Emotion in health care: the cost of caring

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Abstract

Purpose – The purpose of this paper is to understand the centrality of emotion, and how that emotion both created and contributed to meaning, in the communication of health professionals who worked in a regional pilot program for cancer screening.

Design/methodology/approach – As the third phase of a larger study, thematic analysis of semi-structured interviews was carried out with the 19 members of the professional groups, which comprised the service. Brief comments were included from the questionnaire survey in phases 1 and 2 of the study to demonstrate the overflow effects on those served by the organization.

Findings – Emotion was found to be a critical component in the communication interface between the groups. The complexity of the way in which emotion was managed with the client group overflowed into the management of the communication process between the professional groups in the organization. However, it was not always recognised, and thus created difficulties for a number of staff.

Research limitations/implications – Although the research was limited to one health-care organization, it is possible that other health professions are experiencing similar situations as they cope with the certainty of unending change. Also, although secondary interviews were carried out to ensure that themes were credible to participants, it is possible that carrying out the interviews in the work environment may have constrained some participants.

Originality/value – Stresses the importance of the emotional component of communication and how it is recognised to facilitate effective working relationships and support staff coping with change and heavy workloads in health-care organizations.

Keywords Health services, Communication, Management, Psychology

Paper type Research paper

Introduction

Good health is integral to the well-being of society, and organizations in the health sector play an important role in providing services to monitor, restore, maintain and enhance the quality of life in the populations they serve. As many of the activities in these organizations include life-changing events, such as birth, death, and facing the inevitability of mortality, the interface between staff and clients[1] is one that is overlain with emotions such as anxiety, despair, anger, happiness, hope, compassion, joy, fear and distress. As emotion is central to the communication which takes place in health care organizations (Maynard, 1992) it is important to understand how it both creates and contributes to meaning. In this paper, the emotion involved in the communication between health professionals in a pilot breast-screening programme will be analysed to show that health care and emotion are inextricably bound.

The need to recognize the integral emotional component of communication in the service culture of health-care organizations has been labelled "emotional work" (Bone, 2002). That is, the intimate nature of work preserving health and well-being means that

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on many occasions, health professionals genuinely experience and display empathic emotion in the process of supporting and interacting with clients. However, as the health care sector's primary concern is to provide a service, a strong emphasis exists on creating a "service culture" among workers (Grönroos, 2000). Consequently, there is also a component of "emotional labour" (Hochschild, 2003) which requires organizational members to adhere to organizationally prescribed displays of emotion in the workplace. In other words, health professionals are often required to "manage" the emotion interface with their clients. For example, they may modify emotional displays in order to meet accepted social and occupational display norms, regardless of the level of emotion they feel (surface acting). Hochschild further argues that the need to meet prescribed cultural standards is so strong that it may even require individual attempts to alter experienced feelings to ensure an appropriate display of emotion in the work role (deep acting).

Typically, the work environment of health professionals requires them to actively display emotions that are prescribed (or proscribed) by the organization, rather than those they may be experiencing (Ashforth and Humphrey, 1993). The result is that the outward appearance is managed, rather than spontaneous expression of emotion. The purpose is to convey emotions that are "appropriate" to meet the expectations of clients in a service encounter (James, 1993). Such demonstrations may include displays of emotional restraint, or emotional masking (Wharton and Erickson, 1993), where the goal may be to provide the appearance of reserve or "detached concern" (Hochschild, 1983). Health professionals must not only empathize and support clients, but also, when deemed appropriate, separate themselves from the emotional transactions which may be occurring as part of their work (Hosking and Fineman, 1990).

The need for an interface that recognizes emotion is accentuated in programmes that screen for cancer. Dealing with a dichotomy between health and disease creates an emotionally-laden work environment for all participants. For those who take part in screening programmes for breast cancer, it is significant that a mammogram has only the propensity to reveal existing disease, as a disease detection programme inevitably incorporates affect or emotion for participants (Millar and Millar, 1996). Even the threat of detecting something wrong is enough to generate a strong emotional reaction (Millar and Millar, 1993). Nobody is immune: cancer is neither understood nor controllable. As communication involves not only "content" but also "relationship dimensions" which affect how communication is both transmitted and interpreted (Kreps and Kunimoto, 1994, p. 44), there is a critical need to establish rapport with women undergoing screening mammography so that they feel secure during the process. As Planalp (1999) points out, "communicating about emotion can help in coming to terms with any emotionally overwhelming experience" (p. 114). The opportunity to communicate such needs is an important factor in encouraging ongoing participation (Brunton, 2004).

However, the experience or management of emotion is not only central to the external interface of health organizations. Since Mumby and Putnam (1992, p. 471) challenged the rationality of the workplace through recognition of the "feelings, sensations and affective responses to organizational situations", interest has been growing in emotion or affect as fundamental to the process of organizational life itself. As Waldron (2000) contends, emotions are not only central to the client interface, but also emerge from within the fabric of workplace relationships. Thus, health care organizations have arenas of emotion which are both genuine and managed, not only

externally with clients, but also internally with colleagues and groups of other health professionals. It has even been argued that these work relationships are more significant sites of emotion than those required by the actual work tasks at the client interface (Sandelands and Boudens, 2000). To investigate the influence of emotion in workplace relationships, a study was carried out in a health-care organization adjusting to politically induced structural change in a developed, Western country.

Background

The wider social, political and economic environment in which the organization was situated had a relatively enduring premise of providing equality of health care as a publicly funded service. However, the worldwide trend of aging populations means that as the "baby boom" cohort in developed nations is beginning to enter the third age, there will not only be increased demand for health-care services, but also lower numbers in employment to sustain such services (Longley, 1996; Pool, 1996). Simultaneously, the development of technology has provided newer, more accessible and sophisticated methods for both detecting and treating disease than those previously used. Some technologically advanced interventions are more cost-effective. Nevertheless, such advances are also accompanied with increased expectations for better health care. Such expectations in aging populations mean that health-care costs are likely to continue to rise (Cullen, 1998).

The cost of providing publicly funded health care came to the fore with the global economic downturn of the late 1980s. Evoking a scenario involving individual consumer choice and the beneficial effects of competition, the political argument was one of the needs for radical reform to ensure future availability of accessible and affordable health services. Subsequently, organizations were required to provide health care with an emphasis on commercial principles (Ashton, 1995). In the newly established competitive environment, organizations undertook to provide an acceptable service within the financial constraints of an allocated budget.

This has meant substantive changes in the way in which health professionals are required to work. The environment of financial imperatives to attain desired levels of service has meant that there has been a growing emphasis on primary health community programmes. The underlying rationale is one of a more efficient use of health resources by providing services in the community to prevent or detect the early incidence of disease that may avert the need for more costly hospital treatment in the future. However, such transitions from a hospital to a community environment are often founded on the voluntary participation of the population. In contrast to those seeking a cure for symptomatic conditions, populations that are asymptomatic, with no indication of ill health, may not be motivated to participate in prevention or detection programmes. Consequently, the new health care environment is less about professional dominance and more about partnership with the community (Baum, 2002), which directly influences the way in which health professionals need to communicate with the publics they serve. Similarly, as the manner in which health advocacy is communicated has changed (Clarke *et al.*, 2003), there are implications, not only for the organizational interface with clients, but also for the management of communication between the various groups which make up the organizations.

Method

The research was undertaken as part of a larger study between 1999 and 2000 to investigate the influences on the external and internal communication strategies of a pilot programme to screen eligible women for breast cancer. Following ethical approval, a random sample of 1,100 women who had undertaken a screening mammogram was drawn from the programme database to obtain information about their responses to the communication from programme staff. In the first phase of the study 611 respondents returned a self-completion questionnaire. An invitation to participate in focus group interviews was included with the questionnaire, and in phase two, 44 women took part. Although brief mention will be made of some of the comments from the first two phases of the study, this discussion relates primarily to the third phase, which focused on the internal communication in the organization. Following initial analysis of the questionnaire data, voluntary, semi-structured interviews were carried out with the 19 female staff members that provided the regional service.

The organization comprised two primary groups. The 13 staff who worked in the breast-screening unit made up the first group. The five women employed as health promoters or community health educators made up the second. One member was the programme manager, responsible for the overall coordination of the service. Staff in the programme worked in different buildings and in different ways. The unit staff carried out the physical process of mammography, either at the fixed site on a hospital campus or in a mobile van which visited rural areas on a two-yearly cycle. The health promotion staff were based in a separate building and primarily worked in the community, encouraging women to participate in the breast-screening programme.

In the interviews, all staff were asked to describe their perceived work roles in the organization and their interface with colleagues and clients. A semi-structured interview approach was taken to allow participants the freedom to focus on what they thought was significant. The purpose was to elicit relevant and useful data; thus although the interviews could follow the designated schedule, the intention was to allow staff to describe, explore and make sense of, or "map" their experience in the emotional area (Fineman, 1993) of their workplace. Consequently, there was an emphasis on providing opportunities for open-ended feedback.

The interviews were taped (with one exception where permission was declined) and transcribed, resulting in 68 pages of single-line text. After several readings, narrative themes related to the research questions were identified and analysed using the interpretive approach of hermeneutic analysis (Ricoeur, 1981). In other words, the aim was to interpret, understand and accurately reflect the social reality of participants. The goals of the researcher were explanation and understanding. Secondary interviews were carried out whenever possible to ensure that the interpretation of identified themes was credible to participants.

All comments and punctuation were transcribed directly from responses to the questionnaire. In the interview transcripts, oral emphasis, indicated by a raised tone of voice, repetition, pauses or marker phrases was indicated by capital letters in transcription. Pauses were indicated by a series of round dots; one round dot equalled a one second delay (thus a four second delay would be indicated as ∘∘∘∘). Transcriptions of interview quotations which incorporated a slight hesitation of less than one second were shown as (–).

Results

Overall, 11 relevant themes were identified in this study; however, the scope of this discussion is limited to three. The first, the "business" of screening was consistent across all 19 interviews, and will be discussed as the perceptions of staff both within and across disciplines. The second, a troubled transition, was revealed as the unit staff described the difficulties of coping with both the early transition into a national programme and internal organizational restructuring. The third theme, the primacy of technical expertise, was prominent in interviews with the unit staff who carried out the physical process of mammography.

The first two themes appeared to reflect the market influence of the strategic reform process, described above, which has occurred in the health sector in the prior decade. The commercial context is highly relevant to the political influences on the breast-screening programme as the repositioning of health care as a commodity has influenced the way in which staff communicated with participants. The focus of screening as a business was an important influence on the way in which the service operated as the future of the breast-screening programme depended on efficient outcomes. The resulting importance which interviewees placed on efficiency indicated how success was measured in volume regardless of the effect of screening one woman every 10-15 minutes.

Theme 1: the "business" of screening

The rational focus of the organizational setting was revealed in a narrative theme that emerged across all staff interviews (19), including unit staff and health promotion staff; the "business" of screening. Consistent with a market focus, the breast-screening programme was presented in the interviews within an economic discourse of justifying cost and ensuring efficiency, for example, ensuring that *X* numbers of women were screened during a specified period of time. Accordingly, presenting the programme in a commercial context moved the emphasis away from a service ethic towards one of achieving efficient outcomes. Despite the evident dedication of all staff to the breast-screening programme, it appears that the economic rhetoric managed, at times, to supplant the reported "huge effort to attain a woman-centred service" as staff described the need to be "aligned to the business of the clinic".

It was essential to reach financial targets to justify the existence of the programme, thus ensuring that the contract would be renewed. Staff explained that they had to focus on the need to justify the cost. "You must expect staff to work effectively and efficiently – it's just that the system won't work if you can't justify the cost – but that's not always easy". As a result, staff reported that they "felt pressured as there was a constant need to work efficiently to complete the screening round in time" and the need for efficiency dominated the communication process with the women who were being screened. Control was also perceived as necessary by unit staff because "the pace of appointments means no time for discussion"; therefore the situation was managed to incorporate this emphasis. For example, one staff member explained that at times it was difficult as although she "sensed" that women wanted to talk, there was no time:

> It can be quite hard sometimes. You sense you could have a bit of a chat but you have to cut off. You're talking to the lady and your eyes are creeping towards your equipment ∞ or you talk and do things ∞∞∞ I know that's distracting, but you need to get on.

Similarly, there were occasions when it seemed inconvenient, or perhaps too tiring to engage in conversation, as the emphasis on process took precedence:

> Sometimes you sense it [women want to talk] and you just don't allow it to happen °°°° It just depends how your day's going °°° you think, I'll talk because I need a break.

Feelings of conflict were also reported by staff when dealing with the anxiety that some participants exhibited in an unfamiliar environment. They explained that, for a number of women having a mammogram, ten minutes was enough time. However, they also discussed how sometimes women wanted time to reconsider their options, requested extensive explanations about the process, or alternatively, "just wanted time to catch their breath" between the compression of each breast. If the mammogram went over time because of a delay, all the subsequent appointments ran late. Therefore, unit staff reported that it was essential that they "manage the process". When discussing the apparent need of some women to talk when being screened, a staff member explained the difficulty she experienced in trying to:

> incorporate that into the business of the clinic and screening women every ten minutes °°° the practicality of building THAT [talking with women] into other questions and explanations.

Efficiency was reported as integral to the successful attainment of performance criteria. Success was measured in ensuring that an optimum number of women were screened as "the equipment should be made to pay its way". That meant that the staff who operate the equipment were also required to "pay their way".

It is worthy of note that the "business" of screening was the only theme identified by the researcher that was queried by all participants in the secondary interviews. One respondent asked whether, since "the breast screening programme has gone out and actively recruited these women, surely there is an obligation to be efficient?" In other words, if someone had made an appointment, she was entitled to be seen on time. Also, the same respondent argued that "the breast screening pilot programme is part of an epidemiological study" to assess how effective the programme was. Accordingly, staff believed that it was essential to complete the two-yearly screening round on time to protect the validity of the study.

The initial response from one of the health promoters in the secondary interviews was of "being blown away by the thought" of screening as a commodity as they reported that they "worked so hard to keep the service women-centred". The same respondent continued that she "made a conscious effort never to talk in terms of money". However, staff agreed that their contracts were "written in quantitative terms" and that their performance was consequently "measured in terms of numbers":

> I suppose money IS the bottom line and if the contract is not met then it will get pulled °° I guess that is simply the reality of the situation we work in.

Although participants in the secondary interviews reported that they were not happy with thinking about health in a market context, they also recognized that "at the end of the day we have to deal with numbers" even though that was "not the way [they] wanted to think about [their] work".

Theme 2: a troubled transition

A further change for staff in the unit had recently occurred with the transition of the pilot to the national programme. Contracts were allocated for tender and the process of

transition that followed meant that the staff who had been involved in the pilot were not only required to integrate into a national programme, but also encountered internal organizational changes introduced through the appointment of additional health promotion staff. The organization had made fundamental changes in strategy and structure as a separate group was integrated to accept responsibility for the promotion of the breast-screening programme in the community. As well, the programme manager, who had been with the organization for some years, had resigned, and a new manager was appointed just prior to the staff interviews for this research. Nine unit staff mentioned some level of difficulty with the transition process, although they were reticent about doing so. This theme also tended to evoke an emotional response in the interviews, as unit staff expressed some reservations about how their contribution to the programme was perceived by those they referred to as "outsiders" involved in the process of establishing the national programme.

The process of change had not been an easy one. There was an underlying overlay of nostalgia in the responses from unit staff for what had been in the past. For example, they expressed a sense of ownership for the breast-screening programme, that they had such a strong focus and shared "sense of vision on making it successful that they came in and gave it their all". However, they also expressed a sense of "feeling disenfranchised from the others" involved in the administration of the national programme:

> The centre has done the mile and developed a great deal of expertise and we need to be bold enough to say that. It's that tall poppy syndrome °°°° I think when you have done a really good job you SHOULD be able to say appropriately that we are expert. Whereas I sometimes feel like °°° even at a national level °° that has been viewed as an inappropriate thing or feeling to have.

After eight years of being responsible for organizing the entire presentation of the breast-screening programme, unit staff suddenly had to adapt to an externally imposed model of "how things were going to be done without reference to the fact that [they] had done them damned well in the past". The emotional tone was one of nostalgia and loss.

Some ambivalence was also expressed about the new personnel involved in promoting the national screening programme. Six interviewees described some difficulties that had been experienced in the process of integrating health promotion staff with existing personnel. For example, one unit staff member explained that suddenly they lost a great deal of information and associated feelings of control:

> When we were just ourselves [the existing staff] everyone was aware of what was going on. There was this feeling that everybody to a greater or lesser degree had a finger on it °°° um °°°° because at staff meetings information was brought back about everything so people could pick up on the big picture. Now there is that feeling that it's all happening °° but we don't know HOW it's happening. We don't have the control that °°°° perhaps a SLIGHT feeling of being a bit scared that things might be happening that we are unaware of °°°°°° and we only become aware of them when they blow up in our face.

During the first seven years of the pilot programme the unit staff had coordinated the promotional activities along with the timetable for the mobile van. Consequently, they "just ALWAYS knew what was happening". There was a sense of feeling separated from earlier responsibilities with screening processes being fragmented into a more

specialized service. The outcome was that unit staff expressed feelings of being disenfranchised and thus separate from the health promoters who they perceived had "detached" them from their prior tasks. Without exception, all 13 unit staff throughout their interviews reported that they were "part of a close team", and had always supported one another to achieve a successful programme. Nevertheless, one staff member relayed how she thought it was also possible that "their closeness and strength might be perceived as difficult for outsiders".

There were a number of integral differences between the two groups in the way that they approached the breast-screening service. Accordingly, the unit staff not only expressed dissatisfaction with losing control over promotional tasks, but also with not being recognized for what they considered to be their years of hard work. This was compounded at the time of the interviews by a strong feeling that there was no regard for their level of experience and expertise. The reported perception was that the worth of accepted practices and meanings associated with the organization was being discounted not only on a national level, but also regionally:

> We have got some stuff that is worth hearing – and I suspect that at the moment the staff in the unit don't feel that they are getting a hearing °°°° um °°°°° that a lot of good work has gone on – a lot has been achieved, but maybe at the moment, °°° um °°°° because we are so busy pushing forward and advancing the service °°°°°°° but that's fine – the service is ONLY where it is because of all the hard work that has gone before.

The difficulties experienced in the interface with the health promoters were specifically described by six staff members. Their concern was encapsulated in the words of one:

> There are a lot of very experienced people here that have so much knowledge °°°° some feel that the new people who've come aboard haven't recognized that.

Similar feelings of separation were expressed by the health promoters, who related their role as a "link" between the women in the community and the programme. However, they were very aware of their position as "external to the technical process" of mammography. This was reported as an area of concern as their tasks included inviting women in for screening. From the moment these women reached the door of the screening unit, the welcome they received was completely outside the control of the health promoter who had issued the invitation. The concern about the reported experience of some participants had served to "deplete [their] energy" as promotion staff "tried to deal with the fallout" of processes that they believed did not reflect the way in which the service should be provided.

Resistance typified the interaction with both groups. Just as the unit staff held steadfastly to the routines that had existed for the past eight years, the health promotion staff similarly resisted consultation about strategies that had been the responsibility of the other group for almost a decade. The interaction between the two groups resulted in a common perception of not being heard by the other party. However, both parties did recognize that the division between the groups was not functional. Of the 19 participants, 13 mentioned their awareness of the need for "overall co-ordination" of the programme. For example, as one health promoter explained:

> If we want to be serious about this, we have to be as positive as can be °°°°°° and there ARE times when the programme has been fantastic, and at the end of the day do you want this to work or don't you? °° All we have to do is sit down and take a look at things together.

One individual encapsulated the responses of unit staff by saying that it had been "a bit of a rocky road" to try to synthesize the organization as a whole, and eight participants from both groups expressed their "hurt" and "disappointment" at the lack of integration. Both groups were aware of the barriers and expressed the need to "resolve the situation" or at least "find some settlement".

Theme 3: the primacy of technical expertise

One main source of dissent between health promotion staff and those in the unit was the way in which mammography was presented to participants. Where the health promoters expressed their role as promoting screening through "advocacy of women", the unit staff established their role as one of "providing an expert service for their [women's] benefit". Health promotion staff believed that the programme should be presented as part of a positive lifestyle approach of monitoring health status. In contrast, a recurrent and repetitive narrative theme that emerged from interviews with all (13) unit staff was the centrality of technical expertise to their service. This theme was nominated as being of the greatest consequence in their interaction with women. However, along with the focus on screening as a "business" and the associated demand for efficiency, it also covertly influenced the interaction between staff and women having mammography.

The unit staff perceived a focus on expertise as critical to the screening process, not only to meet the safety needs of women through reducing the risk of false positive and negative findings, but also to reassure women that they were "entering a professional, expert environment". Each participant in the group expressed the importance of developing an expert approach to enhance the ongoing success of the centre. One respondent described the unit as "a centre of excellence", with a high level of expertise because staff were "immersed in mammography". There was an interlinking focus between "expertise" and "excellence" throughout ten interviews. One appeared, at times, to imply the other, and both were clearly desirable. In this research, staff strove to "provide excellence in everything we do". For example, the importance of making sure that the resulting X-rays from each mammogram were properly exposed was seen as integral to controlling risk, and tended to override other considerations. In the words of one staff member:

> I feel really worried that women are having false negatives ∞∞∞ and you wonder whether you are really doing women a service. But it's not perfect ∞∞ well ∞ you will always have human error.

The unit staff did not perceive that there would be any reason not to attend for screening. As one explained, "I think the biggest barrier is not being educated, to know it's for their benefit". For example, one stated, "We can't solve the problem [of breast cancer] if women won't come in for screening". However, the contextual needs of participants, such as anxiety and pain experienced, also influence their decisions about participation in voluntary health interventions (Bakker *et al.*, 1998). There is a dilemma inherent in the physical process of obtaining a mammogram. The breast must be compressed; otherwise the quality of the resulting film is reduced. In response to discussion about the discomfort participants may experience with mammograms, an argument was presented by unit staff in favour of the overriding importance of "expertise [as] the primary requisite". Technical outcomes do strongly reflect the risks

of participating in screening mammography programmes as the quality of the films determines the incidence of false negative or positive findings. However, the perspective of participants is equally important.

Staff were genuinely perplexed about the apprehension some women expressed about the process, especially those women who had not experienced mammography before. The narrative of expertise was consistently described as a key criterion in communication with women undergoing mammography. Even in the secondary interviews, the need for expertise was reinforced as essential to engendering the trust of women that they will encounter a safe, acceptable experience:

> If we do inferior mammography we are doing women a disservice as we are increasing their risk. I think it's important that we focus on expertise. I think it's comforting. I'll make the assumption that it's very important to women that they walk into an expert environment.

However, there was a cost involved to staff who were trying to provide excellence in their service. As one staff member explained, "Sometimes it's SO hard just keeping your focus on giving your lady the best you can" as it could be "exhausting" to maintain focus throughout a long day. In this case, the outcome was reported as "a high level of burnout among the staff that is a constant worry". However, there did not seem to be any respite within the environment which required commitment to efficiency and expertise.

Discussion

The management of emotion or "emotional labour" (Hochschild, 2003) and "emotional work" (Bone, 2002) guided the interactions between the work groups as well as governing the communication that resulted at the organizational interface with the community. Not everyone found it easy to adapt to the changing external and internal environment, which influenced the way in which tasks were carried out. As Zorn *et al.* (1999) have pointed out, just because organizational change is the norm in today's environment, it is not exciting for everyone: it can be a source of stress, as indicated in this research. The environment of structural change within the organization meant that boundaries were being redefined. Such a process of redefinition is often marked by a sense of anxiety and emotion for the groups that are involved (Schneider, 1991). Despite recognizing the need for more integration in the organization studied, staff felt unable to bring about a positive conclusion. They were able only to express their resistance, which Huy (2002) suggests signals a significant sense of loss for individuals experiencing organizational change.

The sense of loss was a paradox with the need to make things "work". The organization existed within a socio-political context of change, where health professionals, who have operated in the egalitarian philosophy of a welfare model of health care provision, were being aligned to a competitive market model. The market model was imposed not only through politically induced change, but also in response to a developing public expectation of increased service for decreased cost. Such an ideology views the "problem" of public welfare expenditure as a burden for taxpayers. As one staff member reported, "We are expected to make this thing work – to provide an efficient and safe service for women", whatever the cost may be to those working in the organization.

If emotions shape the event as well as being a consequence (Fineman, 2003), then the responses of staff who reported feeling "disappointed", "left out", "afraid" and "sad" were significant indicators that the transition to a national programme did not appear to be exciting, stimulating or enjoyable, but rather a stressful imposition. Fineman explains that change often involves feelings of intense loss, especially if a person has identified strongly with a work task and then it is taken away. A sense of grief has resulted from the perceived loss of tasks, roles and even identity, reflected in the idealized, nostalgic reconstruction of the past from unit staff. Such nostalgia is used to provide a powerful mode of consolidation to restore a sense of power and control when the sense of loss is acute (Gabriel, 2000).

There was also an overflow effect on those who underwent mammography. As Traynor (1996, p. 337) noted in his study of the British health system, even the traditions of a logical science of health care can be "pushed to the margins and excluded by a new language of rationality and measurement": that of the cost of providing health services. When health professionals are constrained by a lack of time and resources, they feel compelled to overlook the psychological and emotional needs of their clients (Lee-Ross, 1999). In this case, the process of surface acting meant that communication was discouraged as staff distanced themselves from communication cues.

The prominence given to expertise in this study meant that unit staff did appear to restrict the flow of information to participants, as suggested in earlier research (Wodak, 1997). However, it is also possible that the intimate nature of the examination required health professionals to separate themselves from the emotional experience of participants (Smith and Kleinman, 1989). Further, it has also been argued that a tendency to view participants as passive recipients of an expert process may be used to displace the requirement to recognize emotional needs for support and information in a busy work environment (Elwyn *et al.*, 1999). On the other hand, the efforts of staff to disengage or detach from concern can signal that the reality of burnout is occurring in the workplace (Fineman, 2003), a possibility mentioned by staff in this research as they struggled to remain emotionally neutral through suppressing their feelings of frustration about fitting in the communication needs of participants with those of completing their work within the designated time frame. In itself, this creates a stressful working environment for both clients and those providing a service.

The propensity of health professionals to suffer from burnout from time and resource restrictions (Fineman, 2003) brings into question the commodified structural changes which restricted the opportunities to meet the emotional needs of both colleagues and clients. Such an emphasis meant that it was essential for unit staff to use surface acting to "manage" the process and thus distance themselves from others. Just as other health professionals do (Bone, 2002), they tried to manage by engineering a situation in which it was evident that they simply did not have time to address, or even signal that they recognized, the emotional needs of their clients. The overflow from the way in which they manage this infiltrates into the experience of those women who make decisions about participation in a voluntary disease-detection programme (Brunton and Thomas, 2002). From a technical viewpoint, a valuable service is provided, and staff consistently expressed their genuine dismay that some women chose not to participate in a programme that they themselves were clearly committed to. In turn, the strain of "managing" the emotional interface both in the public arena

and workplace may also result in a situation that Hayes and Kleiner (2001, p. 84) define as serious enough to constitute an "occupational hazard".

Perhaps the determination to provide a professional interface has been developed to the point of failing to meet everyone's emotional needs. As Sandelands and Boudens (2000, p. 49) argue, the search for meaning in the workplace is one of "connecting with others". That is, the meaning of work relationships resides in other people. The importance of positive interpersonal relationships with coworkers did have a significant effect on individual perceptions of work, as illustrated by Evans and Fischer (1993). Both the unit staff and health promotion team looked within the confines of their groups for emotional support during this time of change, to provide an "emotional buffer" (Huy, 2002), as they attempted to manage the interface with others. The need to comply with rational rules governing emotional expression and suppression also appeared to underlie difficulties for staff in this study, who felt unsure and uncomfortable about what was expected of them, and whether it was acceptable for them to express their concern openly. This reticence may be partly a result of socialization, as women are expected to be polite and are thus reluctant to express negative emotions (as suggested by Planalp (1999). Whatever the cause, the environment was not one that facilitated free and open reciprocal communication. Some staff expressed dissonance with a process that they perceived was not meeting either their needs or the goals of the organization in the environment of change and uncertainty.

Conclusion

As with most organizational theory, there is a tradition of rationality in health organizations. However, as Fineman (1996) points out, individuals in the workplace do not always follow, or conform to, defined, optimally rational processes. Although it is recognized that this study is limited to one health organization, the findings have revealed the complexity of emotional life within. There are many potential reasons why participation in a community-based screening mammography programme is overlain with levels of emotion for all participants. A work environment that is intensely interwoven with emotion influenced not only those within the organization, but also overflowed onto those at the interface with the community. The comments from staff in the unit illustrate that the rational framework of biomedicine was used to construct a protective frame to emotionally "re-code" the work to help to protect them from higher levels of stress. However, the propensity of the relentless need to monitor and manage the emotional interface both internally and externally, and the potentially negative influence on the health of practitioners (Schaubroeck and Jones, 2000) appears to be leading to a stressful environment and the possibility of burnout.

As Shuler and Sypher (2000) point out, rationalistic logic ignores the needs of staff unless the integral function of emotion is also recognized within that same rationality. As emotions or feelings contribute to the form of the encounter, they are integral to our work relationships (Diefendorff and Richard, 2000). Accordingly, the more that individuals are encouraged to express job-related emotions, the less dissonance they are likely to experience in their work (Kruml and Geddes, 2000). Interaction in the human service work in health care organizations is built on communication, and this communication is infused with emotion throughout. For both organizational participants and their clients, it could be argued that organizations have a

responsibility to ensure that the complex and legitimate role of emotion is not only recognized, but also translated into relevant and appropriate health-care practice, thus promoting benefit for all participants.

Note

1. The author recognizes that the use of the term "client" could indicate acceptance of the commodified language of the marketplace. However, in this case, it is primarily the result of a perceived equally uncomfortable fit of the term "patient" in a community health intervention.

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