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# “I don’t have any emotions”: An ethnography of emotional labour and feeling rules in the emergency department

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## Abstract

**Aims:** This study aims to apply Hochschild's theory of emotional labour to emergency care, and uncover the 'specialty-specific' feeling rules driving this labour. Despite the importance of positive nurse well-being, the emotional labour of nursing (a great influencer in wellbeing) remains neglected.

**Design and Methods:** Ethnography enabled immersion in the ED setting, gathering the lived experiences and narratives of the ED nursing team. We undertook first-hand observations at one major trauma centre ED and one district general ED including semi-structured interviews (18). A reflexive and interpretive approach towards thematic analysis was used.

**Results:** We unearthed and conceptualized four feeling rules born from this context and offer extensive insights into the emotional labour of emergency nurses.

**Conclusion:** Understanding the emotional labour and feeling rules of various nursing specialties offers critical insight into the challenges facing staff - fundamental for nursing well-being and associated retention programs.

**Impact:** • What problem did the study address?

- What were the main findings?
- Where and on whom will the research have impact?

Academically, this research expands our understanding - we know little of nurses' feeling rules and how specialties influence them. Clinically, (including service managers and policy makers) there are practical implications for nurse well-being.

## KEYWORDS

burnout, emergency nursing, emotional labour, emotions, psychological

## 1 | INTRODUCTION

Around the globe, challenges facing healthcare systems have implications for staff providing care. British nurses' rates of stress,

burnout and intention to leave the profession are among the highest in Europe and are higher than the USA (Aiken et al., 2012). Nurses working in the ED are at particular risk of anxiety, depression and burnout (Adriaenssens et al., 2015) – perhaps unsurprising when

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considering emergency departments are struggling to meet demand, with increasing patient attendance over the last 70 years and intense government targets in the UK (The Kings Fund, 2018). The ED is a distinctive environment for nurses to deliver care: often overcrowded (The Kings Fund, 2018), with physical space and time in limited supply, all of which likely to exacerbate stress. Although links between emotional labour (first conceptualized by Arlie Hochschild, in the 1980's) and well-being have already been established academically, it remains under supported in the practice environment (Smith, 2012)—relevant both inside and outside of the emergency setting.

We have little understanding of the emotional labour undertaken in the emergency setting. In response, this research has applied Hochschild's theory of emotional labour to the ED. We offer critical insight into how this nursing specialty impacts on the management of emotion. We offer theoretical and empirical contributions through uncovering the emotional labour of emergency nurses. We conceptualize four of their distinctive feeling rules and offer important implications for practice.

## 1.1 | Background

Despite emphasis on the physicality and clinical skills of nursing work, many tasks involved in care are 'invisible' (Allen, 2014). Much of this nursing work is taken for granted by healthcare organizations and, by its concealed nature, is difficult to quantify and even describe, let alone value. Allen (2014, p.19) argues:

Nursing has many features that make visibility problematic. It is often assumed to rest on the natural caring talents associated with women and it involves bodywork and engagement with intimate aspects of people's lives and death, making it difficult to talk about...

Management of personal emotion is invisible. Hochschild (1983) describes emotional labour as 'the management of feeling to create a publicly observable facial and bodily display' (1983, p. 7). Emotional labour is underpinned by feeling rules, providing standards in this feeling management, determining what is owned and accepted between individuals in 'the currency of feeling' (Hochschild, 1983, p. 18). Feeling rules are moral stances guiding and effecting how we behave (Smith, 2012).

Nurses have always been expected to manage their emotions but the nature of contemporary practice is particularly important. Changes in the provider-patient relationship, acuity of patients, their complex needs, associated financial constraints and availability of resources have an impact on the pressures facing nurses (Williams, 2012). Additionally, there is an ever-greater emphasis placed on efficiency and quicker patient throughput whilst still meeting patient and relative expectations. At the same time, British nurses' shift patterns give little respite from the intensity of

practice—often 12 hr shifts, sometimes without adequate downtime in-between. Nurses' shifts have been linked to stress, fatigue, clinical error and intention to leave (Ball et al., 2014).

An area of practice offering a 'window' (Hou & Chu, 2010) into the challenges facing nurses, and healthcare more broadly is emergency care. Alongside generic challenges, ED also has its own distinctive pressures (NHS England, 2018). EDs are struggling to meet ever increasing demand, growing exponentially in the last 10 years. Intense and strictly monitored government time-critical targets, such as the four-hour wait and ambulance turnaround time are also particularly relevant. The four-hour target has great influence for care delivery in UK EDs. It works to ensure every patient is assessed, treated then admitted or discharged in four hours of arrival (NHS England, 2018). This, together with the nature of ED (usually a 24-hr service without prior appointment, no limit to the number of patients who are seen and a variable patient population where the notion of emergency is widely interpreted), present practical and ethical challenges for staff as they strive to meet service demands (Basu et al., 2016).

Much less publicised and discussed are the implications of these challenges for those staff tasked with delivering care and the emotional component of this work (Smith, 2012; Theodosius, 2008). As noted in the introduction of this article, British nurses' rates of stress are amongst the highest globally (Aiken et al., 2012). Notwithstanding its centrality to well-being, emotional labour is overlooked in practice (Smith, 2012), leaving a significant component of nursing labour depreciated and undervalued. Emotional labour has direct implications for burnout in particular (Bartram et al., 2012; Cheng et al., 2013; Hsieh, 2012), leaving staff vulnerable to further stress and intention to leave (Bartram et al., 2012).

At the same time, the ED environment will undoubtedly influence the range of emotions experienced by staff, particularly nurses. Importantly, these considerations are also likely to have consequences for subsequent emotional labour. However, the application of emotional labour theory to EDs is largely missing from current knowledge. One contribution, from Bailey et al. (2011) focused on how staff (nurses, doctors and others) manage the emotional impact of end-of-life care in ED. Although emotional labour was not the focus of this study, authors found that ED nurses and their colleagues managed their feelings in times of bereavement - a source of significant stress for ED staff.

Other applications of emotional labour theory have included the following clinical specialties: palliative care nursing (Funk et al., 2017); gynaecological nursing (McCreight, 2005); theatre nursing (Timmons & Tanner, 2005); intensive care nursing (Stayt, 2009) and neonatal nursing (Cricco-Lizza, 2014). Conceptualization of explicit feeling rules is largely missing, the focus instead is on emotional labour undertaken in each context. The examples below offer insights into the influence of specialty on emotional labour.

It is perhaps unsurprising that emotional labour of palliative care nurses often relate to the management of grief (Funk et al., 2017). When nurses are unable to facilitate a 'good death', they feel guilt

and anger but suppress these feelings, ensuring maintenance of reverence (Funk et al., 2017). In studying theatre nurses, Timmons and Tanner (2005) found that they were seemingly responsible for upholding a convivial and light-hearted mood in the operating theatre (Timmons & Tanner, 2005). Cricco-Lizza (2014) argues the drivers behind nurses' emotional labour in neonatal nursing related to remaining 'unruffled' and calm in the face of critically unwell babies and their parents. Studies in other intensive care settings (such as adult ITU, studied by Stayt, 2009) placed importance on maintaining functional relationships with patients' families.

## 2 | THE STUDY

### 2.1 | Aims

The nursing specialty is seen to be relevant to emotional labour undertaken. Emotional labour undertaken in ED is likely to be distinctive and underpinned by distinctive feeling rules. Existing nursing and healthcare literature conceptualizing and explicitly naming nurses feeling rules is largely missing. There remains a compelling space to explore those that are influenced by the ED specialty and specialty specific asking:

How and why is emotional labour undertaken in ED? What are the feeling rules underpinning this behaviour?

This study aimed to understand the nature of emotional labour in ED and to conceptualise the feeling rules driving this behaviour. In addition to expanding our knowledge of emotional labour, this research aims to serve as a catalyst for staff support interventions.

### 2.2 | Design

To address these aims, we observed and spoke with ED nurses, witnessing their work and collecting spoken accounts through ethnography, completed in 2019. We wanted to explore and understand the values, expectations and beliefs (feeling rules) to understand perceptions about what drives their behaviour. In so doing we sought to uncover accounts of (individual and collective) experiences of 'doing' emotional labour in ED. An in-depth, ethnographic style of data collection lends itself to qualitative research and interpretivism, a philosophical approach that attempts to understand the 'life world' of individuals in the studied situation (Gherardi, 2015).

### 2.3 | Data collection

For diversity of environment, two EDs were included. One was in a district general hospital, the other, part of a major trauma centre and teaching hospital (both in England). In total, 200 hr of formal observation were completed by the first author including extensive formal semi-structured interviews, informal interviews and conversations.

### 2.4 | sample/participants

Eighteen semi-structured interviews were completed with ED nursing staff (a mixture of staff nurses, sisters / charge nurses). Respondents needed to be actively working in the ED setting, but the sampling criteria did not stipulate age, level of experience or other demographic. The sample size offered diversity of respondents whilst remaining feasible in the given time frame. Respondents were recruited via social-media, email and poster advertisement in the EDs.

Interviews followed a semi-structured approach with a pre-defined topic guide. The questioning focused on the characteristics that staff use to describe an ED nurse and that ensure a nurse's 'success' in this environment. These interviews offered the room to explore participants' perceptions of the emotional challenges of their roles and how they managed these elements.

Reflecting on the first round of interviews and initial periods of observation, we noticed the recurrent use of specific metaphors. We decided to use these explicitly in the interviews that followed, recognizing that 'metaphors in use' can powerfully reveal how we 'conceptualize our reality' and how we make meaning (Kuntz & Presnall, 2012, p. 738). As a consequence, they can provide new insights into conventional and familiar ways of speaking about our experiences (Gowler & Legge, 1989). Field notes from the previous observations from both sites were subsequently re-read and the metaphorical terms used by the ED staff were drawn out, including 'firefighting', 'warzone', 'dungeon' and 'bunker', amongst others. We used visual images to introduce these tropes in the interviews, where they helped to stimulate conversation and yield new understandings. This combined approach prompted interesting and lively discussion, revealing insights inaccessible without these metaphorical triggers. Further questioning took place to unpack the understanding and interpretation of the metaphors and their experiences, and to then check the researcher's interpretations of those experiences. Participants were actively encouraged to challenge interpretations made by the researcher.

Interviews were completed in person at a location of the participants' choice (both inside and outside of the hospital setting). The table in Appendix A offers detailed participant demographics and further information. These pre-arranged interviews were in addition to extensive informal conversation and dialogue during observation. The data were generated by KK who herself had experience of nursing in the ED (at one of the case study sites). KK knew four of the 18 participants. We discuss the implications of this familiarity in the 'rigor' section below. The interviews were recorded and transcribed verbatim.

### 2.5 | Ethical considerations

Ethics approval was sought through the Health Research Authority in addition to university ethics and local R&D approvals (at both hospital Trusts). Each interview participant gave signed, informed consent. All participant details were anonymized and pseudonyms given.

## 2.6 | Data analysis

To aid management of data and systematic approach to analysis from a practical perspective, NVivo 11 software was used. A reflexive, interpretive approach (see Mason, 2017) was taken to analyse data by the research team, in line with epistemological and ontological assumptions established for this study. Analysis began 'in the field' with note summaries and identification of salient ideas. Initial formal coding was non-cross-sectional (Mason, 2017) as preliminary themes were established. A refined list of nodes and sub-nodes (examples provided below) were then established from each individual source (Mason, 2017). A broader cross-sectional approach then allowed for the unveiling of common patterns across the entirety of the data (Richie et al., 2014). This phase began the process of reducing and refining the nodes. This was an iterative process, as suggested by Hammersley and Atkinson (2019), which constantly evolved as further reading (of the same data sources and initial nodes) took place. As confidence developed and further familiarization occurred, 'saturation' (Mason, 2017) was reached.

Once the team had established a final set of nodes and they were applied across the dataset, they used diagrams, charts and visual representations. Organizing the data diagrammatically offered an opportunity to develop analytical thinking by visually showing the relationships and connections between the nodes and the multidimensional nature of the dataset. To illustrate this process, the data extracts below show how, through a process of 'progressive focusing' (Hammersley & Atkinson, 2019), we moved from the data to first order thematic analysis and then to a higher level of conceptual abstraction. Each phase of the data analysis process described involved members of the team working independently and then collaboratively, challenging data representations, assumptions and interpretations.

The process ultimately led to two overarching concepts—'Moderators of ED nurses emotional labour' and 'Specialty specific feeling rules'. For the purpose of this discussion, we will focus on the feeling rules. To further aid transparency, Figure 1: Refinement of Nodes: ED Nurses' Feeling Rules (Appendix B) shows how this concept was reached.

## 2.7 | Rigor

'Testing' assumptions drawn from the data involved various stages, including the first author taking data to the wider team who worked independently to 'test' initial coding. This process was repeated throughout the refinement of analysis to ensure a rigors and transparent technique—a stance which is crucial in building trustworthiness and consequently reliability in findings (Lewis et al., 2014).

Ethnography is an 'embodied experience', shaped by the researcher's implicit choices in relation to what should be observed, what should be left out and what should be treated as powerful (Law & Singleton, 2013, p.495). The rationale behind these choices

is dictated by personal, political and theoretical agendas (Law & Singleton, 2013). These agendas and past experiences influenced what was and was not observed. 'The sociological imagination' (Mills, 1959) calls on the researcher to step outside of usual routines and practices and ensure a degree of self-awareness, questioning assumptions through various practical steps.

Of further relevance is how KK, as a member of the participant community and a researcher, was perceived by different audiences. Buckle and Dwyer (2009) suggest that the insider/outsider relationship is not dichotomous but instead can be represented by positions on a continuum, offering the researcher the opportunity to occupy both roles. Using a 'fluid' approach to the insider/outsider argument (Thomson & Gunter, 2011) is helpful to describe this position and recognize the importance of reflexivity. This reflexivity, was intrinsic not only to data analysis, but throughout the project to ensure transparency and achieve reliability. This reliability can be demonstrated, in part, through the ability and openness to show 'methodological, theoretical and practical/pragmatic steps' (Mason, 2017, pp. 40–41). Using interviews combined with observation helped to give understanding of context behind the collected narratives, giving opportunity to delve in and examine respondents' recounted experiences in the interviews in a deeper contextual framework (Mason, 2017). The process of checking and reaffirming observations and interpretations (Hammersley & Atkinson, 2019) with healthcare staff to ensure understanding also assisted with the quest for quality.

It is also important that data are given correct status from the outset (Heritage, 1984, cited in Silverman, 1997). Interviews were treated as an interpreted social event (Hammersley & Atkinson, 2019), accounts the result of the 'complex negotiation' conducted in the interview discussion (Gherardi, 2015, p.15). The opportunity to examine ED nurses' experiences of emotional labour was offered when data showed recurring themes (Mason, 2017).

## 3 | FINDINGS

Emotional labour is a routine, prominent and essential component of nursing. The study supports its centrality and ubiquity in ED nursing. Here, we present four feeling rules which underpin this emotional labour. As part of these findings, we also present ethnographic insights into the ED environment to offer a contextual backdrop to the feeling rules and emotional labour.

### 3.1 | Feeling rule 1: 'There's not much time for faffing around here' – Feel tough, fearless and detached

This introduces the expected character of the ED nurse, described as a 'brand' in its own right. ED nurses must be unfazed by the setting, be blasé and hide any signs of fear or being afraid, to 'earn their stripes'. The ED nurse does not fit stereotypical images of a nurse; this introduces the relevance of gender. Traditional

expectations surrounding the nature of care relate to feeling and showing warmth, body contact, affection and connection between nurse and patient. Conversely, toughness and masculinity are associated with task-based care is practical and remains emotionally disconnected from patients. For many, therefore, adhering to this feeling rule is a significant source of emotional labour as they juggle meeting so-called 'masculine' expectations with those which are arguably traditionally feminine. Nurses described how you need to develop a 'backbone' to work in ED. Likewise, ED S/N Lucy told me that nurses must be 'straight-talking... there's not much time for faffing around here'.

The phrases, tone and behaviours described above are not often associated with traditional warm and in some cases 'mothering' perceptions of nursing (Gray, 2009). For some ED nurses, the associated feeling rules of traditional nursing (compassion, tenderness, comfort and sensibility) were still influential in their work. This brought a degree of tension as they juggled these with the masculinity and toughness expected to be felt in ED—an example of traditional 'hegemonic masculinity', as argued by Connell and Messerschmidt (2005). The work of Boyle (2005) found a similar merge of feminine and masculine 'faces' in studying the emotional labour of ambulance staff. Here, staff demonstrated a 'paradoxical mix of cultural values and practices', expected to show 'compassion, empathy and cheerfulness to their patients'—arguably more feminine qualities. At the same time, they needed to maintain masculine traits of 'self-control and stoicism', despite the traumatic work (Boyle, 2005, p. 62). These competing feeling rules were a source of conflict for some ED nurses, as each carried different expectations for the type of care delivered. The emphasis placed on a 'masculine' approach to care, does not give attention to building relationships. Lara explained:

I've known a lot of nurses who are quite, almost, I wouldn't say masculine, *but, you know, they're not interested in looking after patients in that way. That's why they work in the ED, they say. They don't want to be doing washing, dressing, stuff like that.* They want to give them drugs, want to assess them, want to move them on. I mean, yes, they will chit-chat and they will develop relationships with patients, *but not on a real kind of dignity personal kind of level, you know...* (Previous ED S/N Lara, Teaching ED, Formal Interview).

In feeling and behaving tough, the nurses must also ensure disconnection from their patients. They must deliver functional care to meet organizational demands, maintain patient flow through the ED and achieve specific time-critical targets. The phrase 'greatest good for the greatest number' was therefore shared often during informal conversation. This phrase comes with a degree of acceptance, it is not possible in ED to give all patients the care they expect or need. In many instances, nurses are unable to offer the traditional style of care they expected to deliver. As a result, this reinforces the feeling rule

that encourages emotional disconnection and distancing. In striving to meet service demands, staff must undertake care rationing:

... the withholding or failure to carry out necessary nursing tasks due to inadequate time, staffing level, and/or skill mix, [which] may be a directly observable consequence of low staffing levels and poor practice environments'. (Schubert et al., 2007, p. 2).

In so doing, this carries with it an associated emotional labour, as they 'decide' who and where to focus their care delivery with limited time and resources available. Here, we argue that care rationing is not just about tasks, but (in ED nursing) an important component is the ability to be and feel 'tough', and nurses should also feel able to limit their physical and emotional offerings to patients. Staff were observed as limiting themselves during interactions with patients. In this sense, emotional labour was used as a defence against relationship building and connecting with patients.

### 3.2 | Feeling Rule 2: 'I've got this' – Feel calm yet in control (do not show you are busy, or don't have time)

This feeling rule calls for emotional labour that presents a competent and cool exterior, irrespective of circumstance. A vivid example is the management of patients with serious and time-critical clinical conditions. The nurse suppresses their own stress to protect the patient and hide their awareness of the patient's potential instability or deterioration.

... I suppose from the outside it could appear that you're managing well, you're getting to your patients, you're putting on a front, you're smiling... *You present yourself.* You tell them what the plan is, what's going to happen, what to expect next. Then you're whisking off to take the next patient or moving on to another area. *So, yeah... patients' or relatives' perception could be that it doesn't look as busy because they don't see what's going on behind the scenes.* They don't see what resus is like, that there's minus two beds [short] in there... there could be probably five or six people in the waiting room wanting to know why they've not been seen straightaway because it doesn't look busy, whereas resus is just behind the doors and there could be massive traumas going off. *[Don't let them] see you're stressed and flustered...* It gives them reassurance... *To show patients that you're confident and you can get on with it, but obviously you know that you're not going to be [laughs] calm in every situation.* (ED S/N Carly and Student Nurse Lily, District ED, Formal Interview)

ED nurses must ensure, irrespective of the circumstances, they present a competent, capable, calm front. They must show that they

are in control, even if things are fraught in another part of ED, and they know at any minute the situation could change. This feeling rule therefore expects nurses to suppress any feelings of anxiety or stress. Examples of this emotional labour were abundant during observations and interviews. This emotional labour often occurred when the nurse deemed the patient's illness or injury to be more of a priority than the patient perceived. The nurse might have noticed a time-critical or serious illness or injury the patient was unaware of, they undertook this emotional labour because it is expected that nurses will reassure their patients and keep them calm. There was also an expectation of presenting a calm exterior to colleagues. Nurses hide the anxiety they feel about the clinical instability or urgency of the patient's condition.

Furthermore, this feeling rule is relevant to suppressing any signs of being busy or feeling flustered; even when the workload feels overwhelming. ED nurses must not show that they feel rushed despite time-critical targets. Emotional labour is also undertaken in hiding feelings of frustration (both towards senior colleagues and patients) when the focus is on achieving organizational priorities, rather than 'quality' patient care. Emphasis is on moving patients through ED quickly and efficiently, rather than spending time with each patient. Some of the nurses want to offer a level of care the ED environment cannot afford. Nurses work to mask this busyness and restricted time from the patients, their relatives and colleagues.

### 3.3 | Feeling Rule 3: 'A Mountain out of a Molehill'—Feel empathy and do not feel resentment (even when patients are attending ED unnecessarily)

Here, the feeling rule relates to feeling empathy, irrelevant of the situation. A significant source of emotional labour, as nurses must suppress their resentment towards patients who appear to perceive their clinical conditions should be a higher priority than is feasible. This is partly a matter of legitimacy: when the nurse questions the patient's legitimacy (that is, their appropriateness to be in the ED), it is harder for the nurse to feel empathy towards them and not resent their attendance—especially the time and attention they take away from more 'deserving' patients. The ability to move between the spectrum of needs and still offer universal reassurance and empathy is seen as essential, irrespective of personal feelings or pressures of the environment:

... you know, you see quite a lot of bad things. You deal with a lot of complex things and... You do have to put up a front, a very professional front, and you have to deal with different levels of communication as well. You'll get someone with mental health problems one minute, get someone with a broken finger the next minute, someone's collapsed... *Then you just have to mould yourself into a different personality... to communicate with them, to get on their level of their need.* (S/N Lara, Teaching ED, Formal Interview)

Between ED nurse and ED patient, there is often an imbalance between the level of significance given to the condition. In other words, there can be a 'mismatch' between carer and cared for relating to the priority given to the illness or injury. This disparity between prioritization requires a specific form of emotional labour as the nurse attempts to deliver reassurance to the patient, even in circumstances where the patient's need is seen as lower than other patients in ED. This specific form of labour is driven by the expectation nurses should feel empathy and not resentment, irrespective of the patient's condition and is commonly found in triage and minor injuries:

... there are different emotions [associated with] each [area], so... assessment for example, sometimes you can feel a bit resentful towards people just because of what they come into hospital with, or if they have come in regularly... you can't help but think things are self-inflicted in people who come in again and again, and *sometimes you can feel a bit resentful because obviously you have to try and control your feelings towards them... It can be [hard] when that patient is not behaving in a very nice way as well. It would be easy to, to lash out at them and say what you think, but obviously you can't.* (ED S/N Evie, Teaching ED, Formal Interview).

This emotional labour is intensified further by the extremes of patient need (and perceived legitimacy) and the minimal space between these patients. Nurses must move between contrasting patient groups, often only separated by a few steps, and adapt their 'masks' to suit. Perceptions of legitimacy are also relevant to managing aggressive patients; again, the legitimacy of patients makes compliance with the feeling rule easier, with less resistance. Less emotional labour is required from the ED nurse as it is easier for them to actually feel empathetic. For example, a patient who is behaving aggressively as a result of their clinical condition is perceived as legitimate and their behaviour justifiable.

### 3.4 | Feeling Rule 4: 'Don't take it too much to heart' – Do not feel (too much) distress and grief

This feeling rule encompasses the need for ED nurses to be stoic. They must not feel excessive sadness or grief for patients, even when circumstances are particularly traumatic or emotive. Suppression of upset is seen as a sign of competence and is actively encouraged by senior members of the ED team. This feeling rule was seen as particularly important 'for' the patient—a balance between showing care and concern whilst remaining 'professional' and clinically useful. Hiding personal distress and sadness is a careful balancing act. Nurses must still offer enough emotion to patients and relatives to show that they care, but not too much. The display of the nurse's feelings is seen as secondary to feelings of the patient and their family. Again, their well-being takes priority, the focus is on clinical competence and support:



I can think of probably a handful of times where it was wholly appropriate that I showed a family how it affected me, and that enabled that parent to reach a level of understanding or at least to come to terms that it is OK to feel as bad as they did because 'Look. *Even the nurse is crying*', but it was still a level... I can't completely lose it because this parent needs me to be sort of their advocate or act sort of on their behalf to help them through this. So, somebody needs to still remain technically in control of that situation. So, it was still: 'I completely feel for you in this situation and I'll show you an amount of...'

Interviewer: You're controlling it?

...you don't wish to go beyond where you are losing control because then that parent has nobody to take control of the whole situation or their respect for you may be diminished a little bit... but 'I'm looking to somebody to help me through this because I've never experienced this before... and they would look to the professional for that...(ED S/N Tom, Teaching ED, Formal Interview).

Undoubtedly, prioritization of the patient's condition and well-being is a driving factor in restricting emotional displays. In addition, staff are actively encouraged to disconnect emotionally from their patients and are therefore able to move on to the next patient without delay, ensuring smooth functioning of the department. This is seen as a barrier between nurse and patient, a protective mechanism – again, by detaching emotionally, ED nurses are able maintain their emotional equilibrium.

ED S/N Sally had recently cared for a dying patient and had suffered a family bereavement at a similar time. She felt uncomfortable working in the resuscitation area as a result and was concerned she would be upset following her own recent experience. She reported she was 'forced' by her manager to detach emotionally and carry on (aligning with the feeling rule). This resulted in significant emotional labour for Sally:

...because everyone else is quite blasé about it, it kind of makes you... like that. So, you don't take it too much to heart... Cause you need to carry on for the next patient who comes in... sometimes you think: 'I don't want to carry on working in resus today'. 'Cause I've literally had the worst situation.' Someone's died. Whereas they'll [her manager] just force you back there, and say: 'Carry on with your shift.' And then it goes away, that sort of feeling of sort of apprehension, for the next thing that's gonna come in...

Interviewer:... it helps?

Yeah. Otherwise I think it would put you off. I think that's how you learn not to be sort of phased by anything that you deal with. (ED S/N Sally, District ED, Formal Interview)

This emotional labour is seen to be completed for the patient whilst maintaining expectations of what it is to 'be' an ED nurse and in a bid for emotional self-protection. Adherence to the feeling rule is more flexible when particular cases relate to personal circumstances. This allows for a degree of outward grief. For example, when a child patient is the same age as the nurse's own child. Despite this, there is little time or space for the nurses to 'process' their own upset. In response, unconventional spaces both inside and outside of ED, such as a sluice or corridor, are sought for mask removal and emotional reprieve.

## 4 | DISCUSSION

Up to now, an exploration of emotional labour in emergency nursing, and the specialty feeling rules driving this labour has been missing. This study aimed to address this limitation, important in part, because of implications for staff well-being and retention. In line with this aim, we offer contribution through the conceptualization and naming of four feeling rules, born from the distinctive ED setting.

Our discussion will highlight two important features of ED nurses' feeling rules: gender and legitimation. These features permeate all four feeling rules which underpin ED nurses' emotional labour. When nurses experience conflict between competing expectations and their own professional values, the feeling rules, ensure the expected behaviour is presented.

Firstly, ED feeling rules are gendered. Both masculine and feminine engrained nursing stereotypes are relevant. The merging of these two (masculine and feminine) expectations is a source of conflict, as the nurses juggle between the two. This process requires varying degrees of emotional labour. As found by Boyle (2015), staff had to navigate both compassion and stoicism to meet the expectations of competing audiences. A specific example of this 'juggling' in ED is the need to feel 'tough' (associated with masculinity). As part of this, nurses must ensure they do not become too connected and involved with their patients, delivering functional care. Caring too much is seen as problematic and too time-consuming in ED, potentially disrupting the flow of patients. For many, adhering to this feeling rule prompts emotional labour—there is tension as they feel traditional (arguably female) nursing values should still be influential.

A masculine approach towards care also has implications for grief—ED nurses must be emotionally detached and stoic, restricting any displays of grief—visual displays of emotion are largely written out of ED. Again, this shows conflict as the nurses suppress true sadness to ensure the 'correct' emotional display is shown to patients and colleagues. This finding also relates to personal protection in an environment where nurses already feel overwhelmed. Nurses can often be used as the 'emotional buttress' (Gray & Smith, 2009) for

patients and relatives, especially in challenging times, such as bereavement. Nurses 'choose' their level of emotional engagement in response: a spectrum that holds emotional engagement and emotional detachment at either end (Msiska et al., 2014). This offers ED nurses a degree of protection from becoming too involved in an already (physically and emotionally) stretched environment, switching off from the emotional component of work using emotional labour (Smith, 2012).

A second feature of ED nurses feeling rules relates to perceived legitimacy. Here, nurses undertake emotional labour to respond to mismatches in prioritization between their perceptions of a patient's needs (assigned prioritization) and the patient's own perceptions. This is another example of conflict and the degree to which it is relevant, fluctuates with how busy the department is. When the department becomes overwhelmed, patients who have needs deemed as illegitimate becoming less important still.

In cases where a patient's attendance is seen as less worthy by the nurse, the nurse's emotional labour ensures that the patient is unaware of this mismatch of perceived priority. This emotional labour is exacerbated by how quickly nurses move between cases. The emotional labour required for those patients deemed illegitimate is heightened. In these instances, significant emotional labour is required to suppress any shock they feel following a traumatic case, as well as to suppress frustration and annoyance they feel at having to empathise with 'trivial' cases (the 'trivial' patient is unaware of the traumatic case). A similar form of emotional labour was briefly discussed in a study of 911 call takers (Newman et al., 2009). Variability between prank phone calls and those that were highly charged in succession, dealing with life-threatening emergencies, increased the intensity of emotional performance for staff.

Conforming to feeling rules in ED is essential to being a 'good' ED nurse, rather than 'just' a nurse who works in ED. Emphasis in achieving the former is placed on showing they are able to cope with the distinctive setting. Although the focus of our study was on establishing the feeling rules of ED, it is also important to note how some staff 'resisted' these rules. This resistance was through feeling and / or showing 'too' much emotion - those nurses who felt as though they did not 'fit in' and stated explicitly, 'I'm not an ED nurse' experienced conflict, tension and resistance to the four feeling rules outlined.

These nurses shared how they needed to suppress their feelings and 'pretend to embrace' the values of ED (Hewlin, 2003; Yagil & Medler-Liraz, 2013). For some, this battle (between enacting the desired feeling rules and their desire to show true feeling) and associated emotional labour necessary was too much. Some nurses had left or were considering leaving nursing due to this struggle. They felt disengaged (Uy et al., 2017). For others, they stayed, but 'resisted' or 'breached' feeling rules.

Here lie the implications of this knowledge for practice. In light of the well-being challenges in nursing, and the relationship between nurses' well-being and patient care - understanding the complexities of emotional labour in nursing, (particularly because this labour

is closely associated with well-being), is critical. Grouping nurses together, as one profession (with the same behaviours and values) does not acknowledge the diverse emotional challenges of different roles. Specialty-specific feeling rules presented in this paper have value for understanding the challenges facing individual environments and staff groups. Subsequently, this knowledge will help us design and implement much needed nurse support interventions which consider the challenges facing each specialty, as well as having broader relevance.

## 4.1 | Limitations

Despite the wealth of rich data generated, there is an awareness, as in all ethnographic work, that findings cannot be directly extrapolated to make assumptions about other settings (Seymour & Sandiford, 2005). Instead, as recommended by Wolcott (2001, p. 123):

... rather than striving for closure, see if you can leave both yourself and your readers pondering the essential issues that perplex you...

It is hoped the findings presented may offer a starting point for research in other distinctive healthcare contexts with a focus on the conceptualization of feeling rules in them.

## 5 | CONCLUSION

This paper offers insight into the emotional labour and 'specialty specific' feeling rules of emergency nursing, a product of the distinctive setting. These feeling rules relate to gender and legitimation. Emergency nurses undertake extensive emotional labour—it is pervasive and intense. There was often a mismatch between professional values and service demands. Nurses knew that the care they were delivering did not align with what is widely understood by the profession as 'good care'. We observed that these standards were impossible in the context of ED; a sentiment which was echoed by the ED nurses and resulted in significant emotional labour as they juggled competing, and at times impossible, demands of practice. The applied implications of this research relate to nurse well-being and retention. By better understanding the emotional labour and feeling rules of nursing, and particularly how these experiences are shaped by individual specialties, we can begin to offer nurses the informed support they need.

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## CONFLICT OF INTEREST

None.

## AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE [<http://www.icmje.org/recommendations/>]): 1) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; 2) drafting the article or revising it critically for important intellectual content.

## PEER REVIEW

The peer review history for this article is available at <https://publons.com/publon/10.1111/jan.14765>.

## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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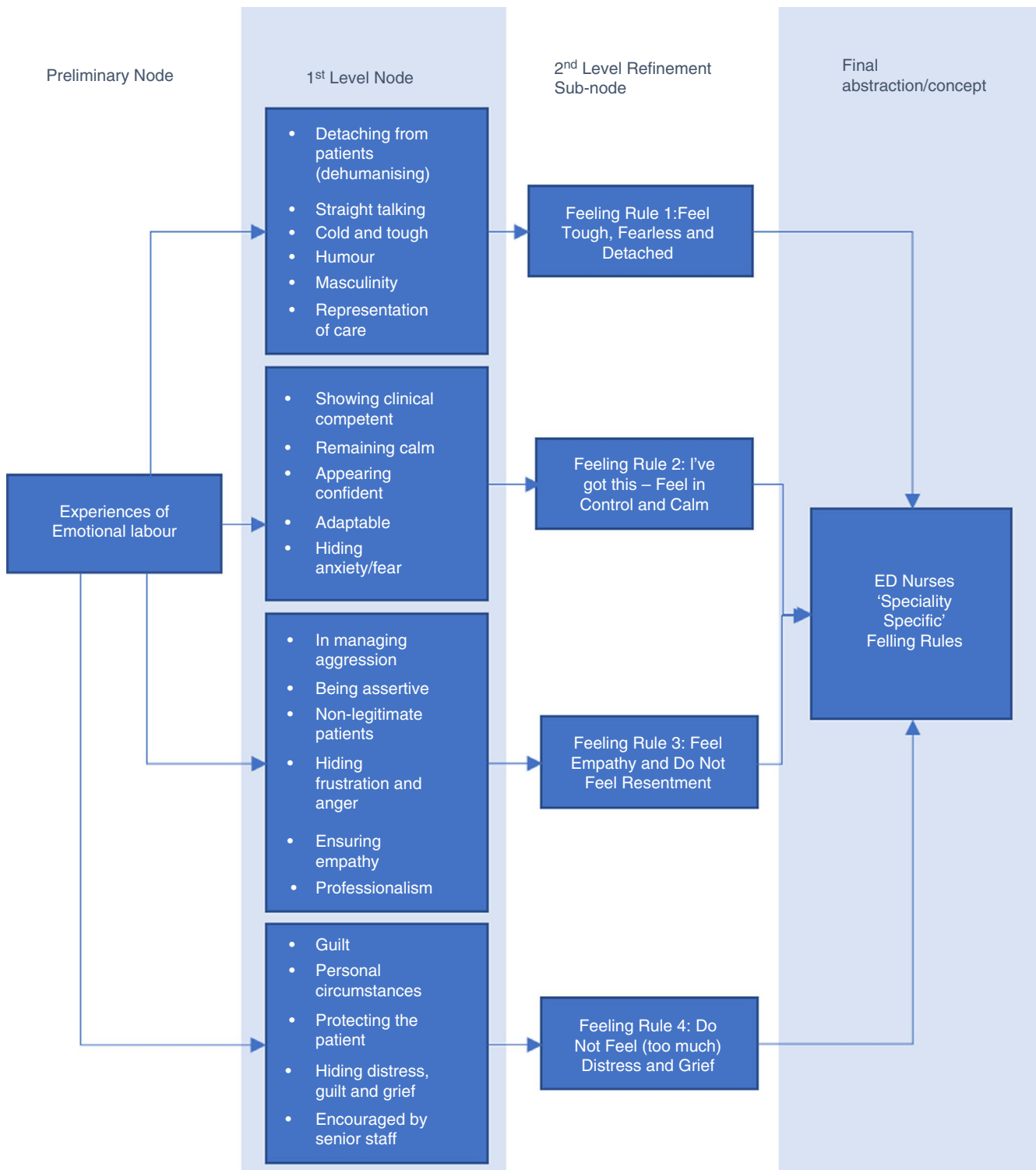
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## APPENDIX A

Pseudonym	Job Role	Interview Length	Case Study Site
Tom	ED nurse	34 min	Teaching ED
Becky	ED nurse	36 min	Teaching ED
Sara	ED nurse	42 min	Teaching ED
Suzie	ED nurse	30 min	Teaching ED
Adam	ED nurse	50 min	Teaching ED
Evie	ED sister	30 min	Teaching ED
Lucy	ED nurse	31 min	Teaching ED
Jane	ED sister	37 min	Teaching ED
Alison	ED sister	31 min	Teaching ED
Clara	Advanced nurse practitioner	30 min	Teaching ED
Bev	ED nurse	26 min	District ED
Carly and Lily	ED nurse and student nurse	26 min	District ED
Tim	ED nurse / department lead	35 min	District ED
Sally	ED nurse	25 min	District ED
Cathy	ED sister	40 min	District ED
Jill	ED sister	20 min	District ED
Mike	ED nurse	20 min	District ED

APPENDIX B



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