

How Institutional Logics Inform Emotional Labour:

An Ethnography of Junior Doctors

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Abstract

Sociological analysis of emotional labour can be aided by considering how institutional logics inform the performance of emotional labour. We consider the link between institutional logics and emotional labour by conducting an in-depth case study of junior doctors in a large UK hospital. We point to three key institutional logics - bureaucratic, consumerist, and professional logics - and show how they inform the emotional labour of junior doctors. We also consider how doctors respond to these logics through enactment processes of choice, resistance, and negotiation. In this way, we make an important theoretical contribution by identifying the way that institutional logics relate to the performance of emotional labour. We also make an important empirical contribution by contributing to a growing body of ethnographies on the emotional labour of doctors.

Key words: emotional labour, institutional logics, medicine

Introduction

In Hochschild's (1983) thesis, emotional labour involves emotional displays within work, commodified according to a market-logic in which the organisation benefits from promoting the interests of the sovereign consumer over the worker. Following Hochschild (1983), emotional labour has been a central concern for sociologists of work and organisation (Korczynski 2002) as well as scholars in management psychology (Grandey, 2003), business and management (Morris and Feldman, 1997), organisational literatures (Bolton, 2002), and healthcare studies (James, 1992; Rogers et al, 2014). This literature has analysed many aspects of the performance and regulation of emotion at work, mediated by the immediate context of the workplace.

Whilst early definitions focused on emotional labour being shaped by a market-consumer-logic (i.e., Hochschild, 1979; 1983), subsequent contributions have also considered alternate imperatives shaping the emotional labour process. Korczynski (2002), for example, showed that ‘rationalised emotional labour’ is often guided by dual logics of customer-orientation and bureaucratic rationality, while Bolton (2005) offered a typology of how ‘commercial’, ‘organisational’, ‘professional’, and ‘social’, feeling rules inform ‘pecuniary’, ‘prescriptive’, ‘presentational’ and ‘philanthropic’ types of emotional management.

While Korczynski (2002) and Bolton (2005) have extended our knowledge of different types of imperatives informing emotional labour, the institutional logics perspective suggests a more comprehensive way to analyse this issue. Literature on institutional logics has identified how organisational practices are steered by multiple logics such as professionalism, managerialism, and commercialism (Reay and Hinings, 2009; McPherson and Sauder, 2013). If institutional logics inform organisational practices, they should also inform the performance of emotional labour. Recent contributions within the institutional logic literature have explored the nature of emotions in light of a wider range of institutional arrangements (Voronov and Vince, 2012; Zietsma and Toubiana, 2018; Friedland, 2018). Voronov suggests future research can seek to identify how a particular logic ‘prescribes and proscribes certain emotions’ (2014: 186). To date, however, no study has examined how institutional logics inform emotional labour.

In this paper, we address that gap. We examine how institutional logics which shape the management and work practices of an organisation also inform the performance of emotional labour. Specifically, through ethnographic research, we highlight key institution logics in a hospital, and show how these logics inform the emotional labour of junior doctors. Junior doctors were seen as a telling focus for this work as, aside from the emotionally heightened nature of the work itself, existing studies of emotional labour within healthcare commonly point to the changing contexts of healthcare and the increasingly managed nature of emotional displays (Bolton, 2002). We show that these institutional logics do not simply dictate the performance of emotional labour, but rather that there is some space for junior doctors to choose, resist and negotiate between logics in the way they perform emotional labour. We make a theoretical contribution by identifying the way that institutional logics relate to the performance of emotional labour. We also make an empirical contribution by adding to a growing body of ethnographies on the emotional labour of doctors.

This paper first reviews literature which categorise forms of emotional labour before identifying how the emotional labour process might be shaped by institutional logics. We then describe the ethnographic methods and give the findings of the study, before discussing the implications of our analysis for understanding emotional labour in the contemporary workplace more broadly.

Forms of emotional labour and contexts of work

Central to Hochschild's (1983) work is a link between emotions, work, and social institutions. Adding Goffman to Marx (1967), Hochschild viewed emotions as dependent on social norms linked with wider ideology, and taking place within a capitalist economy, rather than being instinctual and spontaneous. Hochschild conceptualised feeling rules as the norms which define the appropriate type and amount of feeling which should be experienced in specific situations. Feeling rules, therefore, refer to societal norms that influence how individuals experience and feel emotions in given social situations (Hochschild, 1979). Hochschild makes a key distinction between 'emotional management' of our private lives outside of work and 'emotional labour' taking place within work contexts. In the latter, emotional performances are commodified and can be viewed as part of the capitalist labour process.

Although Hochschild (1983) identifies a wide range of occupations as involving emotional labour, she focused her analysis on occupations in which emotional performances are closely managed. Subsequent studies have examined how specific occupations and work contexts, such as the psychological location and speed of service, shape emotional labour (Ashforth and Humphrey, 1993; Terry et al., 2021; Harness et al., 2021). At the broader conceptual level, Korczynski (2002) argues it is the dual logics of customer orientation and bureaucracy which shape the emotional labour process of those undertaking front line service work. Service workers are expected to attune their emotional performances to uphold the enchanting myth of customer sovereignty and to conform to the requirements of bureaucratic rationalisation. Korczynski (2002; 2003) also theorised that spaces arise for service workers amidst these dual logics, such that there can be opportunities for more socially-embedded exchanges.

Subsequently, Bolton (2005) and Bolton and Boyd (2003) offered a typology of four distinct types of emotional labour associated with various forms of emotional management. They argue that 'commercial', 'organisational', 'professional', and 'social', feeling rules can be linked with 'pecuniary', 'prescriptive', 'presentational' and 'philanthropic' forms of emotional management. They further argue that employees seek opportunities and 'unmanaged spaces' to perform presentational and philanthropic types of emotional management, which are

seen as normative and are developed in childhood socialisation. This typology moves past Hochschild's (1983) binary distinction between public and private emotional work. However, the typology falls short of offering a clear link between feeling rules and types of emotional labour. For example, the typology suggests both professional and organisational feeling rules are associated with prescriptive emotional labour and that social feeling rules are linked with both presentational and philanthropic forms of emotional labour. Further, while the typology invokes certain characteristics of contemporary organisations and considers how these align to particular 'feeling rules' it does not do so in a systematic way.

The debate between Hochschild, Korczynski and Bolton can be interpreted as implicitly concerned with identifying how, and to what extent, competing institutional logics shape the emotional labour process. Read in this light, Hochschild (1983) focuses most clearly on a consumer-logic shaping the nature of work involving emotional labour. Korczynski's (2002) points to the importance of customer-oriented and bureaucratic logics, while Bolton (2005) and Bolton and Boyd (2003) point towards contrasting commercial, organisational, and professional logics without systematically linking these to particular feeling rules and types of emotional management. *Seeing the debate in these terms provides an opportunity to explicitly link key institutional logics to the study of emotional labour.*

Institutional logics and frontline work

The institutional logics perspective sets out to explain how societal-level phenomenon relate to thought and action at the individual and organisational level. Institutional logics have been defined as sets of material practices and symbolic systems including the assumptions, beliefs, and values by which individuals and organisations arrange their activities/experiences (Alford and Friedland, 1985; Dunn and Jones, 2010). Thornton et al (2012) outlined key 'ideal type' institutional orders within contemporary Western societies; namely, market, state, community, family, religion, profession, and corporation, each with its own distinct logic. It is argued that our interests, identities, values, and assumptions are embedded within such institutional logics (McPherson and Sauder, 2012). In pluralistic societies, individuals or organisations assume multiple roles and identities, creating conflicting pressure as well as opportunity for agency as actors navigate between logics. The institutional logics approach has now been used extensively to examine contemporary contexts of work.

An important theme within literature on institutional logics is how particular institutional contexts are characterised by institutional complexity, involving multiple logics which may co-exist as well as conflict with one another at the organisational frontline. This

requires actors to navigate between different logics (Ten Dam and Waardunburg, 2020) in order to carry out work tasks. Institutional logics are subject to interpretation and re-interpretation by institutional actors (McPherson and Sauder, 2013) who may be able to choose strategically how to respond to the influence of multiple logics, engaging with certain logics, whilst resisting the influence of others (Gautier et al, 2018). Research also indicates that institutional actors might select aspects of certain logics, switch between competing logics within the institutional context or blend logics in the day-to-day performance of their jobs (Ten Dam and Waardenburg, 2020). However, academics accept that more attention should be paid to the micro-processes of institutional complexity (Felder et al, 2018). This will facilitate the understanding of how frontline workers negotiate the influence of multiple logics, contributing to our understanding of the dynamics between institutions and professions more widely. Whilst scholars have attempted to explore institutional influences on frontline processes (e.g., Lawrence and Suddaby, 2006; van de Bovenkamp et al, 2017), there is a need for further exploration of micro-processes of interpretation and meaning-making in contexts of multiple, competing logics (Bishop and Waring, 2016). We now turn to focus on what these competing institutional logics mean for *emotional labour processes*.

Emotional labour in light of institutional logics (within healthcare)

If institutional logics influence the work organisation of professionals, then it follows that they will also influence emotional labour performances during interactions at the frontline of work. Institutional scholars have recently acknowledged that emotions are central to how we perceive and understand our social and professional worlds (Voronov and Vince, 2012; Zietsma and Toubiana, 2018). Whilst these contributions have started to connect institutional logics to the emotional aspects of work, these authors have not yet considered connections to the emotional labour process.

Given that our study focuses on the emotional labour of training grade, or junior, doctors, we focus our literature discussion on key institutional logics in healthcare. Within this field, emotional labour has implicitly been considered the responsibility of nurses, with the work of doctors identified as an elite profession topping the healthcare division of labour, in which professionals have relative freedom to shape their emotional performances at work (Freidson, 2001). However, the changing status of medicine has been extensively considered (Ritzer and Walczak, 1988; Freidson, 1988), with recent evidence suggesting that while the high status of certain medical elites continues, lower status doctors have been exposed to new political, economic, cultural, and bureaucratic controls which shape the processes of frontline

care (Ferguson et al, 2021). The work of junior doctors in particular is often highly circumscribed by their organisations, their senior colleagues, other professional groups, and the patients themselves.

The field of healthcare has been amongst the most commonly examined in light of constituent institutional logics (Reay and Hinings, 2009; Scott et al, 2000). Building on prior studies, we point to three key logics within the field of healthcare, namely those of professionalism, bureaucracy, and consumerism (Noordegraaf, 2015). These are outlined below, with the theoretical implications for emotional labour briefly considered for each in turn. This then forms the framework for the subsequent empirical study.

First, healthcare is widely recognised as subject to a logic of **professionalism**, in which medical professionals dictate care practices according to expert professional knowledge. Under this logic, doctors exercise a high degree of autonomy and clinical judgement over their labour process (Currie and Spyridonidis, 2016); they are expected to self-regulate their practice in accordance with professional norms. Doctors also remain relatively free from external regulation (Friedson, 1988) and are able to use discretion when determining clinical interventions (with standardised guidelines in place for reference [Gabbay and Le May, 2004]). While many suggest the mid-20th century ‘golden age’ of medical professionalism has long been challenged by factors including state, technological corporate managerial control (McKinlay and Marceau, 2002), and greater patient voice (Bolton, 2002), doctors – and medical professional associations - continue to hold a degree of power at the policy, organisational and practice level. In line with experience and increased seniority, doctors/consultants hold a higher degree of autonomy with regard to their labour process (Friedson, 1988; Noordegraaf, 2015).

The form of emotional labour associated with a logic of medical professionalism can be characterised as ‘professional empathy’. This captures the professional requirement to retain expert objectivity while conveying individualised empathetic concern in line with what it means to ‘be a doctor’. Cultivating appropriate emotional performances is a central part of professional training and socialisation (Ahuja et al, 2019) and involves developing a commitment to keeping personal emotions in check while both demonstrating sufficient engagement with patients as individuals and dealing with the technical aspects of medicine (Becker et al., 1961). Positive emotional displays are felt to confer professional status and negative emotions are felt to detract from it. Professional empathy could therefore be seen to involve a long-term project of emotional regulation in which junior doctors learn to take on emotional displays in line with professional values (Monrouxe, et al., 2015).

Second, medical professionalism has frequently been considered to be in long term friction with a logic of **bureaucratic rationality** involving increased managerial control over the organisation of care (Friedson, 2001; Reay and Hinings, 2009). An increased focus on efficiency, cost-effectiveness, and managerial control introduces influences of rationality over medical labour processes. Under this logic, work is tightly controlled as a means of achieving greater efficiency. In this light, the rise of bureaucratic rationality within the healthcare context has challenged the status of medicine. Doolin's (2002) study, for example, examines the varied ways doctors engage with and resist a growing market-management discourse during government-led reforms. This is further examined in literature on de-professionalisation (Ritzer and Walczak, 1988), medical re-stratification (Friedson, 1988), corporatisation/proletarianization (Coburn, 2006) and on organisational professionalism. Increasing managerial control over medicine also is an important topic of institutional analysis (Scott et al, 2000) which highlights the way doctor-patient interactions, and the medical labour process more broadly, are subject to heightened bureaucratic controls.

The form of emotional labour associated with bureaucratic rationality can be characterised as 'emotional neutrality'. Under this logic, doctors are expected to organise their work according to the efficient processing of medical tasks, restricting the emotional performances for patients and relatives. While it might be expected that doctors resist bureaucratic controls over their interactions with patients (Ward and McMurray, 2016), it is also acknowledged that professional/public servants are socialised into expecting resource realities surrounding the nature of their work. Instead, 'street-level bureaucrats' (Lipsky, 1980) might choose to offer more expressive interactions to some, whilst potentially avoiding engaging in emotional displays with others.

Third, an institutional logic recognised as of rising importance within healthcare at the international-level (Noordegraaf, 2015) is that of **consumerism**. While a consumerist-logic may be assumed to be less dominant within publicly-funded healthcare systems, it has been identified as rising in the NHS in at least three ways. First, at the national level systems have been installed to allow and encourage patients to 'shop around' for healthcare services (Greener, 2003). Second, NHS provider organisations have been encouraged to adopt consumer service practices, for example installing mechanisms for feedback/rating of service experience (Latimer et al, 2017). Third, there have been broad policy efforts to install aspects of consumer culture within the NHS, for example with adoption of consumerist discourse, raising consumer

expectations, and promoting consumer sovereignty over clinical professional ‘service providers’ (Bolton, 2002).

The type of emotional labour commonly associated with consumer demands can be characterised as ‘consumer empathy’. Hochschild (1983) analysis of consumer empathy was situated in a highly consumer-oriented industry (air-travel), and she demonstrated instances of resistance to demands for such emotional labour. In healthcare, we suggest that managerial efforts to promote consumerism are likely to be associated with resistance from junior doctors who seek to return towards more professional forms of emotional labour (Bolton, 2002).

Despite the presence of bureaucracy, professionalism and consumerism as key logics influencing healthcare, we do not expect actual performances of emotional labour to be simply determined by these logics. Previous studies show that workers play an active role in the way emotional labour is performed (Bolton 2002). We may then expect junior doctors to seek out temporal/spatial opportunities to perform emotional labour in line with professionalism above consumerism or bureaucracy. At the same time, taking up the suggestion of Korczynski (2003) on the potential for socially-embedded emotional exchanges, we also expect to find instances in which junior doctors become entangled with the emotional concerns of the patient before them, interacting in a way that is guided more by social embeddedness than by wider institutional logics. Beyond having to choose between societal-level templates for action associated with particular contemporary social forms (of market, state, or profession), we allow for the possibility that there may be instances in which doctors’ emotional performances are based on a more sense of common social belonging.

In addition, British healthcare is increasingly characterised by doctors/other senior professionals balancing dual roles within the institution – most often that of management and clinician (Forbes et al, 2004; Kippist and Fitzgerald, 2009). This suggests that doctors are socialised into balancing the interplay of key logics at the frontline of work, particularly in line with increased seniority.

Methods

We investigated how emotional labour is enacted in light of institutional logics through an ethnographic study of the emotional labour of junior doctors. We conducted an exploratory case study (Saunders et al, 2016) of junior doctors within a large university hospital in the English National Health Service (NHS). Junior doctors work with patients on ward areas, in specialist clinics, in operating theatres and in other areas of the hospital. In addition to the

clinical aspects of medical/surgical work, doctors also emotionally interact with their patients/relatives throughout the working day – for example, through ward rounds, bedside manner interactions, breaking bad news instances, and within operating procedures/theatres.

Ethnography, underpinned by interpretivist philosophy, has been previously used to examine the everyday challenges and strains of service work (e.g., Paules, 1991). In this case, ethnography was adopted to provide an in-depth understanding of the labour process of junior doctors, including the emotional performances undertaken by doctors during frontline clinical tasks. This required detailed observation of doctors interactions with patients and colleagues, as well as an exploration of doctors' reflection on the emotional elements of their work. Despite the richness offered by ethnography, we appreciate that some authors might argue that our findings are limited to the context within which they were derived. However, there is an opportunity to generalise our findings to other similar contexts in light of Flyvbjerg's (2006) arguments. Institutions facing similar challenges to that of our case study might also experience the interplay of key logics identified in this study, and institutional actors might engage within emotional labour processes in similar ways to that of our doctors.

Wilton Trust, the pseudonym given for this case, consists of three large teaching hospitals and a series of specialist clinics. Patient demographics reflected that of the wider population of the area, with a larger proportion of elderly patients admitted to the trust. Data is drawn from forty semi-structured interviews and fieldnotes taken during observations over a 14-month period from the two larger hospitals of the three and from various specialist clinics. Doctors from medical/surgical services were interviewed from across the training grade spectrum (Foundation Year 1 - Specialist Trainee 8). Three consultants were also interviewed to help contextualise junior doctor data, in addition to healthcare professionals working within equivalent capacities (1 Physician Associate and 1 Advanced Clinical Practitioner).

Interviews lasted between 40 minutes and 2 hours and were conducted within locations indicated by the respondents. Observations were conducted on ward areas, in breakout rooms, during teaching sessions, in specialty clinics, in meetings/seminars and during operation theatres – helping to obtain an illuminative dataset. In total, 150-hours of observation were undertaken. Observation fieldwork complemented the interview data by providing the scope to explore the institutional context of the NHS, associated workloads of medical/surgical labour processes and pace of work for junior doctors. The position of the researcher/observer affected the work of junior doctors in that they often paused and offered explanations of the work processes. The presence of the researcher clearly evoked an apparent need for some of the

doctors to explain/share thoughts on specific work tasks – particularly which related to interacting with patients/other service-users. Observations therefore also involved informal conversations with junior doctors about the nature of their work and texture of their emotional interactions.

The interviews were transcribed verbatim. The data were coded and analysed through interpretive thematic analysis (Braun and Clarke, 2021), supported by the use of NVivo 12. Thematic analysis offers flexibility to make sense of qualitative data given that it does not require pre-determined concepts with which to conduct analysis. Instead, it allows these themes – and thus theoretical constructs – to emerge from the data. In this study, the analysis proceeded in several overlapping stages in light of the wealth of data generated. First, the data were collated and read through in detail. Author 1 then began organising the data on NVivo into specific sections and began to develop/refine initial codes. Author 1 started with multiple codes which ultimately required narrowing down to broader, more overarching themes. Prior literature on forms of emotional labour was considered during the analysis, however the emotional labour types identified in the study emerged from the process of data analysis, and the themes were subject to ongoing critical reflection in light of the wider data. Collecting data and carrying out the analysis was an iterative process. Author 1 ceased data collection when it was judged that (1) data saturation had been reached, and (2) a deep sense of the patterns that shaped the emotional, medical, and surgical realities of junior doctors had been developed and the possibility of new insights had been exhausted. In order to protect the identities of individuals and organisations, pseudonyms have been used and all ethical issues have been considered given the sensitive nature of the research.

Findings

In this section, we consider each logic in turn and show how each logic can be seen to shape emotional labour processes on the frontline of medicine. We also consider how doctors might navigate their emotional labour performances through enactment processes of choice, resistance and/or negotiation.

Bureaucratic rationality and emotional neutrality

Bureaucratic rationality was as a key logic shaping the organisation of junior doctors' work. This is unsurprising given that medicine has grown considerably more prescriptive in recent decades and thus medical practices have become more controlled – particularly for early-career doctors (Smith, 2001; Freidson, 2001). Bureaucratic rationality could be seen in the

predominant focus on the efficiency of processing patients in line with standardised care pathways, time-bound targets, and process and output metrics. Junior doctors' work largely – although not entirely – consisted of routine tasks (i.e., prescribing common medicines, ordering medicines to take away, writing discharge summaries and checking comparatively minor clinical issues), the nature and pace of which varied by the wards/departments they were attached to. Often, treatments could not progress, and patients could not be moved to the next stage of the care pathway or discharged from the hospital without junior doctors completing and documenting a number of routine tasks for each patient. There was therefore pressure on junior doctors to complete these tasks efficiently in order to keep the throughput of the hospital moving. Doctors often commented on the highly structured, time pressured nature of their work and the way in which staffing was organised on a minimal basis to cover the tasks required, without slack to build relationships with patients. Medicine was therefore described by junior doctors as a *production line* service, in which meaningful interactions with the patients were limited due to the focus on efficiency:

...if they can eat and drink order an ultrasound and send them home. The patient next to them the same, if they can eat and drink, order an ultrasound, send them home. So, you kind of come up with these standardised plans which don't really involve any clinical judgments, they tend to just be in place so that we can have as much bed space as possible. And it does feel like it's a repeated process that you do for individual patients who are completely different from each other...kind of production line.

(Dr Sani, F, CST2, 16.05.2018)

then it becomes if you're in just part of a massive machine and just doing whatever you're meant to do. And if you want to sort of finish at a reasonable time you learn to do everything efficiently and really fast and sometimes not thinking too much...we need to see patients really fast because otherwise you will not be able to see everyone. So that impacts on the quality of communication with the patients, you don't always get the most detailed history. And I know like in theory they say it all comes from history and examination, and actually when you have to fill in all the paperwork and then prescribe the medications and then do something else you just start to cut corners and try to find ways of doing things faster.

(Dr Richards, CMT2, 26.11.2018)

In light of such rationalisation, doctors readily suggested that they were required to complete work efficiently which ultimately has an impact on quality of communication with patients. Dr

Stafford notes regretfully that the focus on task efficiency limits the potential for developing a meaningful emotional connection with individual patients.

...you find that you're making these really quick decisions and you haven't really bonded with the patient, you've only known them for a day...

(Dr Stafford, F, CMT1, 19.06.2018)

Time pressure meant that the doctors often felt they were expected to keep emotional displays to an absolute minimum, even when discussing conditions or issues with potentially severe consequences for patients As Dr Sani (F, CST2, 16.05.2018) stated:

...they [consultant] literally just spend two minutes with their patient, we prepare everything, we brief the consultant what's been happening, they [decide], moving on. Which means a result of that interaction might be like, "Okay, you've got cancer, you're going to theatre, this is the end," moving on. And obviously those patients are left feeling distraught...

And Dr Fielding stated:

...I think because of the amount of paperwork and the volume of patients. You don't get a chance – I imagine if it was just the ward on general medicine, you have no opportunity for care. You just keep getting moved to on calls, and on calls. By the time you get back, those people you saw before have gone.

(Dr Fielding, M, CMT2, 29.03.2017)

In this quote, Dr Fielding uses the word 'care' to suggest something other than performing the technical aspects of medicine, and appears to invoke deeper emotional engagement, the opportunities for which were lacking from their work routines. In this way, it can be suggested that most often doctors identified emotional neutrality as necessary in light of the pressures on their work. It was also clear however that they felt this was problematic and was an ongoing point of tension. We can hear the regret in the doctors' voices as they reflected on the lack of meaningful interactions with patients:

One of the reasons most people go into medicine is because they like the empathy side of things. They like the ability to hold someone's hand and tell them about their condition. So that's slowly being weaned away because of service pressures... You need to do all the care, bang, bang, bang with very little time to explain to the patient why you're doing, what the implications are. I think the human side of medicine is slowing dwindling away.

it's the reason for doctors leaving medicine because we came into medicine to help people and one of the biggest things about helping people is not just treating them, medically putting needles in, and giving them antibiotics [...] it's the empathy side of things which is very therapeutic.

(Dr Irfan, M, CMT2, 8.07.2018)

The doctors recognised they were being driven to avoid the 'empathy side of things' and many were becoming disillusioned as a result. However, it was also clear that the doctors did not feel that the bureaucratic-logic was entirely dictating their work in practice. In a number of instances doctors sought to make time and space to go beyond emotionally neutral interactions. Dr Bates talked about how he sought to 'make time' to engage with a dying patient:

I was in the middle of a busy ward round and kept getting interrupted. And I just heard her say, "Doctor" she was just panicking, and so I went and sat with her and calmed her down and held her hand until she wasn't panicking anymore. And at that point kind of time stopped. Nothing else around you matters because the most important thing is that patient in front of you.

(Dr Bates, F, ST1, 20.02.2018)

As this quote suggests, junior doctors also resisted pressure to treat their work entirely as a production process and sought out opportunities for other forms of emotional labour in line with alternate logics. Doctors can, therefore, occasionally, step outside of the demands of external pressures and manage patient interactions as they see fit in line with the case or situation in front of them. This was a common finding across the observations undertaken for this study.

Professionalism and professional empathy

While the organisation of tasks largely followed bureaucratic rationality, the quality of work as well as certain legal responsibilities of the junior doctors were also dictated by a logic of professionalism. Doctors highly valued the ideals of medical professionalism and sought out opportunities to perform their work in line with this. Doctors commonly sought to display expertise as well as their commitment to providing high quality of treatment and care.

In this light, and despite the pace of work, junior doctors sought to convey aspects of professionalism in their emotional labour, where they were able to carve out time and space to do so. During ward rounds, for example, doctors often kept interactions quite short and focused on issues of diagnosis and treatment, but in certain instances exhibited a more engaged and

empathetic ‘bedside manner’. On a geriatrics ward, for example, Dr Smith was tried to reassure an elderly, confused patient:

She says that she feels ‘lost’ because ‘people’ keep coming to check her/examine her and that ‘I don’t understand why they keep coming...where am I, I’m at home’. The FY2 kneels down on the floor to meet the eye level of the patient and is trying to reassure the patient that ‘you are OK, you are in the hospital’. The patient then calms down and listens to the doctor – ‘can somebody please get me a cup of tea’...As the patient calms down, the FY2 attempts to medically examine the patient...

(Observation Notes, F, Geriatrics, 23.11.2018)

A common occasion in which participants found both time and space to convey their professional empathy was when they were ‘break bad news’ to their patients. Such instances of ‘breaking bad news’ were widespread across Wilton, and the sensitivity of the context of breaking bad news called for heightened attention to emotional conduct on part of the doctor. In these instances, doctors often took patients/relatives into a side-room in to provide an additional privacy. This created the temporal and spatial conditions for the doctors to take greater control of the emotional tone and allow the patients and relatives to process the information away from the pressures of more public areas. During an observation, Dr Spacey (F, ST7) on a geriatrics ward needed to ‘break bad news’ to two siblings – their mother was elderly, frail, and close to dying:

The doctor prepared herself in the office before taking the relatives into a quiet space. In this room, she offered the relatives tea/coffee and water. She then kindly offered the relatives a seat and closed the door –...Dr Spacey pulled up a chair close to the relatives before she started to... tease out the level of information that the relatives already had – it was a difficult interaction. Dr Spacey slowly explained to the siblings that their mother’s condition was deteriorating; she was unresponsive to medicine and to verbal communication and it would therefore be a good time to call other relatives. The siblings began to cry [as did I], while Dr Spacey remained collected as she held the woman’s hand and comforted her.

(Observation Notes, F, Geriatrics, 27.02.2018)

A key aspect of professional training for doctors was learning how to maintain the appropriate level of emotional distance from the patients and families/carers. The doctors discussed how they are required to respect the bedspace and privacy of their patients and try to not become too emotionally involved in their care. Thus, doctors maintain a professional barrier from patients. As Dr Richardson (ST1) stated:

there has to be obviously a professional barrier so it's about maintaining that is important. Treating patients with respect; they are – they're people and understanding that patients have autonomy at the end of the day

(Dr Richardson, F, ST1, 7.11.2017)

Dr Rowe elaborated on this point:

trying to be empathic, so trying to have an involvement with your patients but not being too involved. So, keeping a certain amount of distance but understanding the position they're in...we all try and be professional and not take things on board and... we're taught about being empathetic but not sympathetic, so trying to step into someone else's shoes but not taking stuff home with you and everything. So, it's difficult, so you want to be able to separate yourself from the situation...But sometimes that can be hard to do that because obviously we're all human aren't we; we all have emotions and want to be liked and want to do the best job we can

(Dr Rowe, F, ST4, 6.03.2018)

This suggests that it is important for doctors to offer professional empathy to their patients, but at the same time, to maintain a level of social distance. Whilst professionalism influences doctors to engage with patients by offering care and empathy, it also encourages them to maintain a level of distance in order to ensure they do not become too emotionally invested. Often the doctors talked about the importance of striking the right balance between emotional engagement and distance; this was also reflected in many of the interactions that were observed. One of the doctors discussed this:

it's about striking the right balance between having empathy and understanding emotions and why people feel emotions in the scenario that you've been in, [and] also having the right amount of distance. So, you can be empathetic without being emotionally invested. I think that's difficult to strike that balance.

(Dr Wie, F, FY2, 10.09.2018)

Dr Ahmed (M, FY1) described the way that professional empathy could be difficult to maintain:

That turned out to be quite a lengthy conversation, two hours, and a lot of high emotions running, so the patient's family were crying, they were trying to console them, I also keep a professional distance and tried to explain the situation and trying to get to the bottom of their concerns and their feelings. You're holding your professional ground at the time, but I remember as soon as I walked out, I went into the medical office...it was late at night and emotions got to me, and I started to cry and there was nobody there

that I could speak to. Then you go home, you've got to come back and start the whole thing all over again...

Dr James (F, ST1) showed how it might be difficult to strike the balance between empathy and distance in light of individual patients:

It's very difficult at that point, particularly when you're feeling tired, to maintain that professional sense of caring and wanting to do your best for your patient because actually, there's a little part of you that says do you know what? I really just want to leave this. In a lot of other things, you'd say okay, that's fine. I can't deal with you now, but obviously you have to try and overcome that and do your best for them. That's quite psychologically difficult, I think... There's some people who have more challenging personalities than others, so sometimes you have to really just get on with it and just treat them as a patient rather than – you're not trying to become friends with them; you're just trying to treat them and get on with them in that respect, whereas others are very simple, like would be very amenable to what you're saying and things.

Although doctors predominantly aspired to performances of professional empathy where this was possible, maintaining this face could be deeply affecting. Amid offering professional empathy and remaining socially distant at the same time, then doctors can also become emotionally vulnerable themselves. Doctors often conveyed frustration with the lack of time they had to display their professional empathy, but it was clear that when they did get the opportunity to do so this was relished as the appropriate approach for a doctor.

Consumerist expectations and consumer empathy

In certain instances, junior doctors recognised a growing, albeit still peripheral, consumer-logic influencing their work. Less dominant than bureaucratic and professional logics, the influence of the consumer-logic could be heard in the doctors discussing the growing expectations of patients. Several doctors talked about the way that patients made demands over their care or expected services to be organised according to their preferences – reflecting the nature of consumerism within customer-service work (Hochschild, 1983). Doctors often discussed how patients could be demanding, come to consultations with misinformation they have taken from consumer websites, or ask for clinically unnecessary services which are unavailable on the NHS. In certain instances, it was felt that the patients were seeking to establish their sovereignty over the doctors and dictate the terms of 'service'. Indeed, doctors are very-much aware that they operate within an increasingly consumer-orientated environment with respect to both patient-centred care (Latimer et al, 2017; Newman and Vidler,

2006) and consumers at work themselves within the supply chain of medical services (e.g., in light of the internal market competition between providers and the widespread use of private providers within the system).

Dr Bache stated:

some people are really mean, and they don't start being nicer just because they're sick, and you have to really manage your emotions around that and go yes, I'm going to have to be nice to them and treat them with respect.

(Dr Bache, F, FY3, 15.08.2018)

Rather than asserting professional authority over the patient, Dr Bache suggests needing to 'be nice' to patients despite how patients might treat him/her. Other interview responses indicated that doctors were required to manage their emotional expressions when patients felt their expectations had not been met and/or had lost their temper.

it's obviously difficult when someone's being quite aggressive, or being difficult, then it's hard to keep the bedside manner because...they're attacking you, so you've got to just take it basically and you can't say anything back; but I guess that's bedside manner as well isn't it, I don't know (laughs)

(Dr Furr, F, FY2, 21.06.2018)

This suggests that doctors could feel the need to accept disrespectful behaviour from patients. Dr Stephens and Dr Furtal, both very early-career doctors, talk about putting on a face to deal with patient demands rather than showing their real emotions or establishing their professional status, as they felt they were able to do while performing professional empathy. This was a common observation amongst early-career doctors when they were faced with these types of events and largely mirrors the findings of Hochschild (1983) in customer-service work.

there was a point where I didn't want to... not shout, but just bluntly say to her, no, just you have to stay in that's it (laughs), obviously I couldn't say that, so yeah.

(Dr Stephens, M, FY1, 28.08.2018)

It's hard to be sympathetic towards someone who you think is a knob (laughs). Obviously, you always talk to patients with respect and equally, blah blah, but we're all human and if you don't like a person it's hard to give them respect properly...

(Dr Furtal, M, FY3, 7.11.2018)

Whilst consumer empathy was limited in comparison to emotion neutrality and professional empathy, there were instances in which doctors felt the incursion of a consumer-

logic as something which required resistance. The more senior doctors in the study in particular were keen to highlight patient interactions in which they were able to overcome what could be seen as consumer demands over their work. One of the doctors discussed an interaction following rescheduling an operation, highlighting signs of subtle resistance:

so, you eventually get around to seeing her at the end of the shift, after you've tried to see all the sick people first, because she's not sick, she's just angry. She was saying, "Oh, I feel like you're fobbing me off. I feel so frustrated. I'm going to self-discharge. I'm so frustrated." [...] She even got her diary, saying, "I've got it written down for Monday. Why are you going to cancel it?" And I'm saying, "Well, (a) it's not even me, it's my consultant."

(Dr Prescott, F, CMT2, 14.03.2018)

Dr Sani provided another example:

I had a very heated argument with a lady over the phone... and she started accusing me that I was lying, that the whole department was lying, that – so I just had to say, “Look, I’m not going to argue about my integrity over the phone,” but it became like a very heated argument, and she actually involved the matron and, you know, the complaints team of the hospital.

the nature of us having to...respond to all complaints and all allegations made, again, that makes it a consumerist nature. So, every time there’s conflict, we’re encouraged by seniors of our teams to sort of like go down the route of the customer’s always right.

(Dr Tsansaraki, F, CST1, 13.11.2017)

The above quotes suggest that while the participants did not readily see patients as consumers and sought to maintain their professional ‘integrity’, they did also find themselves on certain occasions exposed to the expectation of patients directly and through complaints system – which is highly reflective of customer service work, and organisational demands on their emotional performances in line with consumerist ideals. Whilst the junior doctors were conscious of this, and their emotional performances were adjusted as a result, doctors did have some scope to resist the influence of the logic, either by reference to professional hierarchies for decision-making (deferring to ‘my consultant’) or by invoking professional norms (such as integrity).

Enacting logics and social embeddedness

The three important institutional logics guided the emotional labour of doctors but did not appear to determine them; there were instances where the emotional performances of the doctors fell outside the confines of these logics. Specifically, doctors described the need to feel an authentic human connection with patients, without consciously remaining emotionally distant from them. One doctor suggested that in certain instances you have to show your real emotions when caring for a patient ‘otherwise you are not really a doctor’. Another participant, Dr Wie (FY2) described an example:

there’s a mother/daughter interaction that I will always remember because it reminds me of my mum and me and those are the ones where it hits you and it will stay with you. Mum was dying, and daughter was struggling to come to terms with it and they were having a really beautiful moment...everyone who was treating them came out of the room crying because they all put themselves in their shoes. Those are the ones you remember but I think you remember it for good reasons...It still makes you sad, but I think you’re allowed to be a little bit human sometimes.

Dr Asif (CMT2) offered another example:

I’ve been working on intensive care...we’ve been treating them for sepsis, and we’ve talked about stopping their treatment with family and their – hearing a lot of their family with emotional stories about their loved one. You’re there as a person, a human being and then you go home and that affects you...that’s – you get to know them more as a person and then you get more emotionally affected by seeing them die and the family’s emotions. It would be hard not to be affected by that, even though you see it day in day out.

On such occasions, doctors’ emotional performances were shaped by social embeddedness rather than the institutional logics. Tellingly in the quotes above, it is when the doctor is reminded of one’s own relationship with her mother that she ‘allows’ herself to cry in front of the patient; or when patients are nearing the end of their life and doctors build close relationships with patient relatives. It was also evident that the doctors were aware that engaging with patients in socially-embedded ways risked them being seen as unprofessional, and therefore it is only on certain occasions that such emotional performances could be ‘allowed’ to take place. Dr Mustafa (FY2) explained this:

It’s very difficult sometimes to find the balance between being professional but also, you know, we’re human at the end of the day and you need to have some, show some feeling and obviously compassion and empathy, but it’s where to draw the line where sometimes, you know, you might be completely invested in...a particular patient that

unfortunately passes away...they get diagnosed with cancer... it's okay to show some emotion.

As well as highlighting the strong emotional demands of the junior doctors work, these instances do illustrate that the doctors were occasionally able to 'step out' of the demands of institutional logics in how they enacted their emotional labour.

Discussion

This paper has shown how emotional labour takes place with respect to the institutional logics which shape the management and work practices of an organisation. This takes forward our understanding of emotional labour in professional services. Going beyond this, we have also shown however that institutional logics do not simply dictate the performance of emotional labour, as there is space for doctors to choose, resist and negotiate between logics in the way they perform emotional labour. Overall, then, our ethnographic exploration of junior doctors identified the influence of multiple institutional logics in the performance of emotional labour within medical/surgical contexts. We also showed the agency of doctors in enacting the logics in their emotional performances, not only in the way they variously engaged with logics, but also in the way they 'stepped outside' the influence of these logics and at times engaged with patients as mutually socially-embedded actors.

Returning to prior theory of emotional labour and work context, Hochschild's original thesis focused on work which was oriented towards the customer and under close managerial supervision. On occasion patients, relatives and others were observed as playing the role of a healthcare consumer (Bolton, 2002) and doctors sometimes felt they had no choice but to provide consumerist empathy to their patients – by exaggerating, faking and cynically displaying empathy to consumers. Here, doctors might display emotions in order to please demanding consumers and to avoid potential complaints. At the same time, doctors were mostly observed to resist such subservience to the patient-consumer.

In some ways then emotional labour of junior doctors could be better seen as shaped by the dual-logics of rationality and customer-orientation, as invoked by Korczynski (2002). Certainly, a logic of bureaucratic-rationality dominated the organisation of junior doctors' work. This reflected both the position of junior doctors within the medical hierarchy, and also the changing structure of medicine in general over the past 40 years. The concept of the customer-orientated bureaucracy, however, is still not enough to offer a full picture of the logics informing the emotional labour of doctors. Our study also revealed the crucial role of the third logic of professionalism as guiding emotional labour processes. One way we observed this is through doctors offering a specific bedside manner – incorporating compassion and

empathy whilst also maintaining a degree of emotional distance. Professional empathy involved striking a balance between offering compassionate care to patients/their relatives while demonstrating their control over the encounter and status as experts. Particularly in the context of delivering bad news, doctors were observed to show compassion, repress/express specific emotions simultaneously, whilst offering small gestures of care (handholding, offering tea/coffee). As aspiring members of the profession, the junior doctors highly valued instances in which they were able to convey such professional empathy appropriately, and successfully performing professional empathy could be seen as important to them in process of becoming a professional. Overall, it is only by considering the way three logics together shaped the context of the junior doctors' work that their emotional performances could be understood.

Whilst our data reveal the influence of rationality, consumerism, and professionalism on the emotional labour of doctors, doctors still have a considerable degree of agency to navigate their work processes as they see fit. As theorised by Korczynski (2002), there is the potential for socially embedded exchanges involving workers and service-users. In this study, we observe doctors enacting processes of choice, resistance and/or negotiation when performing emotional labour. We also observe that small spaces exist for doctors to offer emotional interactions that are not influenced by logics of rationality, consumerism, or professionalism. Rather, these were socially embedded exchanges.

Processes of enactment are therefore important in understanding the degree to which doctors might engage with a specific logic; enactment processes also highlight that doctors maintain agency and can navigate imperatives of logics within constraints. Despite being a dominant logic, the logic of rationality appeared to be mostly resisted by junior doctors. Doctors might often remain emotionally neutral in light of resource restraints/increased efficiency, but this was in conflict with doctors' sense of professionalism (Reay and Hinings, 2009; Noordegraaf, 2015). The professionalism logic also prominently influenced emotional labour performances; this logic was observed to be chosen by the doctors.

Generally, the data showed doctors tending to resist the move towards the model of being subservient-to-the-consumer with many rejecting the notion of *patients as consumers*. In this light, influences of consumerism, and therefore consumerist empathy, tended to be resisted by junior doctors. Despite this resistance, there were occasions in which doctors felt no choice but to engage superficially with patients/relatives. During interactions with demanding individuals, for example, some doctors were observed to fake their emotions as a means of getting through these interactions. Similar findings have also been outlined in the context of nursing (Bolton, 2002).

Furthermore, doctors were observed to negotiate small instances of time and space which allowed for socially-embedded interactions. As noted above, for example, Lipsky (1980) states that there is difficulty in public servants offering an equal and meaningful interactional service to all users due to the resource restraints inherent within public sector work. Accordingly, doctors negotiate their work to offer more of their emotions to those they consider in need. This often resulted in socially-embedded emotional labour performances.

In addition, the imperatives associated with key institutional logics are often observed to blend/merge in organisational settings – we recognise that it can therefore be a difficult task to tease out distinctive implications of specific logics on micro-level interactions. Frontline workers are indeed as Bolton and Boyd (2003) describe ‘skilled emotion managers’. Considering that there were multiple institutional logics, emotional performances of doctors blur during interactional exchanges with patients/relatives and related-others. We therefore suggest that it is helpful to consider that doctors may choose specific emotions in specific circumstances. Doctors in surgery, for example, were often observed to offer neutrality when operating on patients. Doctors in general medicine, by contrast, were sometimes observed to offer an influx of emotion associated with plural logics at one time – this often depended on the individual patient case or situation which manifested on the frontline. Teasing out distinctive differences in emotional labour can be difficult because doctors maintain their own agency to choose what is most appropriate in the given context.

Conclusion

Korczynski (2002) and Bolton (2005) have made important strides in extending our understanding of how different imperatives inform emotional labour. However, the literature on institutional logics suggests a more comprehensive approach to the analysis of the factors driving the nature of emotional labour. In this article, we make an important theoretical contribution by conducting the first study to link institutional logics to emotional labour. We highlight the key institutional logics in operation at a hospital – the logic of bureaucratic rationality, the logic of professionalism, and the logic of consumerism – and show how they inform the emotional labour of junior doctors. Our analysis shows that the institutional logics do not simply dictate the nature of junior doctors’ emotional labour. There is some space for junior doctors to choose, resist and negotiate between logics, and also sometimes to step outside of these logics, in the way they perform emotional labour.

In addition to the theoretical contribution of the paper, we have made an important empirical contribution - by contributing to a growing body of ethnographies on the emotional

labour of doctors. Overall, our case study provides a textured sense of the emotional realities of the labour processes of junior doctors. We have shown the tensions, frustrations, anger, lonely tears, gentle shared humanity, and the search for professional pride in how junior doctors enact emotional labour processes. Previously, the studies of emotional labour in healthcare have focussed on nurses. Our study suggests that we must also recognise and seek to understand the emotional labour of doctors.

There is a clear opportunity to generalise from this study to similar contexts (Flyvbjerg, 2006). In addition to other healthcare settings, public service contexts such as further education and academia might also see the interplay of multiple logics at the institutional frontline. Public professionals are routinely subject to multiple, and frequently conflicting, imperatives over their work, and the current study highlights how these conflicting imperatives have a bearing not just on the technical aspects of labour process, but also their emotional performances. Future research can take this further, for example by examining other public service contexts in which the constellations or penetration of institutional logics differ. These contexts therefore might offer another opportunity to explore the identified logics in this study playing out in a similar, yet distinctive organisational field. Further opportunities for theory development include the exploration of additional institutional logics and how these might inform emotional labour processes within frontline roles. This also offers fruitful directions for future research.

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