will not have it here at work or it won't be easy here work. You will find that people will say that nurses don't care, but you will find that that nurse in question didn't care before she become a nurse. If someone has the ability to care at home will have the ability to care at work (Sally, HIV/AIDS counselling nurse, 2014).*

Another nurse shared this view:

*Not really similar like some areas like even when my husband is here I have to give him food and things like that and I have to go an extra mile with the patient if I give them food and they aren't eating, I know something is wrong I must try harder to assist. There are similarities and there are differences (Nancy, Eye ward nurse, 2014)*

The nurse agrees and even insists that there is a great similarity between the work done at home and the work done at work. She can draw parallels between the caring done in the domestic sphere and the caring done in the public sphere. Asanda's response "that women are parents and are like ...", similarly demonstrates women's emotion work, in their ability to provide care to patients as underpinned by views of women's traditional role and caring predictably assigned to women's position in bureaucratic organisation. The nurse admits that there are similarities and differences. They make the example of feeding which can be classified as one the nursing assistant's duties. Nancy points out that while giving her husband food is part of her duties in the private realm and considered unpaid, the same duty is paid for the public realm. Women's precarious position in the labour market is bound up with the gender division of labour in the family and the duties that she performs. Women's subordinate position is reproduced in the private realm and adds to the devaluation of the nursing profession. This was generally the view of the nurses who were interviewed in this study with the exception of a few. Most of the nurses' responses reinforced the old age view that women were better nurses than men because women, in comparison to men, were more caring and, according to Sally, could show greater sympathy. This speaks to the argument of the emotional women and the unemotional man. This view also adds to the image of nurses. The image of the nursing is influenced not only by the stereotypical views of the public and drives the social value of nursing for men down as they are still viewed

as the “other” in the profession. The opposite however is done for women. The expression by respondents in this study of women’s caring as a personal experience and normative feature of traditional femininity and womanhood was reflected, as Sally points out “female nurses are more sympathetic and show greater empathy”. Women’s value in both public and private position was elevated by-both by virtue of being women.

### **5.3.1 NURSES’ SELF IMAGE**

Just like teaching, underlying nursing is the assumption that these are professions that are driven by a “calling”. Something that one is born with and is almost an instinctive need to care for others. Caring labour performed by nurses, which fuses labour and love, is defined by Davies (1995: 18), who reemphasises the idea stated by Poole and Isaacs (1997), as “attending, physically, mentally and emotionally to the needs of another and giving commitment to nurturance, growth and healing of that other” . The idea of bringing hope and providing “care” is a central feature in the nurse’s narrative of what their role entails. Thandi, a professional nurses who worked at St Marys Life group, shared the notion of care as important to nursing in her response, stating:

*If you do not have compassion or caring at home, you will never have it here at work or it won't be easy here at work. You will find that people will say that nurses don't care, but you will find that the nurse in question did not care before she become a nurse. If someone has the ability to care at home, they will have the ability to care at work (Thandi, Medical ward, 2015)*

The nurse draws parallels between caring in the domestic sphere and caring done in the public sphere. She feels that it is important for her to be loving and nurturing (performing sentimental work) because it will be to the benefit of the patient. This indicates that she is doing her job well as nurses need to provide care to their patients. When cases worked out well the nurses interviewed revealed that these cases created emotions that legitimised staff’s notions of themselves as good people who helped others and paid reverence to why they wanted to be nurses.

Most of the nurses that were interviewed, with an exception of few, said that they became nurses because they wanted to “help people “and the viewed that nursing was a “calling”. Nurses in this

study were asked why they wanted to become nurses and some of their responses are included in this study. Most of them in answering this question reiterated that this was indeed a calling.

*I don't want to call it a calling but I think that's what it was. Growing up, whenever there were people who were sick or had sores, I was always the one who was willing to wash their sores or clean them. Sometimes you find that some people will be rough with people when they clean their sores and I always use to wash them myself because I was gentler. When I was older, my mother was diagnosed with hypertension and diabetes and that need to help people grew and I found myself wanting to care for her and wanting to figure out how I can take care of her (Sally, HIV and AIDS counsellor, 2014).*

Another nurse shared the following:

*I really liked to help people so I felt I should know more about how to help people, physically, mentally, emotionally and socially. I really wanted to help people and I really wanted to know the causes of diseases and things like that (Bongi, Psychiatry nurse, 2014).*

Another nurse shared that:

*To me it wasn't just the only option, I started dreaming of becoming a nurses when I was really young, when I was in standard 1 or grade 4 now. I would often say to my mother "mama, I'm going to be a nurse at holy cross clinic emqamlezweni". For me I would say it was calling. For me I never even think of another job that I would rather do than nursing. Even now I still dream of being a nurse at times I wish I could reverse time and become as young as I was when I started nursing in 1975 (Siphokazi, Operating theatre nurse, 2014)*

The men interviewed shared that:

*I love working with people, I love dealing with situations everyday ... meeting new challenges; its challenging for me, so I really like it (Lunga, medical ward, 2015).*

*I choose nursing because I loved it. It was my hope that I could be one of the people that nurses people and helps with sick people. I love nursing when I was still in high school and it was something thought I could do. I can say that it was a calling (Mfundo, Medical ward, 2015).*

As shown by the responses, the self-image of nursing is that that this a professional chosen mainly by those who want to help and heal those who were sick. Even the men who were interviewed in this study, sited that nursing was a calling for them, that they wanted to help the sick. This dichotomy of care being both love and labour has far-reaching effects for nurses and calls into question why they decided to become nurses in the first place. Describing gynaecology nurses' commitment to the "femaleness" of their work, Bolton (2005:173) explains how nurses interviewed in her study "sought to confirm to underlying expectation that nursing is a vocation, involving altruism and overwhelming drive to 'care' for people, rather than offering a career involving choice and skills". Bolton (2005:173) reveals this problematic construction of labour and love, that while nurses in the gynaecology field provide a strong professional identity, the perception of caring still viewed also a "calling or the overwhelming drive to 'care' for people which is linked to the love, rather than a strong profession which is linked to labour contributes to the devaluing of this work. This idea also true for the nurses who were interviewed in this study, who don't see others skills involved in their work except an overwhelming drive to care for people. Siphokazi, Sally and Bongzi share how their childhood experiences of caring for people drew them to the profession and they picked it because of this love. Based on the nurse's accounts, experiences in the private realm formed part of nurse's apprenticeship for the skills and techniques hey now use at work.

#### **5.4 TRAINING MECHANISMS FOR NURSES**

The South African Nursing Council, in terms of the Nursing Act, keeps a register of professional nurses and roll of nurses and nursing auxiliaries eligible to practice in South Africa. In South Africa, two avenues are offered where nurses may be trained and educated: namely, nursing colleges and universities. According to Subedar (2005:92), public sector nursing colleges, most of which are funded by the provincial Departments of Health, train all the professional nurses completing the four-year training course. The training of professional nurses at universities is a four year degree course that also leads to the registration of a professional nurse in general

nursing, midwifery, and mental and community health with the SANC. Since 1989, the SANC has permitted enrolled nurses and nursing auxiliaries to qualify as professional nurses through a two-year bridging programme that allows nurses in the enrolled nurse category to “upgrade” to the professional nurse category (Subedar, 2005:100). The scope and practise of nurses is covered in Chapter Two and all recent figures are also articulated there.

All the nurses interviewed in this study claimed to have some higher qualification in nursing. All the nurses have undergone training either through a university or through a college. This has equipped nurses to do their jobs and they have also received on the job training. When asked if nurses had received adequate training, some of their responses included:

*Yes I have undergone training diploma level, a diploma in psychiatry. I have been trained to deal with psychiatric patients. I have also been trained in counselling because I told you earlier there are different problems in psychiatry so you have to have some knowledge of counselling as well (Bongi, psychiatric ward nurse, 2014).*

Another nurse shared:

*I did a 3 year general nursing, which back in my day was probably one of the best management courses that one could do and I rely on that frequently and I did midwifery. I didn't actually apply for this job, I was asked if I would like to come and do it and I have not apart from doing some courses on first aid counselling, sports injuries and a annual school nurses conference where we do certificated courses and that type of thing. But I don't have any formal training for being a school nurse (Lynn, school nurse, 2014)*

Bongi is a professional nurse and part of the courses in the enrolment of nurse is a course in the Psychiatric nursing care. The psychiatric nursing skills that taught in this course is “therapeutic communication skills, application of interpersonal skills for effective emotional support of mentally ill patients and their families, group activities, maintaining a therapeutic environment, preparation, support and after-care of persons undergoing physical, record keeping and interpretation of patient reports/records, observing and reporting in team context, emergency treatment and lifesaving interventions and patient and peer group teaching’ (SANC, 1993:10)

While nurses had formal training for nursing, such as degrees or diplomas, some of the emotional stresses that they encountered they received no training for. While some of aspects of training were purely educational-teaching staff about the biology of their work-but much of the training should focus on how workers should interact with patients. Out of all the nurses that were interviewed, nurses who were HIV/AIDS counsellors and those who worked in the Women's health clinic claimed that some of the challenges that they experienced at work translated onto their private domestic space. The sensitive nature of the work done in Women's Health Clinic and HIV/AIDS counselling require a higher level of emotional labour than other clinical areas. Nurses working as HIV/AIDS counsellors and those working in the Women's Health Clinic were an entirely female staff that performed every aspect of patient care (e.g. testing, counselling, emotional support and procedure preparation). Each day, nurses who work in either the Women's Health Clinic or the HIV/AIDS counselling centre deal with patients who face difficult decisions and experience a range of emotions from anxiety, fear, anger and shame. Staff in both this facilities help patients deal with these issues and enable them to choose how to handle these emotions. The patients from both these facilities deal with a range of issues such as unwanted pregnancies and finding out their HIV statuses. In both these category the nurses' support them in any way that they can. One nurse who works in the Women's Health Clinic revealed that while she was trained for her job there was something's that extended outside of her job as a nurse:

*You have times when things happen that extend outside of your training and yourself don't feel trained to do them. I sometimes find that, I am now a social worker, a psychologists and work that you are doing is beyond the nursing work that you were trained to do. When you listen to their (patients) problems, they even tell you problems that are outside of why they are at the facility (Ncumisa, Women's Health clinic nurse, 2014).*

The emotion work that nurses perform in trying to comfort patients dealing with highly stressful situations often leads them to wear many hats (as outlined in Chapter Four) and requires a high level of emotion management. The comforting of patients and providing empathy and sympathy often goes beyond just practical nursing that nurses perform and, due to the nature of the work they do in this facility, nurses often provide more emotional support to patients than nurses who

work in surgical or eye wards. One nurse revealed some the important aspects that she learned on the job.

*As much as I can't explain the training process, the most important thing that we are taught is to be realistic with patients and tell them to accept the situation and that there is nothing that you can do to change it. So in that case you must try and counsel the patient into accepting their status (Sally, HIV/AIDS counselling nurse, 2014).*

The emotion work that nurses do in the counselling ward and the knowledge that they become privy to often leaves nurses feeling emotional drained and tired. A nurses in the HIV/AIDS counselling facility revealed that they received no exit counselling or a form of de-briefing.

*We don't receive any exit counselling per say but we do have workshops...we do realize that as counsellors that we need counselling to be able to deal with the things that we face at work. There are some cases where you take the things that happened at work home with you. You are almost wish that there was more that you could do (Sally, HIV/AIDS counselling nurse, 2014).*

Nurses all interviewed in this thesis reveal how that sometimes what is experienced and felt at work is often also felt at home. While nurses in Chapter Four spoke about creating a boundary between these two spheres, this sometimes does not work. Their responses revealed the moral dilemma that nurses in the Women's Health Clinic face, due to the nature of their job:

*The guilt of what you are doing haunts you because you think back to the 10 commandants where it says "thou shalt not kill" but it's you now...you are recognized member of the church but you think that it seems like you are encouraging these kids but you have to help them and you count how many of these kids you have killed because that's how I see it (Zanele, Women's Health Clinic, 2014).*

Another revealed that:

*it really affects me (the moral dilemma) and I find that sometimes at night when I can't sleep I will say that " I do abortions, how long will I continue doing this" and I have been doing it for such a long time. The other thing that makes us affected by our work is*

*that we don't we get a debriefing with psychologists or social workers but we don't get any of that (Zandile, Women's Health Clinic, 2014).*

Unlike all the other nurses that were interviewed, the nurses who worked at the Women's Health Clinic spoke the most about not being able to carry this binary of emotions. It seems that working at the Woman's Health Clinic presents itself as a double-edged sword for the nurses who work there. While they are happy that they are providing a service and that their clients no longer perform backdoor abortions, the moral element also haunts them and how they feel about their job. This creates a moral dilemma with the kind of work that they do and what they do outside of work (such as their religious faith). We can see that nurses suffer from the moral dilemma that comes from doing their job and affects job satisfaction. These findings are similar to work of Bolton (2000:585) who found that nurses expressed strong feelings concerning terminations of pregnancies due to religious beliefs. The complaint of Zandile is similar to that of Sally who said that while the issues that they dealt with in their work were often troubling, they received no form of debriefing or exit counselling, which could prove beneficial for these nurses.

However, all the nurses interviewed said that they received support from their supervisors at work. This support from supervisors and managers goes a long way in helping nurses deal with some of the problems that they face.

## **5.5 NURSE-PATIENT INTERFACE**

The nurse is a pivotal figure in patient care and provides most of the care that is needed. McQueen (2000: 724) states that the provision of care demands good interpersonal skills to form a therapeutic relationship with patients and to communicate effectively with relatives and other health professionals. In trying to understand the nurse/patient interface, nurses were asked if they looked forward to seeing their patients. The responses were very positive except for the nurses who worked at the Women's Health Clinic who stated that:

*No. I do not look forward to seeing patients...you get stressed when you see lots of children in this facility, here to do medical abortions and you ask your" Nkosi yam (God) what happened to using condoms and what about contraceptives" and yet contraceptives are free of charge (Anelisa , Women's Health Clinic, 2014).*

*I also say no because when you see lots of kids at this facility you think of the diseases that are out there and you get fearful for these kids and you wonder are all the kids here aware of HIV/AIDS .The mere fact that they are here means that they aren't using condoms and the only thing they are doing is terminating the pregnancies (Ncumisa, Women's Health Clinic, 2014).*

The nurses' responses revealed a critical concern in their patients' not practicing safe sex because it means that they are they may be exposed to diseases that come with this. This influences how nurses feel about seeing their patients at the clinic. Nurses who worked in the clinic also revealed how personally they felt about the patients who come into this facility and viewed the patients as their own children. According to Mann (2005: 307), nurses perform emotion labour within the nurse/patient interface not because of prescribed display rules but rather to offer authentic caring behaviour because they feel that this is a desirable skill of their job/role and they derive satisfaction from doing so. Nurses were firstly asked if they looked forward to seeing their patients. A quote from Sally reiterates this point:

*Yes I do. Even to the point where my patients are my greatest distraction from whatever problem I am going through at home (Sally, HIV and AIDS Counselling nurse, 2014).*

Nurses were asked on the type of relationship they had with their patients. Some of the responses included:

*It's a nurse-patient relationship. It's because if you are a friend you will not be able to reprimand a patient. And while you are a nurse in psychiatry, you always have to reprimand. You have to be a nurse and use that approach. If you are a friend, you won't be able to reprimand bearing in mind that they are mentally incapacitated (Bongi. Psychiatric ward, 2014).*

A different approach to the nurse/patient relation was revealed by Anelisa:

*We have a good relationship with them. Even from the onset of the meeting a new patient, you tell them that whatever you are going to discuss is confidential and it is*

*private, that no-one will no-one that the patient that come to the clinic to have an abortion done and that everything is between the two of you. There after the patient opens up and you end up forming a friendship and they open up to you (Anelisa, Women's Health clinic nurse, 2014).*

The answers above revealed the kinds of answers that this question received with some believing that there should be clear relationship that spoke to nurses' authority over patients. The idea caring whilst remaining distant is necessary for the nurse in administering care as this is a method for the nurse to come across as professional but not getting personally invested. The nurse creates distance between herself/himself as a means of not losing control in the relationship as she must exhibit superiority and professionalism. This is similar to what Goffman (1959) describes as role distancing, This was the approach that was followed by Bongi who believed in role distancing as a means of being able to reprimand the patient. Getting too close or invested with the patient would hinder this position. Anelisa, on the other hand, believes that a friendly and less hostile environment allows for the patients to open up. Anelisa saw the patient as an equal, where both parties actively work on the relationship of care. These were the dominant responses when asked about the nurse patient relationship.

## **5.6 CONSEQUENCES OF NURSING WORK**

With the number of health practitioners produced in the nursing colleges and universities, it is beneficial to compare the number of nurses produced versus the growing population. The SANC has released a provincial distribution of nursing workforce in South Africa. In table 2.1, found in Chapter Two, the nursing workforce is drastically small in comparison to the population that it services. As the table points out, the Eastern Cape, which was pinpointed as the province with the highest graduate rates, in both nursing colleges and universities has a small nursing workforce in comparison to their populations. The Eastern Cape has a workforce of only 26 686 in comparison to its 6 million population as shown by figure 2.1. The nurse patient ratio in the Eastern Cape as depicted by Table 2.2 is 443 patients to one nurse. The workload that nurses have also affects their level of job satisfaction. Shortage of staff is a big problem facing the nursing profession. Staff shortages, as pointed out in Chapter Two, threaten the quality of patient care, since work satisfaction is compromised when nurses are unable to satisfy their own care standards. Nurses sometimes have to do their jobs against overwhelming circumstances and this

may result in a feeling of loss of control over their work organisation. The problems that are often outside nurse's work can also influence how they feel about their jobs. The shortage of nurse has an adverse effect on nurses. This causes an imbalance between the supply of and demand for nursing professionals. In an increased demand by the population exceeds the growing supply of nurses in the labour market. These factors contribute to the high staff turnover as nurses seek other employment. According to Jooste and Jasper (2012: 58) South Africa has an aging workforce, with 45 646 nurses retiring within the next 10 years, escalating the problems in experience and expertise. With nursing colleges and universities not producing enough nurses to meet the demand, this affects service delivery within the nurse patient interface. The South African public health system has the most problems in terms of workload. The public sector is funded with taxpayer money and is usually under-resourced and over-utilised as this caters for about 80 per cent of the population while the private sector only caters for approximately 20 per cent of the population. The private sector is a profit sector where patients have medical aid or medical insurance, which makes provision for the payment of services rendered by providers (Geyer et al, 2002:11). Lindi, a nurse working Nelson Mandela Academic Hospital, articulated the relation between the shortage of nurses in public hospitals and her work:

*Because we are short stuffed here in this hospital, there are days when I feel much drained from my work I fee emotionally drained by my work to the point where I am not friendly to my own kids when I get home. You realise that you spent all energy here at work and when you get home, you no longer have energy to play with you own kids (Lindi, infection control, 2014)*

Another nurse shared:

*Yes, I do because there are heavy clinics in psychiatry. We have clinics Monday, Tuesday, Wednesday, Thursday and Friday and those re heavy clinics. All the people from the Transkei come because we get referrals from peripheral hospitals as well. ...It's not more about doing the work but its more about talking all the time ... some days you feel so exhausted (Wendy, Psychiatric nurse, 2014).*

These external factors accompanied by the emotional demands on nurses' work has adverse effects on nurses. The nurse in this instance revealed that their clinic absorbed all the cases in the periphery of the Transkei. This speaks to how other hospitals in this area were not equipped to

handle the work that this clinic did. This meant that the nurses in the hospital did a lot of work and this workload affected them and caused general exhaustion and fatigue in the nurse. Apart from feeling drained by external challenges, nurses often face negative consequences due to the emotion work they do. Hochschild (2003) was the first to report that, because workers perform emotional labour, some employees identified themselves with the job-defined roles so much they become unable to disregard role requirements in other areas of their life. The negative consequences of emotion work also had some nurses stating that they felt emotionally drained by their work. Research shows that working with people, especially when they are suffering or ill, requires a great deal of emotional labour. This requires deep acting strategies (changing inner feeling states in order to display an appropriate emotional display) and surface acting (displaying emotions that are not experienced). Brotheridge and Grandey (2002:17), entails three distinct states in which employees feel emotionally spent (emotionally exhausted), display a detached attitude towards others (depersonalisation) and experience a low sense of efficiency at work (diminished personal accomplishment). This means that the emotions that were felt and experienced at work often carried through to home.

*When you lose a patient ...you go home with that and you only get over it maybe 2 days later. You come home with that pain but you try by all means not to show the pain that you live with at home how hurt you are. You try and suppress your feelings as much as possible. Like for example I work in the theatre where I don't think people should die or we don't get a lot of occurrences of death but sometimes we admit gunshot victim and you work so hard on the patients' survival and you almost think that they have survived. Just when you are closing up the patient and are finished and then they die, well that's painful (Siphokazi, Operating Theatre nurse, 2014).*

Nurses from the women's clinic also shared their views:

*When you get home, you no longer have love to show to your kids and I went through a time when I was constantly fighting with my children and they would wonder what wrong. At some point, I even started to ask myself, what was wrong and I would remember that something happened here at work. At some point I even called them and told them "my kids I know that I am not treating you well and I know that this is brought on by the stress from work (I found that even the problems*

*that I faced at work, I would carry them home). Whenever you feel that I don't speak properly to you or when I shout please tell me. I even told myself that weekly I would ask my kids how I was doing (Odwa, Women's Health Clinic, 2014).*

*I feel drained here at work because we sacrifice our tea time and lunch because we are so eager to help patients and when you get home all you want to do is sleep (Anelisa, Women's Health Clinic, 2014).*

This nurse constantly makes mention of working on herself, her emotions, and the right emotions that she must show, to her kids and her clients. The idea of working on one self is central to the idea of emotional labour in that employees are constantly trying to actual feelings to match those feelings that are desired, Is it possible that while workers cannot bring their problems to work, they were however taking all the problems that they faced at work home with them and that affected relations that they had home, and begs the question of which sphere suffers the most. This revealed Bortheridge and Grandey's (2002) notion of burnout, with nurses like Odwa displaying a detached attitude towards her kids. This was due to the work that she was doing at the facility. Siphokazi's answer also reveals how sorrowful the work that nurses perform can be. Another nurse shared her sentiments:

*When you get home you feel exhausted, mentally and otherwise because there are so many people that you see, that tell you their problems, who's problems you need to solve. And some of these problems hurt and burden you. When you get home you feel exhausted and you even pretend to your kids but constantly work on yourself (Anelisa, Women's Health Clinic nurse, 2014).*

*You sometimes feel emotionally drained by your work if you had a lot patients to see that day or if maybe a patient des that you weren't expecting or didn't have any signs of a death being imminent for that patient. That usually drains you as the nurse (Olona, surgical ward nurse, 2015).*

Anelisa revealed how the work that nurses do at work affected the domestic sphere. This nurse constantly makes mention of working on herself, her emotions, and revealing the right emotions that she must show to her kids and her clients. The idea of working on one self is important even

at home. Nurses were further asked if they were satisfied by their jobs. The nurses' responses included:

*I am satisfied because they don't go to back streets abortions like they use too (Zandile, Women's Health Clinic, 2014).*

Another nurse had the same emotion:

*Yes. I feel satisfied by the work I do. While I am an HIV counsellor, I don't only look at one aspect of a person's life, I need to look at the persons social life, I also check their psychological well-being so in some cases where I find while the patient has come as HIV client, I am able to help them socially by referring them to social worker if needs be and is able to get help. Like for example I had a lady that was HIV+ and lived alone because her parents died. I realized while counselling her that she had a social problem of not having food at home and I thereafter referred her to social workers and she received some form of grant from them. I also referred her to a psychologist and she is still continuing with the sessions. So in those cases I find that I'm very satisfied with the work (Sally, HIV/AIDS counselling nurse, 2014).*

*"Yes I love the work that I do. I wish the money was a bit more but I love my job. Nursing is an amazing profession. It is lovely being a nurse, when you see the patients that have worked on saying thank you and you feel work knowing that you have tried you best with every single patient. Even when you go home, you find that you sleep peacefully knowing you have done an amazing job. It is also satisfying when you see a patient that you have worked on leave the hospital well. Even in stances when the patient dies, you know that you have tried your level best you feel relieved God has taken that person and now they are resting" (Afrika, medical ward, 2014).*

The nurses revealed that they felt satisfied with their work because they knew that their work was changing lives and even saving lives. As Zandile says, because of the Women's health clinic and the service that she was providing, clients were no longer performing unsafe backstreet abortions. Sally shared a story of how, through her help, she managed to help someone even

though the things that she did were outside her jurisdiction. This satisfied her and gave worth to the work that she does. While Marx's factory worker was not satisfied because they were separated from the conception and finished product, nurses being privy to their finished product and enjoyed greater satisfaction because their finished product which was a human who walked out of the hospital after their help. Brotheridge and Grandey (2002) found in their study that employees who experience a level of success in their work are more likely to invest in their performance. This shows that while emotional labour may be tiring, it can also be rewarding.

## **5.7 CONCLUSION**

This research objective two investigates the nature of emotion labour within the nurse/patient relationship. The research revealed that nurses often used sentimental work in performing their tasks as this made their work easier. Nurses who worked in the HIV and AIDS and the psychiatric ward performed more sentimental work than any of the nurses who were interviewed and this is due to nature of work that these nurses perform. The emotion work that nurses perform as revealed by their responses, helps the patient manage with disclosure of a sensitive or emotional nature. This can especially be seen in cases with HIV and AIDS where nurses know that there is a stigma attached to HIV and AIDS. It is through allaying the fears of patients that nurses are able to do their jobs. Performing sentimental work increases information sharing and helped nurses in doing their work.

There were two ideas on the nurse-patient relationship with some believing that there should be clear relationship that spoke to nurses' authority over patients. The idea caring whilst remaining distant is necessary for the nurse in administering care as this is a method for the nurse to come across as professional but not getting personally invested. The second believes that a friendly and less hostile environment allows for the patients to open up and believes in close relationship with patients, treating them as friends. Some nurses saw the patient as an equal, where both parties actively work on the relationship of care.

The gendered nature of nursing work was also evident in the comparison of nursing duties being similar to those done in the private realm (i.e. domestic work). . Nurses in this study also revealed that there were predominantly female nurses that can be found in their clinical areas with the exception of the eye ward, surgical and psychiatry. The view that women are better

nurses than men is still one of the dominant narratives amongst nurses who were interviewed in this study. Women, were seen as natural carers and more feeling, possess social and emotional capital that men don't have. This social capital afforded them the status of better nurses. The stereotypical view that nursing is feminine work and this view also implies that men due to inability to care or feel could not be considered emotional labourers. Women as nurses and their links to position as mothers in the private reproductive labour constituted a source of value and expertise for women than men were not privy too. Women's emotion work was also attributed more value in their ability to provide services to patients.

Research objective three investigates the training mechanisms to equip nurses in executing emotional labour. This research findings in this chapter reveal that all the nurses interviewed in this study had undergone training either through a university or through a college. This equipped nurses to do their jobs and they had also received on the job training. While most of nurses interviewed revealed that they were trained for their job, they also revealed that there were often emotional elements of their job that went beyond their training. While some of aspects of training were purely educational-teaching, much of their training should focus on how workers should interact with patients. Out of all the nurses that were interviewed, nurses who were HIV and AIDS counsellors and those who worked in the Women's health clinic claimed that some of the challenges that they experienced at work translated onto their private domestic space. This can be attributed to the sensitive information dealt with in these clinical areas.

Research objective four explores the effects of emotional labor on nurses' work organization. In answering this research objective, consequences of emotion work were examined. The external factors like overcrowding and shortages in personnel, accompanied by the emotional demands on nurses' work has adverse effects on nurses. This meant that the nurses in the hospital did a lot of work and this workload affected them and caused general exhaustion and fatigue in the nurse. Most of the nurses interviewed admitted to feeling drained by their work. The nurses revealed that they felt satisfied with their work because they knew that their work was changing lives and even saving lives. Nurses being privy to their finished product and enjoyed greater satisfaction because their finished product which was a human who walked out of the hospital after their help reaffirmed their sense of self-worth and the importance of their job.. The nurses interviewed also

spoke of how they often carried the problems or emotional turmoil experienced work home with and this revealed how some nurses were emotional effected by their work.

## **CHAPTER 6**

# **DISCUSSION & CONCLUSION**

### **6.1 INTRODUCTION**

The purpose of this study was to look at the use of emotional labour by nurses in Mthatha within the nurse-patient interface. Specifically the study investigated the following questions: (1) Examine the perceptions of emotional labour by nurses, (2) Investigate the nature of expressions of emotional labour at the interface of the nurse-patient relationship, (3) Investigate the training mechanisms to equip nurses in executing emotional labour and (4) Explore the effects of emotional labour on nurses' work environment . I begin by providing an entire synopsis of all the chapters in the research and their critical agreements in answering the research questions.

## 6.2 CHAPTER ANALYSIS AND FINDINGS

In chapter one, I provide a clearer picture of the emotional labour concept and all key areas of development in theorising this concept. I began my conceptualisation of this critical term by looking at Arlie Hochschild (2003:7) emotional labour concept. Building on the work of Hochschild (2003), the concept has been extended by theorists such as Ashforth and Humphrey (1993), Morris and Feldman (1996), Grandey (2000) and the labour process theorists. I have also looked at emotional manipulation strategies of surface acting and deep acting in an attempt by nurses to adhere to feeling rules in the organisation. I have unpacked the gender norms attached to the world of care work. Added to this, is the intersectional nature of women's positions at work and their position in the sexual division of labour. It is clear that emotional labour can clearly be seen in caring professions like nursing.

As a result, in Chapter two I describe the health care context in South Africa. This discussion reveals the female-dominated nursing profession. I also presented the legal framework that regulates the nursing practice and government policies (such as The Strategic Plan for Nurse Education, Training and Practice). This chapter also provides recent figures of the number of nurses trained in all provinces in South Africa. It also revealed challenges that this sector faces, including the shortage in personnel, lack of skills in the labour market, and insufficient nurses trained at nursing colleges and universities.

In chapter three, I set out the research methodology adopted in this study. The aims of the study were introduced along with the research location. It also outlines why an ethnographic qualitative methodology was best chosen to achieve the research goals as it attempts to describe and explain how nurses perceive working with patients. This research methodology also spoke to the sampling techniques of purposive sampling and snowballing utilised in getting participants. In the section titled data collection methods, I elaborated on research questions by subdividing into research questions pertinent to answering the research goals and the overall research question. Finally, expounding on the ethical considerations that this study adhered to in gathering the data. By employing these appropriate methods, I was able to gather significant data and present findings in my Chapter Four and Five.

As the findings are the means by which I answer the research questions at the centre of this study, I shall now provide answers for each research question. At present, it is clear to state that nurses in Mthatha use emotional labour within the nurse-patient interface. I shall make use of the section below to deepen this part of the discussion

### **6.2.1. Examine the perceptions of emotional labour by nurses**

Nurses in this study revealed how vital emotional labour strategies were in maintaining organisational rules set by management. Nurses learn these implicit feeling rules during their training and education. A clear example of implicit feeling rules is the “gentle method” that nurses working at St Marys Life Group hospital were taught during training and have to adhere to. In adhering to the feeling rules, all the nurses interviewed in this study believed that nurses should not bring their problems to work. Nurses understood that only desirable traits like friendliness, smiling and providing a calming environment for patients should be exhibited. In displaying these desirable traits nurses in this study utilised surface acting and deep acting in trying to achieve feeling rules set by management. While nurses know that they must adhere to organisational feeling rules and utilise surface acting and deep acting, they sometimes try to do this at the expense of authenticity of their true feelings. In the case of the nurses who worked in the Women’s Health Clinic, they admitted that they faked their performance for the benefit of the patient. There were some discrepancies in their performance, where some feelings were faked (as seen with the nurses working in the Women’s Health Clinic). The idea of professionalism is at the centre of nurses’ work, and in trying to maintain professionalism, emotional boundaries are set up to maintain power in the nurse/patient relationship. In adhering to feeling rules nurses described how they have to “mask” their feelings in order to express the right emotions or sometimes to present the professionalism and the image of the nurse who is composed and caring. The masking of feelings in conjunction with the multiple roles that nurses play reveals the emotional manipulation of feelings by nurses. The emotional management and emotional manipulation revealed how nurses were emotional labourers. This was done to adhere to organisation rules and nurses own self-image.

### **6.2.2 Investigate the nature of expressions of emotional labour at the interface of the nurse-patient relationship**

This research objective two investigates the nature of emotion labour within the nurse/patient relationship. The research revealed that nurses often used sentimental work in performing their tasks as this made their work easier. Nurses who worked in the HIV and AIDS and the Psychiatric ward performed more sentimental work more than any of the other nurses who were interviewed and this is due to nature of the work that these nurses perform. The emotion work that nurses perform as revealed by their responses, helps the patient manage with the disclosure of a sensitive or emotional nature. This can especially be seen in cases with HIV and AIDS, where nurses know that there is a stigma attached to HIV and AIDS. It is through allaying the fears of patients that nurses are able to do their jobs. Performing sentimental work increases information sharing and helped nurses in doing their work.

There were two ideas on the nurse-patient relationship with some believing that there should be the clear relationship that spoke to nurses' authority over patients. The idea caring whilst remaining distant is necessary for the nurse in administering care as this is a method for the nurse in maintaining professionalism and not getting personally invested. The belief that a friendly and less hostile environment allows for the patients to open up and some nurses believe in a close relationship with patients, treating them as friends. Some nurses saw the patient as an equal, where both parties actively work on the relationship of care.

### **6.2.3 Investigate the training mechanisms to equip nurses in executing emotional labour**

These research findings reveal that all the nurses interviewed in this study had undergone training either through a university or through a college. This equipped nurses to do their jobs and they also received on the job training. While most of the nurses interviewed revealed that they were trained for their job, they also revealed that there were often emotional elements of their job that went beyond their training. While some of the aspects of training were purely educational-teaching, not much of the training should focused on how workers should interact with patients. Out of all the nurses that were interviewed, nurses who were HIV and AIDS counsellors and those who worked in the Women's health clinic claimed that some of the challenges that they experienced at work translated onto their private domestic space. This can be attributed to the sensitive of the information dealt with in these clinical areas.

#### **6.2.4 Explore the effects of emotional labour on nurses' work environment**

The external factors like overcrowding and shortages in personnel, accompanied by the emotional demands of nurses' work have adverse effects on nurses. This meant that the nurses in the hospital did a lot of work and this workload affected them and caused general exhaustion and fatigue. Most of the nurses interviewed admitted to feeling drained by their work. The nurses revealed that they felt satisfied with their work because they knew that their work was changing lives and even saving lives. Nurses being privy to their finished product, received greater satisfaction because their finished product which was a human who walked out of the hospital after their help reaffirmed their sense of self-worth and the importance of their job. The nurses interviewed also spoke of how they often carried the problems or emotional turmoil experienced work home with them and this revealed how some nurses were emotionally affected by their work.

### **6.3 IMPLICATIONS AND RECOMMENDATIONS**

This study examined the use of emotional labour by nurses within the nurse-patient interface. The results of the study offer some practical implications for the nursing industry in South Africa and for nursing management.

This study revealed the stereotypical view of nursing as women's work and gendered emotions that feminise nursing work. While social norms construct the identities of what is perceived as good emotional labourers, this privileges some (female nurses) at the expense of subordinating others (male nurses). The view of caring labour and nursing as "women's work" is an essentialist view of women's capacity and creates a narrative that says women are suited for one kind of job but equally essentialist to the men who are nurses. If the assumption by the nursing profession is that there is only one unique fit for nursing, where does this leave men who are nurses and how do they operate in a space that labels them as the "other"? Does this argument assume that men, in comparison to women, are less emotional? This narrative is problematic and sexist in nature, as it places men outside of the realm of emotions.

Within the South African context, gender differentials between male and female nurses reveal that there is a far greater number of females across all categories. The shortage of professional nurses in the public and the private sectors in South Africa constitute a major crisis in the health

care industry and may, in part, be attributed to the fact that men are often discouraged from choosing nursing as a profession because of the public image that views nursing as a profession that it is suited to women. Stereotypical feminine qualities are advocated and form pre-requisites for entry to the profession. The nurse must be caring, loving and nurturing. The image of the nurse is influenced not only by the stereotypical views of the public, as well as by their own self-image with the language used by nurses in describing nursing as a profession and not just a calling and wanting to care for people.

The task of nursing management would be to pro-actively campaign for decreased gender-based essentialist and sexist notions of nursing work as women's work. Moreover, their emotional labour will become more visible and will likely receive greater financial and social recognition. This will also, in turn, allow for men's work as nurses to not to be viewed through a feminised lens of work and, in turn, will encourage men in the South African labour market to pick nursing as a profession and career. As a result, whether male or female, nurses will be recognised as emotional labourers. In this instance emotions at work, especially nursing shall no longer be gendered.

Nursing management also needs to radically change the image of nursing as just a "calling" and a drive to help people. While care is important to the nursing profession, other skills are deemed invisible and unnecessary. The perception of caring still viewed as a "calling" or the overwhelming drive to "care" for people which are linked to the love, rather than a strong profession which is linked to labour contributes to the devaluing of this work and attribution of this as an unskilled and naturally female profession. This sees the "masking" of nurses' skills and reduces what constitutes a good nurse to the level of individual beliefs. Institutional practises further reinforce the view that nursing is ultimately about caring and no other skill is as important. The profession of nursing needs to validate and create discourse about the skills and expertise required to be a nurses. This, in turn, may give the nursing industry prestige and drive the social value of nursing as the sought-after profession.

Further research should look at the specific use of the emotional labour of male nurses in South Africa and examine the masculine care narrative and the experiences of male nursing professionals. It is essential to hear the voices and experiences of male nurses' who labour under notions of "nursing as women's work".

## **6.5 LIMITATIONS**

As with all research, this study has had certain limitations. The limitations revolve around access to participants at Nelson Mandela Academic hospitals and St Mary's life Group hospital. Bureaucratic processes like individualised internal ethical review committees for researchers slowed down the time in which field work could take place in this hospital. This was overcome by referrals and word of mouth to recruit participants.

## **6.6 CONCLUSION**

The emotion work that nurses do is incredibly important in providing good service. The ability to consistently be friendly, kind and compassionate requires an incredible effort. When such efforts succeed and help patients in their recovery or create a positive view of services offered in hospitals, this labour by nurses has the ability to drive the value of nurses and also the hospital. Emotional labour that nurses provide should be taken seriously as it affects customer satisfaction, customer loyalty and eventually organisational financial performance. To view nursing, that done by women and the emotional effort that they exert onto their work as a simple transference of their womanly virtue from private to public, is extremely damaging to the work that nurses do.

The results of this study reveal that nurses utilise emotional labour strategies like surface acting and deep acting to fulfil management organisational rules. This study explored the use of emotional labour deployed by nurses in the nurse-patient interface. The idea of emotional labour performed by nurses is vital and necessary and often done to maintain professionalism for the benefit of the patient. It is hoped that this study will provide a better understanding of how nurses use emotional labour in providing a service to patients.

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