Emotional labour and the clinical settings of nursing care: The perspectives of nurses in East London

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Summary Emotions in health organisations tend to remain tacit and in need of clarification. Often, emotions are made invisible in nursing and reduced to part and parcel of ‘women’s work’ in the domestic sphere. Smith (Smith, P. 1992. The Emotional Labour of Nursing, Macmillan, London) applied the notion of emotional labour to the study of student nursing, concluding that further research was required. This means investigating what is often seen as a tacit and uncodified skill. A follow-up qualitative study was conducted over a period of twelve months to re-examine the role of emotional labour and in particular the ways in which emotional labour was orientated to different clinical settings. Data were collected from 16 in-depth and semi-structured interviews with nurses based in East London (United Kingdom). Findings illustrate emotional labour in three different settings (primary care, mental health and children’s oncology). Findings show the different ways in which emotional labour is used and reflected upon by nurses in these three clinical areas. This is important in improving nurse training and best practice as well as helpful in offering an initial synopsis of the culture of care in nursing; investigating several clinical settings of nurses’ emotional labour; looking at changing techniques of patient consultation; and beginning to explore the potential therapeutic value of emotional labour.

Introduction: definitions of emotional labour

Hochschild (1983) says that emotional labour involves the induction or suppression of feeling in order to sustain an outward appearance that
produces in others a sense of being cared for in a convivial safe place (Smith and Gray, 2000, 2001).

Emotional labour is particularly typified by three characteristics: face-to-face or voice contact with the public; it requires the worker to produce an emotional state in another; it allows the employer through training and supervision to regulate a degree of control over the emotional activities of workers (Hochschild, 1983; Smith, 1992, p. 7; Smith and Lorentzon, 2007). The term ‘emotional labour’ highlights the similarities as well as differences of emotional and physical labour. Emotional labour requires an individualized but trained response that assists in the management of patients’ emotions in the everyday working life of health organisations (James, 1993, pp. 95–96; Smith and Gray 2000, 2001; Smith and Lorentzon, 2007; Allan and Smith, 2005).

Emotional labour has traditionally been identified with women’s work and the role of the mother in the family. This is especially significant given that images of nursing still reverberate with that of the caring female, particularly with the prototype of Florence Nightingale (Smith, 1992). The portrayal of emotional care as an entirely natural activity is certainly related to the devaluation of emotional labour in cultural, gender and economic terms (Persaud, 2004; Oakley, 1974; Totterdell and Holman, 2003; Glomb et al., 2004).

Although there is a growing shift towards the psychological and social aspects of patient care (Brotheridge and Lee, 2002; Diefendorff and Richard, 2003), an important gap in understanding is the centrality and therapeutic value of emotional labour in the lives of patients.

The task of looking at emotional labour in the health setting involves the assessment of the strategies of emotional regulation that are available to health professionals. This includes the analysis of how nurses manage their own and the patient’s emotions and how nurses come to terms with the difficult processes that are often an unavoidable part of patient care. Such research will have to explicitly deal with uncomfortable and sometimes conflicting emotions that nurses, health professionals and patients have to face.

The therapeutic potential of nurses’ interpersonal involvement with patients is certainly a central feature in what is widely known as the ‘new nursing’. Many say that the ‘new nursing’, if properly overseen, will generate positive outcomes for staff and patients (Hunter and Smith, 2007; Allan and Barber, 2005; Staden, 1998). Critics suggest that the ‘new nursing’ may be flawed in some respects and may place too many demands on the nursing role (Brotheridge and Grandey, 2002; Mackintosh, 1998; Aldridge, 1994). Certainly, the ‘new nursing’ still remains a bone of interprofessional contention and therefore a central point of review in the future. It is part of the task of the present study to begin such a review, relating the ‘new nursing’ to how nurses deal with emotions and how emotional labour is shaped by seniors and colleagues (Allan and Smith, 2005; Williams, 1999; Smith, 1992; Barnes et al., 1998).

If, as Staden (1998, p. 154) says, “a language to communicate care work does not exist”, then research must investigate the ways that emotions are dealt with in a variety of clinical and non-clinical settings. By making emotional labour explicit rather than tacit in nursing practices, there is room to cope more adequately with the emotional pressures, stresses and strategies involved in caring for patients.

From an evidence-base of research, the contribution of emotional labour to nursing practice, training and health policy is clearer. This means that recommendations for research and development can be made in light of important initiatives and guidelines for improvement in nursing (UKCC, 1999a; UKCC, 1999b; DoH, 1999).

The main purpose of the study was to investigate the tacit and uncodified emotions of nurses in several different clinical settings in order to make the skills, dispositions and aptitudes required for emotional labour more explicit and better documented by empirical and evidence-based research. Emotional labour is often ‘swept under the carpet’, associated as a natural facet of nursing or part and parcel of ‘women’s work’. This study aimed to demystify these taken for granted emotions, which will help in documenting the techniques, skills, therapeutic value or otherwise and importance that nurses attach to their emotional labour. Making emotional labour explicit in this way has ramifications for policy, training and nurse practice in different clinical areas as well as perhaps improving and sustaining standards of patient care.

**Methods**

The research will present narratives/stories that are transcribed from interviews with nurses. These are taken from a twelve month pilot investigation conducted in East London in the United Kingdom, in an urban and multi-racial location. Nurse narratives involve the clinical settings of:

- Primary care.
- Mental health.
- Children’s oncology.
These settings emerged naturally from the data but have a surprising resonance with the clinical settings in Smith's (1992) original study.

The qualitative data of the study were collected from a variety of sources, primarily from sixteen in-depth and semi-structured interviews with nurses. Interviews lasted between 45–90 minutes. Meetings with nurses, nurse managers, directors and lecturers at several research seminar groups were also held at the beginning and end of the research, in order to present the research, get feedback on what issues it should examine and also for comments, ideas and criticisms as regarded the project’s main findings. There were also research meetings with staff, mentors, student nurses, administration, management, the Student Council for Nursing and local nurse representatives in order to have a more holistic and participatory research approach and to get a broad spectrum of opinions on the value or otherwise of emotional labour. All of these methods assisted in the investigation of aspects of nurses’ emotional labour and helped to gain a reflective and participatory focus upon which to begin to explore the different clinical settings of emotional labour.

Nurses were recruited to the study via the researcher’s attendance at several pre- and post-registration classes held at the local East London hospital. The researcher particularly attended classes on ‘images of nursing’ and those that taught aspects of sociology and psychology. It was thought that nurses attending these classes would be especially interested in the social, psychological and emotional aspects of nursing and thus want to take part in the project. The researcher would present the project on emotional labour at the start of the class and then sit-in for the duration. Nurses and student nurses were then free to approach the researcher after the class (either in the seminar room or more often than not in the informal environment of the canteen).

The majority of participants were female (12 of a total of 16) and ethnically quite diverse (seven described themselves as White, six as Black and three Asian).

The study draws from the traditions of empirical qualitative data collection and ethnography, which looks at how people make sense of the world around them, their experiences of social relationships and other people (Garfinkel, 1967). Ethnography focuses on participants’ meanings (or ‘members’ meanings’) and perspectives in order to better understand social and emotional relationships. Feminist studies in health were also important (Oakley, 1974; Smith, 1992, 1999: James, 1989; Oakley, 1981) and especially relevant given that on average 84% of nurses in the local trust where the research took place were women. A feminist perspective allows what Smith (1999) terms ‘the logging of emotions’ and brings a focus both on the politics of emotions and on the gendered divisions of (emotional) labour in society that may be unconsciously reproduced in the health services.

The purpose of the sixteen in-depth and semi-structured interviews was to discuss the experiences of nurses in relation to their feelings and emotional labour and to ask them to reflect upon their practices and emotions in different clinical settings. This allowed the research to address, discuss, reflect upon and so better understand the tacit and uncodified emotions often associated with nurses’ practices and emotional labour. Data analysis was conducted by the main researcher and project leader who would meet regularly to discuss aspects of the research on emotional labour and to discuss transcripts of the interviews. Topics, themes and salient issues from the nurse interviews were identified by reading and re-reading transcripts and discussion. Three feedback sessions (focus groups) were held at the local hospital with student and registered nurses to discuss preliminary findings and get a participatory focus on main themes, what issues were important, what quotations to use from interviews in any report or publication and any possible gaps in the research.

The research was subject to the ethical review and assent of both the Local Research Ethics Committee and the University’s Research Ethics Committee. In order to ensure informed consent, participants were told about the research, its aims and what the interviews involved as well as their rights as research participants to anonymity and confidentiality. Participants were assured that they would not be named and that great care would be taken to protect their identity. Because the study involved emotions and discussion of topics of a sensitive nature, participants were told that they could halt interviews at any time and withdraw at any stage of the research. The precise location of the study in East London has been omitted for ethical reasons and to protect the identities and conversations of a highly personal and sensitive nature with nurse interviewees.

In addition, an important local issue raised during conversations and meetings with nurse lecturers, managers and directors of nursing involved difficulties relating to the recruitment and retention of nurses, with reported high levels of staff burnout and high attrition rates with nurses leaving the profession. This was suggested by lecturers, managers and directors to be partly related to...
the emotional pressures and stresses of nursing. The study of emotional labour was therefore considered to be topical, valuable, important and very relevant to the local hospital and in the planning and staff recruitment and retention strategies of the local trust.

Findings- the clinical settings of emotional labour: studies of how nurses care

Three clinical settings were mentioned by nurse interviewees, emerged naturally from the data and involve different types and orientations of emotional labour. The three contexts have different sorts of patients, emotions, nurse narratives, attitudes, dispositions, clinical guidelines and reflection on emotions as well as different ways of managing emotions in patient care. The settings involve different cultures of care and the varied techniques of emotional labour that were used in different situations by nurses.

Primary care, mental health and children’s oncology will be briefly surveyed as case examples. The intention is to demonstrate the ways in which nurses engaged in emotional labour in different clinical settings. The case examples indicate the usefulness of collecting a rich evidence-base on emotional labour. A concrete evidence-base is particularly necessary given that emotional labour is tacit in the nursing profession and needs to be made more explicit. The contexts of emotional labour need to be codified in order to assist nurses in their day-to-day interactions with patients, relatives and other members of staff as well as facilitating the potential therapeutic value of emotional labour (Smith, 1992, 2005; Zapf and Holz, 2006).

Primary care

According to one nurse at interview who worked in primary care as a nurse practitioner:

I have baby clinic once a month at the surgery. All the babies are screaming and screaming, which isn’t at all good for my head and is, you know, really painful for a four or five hour clinic. The babies are frightened... and the mothers are worried and upset... Sometimes the mothers will scowl at me because I’m hurting their babies. I have to give the babies their injections. I might even be interrupting a feed... All the time I’ve got a headache and keep things going. I have to keep the babies and the mothers happy, and have to smile to reassure them and really resist the temptation just to get out of the room.

Several important features of emotional labour could be suggested as being accomplished by the nurse in this excerpt. These features could be suggested to be integral to the management of emotions:

1. The nurse was providing emotional labour in so far as she was managing her own and others’ emotions. Emotional labour makes mothers and children feel more comfortable in the baby clinic.
2. The nurse was engaged in ‘‘dealing with other peoples’ feelings, a core component of which is the regulation of emotions’’ (James, 1989, p. 15). Appearing caring was a core component in what Hochschild (1983) terms ‘‘the managed heart’’. The nurse resists her own feeling to ‘‘just to get out’’ of the baby clinic. Instead, surface gestures (such as a smile) were performed in order to ‘‘keep things going’’ at the clinic (see also Smith et al., 1998, p. 32; Grandey et al., 2005).
3. In a similar way to Hochschild’s study that focused on flight attendants, acting techniques were used by the nurse as a strategy for managing interpersonal relations. The nurse said she had a personal and work self that helped her to orientate herself towards the mother and the baby. This was a presentation of the nursing self (an image of the nurse as a carer, supporting with a smile and by being there) (see also Smith et al., 1998, p. 32; Grandey et al., 2005; Smith and Lorentzon, 2005).
4. The emotional labour of the nurse helped to solidify the interpersonal relationship with the mother. The emotional labour of the nurse worked to create a relatively comfortable environment for patients and relatives in an emotionally pressured, difficult and stressful situation.
5. This maintained a functioning work environment and made the baby clinic a consistent atmosphere for those coming into it. The nurse maintained good relations irrespective of her own feelings (see also Smith et al., 1998, p. 32; Allan and Barber, 2005; Smith and Lorentzon, 2005).

Alternatively, on a more critical and cautionary note as discussed in much research (Aldridge, 1994; Smith and Lorentzon, 2005; Larson 2005; Persaud, 2004; Brotheridge and Grandey, 2002; Hunter and Smith, 2007), it could be argued that the nurse
in the above extract was behaving unethically and without authenticity in covering up her ‘true’ emotions from her ‘professional’ and ‘work-self’ emotions. According to Persaud (2004) the two key tasks required in consultations are to hide negative emotions and to display positive emotions even when the practitioner feels the opposite. Persaud also notes that this can cause emotional dissonance (a disparity between genuine and displayed emotions) and suggests that many psychologists believe that constantly hiding difficult emotions with colleagues and patients is stressful enough but if combined with forcing positive emotions may push practitioners close to burnout. There is also the possibility that colleagues and patients may see through such superficial care.

Mental health

According to a nurse who had over fifteen years of experience in mental health:

It’s almost impossible not to take the way you feel home with you. We do get some chance to talk about patients at work but I usually end up taking work home with me and feeling very stressed... I talk things over with my family, minus the details, you know... One of the most emotionally difficult things about mental health nursing is trying to get to know the patient and feeling that they might do something like try and hit you at any moment.

There are two points to draw out in this nurse’s account. First, stress and “taking work home” were seen as a direct result of not enough reflection with colleagues (Croppanzo et al., 2003; Brotheridge and Grandey, 2002). Similar findings were mentioned in a study of the emotional labour of nurses who worked in orthopaedics (Smith et al., 1998, p. 32). No doubt the nurse’s “taking work home” with him might cause problems away from work with the mental health nurse’s family.

Second, there was the issue of “trying to get to know the patient and feeling that they... might try and hit you at any moment”. Physical aggression, and labelling difficult patients as ‘mad’ and ‘bad’, have certainly been stereotypes of those with mental health problems in the health services and in public life too.

Patients were divided into “good” and “bad” categories by many of the nurses at interviews and during participant observation in student nurse classes (Stockwell, 1972). The division of “good” and “bad” patients was partly based on the social control elements of nursing work, with the “good” patients being viewed as more compliant than those categorised as “bad” (see also Lawler, 1991, p. 147; Zapf and Holz, 2006; Stockwell, 1972). For example, a “bad” patient was someone who had “brought the illness on themselves and can’t really be helped”. Mental health patients, alcoholics, paedophiles and drug users were all seen as “bad patients”. Quite patently, dividing patients in such a way places severe limitations on interpersonal contact and makes all sorts of demands on nurses. The therapeutic ideal of equality in patient treatment sometimes conflicted with personal feelings about “bad patients” (see Newton, 1995; Persaud, 2004). According to another mental health nurse:

Nurses are called on to deal with all sorts of patients. Just there and then and you’ve got to be ready to go and help them (patients). Some patients can be really horrible and even disgusting, which means you have to really emotionally labour... I suppose you could say there are good and bad patients who you treat differently, even though you’re not supposed to, and you’re really supposed to treat everyone the same.

Taboos of intimacy with patients were formed to deal with perceptions of appropriate and inappropriate contact (Grandey et al., 2005; Fox, 1980; Lawler, 1991; Stockwell, 1972). In the case of “bad patients”, emotional distance was encouraged. With “good patients” the reverse was true and informal intimacies were said to be acceptable and encouraged. However, the nurse in the above excerpt noted that “you’re really supposed to treat everyone the same”. This shows that the therapeutic ideal of equality was still ingrained in her professional view. There was room for discussion, perhaps with a mentor, modern matron, ward sister/charge nurse, nurse management or teacher, of how conflicts between her public role as a nurse and her private feelings about “bad patients” may be resolved. Reflection on conflicting emotions about “bad patients” or even patients in general and managing difficult events in clinical practice areas were essential to professional development and reflexive nurse practice (Williams, 1999; Grandey et al., 2005; Zapf and Holz, 2006).

What was particularly of note was the stress that was caused by difficulties that the first nurse had with the care and social control elements of his work. “Trying to get to know the patient” sits in sharp contrast to the image of mental illness as physical aggression. Studies by Handy (1990) as well as Croppanzo et al. (2003), show that the mandate to both care for and control patients with mental health problems leads to unresolved conflicts and emotional distresses for all involved. This was said to reproduce distress and inequalities in health, especially where discrepancies arise.
between daily practices and therapeutic ideals, as was also recognised by the nurse in the second excerpt (Handy, 1990, 1991; Cropanzano et al., 2003; Newton, 1995, pp. 94–96).

The emotional labour involved in children’s oncology and bone marrow transplant

In the children’s oncology setting, nurses have to deal with issues of dying, death, bereavement and managing a 'good death'. The case of children’s oncology was a justifiably emotive and upsetting clinical area in which there was often little hope of a cure and only the possibility of palliative care. Nurses, in particular, have to learn how to manage a 'good death' and emotional labour was a key component for doing this.

As a specialist cancer care nurse said of emotions in the children’s oncology and bone marrow transplant setting:

You get attached to the patient and attached to the family. The last little boy I looked after was diagnosed as leukaemic, had chemotherapy and had bone marrow transplant. The transplant failed and by the time we met him he’d had lots of problems at school and also with his family. He was dying and his parents just wanted him to be an ordinary little boy. They were encouraged to do that by (a specialist cancer centre). I think that’s what all caring agencies promote, that’s normal and maintained as much as possible. But I think towards the end of that little child’s life, it was taken to an extreme by health and social services and the parents. The little boy was apparently having nightmares and could see ghosts, but because the little boy’s parents had been told to maintain the norm they didn’t know when to step away from the norm and show their emotions. The doctors and parents had in a sense stopped listening. I said that it would be good to move the little boy in with the parents, into their bedroom in the last week, but nobody wanted to take on board the fact that the little boy was so poorly and needed to be closer to everyone.

The nurse said that she felt "anger" and "despair" in the situation, which mirrored the emotions of the parents and also related to the issue that the nurse had her own children. She said that her feelings were not dealt with and supported: "You can’t show your frustration if you’re a nurse and you just have to sit on your anger". This dissonance between genuinely felt and displayed emotions was linked with the formation of the "hard nurse" and with high rates of "burnout" (Cropanzano et al., 2003; Brotheridge and Grandey, 2002).

Such an evocative narrative certainly adds further weight to the argument that we need to extend an appreciation of emotional labour so as to allow a more explicit focus on systems of social and emotional support. James writes:

Cancer is a particularly apt disease to review in order to analyse the management, control and ‘labour’ of emotions in health organizations (James, 1993, p. 96).

Children’s oncology was a protracted and painful event for all those involved. As the nurse said at interview:

People can go through years and years and years of hoping that someone close to them might live, but knowing in the end that they are going to die. I don’t know how nurses and relatives can cope with that, really. They just get on with things and have to get on with things.

Nurses, patients and relatives were all involved in emotional labour and engaged in reflections of how to manage medical and emotional demands. All involved had at some level to manage their feelings. In some cases, this meant having to work at maintaining the belief that everything was normal in the patient’s life and in other cases it meant being faced with the uncomfortable task of disclosure or even having to manage a ‘good death’ (Diefendorff and Richard, 2003; Zapf and Holz, 2006; James, 1993). James writes:

The person with cancer and professionals have to regulate their feelings. Even the diagnosis of cancer is surrounded by its own language—‘disclosure’, ‘communication’ and ‘insight’ in lay terms. At a personal level cancer generates disbelief, fear, lies and chaos which are controlled through information, optimism, routine living and social expectation. (James, 1993, p. 97).

The above quotation supports the case that the task of research on emotional labour in the children’s oncology setting should involve an assessment of the strategies of emotional regulation that were available to nurses. This includes looking at how nurses manage their own and the patient’s emotions, how nurses come to terms with the difficult processes that were an unavoidable part of children’s oncology, and looking at examples of successful mechanisms of support and disclosure for patients, relatives and staff.

Systems of support and ways to cope were central, especially given the rates of burnout and the obvious emotional difficulties involved (Huy, 1999; Persaud, 2004). As the nurse said during her interview:

I think if you emotionally burnout, you don’t give anything emotionally and patients soon cotton onto
that fact. There are lots of nurses who are burnt-out and who don't know how to cope and do erect a wall. But then if you continually give and give and give and give, all the things I might be saying might be the right things, and I might have learnt to say all the right things, but they might not really mean anything to me anymore. Although I was doing what I was supposed to be doing, medically at that point, my emotions weren't engaged at that point and I had to get out.

Conclusion

Despite pressures on resources and problems of recruitment and retention in nursing in the United Kingdom, this article has shown that nurses continued to provide emotional labour in a variety of difficult as well as everyday circumstances. Despite the great internal and external pressures of working in the health services, emotional labour was used to support relationships with patients, relatives and colleagues. By doing this, healthcare organisations were literally kept running by the different techniques of emotional labour that nurses use from day-to-day.

The task remains to identify successful policies and examples of good nursing practice that reinforce emotional labour and the support of patients and relatives. There was certainly room to develop the role of emotional labour in policy as well as in nurse practice and training. Making emotional labour in nursing explicit is certainly in line with current nursing philosophy, pre-registration and post-registration nursing courses. Indeed, present nursing philosophy is based on the principle that nurses must have a flexible, reflexive and conceptually driven education. This is seen to allow nurses to work in a variety of clinical and non-clinical settings in rapidly changing healthcare services, during a time of constant change and some would say constant crisis in nursing. Nurses are educated so as to be able to monitor, reflect upon and assess their practice, an important element of which involves emotions. This leads some to argue in quite different ways that nursing is becoming more academic and research-based (Zapf and Holz, 2006; Aldridge 1994; Smith, 1992, 2005).

Future research in the health services should engage other professions, patients, voluntary and advocacy groups. Gender, cultural, personal and professional barriers to emotional labour should be more fully studied and noted. The ways that these barriers influence health practices should also be investigated. Further comparative research on different types of emotional labour in nursing and in other organisations should also be carried out so as to gain a fuller and broader picture of how emotions maintain institutional relationships (i.e. by looking at the different emotional labour in the work of doctors, occupational therapists, nurses and other health staff) (see Firth-Cozens and Payne, 1999). Certainly, as suggested in literature and shown in the research application of the present study, there was ample evidence-base upon which to form a fuller picture on emotional labour in healthcare organisations.

Above all, the emotional labour shown in the three different settings in this study indicated the therapeutic value and importance that nurses attach to their emotional labour. In each of the three settings discussed, emotional labour was reported by nurses to bring added value and help in sustaining a caring environment between nurses and their patients. This gave nurses space to engage with, reflect upon and manage their own and others' emotions, which nurses suggested greatly improved practice and the standard of care. Reflection and supervision of emotions were important methods of preventing burnout and emotional stresses, which nurse lecturers, managers and directors suggested might also be related to local recruitment and retention issues, with high rates of attrition and nurses leaving the profession in the local trust.

Emotional labour was stereotypically portrayed as female, wrap up as part and parcel of 'women's work' and associated with caring in the domestic sphere. The notion of emotional care as an entirely natural activity is certainly related to the devaluation of emotional labour in cultural, gender and economic terms (Persaud, 2004; Oakley, 1974; Trotterdell and Holman, 2003; Glomb et al., 2004). Gender stereotypes often meant that female nurses were ‘invisible carers’ (taken for granted with emotions represented as a ‘natural’ activity) while male nurses were ‘forgotten carers’ (Arber, 1989; Duncombe and Marsden, 1998). Both male and female nurses were constrained by stereotyped gender roles and gendered divisions of emotional labour, particularly as concerned the expression of emotions and taboos of distance and intimacy with patients. For example, in the mental health setting, male nurses were suggested to perform a patriarchal role in controlling ‘dangerous’ or allegedly ‘bad’ patients. Moreover, because nurses in the mental health setting have both a duty of care and social control elements to their work, this was suggested to cause unresolved emotional pressures and stresses in patient care. The mandate to both care for and control the mental health patient was reported as leading to distress and inequalities in health, especially when discrepancies arose.
between daily practices of social control and therapeutic ideals (Handy, 1990, 1991; Cropanzano et al., 2003; Newton, 1995, pp. 94–96).

Emotional labour was regarded by participants as vital to nurses and an integral part of the culture of care in the health services. Examples from primary care, mental health and children’s oncology demonstrate different situations in which emotional labour techniques were required and quite vital to care for patients, support reflexive learning and facilitate best nursing practice. Care and emotional labour, as originally and more recently outlined by Smith (Smith, 1992, 1999, 2005; Allan and Smith, 2005; Hunter and Smith, 2007; Smith and Lorentzon, 2007), was thought by nurses to remain at the very heart of nursing.

The research also had several limitations. First, the research was conducted in one hospital in the East of London. Findings are context-bound to East London and limited, meaning that broader United Kingdom and international research on emotional labour would be advisable and fruitful. Most of the sixteen participants were female and the sample was quite ethnically diverse. Broader research throughout the United Kingdom and internationally is required to reach more conclusive, generalisable and internationally relevant findings. More research also needs to pay attention to the emotional aspects of cultural beliefs. There may be an underlying assumption in this study that emotional labour manifests itself in similar ways in different countries and different cultures, but this may not be the case given cultural differences, divergences in the structure and set-up of health services and different patterns of nurse education and supervision outside the United Kingdom. It might be useful for further research to do a scoping study and systematic literature review that takes into account the geographical and cultural variations involved with regard to emotional labour. Second, accounts by patients involving their emotions and the emotional labour of nurses and other health staff need to be researched to provide a balance of perspectives. Third, concepts that run parallel to emotional labour (such as emotional intelligence, critical companionship, attachment and clinical empathy) need to be explored in the United Kingdom and international health services context. Fourth and finally, the exhortation of Fineman could be reworked as both a criticism of the limited nature of the present study as well as a call for more research:

What is missing are the definitions and redefinitions, interlayering of feelings, feelings about feelings, over time and in experiential depth (Fineman, 1991, p. 216).

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References


