Emotional risk work during the pandemic

Healthcare professionals' perceptions from a COVID-19 ward

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Abstract

In March 2020, COVID-19 wards were established in hospitals in Denmark. Healthcare professionals from a variety of specialities and wards were transferred to these new wards to care for patients admitted with severe COVID-19 infections. Based on ethnographic fieldwork in a COVID-19 ward at a hospital in Copenhagen, Denmark, including focus group interviews with nursing staff, we intended to explore practices in a COVID-19 ward by seeking insight into the relation between the work carried out and the professionals' ways of talking about it. We used a performative approach of studying how the institutional ways of handling pandemic risk work comes into being and relates to the health professionals' emerging responses. The empirical analysis pointed at emotional responses by the nursing staff providing COVID-19 care as central. To explore these emotional responses we draw on the work of Mary Douglas and Deborah Lupton's concept of the 'emotion-risk-assemblage'. Our analysis provides insight into how emotions are contextually produced and linked to institutional risk understandings. We show that work in the COVID-19 ward was based on an institutional order that was disrupted during the pandemic, producing significant emotions of insecurity. Although these emotions are structurally produced, they are simultaneously internalized as feelings of incompetence and shame.

Keywords: COVID-19, risk work, healthcare, emotional production, institutional ordering, institutional ethnography, risk management

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Introduction

Shortly after COVID-19 was discovered in Denmark, hospitals established new wards for the treatment of COVID-19 patients. Care and treatment of COVID-19 patients were organized in accordance with the traditional ordering of medical specialities, where these have been linked to particular diagnosis, knowledge, practices, technologies, quality standards and spaces. Taking care of patients with a contagious, and potentially lethal, virus made working in the COVID-19 ward particularly risky. Based on an ethnographic study of a COVID-19 ward in Denmark, we examine the emotional production of risk work as COVID-19 care. In the literature describing health professionals' emotional responses to providing COVID-19 care, risk is portrayed as both being *at risk* in terms of getting infected and being *a risk* in terms of infecting others outside the hospital. In our study we emphazise being *a risk* as the dominant factor creating emotional responses. As we will show, being *a risk* is more related to fear of harming patients due to inadequate patient care than the risk of infecting others. We show how institutional ordering builds on particular institutional risk understandings and risk management strategies that construct healthcare workers' emotional responses when providing COVID-19 care. Furthermore, we argue that organizing COVID-19 treatment in accordance with the existing institutional ordering of medical specialities creates pervasive emotional responses related to performing healthcare activities. Although several healthcare professions were represented among the staff in the COVID-19 ward, we focus on nursing staff[1] as this was the most prominent group of healthcare workers in the ward. Furthermore, they provided daily care for COVID-19 patients and it was with this group that we interacted the most with during our field study. For this reason we conducted our follow-up interviews with the nursing staff.

The organizational ordering of medical specialities

Health care in hospitals is organized according to specialities, sorted by diagnoses. Patients are attached to wards based on the treatment of specific diagnoses. This also applies to the staff, whose positions are defined by their specialities and to which their competencies are directed. Doctors are, for example, categorised in terms of cardiologists, orthopaedic surgeons, or internal medicine specialists, while nurses may be theatre nurses in orthopaedic surgery departments, fertility nurses in outpatient clinics or intensive care nurses. Among the few exceptions from this organization of the hospital that follows the specialities, we find bioanalysts working across specialities and departments because their work with blood tests relate to patients across diagnoses or type of disease. The ordering of specialities also structures the organization of care and treatment in the modern hospital and technologies are implemented with the aim of ensuring

[1] Nursing staff refers to both nurses and nurses assistants and refereed to as nurses or nursing staff.

efficiency in terms of production and quality in terms of patient safety (Region Hovedstaden, 2010). Examples of this strategic ordering include fast track programmes and patient care pathways, which involve descriptions of specific tasks, activities, workflows and time frames related to a specific goal within a particular speciality and treatment. Other examples include the health digital platform (the electronic patient record in Denmark) and the food distribution system/food delivery service.

According to the anthropologist Mary Douglas (1966), individuals and social groups seek to maintain order and create security. Order is achieved through classification systems and boundary drawing which, in turn, are grounded in fears and beliefs. Symbolic and physical boundaries are established focusing on identifying 'the other', considered as a threat to the existing order (Douglas, 1966). In a hospital organisation, one way to minimize the threat from 'the other' is to create boundaries towards elements not fitting the hospital's ordering of medical specialities. In practice, these boundaries can be maintained by defining the differences through space and materiality. For example, staff identity is indicated through spatial demarcation by saying 'those in the other department' or attaching knowledge to a specific place by saying: 'here we do it this way'. In this way, boundaries are created to separate the 'inside' from the 'outside' and to avoid ambiguities resulting in uncertainty.

Most boundaries are imperceptible and become apparent only when they are crossed or when the order regarding the boundaries is questioned (Douglas, 1966). People who are not socialized into the established order often question processes, artefacts or spaces and thereby challenge the order. These questions may be dismissed by referring to the order or they may create awareness of the legitimacy of the demarcation. The ability to point out boundaries is not limited to human outsiders. Technologies and disruptions, including those related to a virus, can also challenge the order.

The diagnosis and treatment of the SARS-CoV-2 virus and COVID-19 condition was not given the status of a medical speciality but wards set up to treat COVID-19 were organized as one in time and space. During the first wave of the COVID-19 pandemic in Denmark, we conducted ethnographic fieldwork in a large hospital in Copenhagen. In the beginning of this period, Marts until end of May, there was an enthusiastic and almost euphoric atmosphere and close interprofessional collaboration on the ward, through which boundaries between specialities and hierarchies were blurred. Everybody helped each other even if the work was not related to their core professional tasks. The entire interprofessional staff group shared a common and highly collaborative 'fighting spirit'.

However, during the weeks which followed (two months) we observed that the atmosphere changed and boundary drawing practices gradually emerged. We observed an ongoing discussion among the healthcare

staff focusing on which medical speciality and ward the patients with COVID-19 'belonged to'. For example, statements like 'they belong to the pulmonary ward' referred to COVID-19 attacking the lungs, while 'they belong to the infectious disease ward' referred to COVID-19 being a virus. Others claimed that the patients belonged to the geriatric speciality as most COVID-19 patients were older people and admitted from nursing homes. These discussions can be seen as attempts to draw boundaries within the current logic of specialities and patient categorizations as a consequence of increasing uncertainty. Another attempt to draw boundaries shaped by the logic of specialities involved the negotiations about which groups of healthcare staff or competencies should be represented in the new ward. Questioning which competences were most 'suitable' for this new 'speciality' made nursing staff from different specialities and wards typically ask: 'Am I competent to do this?' This insecurity appeared as an overwhelming emotion that characterized the overall experiences of nursing staff working in the COVID-19 ward we studied, as also pointed out in several other studies (see, for example, Serrano-Ripoll et al., 2020, Barello et al., 2020, Yildrim et al., 2020, Willis et al. 2021, Willis and Smallwood 2021).

By studying the everyday dynamics of interactions, practices and objects (Lupton, 2013) we examined the institutional ordering of COVID-19 and how this ordering creates emotional responses. In this sense this is a sociomaterial analysis of interactions between human and non-human elements, the latter including for example quality standards and other technologies. Our ambition is to contribute to the literature on healthcare professionals' emotional responses when caring for COVID-19 patients by using a front-line perspective that points out the specific sociomaterial interactions and practices of care work in the everyday setting (Twigg, 2000) of a COVID-19 ward. We will show how the emotion of insecurity that we found overwhelmed the nursing staff is related to adapting care and treatment to institutional ordering installed to minimize particular forms of risk.

We conceptualize work related to care and treatment of COVID-19 patients as 'risk work' (de Graaff et al., 2021). Our analysis focuses on how the organizational way to deal with the crisis and conceptualize risk is layered upon existing institutional ways of working (de Graaff et al., 2021) affecting and shaping the micro-institutional front-line interactions in particular ways.

Connections between risk, categorization and emotional productions

The Royal Society defines risk as 'the probability that a particular adverse event occurs during a stated period of time, or results from a particular challenge' (Brown, 2020, p. 3). Jens O. Zinn (2016) emphasizes that uncertainty only becomes a risk when an adverse event triggers a demand for action. He points out that it is important 'to distinguish between the definition of risk and the way in which expectations regarding the future are generated since it allows us to observe ways of developing expectations and

strategies to manage them, for example, on the basis of probability calculation, experiential knowledge, wishful thinking' (Zinn, 2016, p. 350). Thus, the focus is on the expectations and notions of what potentially will happen due to the change, as well as the strategies that are established to minimize the uncertainty. These expectations and strategies give insight into the contextual ways of (re)arranging the world around us through categorization (Brown, 2020). Categories are delineated, connected and stabilized in particular ways in a process that legitimizes risk and the strategies for dealing with it (Brown, 2020). When Trump categorized COVID-19 as the 'China virus' he made the Chinese 'the risky others' (Lupton, 2013), placing guilt and legitimizing anger emotions, thereby supporting particular values and creating an affective repertoire (Lupton, 2013). When anger was directed at people of Asian descent, shouted at in streets around the world, it can be seen as an example of how categorizations, morality and emotions intertwine and connect to risk. Investigating emotions can therefore function as an empirical strategy that offers recognition of the dynamics contained in the contextual risk understanding and its consequences (Brown, 2020).

Lupton differentiates between emotions and feelings. Feelings are individual phenomenological sensations that are interpreted and given names such as anger, joy and sadness, whereas emotions are social expressions of these sensations that others can observe and that flow between people and between people and things (Lupton, 2013). In this sense, our focus is on emotions, understanding them as fluid, relational and contextual. Neither emotions nor the understanding of risk are localized within the individual but are created through social and contextual interactions (Lupton, 2013). Understanding the emotional responses of Danish nursing staff to the work in a COVID-19 ward therefore requires, in addition to the micro-cosmos interaction analysis at the frontline, an analysis of the ward's institutional context. In this article, we focus on the connection between emotions and risk related to the pandemic. We examine both the risk that is produced during this pandemic-related work with COVID-19 patients and the emotions that the risk produces and is produced by. In this way, we explore the institutional understanding of risk, the order that is sought to be maintained and the affective repertoire connected to the order. In other words we move away from a traditional psychological perspective on emotions and risk (Lupton, 2013), and focus on how emotions and risk are produced contextually and collectively and are part of ambivalent and opposing actions and categorizations.

Emotion-risk-assemblages: an analytical concept

To study the connection between emotions and risk, Lupton (2013) suggests the analytical concept of emotion-risk-assemblages, inspired by theories from Douglas (1966, 1992). Douglas shows how emotional

responses are created through contextual and historical establishments of what is considered to be the 'inside' as pure, in danger of becoming polluted by something from the outside, the 'unclean' - the risky other - and thus 'a matter out of place' (Douglas, 1966, p. 50). We will apply this concept of emotion-risk-assemblages to connect place, space and emotions. We understand entities such as place, space and emotions as without an inherent essence but as constantly brought into being in relations, which means they are enacted in practice (Barad, 2007; Mol, 2002). The enacted unities or assemblages form and are formed by and connect to other unities such as risk management strategies. Our focus is therefore how space, place and emotions are brought into being in emotion-risk-assamblages to analyze how risk and emotional responses are connected .

An important critique of the concept of emotion-risk-assemblages, relevant to our discussion, is provided by Zinn (2016). In line with Lupton, Zinn describes emotions as social intensities that can be used to examine contextual ways of dealing with risk and uncertainty. However, he criticizes Lupton's emphasis on emotions as constantly fluid and changeable, which gives the impression that emotions are too fluid to control or influence the social order. He argues that it is important to examine and understand degrees of stability and change in emotion-risk-assemblages, because they are often more stable when embedded in everyday practice than otherwise (Zinn, 2016). In an institutional context, such as the hospital, emotions are institutionalized, thus implying some stability in Zinn's understanding. This means that practices are made acceptable and legitimized within some more or less stipulated conditions, as also described by Bennet as "event-space and style of structuration (….) with a particular degree and duration of power" (Bennet, 2010, p. 13). As both Zinn and Bennet emphasize, everything cannot be made possible at any given time, yet practices and emotions are structured by a contextually created order which means that relations, also emotional ones, can be created within a certain contextual spectrum. To a certain extent, emotional production is structured and can therefore be considered with some kind of stability in the becoming in the sense that there are particular contextual expectations of which emotions can be expressed, how, when and by whom, and which values these emotional expressions should be linked to.

Both emotions and risk are thus intersubjective, produced through social relations between both human and nonhuman elements such as bodies, social meanings, emotions, objects, places, and technologies. Examining the responses of nursing staff to their work in a COVID-19 ward is therefore interesting, because the responses are part of an institutional order shaping the values embedded in a type of uncertainty, and taking place within a particular historical, cultural, social and political context (Lupton, 2013). When emotions, such as anger, frustration or shame are established, they do not only come from - or belong to -

the individual; the institution frames these emotions through stabilizing categories and a particular order and demarcation practice.

Only a few studies have so far addressed the question of how emotions and risk in healthcare interact. Fischer and McGivern (2016) have studied how healthcare workers handle risk in clinical work. They argue that dealing with risk involves shared 'intensities', 'which circulate between subjective and material "realities", affecting subjective experience and emotions, rather than necessarily emanating from them' (Fischer & McGivern, 2016, p. 3). They give valuable insights into the affective dimension of organizational life. In line with Lupton, they understand emotions as created through sociomaterial processes and interactions, constituting risk practices.

Grant and colleagues (2019) have studied how healthcare leaders' risk management and the associated emotions affect the legitimization of particular kinds of risks dominating others, for example by making organizational and resource risk more important than patient risk. They argue that risk management, when including workers' experiences of anxiety and fear, can have harmful consequences for patient care. They therefore indicate a need for further investigation of organizational forms and social requirements of risk management.

Willis and colleagues also argue that in healthcare facilities in many countries the emphasis is on efficiency, performance, accountability and austerity. This emphasis leads to a working environment where there is little "organizational slack" and work becomes "intensified" (Willis et al. 2021:2). Intensified work is described through experiences of excessive work hours, unpredictable workflow, expanding work duties and workplace-increased psychological or physical risk, which they describe as "extreme work". They describe psychological risk as partly caused by often having to make moral decisions within this organizational context of extreme work, leading to what Willis and Smallwood describe as 'moral injury' (2021). They show how the COVID-19 pandemic amplified the already existing "cracks in the system" and added stress to an already stressful environment.

Our discussion will add to these studies. Based on our field study, and the analytical concept of emotional-risk-assemblages, we investigate social and contextual processes as the interaction between objects, space and place and 'others' bodies', as the foreign or 'impure' through which risk and emotions are configured (Lupton, 2013).

The field study of the COVID-19 ward

Nursing staff in the COVID-19-ward were recruited from three hospitals and had regularly worked in orthopaedic, gynaecological, obstetric, paediatric and medical wards, covering both surgery, inpatient and outpatient care. The COVID-19 ward nursing staff varied considerably in age, experience, competencies and personal circumstances. Some worked (full- or part-time) only on the COVID-19 ward, while others split their hours equally between the COVID-19 ward and a non-COVID-19 ward.

In the COVID-19 ward, all patients were isolated in their rooms. Given the comprehensive procedure of putting on and taking off protective equipment, so called runners were appointed to relieve the nursing staff. Runners were healthcare professionals, e.g. nurses and physiotherapists who had to provide services to the nursing staff working in the isolation rooms. They also had to ensure the availability of protective equipment outside each patient room. Three of the authors were positioned as runners in the ward, due to their nursing background and being professionally connected to the hospital. However, they were simultaneously allowed to carry out field work aiming to study the work in a COVID-19 ward and how the nursing staff experienced working in that environment and with COVID-19 patients. We therefore entered researcher positions as 'participants-as-observers' (Hammersley & Atkinson, 2007) as it included a high degree of participation within our role as observers. Being runners, we supported nurses doing care work and, in combination with having a research interest in how this work is done and how performing this work is responded to, this led to a close bond with the nurses. This meant that this runner position not only integrated us into the daily ward routines but also gave us unique first-hand insight into the everyday work of the nursing staff (Hammersley & Atkinson, 2007) and their responses to it.

The study was approved by the Danish Data Protection Authority (number P-2020-457) and consent was obtained from the management of the orthopaedic surgery department, the department which had been instructed to open and manage the COVID-19 ward. To provide information to the healthcare staff, we created a poster with a short description of the study and a picture of us and we continuously informed verbally also to other staff groups such as service personnel. The posters were placed at each nursing station. At the beginning of every shift, we presented ourselves and introduced the study and anonymity requirements.

The ward opened on 21 March 2020 and we each had a weekly runner shift from early April until the ward closed on 22 May 2020. During our shifts we jotted down notes and after each shift we wrote detailed fieldnotes including experiences, conversations, thoughts and reflections (Emerson, Fretz, & Shaw, 2011). We later collected the fieldnotes in one chronological 67-page document. This formed one key element of the data corpus upon which our later analyses were based.

Focus groups: reflections of nursing staff on experiences from the COVID-19 ward

Just as abruptly as the COVID-19 ward had opened in March it closed quickly in the end of May, and the nursing staff went back to their original wards. An advantage of supplementing fieldwork with interviews is to gain a deeper understanding of what is important to inquire about, seen from a nursing staff perspective, and thus to be able to explore their thoughts and reflections (Emerson, Fretz, & Shaw 2011). In order to gain insight into the way the nursing staff discussed and reflected on their experiences together, we included focus group interviews (Morgan 1997). The interview guide was based on findings emering from our fieldnotes. To begin with we asked very openly about their experiences working in the COVID19-ward. Then we presented keywords that emerged from our fieldwork in the COVID19-ward, for example competencies, knowledge, contagion, belongingness, quality and uncertainty, and they were asked to talk about those they found relevant and how and why they found them relevant. We conducted five focus group interviews, with 3-7 participants in each group, giving a total of 22 nursing staff. The interviews lasted on average two hours and took place in June and July 2020. They were digitally recorded and transcribed verbatim. Written consent was obtained from each participant.

Analytical strategy: Sociomaterial enactments of institutional ordering

Our approach is performative in the sense that we study how practice as the relation betwen doings (materiality) and speech comes into being and both constitute and are constituted by the contextual. Through this focus on discource and materiality, we study what we call socio-material enactments. Through this strategy it is possible to develop insights into how the connection of institutional ordering, risk understandings and emotional responses emerged. In the data and analysis presented below we focus on three enactments that appeared to be particularly permeated with emotional significance and therefore give us the possibility to illustrate how the emotional repertoire are produced and connect to risk at the micro-social level. These sociomaterial enactments are: enacting the health digital platform, enacting the food distribution system and enacting fluid balance recording. By focusing on these enactments and the practice of demarcation through which they are established, we show how institutional orderings create risk understandings that connected emotional responses to emotion-risk-assemblages in nursing practices during the pandemic.

In the following sections we present these key findings, stressing the connection between objects, space and place and their affective productions (Lupton, 2013). In this way, we present empirically-based concrete emotion-risk-assemblages and thereby relate experiences and reflections to wider contexts of the

organisation in the hospital (Hammersley & Atkinson, 2007). But first we provide some insights into everyday activities in the COVID-19 wards by describing how the work was organized.

FINDINGS

Organization of everyday work for nursing staff in the COVID-19 ward

The 'No Entry' and COVID-19 signs in large red and black letters covered the ward's entrance door with a clear statement of 'danger'. The sense of being at risk was evoked (Lupton, 2013) as the signs indicated a restricted area with limited access. Despite this dramatic impression of danger at the entrance, the ward was much like other hospital wards we have seen.

It was the beginning of April, 2020, and Denmark was in lockdown. While most Danes were isolated in their homes, seeing only their household members, the COVID-19 ward was buzzing with activity. Many staff members were working intensely both on the ward and in the offices. The large and central nursing station was opposite the office secretary. Here a digital smart board with patient information was complemented by a white board to organize care. The white board also contained patient information including patient names and room numbers, care needs and special needs. The white board also revealed the names of staff members on duty and which patients they were assigned to. The ward was divided into four teams, and physically divided into two parallel corridors connected by two crossover aisles and some offices. The staff worked in three shifts: day shift from 7 AM to 3 PM, evening shift from 3 to 11 PM and night shift from 11 PM to 7 AM.

At the beginning of the shift, all incoming nursing staff gathered around the white board together, where the ward manager welcomed staff members and announced information related to the treatment of COVID-19, new guidelines or organisational changes. In general, healthcare professionals were primarily expected to gather patient information and plans through the health digital platform. However, sometimes essential information about changes in patients´ condition, medical treatment and special needs was handed over from the previous shift.

Daytime routines, as in other wards, were built around the distribution of food and medicine that act as obvious workflows producing routines (see also Sellerberg 1991). Each patient´s meal would be transferred on a tray directly from the hospital kitchen using a food delivery container arriving at the ward at set times. When meals were finished, the trays were then collected and returned to the kitchen. Activities such as dressing or mobilizing a patient or documentation work were scheduled in relation to meals, that is 'after breakfast', for example. The food delivery system functioned as an important factor in structuring care

practices on the ward. After breakfast, the rounds began with doctors assessing the patients and different tests were performed such as X-rays or ECG[2] by nurses and other professionals. At noon, lunch and medicine were served and administered followed by nurses documenting and evaluating patients' treatment and care plans as the last step of the dayshift routine. Each time a staff member entered a patient room, they had to put on protective equipment, and when leaving the room, they had to clean and disinfect non-disposable equipment such as safety glasses and shields. The equipment was re-used during the first wave of COVID-19 in order to prevent supplies from running out. An increasing number of patients needed help with basic care such as eating, due to a low respiratory capacity and nurses spend extra time talking to relatives of COVID-19 patients and helping them deal with the consequences of COVID-19 restrictions, particularly related to visiting their family member.

Central in structuring the daily care were technologies such as the food delivery system. Consequently, care for patients with COVID-19 could not be adapted to the morning routines where breakfast was completed by 10 AM, which was why delivering food was easily connected to strong emotional responses, as this example indicates.

> At 1 PM, a nurse says, almost in tears, that she had just completed serving the breakfast because she had spent much time talking to a relative on the phone. (fieldnote)

In the following sections, we present emotion-risk-assemblages to show the interaction between objects (such as the food delivery system), space, place and 'other bodies' seen as the foreign or 'impure' through which risk and emotions are configured.

Fear of doing more harm than good – the enactement of the health digital platform [3]

The health digital platform was a central technology implemented to ensure effectiveness, safety and quality in Danish hospitals (Sundhedsplatformen 2020). This IT system was implemented with the aim of providing insights into the pathways of the patients and guiding the actions of healthcare professionals by

[2] An electrocardiogram (ECG) is a simple test that can be used to check the heart's rhythm and electrical activity. Sensors attached to the skin are used to detect the electrical signals produced by your heart each time it beats.
[3] The Capital Region and Region Sjælland were working on implementing Sundhedsplatformen, which is a digital solution that gathers information about each patient in a single electronic set of medical records. The aim was to create transparency and security for both patients and the healthcare personnel in Danish hospitals. Sundhedsplatformen was developed by Epic, a software supplier, who sold their solution to over 1100 hospitals serving more than 172 million patients. The software was tailored to fit the Danish healthcare system in collaboration with doctors, nurses, and experts in 2014 (Region H, b).

supporting their work and ensuring that it is performed at the highest possible level of safety and quality. However, we found that this technology was built upon a particular order that was challenged by the COVID-19 situation. Care and treatment for COVID-19 patients was, as mentioned, organized as a quasi-speciality with its own ward. Although the healthcare professionals, including doctors and nursing staff, worked at the COVID-19 ward, they were registered in the health digital platform as belonginging to their primary speciality/department. The COVID-19 ward did not exist in the digital platform, only as a physical place, materialized in the digital platform as a section number. This implied that patients and healthcare professionals were connected to the system from 'different places' and only those professionals with their primary physical affiliation to the actual section number could use the technology, as it was designed and achieved the right kind of access, views and possibilities. This following quote indicates consequences of not being able to access the system:

> 'I have no general overview at all and I cannot enter the health digital platform', as expressed by a nurse in tears to a colleague right after arriving for her shift. (fieldnotes)

Having a general overview was vital to her and the other nurses, but the health digital platform that supposedly ensured this was inaccessible. Another nurse observed a connection between the health digital platform and the experience of providing good care, or as she expressed it: 'doing something for someone'. Being able to 'enter' and navigate the digital platform appeared to be more important for providing good care than the actual action performed with the patient. She explained what the insecurity related to:

> (…) and the health digital platform. I know it from the surgery department, but there are no similarities in how to use it compared to up here and… I think it's terrible (…) Then I was assigned to do shifts in the COVID-19 test centre instead and even though the shift was quite long, up to 10 hours by the end, it was okay because at least I could do something for someone and I didn't go home with this feeling of 'oh is there something you missed? Something you haven't documented? Did you forget to click on a particular button in the health digital platform so that everything you wrote disappeared or what? … (interview)

The health digital platform in this way appeared to hinder the professionals in 'doing something for someone', because it could not be accessed from 'another place' or because it looked very different and was therefore difficult and time-consuming to manage. The inaccessible health digital platform established the risk of being unable to create an overview of one's patients and their care needs. This led to emotions of fear of possibly doing something wrong and of providing inadequate care.

Our findings led us to an assessment that organizing COVID-19 care and treatment based on the speciality order disrupted the logic of the health digital platform which usually links specialities to space. Instead of being a system supporting the possibility to provide good and safe care, enacting the order of the platform created risks which threatened the quality of care. This created an emotional response of fear of doing more harm than good as an emotion-risk-assemblage in which fear of harming patients was connected to the risk of missing the patient overview that contributed to good care. The fact that nurses and patients were not registered in the same wards also affected nutritional care, as we will demonstrate in the next section.

Frustrations at being unable to deliver individualized care – the enactement of the food distribution system

The normal procedure in the hospital for providing food for the patients had been that nurses would order food a la carte for each patient. Because the food system was connected to the particular speciality wards and their health digital platforms, the nurses in the COVID-19 ward were unable to order food for their individual patients. The way to deal with this was to deliver standard trays for all patients consisting of 'normal diet' and some with 'vegetarian diet'. Later, we noticed that different diets were added, including 'diet for limited appetite', and food for people who had difficulty chewing. These consisted of three little bowls with three kinds of coloured mash. Based on their colours, it looked like peas, potato and beetroot. The aim of the typical procedures in the hospital is to order food from a menu based on the preferences of the patient, in combination with the nurses' professional knowledge on nutritional needs. This kind of intended differentiated care was, however, disrupted on the COVID-19 ward. The nurses tried to accommodate the preferences of the patients when the standard trays arrived at the ward. They negotiated with bananas as they were requested by patients as well as soups and oatmeal, preferably handed out while hot. However, as described earlier, the food was delivered at scheduled times which did not fit with the complex and time-consuming care of COVID-19 patients.

Nutritional care was a key aspect of daily work for the nurses, who encountered widespread nausea and poor appetite among COVID-19-patients. As a result of age and comorbidities, multiple COVID-19-patients also had difficulty chewing and swallowing food. Standard trays were rarely suitable, and the nurses had to be creative to make food accessible in the ward, for example by using or combining biscuits, yoghurt and protein drinks. Food distribution that implied meeting the preferences of the patients became a frustrating practice. It was time-consuming and inhibited professional nutritional care, because systems and

technologies based on the ordering of specialities such as the food delivery system did not allow for it. One nurse expressed her frustration:

> The food was huge portions of like chilli con carne and it's like phew... and just some avocado... and a big portion of rice, well... that's not something you would want when you are nauseous or anything. It was not very inviting (…) And also big burger buns and food you could barely… and sauce and potatoes (interview)

According to another nurse: 'COVID-19 doesn't make it easy for them [the patients], they cannot breathe, they cannot smell and most of them have fatigue. This does not provide the best basis for eating' (interview). The first nurse explained the frustrations of not being able to get the food wanted by patients with low appetite:

> Sometimes we've had some patients who just want pasta bolognese but this can't be done. Or they feel like an egg right here and now and that's just not possible because of the agreement we have with the kitchen (…) Normally the trays arrive, and there's this and that written on them plus how many calories and proteins are in it (interview)

The final comment here referred to the way that the option of choosing between the trays based on calories or proteins were not an option either.

The nurses experienced a discrepancy between their professional knowledge of the importance of nutrition on the one hand and, on the other, a system that did not accommodate this practice, but a practice they perceived as essential to the individual patient. The food ordering system, promoting efficiency and quality, was transformed into a risk of not being able to perform individualized care. This contrasted with the professional demands nurses were faced with, politically and organisationally, of providing individualised care of high quality that simultaneously supported providing care in cost-effective ways (Lehn & Holen, 2016) and led to frustrations at being unable to use their professional knowledge to provide care. Amid such demands, frustrations were connected to the perceived risk of not providing individualised care or harming patients. In the COVID-19 ward the food ordering system as a welfare technology became part of a tension between institutional work schedules to secure efficienct, high quality care and the need for flexibility in the interactions with the patient (La Cour & Højlund, 2019).

While these two examples perrtain to how risk understandings and inflexible standardisations configure connections between risk and emotions, our next example shows how risk understandings and changed conditions and demands produced understandings of injustice that conversely led the nurses to request more standardisation.

<u>U</u>nderstandings of injustice linked to the experience of responsibility - Recording the enactment of maintaining fluid balance:

For many of the nurses, caring for COVID-19 patients meant breaking with existing treatment logics, including fluid balance and fluid balance recording. Living up to the responsibilities of performing these practices was further challenged by the lack of supportive structures, such as missing weighing scales or the way safety guidelines made it impossible to assess a patient's urine balance, thus inhibiting the nurses ability to perform proper fluid balance and recordings. A nurse described the medical emphasize put on the fluid balance in the care and treatment of COVID-19 patients

> But they [the doctors] were highly aware of intake and output [of fluid] because they were told these patients need a zero balance, meaning all that comes in has to come out or go below to minus. Because of this they [the doctors] were all really invested in whether the patients had drunk too much. They were told this from the beginning and at all their morning conferences. (Interview)

The next quotes illustrates how the emphisize is passed on from these doctors to the nurses, and how the nurses experienced fluid balance becoming their responsibility, without the structural possibilities to perform this task.

> In the notes from ward rounds it said, 'daily weight' and 'fluid balance of zero'… but when no one has a catheter… Then we have to weigh the patients but that isn't possible either because I haven't got scales. (Interview)

Another nurse added:

> Yes and then we had those scales you have to stand on… and our patients were unable to stand up. Well I was just like… there should be some kind of standard if you are so dedicated to the fluid balance being zero or minus 500 [ml]. They use catheters in the acute medical wards so this cannot be right. It was so unfair... For them [the doctors] to say: 'it is very important that you weigh the patients' well then give us scales! (Interview)

The conversation continued:

> I don't understand it… it's so ridiculous. And when… All the, ehm, notes from the ward rounds, they said like 'yes, it is yet to be decided' or 'the patient has still not been weighed ' and ehm… 'they have to weigh the nappy to find out how much they [patients] pee'. And I was like, come on, that's just… Enough of that, God dammit! (interview)

Emotions of frustration and anger were expressed in relation to understandings of injustice. The systems and normal procedures associated with maintaining a certain form of fluid balance were experienced as impossible to achieve. Nevertheless, the requirement to work within these systems continued and the nurses responded to this percieved injustice by asking for new standards.

Procedures and standards are not neutral objects guiding practice. We observed how they affected practice by creating what the nurses called 'standard remarks' also called 'smart phrases' such as 'daily weight' . In the next quote, the nurse explained how these linguistic practices were standardised producing expectations and ignoring specific situations and realistic possibilities. For this nurse, the consequence of practising 'smart phrases' involved the feeling of being left with the responsibility to do the impossible in practice:

> But I do feel… it seems that, ehm… these phrases came from the doctors and also in my daily work.. that a standard, ehm… standard… smart phrase is blurted out and then we [the nurses] think about which patients they [the doctors] have… does this patient have a catheter? … what does 'daily weight' mean, is it a possibility? If yes, how? (interview)

In this quote we see how smart phrases or standards relating to the recording of fluids of COVID-19-patients contrasted with the practical (im)possibilities the nurses experienced, resulting in emotions pertaining to unfairness, including confusion and frustration.

Discussion: Institutional ordering, risk management strategies and emotional responses during the pandemic

In this final section we discuss the contextually-situated interactions between institutional ordering, categorizations, morality, riskmanagement and emotional production.
Ordering practices are connected and stabilized through systems and technologies (Douglas 1966) such as the food distribution system, the fluid recording procedure and the health digital platform. These were installed in the COVID-19 ward with the intention of being supportive and minimizing risk; however, we have shown how they could be experienced as having the opposite effect; threatening the existing order (Douglas, 1966) and therefore experienced as risky (Lupton, 2013). The objects, developed as systems of quality and efficiency, were turned into threats to the performing of individualised care as a moral imperative, by which 'good care' was percieved by the nursing professionals as care adapted to the specific situation and interaction with each patient. Nurses described being able to see what they should do to

perform this form of care, but not being able to carry it out. In other words, these 'supporting' systems were understood as compromising care.

When patterns of COVID-19 care were based on established and inflexible ordering practices such as systems and technologies, they tended to contribute to insecurity and strong emotional reactions among those at the frontline who were responsible for the implementation. Although it was primarily external conditions that nurses described as making it difficult to do what they perceived as best for the patient and to fulfil organizational requirements, they internalised these emotions in relation to their own competencies and professional identities. Feelings of inadequacy made many nurses doubt their own competencies; a recurring theme in the interviews. Several stressed that one could not just move professionals around and expect that because they had the same education, that they could practice the same kind of care in a hospital that is so specialized with competencies aimed at specific specialities and diagnoses. However, in practice and with regard to the question of competencies, the health digital platform was often an example of what it meant to come from another speciality, and to feel incompetent or not being able to do good for the patient. Thus, risk was established between quality, efficiency and individualised care as stabilising but contrasting categories, the tensions between which we interpret as producing these emotions as the affective dimensions of organisational life.
Despite nurses being proclaimed heroes (Halberg, Jensen & Larsen, 2021), providing care was described as having become a fight to which many nurses did not feel they contributed in a qualified way. Our findings show how the experience of being able to make a qualified contribution became a matter of having the necessary competencies to avoid the risk of failing. Our analysis also shows that what triggered this kind of risk was largely framed by institutional ordering systems which functioned as risk management strategies. These strategies had been implemented with the promise of ensuring efficiency and quality but instead ended up legitimising emotions of fear and frustration and a sense of injustice among nurses.

Refering to Douglas (1966), we argue that ordering practices build on institutional risk understandings that form strategies for dealing with risk. We have shown how systems and technologies are part of institutionalised ways of understanding and establishing workflows belonging to orderings. These orderings are, in turn, based on categories of efficiency and quality connected with medical specialities as institutional demarcation practices which legitimise risk by defining 'the other' (Douglas, 1966, p. 50). According to Douglas, these demarcation practices are grounded in fears and beliefs to maintain order and create security (Douglas, 1966), which we have demonstrated through the presented enactments. These enactments were permeated by emotions of fear of not performing the categories of quality and efficiency they build on in the COVID-19 ward. One may say that these ordering practices and risk management

strategies can be seen as organisationally (in)effective when nurses internalizie these fears by translating them into questioning their own competencies and trying to do better. The emotional responses can therefore be seen as part of an institutional order shaping the values embedded in a type of uncertainty (Douglas 1966). We therefore argue that categorizations of quality and effciency are supporting particular and contrasting values in the quest of individualised and standardised care.

Ordering is done through systems and technologies set into the world to create safety and efficacy. But in our study, when the non-standardized had to be standardised, or new requirements were set without the necessary tools to solve them, the opposite was created, namely the risk of failure. Therefore, the frustration could be even greater when one experienced receiving no help to deal with the situation from which the heightened emotions arose. For example, a well-meaning reminder from managers to remember to eat, to take breaks and to help each other, concluding with the possibility to talk with the hospital's stress coach, was not necessarily considered as caring.

The risk strategy and way of structuring COVID-19 care as we have demonstrated in combination with the kind of caring for employees mentioned above, ultimately placed the responsibility of performing the inherent moral imperative of individualized care in cost effective ways through inflexibel systems on the individual nurse. The nurses were offered help to deal with the emotions created, but received no help to change the structural factors that the emotions were created through. The emotions produced were not only internalized into individual feelings of incompetence but also shame of not performing good care. However, this specific form of shame was not the only one: also shame regarding the emotions that were produced. Nurses stressed to us that the virus seemed to hit the hospital system and healthcare staff even harder in other countries around the world and therefore they questioned their own emotional responses in comparison. An article in a Danish newspaper, *Berlingske*, emphasised that the inflexibility produced through systems and standards was a price that must be paid by countries with particularly efficient hospital systems (Christensen, 2021). From this perspective, emotions were framed in broader media discourse as a calculated, necessary and economised risk.

In this latter sense we argue that specific emotion-risk-assemblages (Lupton 2013) can be seen to have emerged in the pandemic due to specific formats of institutional ordering. However, we argue that they were nevertheless amplified emotion-risk-assemblages with some kind of (calculated) stability, as also argued by Zinn (2016). Since 2007, Denmark has undergone a major reorganization of the somatic hospital sector with increased specialization of hospital organizations and ongoing national demands for productivity increases, activity-based payments of hospitals and a growing number of quality assurance programmes to assess performance (Christiansen and Vrangbæk 2018). Inspired by neoliberal policies, this

reorganization contributed to what is known as the Scandinavian welfare paradox of high standard health services and productivity, but increasing inequalities in health (Diderichsen et al. 2012) and stress particularly among nursing personnel (Christiansen and Vrangbæk 2018). One may therefore ask - as is also done pre-pandemic in international literature (see for example Brown 2008 and McDonald et al. 2008) – whether it was only the pandemic as a '100-year event' (Christensen, 2021), that did not fit in the institutional ordering, or whether the staff in their daily practices often experienced having to deal with situations and patients that do not fit into the existing systems. Emotional struggles may therefore form a daily experience of working within an economically efficient system which imposes actions to satisfy control mechanisms, divorced from norms and values (Brown 2008), yet stressing individualized care.

In line with Willis and colleagues (2021), we argue that the COVID-19 pandemic amplified the already existing "cracks in the system" and added stress to an already stressful environment. These authors point to a reality gap between health management and front-line staff, drawing attention to the moral dimensions of the work of front-line health professionals when adhering to changing workplace guidelines. We argue that COVID-19 work was not only a question of adhering to changing workplace guidelines but also of pushing healthcare workers, and among them nurses, to fit new circumstances requiring new practices into existing and inflexible systems. We further draw attention to how emotions are produced between these complex and contrasting demands of both practising changing and inflexible guidelines and systems and being at the forefront of experiencing and handling the situational consequences of inadequate care or, as termed by Willis and colleagues, the moral dimensions.

We agree with Willis and Smallwood (2021) in pointing out the importance of a system-wide approach to providing a safe workplace with a focus on workplace and structural remedies rather than individual-level strategies and exhortations for individuals to take care of themselves. Hospitals must engage in risk management not only from a focus on production and patient safety but also with a structural focus on creating a safe workplace environment, which is a broader concept than minimising the risk of becoming infected. We show that key risks implying significant emotional production would seem to emerge within a non-flexible digital system, barriers to individualized care regarding for example food, and to providing professional care. In line with Fischer and McGivern (2016), we therefore argue that risk and emotions are organisationally produced through sociomaterial processes.

De Graaff and colleagues (2021) examined the macro institutional level of risk management of COVID-19 in a university hospital in the Netherlands. They show how risk management strengthens traditional institutional arrangements supported by hierarchical and goal-oriented risk work aimed to conquer risk and uncertainties. This is risk work that appears to prioritize existing institutional logics at the expense of the

necessary flexibility, which is why they call for an appreciation of more adaptive risk work (2021). In line with this, we have explored how risk understandings are formed through institutional categories of quality and efficiency as grounds for systems and technologies that should support work but appear instead to be poor at adapting during a crisis, affecting the group of healthcare workers whom de Graaff and colleagues describe as being 'at the sharp end of care' (2021, p. 124). We have shown how this position of being 'at the sharp end of care' produces emotions of frustration among the nurses, as a reaction to the hierarchical handing down of orders without the structural conditions available to perform them. We also found that organisational and resource risk could come to be prioritised ahead of patient risk (see Grant et al. 2019), with the risk of producing a bad working environment. Concerning risk management strategies, we argue not only for an enhanced focus on patient risk through interactions with front-line staff but also for more attention to creating safe(r) workplace environments. We support De Graaff and colleagues' argument that risk management could be enhanced by engaging more with the voices of healthcare workers, and research findings such as those presented here can contribute to this.

Conclusion

In this article, we have demonstrated how institutional ordering, risk management strategies, morality and categories connect and intersect in shaping the affective dimensions of organisational life in a COVID-19 ward. We have shown how the organization of Covid-19 care and treatment embeds contextual risk understandings that create emotional responses among those who perform front-line work in an everyday setting in a new and temporary COVID-19 ward. We found a risk understanding based on contrasting categories, such as quality, efficiency and individualized care, assembling emotions and risk through sociomaterial enactments. Within these enactments, emotions are produced, including fear of doing harm, frustration at not being able to perform individualized care, and injustice at being held accountable for practices activated by structural conditions outside the nurses' control.

We have demonstrated how ordering practices enacted through technologies and systems as risk management strategies are closely tied to the speciality order and specific locations through which the hospital operates. However, such systems prove inflexible when maintained during the pandemic. The health digital platform, the food distribution system, and the fluid recording system appear as objects of concrete and symbolic value that refer to the special (traditional) order and trigger emotional experiences and affective dynamics (Blackman & Venn, 2010, referred to in Lupton, 2013). These ordering practices are therefore key to understanding what mobilizes particular emotions and risk understandings within the hospital.

These ordering practices are permeated by a meshwork of emotional significance. However, we have demonstrated that these emotional responses transformed into individual feelings of inadequacy in performing adequate care as well as the fear of being the direct cause of patients deteriorating or even dying. Nurses cried on their shifts due to fear of harming patients as a consequence of maintaining inflexible systems and technologies that were supposed to support quality and efficiency, but which instead had a quite different effect. The nurses gradually internalised emotions of fear, frustration and injustice into individual feelings of inadequacy as a matter of inadequate competencies.

We have demonstrated how underlying central risk understandings rooted in the categories of quality and efficiency is practised and maintained by systems and technologies. However, when these systems and technologies could not be adapted to changes, it led to a risk of not performing adequately, which then created a fear of failing. This risk seemed to be more prominent in their everyday working experiences than the risk of infection, that could endanger their own and others' health.

When the nurses were pressured and, over time, found it difficult to bear this pressure, we conclude that it was as much a question of the (dis)order they directly experienced in their work. In this case, the (dis)order could leave nurses with decisions that were usually directed on a general level by standards and guidelines. Amid this uncertainty, professionals drew and relied upon their professionalism, yet they found that the inflexible organisational systems placed important restrictions on their actions while these structural conditions of a (dis)order left the nurses with the feeling of not being competent in doing care work. We argue that the COVID-19 pandemic has amplified the already existing 'cracks in the system' and exposed what nurses experienced in their everyday worklife pre-pandemic; which involved trying to 'fit' diverse patients and practices into inflexible systems that ultimately leave nurses with the feeling of incompetence and stress. This might explain the nurses exodus we have experienced in Denmark following the pandemic and which is appearent in other countries too (Khomami 2022, Noer 2022).

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