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Management of Emotions in Accelerated Medical Relationships

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Anne Roelsgaard Obling

Doctoral School of Organisation
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Preface

This thesis is the result of an ethnographic fieldwork at a major university hospital in Denmark that I undertook between June 2009 and January 2011. I was an ‘embedded’ observer in a cancer clinic and entirely dependent on the staff – administrative and clinical – for access to facilities, people and diseases. That said, I was never asked to modify my writings in any way or to show the content of my field notes or tape recordings. Neither does the hospital have any formal share in the overall thesis. The responsibility for the final outcome is on my shoulders alone. As an embedded observer I was to handle personally sensitive data, such as specific details in patient records, with confidentiality. There is no information in my writings which can be traced – directly or indirectly – back to individual patients or relatives at the hospital and hence disclose their identity. My observations lasted anywhere from 20 minutes (the length of a typical staff meeting) to five working days in a row. During a day of observation, I followed doctors from they arrived in the early mornings; when they attended the morning conferences, until they left the hospital in the late afternoon after hours of clinical work in the outpatient clinic. I also followed them in their offices and in the operation theatres. Many tableaux from the thesis you are reading now were recorded in my notebook and then reconstructed in the later writing. Wherever possible, I have used my free access to the hospital to check the accuracy of my writing, for example by procuring typical situations more than once or by going through precarious details with involved staff members. Statements that appear in quotation marks (‘...’) were recorded directly on my tape recorder or in my notebook while the person was speaking, or immediately hereafter. Through the process I have shared my ideas with the staff members involved to make sure that they understood the purpose of my work and also in order for them to have a chance to feel comfortable with my presence. Throughout the thesis, I have shortened quotes from documents and interviews in order to make the text more readable.

In addition to my fieldwork at the hospital, I have worked with the sociologist Nanna Mik-Meyer. In her work, Mik-Meyer has focused on general practitioners and their preoccupation with patients who attend the consultancy with medically unexplained symptoms. Parts of the raw data material from some of her previous studies became the basis of a co-authored article, which is included in this thesis. Utterances from individuals described in this article are directly quoted from a larger quantity of interviews with general practitioners in primary care medicine.

Chapter 1: Introduction

‘Continuous reflection, foresight, and calculation, self-control, precise and articulate regulation of one’s own affects, knowledge of the whole terrain, human and non-human, in which one acts, become more and more indispensable preconditions of social success’
(Norbert Elias, *The Civilizing Process*)¹

Picture the scene. It is eight o’clock Thursday morning and the professional residents of a breast cancer clinic are gathered in the staff room. The setting is a prototypical meeting room for staff members; it can be located on every floor and in every department at the hospital. The room is narrow and opens up in the back towards windows with a vista to a large green leisure area flanking the side of the hospital. The meeting table is ellipse-shaped solid Scandinavian design, white as the walls and the colour of the staff members’ crisp uniforms. Every second Thursday, doctors, nurses, students, patient pathway coordinator, secretaries and heads of department meet in the conference room for an interdisciplinary staff meeting. The agenda of the meetings vary between introduction of new treatment methods, changes in IT systems, re-scheduling of tables in the operation theatres, problems with documentation of certain performances – for example nutrition screenings of hospitalised patients, presentation of new research and so on. Today, the issue to be presented and discussed in the plenum is a new model program developed by some of the nurses in the clinic. The model program addresses different work tasks and focus areas of nursing in a typical breast cancer patient pathway. In other words, it addresses what the nurses are supposed to do in different work phases of the pathway.

¹ Elias, N. (2000 [1939]) *The Civilizing Process*, Malden, MA: Blackwell Publishing, p. 398.

The staff room is already crowded because on Thursdays, as every other weekday, the doctors – including head of department, senior consultants, junior doctors and medicine students – begin their workday with mandatory participation in a morning conference, scheduled to start at a quarter to eight. The doctors occupy all the chairs around the table and the only chairs available for the rest of the staff are chairs located against the wall or near the very entrance of the room – with very limited view of the event. Hence, half of the attending staff participates in the meeting standing on their feet.

One of the nurses raises her voice and calls for attention. Prior to this, she has connected a laptop to a projector with help from one of the juniors. She is ready for her presentation of the model program, which she now introduces in front of a white-board:

‘We [the nurses in the clinic] have now rethought and developed our model program for patients diagnosed with tumour mammae [breast cancer] so it fits with how we [the clinic] have reorganised our accelerated, optimised patient pathways’

She shows her colleagues a PowerPoint slide of the detailed nursery tasks which are to be conducted when a patient visits the clinic after surgery to be informed by a doctor of the results of biopsies of her breast(s) and prospective post-surgery treatment. The PowerPoint slide is a one-to-one copy of a page in the model program. The page is divided into two columns: one named DOCTOR in capital letters and one named NURSE also in capital letters. The column of nursing is ten times the size of the column of doctoring. The few tasks described in the DOCTOR column mainly point out what kind of information the doctor must hand over to the patient, for example it says, ‘Providing information about definitive microscopic analysis answers’ and,

'Providing information about possible adjuvant treatment'. The written tasks of the nurses are different from those of the doctors. They are described as 'showing care and psychological support and being sensitive to reactions/frustration and taking action upon those feelings' and, 'talk with the patient about expressing thoughts and feelings in regard to surgery result/new surgery'. The presenting nurse patiently works her way down the two columns of specialised work tasks; reading out loud every written point on the slide and going through the material as going through a grocery list on a refrigerator door.

A senior doctor starts giggling and the audience of the meeting turns around to face her. She explains herself:

'I find it rather funny that this model program shows an almost urgent need to record that you nurses constantly conduct care work and psycho-social support to the patients. It's almost like it isn't one of the most profound tasks of doctoring to practice care and empathy in our everyday work. Perhaps, compared to you, we just don't need to record it every time we truly engage in care work. Don't you think that we [the doctors in the clinic] are empathic towards our patients? Don't we display empathic responses? Or is the problem that we, according to your standards, are not empathic enough in the multiple encounters we have with our patients?'

The senior doctor continues shaking her head while commenting on the PowerPoint slides, asking questions to the progressing presentation, while the nurse in front of the white board starts looking pretty annoyed and slightly resigned, as if she knew it would come to this. She has lost the attention of the audience and during the rest of the presentation, the doctors discuss in smaller groups how absurd it is for the nurses to proclaim the right to do 'sincere' care work and record proceeding acts of empa-

thy and emotions, while taking care of patients. The model program, which, apart from scheduling and outlining tasks of nursing in a typical breast cancer patient track, also addresses tasks of empathy work, is nevertheless fully demonstrated and later backed up by heads of department as a piece of 'solid documentation' of the accomplished work carried out in the clinic.

Why emotions and why now?

This thesis is about 'empathy', cancer illnesses, doctors and a increasingly persistent request for emotions in accelerated medical relationships. It is concerned with exploring the relationship between emotions in a cancer clinic and forms of professional conduct therein. A recurring line of argument in the thesis is that 'questions of emotion' offer ways through which we may come to understand how activities of individual human beings are interlinked with forms of social life. This means ways to consider the active, shaping influences between individuals and social, medico-scientific and political worlds. Furthermore, the attention to these questions – or more specifically to behaviour, feelings, gestures, impressions, sentiments, manners, affects, expressions, and etcetera, and the codes, norms and values directing and regulating them – can help us understand how individuals emotionally express and experience themselves in specific historical moments, organisational contexts and social situations. The case in question, the cancer clinic and its inhabitants, seems like a particularly apt case for studying empirically these themes, because of the recent introduction of so-called accelerated cancer pathways in the Danish health care system. And why is that?

The treatment of cancer illnesses is increasingly organised in terms of accelerated cancer pathways or 'cancer packages' (The National Board of Health, Denmark, 2008a). These so-called packages are part of a larger strategy to improve the overall health outcome by offering patients fast, effective and efficient care. The packages are characterised by streamlined patient flows; extremely standardised ac-

tivities; better techniques of micro-surgery and medication; early hospital discharge of patients; a growth of registration and documentation practices; a renewed focus on patient information and communication and implementation of waiting time policies. In addition, I will argue, they entail an increased regulation and training of the ‘soft’ side of the professional-patient relationship, e.g. ‘empathic communication’ and ‘interpersonal respect’.

In an atmosphere of rationalised and standardised medical work processes and performance measurement technologies, I want to suggest that the development of cancer treatment regimes has created some challenges in relation to the clinical encounter and questions of emotion therein. Moreover, I want to argue that the reason for this lies at the heart of what is known as contemporary modes of governance, where key characteristics are distributed accountability, audibility and efficiency (Power, 1997; Miller and Rose, 2008). This, I want to argue through the thesis, is inextricably linked with concerns of framing the direction and content of the clinical encounter, and hence, concerns about regulating the emotional engagement between doctors and patients.

Medicine is generally a field in which emotions are contested, negotiated, managed and produced, and the importance of emotions in health care has long been recognised by medical practitioners. However, its role in accelerated medical relationships is less straightforward. A natural consequence of today’s attempts of rationalising medical practices may be conceived as pushing doctors in a direction of less emotional engagement and more objective detachment from the clinical encounter. The rearrangements of the pathways leave little room for the provision of emotion management, and often leave us with the impression of a ‘cold’ doctor. What patients yearn for is empathic, engaged and responsive doctors who understand and attend to their personal needs (see, for example, The Danish Survey of Patient Experiences, 2010). Patients, relatives and lay people in general complain about a lack of ‘empa-

thy', 'responsiveness' and 'compassion' in clinical encounters. They request engagement, communication and extra-personal attention and empathy from the practitioners. This call for more 'warmth' in medicine has not been overheard. Both medical practitioners and scholars within the disciplines of medical humanities or narrative medicine agree that there is a need for recognising and offering 'psychosocial support' and 'empathy'. Notions of the 'empathic healer' (Bennett, 2001); the 'empathic practitioner' (More and Milligan, 1994) or the 'compassionate practitioner' (Gilbert, 2009) have emerged. Consequently, medical professionals are called upon – not only to be efficient and effective and to cure diseases and save lives, but also to perform 'authentic' or 'deeply felt' emotional engagement in interactions with patients.

Perhaps symptomatic, political debates regarding the rearrangements of cancer illnesses and their treatment mainly focus on the managerial aspects of streamlining the pathways such as the coordination of diagnostics and treatment processes across occupations, units, hospitals and sectors. One example is 'Governance of cancer pathways' (Dansk Sundhedsinstitut, 2008), which focus on the importance of 'well-defined standards for appropriate waiting times and quality; systematic monitoring and consequences of dismissing targets' (2008: 5). However, as is evident from the complaints from patients and practitioners, there is a concurrent need for better managing also the implications of the rationalisation and standardisation of clinical pathways on the way patients and professionals feel and cope during the treatment processes. I conceptualise this as a call for *management of emotions* in doctor-patient relationships. So far, this theme has predominantly been addressed in relation to the psychological and social comfort work done by nurses. Nursing practice is a textbook example of how professionals manage emotions in health care organisations, and, as a particular field of study, this has been covered at lengths. Far less so is this the case when we focus on doctors. Therefore, the focus of this thesis is to zoom

in on emotions in medical care, especially in relation to the conduct of doctors in a contemporary organisational framing of less time and calls for more empathy.

What is striking in the previously described morning meeting in the cancer clinic is the straightforward articulation of emotions in a context of a presentation of the recently rearranged pathways for cancer patients. Concurrently with the rationalisation of the pathways, which is manifest in the presented model program, the emotional aspects of the pathways emerge in the contexts as significant objects of interest. In the pictured example, we see how the presenting nurse tries to purify the conception of empathy, understood as empathic responses and empathic behaviour, from other work tasks in clinical practice. She furthermore monopolises it as a property of the nursing profession. However, her presentation is aggressively obstructed by a doctor who claims that empathy is already comprised in medical care. The doctor calls empathy a ‘profound task of doctoring’ and she claims that empathy cannot be separated from other skilful competences of a doctor, such as clinical reasoning or decision-making. The situation turns our attention to the possible connections between forms of empathy, rationalisation efforts – such as attempts of speed and standardisation – divisions of labour and professional conduct.

In trying to address this relationship, I use a simple analytical principle as my guide: to avoid the injunction of a priori distinctions between ‘emotion’ and ‘reason’; ‘emotionality’ and ‘rationality’; ‘passion’ and ‘logic’, and so forth. In the history of Western thought there is a long tradition of separating emotion from reason, seeing them as opposites and as different kinds. Emotions are often taken into account as something irrational that is perverting or disrupting reason. A classic example is Descartes’ placing of emotions in the corrupt body and rationality or reason at the centre of human identity. It is the emotions, passions and sentiments that are ‘the harm of this life’, because they are not an integral part of the mind and cannot in any way be absorbed into strict science (Rorty, 1986: 533). However, as argued by Jaggard (1989), the relationship between emotion and rationality has never been categorical

and the split between them not absolute. The metaphor of a charioteer steering a wild horse, originated by Plato in *Phaedrus*, is an enduring characterisation of this relationship between emotions and reason. Reason is the charioteer; emotions are the horses he tries to steer. In this model, emotions must be managed and directed by reason. This is not the same as stating that emotions need to be suppressed. Only an idiot would not express anxiety in precarious, frightening situations. However, even life-threatening situations are thought possible to stabilise through the channelling of appropriate emotions. Here, according to the interpretations of Plato, emotions have a function in the establishment of social order, which is also captured in the metaphor of a charioteer and his horses: imagine the function of the former without the powers of the later.

To avoid taking over the ‘work of purification’ (Latour, 1993: 31) in this study of emotions and, for instance, cementing problematic distinctions between emotion and reason, I will instead try to explore how such distinctions arise and become stable in various organisational contexts. Adopting such an approach also implies that it becomes impossible to separate emotion and reason from the specific historical moments and social situations in which they emerge. Hence, attention is paid to techniques and practices of individuals and how individuals use forms of emotionality, in what situations and for what purposes, instead of focusing on some restricted dichotomies that circumscribe how emotion or rationality might be described and understood on an abstract, metaphysical level.

This theoretical attention leads to an interest in exploring the relationship between emotions in a cancer clinic and forms of professional conduct therein. More specifically, I centre on the following research question: *how is emotion framed, trained and performed by doctors in accelerated medical relationships?*

The importance of analysing practice

The thesis addresses the everyday work of doctors in a cancer clinic. What I will present is an account of how doctors perform medical care in a tense climate of rationali-

sation and standardisation processes at a public hospital in Denmark. I argue that health care organisations are governed as profound territories of different and diverse concerns, and, in addition to this, I intend to show how changes of organisational contexts have massive implications for both professionals and patients – with an empirical focus on the former. My concern is political in the way that it addresses the concerns of practitioners in a concrete work setting. By political, I refer to an argument put forth by Clegg. He writes: ‘there is an ethical dimension to [...] organisation studies [...] the organisation analyst has a responsibility towards the subjects of that science. When we investigate organisations we also address the impact of major structures of society on the lives of ordinary people’ (Clegg, 2002: xxvi).

The thesis focuses on the changing conditions under which doctors are made to work. As the analyses, developed in later chapters of this thesis, will show, traditional ideals of medicine (such as objectivity and affective neutrality) will be called into question when attempts of transforming the health care sector anew necessarily include its professions and the conduct of its practitioners. As such, the thesis must be considered a work of critique, even though the criticism is not directed towards the medical profession *per se*. Instead, the thesis intends to lend support to clinical medicine. In her ethnography of atherosclerosis, Mol (2002) highlights in a similar way that her work ‘lends support to clinical medicine’ (2002: 183). She exemplifies this attitude with the statement that ‘surgeons only open up bodies if they think they can gain a curing result by doing it’ (*ibid*). The position of Mol is non-sentimental because, in her work, doctors’ conduct is investigated by looking at the practices – or in Mol’s own terms – the enactments constituting the medical activities in questions. Inspired by this attitude, I intend to go along with the key objective of doctors in the cancer clinic, which is to diagnose and prospectively cure people suffering from malign cancer illnesses, and engage directly with the individuals who undertake important and often lifesaving medical care. Hence, it may be possible to

support the ideals of clinical medicine and address the critique towards the changing techniques and technologies of contemporary health care practice.

I have no intention to produce a comprehensive account of medicine in general; that is, of how doctors think about and carry out medicine. Rather, I concentrate on just one element of medical care, namely how emotion is framed, trained and performed in a cancer clinic. The academic interest in emotion and the management of emotions is by no means new. Neither is the interest in the issue set in health care. There is a large and ever-growing literature on emotions and health and emotions and organisations – also literature that use hospital settings as research sites. Nevertheless, today's strong focus on effectiveness and efficiency in Western health care services and a pressure on public organisations, such as hospitals, to rationalise, evidence base and optimise their performances, reinstate the academic interest and poses new questions concerning emotion. And yet, among the things I hope to bring to this rising interest in emotion – in healthcare as well as in organisation studies – is a caution against sustaining the dichotomies being produced in, or as a response to, such rationalisation attempts. Instead, I will argue, there is need for empirical studies of the way emotions and rationalisation are co-developing in different forms.

Structure of the thesis

The questions of emotion are guiding the thesis and framing the individual chapters. The thesis is divided into two parts – a frame (Chapter 1-4 + 9) and four articles (Chapter 5-8). The frame begins with a description of the organisation of cancer illnesses and their treatment in the Danish health care system. Accordingly, Chapter 2 introduces the concept of 'accelerated medicine' and it explains the development of the so-called 'cancer treatment packages'. It further introduces the issue of emotions in accelerated cancer care and it pays attention to how questions of emotion arise from the empirical context.

Moving on from here, Chapter 3 deals with theories of emotions in organisations. In this chapter both classic sociological literature and more recent theories of emotions, social order and organisations are addressed. In addition to this, I review texts that focus especially on emotions in health care practice and discuss how some of these texts fall short in their approach to emotions because they tend to elevate emotions to the disregard of rationality and rationalistic activities. The chapter then moves towards a preliminary draft of my own theoretical approach, which is further developed in the remaining chapters of the thesis.

Chapter 4 explains a number of methodological challenges which accompany my qualitative study of emotions in a cancer clinic and its surroundings. It describes the situatedness of my PhD project and my access to the clinic and its occupants, and it explains how my object of inquiry developed over time – from foci to a developing focus on emotions. It also contains a relatively clean description of the conducted fieldwork; of the qualitative methods and the amount of material used for this research, and it describes how each analysis in the thesis takes smaller parts of the empirical material as its point of departure. Finally, it discusses problems of ‘involvement’ and ‘detachment’ (Elias, 1987) in the study of emotions and it pays attention to a kind of ‘methodological vocation’ which is described as the vocation of researchers to approach emotions without sentimentality.

In summary, Chapter 2-4 move steadily towards the analyses of the relationship between emotions in a cancer clinic and forms of professional conduct therein. The analyses are structured into the headlines ‘framing’, ‘training’ and ‘performance’ of emotions in order to analyse in detail the frames, techniques and practices which direct and regulate the conduct of doctors in everyday, accelerated medical relationships. I will now briefly address the aim of the four analyses. Afterwards, I will make a few comments on the relationship between them.

Chapter 5 explores how emotions are framed in medical relationships and it addresses how this framing equips doctors to act in certain ways in particular situations. Using the development of accelerated cancer pathways and a wide range of health care reform documents as an empirical case, the chapter explores how doctors are encouraged to become more emotionally available to patients. As the chapter demonstrates, this call for emotionality is accompanied by increasing demands on doctors to manage the emotions of others in recordable, measurable and standardised ways. To be a compassionate doctor involves an exhibition of a particular emotional behaviour in medical relationships, what Elias calls a ‘controlled de-controlling of emotions’ (Elias and Dunning, 1986: 44), namely that of a ‘sincere’ or ‘authentic’ behaviour which doctors are required to enact and to be committed towards. What this points to, I argue, is a set-up where health care reform documents encourage room for personal and unique concerns in medical relationships while expecting maximum acceleration and standardisation of these relationships.

Chapter 6 continues the investigation of questions of emotions through a discussion of how empathy and responsiveness, as specific techniques of emotion management, arise as the outcome of well-structured forms of training and practice in the cancer clinic. The chapter focuses on a training workshop in ‘empathic communication’ through which doctors from the clinic learn to recognise and control the emotional frame of doctor-patient interactions. It addresses how the training and practice of communicating empathically in these interactions rely on standardised scripts, which in turn direct and cultivate the conduct of the doctors involved. In line with the argument in the previous chapter, it concludes that humanistic values increasingly become the target for techniques of micro-management such as qualitative measurement and performance audit. In other words, the chapter argues that attempts to improve ‘soft’ dimensions of medical services entail a further standardisation of these aspects.

Chapter 7 addresses the question of how doctors relate emotions to their understanding of professionalism and principles of standardisation and speed in the treatment of cancer illnesses. In a present work environment of reforming and rationalisation drives, the chapter directly asks ‘how doctors feel’. This question is explored through doctors’ personal biographies of emotional experience and challenges in relation to their routine and everyday situations. The chapter explains how emotions and emotional display are frequently performed in a rationalised way to help doctors ensure the progress and efficiency of the accelerated treatment regimes. However, the chapter scrutinises how the rearrangements of cancer illnesses and their treatment into ‘accelerated packages’, and attempts to separate social and psychological dimensions of medical services from technical dimensions of these services, complicate doctors’ ability to incorporate emotions into their practices in a ‘proper’ way. What this points to, is the need for researchers to investigate how different forms of organising technical tasks within health care, entail different ways of organising emotions and emotional practices within this field, and how this generates organisational problems of all kinds for both patients and health care workers.

Chapter 8 completes the shift from the ‘framing’ and ‘training’ of emotions to concrete ‘performances’ of emotions in medical relationships. It makes this shift in a relatively radical way because it addresses questions of emotion through a study of how general practitioners (GPs) approach patients with medically unexplained symptoms (MUS) in primary care. Concerns about the role and function of emotions in the core of the medical enterprise come under closer scrutiny here, because the chapter explores how GPs are diagnosing with feelings. Accordingly, the chapter investigates how GPs diagnose MUS patients as legitimately sick patients. What makes this classification procedure difficult is that MUS patients fall inside a particular residual category in the eyes of the doctors. This defies the doctors’ capacity to decipher the patients’ intentions and motives, making it hard to empathise with them. To confirm

the subjective complaints of patients, the GPs must rely on their personal opinions and evaluations of a patient's particular circumstances when deciding whether the patient is legitimately sick or not. These different strategies for managing the complaints of patients are connected to ways of dividing individuals into certain categories of persons characterised by deviant features such as unpleasant personalities and manipulative appearances. The chapter emphasises how the affective connection between the patient and the doctor becomes paramount to the outcome – the diagnosis – of the clinical encounter.

This occupation with frames, techniques and practices through which doctors are equipped with the capacity to act as certain sorts of people, and how this particular performance takes form in practice, is manifest throughout the chapters. The connection between the 'framing', 'training' and 'performance' of emotions in medical relationships is investigated in detailed empirical analyses of how notions of 'compassion' and 'authenticity' emerge in the heart of accelerated, standardised medical services, and moreover, how doctors get to know about and manage peoples' feelings and make themselves emotionally available to others in social interaction.

Notes on the format of the analyses and their audiences

The PhD thesis is an article-based thesis. This means that it consists of a 'frame' and four separate articles. The articles appear in different stages 'outside' of this thesis: A translated and shortened version of Chapter 5 'The compassionate doctor' has been accepted for publication in Järvinen, M. and Mik-Meyer, N. (eds) *What makes a professional?* (In Danish: *Hvad skaber en professionel?*), Copenhagen, Hans Reitzels Forlag (June, 2012).

Chapter 6 'Training of controlled empathy' has been accepted for publication in a special issue of the Danish journal, *Forskning i Sygdom og Samfund*, (September, 2012).

Chapter 7 'Doctors' emotional experience and challenges' has been accepted for publication in *Journal of Health Organization and Management*.

Chapter 8 'The negotiation of the sick role' has been accepted for publication in *Sociology of Health and Illness*, Vol. 34 (7), (September, 2012).

Chapter 2: Organising cancer illnesses in the Danish health care system

Introduction

A cancer clinic at one of the most specialised university hospitals in Denmark makes up the empirical foundation of this inquiry. The clinic is a surgical unit, specialised in breast cancer diagnostic and treatment. It is located on the 10th floor of a tall building in the centre of Copenhagen. The clinic comprises consultancy rooms, ward, doctors' and nurses' rooms, common staff meeting rooms, cleaning rooms, kitchen, storing rooms and so on. The operation theatre is located on the third floor and so are most of the doctors' offices. The clinic is staffed by 15 doctors, including senior consultants, assistants and juniors. In addition to this, nurses, secretaries and coordinating staff are employed in the clinic. Recently, the clinic has been merged with another surgical unit and is now part of a huge clinic with newly appointed heads of department. One of the senior consultants, interviewed as part of this research, described this merging as being 'a matter of administrative cuts'. He furthermore explained that 'the merging with the other clinical unit has yet no experienced effects when it comes to our daily work, namely the diagnostic and treatment of women with breast cancer'. His words justify why I have chosen to describe the cancer clinic as an autonomic clinic throughout the thesis, hereby leaving the merging of the two clinics aside when it comes to empirical attention.

The cancer clinic is a typical example of a sub-specialised unit where most of the patients are diagnosed with the same illness, namely that of breast cancer. Annually approximately 12.500 (2009 numbers) patients attend the clinic, out of which 860 are diagnosed with cancer and thus undergo surgical treatment in the clinic. The homogeneity of the clinic's patient sample – in regard to its unifying illness label – makes it possible to describe the patient trajectories of the clinic in terms of one single standardised patient trajectory, which every patient attending the clinic goes through. I term this patient trajectory '*accelerated cancer pathway*' and in the

next section I will describe in detail what the term comprises. The aim of the description is not only to give the readers a general familiarity with the term, but also to set down some of the basic premises on which the thesis' arguments rest. By talking about these premises, the reader may come to think of the subject matter presented here as a mapping of current forms of organising cancer illnesses and their treatment. This mapping is only partial but nevertheless adequate for the purpose. It provides a backdrop for my selection of facts, people and stories from the cancer field and helps to define the purposes that the rest of the thesis will have to satisfy.

From melancholy to present forms of organising cancer illnesses and their treatment

A very brief medical history of breast cancer illness goes back to Claudius Galen, a Greek doctor and biologist living in the second century who believed that cancer in the breast region was caused by excess of black bile, which is the Greek word for melancholia. Galen's observation inserts an early historical interest in the relationship between emotion and cancer, because melancholy was used to label someone who was both depressed and emotionally reserved and non-assertive (Giese-Davis and Spiegel, 2003). The therapeutic consequence of this belief was that patients were offered purgation and bloodletting services. Those patients who died because of the treatment were either patients who were not sufficiently convinced in Galen's methods or patients who lacked the constitutional vigour to sustain prolonged bloodletting (Baum, 2007).

It was not until the second half of the nineteenth century, that breast cancer became accepted as a disease of cellular pathology within the breast and it was recognised as a disease which spread along the lymphatic system to other areas of the body. From 1894 up to the last half of the previous century there was only one standard procedure in the treatment of breast cancer: the routine use of radical mastectomy (removal of the breast). The treatment can be traced back to Dr. William Stuart

Halsted, who was professor in surgery in the beginning of the 20th century. Halsted's hypothesis was that breast cancer is a locoregional disease which spreads from its origin. The way to cure cancer patients was to eradicate the localised disease. In the 1950's, the mastectomy method was supplemented by radiotherapy and it was now possible to perform a less mutilating mastectomy. In the beginning of the 1970's, adjuvant treatment (medical oncology) was developed. Around the same time, research made it possible to divide patients into high-risk or low-risk groups based on the number of positive lymph nodes found in the patient's body. These developments changed the treatment of breast cancer into a systematic approach where treatment was directed towards the spread of the disease. During the last two to three decades new medical technologies have been developed such as steadily more intensive adjuvant treatment; sentinel lymph nodes biopsies and minimally invasive surgery. Generally, more gentle treatment methods have thus been invented to both meet increased demands for quality and to make interventions safer (Kehlet & Wilmore, 2002).

The Danish Breast Cancer Cooperation Group (DBCG) was established in 1977. The objective of the DBCG project was built on an aphorism by the famous surgeon – and founder of the Mayo Clinic – Dr. Charles H. Mayo, whom in 1916 proclaimed: 'The keynote of progress in the 20th century is system and organisation' (Blichert-Toft et al., 2008). The purpose of the DBCG was to standardise the treatment of breast cancer with reference to novel therapeutic principles of diagnostic and treatment. The establishment of the group changed the ways in which surgical and non-surgical partners collaborated in a systematic way. As a multidisciplinary professional group, DBCG developed – and continues to develop - guidelines for databases, translational research, platforms and other infrastructure (Overgaard, 2008).

The guidelines developed by DBCG follow diverse quality assessment programmes of the Breast International Group (BIG), and are consistent with international standards for breast cancer treatment. Today, nearly all treatment units in Denmark have applied the DBCG guidelines for diagnostic procedures, surgery, ra-

diotherapy, systematic therapy, and follow-up for early-stage breast cancer. The clinical guidelines are used by the doctors in their daily medical work and they guide clinical judgment and medical decision making processes in the treatment of patients. These guidelines became fundamental building blocks for the cancer treatment packages to which I now turn.

In 2000 the clinical focus on cancer illnesses and their treatment was directly coupled to economics, and political and customer concerns. In 2000, The National Board of Health, Denmark (NBH), introduced the national: ‘Cancer plan: Status and suggestions for initiatives concerning the treatment of cancer’ (NBH, 2000). The cancer plan report was initiated by The Danish Ministry of Health as a consequence of a public debate concerning the overall quality of cancer services in Denmark compared with other Nordic countries. An epidemiologic task force found that Danish cancer patients had a lower chance of surviving their cancer illnesses viewed in a five years perspective compared to patients in their neighbouring countries (2000: 37–46). The report concluded, among other things, that new ways of organising cancer treatment – including ‘the organisation of work and work methods’ – may raise the quality of cancer services and thus lead to a reduction in mortality (2000: 13-18). Furthermore, the report stated that accelerated diagnostic procedures and surgical interventions are significant means to improve these services and thus improve their outcome. The report also recommended the implementation of breast cancer screening programs. Between 2000 and 2005, the screening programs were implemented nation-wide. In addition, in 2001, the Danish Government introduced a ‘waiting time guarantee’ assuring every patient with suspicion of cancer a right to get diagnosed by a specialist within two weeks. And from the day of diagnosis to the day of treatment, the waiting times were limited to maximum two weeks. The waiting times were politically defined and covered a diverse range of cancer illnesses (also cardiovascular illnesses were covered by the guarantee).

However, the implementation of various means to improve the outcome of the services provided was not without problems. The introduction of politically defined waiting times led to the problem of keeping the waiting time promises. And the screening programs led to an increased amount of women diagnosed with early stages of breast cancer which raised the total healthcare expenditure on cancer treatment services. Also demographic changes, such as an ageing population in need of cancer treatment brought about by increasing life expectancy, had a financial impact on the health care system.

Generally however, these organisational challenges were not met with a huge supply of financial resources to the cancer field. Instead, they were met with concrete attempts of organisational change, as I will turn to next.

Introducing the terms ‘packaged care’ and ‘accelerated cancer pathways’

In 2005, in continuation of the first cancer plan, the NBH published a follow-up plan with the name ‘Cancer Plan II’. It specified a new organisation of cancer care in the Danish health system and described how concrete organisational actions were connected to centralised monitoring systems in order to systematise cancer care services across hospitals departments, sectors and individual practitioners. An important aim of this second report was to ‘provide a well-organised packaged trajectory to cancer patients on the highest possible international quality level without unnecessary waiting time’ (NBH, 2005a: 10). The report understands the term ‘well-organised’ in relation to activities which are planned and performed by health professionals in a focused manner and with a high degree of application. This entails that necessary resources must be assembled. The report wrote that ‘taking departure from a range of well-organised work tasks and patterns of co-operation makes it possible to establish a patient trajectory where the individual patient – without unnecessary delays and efficient allocation of resources – is offered an uninterrupted series of treatment from general practise to involved hospital departments’ (2005a: 7). This series of diagnos-

tic and treatment procedures, the report recommends, must be organised in ‘packages’: standardised, accelerated pathways. In this way, the term ‘cancer packages’ (in Danish: ‘Kræftpakker’) is introduced as standardised trajectories to patients who are suffering from cancer illnesses and which ensure that the majority of the patients diagnosed (or with suspicion of a diagnosis) within specific cancer categories (e.g. lung cancer; breast cancer or gastric cancer) can be offered the same ‘package’ of therapeutic processes, and can expect a minimum of delays at hospitals and across primary and secondary health care sector. The organisational design of ‘cancer packages’ was intimately associated with another widespread concept of ‘accelerated medicine’, which also took form in these years. Both concepts emerge from an ambition concerning the establishment of economic, effective and efficient patient trajectories in the health delivery system. The overall focus of the concept of accelerated medicine is an optimisation of the organisation of professional work processes through increased interdisciplinary teamwork, implementation of technological interventions (for example micro-surgery) and formalisation of communication and patient information. Through these means, the concept aims to reduce the patients’ length of hospital stay and hence release resources and capacity to be used elsewhere in the public health care sector (The Secretary of Ministers, 2007). I use the term ‘accelerated medicine’ as an assemblage term to capture core connotations of the concept, such as ‘packaged diagnostic and treatment’; ‘optimised care’; ‘accelerated trajectory’, ‘fast track surgery’ and ‘early recovery’. I also intend to use the terms ‘accelerated clinical pathways’, ‘optimised clinical pathways’ or ‘treatment packages’ more or less synonymously through the text.

Under guidance of NBH, task forces were appointed to develop the concept of ‘cancer packages’ within specific illnesses. In 2008, a ‘Breast cancer package’ report saw the light of the day (NBH, 2008a). The report described a standard trajectory for breast cancer patients – from they visit the general practitioner in primary care, get diagnosed at the hospital, undergo surgery and adjuvant treatment to control

programs and palliation. Processes of nursing care, communication and patient information are also specified in the material. In the trajectory description, psychosocial support procedures are explained as essential for the outcome of the trajectories. These kinds of procedures are defined in a separate document as ‘the health professionals’ specific efforts in relation to psychological, emotional and existential dimensions of the entire trajectory’ (NBH, 2008c: 5). The efforts are integrated with the clinical actions of the trajectory as concrete work activities which must be performed by the doctors in relation to every patient undergoing diagnostic and treatment in breast cancer clinics. The trajectory description, which determines activities of accelerated clinical cancer pathways, is evidence based, national and nation-wide guidelines and recommendations, or so the report says (NBH, 2008a). In cases where no evidence is available, the trajectory descriptions are based on ‘best available practice’. In the particular case of breast cancer illness, it is the previously mentioned DBCG guidelines that support most of the actions in the trajectories. This model explains the treatment phase of the trajectory and its different work activities (clinical, logistic, information, specialty, monitoring):

Clinical action	Logistic action	Patient information	Medical specialty	Monitoring
Pre-examination in the out-patients clinic	Booking: surgery	<ul style="list-style-type: none"> • Delivery of diagnosis • Plan for further action • Informed content • Summoning: surgery 	Surgeon	Monitoring: informed content
Hospitalisation			Surgeon	Monitoring: treatment start

Surgery			Surgeon	
Histology result			Pathologist	
Decision: <ul style="list-style-type: none"> Chemotherapy, hormonal treatment and radiotherapy 	Booking: consultation in the out-patients clinic	Summoning: Consultation in the outpatient clinic	Multidisciplinary team	
Consultation in the out-patient clinic	Booking: <ul style="list-style-type: none"> Oncological pre-examination GP: Epicrisis (case summary) 		Surgeon	Monitoring: surgical treatment finished

Model 1: A trajectory model, NBH, 2009a: 22

The rubric ‘patient information’ describes in bio-medical terms some concerns about the diagnostic moment and judgments about treatment plan. The rubric ‘clinical actions’ describes the various forms of clinical activities in objective pathological categories.

In the breast cancer trajectory model two formalisation aspects are present: detailed and precise specification of tasks and responsibilities of medical specialties and individual practitioners within an ordered process line of medical work. Every performance of the trajectory is specified and the performances are routinely monitored. Furthermore, it is co-ordinated and integrated via a complex IT-based system that makes it possible to measure the output of the cancer programs on a central-

ised level. This is to measure the development in productivity rates and to measure ‘the time span from hospital referral to treatment’ (NBH, 2011). The treatment phase of the program and a specification of time standards coupled to the different work tasks can be presented like this:

- 0 Day. Managing patient referral; booking of patient-doctor consultations and examinations
- 3 Day. Preliminary examination (including clinical examination); patient information; patient interview (nurse, anaesthetics, physiotherapist); eventual supplementing picture diagnostic tests
- 6. Day. Patient time to use for reflexion
- 6. Day. Valuation of co-morbidity
- 7. Day. Surgery (hospitalisation and (optimal) discharge of patient)
- 8. Day. Eventual discharge of patient

Model 2: A treatment phase model, NBH, 2009a: 13-15.

This is a standard example of a trajectory in a cancer clinic, running from the moment a patient is examined for breast cancer, receives a cancer diagnosis, undergoes surgery and is discharged from the hospital. This leaves the doctors in the clinic with eight days to make an exact diagnosis; to make preparations; provide emotional or psychosocial support; remove the cancer tumour, stitch up the patient and discharge the person from the clinic. The trajectory description codifies general processes of a breast cancer trajectory, as opposed to clinical guidelines which function more as specific tools or practices in a medical line of work. So-called ‘time of sequences’ of the trajectories are written in the left column of model 2. These time estimates are

also measuring points from where the clinic is hold responsible for meeting or failing to meet the standards.

The cancer clinic in my study was well-prepared for the introduction of these ‘cancer packages’. From programs of accelerated medicine, manifest in the clinic by concepts of fast track surgery and early recovery (Kehlet and Dahl, 2003), the clinic had already developed local initiatives for accelerated procedures which included standardised drug modules (to prevent post-operative pain and nausea), technical interventions (early removal of drainage tube) and changes in patient passages between department units – for example, most patients are removed directly to the clinic ward instead of trespassing through the hospital’s recovery ward (Gärtner, 2010; Mertz et al., 2009). Procedures of extended information to patients had also been implemented. The nurses for instance now call the patients after their discharge to make sure that newly operated patients are generally well-functioning according to standards of physical and emotionally recovery.

It is not hard to detect how the cancer clinic and the conducts of its doctors and nurses follow strictly formalised rules in the accelerated cancer pathways. In addition to this well-ordered line of activities, another important dimension in the cancer clinic has been standardised and accelerated: something which in the trajectory descriptions goes under the names ‘psychosocial support procedures’, ‘communication’ and ‘patient information’. I will now turn to this issue.

Introducing the ‘soft’ dimensions of accelerated cancer pathways

Simultaneously with the introduction of the two national cancer plans, a report issued by the Danish Ministry of Interior and Health was published under the headline ‘The patient’s encounter with the health care system’ (The Ministry of Health and Interior, 2003). It says in the report that it focuses on ‘so-called human relations, which are often referred to as “the softer values” of health care services’ (2003: 3). Furthermore, it explains that it aims to improve these soft dimensions of medical care

through initiatives to rearrange professionals' work activities. The report suggests that hospital departments promote an organisation culture where professionals possess competences to recognise the 'values, feelings, assumptions and thoughts of the patients' (2003: 8). To be able to promote and frame such a culture in the clinic, the professionals need to undergo 'supervision, training and education in a variety of communication techniques' (2003: *ibid*). The report recommends that professionals 'display sincerity, responsiveness, trust, engagement' in the practical execution of diagnostic and treatment procedures (2003: 9). It states that the individual professional must provide the way for patients to 'display their emotions in a spontaneous way' in their encounters with the health system (*ibid*). Professional involvement in the provision of cancer services implies 'combinations of emotional and practical conduct' (2003: 32), the report explains.

This kind of professional conduct is likewise promoted in a report from The Danish Cancer Society (KB), simply covering 'The world of the cancer patient' (KB, 2006). Based on an extended patient satisfaction survey, the report articulates cancer patients' need for an improvement of health services: 'Cancer patients far from receive the optimal treatment they need. Especially their needs as individuals and human beings are often let down or left unrecognised' by the health care system (2006: 2). This call for improvement of cancer services thus includes an improvement of the health care workers' psychosocial or therapeutic competences. The workers need to understand the individual patient as 'a unique person instead of merely a number in the line of patients in the trajectory' (2006: 17). As described in the report, one way to meet the patients' needs is through the improvement of communication or communication skills. The report especially appraises 'good communication which includes empathy, respect, responsiveness, and time and engaged presence of professionals' (2006: 16) as a significant element in the organisation of accelerated cancer pathways. Here, communication is understood both as a practical skill – for example in relation to the delivery of information – and as a therapeutic skill which may help

to improve ‘cancer patients’ psychological, emotional and spiritual health’ (2006: 15). Through the medium of communication, doctors can become emotionally available to cancer patients.

The ‘National Cancer Plan II’ (NBH, 2005a) refers explicitly to the recommendations of these reports, and the above mentioned ‘soft’ dimensions of medical care are written into the cancer plan’s appendix. In this way, the recommendations are also represented in the breast cancer trajectory description under the headlines ‘patient information’, ‘communication’ and ‘psychosocial support to patients and relatives’ (NBH, 2009a). In the description, this inclusion of these dimensions are furthermore emphasised as proper work. The definition suggests that it takes continuous efforts and time to include these dimensions as ‘an integrated element of the entire achievement which is – and should be – offered to patients in every phase of the illness trajectory’ (2009a: 28).

In the local cancer clinic I have researched, it is widely acknowledged among the doctors and nurses that for instance communication and information play a significant role in the accelerated treatment pathways. These activities are therefore not only evident in the generic trajectory descriptions. They are also written into the clinic’s local procedure plans (see for example The Cancer Clinic, 2009). To be able to meet the aims of early recovery and discharge in the pathways, the patients are required to understand the various steps of the trajectory in detail. This includes that they are prepared to make an informal approval of the services offered, to undergo treatment and leave the hospital shortly afterwards. The clinic’s procedure plans describe in what way the patients who undergo accelerated procedures of diagnostic and treatment will be prepared by doctors and nurses in the clinic for the coming interventions. This preparation work is explained on a practical level (‘inform the patient about diagnosis and treatment’) and on an emotional level (‘communicate with the patient about the need to express feelings and thought in relation to the cancer illness’). As also emphasised in the trajectory descriptions, the delivery of information

and psycho-social support to patients is monitored alongside, for instance, a recording of clinical activities. The clinic's local monitoring process involves that these elements are written into a patient record system in a standardised language in order to be externally extracted – for example when the clinic receives audit visits from the hospital's department of quality or international accreditation agencies.

In 2012 the cancer clinic and the surrounding hospital will be accredited by the Danish Quality Model (IKAS, 2009). The cancer clinic has been accredited four times since 2000. In relation to previous audit rounds, the delivery of standardised forms of psycho-social support and communication will, according to centrally placed audit officers at the hospital, be a new, important topic of interest for the accreditation agency. Central to this procedure is the quantitative measurement of doctors' manners and behaviour within medical relationships.

The rest of this thesis will mainly be devoted to examining these so-called 'soft' dimensions of medical care. My argument will be that the development of accelerated cancer pathways involves some means of adjusting the conduct of doctors. These means may insert new emotional injunctions to doctors, which involve that certain emotions are explicitly framed, trained, performed and monitored in the clinic for the purpose of improving the overall service outcome of the cancer trajectories.

Chapter 3: Theories about emotions in organisations

Introduction

Emotions in organisations have taken up considerable research interest in recent decades adding new perspectives to the classic sociological literature on the topic. However, a number of analytical challenges seem to accompany this interest. First, there is a lurking tendency to separate emotions as distinct from 'rationality'. Second, there is a related tendency to elevate emotions as more 'authentic' or 'sincere' than rationality. Third, many recent texts are prone to a sentimental tone regarding emotions. I intend to pay attention to these challenges while I read a selection of theories and texts that addresses and debates emotions in organisations.

In this chapter, I will first address both classic literature and more recent theories on emotions, social order and organisations. I will make a short introduction to the study of emotions in social sciences and address an interest in 'questions of emotion' across academic disciplines. I will demonstrate how an interest in emotions and affectivity occupy an important place in Weber's theory of emotions in modern bureaucracies, Parsons embracing of emotions in his theory of social action and Elias' exploration of a long-termed civilising process of increasing affect-control. Next, I will show how the concern with questions of emotion is also written into the sociological literature by a later generation of sociologist such as Goffman, Hochschild and Strauss. These three theorists pursue William Shakespeare's dictum, 'all the world is a stage and the men and the women merely players'. By doing this they embrace emotions in a micro-sociological perspective with an explicit focus on the daily, step-by-step efforts, taken on by each member of society to constitute a functioning social order.

Second, I will address texts that specifically focus upon emotions in health care practices. The first body of research in this section will argue that emotions are important social components in organisational functioning of health care

organisations. The second body of research will envision, through the nursing profession, how emotions are personal properties that can be used, manipulated and controlled in the hand of others.

Third, I will discuss and outline a theoretical framework which combines the approaches without falling prey to the three aforementioned analytical challenges. This framework will open up different perspectives in relation to the remaining chapters of the thesis.

Emotions and epochal battles in social sciences

In the last decades a significant interest in emotions has arisen in the social sciences. Authors have phrased this interest as a sign of an ‘affective turn’ (Clough and Halley, 2007); a ‘new epistemology’ (Athanasion, Hantzaroula and Yannakopoulos, 2008); an ‘affective society’ (Watson, 1999), and a ‘post emotional society’ (Mestrovic, 1997). Some authors have even characterised contemporary society as ‘generation emotion’ (Ankowitsch, 2002). The fields in which this intellectual attention to emotions expands are many. It includes anthropology, psychology, sociology, political science, education studies, geography, philosophy, genetics and neuroscience.

One can also witness an increase in the interest of questions of emotion within organisation and management studies. While the topic of emotions was largely non-existing in organisational studies in the second half of the twentieth century, today, many researchers are writing emotions back in the game. The acceptance of and interest in emotion-oriented research is manifest in a range of special issues of journals that hit the newsstands these years – for example *Human Relations* (2007); *Human Resource Management* (2002) and *Journal of Health Management and Organisation* (2005). The journal *International Journal of Work, Organisation and Emotion* also testifies this interest. Strangely – as if by an act of academic interaction – while doing research for this chapter I received a call from *The Journal of Political Power* for a special issue on ‘Power and Emotion’, where the editors frame emotion (and power) as essential features of the conduct and constitution of social life.

The above occurrences point towards a revitalisation. The organisation theorist, Stephen Fineman, situates the status of emotions in organisation studies in *The Sage Handbook of New Approaches in Management and Organisation* (2008). He writes:

‘In the past decade or so emotion has moved from being a marginalized, even silenced, discourse in organisational and management studies to being something of a “must” [...] Emotion is no incidental fuzz to “proper” business, but a substantive feature of what happens and what matters’ (2008: 239).

Previously, organisation studies have indeed been occupied with addressing emotions and emotional aspects of human behaviour but they have done it, I will argue, along the lines of what is expressed in the above quote of Fineman, in ways that effectively separated emotions from organisational life. A well-placed example is Morgan’s (1986) image of the organisation as a psychic prison that fosters a kind of ‘production psychosis’ where individuals’ feelings are trapped in the rational structure of the organisation (1986: 224). Along the lines of this captivating image, organisation and management researchers have traditionally approached emotions as vital objects of resistance or as individual properties that were being hemmed in by rational organisation structures in the service of predictable means and ends. These previous attempts – as illustrated in Morgan’s theorising – to overcome an apparent neglect of emotions tend to reproduce the ontology of the older approaches – for example Frederic Taylor’s rationalistic technocratic theories of organisations (see for example Taylor, 1967 [1911]) or Weber’s work on rationalised bureaucracies (see for example Weber, 1978 [1925]) – that they were critical of. In relation to organisational analysis, these attempts fostered some guiding principles of ‘individual feeling’ on one side and ‘organisational rationality’ on the other (e.g. Albrow, 1994), which in my opinion is not

suitable for a coherent understanding of how emotions function within the framework of organisational life.

The contrasting position developed and offered throughout this thesis is therefore quite different from the above example. Emotion and reason are seen as intertwined components constituting the activity or the conduct in question both for the organisations and for the individuals. My analysis of emotions at work in a cancer clinic thus departs from the traditional principles of ‘individual conduct’ and ‘organisational conduct’.

As I have mentioned in the introduction, a small group of sociologists have sought to explore ‘questions of emotion’ through their theorising on persistent sociological concerns – for instance the question of ‘individual’ and ‘society’. Even though Weber, Parsons and Elias, whom I will turn to next, wrote in manners motivated by a faith in empirical science and the capacity to observe human behaviour and social arrangements by highly detached means (Greco and Stenner, 2008), they all had a profound interest in the place of emotions in modern society.

One of the reasons for turning to these classic sociological approaches to understand emotions at work in a cancer clinic today, is to overcome the always present danger of claiming a unique novelty associated with the study of emotions; an approach, which easily would oversee historical continuities and important achievements within previous research. Roughly spelled out, one might even say that we do not need new theories of emotions. Instead, what are called for are detailed empirical inquiries of already existing propositions that arise from domains of already existing social theory. It might be that there has been a tendency towards emotion-related studies in different fields over the last decade, but emotions per se have always been an integrated part of understanding. As a means to stay away from redescribing ‘epochal battles’² (Hunter, 2006) and to avoid approaching questions of emotion in a

² Making epochal claims have a long history in the academic tradition. The main problem with making different classifications of forms of society (such as, for example, ‘affective society’, ‘acceleration society’, ‘network society and et-

overly sentimental way, for example by approaching them either as novel ‘objects of resistance’ or as pure ‘sources of documentation practice’ (see my introductory story from the cancer clinic), this chapter will seek to establish a nuanced, combined theoretical framework. This framework will point both backwards in relation to its engagement with classic sociological concerns of human conduct and lead forward in relation to situating the inquiry in a very contemporary context. Also academia stands on the shoulders of giants.

Weber and emotions in bureaucracy

In his work, Weber linked bureaucratic forms of rationality with the rise of modern capitalism. The prime manifestation of the rationalising process was the emergence of the bureaucratic organisation. This organisation type was designed to achieve specific goals, characterised by a high degree of division of labour and detailed norms and rules that governed the behaviour and manners of the employed staff in a certain way. The bureaucratic organisation was an almost perfect rational form because it stands under the principle of *sine ira et studio* (in Latin: ‘without hate and zealotness’). For a bureaucracy to develop the most efficient methods of achieving its goals, it must depersonalise every possible work procedure. This vocation explains the codes of conduct guiding the activities of the individual employee – including principles of self-control and, not least, self-constraint. Weber writes in *Economy and Society* (1978):

‘Bureaucracy develops the more perfectly, the more it is “dehumanized”, the more completely it succeeds in eliminating from official business

cetera) or turns (‘affective turn’, ‘emotional turn’, ‘linguistic turn’ and etcetera) as the point of departure, is that one tend to emphasize societal changes as essential, leaving previous conceptualisations of existing orders behind as something completely different from new emerging forms. See for example Schanz’s critique of postmodernity (Schanz, 1999) or Hunter’s discussion of intellectual ‘epochal’ battles in social sciences and humanities, and how these battles have provoked endless, yet fruitless, series of dialectical reconciliations (Hunter, 2006).

love, hatred, and all purely personal, irrational, and emotional elements which escapes calculation’
(1978: 975).

In this sense, emotional conduct is dismissed as being irrational merely because of its lack of calculability; its instances of impulses and, not least, because of its foreignness to official rule following. Weber further writes:

‘[He] performs his duty best when he acts without regard to the person in question, *sine ira et studio*, without hate and without love, without personal predilection and therefore without grace, but sheerly in accordance with the impersonal duty imposed by his calling, and not as a result of any concrete personal relationships’ (1978: 600).

A straightforward interpretation of this statement may be that Weber and his ideas of bureaucracy eliminate everything which cannot be made calculable, namely individual and unruly emotions. In extension of this interpretation, some authors have argued that the rule-based iron cage of organisational control suspends the emotional elements of the individual and leads to an increasingly dehumanisation of organisational life. One strand of this argument stems from the work of Bauman for whom instrumental processes of the rational bureaucracy result in a ‘dehumanisation of the objects of bureaucratic operation’ (quoted in Du Gay, 2000a: 40). Hence, one of Bauman’s concerns is to save elements belonging to the emotional, irrational and private sphere from the rational, non-emotional and public sphere. The work of Weber has indeed been approached from different positions, and my suggestion is that we look for alternatives to Bauman’s dualistic account if we are to understand emotions and reason as intertwined modalities of human conduct. In relation to my analysis of emotions in a (bureaucratic) hospital setting, I find it useful to reflect on how We-

ber's theorising on questions of emotion gives way to thinking about particular work settings and the forms of conduct which emerge from these settings.

Du Gay challenges the 'dehumanisation thesis' by stressing that the emphasis upon depersonalisation in Weber's work, for example when Weber (1978) writes 'that bureaucracy develops the more perfectly, the more completely it succeeds in eliminating from official business personal, irrational, and emotional elements' (see full quote written above), is a commitment to the purpose of the office, independent of personal idiosyncrasies. For Du Gay (2000a), the stress on *impersonality* as a crucial feature of bureaucratic rationality in Weber's descriptive analyses, is not tantamount to a denial of humanity or emotional relations as long as 'these do not undermine the ethos governing the conduct of that office, through for example, opening the doors to corruption or encouraging inappropriate forms of patronage' (2000a: 75). If we follow this line of thought, we see how Weber does not dismiss emotions as such, as long as they do not set aside formal procedures of the office. In this regard, a good medical professional for example, is 'impersonal' in a manner which is objective, so she or he is able to attend to the matter at hand. Hence, the conception of impersonality also refers to professional work activities and the professional (bureaucratic) capacity to treat for instance clients as cases, without paying attention to their status or personal attributes, such as type of personality or (deviant) character. This is clearly the case in the cancer clinic, where doctors must decide upon cases unaffected or unbiased by personal relations. The bureaucratic regulation of emotions has two main purposes. First, it shields the employees from getting (too) emotionally involved in particular cases. Second, it protects the recipient of bureaucratic services, the person who attend the office for help, from being judged according to the office holder's personal motives.

To some, the preoccupation with emotions in Weber's work – as a companion to reason – might be a surprise in the light of readings of more traditional understandings of Weber and his genealogy of the *Berufsmench*. However, his concep-

tion of rationality and rational action might not be a definitive. Most obviously, Weber's analyses of 'charismatic authority' (1978: 241-245) demonstrate how processes of rationalisation do not lead to a disappearance of emotions or an emotional deficit. Instead, emotions are redistributed in a variety of different forms of conduct through social life. Reason and emotion, in short, are never entirely separable. According to Hennis (2000), Weber himself was horrified by 'the emergence of which was the central theme of his studies: the arrival of the "specialists without spirit" and – perhaps even more topically – "sensualists without heart"' (2000: 80).

Certainly, Weber does allow for emotions in the bureaucratic office as long as they are a part of rational work processes and not, for example, an exercise of personal patronage, based on holistic beliefs or magic talents. We also see how the management of emotions in public administrations has profound value for the social order and for the purpose of the organisation to stay intact. Weber (1978) shows in his analyses of the bureaucratic organisation, how possible conflicts emerge if a substantive justice is oriented toward some concrete instance and person, because it will unavoidable 'collide with the formalism and the rule bound and the cool "matter-of-factness" of bureaucratic administration' (1978: 980). Hence, we see that Weber in relation to the relative positions of reason and emotions points to the fact that there are serious amounts of (emotion) work involved in being impersonal and ascribing impersonality to social interaction and, therefore, we also see how this vocation of detachment becomes a central issue of concern in both his writings and in relation to the research manners he applies to the study of social realities.

Parsons and the conduct code of 'affective neutrality'

As inheritor of Weber, Parsons' theorising also embraces emotions. The tendency to see emotions and rationality as opposite ends of a continuum is perhaps more persistent in the work of Parsons than it was the case in Weber's work. This is mainly due

to Parsons' emphasis on the process of modernity as a long-termed history of rationalisation of social relations – without exceptions.

Parsons is preoccupied with exploring the conditions of possibility of human conduct in modern society. His understanding of modernity is inspired by Tönnies and his distinction of *Gemeinschaft* (i.e., community) and *Gesellschaft* (i.e., society) as a way to understand the transition from pre-modernity to modernity as a move from nature to society. Parsons argues that this transition implicated a transition from emotions to reason. Drawing on an analysis of Tönnies' social typology, Parsons believes that 'community' is characterised by *affectivity* while 'society' is characterised by *affective neutrality*. The pattern variable points to the rules and values, which determine the activities of social actors in specific situations. In this regard, his concept of 'affective neutrality' also refers for instance to the specificity of emotion (or affect) management that is expected or appropriate in given organisational forms of interaction. For example, contact with other individuals in a bureaucracy is maybe most effective when devoid of emotions and characterised by 'affective neutrality'. According to Parsons, 'affective neutrality' is a significant feature of professionalism and professional work practices. In one of his descriptive analysis, he deals explicitly with modern medical practice and its practitioners (see Parsons, 1951: 428-79). The functional specificity or the affective neutrality of the medical profession enables medical individuals to perform their clinical tasks 'without regard for persons'. Parsons writes:

'[Affective neutrality] enables *the physician* to penetrate sufficiently into the private affairs, or the particular nexus of his patients to perform his function. By defining his role in this way it is possible to overcome or minimize resistances which might well otherwise prove fatal to the possibility of doing the job at all' (1951: 459).

In contrast, affectivity points to the expression of gratification of emotions or an individual pursuing of ‘any interests private to himself as distinguished from those shared with the other members of the collective’ (ibid). Following the latter perception, we may conclude that Parsons did not deny the presence of emotions. Rather, he delegated emotions to the private spheres – for example the sphere of the family or friendships. From this follows that if individuals anyway go public with their emotions, these emotional outbursts can be interpreted as disturbances to the social system.

In sum, we see how Parsons’ conception of rational (i.e., instrumental) actions contrasting expressive action (i.e., emotional) may frame the relationship of emotion and rationality as being that of two opposites. However, if this was the case there would be no reason for including his theorising in the framework of this thesis. Instead, and very much like the interest of Weber, Parsons is preoccupied with how public office holders keep inappropriate feelings at bay in their professional work activities and how they manage to sustain an image of a certain kind of person. Ideally, the vocation of ‘affective neutrality’ provides the conditions of possibility for a doctor and his patients to meet on impersonal ground in the medical encounter. Parsons provides us with a conception of the clinic that is hemmed in from personal beliefs and value-laden judgments. This particular kind of space furthermore leaves issues such as economic status and personal attributes free of observation. He writes:

‘It is also important that doctors should not let their personal dislikes of particular patients be expressed in a poorer level of treatment or even positive “punishment”. And doctors would scarcely be human if they did not take a dislike to some of their patients’ (1951: 459)

As indicated in the quote, Parsons also acknowledges that this functional setting is heavily challenged in doctor-patient relationships. The emotional expectations of the

patients and their families, which are typically sources of hope and frustration, are contested in medical practice – and especially in situations where no explanations or treatment suggestions can be provided. The doctor must then work hard to regulate the emotions of frustrated individuals. The powerful attachment that patients express through their emotions in a medical encounter may be hemmed in effectively by the doctor if she or he adheres to a professional attitude of, for instance, ‘affective neutrality’. From another point of view, physical intimate situations can also provoke emotional reactions (e.g., disgust, anxiety) in professionals. Here the professionals must work through various techniques to sustain themselves as professional persons. However, because of the particular function of the medical encounter, Parsons suggests that doctors – even though they are expected to have a purely rational orientation to undertaking their work – are constantly susceptible to personal responses in their intimate dealing with others human beings. This makes Parsons’ theorising on medical practice an apt work for this thesis, because he situates the delicate balance between emotional expectations of individuals and professional codes of conduct in the very heart of the doctor-patient relationship.

Elias and historical processes of ‘social restraint towards self-restraint’

Weber’s interest in emotions at work in specific socio-historical settings is continued in the work of Elias. As registered recently, Elias’ influence on organisation studies is considered minimal and to date his approach has been largely neglected by the field (see for example Van Iterson, 2009). This is puzzling because the broad interests of his historically informed account of *The Civilizing Process* (Elias, 2000) – ranging from the account of modern state formation and changing standards of manner and morality, to forms of affect-control and self-constraint in social relations – provide enough intellectual goods to engage with empirical oriented organisation studies. Elias’ work sheds light on the forms of emotion management and bodily control, which emerged as part of the historical processes of rationalisation. He emphasises

how emotional standards are depending upon specific social arrangements, practices and techniques rather than being essential properties of a human being. This is interesting in relation to the questions raised by this thesis, since Elias' work provides the means to understand the emotional conduct of doctors 'outside' the individual practitioner. He offers a position that turns our attention to tendencies in our society, which insert for instance demands for 'compassion' as a normative performance allotment in today's professional bureaucracies.

A core theme in Elias' work is how changes in power structures are reflected in changes in the 'psychological make-up of people' (2000: 369). He links the notion of *civilité* or *civilization* to changes in codes of conduct, and shows how emotions are increasingly controlled in rationalised (i.e., civilised) societies. By doing this, he develops Weber's (1978) historical view on bureaucracy, and the impact of rational practices on the organisation of the social sphere and interpersonal relationships. In his work, Elias links an emergent notion of *civilité* with changes in the production and display of emotions, or, as also Goffman later turns his attention to, changes in how individuals go public with emotions.

One of Elias' core points is that, as processes of civilisation have developed, so have demands for emotion management increasingly become internalised. He demonstrates how rules of behaviour and manners became both far more complex and far more controlled since the Renaissance, as particular evident in the emergence of the modern state and the 'civilised' individual. Elias writes:

'As more and more people must attune their conduct to that of others, the web of actions must be organised more and more strictly and accurately, if each individual action is to fulfil its special function. Individuals are compelled to regulate their conduct in an increasingly differentiated, more even and more stable manner' (2000: 367).

The development of an increasingly complex web of social interdependencies in turn makes it necessary for individuals to constrain and manage their emotions – both of the self and of others – and hence an increasing social restraint towards self-restraint was established (Van Krieken, 1990, 1996). Elias pin-points how the experience of certain emotions, such as embarrassment and shame, emerged as bodily expressions in the sixteenth century and encouraged individuals to increasingly repress their passions and to constrain themselves from the vantage point of others. Certain feelings then gained status as instruments of control of self and others. As regulatory rules they were accepted out of fear of losing out in the ongoing competition for status, power and economic resources and not least out of fear of feeling shame and embarrassment in front of others. The behaviour associated with *civilité* was hence directed to the regulation of the conduct of individuals. What was getting rationalised in these civilising processes was, according to Elias, not only the product of individuals, but primarily ‘the modes of conduct of certain groups of people’ (Elias, 2000: 412). This included proper table manners of people eating together, gestures, facial expressions, ordinary dressing and handling of natural bodily functions, such as spitting rules and how to blow one’s nose in public.

Consequently, specific codes of habits of thinking and patterns of affect-control are characteristics of particular organisations. Elias demonstrates this argument empirically in French court societies, the nuclear family and areas of sport and leisure. At the court, for instance, highly detailed codes of emotion management and bodily comportment were developed that served to distinguish individuals in terms of their social status. For a knight to sustain his ‘knight status’, he was dependent on a rationally calculated adherence to certain codes of manners and rules of impression management (Kuzmics, 1987). Whereas previously in history, violence or emotional outbursts were met with affect, now, calculated situations were met with calculated appearances.

It is important to mention in this context that Elias' theory of the civilising process of human conduct does not involve a repression of emotions or emotional life as such. In other words, Elias' historical analyses of changes in personality structures and socio-political changes and of how these correlate involve an analysis of how the experience of some emotions (e.g., embarrassment) expands and how the experience of others emotions involves restraints (e.g., anger) in Western societies.

What started out as merely external control in the name of monitoring gradually became internalised through the entire structure of society as the conscious ability of individuals to automatically regulate instincts and bodily and emotional expressions. By studying manner books from different eras, Elias furthermore analyses the development from external social restraints on manners and etiquette to a more informal approach to emotional conduct. However, as Elias emphasises, the shift from social restraint towards self-restraint implies often more well-choreographed and socially sanctioned rules of appropriate emotional display. In others words, codes of conduct have become less rigid and more differentiated but at the same time new demands to the 'affect-economy' (Elias, 2000: 399) have emerged, which includes the emergence of highly sophisticated techniques of emotion management. This development has been given further notice in the work of the Elias follower, Wouters (1986, 1999), who describes the processes of 'informalisation' of emotions like this:

'the relaxation of the social codes [...] in combination with increasing social demands on self-control; it implies a change in the patterns of social control and self-control and also a higher level of reflexivity on the part of individual people (1999: 416-417).

The expression resembles the one used by Elias when he speaks about processes of 'constrains to be unconstraint' (Elias, 2000: 365-379). It indicates that processes of self-constraints have not only become more flexible, at the same time they have also

become stricter in recent developments of controlling emotions. These dimensions take on new forms in our current era of for example self-help culture. The well-known situation where a self-help coach says: ‘just be your natural self in order to give other people the impression of the person you really are’ does not represent a loosening of emotional display, but rather represents a refinement of emotion codes through seemingly more ‘natural’ or ‘sincere’ practices. The coach’s call for ‘authentic’ behaviour or ‘just-be-you-behaviour’ may employ lots of calculated (emotion) work on behalf of the client.

In sum, the work of Elias contributes to an understanding of emotions at work in specific historical and organisational contexts. It may provide us with a preliminary lens to look through when we analyse for instance processes of formalisation and informalisation of feelings in a hospital setting. His perspective draws attention to how the conducts of doctors and the exhibition of specific emotions in medical relationships are interwoven with social rearrangements of cancer illnesses and the introduction of new forms of governance in relation to medical practices and manners.

Goffman and the staging of a cynical performer

Elias provides an excellent platform from which to understand the historical mouldering of emotions through processes of rationalisation. His preoccupation with the sociological concern for the relationship between human agency and the social world is manifest in his preoccupation with social formations of individuals. His sense of selfhood and the formation and regulation of individuals’ conduct – including the display and expression of emotions – is also well developed in the work of Goffman.

Goffman was, as his work clearly demonstrates, not exactly embarrassed in his dealings with emotions. The main thrust of his micro-sociological perspective on emotions may be his explicit focus on the daily, step-by-step efforts, taken on by each member of society to constitute a functioning social and interactional order. He

proposes that emotions are socially constituted and actively managed on a daily routine basis by reflexive individuals who freely participate in the creation of all kinds of emotional performances. Goffman's perspective challenges the traditional way of thinking about human agency and social structures and we may see how emotions become a cornerstone in that manoeuvre. Goffman (1959) writes:

‘As human beings we are presumably creatures of variable impulse with moods and energies that change from one moment to the next. As characters put on for an audience, however, we must not be subject to ups and downs [...] a certain bureaucratization of the spirit is expected so that we can be relied upon to give a perfectly homogenous performance at every appointed time [...] we are helped in keeping this pose by clamps that are tightened directly on the body, some hidden, some showing (1959: 63-65).

Goffman stresses the role of the situation; the frame and the interactional order, which give direction to human conduct. As such, a situation always carries with it an official frame of what it is appropriate to feel. This frame is set within a wider structure of values, norms and cultural beliefs in which individuals work effortful trying to make emotions and frame consistent. Within this frame individuals can act in a strategically and calculated fashion appropriate to the situation.

Like Elias, Goffman's work implies that there are generic emotions of everyday life, such as embarrassment³ and shame. He understands embarrassment as the disparity between self-identity and social identity; i.e., a threshold between at the one hand the way individuals see themselves as competent members of society and at the other hand the way others see them (Goffman, 1956). As an experienced emotion and bodily expression, embarrassment is an important element of rational action. Embarrass-

³ The emotion embarrassment plays a central part in especially Goffman's early studies (Goffman, 1956; 1959; 1961). He argued that embarrassment had 'generic properties of interaction' (1956: 264).

ment, along with feelings of guilt and shame, can be understood as a central emotion to organisational control, prompting the way an individual is judged in the face of others and, thus, the way one can sustain self-control and not be 'gripped' with feelings in inappropriate situations. Instead of turning these emotions merely inwards (consider Goffman's famous distinction between front stage and back stage), Goffman was curious towards the emergent emotions that surface during face-to-face encounters. The stage and performance concepts as typically drama metaphors are crucial in Goffman's conception of social life. Self-presentation amounts to the way:

'the individual in ordinary work situations presents himself and his activity to others, the ways in which he guides and controls the impression they form of him, and the kinds of things he may or may not do while sustaining his performance before them' (1959: Preface).

Goffman assumes that the self we live by constitutes action as well as it is constituted by it. Even though selves are modelled as personal selves, the image of the personal self is itself a presentation that is publicity accomplished and constantly worked on and worked with. The self is therefore considered a social product⁴. It is crafted by interplay of circumstantial demands, restraints, and resources on the one hand and self-constituting social actions on the other. Even though the self is constrained by culture, language and biological peculiarities of one's life, it is given some slack in the dramatic performance in front of others. Performers can engage in strategic, cynical behaviour to achieve not only dramatic goals but also specific goals that are unknown or unrecognised by an audience.

⁴ Goffman's analysis of the presentation of the self is a critical attack on the social institution of a self-contained individual. We see a similar critique developed in the work of Elias, where the myth of a closed self, 'homo clausus', which is located inside human beings, is challenged (Elias, 2000: 479-481).

Goffman's conception of self in everyday life is constantly preoccupied with how this self stands in the eyes of others and how it implies states of different emotions: pride, humiliation, shame. His thesis was that if one or more of the perquisites for interaction are unconvincing or are altogether missing, then strong emotions would occur. In this way, the impression one makes can be threatened by inappropriate conducts. Performers may play incomplete because they are flushed with emotion and therefore feelings might intervene in their performance. Goffman (1959) mentions three groups of inopportune events. He writes:

‘First, a performer may accidentally convey incapacity, impropriety, or disrespect by momentarily losing muscular control of himself. He may trip, stumble, fall; he may belch, yawn, make a slip of the tongue, scratch himself, or be flatulent; he may accidentally impinge upon the body of another participant. Secondly, the performer may act in such a way as to give the impression that he is too much or too little concerned with the interaction. He may shutter, forget his lines, appear nervous, or guilty, or self-conscious; he may give way to inappropriate outbursts of laughter, anger, or other kinds of affect which momentarily incapacitate him as an interactant; he may show too much serious involvement and interest, or too little. Thirdly, the performer may allow his presentation to suffer from inadequate dramaturgical direction. The setting may not have been put in order, or have become readily for the wrong performance or may become deranged during the performance (1959: 60-61)’.

Generally, Goffman's approach to understanding emotions at work captures that individuals actively manage emotions according to the rules of a particular situation. These rules include *expression rules* and emotional performers who are capable of managing emotions in accordance with such rules. Expression rules are conventions

guiding the display of feelings that performers must adhere to in the situations. The rules oblige performers to ‘give off’ some feelings and not others depending on the situation. In abiding by the expression rules and suppressing and controlling alternative expressions, performers can create a favourable impression on others. Goffman assumes that when individuals appear before others he or she will try to control the impression they receive of the situation. The *arts of impression management* refer to the sample of techniques and attributes that are required of a performer ‘for the work of successfully staging a character’ (1959: 203). Essentially, when performers are ‘on stage’, they must express the emotions appropriate to the part they are playing. In this sense, emotions function as social ventricles. For example, when a doctor discloses a diagnosis of cancer to a patient, he may deliver the information in a respectful, anxiety-reducing way, so he and the patient together can focus on the next step of the treatment process. A contrasting behaviour, for example if the doctor makes fun of the situation and adheres to a humorous behaviour, would make an impression that is totally out of place in relation to the interaction rules of the specific situation. Goffman argues that in order to avoid negative emotions (like anxiety or confusion) individuals are more than ready to follow interaction rules such as expression rules.

Although Goffman’s view on the role of emotions in social interactions is much more complex than I have hinted at above, he basically understands the expression and display of emotion as depending on the specific contexts or stage performances in which they occur. In regard to my empirical analyses of doctors’ conducts, expression rules are equipping the doctors – as performers on a stage – with certain capacities to perform in the cancer clinic. The role of ‘doctor’ and the role of ‘cancer patient’ are defined by the setting and the rules that structure, for instance, the medical encounter in the outpatient clinic. ‘To be a given kind of person is not merely to possess the required attributes, but also to sustain the standards of conduct and appearance that one’s social grouping attaches thereto’ (1959: 81). However, how do we, according to Goffman, focus on the emotional ‘ups and downs’ of routine daily inter-

actions? Well, the answer is that we become aware of emotion work in situations where individual's feelings do not fit the situation and there is a discrepancy between the latter and legitimate feelings – of what one 'should' feel and what one 'tries' to feel. In his analysis of social interactions in welfare institutions, Goffman shed light on how often polished selves – the client, the mental patient, the social worker, the doctor - become disorganised in the course of routine social interaction and how these selves try to overcome or avoid the problems through preventive or corrective practices. This disorganisation becomes an objective for the emotion-interested researcher.

Hochschild and the search for an unmanaged heart

Goffman's approach to emotions in human encounters is a stepping-stone for Hochschild's work on how (capitalist) society makes use of emotions through the commercialisation of human feelings and the loss of authority this involves. Hochschild adopts important elements of Goffman's framework to her work, but adds a critical edge drawing on Marxist concepts of alienation and Freudian concerns with pathologic emotions and the suppressing of affects in modern societies. Let us take a closer look at her social theory of emotions. Her conception of 'manufactured feelings' and 'authentic' feelings demands some attention, because it installs some confusion, which I believe to be connected to her understanding of the self. This issue will be explained later in this section. I have first and foremost chosen to engage with her work because of her major influence on the last decades' empirical emotion studies, in particular studies of emotions in health care.

First, Hochschild (1983) provides us, in her own words, with 'a set of illustrated ideas about how society uses feeling' (1983: 17). Society reveals an *emotion culture*, consisting of a complex of ideas about what people are supposed to feel in various types of situations and how we must manage our emotions in front of others. This emotion culture is composed of various *emotion ideologies*, which define proper

attitudes, feelings and emotional responses in social activity. *Emotion rules* specify the emotions that individuals should feel, experience and express in specific situations. Hochschild writes:

‘Feeling rules are standards used in emotional conversation to determine what is rightly owed and owing in the currency of feeling. Through them, we tell what is ‘due’ in each relation, each role. We pay tribute to each other in the currency of the managing act. In interaction we pay, overpay, underpay, play with paying, acknowledge our dues, pretend to pay, or acknowledge what is emotionally due another person. In these ways [...] we make our try at sincere civility’ (1983: 18).

Feeling rules, as implicit codes of conduct, are thus the ideological strategies we reproduce to deal with distressing, uncomfortable or inappropriate emotions and feelings. *Emotion management* is the type of work it takes to deal with feeling rules. Traditionally we may think of emotion work as something we do when we care for our families. However, Hochschild (1979) takes the concept further by situating it in a commercial context. She defines *emotion work* as:

‘the act of ‘trying to change in degree or quality an emotion or feeling [...] Emotion work refers more broadly to the act of evoking or shaping, as well as suppressing, feeling in oneself’ (1979: 561).

Emotion work involves individuals’ management of feeling in order to conform to the demands of a particular situation. The use of the word *work* stresses that we have to do with something that is actively done to feelings. This work is done with a purpose of producing suitable emotions, ‘I tried to calm her down’, ‘I was crying inside but forced myself not to show it’. We see here how Hochschild takes Goffman’s important distinction between front stage (where performance take place; where a

‘show’ is on) and back stage (the work going on behind the scene) one step further in her work. She distinguishes between emotion work as belonging to the private realm (back stage – for example the family, friendships) and *emotional labour* as belonging to the public realm (front stage – for example the work place, the office). Emotional labour is ‘the management of feeling to create a publicly observable facial and bodily display’ (Hochschild, 1983: 7). Through this term, Hochschild coins the invisible character of the dimensions of the relational work people do as part of performing their job.

In the private realm, emotion work is considered part of our private lives. In the public realm, emotional labour is sold for a wage as a commodity. Hochschild associates this type of labour with jobs that require workers to produce a positive or negative emotional state in others and endure supervision and control over their emotional activities. She argues:

‘[E]motional labour includes knowing, and assessing as well as managing emotions, other people’s as well as one’s own [...] as part of the personal manager’s emotional labour, he has to learn the company’s “emotional map”’ (1993: X).

As such, real-time emotions are a large part of what workers manage on their job and ‘emotional labour is a big part of white-collar work’ (1993: xii). This kind of labour is significant in professional bureaucracies such as hospitals, welfare offices and schools, and private companies such as call centres, air companies and fun parks⁵. In her analyses of how flight attendants manage to sustain the pleasant demeanour dictated by feeling and display rules in the face of rude passengers in air traffic,

⁵ Drawing on Daniel Bell’s (1973) definition of service work in post-industrial society, this includes jobs in transportation and utilities, distribution and trade, finance and insurance, professional and business jobs, jobs deriving from demands for leisure activities (recreation and travel), and jobs that deal with communal services (health, education and government).

Hochschild challenges Goffman's concept of *surface acting* by focusing on how individuals cope with emotion rules and emotion ideologies and how people are forced to engage in behaviour that arouses negative emotions (e.g. stress, alienation). Surface action refers to a strategy of pretending to feel for instance happy, when one does not feel happy at all, and hence the emotional display of happiness is merely a display act. *Deep acting* in contrast, takes us one step further away from the stage on which we 'just' play a character. Hochschild (1983) writes:

'For Goffman acting is surface acting. The actor's mental focus is on the slope of a shoulder, the angle of a glance, or the tightness of a smile; not on any inner feeling to which such gestures might correspond [...] we need a self with a developed inner life' (1983: 226).

In building upon the work of Goffman, she is also adding to his work by focusing on the inner voices of actors. She writes: 'The emotion-management perspective fosters attention to how people try to feel, not, as for Goffman, how people try to appear to feel' (Hochschild, 1979: 560). By doing emotion work and comply with feeling rules, individuals try to alter their inner state and what they feel 'deep down'. In contrast with 'surface acting', deep acting describes the actual work on individuals' emotional state. For example, an individual can try to change her expressive behaviour such as trying to cry so as to accommodate her inner feelings.

According to Hochschild, Goffman is black-boxing both emotional reflexive actors and social structure, who is the origin and causes of change in codes of conduct in his work. Her focus on 'the self as emotion manager' (1979: 555) is a way to install a battling inner self in micro-sociological theory. It is a self which is capable of feeling; who knows what to feel in specific situations and who is capable of managing own feelings. However, I find it analytically difficult to differentiate between what individuals consider belonging to them (for example feelings representing their

‘inner’ selves), socially appropriated feelings, and feelings that are displayed for public exchange and consumption (e.g. Wouters, 1989). We see how the inner/outer distinction is well-developed in Hochschild work when she distinguishes between the commodification of (phony) emotions as capitalist properties and an authentic inner self with sincere feelings. The demands to corporately restricted emotion management result in ‘the issue of estrangement between what a person senses as her “true self” and her inner and outer acting becomes something to work out, to take a position on’ (Hochschild, 1983: 136). By drawing a relatively sharp distinction between private, emotional self and emotional demands of public jobs, Hochschild notices that ‘emotional labour poses a challenge to a person’s sense of self’ (ibid). I will argue that one of the main problems in drawing this distinction, is the idea that ‘authentic’ and ‘sincere’ private emotions are entities belonging to a self-contained self (reconsider Elias notion of ‘homo clausus’ – see Elias, 2000: 474) which must be protected against occupational exploitation.

Hochschild never applied her emotional labour perspective to the medical profession or to nursing. Especially the latter would have been a natural expansion of her empirical inquiries into the study of emotions at work. One of the reasons for this omission might be found in the way she constructs the argument of professions and professional codes of conduct in the discussion of emotional labour and jobs (see Hochschild, 1983: 56-76). To limit emotional labour to specific jobs, she includes three criteria in her theoretical framework – first, face-to-face or voice-to-voice contact with the public; second, the requirement that employees should produce a particular emotional state in another person; and third, methods of supervision and training of the employees which allow the employer a degree of control over the emotional activities of employees (1983: 147). Compared to a flight attendant, Hochschild notes that doctors do have personal contact in public and they try to affect the emotional states of others, but they do not work with an emotional supervisor immediately at hand. She writes: ‘Rather, they [doctors] supervise their own emo-

tional labour by considering informal professional norms and client expectations' (1983: 153). Surprisingly, when Hochschild talks about emotional labour as efforts or work undertaken in most service jobs, it in reality comes down to include only a few emotional labour jobs such as flight attendants, hairdressers and beauty stylists. She clearly makes the limitation to serve her focus on gender and social status: the exploitation and cost of emotional labour, typically goes on in lower income, female jobs. In building this argument, she seems to ignore emotional labour of 'true' professions, which is where this thesis makes an empirical contribution to her work.

In sum, Hochschild's contribution to the work of Goffman is to demonstrate how individuals do not simply manage their emotions to give off a good impression, but also how they are forced to violate their 'inner' feelings to comply with situational feeling rules that are inherent in certain job profiles. Her idea of deep acting includes that individuals take on laborious work to alter their 'inner' feelings so these feelings fit with outer expectations and social norms. The latter concern is linked to broader questions of individuality, power and social structure, and Hochschild connects emotional labour to a 'dark side' of (capitalist) ideology in Western societies. According to this approach, we can think of emotion as a covert resource which can be exploited and regulated like money, knowledge or physical labour. Those who perform emotional labour thus become subject to 'the rules of mass production' (1983: 198). From this follows that also our feelings now emerge as targets to colonising attempts and organisational control, and thus nothing is sacred to capitalist exploitation.

Despite illustrating ideas about how organisations use feelings, we see how Hochschild's approach to emotions is open for criticism on a number of accounts, because her theoretical grounding in the image of the self as a self-sufficient and quite independent being, exhibits some problematic conceptual traps. Especially her distinctions between inner/outer; public/private and 'manufactured or fake feelings'/'authentic or sincere feelings' have had widespread appeal in studies of emo-

tions in health care, where they reclaim sincere or authentic feelings from cooperate attempts of control, manipulation and various forms of management. I will return to this issue later in this chapter.

Strauss and invisible, informal emotion work

Next, I will turn to the writing of Strauss and his conception of *sentimental work* in his sociology of organisations. He may provide us with a missing link in relation to Hochschild's theorising, which enable us to approach emotion work done by professionals (doctors) not only as work done for a wage but as work required for other activities to be done both effectively and with respect for the individuals involved. In *Social Organisation of Medical Work*, Strauss and his co-authors (1997) explicitly focus upon work in relation to the management of illness trajectories as specific organisation phenomena. The concept of trajectory is used to analyse social interaction and it refers to the 'complex interactive acts required to manage that course, along with the consequences or outcomes of that management' (Corbin, 1991: 33). The concept has profound value for Strauss et al.'s approach to the organisation of work because it allows him to break the overwhelming category of work into pieces and interactive acts and to explore their consequences for actions and, not least, for how actors respond to changing conditions.

In the specific work on illness trajectories and chronic illness, Strauss et al. (1997) claim that the work of physicians, nurses and associated technicians has been 'radically and irrevocably altered by today's prevalence of chronic illnesses' and the technologies developed to manage them' (1997: Preface). On this background, the authors ask 'how, in detail, has that work changed' (ibid.). In order to focus explicitly on work and change in work, the authors break down work into different categories of work, such as 'Machine work'; 'Articulation work'; 'Comfort work'; 'Safety work' and 'Sentimental work'. What counts as work in this optic, 'does not depend a priori on any set of indicators, but rather on the definition of the

situation' (Star and Strauss, 1999: 14). For instance, to die with grace in a busy medical ward can under some circumstances be defined as a kind of legitimate work and keeping a marriage going may be fun, but it also involves tremendous amounts of work. The fundamental pluralism of action paths in workplaces, such as trajectories or marriages, means struggle, conflict and negotiation on an everyday routine basis about what should be done in a given situation – and by whom. One category of work is *Sentimental work*. According to the authors:

'Sentimental work presents an 'important, varied, often subtle, and sometimes very complex type of work [...] and is present as ingredient in any kind of work where the object being worked on is alive, sentient, and reacting' (Strauss et al., 1982: 254).

A great deal of 'real medical activities' depends on sentimental work (1982: 274), especially the main line of diagnostic and therapeutic treatment in a trajectory will be affected if sentimental work is not done or is done ineffectively. For example, the doctors have to manage the emotions of patients while they are continually making mutilating bodily interventions such as taking biopsies and provoke other situations which involve great physical pain. Sentimental work is likewise evoked to ward off patient anxiety for instance in cases where a diagnosis of cancer is disclosed and the doctor tells the patient not to worry too much. Like physical labour, sentimental work requires experienced, skilled and reflexive work, which is subject to divisions of labour.

Sentimental work is often considered invisible mainly due to its informal, ad hoc status in medical work. By invisible, I refer to work that is not actually seen (consider Goffman's notion of back stage work) or work that is kept secret, regarded as shameful or dirty, taken for granted or performed 'when those engaged do not think of it as involving work' (Strauss et al., 1997: 148). Strauss et al. show how sen-

timental work, regarded as invisible work, appears in health care organisations in the service of managing and shaping patient trajectories. Opposed to Hochschild's account, there is nothing extraordinary or alienating in sentimental work. It is necessary work to be undertaken by professionals, patients and relatives. Furthermore, Strauss et al. argue that sentimental work and the baseline for doing this kind of emotion work have been profoundly affected by changes in the medical organisation, for example by rearrangement of patient trajectories and technological developments.

Strauss and his co-authors suggest that emotion management is a common feature involved in 'technical' medical work, not only expressed in the work of lower middle-class, female work, as suggested by Hochschild, but also in work conducted by professionals such as university teachers, politicians and doctors. The authors demonstrate how one may approach emotions in the social organisation of everyday medical work similar to the way one approaches other organisational phenomena. Emotions do not have a magical or sacred status in the organisation. Instead, they constitute an important part of rational medical action. Thus, sentimental work may be regarded as a mundane, routine activity that professionals (doctors, nurses) must take part in either 'because it is necessary to get the work done efficiently or because of humanistic considerations' (Strauss et al., 1997: 129). I think the last sentence is important here in relation to a side-ordering of efficiency and humanistic considerations in medical activities. This idea of a side-ordering of various considerations becomes especially important later in the thesis when I analyse various forms of emotion work in the accelerated cancer pathways, and where so-called 'soft' dimensions of care, such as attention to the patients' psycho-social well-being, are intertwined with concerns of productivity and performance measurement.

Literature on emotions in health care

One of the areas in which research on emotions has been most developed is health care. Within this research field, micro-interactional processes of the management of

emotion in everyday routine work have been studied and linked to broader discussions of how social and cultural factors impinge on the formation and regulation of the conduct of health care workers.

There have only been few empirical studies directly examining the role and function of emotions outside of the nursing profession in the overall area of health care (see Mann, 2005 for an overview of the literature on emotion work and labour and nursing). This is probably due to the assumptions many researchers have in relation to the ‘caring’ role of the nursing profession. One reason why the study of emotional aspects of, for instance, doctoring is undeveloped may be that researchers have been inclined to adopt a dichotomy articulated within the nursing profession itself that traditionally sees emotion work as belonging to the caring role of nurses while doctors are detached from that sort of things and only are involved in processes of giving information about technical interventions (e.g. Smith and Gray, 2000). I have expressed the facilitation of emotional division of labour previously in this thesis, e.g., the introductory story from the cancer clinic, where a nurse took ownership of the expression of empathy.

One of the core issues of theorising on emotions has in previous sections been addressed as the issue of a longstanding bifurcation between emotion and rationality. This debate continues to be reflected in empirical studies of emotions in health care and I will therefore next turn to authors who 1) intend to bridge this divide and authors who 2) continue to work within this divide.

Bridging the divide. In short, the literature, which I have chosen to engage with here, has a profound attention to the complex intertwinement of emotion and rationality in relation to emotions at work. It addresses the importance of emotions to basis purposes and values of health care organisations.

Working within the divide. Second, I also engage with literature that explores how nurses react to structural and economic changes in the work place in relation to their ‘felt’ and displayed emotions. I ask the reader to reflect on how these ‘felt changes’

of nurses are reframed in the reviewed articles in relation to a notion of ‘authentic’ feelings.

The texts to be examined reflect these two core positions. Each of them will be taken up in turns. Expositions by the various authors will be highlighted as they speak to those positions. Last, I will sum up this listing and point forward to how I intend to approach emotions in my empirical inquiry.

Bridging the divide: Emotion and rationality in health care

‘Emotion is rarely seen as systematic or structured and is often used as a contrast with rational’ argues James (1989) in a text on nurses’ regulation of feelings in a hospice setting (1989: 17). According to James, this polarised thinking presents an image where rationality is hold supreme and where emotion is seen to contain negative connotations of unpredictability and irrationality. From this perspective follows that emotions are seen as an uneasy fit with organisational values of efficiency, standardisation, time tabling and performance measurement in health care organisations. In order to pave the way for a more coherent image of rationality and emotion, James suggests that for the most part the management of emotions is a routine, predictable social process that relies on conscious, skilful work rather than on ‘personality’ or ‘natural skills’, as Hochschild suggested. In emphasising the management of feelings within social processes, such management is a day-to-day matter, relying on professional codes of conduct.

The dichotomous nature of rationality and emotionality, which is evident from a public/private or outer/inner separation of the two concepts, is also challenged by Bolton (2001). Set against a backdrop of structural changes affecting the British public sector services in the late 1990’s, Bolton demonstrates how nurses working in a NHS trust hospital are able to juggle the emotional demands made to them by presenting different faces to patients. Sometimes a smiley face is displayed, sometimes a humorous face is needed and sometimes a professional face makes the social interac-

tion work. Nurses can therefore be described as *emotional jugglers*. They are able to wear ‘masks’ and present professional demeanour, while at the same time being emotional present and fully engaged in the interaction order of the hospital setting. Compared to flight attendants or service workers in a call centre, nurses are ‘knowledgeable agents’, as Bolton writes elsewhere (2005: 103). The difference comprises that nurses are ‘capable of mixing all forms of emotion management according to rules other than those solely controlled by the organisation’ (ibid). This capacity for emotional juggling enables nurses to fulfil their job obligations, which are compatible with the instrumental goal orientation of for instance processes of productivity, while providing emotional care for individual patients. Bolton does not theorise through a distinction between ‘public’ or ‘commercialised’ feelings on one hand and ‘authentic’ or ‘genuine’ feelings on the other hand. Instead, care workers can present a ‘smiley happy’ face as part of their job without this face necessarily signalling a commodified feeling that is packaged to be consumed by the patient.

Bolton highlights in her work some of the contradictions of emotions at work, but she does it in a way which I define as a ‘non-sentimental’ approach to workplace emotions. Through a critique of Hochschild’s concept of emotional labour, which Bolton thinks is inadequate for capturing the complex emotion management of professional care workers, she also scrutinises the assumption of normative control of emotions in Hochschild’s work. This form of control implies that consumer capitalism has ‘appropriated all of our feelings so there is no longer any room for sentiments, moods or reactions that have not been shaped and commodified via the “commercialisation of intimate life”’ (Bolton, 2005: 2). The non-sentimental approach to emotions does not emphasise some emotions, for instance those of the private sphere, to the disregard of other emotions, for instance those of the work place. Hence, it would also be a mistake to approach professionals’ detached performances as ‘cold’ performances, devoid of compassion or ‘real’ feelings. I think the important argument Bolton makes here, is that it takes the same amount of hard work for nurses

to stay detached as it takes for them to appear, for instance, compassionately engaged. Both kinds of professional appearance involve rational, skilled performances of social actors.

The body of research argues that emotions are important social components in organisational functioning of health care organisations. Rather than being ‘illogical’, ‘irruptive’ forces, emotions enrich the attainment of organisational outcome, such as the outcome of the medical encounter. Emotions are central to both patient care and are necessary for health care professionals’ participation in clinical work procedures.

Accordingly, a central study by James (1993) pays attention to the management of emotions during the disclosure of a diagnosis of cancer. James argues that ‘cancer is a particular apt disease to review in order to analyse the management of emotions in health care organisations’ (James, 1993: 96). Emotions are evoked within a diagnosis of cancer because of the diagnosis’ physical implications and its social consequences. The consequences of the disease for the individual patient mean that the disclosure of a diagnosis is not just about passing on information, but is also a mean to regulate the disbelief, fear and chaos a diagnosis often evokes. The doctors, who have knowledge of the cancer illness, also have the power and responsibility to regulate and manage the feelings surrounding the disease. According to James, professional care workers learn skills of emotion management commensurate with their position and role in the hospital organisation. She observes some of the techniques through which emotions are managed in a cancer unit, and she makes these techniques applicable to ways of organising emotions in the hospital organisation. The techniques include: the use of particular kinds of space and time (e.g., the waiting room, the medical encounter, the time table); consequent denial of negative emotions; limiting the amount of information released (e.g., holding back information of survival prognosis); formal and informal disciplinary rules (e.g., the regulation and expression of ‘professional’ feelings, such as feelings of the ‘caring’ nurse), and hierar-

chical ordering of the possibility of emotions (e.g., the doctor manages the emotions of the medical encounter by constraining its expression and hereby also dictates how others – for instance nurses – should manage feelings). James’ study shows that emotional labour is tougher for some than for others, depending on their level of involvement with the cancer patients.

From this perspective follows that health care workers’ capacity to act as ‘emotional jugglers’ or to conduct themselves as certain kinds of social persons in medical relationships depends on competing forms of knowledge and status. However, we must also assume that the different ways of managing emotions during the disclosure of a diagnosis of cancer are dependent on occupation-specific socialisation practices which define the rules for appropriate expression of emotions for workers.

From an education perspective, Larson and Yao (2005) argue that emotion management training is required in medical practice and they identify the need to teach the acting skills of emotional labour. Empathy is often evoked in thinking on the emotional relationship between health care worker and patient, and this is also the case in this article. The authors define ‘empathy’ as a ‘powerful skill’ (2005: 1100) and they propose that empathic responses can be learned through intensive training. They argue that doctors are more effective and enjoy more job satisfaction if they recognise that their work include emotional labour, and if they reflexively engage in the managing of patients’ feelings. The training of emotional skills thus includes both those of ‘stage performance’ and those of coping with the after effects of a stressful work.

This argument is backed up by similar studies that are preoccupied with the training dimension of empathy and emotion management (e.g. Teherani et al, 2008; Neumann et al, 2009). These studies assume that when emotion management is explicitly taught, doctors will experience less stress on the job and the possibility of job burnout will be reduced. The education perspective captures that techniques or

skills of emotion management can be trained alongside other work resources to improve the health outcome of encounters between doctors and patients.

The reviewed texts on training of emotional skills emphasise that emotion work in health care has many connotations associated with self-defensive techniques. Two classic texts deal especially with the issue of how health care workers often attempt to limit their emotional investment within medical relationships through the use of precautionary or protective strategies.

Smith and Kleinman (1989) look at how emotion management is trained in medical schools. They call this training ‘the hidden curriculum’ of the medical education. The training is ‘hidden’ because it is neither subject to explicit training or learning methods nor is it something that the students collectively talk about. The authors explore through participant observation of medical students how *affective neutrality* (Parsons, 1951) is learned as a professional ideology. When dealing with patients, the students learn to manage ‘unprofessional feelings’ (e.g., disgust, aggression) and to control unwanted emotions (e.g., anxiety, fear) involved in their work (Smith and Kleinman, 1989: 57). Basic emotion management strategies, for instance strategies of objectification, provide students with uniform guidelines and resources for managing their feelings in front of other people. These strategies are also part of a larger protective system to help shielding the individual doctor off from showing strong emotional responses in public. Through the use of professional codes of conduct – such as for example that of ‘affective neutrality’ as protective shields – doctors are able to display various feelings in medical encounters without becoming alienated on a personal scale.

Menzies’ (1960) analysis of nursing and the emotional transactions between nurses and patients in a London teaching hospital is a classic study of how protective shields work in health care. Menzies’ core argument is that the intimate body work involved in nursing and the daily confrontation with human suffering and death,

means that the job situation ‘arouses very strong and mixed feelings in the nurse: pity, compassion, and love; guilt and anxiety; hatred and resentment of the patients who arose these strong feelings; envy of the care given the patient’ (1960: 98). In face of these unaddressed feelings aroused by the special circumstances of the work setting, the organisation of emotions in nursing takes on characteristics of a ‘social defence system against anxiety’. This system consists of defensive techniques of emotion management to protect the nurses against the experience of strong negative emotions. Menzies lists a long catalogue of techniques, which includes: splitting up the single nurse-patient relationship into task lists, which are allocated to a group of nurses instead of to a single nurse so the relationship do not get too intimate; depersonalisation, where patients are named as cases by numbers and diagnosis codes; detachment from excessive involvement and denial of disturbing feelings; ritualised performances, where standardised nursing procedures actively discourage nurses to take on decisions on their own; ‘impression management’ in front of patients, where ‘brisk, reassuring behaviour and advice of the “stiff upper lip”, “pull yourself together” are characteristic’ stage performances (1960: 103), and so on. In sum, the social defence system does facilitate the evasion of feelings, but the self same techniques which help to protect the nurses also reduce the humanistic aspects in the provided services. As such, the ‘paranoid-schizoid defence system’ (1960: 117) only provide a momentary relief from the hard work of managing the feelings of others.

It is important to notice that doctors and nurses are not the only persons within medical relationships who make use of protective techniques in their emotion work to limit their emotional investment and to contain anxiety. Also patients and relatives make use of these techniques when they attend the health care system for help.

Lupton (2003b) criticises the contemporary movement of consumerism in health care that on one hand assumes an autonomous patient who is self-reliant, informed and reasonable and on the other hand assumes a doctor who is willing to

share his own feelings and thoughts with the patients and understand them as individuals in the medical encounter. She points to occasions where ‘consumer patients’ demand that the doctors engage in the patient-doctor relationship as a meeting between two equal individuals. From this perspective, patients tend to construct the doctor in an anti-medical light as the ‘other’, ‘them’ or the ‘system’ as part of a strategy to hem in their own disturbing thoughts and emotions. This kind of emotion management, Lupton argues, which works through the use of protective or precautionary strategies, becomes problematic in cases of serious illness, where people are especially vulnerable and anxious. Lupton finds that patients must have a certain degree of trust in their doctors’ abilities and legal accountability for the medical encounter to be carried out successfully. Without this trust, patients might find themselves experiencing even greater uncertainty and anxiety than they already do. In situations, where people are genuinely ill they need doctors who comprise a ‘reassuring’ alliance in the ‘mutual project of becoming well’ (2003b: 169). Hence, a doctor’s job belongs, according to Lupton, to a significant other service sphere than for example Hochschild’s flight attendants. This stand point implicates that a so-called ‘rational’, ‘observing’ or ‘bureaucratic’ doctor might prove to be a better help to an ill patient than the service provider who attend her clients as a saleswomen, who offers value-free goods.

Working within the divide: The colonising of ‘sincere’ emotions in health care

Bone (2002) examines dilemmas of emotional labour in nursing under ‘market-driven health care’ based on qualitative interviews with practicing nurses in California. She argues that the invisible and often undervalued work of emotional support conducted by nurses is being displaced and transformed today within new structural arrangements in managed care organisations. She analyses how lack of time, increased work load and lower staffing become the biggest structural constraints to doing emotional labour. To meet the changing organisational conditions, nursing becomes a question

of mastering 'emotion standards of *detached involvement*' (2002: 146, my emphasis). According to Bone, this rationalisation of emotion work might subject nurses and patients to new means of disciplinary practices and co-optation. She sees 'genuine' therapeutic emotional support as the least accounted for dimension of nursing today. In this way, personal and therapeutic elements of healing may be hemmed in by technically defined skills. The danger is that nurses adapt emotional labour to new managed care contexts. One of the results of this adaptation might be that 'nano-second' emotionalities replace more traditional 'caring' nurse-patient relationships with great costs for both patients and the nursing profession. Bone argues that this implies for the latter, that nurses may experience tensions between empathic, personal concerns and demands for rational, organisational detachment.

Olesen and Bone (1998) argue that environments of structural and economic change in the American health care system entail alteration of codes of conduct. When patients become customers in a health care market, the emotional components of interactions change. The authors point is to demonstrate that changes in social and economic contexts influence emotional labour and the gamut of emotional expression in organisations. When nurses attend patients as customers, the discrepancy between codes of conduct (prescribed by a professional ethos) and demands in relation to what one should feel in a given situation generate problems. The authors suggest that these problems take the form of nurses experiencing 'ambivalence, shame or anger in discrepant situations' (1998: 134). The result is that nurses start to construct new emotional expressions to match the awkwardness of novel nurse-patient interactions, where rules of feeling now resemble those developed in other face-to-face service jobs (e.g., flight attendants, shop floor employees, restaurant servants).

Following this line of thought, studies have explored how new forms of control in nursing, especially the use of consumer feedback or patient satisfaction as a

management control strategy, constrain nurses and force them to perform ‘manufactured’ emotional labour which they experience as alienating (Cooke, 2007).

Theodosius (2008) observes that nurses, like Hochschild’s flight attendants, have very little time in current treatment regimes to do emotional labour. She argues that nurses’ ‘sense of *emotional authenticity* is lost in prescriptive puppet-like emotion expressions. This is distressing because emotional labour is an essential component of the need and purpose of nursing care’ (2008: 47, my emphasis). In another text, Theodosius (2006) claims that she wants to ‘rescue emotion from emotion management’. In her opinion, care consists of emotional components which cannot be managed or even articulated, which make these components all together unmanageable. Theodosius’ work is a good example of how an interest in emotions in health care represents an opening for the nursing profession to reclaim its role as care providers, holding on firmly to a traditional emotional territory of nursing. Her stories mime the introductory story from my cancer clinic, where the nurse tried to monopolise emotions to nursing practice.

I mentioned in the beginning of this section on emotions in health care, that only few studies so far have been engaged in examining the role and function of emotions outside of the nursing profession, and in relation to this I mentioned that this was probably due to the assumptions many researchers have in relation to the ‘caring’ role of the nursing profession. These assumptions, as we have seen unfolded in the above discussion, may find inspiration in a theoretical grounding of emotions in the inner realm of individuals, in particular when drawing on inspiration from the work of Hochschild. One of the consequences is that the constructive nature of ‘caring’ is often mistaken for an ‘authentic’ caring personality, which lies within the individual (female) nurse. Another issue I will mention here is the fusion of emotions with gender. A persistent conceit exists through which men are associated positively with rational thought and action while women are negatively associated with emotional reac-

tion. Recently, I read in my morning newspaper about a journalist who claimed that ‘females are by nature both more empathic and more soft’ (Dagbladet Information, 2011). This obviously false distinction between male and female feelings, which facilitates a gender division of emotions and emotion work, is also present in studies on emotions and professions in health care.

This latter body of research on the nursing profession is noteworthy in relation to its rather sentimental attitude to thinking about emotions in health care. Here, emotions are typically approached as 1) properties which have been colonised by the ‘system’, ‘capitalism’ or ‘bureaucracy’, or as 2) properties which have been lost in a current environment of managerialism and now must be brought back into practice. In other words, the literature tends to envision emotions as personal properties that can be used, manipulated and controlled in the hand of others – for example in the hands of the ‘system’, the ‘organisation’, the ‘bureaucracy’, and so on. From this follows that individuals must resist the organisation and protect their ‘real’ feelings from getting colonised by others. Emotions can be approached as a site of resistance or the last frontier from further standardisation and commoditisation. The perspective emerging from this division locates emotions in a private sphere where each individual has the responsibility of providing shelter from the outer realm. In retaining a theoretical grounding of emotion in the human being instead of in the social realm, the perspective provides support for the idea that emotions are isolated, individual entities. This polarised thinking presents an image of bureaucratic organisational life devoid of emotions, where ‘authentic’ emotional experience, which is embedded in the individual, is opposed to ‘manufactured’ or ‘commercialised’ feelings, that is dictated by ‘the organisation’. Such accounts, I argue, may then continue to essentialise emotions and to sustain a dichotomous way of thinking of emotions in health care.

The number of analytical challenges, which seem to accompany the interest of emotion in organisations, points to the importance of developing a nuanced theoretical framework which does not limit itself to a restricted focus on ‘individual feelings’ on one side and ‘organisational rationality’ on the other side. To bridge this divide, one therefore needs to leave the attention to authenticity, interiority and individuality of emotions behind. In the next section, I will suggest how we may approach emotions in a way that avoids this kind of conceptual entrapments.

A combined theoretical framework to the study of emotions in organisations

Time has come to draw from the various approaches, points and concerns that I consider fruitful for a balanced and nuanced approach to the study of emotions in organisations. This chapter has reviewed several major perspectives to address questions of emotion.

A possible way to summarise this chapter is to lend the word to Wittgenstein (1999 [1957]) for a short comment. In his investigation of philosophical problems, Wittgenstein criticises general explanations of inner feelings and private sensations, and he points to the circumstance that, for an utterance of an inner feeling to be judged meaningful, it must be possible in principle to subject it to public standards and rules of a specific context. Describing the form of a philosophical problem, he writes:

We ask “What does ‘I am frightened’ really mean, what am I referring to when I say it?” And of course we find no answer, or one that is inadequate. The question is: “In what sort of context does it occur?”

(1999: 161)

This rather simple example has two significant aspects. First, to be ‘frightened’ or to feel ‘fear’ is dependent on social situation or context. Second, though Wittgenstein

does not indicate it directly here, emotional expression and experience of ‘fear’ is grounded in possible historical continuities and discontinuities in a long-termed history of emotion codes or standards of emotional behaviour and restraints. The meaning of ‘I am frightened’ is therefore not fixed in stone, but is rather, to some reasonable extent, context varying. A contrasting position would search for the essence that lies behind the appearance of a phenomenon, such as seeking to discover the reality behind the bodily expression of fear. The ‘fear phenomenon’ would then be traced as an innate essence in individual biology and only secondly would one starts to situate emotions in the social realm.

One of the key characteristic of the sociological theory on emotions, that I have reviewed in this chapter is the stress on the contingent character of emotions, depending on variables such as context, particular situation, historical time, culture and trends. Instead of approaching emotions as universal stables, the literature emphasises the performative value of emotions in particular social arrangements. Following this perspective, it becomes possible to trace and diagnose contemporary forms of emotionality or changes in social conduct as depending upon complex historical circuits of individual, cultural and social relations. Emotional expression then follows from the social arrangements and power relations that surround it.

In order to sum up my inspiration from the sociological theory on emotions, I have listed some key points which have major influence on my exploration of questions of emotion in the cancer clinic and forms of professional conduct therein. First of all, some of the important learned lessons:

- Emotions are produced effects rather than essential dispositions
- Emotions emerge through assemblages of a larger scale (societal patterns, power structures and psychological make-up of sentiments)
- Emotions are produced through organisational codes of conduct and standards of regulation and affect-control

- Emotions serve as a function in maintaining social order
- Emotions can be worked at by individuals to produce a reasoned social
- Emotions are an essential part of professional work and as such a part of professionals ethical handling of individual person cases
- Emotions may enrich the attainment of organisational outcome

My own theoretical approach, as developed in the remaining chapters of the thesis, attempts to bring together many of the foci developed under the headline of ‘emotions as historic, cultural and social constitutions’. This overall theoretical framework then signals an orientation towards constructivism. A constructivist perspective regards emotions as a series of relative constitutions, which are dependent upon the socio-historical settings in which they occur. These components are contested and reframed at the level of everyday practices of individuals and organisations. Emotions are shaped and experienced by human interactions; they are framed and reproduced through social practices. The perspective implicates that emotions are never seen as an independent reality, relying upon a universal vocabulary. Instead, it emphasises the plasticity of emotions in relation to their characteristic of being components in the production and co-production of social reality.

When one acknowledges that emotions are socially constituted, one also implicitly pays attention to the productivity of emotions, based on the simple argument that emotions both *are* practice and are constitutive of the possibilities for practice (Williams, 2001). By making this claim, it becomes possible to pay attention to what it is that count as emotions, which means to look at emotions as more or less specific practices, procedures, products and configurations and, not least, as concrete processes of social world making. If we understand emotions through this constructive/constitutive lens, as I do in the thesis, the point is not so much to debate the onto-

logical status of emotions⁶, but rather to turn the attention to how emotions and emotional expression become manifest in specific socio-material processes of organising.

Rather than repressing emotion as the ‘other’ of reason, this perspective on emotions demonstrates the mutually constitutive relation between reason or rationality and emotion. Instead of being irrational or an expression of irrationality, emotions function as cues and markers that form a necessary orientation system fundamentally enabling perception of reality and, ultimately, forms of rationality (Townley, 2008 – see also Jagger, 1989). The strength of the emotion perspective may therefore be its ability to transcend forms of dichotomous ways of thinking about rationality and emotions in social sciences. Furthermore, it might even provide the way to deal with a central sociological concern with regard to the relationship between personal troubles and public issues of social structure (Williams and Bendelow, 1998). The perspective includes asking questions about how individuals’ activity and experience are interlinked with codes of conduct that are themselves historically and socio-culturally grounded. In this way, emotions are interlinked with and shape relations of power and the governance of social conduct.

My theoretical approach addresses the importance of emotions to basis purposes and values of health care organisations. This perspective emphasises, in line with other researchers, that emotions are no adjunct to work and the instrumental goal orientation of work life (e.g. Putnam and Mumby, 1993; Ashforth and Humphrey,

⁶ I find it necessary to mention a few, but important omissions here. First, I will not be defining ‘feelings’, ‘passions’ and ‘sentiments’, ‘mood’, temperaments’ or explaining their relationship to emotions. It has the consequence through the text, that I make use of the words ‘feelings’ and ‘emotions’ as if they were one and the same. Second, I have more or less ignored the question of biology. Emotions have long been a ‘hot’ topic of affective sciences. In disciplines such as neuroscience, the search for distinct emotional systems and universal emotions (e.g., rage, distress, excitement, happiness) is developing. However, with reference to the constructivist/constitutive approach to emotions, I assume that emotions are not simply psychobiological phenomena, but are historically formed components of social action. Third, I will mention the discussion on affect and emotion as another important omission. I intend to use the two terms as if they were interchangeable. More than anything else, I think the uncompromising distinction in terminology – between emotion and affect – has more to do with intellectual heritage and the need to distinguish oneself from other groups of academics, than with actual conceptual difference. In this project, I am not concerned with drawing radical terminological lines, which make it difficult to engage with operational practices and lived experience of individuals towards which I have turned my attention.

1995; Fineman, 1993, 2006). In fact, many rational strategies of health care are pursued on highly emotional grounds and what we describe as rational, for instance in medical relationships, is in fact very emotional. The approach described here involves what I term a ‘non-sentimental’ attitude to thinking about emotions in organisations. This attitude embraces both emotionality and rationality in its conceptualisation of organisational activities, focusing on how management of emotions are formulated and formed through training and practices in particular contexts and circumstances. In this way, I attempt to stay clear of the analytical ‘dangers’ addressed in the very beginning of this chapter.

Chapter 4: To study emotions - Focusing, gathering and writing up material on emotions

Introduction

In the previous chapter, the management of emotions in work and organisational settings has been conceptualised through the thinking of a distinctive group of sociologists and through the review of emotion studies, particularly in relation to health care. The way emotions are approached in the literature has been shown to have an impact on how one understands emotions in empirical inquiries. This is methodologically significant since emotional conduct is difficult to observe and understand. For researchers who seek to emphasise the *work* that goes into the management of the emotions, it is useful to study emotions and emotional practices in organisations using a variety of research methodology, including ethnographic methods. However, before describing the methods and the amount of material used for this research, and before reflecting upon how the selection of methods enabled me to gather material on the research core topics, I first need to confront a more pressing matter. Namely, how did I come to define my object of inquiry in the first place? This is an important question, since the answer both leads back to an explanation of my personal kind of access to the researched organisation, and points forward to a methodological discussion on how to study emotions in work places. Therefore, this chapter begins with a description of the situatedness of my PhD project and my access to the cancer clinic and its occupants. Next, it explains how I defined my object of inquiry. Then, it moves on to reflect on how to study emotions and discusses the problems involved in this process, including problems of *detachment* and *involvement* in social science studies. Finally, the chapter recollects how writing up material on emotions becomes a reflexive act of generating emotional conduct in organisational life, and how this writing process may also be approached as an affective separation from the field of study.

The situatedness of the PhD and my access to a cancer clinic and its occupants

In this section, I will describe my relations with and access to a cancer clinic and its occupants. I will do this through an explanation of the situatedness of my PhD project, because this situatedness also determined the access to my field of inquiry. Furthermore, I will explain how my type of access both became a problem as well as a solution to defining my object of inquiry. The personal biography provides further means to discuss how research on emotions in health care comprises certain methodological challenges.

As previously mentioned, a major centre⁷, located at the university hospital in Denmark, where I also conducted the research, has funded a larger part of my PhD project in a partnership agreement with Copenhagen Business School. Before beginning this study, I worked four years at the hospital as an internal consultant in the centre's administrative unit. Originally, I had started working in a Cochrane Collaboration unit⁸. Looking back on this job experience, I think my current occupation with soft dimensions of medical care somehow counter intuitively derived from this initial work with golden standards of medical research methodology, such as clinical algorithms, meta-analyses and Cochrane reviews. I hope to shed light on the rationale behind this reflection as the chapter develops. On the basis of an educational background in the humanities, I was later employed in the centre as a consultant in communicative affairs to support both the heads of the centre and the centre's clinical staff members in order to improve the external and internal communication with political institutions, clinical collaborators, patients and lay people in general. The job title provided access to what I like to think of as the hospital's engine room. My perception of this engine room comes close to Goffman's (1959) dramaturgical under-

⁷ In Denmark, university hospitals are typically structured into medical and surgical treatment centres, diagnostic centres and administrative centres, hold together by a managing committee.

⁸ The Cochrane Collaboration is an international network where its members work together to develop, update and promote systematic reviews which are based on evidence based research methodology. The reviews are published online in a database which is called *The Cochrane Library* (see also www.thecochranelibrary.com).

standing of a ‘backstage’ region, which in his terms is an organisational region where:

‘[...] the team can run through its performances, checking for offending expressions when no audience is present to be affronted by them; [...] poor members of the team, who are expressively inept, can be schooled or dropped from the performance. [...] the performer can relax; he can drop his front, forgo speaking his lines, and step out of character’ (1959: 115).

One can compare the hospital’s engine room to the outpatient consultation room that a patient attends if he or she for instance needs to be tested for hypertension. The latter region gives the person access to a concrete work setting where particular actions and roles are performed. This region is what Goffman terms the ‘front region’. However, the front does not immediately give access to the place where the hospital organisation typically constructs its ‘illusions and impressions’ (1959: 114). I mention this here, because through my ‘free access’ to the hospital, I not only had access to various confidential material on the hospital organisation, such as policy-making reports, standard contracts for surgical and medical treatment units, financial overviews and strategic visions for future treatment developments. In this engine room, I also had access to staff members’ reflections and discussions about how they experienced, thought and felt about doing different kinds of work at the hospital; how they felt about changes, and what they thought about new managerial attempts to regulate their conduct. When I changed status from consultant to PhD researcher, the scene of my everyday life shifted from the hospital to the university, but a very useful peephole remained open into the hospital world. The consequences of this kind of access are worth some reflexion because it may have affected the way I came to approach the front regions of the hospital.

A deal was set up. When I signed the PhD contract with Copenhagen Business School, I also signed a contract with my former work place. As part of my PhD contract, I agreed to work eight hours a week at the centre. During the contract period, I was thus enjoying a weekly workday at the hospital, where I frequently went to meetings with administrative colleagues and meetings with clinical staff (doctors, nurses, secretaries and dentists). Parts of my work schedule lay in extension of my previous consultant tasks within communication, and I also continued to rely on my personal contacts. I had previously collaborated with some of the doctors and nurses from the cancer clinic. I had met the clinic's head of research (the person was also the former head of clinic) through a common involvement in developing the centre's research profile. This person presented me to a research group at the hospital, who was interested in breast cancer illnesses and their treatment, including diagnostic methods, surgical techniques, nursing care, exercise and early recovery, anaesthesia, pain and vomiting medication. The group was led by a concern for ways to improve interventions to make patient trajectories both more effective and more efficient. The meetings in the group whetted my appetite for a sociological investigation of accelerated medicine. I found that new ways of organising cancer illnesses at the hospital were not without consequences for the conduct of medical practitioners in their day-to-day work. I will return to this issue later in the chapter.

When I decided to do a PhD, the head of research granted me official research access to the cancer clinic and its occupants. He also introduced me to the staff members when I later arrived on the ward.

At the hospital, I had my own desk and my own computer and a sign on the office door with my name on it. In the beginning of the PhD, my consultant job was to facilitate change processes in the centre, especially in relation to processes that had to do with the merger of clinical units. However, as I got more involved in my field-work, I needed to withdraw myself from these process facilitation tasks, and from then on, I spent most of my weekly workday writing official documents, newsletters,

web texts, and etcetera, for the heads of the centre. Through this preoccupation with merely administrative tasks, I was being legitimately sheltered off from the clinical environment. The argument for this separation was twofold: I did not have the necessary time to engage myself satisfyingly in the work. And the more I got involved in my fieldwork, the more it became necessary to separate the two job functions; i.e., to separate the function as consultant from the function as PhD researcher. The last couple of months of my project, I had almost entirely stopped working as a consultant in the administrative unit, and the weekly workday at the hospital was mostly spent writing up notes and talking to colleagues about dimensions of my project. Three and a half months before handing in the thesis, my contract with the centre came to an end and I stopped working at the hospital altogether.

These observations hopefully explain that not only did I sign a physical contract with the hospital when I started my PhD project. I somehow also signed an emotional contract with the clinical environment at the hospital. The fact that emotions are not epiphenomenal but are part of one's job is illustrated well in studies on emotion, work and organisation, as reviewed in the previous chapter. The fact that people are expected to 'give themselves to their work', as for example Boltanski and Chiapello (2007: 98) argue in their analysis of flexible capitalism, also involves that the work organisation may employ one's emotions both through the work contract and through the formal and informal work activities it demands of its employees.

In my case, this 'emotional contract' meant that I felt attached to my work place; I identified with my colleagues and the clinical staff members and their routines, and I felt committed to defend the hospital's precarious ways of doing things when this was demanded of me. In relation to my employment as a consultant, this attachment probably added some value in relation to my personal qualifications, especially when considered from the managers' perspective. However, the value of this attachment was questionable when it came to my function as a researcher. For instance, during my consultant years, I had participated in some work of streamlining

surgical procedures into so-called ‘speed-units’. From an administrative/economic perspective this was an interesting experiment because by changing the time tabling of the operation ward, one may succeed in changing some sacred clinical rituals: an earlier morning start in the operation ward meant that the involved doctors could not participate in their morning conference in the clinic. This example shows how I in my previous consultant job reproduced attempts of controlling the medics through new forms of governance techniques. It was now the self same attempts, I wanted to scrutinise in my research. But in order to thoughtfully problematise these procedures and to be able to observe them from a detached, sociological perspective, to see them from a safe distance where I did not share solidarity with either administrative or clinical concerns, it was extremely necessary for me to exit the hospital’s ‘engine room’.

This described difficulty of detachment from my former occupation also affected how I came to define my object of inquiry through taking some serious detouring routes. I will next explain the routes to the development of a focus on emotions in accelerated medical work. Subsequently, I will return to the issue of emotional attachment in relation to social science studies.

Defining my object of inquiry: From foci to a developing focus on emotions

The grounding of this PhD project was from the beginning attached to an empirical interest in accelerated medicine and the introduction of accelerated treatment regimes in the Danish health care system. The concept of accelerated trajectories was described in 2007 in an influential policy report, which was published in relation to the Danish Government’s launching of a quality reform of the public sector (see The Danish Ministry of Health and Interior, 2007). The concept was emphasised as ‘an important experience which needs to be systematically implemented at all hospitals in Denmark’ (2007: 94). On behalf of the Danish Government, the National Board of Health developed from 2005 to 2008 the so-called ‘cancer packages’, which are stan-

dardised, accelerated cancer trajectories, which soon afterwards were implemented throughout the health care system. I mention these things to explain how the PhD project was being fostered by specific changes to the organisation of medical work that took place while I was employed at the hospital as a consultant. The heads of the centre, where I was employed, were interested in gaining knowledge about how patients experienced the restructured trajectories. Due to a 'patient-centred' concern, they were also interested in how doctors could make themselves 'more' and 'better' available to cancer patients and their relatives in relation to the psychological and social problems associated with cancer illnesses and their treatment. These problems, which were addressing cancer patients' psychosocial health needs, have been documented in larger patient surveys and reports (see for example KB, 2006; Region H, 2008).

While working on different projects in the administrative unit, I did some work together with a breast cancer clinic at the hospital. The clinic was generally described in the administrative unit as extremely well-organised and highly skilled in its ways of attending to the needs of its patients. The clinic's ways of organising cancer illnesses and their treatment in standardised trajectories were also by the heads of the centre thought useful for other clinical units at the hospital. Hence, I spent some work time writing up the clinic's experiences and collecting various materials on accelerated medical work for merely administrative use. This initial gathering of material and the contact to the people who were a part of these trajectories became a valuable help when I was enrolled as a PhD, because it gave me a platform from which I could depart. It also gave me a research site at hand: a cancer clinic and its occupants. However, what this material did not help me with, was defining my precise object of inquiry and I will next explain my difficulties in doing that.

Broadly speaking, the cancer trajectories are, among other characteristics, defined by 'standardisation', 'quality', 'speed', 'accountability', 'audit' and the aim of meeting various 'performance' and 'measurement' targets. These key charac-

teristics led my attention to literature on public performance measurement (see for example Power, 1997) and Post-Foucauldian literature on governmentality (see for example Osborne, 1993; Dean; 1999; Miller and Rose, 2008). Following this line of thought, I wanted to explore the introduction of ‘cancer packages’ as a new form of governance, that, and here I was inspired by Osborne, entails liberal ways of organising medicine (Osborne, 1993: 345). I understood the latter as a new alliance of political, clinical and managerial concerns which aims to insert economic initiatives in various aspects of clinical practice to improve the output of health services⁹. The ‘cancer packages’ provided a good example of this tendency. When I started my fieldwork, I started to apply this approach not only to the documents that I had previously gathered, but also to the people I interviewed as part of my fieldwork. Specifically, I went to see people who were preoccupied with the development of cancer trajectories. Among these preliminary interviews, I remember talking for three hours with a retired professor in surgery, who came to visit me at Copenhagen Business School in November 2008. He introduced me to the historical development of breast cancer illness and its medical treatment breakthroughs from 1970 to today. At the same time, I began to reread ‘The Birth of the Clinic’ by Foucault (1973), which is a brilliant book about how the ‘clinic’ emerged as a site for learning and curing practices in the eighteenth century, and how this new organisational form of the hospital brought certain objects into focus, such as the (patient) case and the observing person (doctor). I was interested in how the role of the latter may have begun to take on new dimensions since Foucault made his observations - from that of Foucault’s observing person to a more personal or subjective person.

During autumn 2009, I started making observations in the cancer clinic. I observed doctors when they attended patients, relatives, colleagues and others in the clinic and its surroundings. I observed interactions in the outpatient clinic, operation

⁹ See Roelsgaard Obling, A. (2010) Pakkede patientforløb og styringsambitioner i det danske sundhedsvæsen, In Kjaer, P. and Reff, A. (eds.) *Patienten i centrum*. Copenhagen: Copenhagen Business School Press, pp. 101-129.

theatre, inpatient ward, and staff meeting room, corridors and doctors' private offices. When the doctors had conference meetings with their colleagues or attended patients in the outpatient clinic, I sat in. If they had coffee with colleagues and discussed their experiences, I would go too. I accompanied them on rounds in the clinic's ward and sat in on conversations with newly operated patients or worried relatives. When the doctors used electronic devices such as computers to access different databases or safety report systems or recorded patient stories with help of a dictating machine, I watched and listened. The choice of doctors being followed was not based on any particular criteria. Some doctors were suggested to me by the head of the department, others because of their availability on my observation days.

A central concern was to specify the aspects of medical work in the trajectories I actually wanted to focus on. Still struggling to make this decision in this phase of the project, my observations were unsystematic in a way that they surely discovered many aspects of interaction and everyday behaviour of the clinic and its occupants; however, in trying to cover 'every' aspect of medical work, I accomplished nothing. Should I focus on the production of medical knowledge in the trajectories? Should I keep the attention on clinical governance and audit practices? Or should I look at certain kinds of social interaction and for instance explore how doctors frame deviant patient cases or 'misfits' to the standardised procedures in the trajectories? Instead of confronting these difficulties, I decided to spend four months at Goldsmiths in London. Due to the lack of focus, my contact person (and later co-supervisor), Monica Greco, and I discussed some possible ways to frame the questions my fieldwork raised. She suggested that I looked into the literature of medical humanities or narrative based medicine (see for example Montgomery Hunter, 2001, 2006) to help me capture some of the different aspects of medical work the doctors in my trajectories were called upon to perform. This is literature which is often written by doctors who have turned to humanities to understand the more artful character of medical practice and organisation. This artfulness includes the communicative, emo-

tional and personal aspects, which are part of doctors' job when they attend to the needs of patients in medical encounters. Generally, doctors' skills of intuition or talent, certain professional behaviours (detachment, empathy), and their mastery of practical procedures are described in this literature as the 'arts of medicine' (see for example Nettleton, Burrows and Watt, 2008).

Coming from evidence based medicine and standards in cancer treatment to new modes of governance in health care to these more intangible aspects of medical work surely expanded my view on clinical practice. I began to reread my field notes in this light, paying particular attention to the character of the different kinds of work processes I had observed. Indeed, I found this new focus on the various conducts of doctors inspiring because it provoked a reductionist, EBM perspective, which merely sees doctors as applying scientists, whose job is to remove uncertainties and individual humanistic concerns from clinical practice (for a 'purified' form of this argument see Baum, 2007).

I became preoccupied with questioning the intangible aspects of medical work from a governance perspective, which sees medical practitioners as constrained by standardised, corporately framed diagnostic and prescribing procedures, and I began to explore questions like: How do we study these intangible aspects? How are these aspects reframed by the medical practitioners in ways that make them available for external observation? And how may these aspects become visible objects of inspection?

A small breakthrough came when my co-supervisor, after yet another discussion of my fieldwork exclaimed: 'It seems to me that the only elements which are left to orchestrate in your cancer clinic are emotions'. We had previously discussed what actually separated the doctors in my cancer clinic from Hochschild's flight attendants in Delta Airlines, so the emotion perspective was not an entirely new perspective to me. In light of this discussion and of my previous interests, I decided to focus my inquiry upon emotions and emotional aspects of medical work in the cancer

trajectories. Greco introduced me to her systematisations of the field and helped me to find my own place in emotion studies. When I later returned to Copenhagen, long conversations with my supervisor, Signe Vikkelsø, stimulated me to extend the range of my thinking. Especially her continuous pin-pointing of the importance of detailed empirical descriptions, inspired me to look into emotions as they anticipate in concrete practices in the cancer clinic. This likewise helped me to understand how emotion work takes place alongside other aspects of medical work; each aspect mixed up with one another, and each aspect equally necessary for the line of medical work in the cancer trajectories to be carried out successfully.

The shift from various – way to many – foci to a developing focus on emotions induced alterations in my methods and material. The earlier work generally assembled two types of evidence: 1) material on changes in the organisation of cancer treatment – the character of speed, the value of evidence, the methods of accountability, and so on – and 2) unstructured observations of practices, such as doctors ways to relate to principles of evidence based medicine in their daily activities. In the further process of defining my object of inquiry, the developing focus on emotions included that my methods and material increasingly focused on: 1) the description of how and when emotions occur as social components in practice and for what purposes, and 2) the examination of how doctors experience and understand emotions in various parts of their conducts. As a result, the inspiration from literature on ‘performance measurement’ and ‘audit cultures’ transmuted into a concern of locating contemporary demands for certain emotions and emotional expression within their specific social contexts. In this way, attempts to govern the conduct of doctors through various techniques – for instance through audit devices – were linked to the issue of how doctors anticipate more or less rationalised forms of socially sanctioned explanations and ambitions.

Gathering material on emotions

In relation to the refinement of my object of inquiry, the next step of my fieldwork was a series of 14 semi-structured interviews with doctors in the cancer clinic. Compared with my previous explorative interviews, which aimed at gaining knowledge of the formal organisation of accelerated cancer pathways, in this interview series I wanted to talk with the doctors about their personal (i.e. individual) understanding of emotional aspects of their work in the pathways. Concurrently with my own empirical research, I had been working with a colleague, Nanna Mik-Meyer, on an article based on a larger qualitative interview study, concerning how general practitioners (GPs) approach patients with medically unexplained symptoms (MUS). Our main argument in this article was that GPs not only use traditional biomedical diagnostic tools when attending patients with MUS, they also rely on their personal opinions and evaluations of a patient's particular circumstances in deciding whether the patient is legitimately sick or not (see Chapter 8 for the entire argument). Due to these findings, I was riveted by the ambivalence of emotions in one of the core practices in medical 'truth making' practice; namely medical diagnosis. In extension of this article, I wanted to explore in further detail how doctors in the cancer clinic experience emotions and the way emotions form part of their professional conduct. Current ways of organising technical aspects of medical work in the trajectories may also affect the organisation of emotional transactions in the trajectories, and as a result affect how doctors experience and understand emotions, or so was my hypothesis.

Following a constructivist perspective on the study of emotions, I had no intention of trying to trace what the participating subjects 'really' felt or to determine the authenticity and 'under-the-surface' feelings of the informants. Instead, I was interested in their presentations of personal biographies of emotional experience and emotional challenges. My initial interview guide was constructed so as to provide an understanding of doctors' views on and responses to their work life, and to understand how these people frame and reframe emotional injunction in their work. I was

interested in 'how it feels being a doctor'. Characteristic of a constructivist inquiry, the attention in the interviews was focused on the *activeness* of the interviews. This is not a new catchword to qualitative interview methods. Holstein and Gubrium (1997, 2002) argue in their work on interview method that all interviews are active interviews, hereby emphasising that the interview is not so much a neutral conduit or a knowledge container as it is a unique site for producing reportable knowledge. The constructivist phrase 'all meaning is socially constituted' (Berger and Luckmann, 1966; Garfinkel, 1967) gains momentum in active interviewing method, because it here becomes obvious that meaning and meaning structures are actively assembled in the interview encounter through interviewer and respondents' collective accomplishments. The emphasis on process in the interviews also included that the questions I asked in the interviews varied a little from interview to interview because the respondents conceived the questions asked differently. However, except differences in respondents' ways of answering questions, I tried not to lose too much track of the research topics guiding the interviews and the content of my questions, and how these were understood and communicated by the respondents. All interviews (with exception of a few clarifying interviews in the beginning of the research) have been audio-recorded and transcribed. Shorter interviews during participant observation were not recorded. Neither were more spontaneous conversations. In addition, notes on some of these conversations were written during the fieldwork.

I also revisited the doctors in the clinic. When emotions are approached as contingent social components, depending on social situation, context and historical time, then the ability to understand emotions at work is highly depending on methods to identify and describe how the conduct of doctors is organised in specific situations. At that time, I found fieldwork in the clinic to be a reliable choice of method because in order to observe how individuals can both 'affect' and 'be affected' in social interaction, and to recognise the complex interweaving of emotion and reason which makes up the course of doctors' job, I needed to be part of the context. Importance

was hence given to direct ‘in situ’ observation of concrete sequences of activities in the clinic (see also Goffman, 1989; Baszanger and Dodier, 2004). However, compared with my previous fieldwork, I now had my attention focused on the situations in which doctors offered emotional services or responses aiming to facilitate patients in particular situations. In other words, I paid attention to how doctors managed emotions in relation to patients, relatives – and not least themselves – in the cancer clinic.

To sum up, my fieldwork in the cancer clinic was spread out over almost two years from June 2009 to January 2011.

First, I talked with several people to gather material on the historical development of the accelerated cancer pathways. In addition to these interviews, I later interviewed doctors in the cancer clinic to explore more directly how they experience and understand emotions at work. The appendix shows the entire list of interviews (see Appendix A). The interviews are indexed with anonymous names and I refer systematically to those names throughout the thesis.

Second, I made observation of a training workshop in ‘empathic communication’. I have field notes from this workshop with doctors and nurses from the cancer clinic, and I have three transcribed interviews with heads of the cancer clinic and the consultant who facilitated the workshop. In addition to this material, I have a collection of documents from the workshop (invitation letters, teaching material, workshop presentation). From my previous employment at the hospital, I have material from workshops of a similar kind, where doctors were trained in having difficult conversations with patients – for instance conversations about poor diagnosis or future health perspectives.

Third, I have observed lots of encounters in the cancer clinic (conferences, operation theatre, ward rounds, and etcetera) and I have spent 15 days observing patient-doctor interactions in the cancer clinic’s outpatient consultancy rooms.

The appendix shows the type, location and frequency of my observations (see Appendix B).

Finally, I have listed all the official documents I have used through the thesis in the appendix (see reference list). The document material include policy documents, clinical guidelines and practice recommendations, strategy reports, patient satisfaction surveys, medical textbooks and practice journals and locally circulated information material such as letters and e-mails. Material is also drawn from attending both academic and practitioner conferences on the organisation of cancer illnesses and their treatment.

Starting out from various foci on medical work to a developing focus on emotions, I began more systematically to ask the question: *how is emotion framed, trained and performed by doctors in accelerated medical relationships?*,

Each chapter or article in the thesis takes as its point of departure a smaller part of the fieldwork, and each chapter deals in particular with one of the above raised concerns. Chapter 5 deals with policy documents gathered in the early stages of the project that inset emotional injunctions to doctors and I analyse how doctors in the cancer clinic reframe these injunctions. Chapter 6, which is preoccupied with analysing how certain emotions are trained in the clinic, draws on material from the training workshop. Chapter 7 and 8 are both preoccupied with a concern of how emotions are enacted by doctors. However, the two chapters take different material as their point of departure. Chapter 7 relies on the small semi-structured interview series with doctors in my clinic, while chapter 8 relies on a larger interview study with GPs in the primary health care sector. Even though the chapters vary in their ways of engaging with the fieldwork, they also overlap and – that is the aim – enrich each other. Of course this sometimes means that they appear repetitive, which I think is one of the article-based thesis' main structural challenges and therefore not unique to my particular thesis.

I think every researcher is occupied with defining when his or her material collection is sufficiently satiated to successfully carry out the research project. In his writings on 'intellectual craftsmanship', Wright Mills (1959) argues that, once one has decided upon a topic and has entered it, one does not need to 'study' it, because suddenly it will appear to be everywhere. I experienced this insight in relation to my process of gathering material, because suddenly also apparently unrelated issues emerged as casting new light on the research and its discussions. For example, it occurred to me during an academic seminar that fellow researchers within organisation studies have recently started to argue that we, as researchers, should strive for putting back feelings into our research methods. I noticed that personal characteristics of the researcher, which are closely tied to emotions such as 'authenticity' or 'sensitivity' or even 'love', were brought forward by some of the participants as a methodological solution to an apparent 'coldness' or 'detachment' of social scientific inquiry. Some of the arguments, which were brought forward in these discussions, had a similarity to the arguments of 'more emotionality' in relation to the conduct of doctors in the cancer clinic. The two different settings – that of cancer treatment and that of social science research – thus seemed to share a language of emotions, in which some emotions were approached as more gratifying than others. At the time, I remember that I found these arguments strange. Anyhow, they deserve attention in relation to some methodological problems concerning involvement and detachment that I have faced in this study of emotions. I will next turn to this issue.

Problems of involvement and detachment in the study of emotions

One cannot say of a person's outlook in any absolute sense that it is *detached* or *involved* (or, if one prefers, 'irrational', 'objective' or 'subjective'). Only small babies, and among adults perhaps only insane people, become involved in whatever they experience with complete abandon to their *feelings* here and now; and again only the insane can remain totally unmoved by what goes on around them. Normally adult behaviour lies on a scale somewhere between these two extremes' (Elias, 1987 [1956]): 3, my emphasis).

In an essay concerning knowledge in social sciences, Elias (1987) discusses some methodological difficulties in relation to how the researcher should be engaged with her object of inquiry. In relation to this, he discusses the terms 'involvement' and 'detachment'. The terms do not refer to two separate sets of human attributes, such as one psychological or emotional and the other scientific or rational in character. Instead, he argues that one cannot separate the two phenomena and he denies that any sane adult could be either wholly involved in or wholly detached from what goes on around them. Thus, according to Elias, it is not possible to obtain any ultimate detachment or complete objectivity in relation to studies of social arrangements.

What Elias draws attention to here, is the double character of demands to researchers within social science studies. On the one hand, the researcher's ability to sustain affective neutrality and detachment is crucial for carrying out her scientific work. On the other hand, the researcher's sense of sensibility and her affective experience of particular situations and participants, contribute to the production of the knowledge of social processes which comes together in the research. I think this double character is worth some consideration, especially in studies like mine in which one of the aims is to redescribe the public sphere as saturated with emotions. The methodological

challenge consists in doing this from an ‘affectively neutral’ stand point and without being ‘gripped’ by emotions. And how does one manage this?

To keep a distance from taking over the statue-like figures of ‘involvement’ and ‘detachment’, as being radically in opposition to each other, I have tried to study emotions: 1) without sentimentality, and 2) with sensibility to the performative value of particular contexts. In making this kind of methodological vocation, I have foremost tried to stay clear of any sentimental approaches of either bringing back emotions into medical practice or of protecting certain emotions in this practice. This does not mean that I have intended to replicate historical attempts at separating reason or rationality from emotion in social sciences, where a foregrounding of the former tends to silence the characteristics of the latter and hence leave it out of empirical studies in the context of work and organisations. Instead, I have paid attention to the relatively contingent character of emotions, consisting of the dependence upon variables such as social situations, historical time, and institutional context. To study emotions without sentimentality is easy to say but difficult to invoke in practice. Because what and whose emotions do we, as researchers, operate through when we attempt to categorise some practices as more emotional than others or when we attempt to highlight a particular emotion in empirical descriptions to the disregard of other emotions?

In a previous section on ‘approaching emotions’, I referred to Wittgenstein’s explanation of how we may approach emotions as ‘meaningful emotions’ in relation to the expression and understanding of emotions in social life. The core of his argument was that the role and function of particular emotions vary across contexts. From this followed that emotions are of many types and may have different intensities in human conduct. To take a glaring example, in a novel, the American novelist Raymond Carver (1995) discusses the category ‘love’. The title of his novel is perhaps not surprising: ‘What we talk about when we talk about love’. He describes an interchange between two married couples and their discussion of ‘love’. He writes:

'There was an ice bucket on the table. The gin and the tonic water kept going around, and we somehow got to the subject love. Mel thought real love was nothing less than spiritual love [...] Terri said the man she lived with before she lived with Mel loved her so much he tried to kill her [...] I picked up Laura's hand. It was warm, the nails polished, perfectly manicured. I encircled the broad wrist with my fingers, and I held her' (1995: 138-139).

'Love' is definitely an emotive word. In the above written quote, it conveys something of the author's experiences. However, the statements, 'real love was nothing less than spiritual love', 'loved her so much he tried to kill her' and 'I encircled the broad wrist with my fingers, and I held her' also give texture to the meaning of the individuals' feelings of love. The first sentence presents a transcendental definition of love, while the next sentence presents a more extreme, pathologic version of the word. The last sentence is somehow placed in-between the two previous sentences. On one hand it presents a physical expression of love. On another hand, it contains some uneasiness, especially uttered in the last four words 'and I held her'. In offering these interpretations, the reader is no blank sheet. It is precisely by these reconstructions that the signs of the sentences are imputed with a certain kind of emotionality. Hence, our own identity or biography matter in emotion inquiry. The researcher's emotion work is both a part of the approaching and the validation process (Fineman, 1993; 2006).

The relative embeddedness of researcher and the researched objects in emotion inquiry is not only a mean to reflect upon the nature of emotions. It is also a mean to address a political concern. Because whose emotions do we actually resonate with when we ask questions of emotion in our research? The significance of the expression of certain emotions may be attached to a moral labelling (Goffman, 1990b).

In one of the articles in my thesis, I draw on an example of a patient who ‘expressed too much aggression’ and a patient who ‘was cold and did not express any emotion at all’. The doctors in my clinic presented these examples as examples of deviant emotional outbursts and hence as not appropriate for the representation of a ‘patient’. Other sources, for example newspaper articles, public statements from patients, and debates in psychiatric circles might represent these emotional events very differently, depending on interest. If we take emotions to be shaped through social processes of all sorts, then we are necessarily confronted with ‘many possible voices to represent feeling and emotion’ (Fineman, 2006: 688). As emotion researchers, we must therefore try to avoid foregrounding a particular language, for instance a language of ‘sentimentality’ and pay attention to how the framing and enactment of emotions also are a kind of moral currency.

The above account has introduced some of the problems of conducting research that is sensitive to claimed characteristics of emotions and to altering contexts. I have shown some of the general problems in emotion research (focusing, gathering, appreciating emotions). At the same time, some specific research problems in the context of my personal biography were highlighted, such as my role as researcher and my problems in relation to involvement and detachment with my field of inquiry.

Writing on emotions

In relation to the above considerations on ‘involvement’ and ‘detachment’, I acknowledge that I have my own emotional investment in this PhD project, even though I have tried to stay clear of the spirit of a ‘passionate sociology’ (Game and Metcalfe, 1996). My methods have definitely generated ways of talking and writing about and presenting emotions in the scrutinised contexts and my involvement has contributed to a production of an awareness of social constraints in specific interactions. However, research and writing activities are always a subjective matter, and as I have tried to show in this chapter, my own preoccupations and interests are inflected

in my experiences and form part of the reflexive act of generating insight through the process of writing up the thesis. Whenever I discuss emotions in the thesis, the reflections are thus a mixture of personal experiences, other peoples' writings on the topic, and of course, the material I have gathered in the fieldwork.

In the first section of this chapter, I described my access to the cancer clinic and its occupants, and I described the chronological process of becoming detached from my field of inquiry. Not only did the physical process of distancing myself from the hospital help in that matter. Also the process of writing up the thesis was a useful detachment procedure. In one of his essays, Elias (1987) has a picture of a fisherman who is captivated in a maelstrom and thus involved in, what he terms, 'a critical process which at first appeared wholly beyond his control' (1987: 46). I use this analogy to reflect upon my own difficulties in relation to my access conditions and my involvement with the hospital. Elias continues his essay by explaining how the fisherman in the beginning 'clutches at some imaginary hopes. Fantasies of a miracle, of help from unseen persons may have crossed his mind'. However, this does not change a thing. First when the fisherman realises that he must stand back and turn his thoughts away from himself to the situation in which he is caught, he manages to change the situation and then 'he began to think more coolly' (ibid). I think this insight is important in relation to my own experiences with affective separation from the field of study. I am not less emotionally involved today, than when I started out writing this thesis. Neither am I less engaged. However, an ability 'to think more coolly' about things have slowly emerged during the research process and the additional writing process, that have detached me from the activities and the people I formerly was a part of. This process of detachment also implied that I eventually started to make sense of the things I had observed and to ask focused questions to the empirical realities I had experienced. Hence, this emerging self-awareness also helped me to refine my object of inquiry. The thesis presented here is a result of this process.

One thing is how my methods and my process of detachment have helped me to refine my object of inquiry. Another thing is to explain how this object is presented throughout the rest of the thesis.

With regard to ethical concerns, it should be mentioned that while the participating organisation has co-financed my thesis, it has been difficult to provide it with total anonymity. As far as possible, I have tried to conceal the identity of the local cancer clinic and its surroundings, especially in the four articles, where the precise naming of these institutions did not have any function anyhow. Of course individuals – professionals and administrators as well as patients and relatives – have been given full anonymity throughout the research. Denmark is a small country. The professional cancer community is equally smaller and bustling with interconnectedness. Thus, the most general identifiers have been used to identify the source of the quote. I have followed the British Sociological Association on how to conduct research in an ethical responsible way. This includes general rules for participant acceptance, and procedures for processing and storing of data. It also entails recommendations for how to communicate the result of this research in appropriate ways in journals and public media. Apart from rules on ethical responsible research no formal ethical approval to conduct a research project like this has been required in Denmark.

In relation to practical concerns, I have translated all fieldwork citations from Danish to English. This implies that translation of the participants' spoken language in some places has been reduced in relation to its vividness and its degree of detail. However, I have strived to maintain the original meaning of the citations, and I hope that the language deficit does not make the meaning of my translations too ambiguous or unclear to the reader. In relation to writing a thesis, which is situated at a hospital, I have paid attention to learning some of the idiosyncrasies and vocabulary of the doctors present in the study. In situations where I have had difficulties to un-

derstand a medical terminology, I have turned to people at the hospital or doctors in my circle of acquaintances for help.

In relation to accountability concerns, I have clearly marked throughout the thesis, and especially in the four analysis chapters (Chapter 5–8), when for example utterances from my material are directly used as empirical evidence or when I have reconstructed these utterances as reconstructions of realities. Finally, which brings me to the end of this chapter, throughout my work I have tried to make transparency between my own engagement in the field, the methods involved and the process of generating and redescribing social arrangements in this field.

Chapter 5: The ‘compassionate’ doctor - Emotional injunctions to medical professionals in accelerated medicine

Abstract

This paper focuses on emotional injunction that programs of ‘accelerated medicine’ impose on medical professionals. The paper explores recent reforms of the public health sector as modes of clinical governance that encourage doctors to become more emotionally available to patients. It further examines how these reforms inset increasing demands on doctors to manage the emotions of patients in recordable, measurable and standardised ways. Empirical attention is drawn to descriptions of accelerated cancer pathways and how these descriptions anticipate emotional injunctions to doctors, such as injunctions to doctors to exhibit ‘empathic’ engagement or ‘authentic’ engagement, while they respond to the needs of patients. An Eliasian perspective on the management of emotions in work and organisational settings is used to make sense of the injunctions and to capture how the conduct of individual professionals is interwoven with recent reforming drives. The perspective is furthermore applied to debate processes of formalisation and informalisation in relation to the ways people are expected to behave in medical relationships.

Keywords: Emotional injunctions, accelerated medicine, doctors, Elias, public health care sector reforms.

Introduction

Over the last two to three decades a body of work has emerged on the impact of the wave of public health sector reforms in Western societies on the medical profession (e.g. Dent, 1993; Fitzgerald and Ferlie, 2000; Doolin, 2002; Harrison and McDonald, 2008; Waring et al, 2010). The impact of these reforms has been explored by critically questioning the role of New Public Management and principles of quality, au-

ditioning and performance measurement that attempts to make medical treatment more effective. Ewan Speed (2011), for instance, has argued that recent reforms in the UK National Health Services (NHS) have led to significant changes in regard to governing medical work. He introduces how these reforms entrench organisational forms, which 'dominate and regulate health professionals through less and less visible, but more and more pervasive command and control mechanisms' (2011: 101). One of these mechanisms of control is manifest in the reforms' emphasis on 'quality' or 'quality improvement' (2011: 94). As a mode of governance, the emphasis on quality involves both a regulation of instrumental aspects of clinical work procedures and a cultivation of 'softer' relationships, i.e., a control of social and psychological attributes of working subjects. The reforms install a political aim to treat 'the users of services as queens not pawns' (2011: 99). As 'queens', patients must be attended by engaged doctors, who invest themselves on a subjective level in the delivery of health care services. Likewise David A. Buchanan and Louise Fitzgerald (2011) demonstrate how a new generation of performance and measurement targets, aimed at improving quality and efficiency, includes demands on professionals to exhibit 'compassionate care' (2011: 72). They ask rhetorically how the delivery of compassion 'is to be measured, by whom, how often and where, and against what standards and benchmarks' (2011: 73). Compared to the delivery of traditional medical services – for example to take someone's blood pressure, the measurement of emotion conducts involves yet unsolved problems.

If we expand the empirical field of investigation to the public sector and civil servants at large, the sociologist Paul du Gay (2008) draws our attention to contemporary political and managerial demands for increased enthusiastic responsiveness in public offices. He claims that public servants are met with two emotional injunctions: one, which requires bureaucrats to be passionately responsive to the needs of their clients, and one, which requires bureaucrats to be enthusiastic advocates of particular policies. The demands for responsiveness and enthusiasm when applied to

professional work of civil servants include the aim to ‘inculcate in bureaucratic conduct a sense of compassion or close identification with others’ feelings’ (2008: 336).

However, the idea of bringing compassion – or even better bringing *back* compassion into clinical procedures as something which has been lost in ‘an era of scientific-bureaucratic medicine’ (Harrison, 2002) and medical expert dominance, I will argue, is not only manifest in current reform attempts, but can also be found in medical practitioner literature, namely medical humanities literature or narrative based medical literature. This literature, which is often written by doctors, has turned to the humanities to understand the ‘uncertainty and turmoil in medical practice and organization’ (Brody, 1998: xv). The English historian of ideas, Monica Greco, describes the discipline as work ‘who has turned to humanities with the aim of enabling doctors to address better the complexity of each medical situation, particularly with regard to its more intangible, personal and communicative aspects’ (Greco, 2008: 30).

According to one author, Dr. Audrey Shafer, who is also the editor of the medical humanities journal, medical practice should not only be more effective but also strive ‘to perfect and pop out a humanistic, compassionate, complete doctor’ (Shafer, 2009: 4). Among the most significant features of the literature is the request for what the general practitioner Rita Charon (2001) terms ‘*empathic engagement*’ and ‘*authentic engagement*’ (2001: 1897-1898) in medical relationships. She argues that these forms of engagement can be ways to ‘improve the effectiveness of the professionals’ in current times when medical procedures speed up as a result of rearrangements of the health care system. She writes that through authentic engagement and true responsiveness with patients, doctors can achieve effective, engaged therapeutic relationships and be ‘moved to act on the patients’ behalf’ (2001: 1897). In relation to processes of clinical treatment and care, Charon describes ‘empathic engagement’ and ‘authentic engagement’ as specific competences, which the doctor is required to exhibit in patient-doctor interactions. She furthermore writes that when

requiring such competences ‘it may be that the physician’s most potent therapeutic tool is the self, which is attuned to the patient through engagement, on the side of the patient through compassion, and available through reflection’ (2001: 1899). Doctors are thus required to turn to individual patient cases with ‘passionate’, ‘personal’ and ‘engaged’ commitment.

In this article, I want to pursue the argument that public health care reforms and the request for medical professionals to exhibit ‘compassionate’ care, and forms of ‘empathic’ engagement raised in medical humanities literature, are hardly distinguishable: both inset emotional injunctions to medical professionals, which include a call for doctors to become more emotionally available to patients and to exhibit a particular emotional behaviour in medical relationships, namely that of a ‘sincere’ or more ‘natural’ behaviour. On one hand, we see a movement towards rationalisation of medical services, tied to tropes of ‘effectivity’, ‘quality’, ‘standardisation’ and ‘audit’. On the other hand, we have a movement towards a heightened degree of emotional sensitivity required on the part of individuals, encouraging a seemingly emancipation of emotions in medical relationships.

I will argue that the current framing of the role of emotions in medical work, and an apparent relaxation of emotional codes of conduct in this work, is manifest concurrently with formalised attempts to manage the emotions of patients in recordable, measurable and standardised ways. The latter tendency hence represents increasing constraints towards processes of emotional control in medical work and new modes of clinical governance rather than a loosening of emotional behaviour and manners.

The paper explores this assertion through an analysis of recent health care reforms. These reforms are understood as framing the role of emotions in medical work. In particular, I focus on the changing emotional demands the treatment concept which I term ‘accelerated medicine’ impose on doctors and on how doctors are expected to exhibit a variety of emotional skills in patient-doctor interactions, as for ex-

ample the exhibition. The inquiry draws on empirical data material from research on the introduction of accelerated cancer pathways in a cancer clinic at a major university hospital in Denmark. The article is structured as follows: First, political and managerial documents issued by, among other agencies, The National Board of Health, Denmark (NBH), describing the organisation of the accelerated cancer pathways and the institutional framing of the role of emotions in these pathways, are reviewed. Second, attention is paid to the possibilities for doctors of managing patients' feelings (and own feelings) in the rearranged pathways.

The approach to the management of emotions in work and organisational settings

To approach emotional injunctions to doctors in accelerated cancer pathways, I will use an Eliasian perspective on emotions, however without applying his greater framework of figuration sociology to the inquiry. His perspective is worth exploring in order to draw attention to how professional codes of conduct and exhibition of emotions in medical relationships are interwoven with the introduction of new modes of clinical governance in relation to cancer illnesses and their treatment. This section first explains some core elements of 'The Civilizing Process' theory (Elias, 2000) to understand socio-historical developments of formalisation and informalisation of emotions in processes of civilisation. Next, the section departs from the Elias follower, Wouters, to explain how we today witness an increasing demand for 'smoother' manners in health care organisations while these manners increasingly are formalised in measurable, standardised ways.

A core theme in Elias' work is how historical changes in power structures are reflected in changes in the 'psychological make-up of people' (2000: 369). Elias links the notion of *civilité* or *civilization* to changes in human codes of conduct and demonstrates how emotions are controlled in rationalised (i.e., civilised) societies. By doing this, he develops Weber's (1978) historical view on rationalisation, bureauc-

racy, and the impact of rational practices on the organisation of the public sphere and interpersonal relationships. Elias describes the social advantages of ‘those able to moderate their affects’ (2000: 370) and he demonstrates how specific forms of ‘affect control’ and ‘management of the emotions’ are products of dual developments of socially instilled agencies and self-restraint. These modes of regulation are different from earlier versions of external control such as physical force or acts of extreme violence. In his view, the increasing functional differentiation of society has since the Renaissance caused an expanding mutual dependence of its members, which has led to a social necessity for controlling one’s feelings in public. One must interact and ‘be hospitable to a potentially vast array of others’ (Newton, 2001: 488), which also includes that one must interact with a ‘smooth’ face within employment and professional settings.

Also Weber stressed what he saw as a dual process of rationalisation and emotional self-restraint in the emergence of modern societies. Indeed, one of the strengths of bureaucracy was that its employees would follow standardised rules and procedures ‘without regard for persons’ and conceal personal (i.e. individual) feelings, such as love and hatred, in dealing with human affairs (Weber, 1978: 600). In relation to emotions, and in conflict with many readings of Weber, the emergence of the bureaucratic organisation was not equal to a development of emotional deficit. Weber acknowledged that emotions are an essential part of professional office work, but he argued that emotions must be controlled in matters appropriate to an ethic handling of office cases. However, Elias goes even further than Weber in emphasising the importance of affect control as a constitutive element of modern societies. New patterns of emotion management are connected to the development of peoples’ increasing capacities of foresight, calculation and control. This also includes the capacity of individuals to observe and regulate themselves from the vantage point of others and to understand that expression of emotions has social consequences. Elias demonstrates for instance how the experience of repugnance and embarrassment en-

courages individuals to increasingly repress some passions in public encounters (e.g., anger, rage) while it opens up the possibility of the expression of other emotions (e.g., sympathy, happiness). The key objective here is that in professional work consisting of rational, bureaucratic actions, emotions are not as such neglected. Instead, emotions are increasingly being mouldered as part of the development of rational human agency. This happens in a complex interplay where people balance their emotions vis-a-vis others. Likewise, as also Goffman (1959) has described, people need to attune their conduct to that of others and their 'web of actions must be organised more and more strictly and accurately [...] in an increasingly differentiated, more even and more stable manner' (Elias, 2000: 367). Emotions, passionate impulses and desires undergo a civilising process with the result that they become increasingly formalised. The behaviour associated with *civilité* is shown to be directed towards the regulation of the conduct of individuals through detailed behaviour rules. Elias explains through lengthy empirical inquiry into etiquette books of the upper middle class in Europe from the late Middle Ages to the Renaissance, how highly refined rules of etiquette, such as how to eat meat and use knife and fork at a table, how to undress in the bedroom and how to blow one's nose and spit in front of others represent a transformation of human manners. He argues that through the civilising process these formal standards of socially sanctioned emotional behaviour are gradually replaced by more informal – and often more implicit – codes of conduct as an 'increasing social restraint towards self-restraint' (2000: 365).

In addition to Elias' theory of civilising processes and the 'commingling of patterns of conduct', Wouters presents the argument that self restraint today has become both more skilled and more subtle. He refers to this trend as '*informalization*' (Wouters 1986; 1999; 2009). The term refers to 'the relaxation of the social codes [...] in combination with increasing social demands on self-control; it implies a change in the patterns of social control and self-control and also a higher level of reflexivity on the part of individual people' (1999: 416-417). The expression resembles

the one used of Elias when he speaks about processes of ‘constrains to be unconstraint’ (Elias, 2000: 365-379). It indicates that processes of ‘self-constraints have not only become more flexible, at the same time they have also become more strict’ in recent developments of emotions control (Wouters, 1986: 1). According to Wouters, this trend gained momentum in the 1960’s and 1970’s, but is anyhow still one of the main characteristics of the civilising process. If we draw upon the Woodstock Festival as an example, we might get the impression that the festival and its surroundings’ emancipation rhetorics include a radical emancipation of emotions, since the refinement of self-restraint implies less rule-based standards of emotional behaviour and more ‘naturalness’ in expressions. But Wouters argues that informalisation implies a ‘different pattern of self-restraint [which] demanded not only greater sensitivity to varieties and greater flexibility in social conduct, but also a higher level of self control’ (1986: 1). The apparent relaxation of emotional control and the performance of seemingly natural or relaxed ‘decontrolled’ actions go hand in hand with a refinement of emotion management: such is the argument.

Where do we see empirical evidence of informalisation in present-day work settings? According to Van Iterson et al. (2001) fieldtrips to public offices, such as tax bureaus, social welfare offices and hospitals, may give one the impression of a ‘lowered acceptance of power and status differences, abating ceremony in meetings’ and ‘increasingly relaxed interaction’ between people in the observed places (2001: 507). The authors also draw our attention to ‘the growing tolerance for informal clothing, the use of first names and colloquial speech, confessing private feelings and expressing emotions [...] and in general the blurring of the boundaries between “work life” and “private life”’ as examples of aspects of informalisation processes (ibid). In addition, Van Vree (2011) points to transformations of the ways in which people behave in professional meetings to provide evidence of the informalisation trend. Generally, dominant meetings manners – regulated by rigid rules and customs to keep polite manners and to control meeting participants when social tensions increased -

have become smoother, easier and more flexible. However, whereas meetings have lost some of the formal characteristics, attending meetings now places greater demands on one's own initiative and feeling of responsibility. Informal meetings codes constitute just another set of pressure on how to behave, which might be experienced as even more restraining than previous formal rules. Participants in meetings must still act appropriately in front of others, but it is becoming more complicated what kinds of rules are guiding their behaviour. People thus need to find an agreeable balance between formal and informal behaviour; between formally defined standards of professional behaviour and informally unstated concerns of 'truly engaged' behaviour.

To sum up, processes of informalisation do not represent a loosening of emotional display or more relaxed emotion codes, but rather their refinements through seemingly more 'sincere' or 'natural' practices. Health care reforms which demand more 'empathic' engagement or more 'authenticity' of doctors' conduct, call for research attention, because they might tell us something important about the organisation of refined professional behaviour in health care organisations.

Method

The article is based on reflective analyses of material from a study concerning the management of emotions in accelerated medicine, which was completed in Danish health care services between June 2009 and January 2011. The selected material in this article provides evidence relating to some of the consequences of recent rearrangements of cancer care in Denmark, especially in regard to the emotional demands that these reforms impose on doctors working within cancer services. The Danish study supplements previous studies from especially UK National Health Services (NHS).

The analysis has the following structure. First, I review documents issued by The National Board of Health, Denmark, The Danish Government and clinical

articles published in practitioner journals, using a relatively simple ‘informed content analysis’ (Prior, 2003: 21). The documents contain detailed trajectory descriptions and I focus on their definitions of technical, social and psychological components of medical work in the trajectories. The sources of data are approached to analyse ‘the active contribution of texts to organizational processes’ (Cooren, 2004). The document material is selected in relation to its status as public reform material, which is exemplified in policy documents such as The National Cancer Plan I-III and The Health Packet 2009. As reform attempts, these documents have brought about new ways of organising health care processes as essentially a matter of changing existing routines to provide efficient and effective cancer diagnostic and care, or so the explanations go. In the material, particular categories are highlighted, which are categories of ‘empathic’ engagement and ‘compassionate’ care, such as, ‘empathy’, ‘authenticity’, ‘engagement’, ‘responsiveness’, and so forth. The second stage of the analysis builds upon interview and observational data from a cancer clinic to discuss the practical circumstances of managing the feelings of others in the programs of accelerated medicine.

Accelerated cancer pathways and the conceptualisation of the ‘stand up patient’

In Denmark the organisation of cancer illnesses and their treatment have recently been rearranged to improve the provision of health care services to patients with cancer. The National Board of Health, Denmark, has introduced two national ‘Cancer Plans’ (NBH, 2000; 2005a) and an outline for Cancer Plan III has been approved at The Danish Governments annual budget proceedings (The Danish Ministry of Finance, 2010). A fundamental element of the Cancer Plans is the implementation of the so-called cancer treatment packages (in Danish: ‘Kræftpakker’) to optimise therapeutic procedures and minimise delays at hospitals and improve continuation and co-ordination across the primary and secondary health care sector. The treatment package concept bears close resemblance to the widespread concept of ‘accelerated medi-

cine’¹⁰: both emerge from an ambition concerning the establishment of economic, effective and efficient patient trajectories in the health delivery system (Roelsgaard Obling, 2010). I intend to use the term ‘accelerated cancer pathways’ or ‘trajectory programs’ throughout the article to minimise confusion to the reader.

Accelerated cancer pathways have been developed as an attempt to contain costs in an era of rising health care expenditures, limited financial resources and a political attention towards matters of public concern, such as empowering patient choice (‘patient-centredness’ rhetorics) and reducing waiting times for diagnostic and treatment. The trajectory program also seeks to meet clinical objectives by reducing the mortality rate of Danish cancer patients. The immediate effects of the implementation of the trajectory programs have been noticeable in regard to more rapid diagnostic and treatment procedures (NBH, 2010a), reduction of length of hospital stay¹¹, standardisation of clinical procedures across hospital units, quality improvement initiatives concerning for example standardisation of after surgery recovery procedures, and new administrative processes of documentation and performance measurement (NBH, 2010b).

A pervasive concern in the trajectory programs is what I term the *stand up patient* concern. Opposite to a traditional concern, where the patient must restore her bodily malfunction through bed rest and a non-defined length of hospital stay, the ‘stand up patient’ concern promotes the notion that patients become more ill if they stay in their (hospital-) bed for too long. Thus the point is here that the length of their hospital stay must be reduced. From this also follows that patients may get cured more efficiently through accelerated diagnostic and treatment processes, where wait-

¹⁰ I intend to use the terms ‘accelerated clinical pathways’, ‘optimised clinical pathways’ or ‘treatment packages’ more or less synonymous through the text. All terms indicate an occupation with continuation and standardisation in a given line of treatment and therapy, and focus on economics, quality and performance measurement. The term ‘accelerated medicine’ is used as an assemble term to capture core themes of accelerated cancer pathways, such as ‘packaged diagnostic and treatment’, ‘optimised care’, ‘accelerated trajectory’, ‘fast track surgery’ and ‘integrated care’.

¹¹ The general length of hospital stay for women who has been surgical treated for breast cancer has recently been reduced from 3,6 days to 1,2 days (Gärtner, 2010). This also includes women who had been operated for a tumour in the breast and where the whole breast has been removed.

ing times – including recovery time - are reduced while they are hospitalised. The patients' efforts to regain strength are transferred to locations outside the hospital – for example to private homes or rehabilitations centres. In a document issued by the Danish Government concerning quality reforms in the public sector it is stated that the result of the accelerated programs is 'that patients faster can get back to a normal life' (The Secretary of Ministers, 2007: 1). The health benefits to the patients are invoked as the key driving agent of the reform, but means of resource allocation also lie in the centre of these reforms. Advocates for the 'stand up patient' concern focus on accelerated trajectories as a future way to organise illness trajectories that will include 'optimised quality and economics with a reduction of hospital beds as a derivative consequence' (Kehlet and Hoejgaard, 2004: 4707).

Emotional injunctions to doctors in accelerated cancer pathways

An essential part of the accelerated cancer pathways is the introduction of new modes of clinical governance, i.e., new forms of controlling professionals' activities in clinical work. The activities in the accelerated cancer pathways are organised by written 'trajectory descriptions' which in detail determine how doctors ought to diagnose, treat and inform patients in the pathways. As originator of the trajectory descriptions, The National Board of Health, Denmark, describes in a policy document the aim of introducing the accelerated cancer pathways in the public health sector as that of providing 'optimal' services along a variety of parameters. It says in the document:

'The aim of "cancer packages" is to provide optimal diagnostic and treatment to patients in regard to shorten the pathways and hence improve prognosis, quality of life and decrease the anxiety caused by waiting time, where the cause of delay is unknown' (NBH, 2008a: Foreword)

The term 'packages' defines 'patient pathways, where every step is organised as time and content well-defined events, which follow a pre-booked trajectory plan' (NBH,

2005a). Furthermore, NBH emphasises that it is of crucial importance to ‘diagnose and treat most [cancer] patients in *very fast* trajectories’ (NBH, 2008b: 1, my emphasis). The descriptions show how hospitals must adopt ways to streamline and accelerate patient flows through what resemble methods of lean management and business process redesign. In other words, it is performance and management practices similar to those used to reduce financial costs, improve quality and address problematic bottlenecks in the Japanese car industry. The contention is that tight process control and closely integrated operations are more productive (Lowe et al., 1997).

The trajectory descriptions, which determine clinical work procedures as well as social and psychological aspects of these procedures in the accelerated cancer pathways, are mainly based upon evidence based, national and nation-wide clinical guidelines and recommendations¹². They consist of detailed procedure descriptions of the pre-hospital care phase of the pathways (for example pre-diagnostic examinations in primary care); the diagnostic phase; the treatment (surgical) phase; and the adjuvant phase. But descriptions of more general elements in relation to rehabilitation, palliation, provision of nursing care and delivery of patient information (NBH, 2005a; NBH 2008a) are also included in the documents.

A closer look at one of the descriptions, namely a description of the organisation of breast cancer illness and its treatment sheds light on the treatment phase of the program (NBH, 2009a: 15):

- 0 Day. Managing patient referral; booking of patient-doctor consultations and examinations (3 days)

¹² Clinical guidelines are frequently used by doctors in their daily medical work. The guidelines typically guide medical decision making processes in the treatment of patients. Typically in cancer programs, the nation-wide clinical guidelines are developed by a professional society which is in charge of keeping the guidelines up to date and who are responsible for communicating the content of these guidelines to doctors across the private and public health care sector working within the field. See for example the work of The Danish Breast Cancer Group (<http://www.dbcg.dk/>). National clinical guidelines are developed by The National Board of Health, Denmark. The clinical guidelines support the various actions in the patient pathways and are thus a fundamental part of the development of the cancer ‘trajectory descriptions’. See for example the NBH document on ‘Connection between clinical guidelines and ‘trajectory descriptions’ (NBH, 2009b).

- 3 Day. Preliminary examination (including clinical examination); patient information; patient interview (nurse, anaesthetics, physiotherapist); eventual supplementing picture diagnostic tests (2 days)
- 6. Day. Patient time to use for reflexion (3 days)
- 6. Day. Valuation of co-morbidity
- 7. Day. Surgery (hospitalisation and (optimal) discharge of patient)
- 8. Day. Eventual discharge of patient

This is an example of a standard pathway, running from the moment a patient has been examined for breast cancer, has received a cancer diagnosis, undergoes surgery and gets discharged from the hospital. Altogether this leaves seven perhaps eight days for the doctors in a breast cancer clinic to deliver a malign diagnosis to the patients and her relatives; to prepare the patient emotionally and practically for future bodily interventions; to remove the cancer tumour, stitch up the patient and discharge her from the clinic. The doctors do not make this work alone. Besides nurses and secretaries, new supportive staff functions have been introduced to facilitate the ‘flow time’ of the pathways. The introduction of a ‘personal’ contact person is a good example of this. The role of this contact person is to establish human continuation in the pathways and ‘to secure that patients do not experience a feeling of lostness in the system’ (NBH, 2005a: 21), as the acceleration of procedures necessarily entails that the patients meet many different professional faces, each responsible for smaller bits of the pathways (see also NBH, 2008b). In addition to this support function, a pathway coordinator or case manager position has been introduced at hospitals to facilitate the speed-ups of the pathways (for example through pre-booking of diagnostic examinations) and to secure that involved professionals across medical specialties and clinical departments co-operate around the patients’ treatment processes. The two examples of supportive staff functions are not distinguishable from the core function

itself but are attempts to ensure a much needed coordination of divisions of labour and clinical personnel in the rearranged pathways.

What emotional injunctions to medical professionals do the trajectory descriptions contain? This is a proper question since one can assume, when departing from an Eliasian perspective on emotions, that structural rearrangements of cancer treatment also imply an introduction of explicit emotional demands to doctors in order to establish standardised patterns of professional behaviour in the pathways. The National Board of Health (2008a) states that ‘patients ought to experience a transparent trajectory where every future step is well-defined and where possible questions can always be answered’ (2008b: 5). In order to prepare the patients for the pre-scheduled sequences of the accelerated trajectory and to ‘reduce the insecurity of patients’ (2008b: 2) a doctor’s job includes taking active part in emotion management activities. This involves reducing, by means of strategic work activities, the feelings of anxiety experienced by many patients facing serious illness, such as cancer. It also involves preparing the patients for their mutilating surgery in which they are probably going to have a breast or parts of a breast removed; as well as preparing them for the subsequent chemotherapy and for the following years in which they must attend control visits at the hospital to ensure that their cancer illnesses are not progressing. For the concept of the ‘stand up patient’ to work in practice, patients must be regulated in detail through the pre-scheduled treatment procedures – emotional, behavioural, practical - so that the accelerated cancer pathway can be fulfilled on time and so that the clinical interventions, for example fast removal of the breast and early recovery, can succeed without disturbing interruptions – for example caused by an anxious, angry or too depressed patient.

To prepare the patients for accelerated procedures of diagnostic and treatment and to reduce anxiety, the descriptions inset demands of emotional behaviour that doctors must exhibit in the pathways. More specifically, the precondition for a successful cancer pathway is that doctors ‘exhibit sincerity, obligingness, trust and

comprehension' in their encounter with patients (NBH, 2005b: 2). In continuation of the doctors' plight to give off certain emotions, they must also 'provide room for patients' spontaneous expressions of emotions' (ibid). The doctor is thus responsible for promoting a 'particular ethos or emotional atmosphere' (Goffman, 1967: 35) in doctor-patient interactions. The policy document Cancer Plan II, explains how this ethos is connected to the development of concrete competences or skills of the doctors (NBH, 2005a). It describes how public hospitals concurrent with the establishment of the accelerated pathways are told to 'develop and promote a culture where health professionals have competences and skills to identify with patients' values, emotions, responses and mentality' (2005a: 2). An appendix to the Cancer Plan II document explains how these competences and skills ought to be trained under a rather broad umbrella, termed 'training of good and efficient communication skills'. Efficient communication is understood as 'empathic, dialogue-based, respectful, and individual' (NBH, 2005a: 54) communication between patients and doctors, and 'good' communication is regarded as a solution to social and psychological difficulties that might occur in the accelerated encounters. Efficient communication techniques are here regarded as even more necessary than in traditional illness pathways, mainly because there is less time for the health professionals in the accelerated pathways to give room for patients' emotions and to prepare these individuals to undertake treatment in the pathways, or so the argument goes in the appendix to the Cancer Plan II. Also the many specialised work activities, which are spread out on many different hands in a very accelerated time span raise a legitimate concern in relation to informing patients about what is going to happen next; who is going to perform the next bodily intervention and who are responsible for what during the planned treatment process, and thus a concern about the attainment of the patients' approval of those interventions. However, the trajectory descriptions anticipate interpersonal difficulties in the pathways as merely technical difficulties. The compressed organisation of cancer diagnostic and treatment is presented as fostering patient needs for more in-

formation and better communication. Are these two needs met, no ‘inappropriate’ emotions will occur that would slow down the flow of actions.

Individual professionals and ‘one shot available’ for managing patients’ emotions

The acceleration of medical work in the pathways has opened up a spectrum of new ways of coordinating and adjusting the doctors’ clinical activities. The very conditions for managing patients’ feelings in the pathways are restricted, mainly as an effect of the pathways’ focus on manufactory speed and its character of rigid business process-design. The compressed ways of organising medical work in the pathways, as emphasised in the trajectory descriptions, also provide the frame for managing emotions in the patient-doctor interactions. An intern consultant who has introduced a cancer clinic’s doctors to empathic communication techniques at the hospital, where the research for this paper was conducted, explains what sort of difficulties the rearrangements of the pathways might imply in relation to doctors’ possibilities of managing the emotions of patients and relatives. She says:

‘The rearrangements of the clinical pathways, which imply that patients undergo breast cancer surgery in the morning and are getting discharged a couple of hours after the intervention, might interfere with the way the professionals relate to their patients. In practice, the doctors may have only one shot available to make sure that the patients are emotional stable for the coming medical interventions. In other words, that the patient has understood the delivered messages and that she is prepared for what is coming up next’

This ‘one shot available’ of doctors to regulate the feelings of patients in a way that they are prepared for a compressed, future line of diagnostic and treatment proce-

dures, and the way in which this ‘shot’ is handled is hence a crucial concern. As previously mentioned, it does not take many emotional disturbances – for example an aggressive patient who is furious at the system and therefore wants to make legal complaints – for the accelerated pathways to be deprived of their speed. An editorial in Journal of Danish Medical Association (Gaub, 2010) draws attention to what this ‘one shot available’ might involve in relation to emotional demands to doctors. The editorial sums up current experiences with the introduction of accelerated cancer pathway in the following way:

‘The speed-up diagnostic process of the pathways raises great demands to the continuity between patient-doctor and patient-nurse, to communication and to the provision of empathy’ (2010: 273)

It is evident that the speed concern not only affects the organisation of technical aspects of medical work, but also constrains ‘softer’ relational procedures in patient-doctor interactions, such as for example the doctors’ provision of ‘empathy’ or ‘responsiveness’ in those interactions. A practitioner article on accelerated cancer pathways in the same journal states the importance of professionals’ capability to show a mixture of ‘personal’ commitment, ‘responsiveness’, and ‘empathy’ in interactions, in order for the patient to be ‘recognised as an individual person by the staff and not just a number among others down the line’ (Junge et al., 2010: 274). A consequence of this attention to ‘soft’ dimensions of medical work is that ‘this issues substantial demands to physicians’ and nurses’ capacity to encode patients’ individual reactions over a shorter time’ (2010: 277). The article further remarks that the introduction of accelerated cancer pathways contains three emotional injunctions to the staff involved: namely that of ‘personal commitment’, ‘responsiveness’ and ‘empathy’.

If we move the empirical attention for a moment from public health care reform documents to evidence collected in a local cancer clinic, it becomes evident

how discourses of ‘empathic engagement’ and ‘compassionate care’ are articulated in the clinical environment. As also mentioned in the introduction of the article, the emotional injunctions to doctors are reframed by the practitioners themselves in their everyday work. This is evident at staff meetings and morning conferences, where continuous discussions of the quality improvement of the pathways are held. These discussions often take form of a discussion of experienced communication problems in patient encounters or the doctors share stories about particular troublesome characters (patients, relatives), which they needed to engage themselves in, in extraordinary or more involving ways than normal. In an interview conducted for this research, a doctor (David) gives this explanation of the current focus on provisions of ‘empathic’ engagement in the cancer clinic. He says:

‘Before our patient pathways were redesigned we actually thought that we provided empathic responses [...], but then we discussed the issue during a staff meeting and we came to the conclusion, that we actually bore more resemblance to a hotel facility than to a therapeutic facility. Previously, we did not provide empathic care or empathic communication to our patients while they were hospitalised and while they underwent treatment in our clinic. After this insight and the following rearrangements of the cancer pathways, we added empathic communication as a crucial element to our activities in the pathways’.

‘Empathic’ engagement is not a free-of-charge kind of engagement that the individual doctor can freely choose to provide at will. Instead, it becomes ‘a crucial element of the pathways’, which must be performed alongside the line of more technical work tasks (e.g. to take a blood pressure or to remove a breast). Furthermore, the exhibition of ‘empathic’ engagement is followed by the same recording and measurement demands as every other clinical activity in the clinic (e.g. taking a biopsy sample; exam-

ining the lymph nodes under the armpit; prescribing medicine for nausea and vomiting): the provision of ‘empathic’ engagement must be recorded in the patient record system. David explains this request for recording practice:

‘In a modern hospital, where everything is measured and controlled, one must always record one’s conduct. This includes a registration of the exhibition of empathy. If you are not willing to do this, the clinic’s spending account may get reduced by the hospital management, because then we are not able to document that we spend our time in the consultancy rooms providing sincere care. If your job is to manage an emotional problem of a patient and if this problem is not measurable, then you get into deep troubles in cases where you need to explain your rationale for doing things to others, for example in auditing. We thus need to write down what we do. By doing this manoeuvre we also make sure that everybody follows the same standard procedures’

A possible reading of this statement is that clinics or hospital units that record their public exhibition of ‘emphatic’ engagement most effectively in the record system are likely to keep their granted budget, since they can prove that the consultancy time spend in the clinic is spend managing ‘an emotional problem of a patient’ and they can thus prove that they meet diverse interests, such as political and managerial pledges and clinical objectives. It also embraces lay expectations towards ‘being met by the doctor as a whole person instead of a case among many others’. On the doctor’s part there was not any irony in the statement with regard to this rather contradictory dimension of the provision of empathy. The ‘soft’ dimensions of his work must be surrounding by the same quality standards and biomedical rationality as the ‘harder’ aspects of his work, or that is the impression he gives.

Various forms of emotional conduct not only has to be recorded in patient records, as written confessions of engagement to secure the annual budget, but must furthermore be recorded as part of the concerns of a national quality plan, entitled *Quality First* (Region Hovedstaden, 2010). This quality plan outlines ten strategically objectives for ‘bringing the patient in focus’. One of these objectives is that patients ought to feel safe, respected and understood when discharged from the hospital. To facilitate that this objective is followed at local department levels, an annual performance measurement of how individual professionals manage to make patients feel confident before hospital discharge has recently been implemented (I draw here on an internal auditing document from a university hospital in Denmark, 2010). The annual assessment of the management of patients’ feelings is introduced together with initiatives to educate doctors in knowing the emotions of others through medical training and communication courses. Through this training, the doctors are expected to be able to manage the emotions of patients both more effectively and more efficiently.

Discussion

As has been shown, the occupation with various forms of engagement in accelerated medical relationships is saturated with demands of efficiency, quality and new techniques to improve the outcome of the pathways. Herein lays an apparent peculiarity: the more the importance of ‘compassionate’ care is stressed in accelerated medical work and the more emotional display of the doctor is focused upon, the more emotions become subject to measurement, standardisation and control. These manoeuvres are easily understood on a paper level. Putting them into practice proves a lot more difficult, because how does one actually measure the delivery of for example ‘sincere, ‘empathic’ engagement? In the beginning of the article, I quoted the two English scholars, David A. Buchanan and Louise Fitzgerald (2011), for rhetorically asking how the delivery of compassion in patient-doctor interactions is to be measured and by whom. The previous quote from a doctor suggested that when there is no hard

data available, the obvious response is to generate some, and thus to measure empathic responses and emotional behaviour alongside other clinical interventions.

There is nothing radically new in suggesting that for patient-doctor interactions or professional-client interactions to succeed it requires emotion management on the part of professional workers to regulate the feelings of patients or clients in public meetings. For instance, it takes elaborated effort to reduce feelings of alienation when patients attend the medical system (James, 1993; Lupton, 2003b; Bolton, 2005). Management of emotions typically operates through what Elias terms 'emotion codes' or 'codes of emotional display'. These codes are socio-historical constructed and are hence up for steady historical and cultural unravelling. In the context of this paper, doctors apply emotion codes of medical rationality to handle patients' feelings when a patient attend the clinic for advice about, and treatment of, complaints. These codes are typically internalised norms and values regarding the experience and expression of emotions, which are learned through vocational training, supervision and hours of clinical practice experience (Smiths and Kleinman, 1989). As such the emotion codes function as standards of socially sanctioned behaviour regulating the experience and expression of patients' emotions (not to forget the regulation of doctors' own feelings) in the different diagnostic and treatment phases of the accelerated cancer pathway. While there is nothing groundbreaking in suggesting that the managements of feelings is a necessary part of doctors' work, it is the very presentation of emotions in the trajectory descriptions of accelerated medical work which represents a significant trend. The descriptions contain a promotion of for example 'good' communication and 'responsiveness' as effective, personal competences of the doctor, and moreover as competences which are currently lacking in medical relationships. The trajectory descriptions' occupation with reducing waiting times and with treating patients more rapidly leads to the concern that human components of the programs are missing. Hence, emotional competences of the doctors ought to be developed to bring back the 'human' components into practice. In fact, these compe-

tences are presented in the descriptions as crucial for the success of the pathways. The emotional competences promoted by the reviewed documents issued by the National Board of Health, Denmark, are competences in tune with contemporary values of ‘empathic’ engagement or ‘authentic’ engagement, which are promoted by the medical humanities literature. This kind of literature, as explained in the introduction, exactly requests doctors to engage authentically with their patients and to engage themselves ‘entirely’ (i.e. they ought to deploy skills of social intimacy) in the consultancies in order to provide efficient treatment and care (e.g. Charon, 2001; Shafter, 2009).

If we accept that the trajectory descriptions can be viewed as inseting demands of specific kinds to emotional behaviour in the accelerated pathways, then the implications of emotional injunctions to doctors’ work are significant. This includes formal standards of interactional behaviour to use for example in precarious situations where the doctor ought to deliver a cancer diagnosis to a patient as well as more informal concerns of dialogue-based, responsive behaviour to utilise in meetings where the aim for example is to ‘empower’ the patient and her ‘inner’ strengths in the treatment process, or to calm her down if her world is falling apart, provoked by her illness. That is, I argue, an insertion of both formal and informal rules of emotional behaviour in relation to public meetings between professionals and patients. First, as formal rules the trajectory descriptions compel the doctors to act correctly according to a set of formally defined standards – and of course according to professional emotion codes. Second, as informal rules the descriptions inset demands to the doctors to behave accordingly to a set of unstated, flimsy, yet strongly expected ways of behaving, for example through ‘empathic’ engagement or ‘compassionate’ care. This commits doctors to find a delicate balance between formal and informal emotional behaviour while they respond to the needs of their patients.

Following this Eliasian perspective, it may be argued that the distinct emotional injunctions, which are promoted in the trajectory descriptions, may repre-

sent a further step in processes of civilising emotions and, what is more, the descriptions inset a quest for the strategic and deliberate elicitation of particular emotions, while it simultaneously frame the role and experience of other ‘inappropriate’ emotions. During this most recent phase of social development, the challenge of doctors is to regulate their conduct, not only by means of professional ideologies, clinical guidelines and rigid rules of standardisation, but also by means of conscious reflexion on deliberate expression of emotions. The further civilisation of the conducts of doctors may lead to increasingly more complicated and more extensive modes of self-presentation in medical relationships. A possible outcome of this could be a higher risk of job burnout or morale fatigueless within the profession of medicine.

Concluding thoughts

The aim of this paper was to show how recent health care reforms and the introduction of accelerated cancer pathways inset emotional injunctions to medical professionals. Through review of documents and other qualitative material it has been demonstrated that these reforms require that medical professionals exhibit particular emotions in patient-doctor interactions and that the management of patients’ feelings is conducted in ways that can be recorded and be subject to quality improvement. The core of the papers’ argument is the apparent contradiction between the emotional injunction to doctors to become emotionally available to patients and the fact that this availability (for the provision of empathy and authenticity) itself must be measurable and rationalised.

The request for emotions and emotional behaviour in medical work is not as simple as it might sound. On one hand, the trajectory descriptions for example ask us to pay attention to emotional engagement; it asks for ‘authenticity’ and ‘sincerity’. The descriptions encourage doctors to display and experience ‘sincere’ emotions while providing various medical services to patients. And they furthermore ask the doctors to use ‘themselves’ in this process. This is in tune with the lay paraphrase

‘patients want real, unique people not robots when they attend the health care services for help’. On the other hand, the descriptions anticipate the need for making this emotional appearance measurable and subject to quality improvement, and hence they frame emotions in patient-doctor interactions as something, which can be managed, evaluated and measured. Urges for formality and informality of emotional behaviour in medical work complicate what it is exactly that is expected of doctors in public meetings (e.g. Van Vree, 2011). The emotional injunctions inset by recent reforms of the public health care sector hence promote both a ‘humanisation’ ideal and a ‘standardisation’ ideal in the management of emotions: the reforms expect doctors to be compassionately engaged while they also expect them to display emotions in extremely regulated ways that are measurable and can be benchmarked across department units and health care organisations.

Present trends of ‘compassionate care’ may be seen as a trend where emotional restraints are cast off in favour of more self-expression and liberated emotional expressions of ‘empathy’, ‘authenticity’, ‘engagement’ and ‘responsiveness’. Wouters (1989) however, argues with reference to Elias that this development can more accurately be seen as a tendency of ‘controlled de-controlling of emotions’ (1989: 106). The complexity of medical procedures in the accelerated cancer pathways and discourses of ‘compassionate’ care and more ‘human’ engagement, result in increasing emotional control rather than in the loosening of ways of emotional behaviour of medical professionals in the public health care sector. If one interprets the emotional injunctions issued by the National Board of Health and other public agencies from the vantage point of Elias, the discourses of emotionality and the realisation of a ‘compassionate doctor’ is just a further evolutionary step in the long-term structural development of societies and the changes in peoples’ social character.

The emotional injunctions to medical professionals appear contradictory when we situate them in the clinical environment of the accelerated pathways in which they are brought to work. The health care reform documents encourage proc-

esses of standardisation while expecting room for personal and unique concerns; they emphasise intimacy while expecting maximum acceleration of services; they advocate for looser or more relaxed forms of emotional behaviour while strengthening regulation and control of others' and own emotions; they grant attention to the individual patient while expecting streamlined flows of patient cases, and finally they demand reflexively orchestrated ways of managing emotions while reducing the available time for this kind of work down to 'one shot available'.

Somehow counterintuitive, then, it seems that emotions and the management of emotions play a significant role in organisational structures that systematically both accelerate and reduce human interactions in public meetings, while intending to make these interactions more 'human'.

Chapter 6: Training of controlled empathy in accelerated cancer care

Abstract

This paper uses the dramaturgical lens of Goffman to explore the training of controlled empathy in accelerated cancer care. The paper focuses on a training workshop in ‘empathic communication’, during which doctors from a cancer clinic learn to recognise and control the emotional framing of doctor-patient interactions. Through a descriptive analysis, it addresses how communication techniques are rehearsed and it discusses the effects of this training. It is shown that the performance of communicating empathically relies on standardised scripts, which direct and cultivate the conduct of doctors. The paper concludes that contemporary reforming drives in public health care insert a renewed focus on humanistic values in medical interactions between doctors and patients, such as a focus on doctors’ modes of engagement in these interactions. However, these values increasingly become the aim of techniques of micro-management such as qualitative measurement and performance audit. In other words, attempts to improve ‘soft’ dimensions of medical services entail a further standardisation of these dimensions.

Keywords: Medical training, empathy, doctors, Goffman, cultivation of conduct.

Introduction

The paper explores the training of ‘empathy’ and ‘empathic responses’ in medical interaction. More specific, it focuses on how doctors’ management of emotions can be trained as a response to a current movement towards rationalisation and tighter control of medical work. In addition, the paper explores how this training may also be a response to a current movement towards making medical services – including interactions between doctors and patients - more human.

My empirical inquiry is situated in the context of present-day healthcare in Denmark. Recent introductions of managed care processes for the production and efficiency of public healthcare services have resulted in a reorganisation of cancer illnesses and their treatment in to accelerated patient pathways, focusing on clinical work procedures, quality improvement and documentation standardisation. In the Danish health care system, cancer illnesses are organised in so-called treatment ‘packages’. The purpose of the introduction of these packages is to reduce waiting times and organisational delays, speed up processes of diagnosing and treatment, and strengthen the coordination of patient treatment between hospital units and sectors. Attempts to organise the treatment of cancer illnesses into streamlined production units are not only present in Denmark but for instance also in the UK (e.g. Harrison and McDonald, 2008).

On the one hand, the accelerated cancer pathways are part of a clinical strategy to improve the overall health outcome by offering patients safer and more effective care. On the other hand, the pathways are a symptom of New Public Management and managerial means to rationalise public services and directing the conduct of public professionals (Power, 1997; Du Gay, 2000b; Miller and Rose, 2008). Generally, the intention is to make health care organisations more accountable, more customer-oriented and more efficient in their use of resources. These requests for performance improvement involve a movement towards rationalising medical work. As a new mode of governance, these reforming drives not only concern the so-called ‘hard’ dimensions of medical work (EBM, clinical procedures, economic incentives, safety and audit tools). As an object of interest of this paper, the reforming drives also include a pronounced focus on ‘soft’ dimensions of medical services. I call these dimensions soft, because they, among other things, comprise the ways in which health care workers today are expected to make themselves emotionally available to patients through a facilitation of ‘partnership relationships’ between doctor and patient (Bub,

2004) and through ‘patient-centred’ interactions (Mead and Bower, 2000, Mead, 2002).

The paper takes its point of departure in this configuration of today’s medical services and demonstrates how the ‘emotional availability’ of doctors becomes object for attempts of governance, intended to structure and control the interaction between patients and doctors as well as to cultivate the conduct of doctors. The body of the research presents material collected from a training workshop in ‘empathic communication’. Participants in the workshop were health care workers from a cancer clinic. The training involved that especially doctors participated in stage performances and were trained in performing ‘empathic’ responses in interactions with patients. The aim of the workshop was to make these relationships more efficient; to save time and improve the quality of care. The exact clinical ‘problem field’, which the training workshop was an answer to, is the difficult or serious communication act where details about diagnosis and clinical treatment plans are delivered in the medical consultation.

An intrinsic focus in the accelerated cancer pathways is a focus on the development of communication skills, including empathic response skills. The assumption is that better communication between cancer patient and doctor not only improves the over-all health outcome, but also facilitates the accelerated procedures of medical interventions in the pathways. According to the imperative of effective communication, which is put forth by for instance official descriptions of the cancer pathways (The National Board of Health, Denmark, 2008a; 2009a), a good doctor masters various communicative competences. As a competence, communication can be used by doctors to help coordinate actions and emotion conducts between themselves and patients, and within themselves. Central to these ideas about communication competence is how communication can be mobilised as means of cultivating the conduct of the doctor (May et al., 2006). By claiming that problems in interactions

between patients and doctors are merely technical in nature, the training in communicating empathically is identified as a possible resolution.

‘Empathy’ or ‘empathic responses’ is often evoked in thinking on the emotional relationship between doctors and patients. Larson and Yao (2005) define ‘empathy’ as a powerful skill’ (2005: 1100) and they propose that empathic responses can be learned through intensive communication training. The authors argue that doctors are more effective and enjoy more job satisfaction if they recognise that their work includes the management of emotions, and if they reflexively engage in the work of coordinating emotions between people and within themselves. The training of managing emotions includes both those of ‘stage performance’ and those of coping with the after effects of a stressful job. The authors argue that emotion management training is required in medical practice and they identify the need to teach some acting skills of this kind of labour. This argument is backed up by similar studies that are likewise occupied with the training dimension of ‘empathy’ (see for example Teherani et al, 2008; Neumann et al, 2009). These studies assert that when empathic skills are explicitly taught, doctors will experience less stress on the job and the possibility of job burnout will be reduced.

The paper makes two contributions to existing debates on ‘patient-centredness’ and the ethics of communication in doctor-patient interaction (Mead and Bower, 2000; Mead, 2002; May et al., 2006). First, it discusses how a training workshop in empathic communication is an example of how communication relies extensively on the use of a standardised language and the proper management of emotions in order to coordinate activities and the conduct of individuals in medical interactions. Second, the paper discusses how communication is ‘a slippery sociological centaur’ in the organisation of medical services (Illouz, 2007). It is slippery because it merges seemingly ‘soft’ therapeutic action with rationalised practices in order to make doctors emotionally available in accelerated medical relationships. In addition, I argue that doctors’ behaviour become an objective for performance improvement in

health care organisations, as this behaviour can be intensively trained and become subject to comparison and susceptible to cost-benefit. This development in turn challenges the understanding of ‘soft’ dimensions of medical services, which previous studies within health care largely perceive as invisible and informal, and therefore inaccessible to management (Strauss et al., 1982, 1997; Star, 1991; Star and Strauss, 1999).

Theoretical framework

A dramaturgical lens developed by Goffman (1959) provides theoretical inspiration for my approach. This lens is employed to analyse the workshop as a specific kind of region where the doctors, as performers, engage in a drama before an audience and strategically present themselves in ways intended to foster favourable impressions in both competing performers (patients) and audience (doctors, nurses, consultants).

Many performers—for example, health care workers, scientists and lawyers—keep their preparation for public display hidden behind the scenes. This is also the case in this research, where communication skills are trained at a medical training facility to strengthen the everyday performances of doctors in a cancer clinic. Goffman (1959) uses the term *arts of impression management* to refer to the set of techniques and attributes required of an actor ‘for the work of successfully staging a character’ (1959: 203). These techniques also guide the display of feelings to which performers must adhere. Essentially, when performers are ‘on stage’, they must express emotions appropriate to the part they are playing. Training is required to manage the impression of others and to be recognised as ‘skilled emotion workers’ in public encounters (Bolton and Boyd, 2003). Goffman’s idea of impression management and its effect upon organisational action patterns provides a means of understanding how emotional responses are actively managed by performers according to the rules of a particular situation.

Following Goffman, Hochschild refines his dramaturgy of work settings to understand how emotion in organisations is managed in a number of ways. Hochschild (1979) defines *emotion work* as ‘the act of trying to change in degree or quality an emotion or feeling’ (1979: 561) in oneself as well as in others. Emotion work involves individuals’ management of feelings in order to conform to the demands of a particular situation. Hochschild uses the term *emotional labour* for emotion management that is performed for a wage. Emotional labour is associated with jobs that require workers to produce a positive or negative emotional state in others. According to Hochschild, we can think of emotions as a covert resource that can be organised, trained and regulated as something organisations need to pursue and fulfil their commercial aims. The purpose of emotional labour, she states, is to promote a good company image, which persuades customers to believe that they receive warm and intimate service, leaving an impression of high-quality customer service. The individual worker is thus getting paid to ‘smile’, to be ‘caring’ and to be ‘responsive’. Hochschild’s work has had major influence on emotion-oriented studies in health care, particular with reference to the nursing profession (James, 1989; Bolton, 2005; Mann, 2005; Theodosius, 2008). However, this literature rarely deals with how the management of emotions can be conceived as a technical problem, which can be refined and directed as part of the re-skilling of doctors. This paper exhibits the detailed training through which doctors are equipped with the capacity to act as a certain sort of person, namely that of an effective emotion manager.

As a supplement to Hochschild’s work on the management of emotions, Strauss et al. (1982) offer the term *sentimental work* to coin ‘soft’ dimensions of medical services. These authors see sentimental work in terms of often more informal aspects of medical work, which normally take place as invisible work activities ‘behind the scene’ of clinical action, for instance, in the undocumented provision of psycho-social support to suffering patients. Sentimental work can be employed to ward off disturbing feelings in interactions, such as patient anxiety. This paper is inspired

by the notion of sentimental work. However, I challenge the characterisation of sentimental work as merely informalised, invisible work (e.g. Star, 1991; Star and Strauss, 1999; Strauss et al., 1997) and demonstrate how this kind of work indeed has become subject to management in contemporary health care organisations.

Material and methods

The paper uses qualitative material collected from a one-day training workshop with doctors, nurses and leading staff members from a cancer clinic. This includes participant observation, interview and document material. The material has been collected as part of a larger project of research into the management of emotions in accelerated medical relationships. The larger fieldwork was carried out between June 2009 and January 2011 in administrative and clinical units of a cancer clinic and nearby facilities at a major university hospital in Denmark.

I had access to the workshop as an ordinary participant. Even though I did not take actively part in the role-playing scenarios or any of the other exercises during the day, I was part of audience. The workshop lasted approximately seven hours. Altogether 18 staff members participated in the workshop: eight doctors (female and male senior consultants and junior residents), eight nurses (female), two consultants (a female psychologist and a medical teacher). Some of the doctors in the sample had been employed in the cancer clinic for many years, while others were relatively newcomers. The same was the case with the nurses involved. I have chosen to focus solely on the doctors' stage performances in this paper in order to follow the workshop's aim of re-skilling doctors through the use of communication skills.

I did not audiotape the activities of the workshop scenarios mainly because of explicit concerns expressed by some of the participants that the scenarios were too sensitive to be recorded. I therefore wrote fieldnotes during the various workshop sessions. The notes cover both the observed activities and some informal conversations that I had with participants during the day.

In addition to the participant observations, three qualitative interviews with one consultant and two department heads are included in the material. The main focus of the interviews was to gain a deeper insight into the establishment of the workshop and to understand how the informants, as initiators of the workshop, believed that the workshop was a necessary move in the development of the clinic's accelerated cancer pathways. The interviews had a semi-structured character in relation to how the interviewer primarily asked questions of 'how' and 'what' to understand the background history of the workshop (e.g. Fontana and Frey, 2002; Gilham, 2005). The three individual interviews each lasted approximately one hour. They were all conducted at the hospital, and the interviews were fully transcribed. The identities of the participants in the workshop as well as interviewee identities have been concealed in the paper.

A presentation of a training workshop

The writing that follows first presents the preliminaries of the workshop. Then, it presents the drama, its performers and its audience. The workshop activities are presented using Goffman's conception of region (1959: 109-115): the workshop is conceptualised as a 'backstage' region where doctors train and discuss the emotional responses (a training and discussion that is carefully concealed from the front region audience), which they are expected to deliberately display in the front region (the cancer clinic). Finally, it discusses the stage performances in a context of new modes of governing public health care services.

The situatedness of the workshop

Doctors and nurses employed in the cancer clinic were officially invited to participate in a workshop to train communication skills and competences related to the serious conversations that take place in the clinic, including the disclosure of clinical treatment possibilities in relation to malign diagnosis. The idea of the workshop has partly

emerged from annual appraisal interviews, where staff members requested further training that would better equip them to meet emotional needs of their patients. However, the workshop is also relevant in relation to some implemented structural changes in the clinic. Recently the clinic's patient trajectories had been rearranged into accelerated, streamlined production flows. Generally, this process of redesign has four purposes: to improve the health outcome, to reduce waiting times, to regulate and standardise work tasks, and to meet the objectives of performance measurement. Every medical activity in the pathways relies on detailed policy descriptions, which have been developed in the National Board of Health, Denmark (NBH, 2008a; 2009a). The cancer pathway descriptions detail 'what needs to be done', 'who should do it' and 'how [we should] register our conducted interventions'. These descriptions also cover communication at large, from information about clinical treatment possibilities to interpersonal communication between health professionals and patients. This also includes procedures of 'empathic' patient conversation(s) and delivery of 'proper' information throughout the pathways. Communication is defined as a mean to execute the accelerated activities of the pathways effectively while attending to 'patient-centred' concerns of trustworthy, responsive communication.

The workshop was thus situated as a double-headed arrangement. On the one hand, it strengthens rationalised dimensions of the structural rearrangements of the accelerated cancer pathways. It focused on the parts of the pathways, which involve communication and emotional transactions between doctor and patient. On the other hand, the workshop meet some concrete needs of workers in the cancer clinic, who have requested such training to improve their way of handling emotionally challenging situations in the pathways.

Invitation to join the workshop

Let me first describe the practical set-up of the workshop. During a planning phase, the head of nursing has met with two consultants from respectively a development

department and a medical training department at the hospital. Their meetings have resulted in a detailed training description and they have collectively constructed two illness cases. These cases are typical of emotionally challenging situations in the clinic and they frame the content of the later role-plays.

Approximately one week before the workshop, the staff received a formal letter from their department heads informing them about time and location of the planned event. Workshop participation was mandatory (i.e., ‘On October the 8th, you need to attend a training course at 8.30 AM’), and the staff was divided in half so that they could join workshop in two shifts without completely closing down the clinic’s acute activities. A description of the training course was attached to the letter, which was signed by the consultants ‘who look very much forward to finally meeting everybody’. The purpose of the workshop was explained to staff members in the letter. It says:

‘Through the use of communication tools, participants will be able to structure and manage a difficult patient conversation, while being conscious about what they are bringing to the conversation – on both a personal and professional level – with respect to the patient’.

The construction of a respectful conversation between patient and health care worker has often been conceptualised through the notion of ‘empathy’ and the development of skills of empathy and sympathy (Mark, 2005). The emphasis on learning skills of empathy is further explained in the invitation:

‘Achieving and controlling skills of empathic communication is not a question of personal style or of having the right personality traits [...] empathic communication skills result in effective consultation, satisfied patients and an increased overall patient comfort’.

The emotional components of communication involved in the service culture of health care organisation can be labelled ‘emotional labour’ (Hochschild, 1983). This includes the management of patients’ feelings through for instance recognised and controlled communication skills. The workshop invitation situates a need for the establishment of ‘patient satisfaction’ in the consultation between doctor and patient, and the question becomes how the training in techniques of emotion management can be effectively achieved at the workshop.

The training sessions

On a particularly rainy October morning, half of the clinic’s nurses and doctors gathered in a training facility. Department heads had joined a similar session the day before and were therefore not present on this particular day. In their role as hostesses of the event, the two consultants welcomed the participants and introduced them to the workshop activities. The workshop consisted of three separate sessions: an oral presentation on how to perform a serious/difficult conversation, a two-person teamwork (including discussions about and training of empathic communication skills in smaller groups) and role-playing scenarios with simulated patients. The first two sessions provided the education platform on which the subsequent role-playing scenarios were based.

One of the consultants explained at the beginning of her oral presentation that:

‘It is not necessary to be a psychiatrist to use empathic communication. What is required is that you are self-aware of clues for empathy, as these clues arise during encounters. Typically, the clues will come from patients’ emotional outbursts, and these will be the clue to your empathic response. Today, we shall focus on training these emotional responses’.

The professional conversation, the participants were told, is a 'patient-centred' conversation. It takes as its points of reference both the patient's knowledge and understanding of his or her illness, and the patient's particular emotions. The patient-centred conversation consists of three parts: content (e.g., information about test results); process (e.g., facilitation of conversation) and relations (e.g., emotional support through active listening). The performers were taught about the importance of facilitating the conversation process while recognising the needs of the patient. The performers were also introduced to elements of crisis psychology. Empathy, or as they were told, the ability to identify with another person's point of view and feelings, is an instrumental skill in health care worker-patient relationships through which the patient must be recognised and labelled as an emotional individual. Furthermore, empathy can be evoked to sustain the flow of medical situations.

Once in a while during the presentation, the participants were told to practise small conversations in pairs. One of these exercises was, for instance, a mirror exercise, in which the teams were told to communicate an essential experience from the clinic to one another and then to re-tell the story in detail, mirroring every sentence and summing up the main content of the story. One of the participants took her point of departure in a recent experience with a young mother who had a very bad prognosis due to her progressed cancer illness. The doctor explained how she tried to facilitate this woman and how this was difficult because the doctor experienced that she was getting too emotionally involved in the situation on a personal level. After each story, audience had to tell the performer that his or her particular experiences were both meaningful and understandable. Their task was to show cues of empathic communication and thereby appreciate the emotions, values and reasoning of another person. Listening to others, or in this case mirroring another's feelings and interpretations, was described by the consultants as crucial to the ability to prevent conflict during interaction. Moreover, active listening furthers the creation of cooperation between professionals and patients and facilitates intimate clinical procedures.

The next step in the program was to train emotional responses in order to evoke an impression of an engaged doctor in others. To focus on emotional responses, the oral presentation took the participants through the general rules of empathic communication, which they must follow in role-playing scenarios where serious messages (i.e., details on the diagnosis of cancer and treatment possibilities) are delivered to patients. Statements that facilitate empathy, the participants were told by the consultants, include queries (e.g., ‘How does this information make you feel?’ and ‘Can you tell me what you feel now?’), clarifications (e.g., ‘I want to make sure that we agree on this’ and ‘Do you understand why this next step is important?’) and responses (e.g., ‘I can understand what you feel’ and ‘It sounds like you are very upset now’).

In pairs, the participants then discussed what tends to work and not work in interactions with patients in the clinic by drawing on their own experiences. Issues such as professionalism, emotional outbursts (e.g., anxiety or anger), recognition of patients’ feelings and control of conversations were debated and these topics were subsequently discussed briefly in a plenary session before the role-playing scenarios. One participant summed up his experiences from the exercise, clarifying that:

‘All of us must agree that the most important thing, no matter how much we talk about communication and attend to what the patients prefer, is that we rely on our professionalism. This means that we must act relatively certain and simultaneously try to be both intellectually and emotionally responsive, which also includes taking control with and guiding the content of patient encounters’.

Goffman (1956) writes how ‘during interaction the individual is expected to possess certain attributes, capacities, and information which, taken together, fit together into a self that is at once coherently unified and appropriate for the occasion’ (1956: 268).

As stated by the participant in the quote, there is no discernable difference between one's self presentation as intellectual (i.e., detached professional), who frames and control the interaction, and the presentation of an emotional self, who responds to the affective needs of a patient. However, what is important in this statement is the problematization of communication in relation to a classic conceptualisation of a doctor-centred model of medical consultation. The focus on communication may involve a refiguration of the consultation and the kind of work this particular situation involves on the part of doctors.

The next item on the agenda was a staging of two role-playing scenarios.

Staging the role-playing scenarios

While planning the workshop, the department heads had identified two typical cases of emotionally challenging situations for the staff: one case in which a patient reacts emotionally cold and distant and another case in which a relative to a patient reacts emotionally inappropriate and is too emotionally involved. The two cases represent situations in which an individual fails to respond and give off a predictable impression to a predefined, scripted situation. The patient and the relative are presented as either not emotional enough or too emotional to match a general presentation of a 'cancer patient' and a 'cancer relative'. The performers on the stage are: two professional actors who play the roles of respectively 'patient' and 'relative', male doctors who play the part of 'doctor' and female nurses who play the part of 'nurse'. The stage is designed so it looks like an ordinary outpatient consultancy room. Before the role-playing scenario started, the consultants instructed the performance team to act 'naturally' as if the stage performance was taking place in the clinic. The team was also told to keep in mind the 'props' they had been given during the morning session on the rules of empathic communication.

First stage performance: A patient who is emotionally cold and distant

The script of the role play is written down in handout notes, which the performers read through as if they were medical record sheets:

‘The time is 14:05 PM and in cooperation with the nurse, you are going to talk with a patient. Your task is to inform the patient about surgery and plans for further treatment, including the duration of the hospitalisation stay, the hospitalisation procedure, adjuvant treatment (radiotherapy) and pain therapy’.

This first role-play was constructed to challenge the performers with an illness case, where the patient’s behaviour is described as deviant in terms of her cold attitude. The note further explains that:

‘The doctor has just been informed by the nurse that the patient has been complaining several times about the long waiting time and is now seriously upset. The patient is very annoyed with the system [the healthcare system]’.

The role-playing then starts. The patient is an elegant middle-age woman, dressed in black and carrying a laptop handbag. She is clearly annoyed with everything and complains about why everybody seems to have ignored her during the long waiting time. The two performers, i.e., doctor and patient, engage in a conversation:

Patient: I would like to know the exact date of surgery. I need to find somebody who can take care of my kids while I’m hospitalised.

Doctor: I will find you a date in our booking system. You will be asked to attend the clinic around 7 AM on the day of surgery [...] During the sur-

gery, we will take some tissue samples for pathology [...] Next, I will demonstrate how we plan to do the surgery.

Patient: I live together with my two kids. I'm divorced, and I have full custody. I need to have some answers – for example, how am I supposed to inform my work about my illness?

Doctor: We have found a malign lump in your breast, and we need to remove it. We will make a surgical excision of your lymph nodes in the armpit. I now want to show you how we make a so-called sentinel node procedure [He draws a rough sketch of the lymph node system].

Patient: It is difficult to comprehend what all this actually entails [...] Should I be worried about my future?

Doctor: After the surgery, you will be offered radiotherapy. Radiotherapy is standard after-treatment to patients undergoing lumpectomy [...]. Now we should talk about the schedule of the day of your surgery.

During the performance the doctor manages the various impressions that he earlier learned during the group exercises to facilitate empathy. He nods; holds eye contact; makes small conversation breaks, and tries to use the phrases that the performers have practiced to provide 'active listening'.

However, most of all, he seems to have captured the objective of 'being in control of the conversation'. He neither asks the patient about her frustration against the 'system' and, perhaps more important, nor does he respond to the patient's small cues to change the script - for example, when the patient wants to talk about her future prognosis and family situation.

The doctor's display of empathy is hence boiled down to a registration of the emotions of the patient and he tries to neutralise or manage the emotions of the patient, which he finds disturbing to their relationship. The doctor directly faces the audience and tells it that he perceives the patient as 'being cold and non-responsive'.

In his opinion, she does not fit into the official ‘frame’ of the situation because her mode of appearance is deviant from for instance a presentation of a crying individual.

The consultant interrupts the stage performance after approximately 30 minutes. At that time the performers have agreed on a treatment procedure and a date of surgery. They have also shook hands and said goodbye. The consultant credits the doctor for following his tight script of procedures and for delivering a clear message. One audience notices: ‘The performer [the doctor] did a very nice job. There is a lot of information to go through in our compressed patient interactions, and the performer managed to deliver the information details without getting tackled by the patient’s attitude problems’.

The consultant then asked them, what would have happened if the doctor (an actor) had missed important bits of information. One of the participants answered: ‘Then we definitely need to see or talk to the patient again’. She continued:

‘These patients will make formal complaints about the quality of information; they will feel insecure and will have difficulty in letting us go, and perhaps they will turn down treatment offers. Basically, they won’t have any trust in our system. We also need to pay attention to the patient’s individual needs so that we can enter the provision of empathy in our medical records’.

The example demonstrates how the doctors, on the basis of some standards of communication, are extremely occupied with the delivery of detailed information about the patients’ treatment possibilities and planned procedures. The more intimate matters concerning cancer illness and the effects on individuals’ lives are not a part of the script of delivering a treatment plan. Hence, the script does not evoke empathy in a classic interpretation of the term; rather it provokes what I term controlled or restricted empathy. In the last quote, it is furthermore noteworthy how one of the per-

formers couples various demands to the delivery of information, including the provision of empathy and the ability to turn to individual needs of those who attend the clinic for help. It may also point to how emotional expression or behaviour, such as skills of (controlled) empathy or sympathy, in today's health care organisations needs to be performed in standardised ways in order to be recorded, audited and benchmarked across hospital department units. This thought is backed up in the interview data where a doctor ('David') stresses how the registration of the exhibition of empathy is connected to the clinic's annual budget negotiations with the hospital administration.

Second stage performance: The relative who is too emotionally involved

The second stage performance was staged with performers similar to the first play ('doctor', 'patient'), but with the addition of a family member. The stage script also resembled the first, but the key challenge was slightly altered. The script says:

'You are delayed in your outpatient program and have not been able to attend the waiting patient and her relative before now. You have not met the patient before (a colleague has conducted a biopsy the previous week and delivered a diagnosis of cancer on that basis)'

In addition, the performers are told that the patient has brought along her daughter. This daughter has a background in nursing, and she is very emotionally affected by her mother's diagnosis. The role-playing starts.

The daughter has some difficulty in understanding why a mastectomy (i.e., removal of the breast) is a necessary step to secure her mother's health outcome and she continually returns to this topic throughout the conversation. She also cries and offers some serious emotional-laden playacting. The doctor draws on various tricks to convey empathic responses to the daughter's emotional outbursts - for ex-

ample by asking open questions: ‘How do you feel about receiving this information?’ and ‘Can you tell me about any of your thoughts right now?’, and by showing that he has recognised her feelings: ‘This is not easy, I know’ and ‘I understand that you feel upset right now’. However, the doctor is left somewhat confused 20 minutes into the role-play. By this time, he has already turned to the audience once to explain that ‘a curtain has dropped between me, the patient and her illness’. He also says that ‘the daughter clearly does not embrace my information’. The doctor then signals, that he is in trouble. He starts to blush and stumbles over his words and uses response cries such as ‘um’ and ‘uh’ and ‘oh’, which express that the interaction is in some kind of crisis. The result of a break down is serious, because the doctor risks losing ‘face’ in the presence of both fellow performers and audience. The consultant therefore breaks off the session to limit the extent of interaction damage and asks the performer directly what next step she proposes to reconstitute the emotional balance of those involved. The performer answers – probably in order to save his own show and ‘to successfully stage his character’ (Goffman, 1959: 203):

‘In a real situation, I would ask the patient to take off her clothes and physically show her by touching her why it is necessary to remove her breast. And then I would explain how choices in surgery techniques have consequences for her survival of the cancer illness [...] And then I would tell her to leave her daughter at home the next time we meet.’

The last comment makes the audience laugh. It is no coincidence that performers and audience at this point start to make fun of the situation. Reconsider Goffman, when he writes that ‘joshing sometimes occurs as a mean of releasing the tension caused by embarrassment’ (Goffman, 1956: 271). This ‘joshing’ laughter functions as a sort of channel of distraction, which the performers and the audience can use in turn as a way of emphasising that ‘this is not a real situation’ or in order to declare that what

occurs now is not serious. The consultant then asks what was funny about the comment, and the audience explains that:

‘The doctor just tries to do his job properly and stay in control of the situation and himself. The daughter and all her demands to our services, in contrast, make it extremely difficult for the doctor to deliver some important messages, which are necessary in order for the patient to make an informed choice in relation to future treatment options.’

The consultant’s insistence on the seriousness of the conflict provides room for the above quoted response to the situation. It is somehow ironic that the performers (doctors) respond to the theatrical practice of the role-playing scenarios, where the ‘roles’ of doctors are deliberately rehearsed, as a kind of backstage area with respect to the front stage region of the clinic itself. However, the staged role-play scenarios are also proper Goffman situations – or front stage regions - in their own right. It presupposes a presentation of self on the part of the participants. The props used for presentations of ‘doctor selves’ include controlling the timing and style of the strenuous stage performance and an over-all capacity to play/act official/professional roles. The limitation of the analysis presented in this paper, if we attend to the workshop as a proper situation, is the lack of material on the withdrawal to the ‘private sphere’ where no colleagues or public are present.

Discussion

At the workshop, we see how effective communication is presented and adjusted so that performers can do a spotless performance of controlled ‘empathy’ on the front-stage. As such, the workshop allows us a peep-hole to the backstage region where doctors’ ‘empathic’ behaviour is rehearsed in certain ways.

When analysing the workshop, it becomes clear how stage props, each of which defined slightly different versions of ‘empathy’, became available to the performers, who then tested their performances and checked for contradicting displays of empathy in the medical training facility. First, the program pamphlet, which was mailed to the participants of the workshop in advance, explained that after the training, doctors would be able to achieve a higher level of awareness of themselves and others through the use of communication tools. Moreover, doctors would be better able to structure and manage a difficult patient conversation. The material explained that especially empathic communication has been documented to lead to more effective consultation. Empathic communication thus became a toolkit to help doctors ensure an effective, time-compressed consultation. Objective procedures to manage inappropriate emotions in the medical context were at the heart of this toolkit as well as the notion of ‘empathic communication’.

Second, the notion of ‘empathic communication’ took on a new twist during the consultants’ oral presentations. Building upon concerns of ‘empathic communication’ as a means to recognise and manage the emotions of others, the presentations portrayed a balancing act between the professional conversation as a patient-centred conversation and the need for doctors to control this conversation. One way to understand this balancing act is to interpret the act in light of a traditional optic of power relations and medical relationships (e.g. Lupton, 2003a). According to this, the patient must be recognised as an emotional individual whose emotions must be controlled in order to facilitate the conventional objectives of the patient-doctor interaction. The purpose of the interaction then appears to be to void it of emotion. However, such a point of view would stand as a confirmation of a long held belief that emotions in organisations are irrational, idiosyncratic disturbances that are best kept undercover. In contrast, we need to pay attention to how the performers were also training in being able to manage ‘deviant’ feelings of others. Inappropriate emotions and not emotions per se, might cost disturbances in relation to the organisation of the

cancer pathways. A patient who is too aggressive or a patient who is too cold and not emotional enough (that is, the patient types presented in the two role-plays) might resist further clinical procedures and/or necessary treatment. A part of doctors' role is not only to make patients feel in a certain way but also to facilitate that these patients display their feelings according to some rules or standards of the situation.

Third, the team exercises added a therapeutic element to 'empathic communication'. It was considered essential to prevent conflicts in interactions through the use of for instance 'active listening' speech technique. Conflicts require time, and patient conversations in the cancer clinic are expected to take place in highly condensed time frames of approximately 15-20 minutes (exclusive the time spend on finding a consultancy room, looking for the nurse, collecting the patient record, etcetera).

Finally, through the role-playing scenarios, the professionals rehearsed the various aspects of 'empathic communication' in order to become ready to go frontstage and perform their newly adjusted skills. In its traditional configuration, the notion of empathy plays a significant role in the creation and maintenance of health care worker-patient relationships (e.g. Halpern, 2001). Techniques of empathic communication, such as 'active listening' and 'recognising responses', are intended to both contain emotions and allow them to vent. This was not exactly the case in the staged role-plays. When a patient's emotions are recognised, the main task of the doctor is to manage these emotions and to disengage them in an appropriate fashion. The doctor engages in the role-playing scenarios by delivering bits of value-free, emotionally neutral information. By treating facts as emotionally neutral, the doctors manage to separate emotions from the interaction and by performing this manoeuvre they may also avoid getting too emotionally involved in the interaction. They focused on pathology, possible treatment procedures and clinical details such as 'the exact size of the operation seam' or 'the colour of the radiation fluid used in the sentinel node technique'. In other words, emotions between and within the doctor and patient

were getting rigidly regulated by using formalised communication patterns of neutral speech to secure a scripted aim of distributing ‘clean’ information.

In a Goffmanian perspective, this backstage rehearsal is necessary to facilitate a smooth frontstage so that medical interactions achieve satisfactory patient outcome without too much emotional awkwardness. The shift in context from a frontstage (the clinic) to a backstage (the medical training facility) allows us to understand these performances as fabricated activities that sustain a working consensus on how effective communication, including empathic responses, are directed to be performed in accelerated cancer pathways. Returning to Hochschild’s notion of ‘emotional labour’ (1983), we may view the doctors’ own request for the training workshop as evidence of the fact that they recognise the management of emotions as an important, but difficult part of their job. However, the concept of emotional labour has a depth, which is not properly addressed through the training of communication, because it includes the work one does on oneself or the work doctors do to manage their own emotions. On this background we may see how the installation of communication skills – such as skills of empathy and sympathy – does not address the complexities of medical interactions in terms of offering relief to suffering individuals. Instead, these skills concern a standardised distribution of information and, hence, doctor self-regulatory exercises which reflect the imperatives of effective communication.

Conclusion

The paper had its point of departure in a configuration of today’s medical services, which is characterised by attempts to both rationalise and humanise medical services. On this background, the paper demonstrated how communication is installed and trained as a means to control the conduct of doctors in medical interactions. The paper showed how communication skills are rehearsed at a medical training facility and it showed how certain skills, performed under the auspices of ‘empathic communication’, could be rehearsed as strategic components to support the medical baseline

work in accelerated medical services. Communication skills can be refined to secure formalised goals of speed and production effectivity. Patterns of empathic speech in which emotions are managed become important resources in providing customer service, increasing quality and so on.

The paper also scrutinised how the ‘emotional availability’ of doctors in interactions with patients becomes the aim of new forms of micro-management. More specifically, I argue that the workshop reveals how the broad notion of effective communication in the accelerated cancer pathways emerges as a means of cultivating the conduct of doctors. This research suggests that when empathic conducts are translated into clinical standards, they become available for qualitative measurement and audit processes. In contrast, Strauss et al. (1982, 1997) emphasised that sentimental work happens outside the rationalising realm of the medical world. Hochschild (1983) likewise argued that emotion work, which governs emotional exchanges in social interactions, is free of external observation (1983: 56). Contrary to this emphasis on emotional exchanges as hidden, informal activity, this paper shows that the behaviour of doctors in accelerated patient pathways is increasingly becoming a key issue of quality improvement initiatives and, therefore, a transparent property of health care organisations. During the above discussion on the training workshop, we saw how communication competence as a certain kind of behaviour is made both publicly assessable and accountable.

Likewise, doctor ‘empathy’ is a key concern of hospital managers, patients and policy makers. This study demonstrates how this concern includes an assessment of how empathic communication is delivered, by whom and with what effects. One must measure in patient records whether patients are treated with empathy and whether they are ‘empathically’ informed about diagnosis and treatment procedures. This demonstrates that ‘humanistic’ aspects of medical work now serve as an aim of efficiency improvement. The renewed focus on emotions in health care organisations is thus buttressed by mechanisms of control and surveillance, which are

all-the-more constraining because they are ‘softer’ (Harris et al., 2011). This revitalisation of emotions also means that a more salient role of emotions in organisations should not simply be taken at face value as in fact more ‘human’ but rather as an expression of the fact that emotions are considered obstacles to improved organisational efficiency.

The study thus adds to previous studies on the significance of current reforming drives in public health care services and their effects upon the conduct of health care workers (Olesen and Bone, 1998; Fitzgerald and Ferlie, 2000; Bone, 2002; Nettleton et al., 2008; Waring et al., 2011). Discussions about reforming drives in health care organisations and the development of techniques to cultivate the conduct of professionals should not be seen in isolation from attempts to understand the governance of individuals’ feelings in other contexts of employment. For example, Terpe and Paierl (2010) explore the consequences of new service-oriented administrative reforms that have recently been introduced in labour administrations. They analyse how the emotion work of German administrative employees is influenced by the reforms political and managerial aims. However, additional work is required to build a fuller understanding of how the emotional landscape of employees in the public sector changes through reforms of old administrative structures and aims of transforming the conduct of public employees towards smoother and apparently more ‘human’ manners and behaviour.

Chapter 7: Doctors' emotional experience and challenges in accelerated medical work

Purpose: This paper analyses doctors' personal biographies of emotional experience and challenges in accelerated medical work. The aim of the empirical inquiry is to focus on the ways that doctors relate emotions to their understanding of professionalism and principles of standardisation and speed.

Methodology: Drawing upon a small series of semi-structured interviews (N=14) with doctors working in a cancer clinic at a major public university hospital in Denmark, the paper adopts a constructivist framework to analyse doctors' own understandings of emotions and the management of emotions in (accelerated) social interaction.

Findings: As cancer trajectories are increasingly accelerated, the available time for doctors' contact with patients has been shortened, while the range and type of managing emotions in the trajectories has simultaneously increased. This is shown to challenge doctors' emotional codes of conduct and to require new forms of emotional regulation in medical encounters.

Practical implications: The study addresses how doctors' experience and understanding of emotions are affected by recent health care reforms to rearrange cancer services.

Originality: The paper draws together previous research on emotions in health care organisations to explore doctors' own view on recent rearrangements of cancer services and to understand their experiences with these rearrangements in relation to the connection between emotion, speed and processes of standardisation. While

emotions and rational, clinical work activities are often taken to be opposites, the paper addresses that the dimensions imply each other and that affection is frequently brought to rational use in accelerated medical work.

Keywords: Doctors, emotions, rationality, accelerated medical work, public health care services.

Introduction

The American novelist John Updike's (1995) introduction to the medical novel 'House of God' discusses a widely held belief about doctors' emotional distance to patients in medical encounters.

'We expect the world of doctors. Out of our need, we revere them; we imagine that their training and expertise and saintly dedication have purged them of all the uncertainty, trepidation, and disgust that we would feel in their position...For them, the flesh and its diseases have been abstracted, rendered coolly diagrammatic and quickly subject infallible diagnosis and effective treatment' (1995: Introduction).

The paradigmatic image of 'detached' doctors, as highlighted in the quote, is manifest in sociological work on doctors and presents an image of the medical profession that is shared by many lay people as well. The core assumption is, as Updike emphasises, that clinical affairs are being dealt with by doctors in a way that is 'coolly diagrammatic'. Abbott argues how the skilful doctor must dissociate emotion from reason and apply medicine as a rational and objective knowledge system to particular cases (Abbott, 1988). And Kirmayer (1988) writes about how doctors have 'exaggerated standards for rationality based on distancing from bodily feelings and emotion'

(1988: 63). However, this separation of rationality from emotion has been widely challenged and the importance of emotion to basis purposes and values of organisational life has been addressed for the last two decades by literature on emotions in health care (James, 1989, 1993; Bolton, 2001, 2005). As for example James (1989) writes, it is easy to be persuaded about that social expressions of emotion directly contrast the predictable, logical behaviour associated with 'rationality'. In opposition to this approach, she proposes that emotions and display of emotion is not simply enemies to rationality and rational action. Instead, emotions are rational parts of everyday life as purposive, meaningful responses to specific situations.

This literature emphasises that professionals (doctors, nurses) are required to be empathic, responsive and feeling individuals 'for the patients' sake'; i.e., an important part of their job is to make themselves emotional available to others and comfort people who are in need of emotional support. Additionally, it has been argued that emotions are an important part of completing medical work tasks effectively, without too many disruptions and vexations. According to Mark (2005) 'the dominance of rationality serves both a scientific and emotional purpose' in the health care setting (2005: 279). She explains how the former 'provides the cognitive means by which emotionally unacceptable procedures and activities are allowed to occur to individuals as patients' (ibid) and argues that the organisation of health care work today needs further attention. In particular, she finds that the continual 'juxtaposition of emotion with scientific rationality in the provision of health care' (2005: 278) has great consequences for both individuals and the organisation.

If one departs from Mark's approach and takes into consideration the pace of reform and rationalisation efforts within health care, it seems reasonable not only to readdress this 'juxtaposition' but also to focus on the complex intertwinement of emotion and rationality in relation to current ways of organising medical services. This is done in this paper by discussing the findings from an empirical study, using semi-structured interview method with 14 doctors working in a cancer clinic about

how they relate emotion and techniques of managing emotion to their understanding of professionalism and principle of standardisation and speed in clinical work activities. The context of my case is cancer treatment in Denmark, which has recently been substantially reorganised. Introductions of accelerated cancer programs have resulted in a restructuring of cancer pathways, informed by managerial and clinical purposes of reducing waiting times and organisational delays, speeding up processes of diagnosing and treatment, and strengthening the coordination of patient treatment between hospital unit and sectors. I argue that these new structural rearrangements affect the forms emotional expression takes in medical work.

Through analyses of doctors' emotional experience and challenges in their work, the paper shows that emotions not only constitute important social elements of medical work, but that emotion and emotional display is also frequently enacted in a rationalised way to help doctors ensure the progress and efficiency of accelerated cancer pathways. Emotion constitutes new ways of providing effective and efficient health services in the current situation of limited economic resources to public health care and a political and managerial climate influenced by New Public Management principles of efficiency, accountability, cost reduction and speed (see for example Harrison, 2002; Harrison and McDonald, 2008). The paper discusses the implications of such intimate connections between emotions, speed and standardisation and argues that this contributes to existing debates on emotion and emotion management in public organisations, such as recent discussion concerning how employees are getting trained or instructed in managing rational emotions while providing 'compassionate', 'personal care' (Du Gay, 2008; Terpe and Paierl, 2010).

The paper is organised in the following way. First, the theoretical frame, which informs the discussion of the role of emotion and the type of emotional transactions in accelerated medical work, is introduced. Next, the method of the empirical inquiry is presented. Then follows the analysis of the emotional challenges that doctors experience and make sense of in their everyday work and the strategies they em-

ploy to handle these. Finally, the paper wraps up with concluding remarks about the complex interweaving of reason (rationality) and emotion that motivates doctors' feelings, experiences and thoughts.

Theoretical framework

'To drop the tools of rationality is to gain access to lightness in the form of intuitions, feelings, stories, improvisation, experience, imagination, active listening, awareness in the moment, novel words, and empathy. All of these non-logical activities enable people to solve problems and enact their potential'.

This quote from Weick's (2007: 15) critique is based on his studies of wild land firefighters and the use of rational tools in social action, as well as the emphasis attached to reason and rationality in existing studies on work and organisations. His critique suggests that emotion and rationality belong to two different organisation spheres, where the latter hems in the true potential of the former. The assumption is by no means unique. Authors have suggested since the beginning of the modern period that 'emotion became known as the enemy to rational processes instead of its ally' (Douglas and Ney 1998: 80). The consequences are that characteristics of the conduct of organisational life such as empathy, active listening and imagination (as pointed out by Weick) have been forcefully divided from supposedly more 'logical' or 'rational' activities, which otherwise characterise organisations and their basic norms and practices.

This paper follows the work of Putnam and Mumby (1993), among others, which presents emotion and managements of the emotions as entirely compatible with instrumental goal orientation and instituted purposes and values in organisations (see also, Albrow, 1994; Ashforth and Humphrey, 1995; Fineman, 2006). Putnam

and Mumby set forth a way to position emotion as ‘central to the process of organizing and as integral to participation in organisational life’ (1993: 36). They write that emotion ‘is not simply an adjunct to work; rather it is the process through which members constitute their work environment by negotiating a shared reality’ (ibid.). In this way, organisational practices can be viewed as enmeshing the rational and the emotional: they are two sides of the same coin.

In a health organisation context, the perspective also challenges dualistic analyses that separate compassion from detachment, improvisation from routine, objectivity from involvement and emotion from authentic feelings in the provision of health care services. Professional demeanour, pretence of sincere concern and welcoming smiles all facilitate and lubricate medical work procedures, including social and psychological aspects of care, which are often presented by practitioners as the ‘soft’ dimensions of their work (see ‘cancer care for the whole patient’ in Adler and Page, 2008). The health organisation context defines norms of feelings and facial and bodily display of emotion that doctors are required to use in patient-doctor interactions. As Fineman (1993) argues, these particular emotion codes are internalised as part of the conduct of doctors and are often promoted as a part of the hidden curriculum of medical training (Smith and Kleinman, 1989).

One of these emotional codes may be characterised as *affective neutrality* (Parsons, 1951: 61). Nowhere is this ideal of detachment so firmly entrenched as it is in medicine. Affective neutrality refers to self-restraint and self-discipline in relation to the amount of emotion or emotional display that is expected or appropriate to ‘give off’ in social interactions and how one can stay ‘cool’. According to Parsons, affective neutrality is a significant feature of doctors’ appearance. As such, the taming of doctors’ behaviour is a necessary precondition for intimate interaction with others (patients, relatives) and one that enables doctors to attend to the complaints of suffering individuals in a reasonable and reliable way, stripped of personal (i.e., individual) bias. Parsons writes that by defining the doctors’ ethos in this way, ‘it is possible

to overcome or minimize resistances which might well otherwise prove fatal to the possibility of doing the job at all' (1951: 459). A number of 'control mechanisms' or 'technologies of government' (Miller and Rose, 2008) work to frame and reframe this particular ethos in practice, for example, through the self-presentation of the doctor as having a 'matter of fact' attitude to her patients, without undue personal involvement.

Hochschild's emotion theory (1979, 1983, 1998) presents a different understanding of the role of emotions and emotion management in health care, which includes strategic and manipulative control of others' feelings as part of service workers' job. Hochschild's main concern is with the social engineering of feelings as resources or commodities, which can be reproduced and exploited as part of the new (late-) capitalist spirit. Her term 'emotional labour' indicates that feelings of employers' are managed to 'create a publicly observable facial and bodily display (1983: 7). In the service industry, workers' feelings (conceptualised as feelings derived from their private spheres) are becoming public available and consumed by customers as part of a commoditised social interaction. Hence, in Hochschild's theory there is a discrepancy between 'sincere', 'inner' emotions, moods and their display and more rational, goal oriented actions in public service work. It is thus questionable whether the term 'emotional labour' actually captures the complexity of emotion and rational emotional transactions in health care (for a thorough critique of Hochschild's theory, see also Bolton, 2005). Where Hochschild frames the commoditization of emotion in labour, Strauss et al. (1982) presents a less politicised approach to the role of emotions in work, where the object being worked on 'is alive, sentient, reacting' (1982: 254). In a larger study on the social organisation of medical work the authors describe the organisation of so-called 'sentimental work'. Sentimental work involves 'staff members' and patients' maintaining of composure, keeping up of spirits of courage' (1982: 255). In this way, sentimental work is understood as emotional transactions or work completed to manage the emotions of patients and others (for example the doctor's own emotions) in illness trajectories in public hospitals. In contrast to

Hochschild's perspective, Strauss et al. suggest that there is nothing extraordinary or alienating in the provision of sentimental services. It is a necessary type of work undertaken by doctors, among others, to accomplish the 'real' medical tasks, such as taking a blood pressure or cleaning an operation wound. Strauss et al. argue that the impetus for doing emotional work has been profoundly affected by historical changes in the medical field. The paper proceeds from the assumption that current structural changes of cancer services represent a challenge to the way emotions and emotion management has previously been part of medical work, both in the sense of the required ethos and the emotional work associated with practically enacting this ethos.

Method

The sample analysed in this paper is 14 ($N = 14$) semi-structured interviews with doctors in a cancer unit at a public hospital in Denmark. The interview sample was collected as part of a larger study examining the effects of recent changes in the management of Danish health care services to hospital doctors. The larger study was carried out between June 2009 and January 2011.

Procedure

Access to the cancer clinic was gained through the clinic's head of research. This person also provided the contact information for the doctors. Invitations, accompanied by background information about the study, were distributed via email, asking doctors in the clinic to participate in an interview study on their experience and understanding of medical work in accelerated treatment programs. The choice of location for the interviews was decided by the doctors. The interviews were conducted in consultancy rooms in the outpatient clinic, in office facilities of the clinic and in a staff meeting room. Meeting in the staff room proved to be difficult, and this location was not used after the first interview. The first interview was disturbed by nurses entering the room for a cup of coffee. While others were in the room, the respondent was dis-

tracted, lost track of where she was in her stories and had difficulty sharing the emotional aspects of her work, as those parts of the interview were too sensitive to share with external ‘intruders’. Another obstruction worth mentioning was the set time-frame for the interviews. All the interviews were to be conducted while the clinic was open, which meant, as one of the respondents pointed out, that the interviews took the doctors’ time away from the patients. We were thus required to adhere strictly to the allotted time. The interviews were scheduled in the respondents’ daily work roster and they were set to last between 20 – 30 minutes. The observation emphasises how time management is of utmost importance for medical staff. However, the importance of sticking to the allotted time might have two functions. It enables the doctor to see many patients in a short period, but it might also be used in medical practice as a strategy for maintaining authority and professional detachment (Lupton, 2003a). In relation to the interviews, this strategy was employed in the end of the interviews, where the respondents started looking at their watch or began to focus on the importance of returning to their patients.

In the interviews I had no intention of trying to trace what the participating subjects ‘really’ feel or to determine the authenticity and ‘under the surface’ feelings of the doctors. Instead, I identify different layers in the way doctors understand and present emotional aspects of their work to others. This corresponds to Goffman’s (1974) work, in which he explores how and when something is framed as the ‘real’ thing and circumstances in which something is said and something else is left unspoken. My initial interviewing guide was constructed so as to provide an understanding of the doctors’ views on and responses to their working lives, and to understand how these people frame and reframe emotional injunctions to their work. I was also interested in ‘how it feels being a doctor’ in a current environment of New Public Management and principles of efficiency, accountability, cost reduction and speed. To my knowledge only few qualitative studies (except from Lupton, 1997; 1998 and Nettleton et al., 2008) have sought the feelings of doctors upon these issues.

The 14 qualitative interviews were all audio-taped and transcribed. The identities of the interviewees quoted in this paper have been concealed for ethical concerns. To ensure this anonymity, some statements and other empirical evidence in this paper have been adjusted, so they cannot be traced to individual staff members in the cancer clinic. My primary interest was to listen to the discursive aspects of emotions and emotional challenges as these were articulated through the interviews. Hence a discursive approach, informed by a constructivist perspective, was employed on exploring the interviewees' views and experiences of reality, when these were articulated and made sense of to others (the interviewer).

Emotions in accelerated cancer care

So how did the doctors relate emotions to their professional work activities? The next section presents the discourses used by the participants and it provides examples of the ways that doctors describe and relate emotion to their understanding of professionalism and principles of standardisation and speed in the accelerated cancer pathways. It furthermore explores how the participants are affected by recent attempts to organise cancer treatment into streamlined production flows.

The professional role of a doctor

In the interviews, the doctors were asked to characterise their professional role in relation to their substantial work tasks in the accelerated cancer pathways. Many of them described their role in terms of 'providing efficient care' (Deborah); 'facilitating optimal treatment' (Michael); 'making the greatest effort possible in regard to the individual patient' (Erving); 'curing the patient and leaving her with a minimum of physical distress' (Sarah) and 'to provide treatment options for patients who have complaints within the area of our medical expertise' (David). In addition to providing optimal care, professionalism, according to the interviewees, consists of 'dealing with the specialised sequences of the patient pathways as good as possible' (Lucy). Mi-

chael adds another 'soft' element to the 'technical' descriptions of his professionalism:

'When one is serious ill, there is a need for somebody who actively listens to ones' complaints. This is a profound element of my professionalism, besides all of the other vital elements in the patient pathway, such as the observance of waiting times, record-keeping in our clinical databases, capacity management, etc.' (Michael)

When Michael lists some of the different work tasks that constitute his daily work, there is no significant difference in the emphasis on 'active listening' in patient-doctor interaction, keeping track of the clinic's waiting times to see a doctor, and diagnostic test methods. All elements are described as vital parts of his work. Even the severely criticised 'rituals of verification' (Power, 1997), such as rigorous data recording, is presented here as a proper professional task. Some of the doctors explained how the ability to follow clinical guidelines and recommendations, which define the medical procedures of the cancer pathways, are perceived as genuine professional tasks and something which improve the clinical quality of their work.

None of these explanations about professionalism and the doctor's role are very controversial and confirm by and large the picture provided by Parsons on the doctors' functional competences as an entanglement of technical, and social and psychological competences (Parsons, 1951). Alongside the biomedical aspects that fall under the technical competences of the doctor, such as the task of removing a cancer tumour, there are more social aspects implied in the medical job, such as emotionally preparing the patients for bodily interventions or be emotionally available to patients through techniques of 'active listening'. This wide spectrum of job tasks also affected what the doctors thought were gratifying in their work. The doctors talked about the satisfactory feeling of performing surgery and how it feels almost exhilarat-

ing to make a clean cut in the flesh and feel how the ‘scalpel easily separate tissue and skin and how the sentinel node snap into ones fingers’ (Eva). They also described encounters with patients as gratifying if they felt that the patients were open to an intervention. For example, one doctor said: ‘One of the greatest pleasures in my work is to attend a patient in the outpatient clinic who immediately is very offensive and then slowly through our communication opens up and tells me what she actually feels’ (Sarah). Most of the interviewees mentioned how patients who easily agree to a proposed treatment sequence cause feelings of contentment. The opposite can also occur; for example, a patient may respond in a way that the doctors experience as emotionally inappropriate. The interviewees talked about troubles with ‘misfitting’ patients and how these people might cause general frustration among the professionals when they attend the clinic for help.

‘In cases where the patient declines your guidance, then she can be categorised as a kind of a misfit. Our treatment program encourages individuals to follow its recommendations. In the case of a patient who reacts pathologically, my professional task is to stay calm and not get personally affected – for example when a patient insults me or if she refuses to follow my leads’. (Paul)

The separation of emotional display from the presentation of a professional appearance is experienced as pivotal in situations where patients do not follow advices or react in ways that are perceived emotionally ‘pathological’. One doctor described how she ‘need(s) to be disengaged on a personal level while providing effective care’ (Sarah). In the same vein, Erving explained that he ideally must separate emotion and rationality in his clinical tasks in relations to his professional codes of conduct, and he noted how this separation can be difficult to uphold in practice:

‘My professionalism demands that I am able to separate the emotional aspects of my work from the more rational aspects of my work [...] However, I must admit that I emotionally connect differently with one patient than another and, therefore, also might behave differently’ (Erving)

The explanation in the quote, which was heard from other doctors in the sample as well, indicates that (emotional) codes of conduct are defining the doctors’ display of professional appearance. The doctors expect themselves to behave in a certain way to meet colleagues’ and lay peoples’ expectations of ‘the world of doctors’ (cf. Updike, op.cit.). Emotionality in this interpretation involves a loss of control over one’s emotions; to be ‘gripped by emotions’ and it might as well involve irrationality. Erving was not the only doctor who recollected particular patients and explained how interactions with them challenged his ability to, in his own words, ‘separate emotional aspects from rational aspects of my work’. When asked if it is considered important to separate emotions from doing rational clinical work activities, many of the interviewees strongly supported the notion that ideally one must always be able to separate the two. By saying this, the doctors reconfirm and promote the ideal of affective neutrality set forth by Parsons (1951). However, this ideal is continually getting challenged. The doctors’ experiences do not leave them emotionally ‘coolly diagrammatic’, as discussed in the next section. Some ‘troubling’ persons not only challenge the doctors’ ability to sustain a professional appearance and to go public with a ‘smooth face’, but these patients may also cause confusion in the doctors’ way of attending to particular situations in the cancer clinic.

Emotional experience and challenges

While the interviewees generally agreed that that they intend to treat all patients equally (for this is regarded as an essential and indispensable dimension of their professionalism), they said that emotionally, they responded differently to some patients:

‘Some patients have easier access to your stomach pit than others’ (Mary); ‘some people talk more directly to your heart, and they unlock your emotions’ (Sarah) and ‘some of my patients are more difficult to shake off than others’ (Monica). Troubling patients, regarded by the interviewees as patients whom you “carry with you” after office hours, are people who somehow affect the way doctors feel. Some of the interviewees suggested that their emotional state was affected partly by the ‘emotional climate’ and partly by particular illness stories. By emotional climate, I refer to the interviewees’ conceptualisation of the foundation for emotional attachment to others. Doctors also used the term ‘chemistry’ to relate the idea of emotional climate in the interviews: ‘Sometimes, no chemistry is present, and you just have to accept that and go on with the line of work’ (Michael); ‘Of course I have cases where the chemistry is awful, no matter the efforts I make to improve it’ (Deborah); and ‘You can easily feel if the chemistry is just right’ (Eva). When the appropriate climate is missing, doctors describe the interaction in more generalised terms: ‘The other day, I had an interaction with a patient who really didn’t like me. There was no chemistry between us at all’ (Sarah) and ‘She [the patient] was on a totally different wavelength than me’ (Paul). Although the emotional climate is commonly recognised by the interviewees as important and something one should work on to improve, poor ‘chemistry’ is also recognised as a part of the job, where sometimes the doctor or the patient requests that another person take over the responsibility of the treatment.

The doctors explained that particular illness stories affected them and caused an emotional response: ‘It is either the very young patients who get cancer or patients whose illness trajectory is wretched’ (Susan); ‘Young people creep into you. It is a common concern for all of us, and one can register it in the corridors of the clinic’ (David); ‘When you face a young mother in the clinic who is 34 years old and who has just given birth to her first child, it is impossible not to think when you enter your front door after work “oh, life is just unfair to certain people”’ (Lucy). To disclose a cancer diagnosis to a young woman in her early thirties is emotionally strain-

ing ‘because you know her prognosis is really bad and...well, no matter how much you try to stay detached, you somehow get affected’ (Erving). Most of the stories that the doctors considered troubling included stories about young women who were considered ‘really ill’ or ‘genuinely ill’. Young women with an aggressive, advanced stage tumour are regarded, as one of the doctor’s says, as ‘the worst patients I can possibly think of to have on my outpatient clinic schedule’ (Eva).

A certain category of ‘demanding’ patients are commonly described as influencing how the doctor feels – both with regard to her own role as provider of public health services and with regard to the role of the patient as consumer of these services. As some of the doctors explain, ‘I get really angry when resourceful people in totally unrestrained manners try to enrich themselves with our services and push themselves forward in the service line’ (David) and ‘The archetype of a demanding patient is a colleague or a school teacher who attend the clinic with objectively unjustified demands for treatment’ (Michael). The doctors commented that demanding patients are ‘difficult to handle’ (David); ‘intimidating’ (Brian) and ‘they really strike me with contempt’ (Susan). The doctors’ feelings of disgust are regarded as strictly forbidden feelings to display. These feelings are specifically manifest in situations where patients behave as demanding, well-oriented consumers who have explicit expectations to the quality of offered services. A way to attend to the needs of demanding ‘consumer-patients’ may be to attend to them as people who has social or psychological problems instead of attending them as people who are in need of medical services (see also how GP’s attend people with MUS in primary care in Mik-Meyer, 2010; 2011; Mik-Meyer and Roelsgaard Obling, 2012). Hence, it also become easier to deny them access to the clinic’s accelerated services, proposing that these people look for other care options. This is for example the case when people ask for cosmetic surgery, which is a service that is not financed by the public health care system in Denmark.

Techniques to manage the emotions

In the last section, I briefly touched upon categories of patients and situations that were described as particularly troubling by the doctors. The doctors believed that some people interfered with their plans and procedures and were extra-ordinary time consuming. As one of the interviewee's explains:

‘Some people respond very pathologically [...] they also make your day into rubbish because your time schedule becomes completely ruined by the work you have to do to calm the person down to be able to get on with your duties’ (Susan).

One way of dealing with deviant cases is to master techniques of emotion management, which are techniques frequently used to prevent the occurrence of emotional incidents. Management of the emotions might be used when patients or relatives in the accelerated cancer pathways react to malignant diagnoses by becoming extremely upset or angry or, perhaps even worse, does not show any emotion at all. For example, a doctor explains how he ‘always uses the same explanatory models and ways of presenting bad news, which he seldom deviates from, because the models have proved themselves effective as techniques’ (Michael). As described in the following quote, doctors are expected to appear engaged and responsive and to be able to look at a situation from the patients’ perspective.

‘You also expect your real estate agent, when he shows you around in a house, to be engaged every time the two of you meet. He must show you all of the rooms, and he must be responsive to every individual need. He also needs to appear cheerful and optimistic’ (Paul).

This doctor explained how, through a particular appearance, he is able to create a more comfortable situation for the patients and make them feel secure in the interaction. Neglect of emotion management might threaten the line of prescheduled diagnostic and treatment procedures, which are defined in the cancer pathways in relation to a set of standard trajectory descriptions. In the interest of both the organisation and the individual patient, the doctors are therefore willing to take on serious ‘work’ (Strauss et al., 1982) to maintain composure and thus be able to accomplish the prescribed medical tasks. One basic defensive measure that the doctor can employ if a situation develops is to ‘start putting forward all of the practical details that need to be arranged’ (Monica). To pay attention to practical details in the medical interaction is to focus on ‘we need to plan your surgery’ (Sara) and ‘focus on all of the stuff we actually can do to cure them instead of focusing on their misery’ (Monica). Another technique to address the situation might be to suggest a second treatment option. As one of the interviewees (Erving) explained, ‘you might be compelled to suggest an additional examination to moderate them a bit [...] to cool them down’.

The work undertaken by the doctors to maintain composure in the cancer pathways also include work or efforts in relation to upholding the appearance of an emotionally detached doctor. When asked if it is important to manage one’s emotions, the interviewees gave the description of the paradigmatic doctor as a person who must always manage to stay personally (i.e., individually) detached, even in a situation where this detachment is challenged by the doctor’s own feelings (compassion, sorrow).

‘Deep inside, I just want to cry with them [cancer patients], but for the sake of providing good care and of course to protect myself, I must always pretend to be calm’ (Ann).

Some of the interviewees’ identified a certain technique to manage their feelings that prevent them from becoming emotionally involved with individuals who are serious

ill. Eva explains how she manages the misery of suffering patients by imagining that ‘after I have successfully removed the patient’s tumour ...she will experience an uncomplicated healing process’. This technique becomes a technique of self-defence because, as Eva also explains: ‘I make this way of thinking even in cases where I know that no cure is possible and the prognosis of the patient is really bad’. Thinking of colleagues’ abilities to cure patients can provide a buffer to precarious situations, where the ability to balance one’s own needs with the patients’ needs becomes challenged. These techniques may be used more frequently in accelerated trajectories than in traditional trajectories, because there are many different professional faces involved in the patients’ diagnostic and treatment procedures in a very short time interval. Hence, there is always a colleague further down ‘the production line’, which the doctor can refer to as making a difference in relation to the patient’s curing possibilities.

Another technique the doctors can evoke is to focus on professional ways of (dis-)engaging with others.

‘Your whole body screams in disgust with a person who is literally shouting at you and calls you all kinds of nasty names [...] nevertheless you must try to lend the person assistance, following the norms of your professional codes, which tell you to stay calm’ (Mary).

The quote reveals one type of dirty work, which according to Strauss et al. (1997), consist of tasks ‘so exhausting or stressful as to tip forward the non-gratifying or so ultimately the dirty side of work’ (1997: 248). The doctor explained that she can rely on her codes of conduct as a strategy for moderating or minimising the experience of her more difficult tasks, as a mean to distance herself from dirty aspects of medical work, and as a way to sustain her ‘professional involvement’ without being gripped by personal, inappropriate feelings (Mary).

In sum, the discourses suggest that the doctors frequently use various techniques to manage their emotions. This includes techniques to: 1) help doctors to ensure the progress of diagnostic and treatment procedures in the cancer pathways, and 2) help doctors to sustain their professional ‘ethos’. The former implies that the doctors rely on these techniques when a patient needs to be emotionally regulated to ‘fit’ better into the prescribed procedures. The latter involves that the doctor herself apply techniques to address and overcome challenging, stressful, or discrediting situations.

Emotions in standardised work procedures

Discourses of standardisation were frequently employed when the doctors explained the organisation of their work in the cancer pathways. Several of them referred to the importance of consistently following the same procedures, and one doctor mentioned, ‘it is important that our patient pathways are always standardised and effective’ (Sarah). This idea was supported by Mary, who mentioned ‘that our patients should experience that everything is organised following a rigid plan of procedures’. It is also supported by Deborah when she said that ‘at least we have a plan we can offer them’. During the interviews, it became obvious that the clinical guidelines and recommendations that doctors draw upon to make decisions about diagnostic and possible treatment procedures not only structure the sequences of action in the pathways but also provide guidance on how one should feel in given situations. For example, one of the interviewees (Eva) described how she ‘sticks to my guidelines because I can’t always grasp young women with cancer and their gamut of feelings’, and another interviewee explains how ‘one can always rely on the guidelines if one feels a bit uneasy’ (Brian). Hence, the guidelines are used as strategic protective shields to employ in situations when the doctors become emotionally challenged. The guidelines help to reinforce the paradigmatic (self) image of the doctor when this image becomes threatened by dissonant feelings.

When the inter-

viewees were asked to comment on current political and managerial climate influences by principles of New Public Management (efficiency, standardisation, accountability, cost reduction and speed), they articulated feelings of ambivalence. A recurrent theme was that ‘one wins something and loses something when standardisations are implemented’ (Lucy). This theme reappeared in various negative responses, such as: ‘We practice a lot of roundabout routine procedures that continuously remove us away from the patient’ (Paul); ‘Our patient pathways remind me of a sausage factory’ (Susan); and ‘I feel like an old record player that plays the same tunes again and again’ (Paul). The image of a Taylor-inspired manufacturing line is also present in the next quote:

‘There is no doubt, that the prize of standardisation of health care services is high [...] from being a matter between you and the patient, medical work is now more or less standard manufactory line work, where your job is to fix a few things along the line. You can then be lucky to be in charge of a significant part of the line. Additionally, things can be organised in inopportune ways, which means your job is reduced to replacing a defect bolt and that’s about it’ (Lucy).

The interviewees understand themselves as becoming emotionally detached from their work in several distinct ways. This detachment is significant in cases where they cognitively cannot separate one patient from another, which was apparent in statements that the doctors made about the restructured pathways into streamlined service flow, where the patients emanate in one another. Because most clinical decisions may have already been made by other colleagues, the individual doctor is left to tinker with only routine matters. As explained by one of the interviewees, ‘To be left with just a small part of the assembly line leaves me unsatisfied’ (Lucy). The feelings of ‘too much detachment’ are also present in cases where the interviewees’ themselves feel physically distant from the patient, as in cases where they have not had the op-

portunity to examine the patient themselves. In the interview sample, some of the doctors explained that it feels frustrating if the initial meeting with a patient occurs in the operation theatre, where the patient is anaesthetised and fixed to the hydraulic surgical table. In these cases, the doctors felt that they had been reduced to the role of a mere scalpel: ‘Sometimes in the operation theatre I try to recall the patient, who is under anaesthetics in front of me [...] it actually bothers me that she is already out of my radar, and I can’t even recall a minimum of the person’ (Brian).

The ‘dislocation of the case from the patient’s bedside’, also noted by Atkinson (1995: 149), makes up a profound element of contemporary medical practice, but it furthermore leaves a feeling of uneasiness, as explained by several interviewees of this study, who felt themselves detached from their patients if they only have to deal with the pure ‘cases’. This remoteness from the ‘whole’ patient leads to disturbing feelings: ‘Sometimes I experience this confusion of loads of cases somehow alienating’ (Monica) and ‘I feel insecure when my professional decision making is removed from the physical presence of the patient’ (Deborah). These examples support the argument of Rose (2007), when he claims that today doctors are ‘hemmed in and constrained by the requirements for the use of standardised, corporately framed diagnostic and prescribing procedures’ (2007: 11). Furthermore, it widens the empirical scope of his argument in showing that ‘to be hemmed’ in causes various feelings of frustration among the doctors. Above considerations suggest that the standardisation of work activities in the accelerated cancer pathways hinders the development of a total impression of the patient, and consequently, it becomes difficult for doctors to assess the emotional state of patients and adjust their professional ethos to this. ‘To be left with only a smaller part of the manufacturing line’, as one of the interviewees explained, might also effect the type of emotion management a doctor can provide in a split second and under conditions where the ‘cases’ are separated from processes of clinical decision making and bodily examinations.

Conclusion

A central aim of this paper was to identify doctors' emotional experience and challenges in accelerated medical work. Through an analysis of the ways that doctors relate emotions to their understanding of professionalism and to work activities that characterise rational organisational forms, the paper has investigated the complex interweaving of reason (rationality) and emotion that motivates doctors' experiences and thoughts.

A key finding is that doctors identified emotions in terms of resources. As resources, emotions were not experienced as being antithetical to the doctors' provision of medical service. Instead, emotions were approached as necessary components in the production of objective, reliable and standardised care. Doctors' emotional availability to patients is thus not opposed to or separate from the 'rational clinic' (Wulff and Goetzsche, 2000) or the provision of 'rational diagnosis and treatment': professional medical work is a delicate combination of both. It is therefore next to impossible to separate procedures that require rational versus emotional responses in doctors' everyday work in the cancer clinic. In this light, rational procedures of diagnostic and treatment in the accelerated cancer pathways are not predicated upon the curbing of emotions, but on the management of 'reasonable' emotions. This study therefore suggests that reason (rationality) is not opposed to emotion, but both are part of effective and efficient cancer treatment, and hence both dimensions 'make up' the doctors' minds.

The analysis presented in the paper highlights some of the emotional codes of conduct, that are characterised by the participants as a form of what Hochschild terms 'emotional dictionary' (Hochschild, 1998), which defines those feelings that are appropriate to display in specific circumstances. In this way Updike's paradigmatic image of doctors and medical activities as 'coolly diagrammatic' are to be understood as an shared ethos which includes an understanding of what a doctor should feel, how she emotionally should be available to another person, and

how she must sustain this idealistic appearance. The doctors' well-established ideas presented in this paper about emotional codes of conduct include also the Parsonian ideal of affective neutrality, which is framed by the participants as a precondition for successful and effective patient-doctor interaction. Affective neutrality allows doctors to attend to patients individually, but protects the doctors from exhaustive personal involvement. However, this ideal does not prevent doctors from being emotional challenged by 'troubling' individuals. For example, the doctors acknowledge that it takes considerable time and effort to provide an emotional climate and accommodate demanding patients. Compressed work schedules and accelerated timetables often make improvement of this climate difficult, even impossible, and the result is feelings of a failed encounter on behalf of the doctor.

Another key finding is that it takes serious work for doctors to reframe the paradigmatic image of doctors as detached observers in emotionally challenging situations. One way that the doctors are able to do this is through the use of emotion management techniques that, in a Goffmanian sense, makes it possible for the professionals to stage a particular character and thereby 'saving the performers' show' (Goffman, 1959: 207). The participants of this study were aware of several techniques of emotion management, which they frequently use to manage their own and others' emotions in the accelerated cancer pathways. This work is done in situations typically where patients display too much emotion or where patients demonstrate an inappropriate display of emotion. The latter also includes the display of inappropriate emotions, which is experienced by the participants as equally disruptive as a display of too much emotion. It is therefore not enough to be a detached observer and sustain affective neutrality in patient-doctor interactions: doctors need to practice serious micro-regulated tasks of emotion management to maintain composure in these interactions, even in situations where there is very limited time to practise this kind of work.

The interviewed doctors were sensitive to a current environment of New Public Management and principles of efficiency, accountability, standardisation, cost

reduction and speed which have been implemented in health care organisations during the last two to three decades. Most of them agreed that there is a price to standardisation of health services, which they specifically experienced as a form of detachment where they gradually become removed from their traditional field of intervention, which is the patients' bodies, feelings and thoughts. However, the doctors must adhere to behavioural norms: they must demonstrate empathic, responsive or caring behaviour even in situations where their duties require them to focus on only a smaller part of the patient trajectory or in cases where their personal contact with a patient is very limited. Importantly, this paper suggests that the rearrangement of the cancer pathways into streamlined manufacturing-like processes, which include a reduction of waiting times and organisational delays and accelerated procedures of diagnostic and treatment of patients, complicate doctors' ability to incorporate emotion into the stream of medical care in a 'rational way'. The streamlining of the cancer pathways accentuates the importance of skilful emotion management because the actual encounters with patients are generally reduced. However, there is only a restricted time for putting this increased emotion management into practice and the issue is only addressed in an individualised way, i.e., as the doctors' personal reflections. The rearrangement has led to conflicting demands of the emotional availability of doctors and the timeframe set for this appearance in the accelerated cancer pathways, and one might observe how the ultrafine equilibrium between affective neutrality and affective involvement has become slightly unbalanced. However, additional research needs to be conducted to explore how the impact of public health reforms inset new emotional injunctions to doctors and thus affect the delicate doses of emotionality in professional conduct.

The findings from this study have implications for how we critically approach emotions in organisations. Different forms of organising entail different ways of putting emotions to rational use, which concurrently provide different challenges to doctors. Here, the rearranged cancer pathways can be viewed as a form of organis-

ing that neglects to address the way emotions are indispensable in a skilful medical practice. Instead, the organisation of cancer pathways builds upon the (faulty) assumption that reason and emotion can be separated and compartmentalised into isolated work tasks or steps that subsequently can be distributed among different practitioners. The structural organisation of cancer treatment thus repeats a tendency in management and organisation studies to view emotion and rationality as belonging to two different spheres. These ways of organising the ‘emotional’ and the ‘rational’ are repeated in the increased presence of so-called ‘emotion programs’ in health care, where social and psychological aspects of medical work are organised to better supplement streamlined, effective and measurable clinical and administrative procedures in accelerated cancer pathways (see for example the call for medical ‘emotion’ training or the emergence of cancer rehabilitation centres, Adler and Page, 2008). The structural division of ‘rational’ and ‘emotional’ aspects of medical work attest for a need for further exploration, because this juxtaposition indeed seem to have consequences for both individuals and the organisation, as Mark (2005), among others, previously has indicated.

Chapter 8: The negotiation of the sick role - general practitioners' classification of patients with medically unexplained symptoms

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Abstract In encounters between general practitioners (GPs) and patients with medically unexplained symptoms (MUS), the negotiation of the sick role is a social process. In this process, GPs not only use traditional biomedical diagnostic tools but also rely on their own opinions and evaluations of a patient's particular circumstances in deciding whether that patient is legitimately sick. The doctor is thus a gatekeeper of legitimacy. This article presents results from a qualitative interview study conducted in Denmark with GPs concerning their approach to patients with MUS. We employ a symbolic interaction approach that pays special attention to the external validation of the sick role, making GPs' accounts of such patients particularly relevant. One of the article's main findings is that GPs' criteria for judging the legitimacy of claims by those patients' that present with MUS are influenced by the extent to which GPs' are able to constitute these patients as people with social problems and problematic personality traits.

Keywords: medically unexplained symptoms, general practitioner, sick role, classification, legitimacy

Introduction

In western countries, there are growing numbers of people who report pain throughout the body that cannot be medically diagnosed (Ring *et al.* 2005). The reported pain

of these individuals cannot be fully explained by pathology: no physiological tests correlate with the reported symptoms of the patients. This is a patient group that tests the credibility of doctors and the legitimacy of patients: doctors risk professional credibility for their failure to diagnose certain patients' problems while patients who have symptoms whose causes cannot be diagnosed feel the shame of being illegitimately sick – that is, they are deviant cases for whom a classification rule cannot be applied, despite the claims that they make. These are patients who, in Jutel's (2010) words, 'feel poorly, but for whom no medical explanation can be given' (2010: 230).

In the sociological literature, such deviant and illegitimate patient cases are often characterised as suffering from 'medically unexplained symptoms (MUS)' (Bendelow 2009: 57). This is an overarching category incorporating a variety of different conditions such as chronic pain, stress, milder forms of depression and contested illnesses, including fibromyalgia, chemical intolerance, irritable bowel syndrome and chronic fatigue syndrome. Although these illnesses have little in common and this patient group is by no means homogenous, these patients do fall into a particular (residual) category in the eyes of general practitioners (GPs). The patients repeatedly consult their GPs over physical pain that cannot be diagnosed medically. However, in addition to this common feature mentioned by GPs, we note that the acronym MUS is, like any other category, constitutive in nature (see Hacking 1986, Jenkins 2000). As a container category, MUS both contains individual symptoms and complaints of patients and works as a reductionist label that organises different patients into a unitary group. As an unintended consequence of this classification, the MUS label produces and stabilises the expectations of the patients in this group. Here, we focus on that act of classification – in medical terms, the diagnostic trajectory.

This article presents the results from a research project conducted in Denmark in 2008–2009 that focused on patients with MUS (Mik-Meyer 2010, 2011). In the article we show how GPs recognise this patient group, bearing in mind that GPs focus

their professional attention as much on the suffering of the patients as on the medical classification of illness. As already demonstrated by Parsons (1951, 1978) and by Balint (1964), the role of a GP is to both address patients' subjective distress and to diagnose illness through a physical examination. When GPs attempt to find out what is the matter with someone, they must attempt to attribute symptoms to causes and make a diagnosis. This diagnostic process involves linking different symptoms with each other so that eventually the combination of symptoms can be labelled as a disease or a pattern of illness and hence given an explanation.

Patients with MUS, however, make the completion of these tasks difficult. Many of the illnesses in the broad MUS category fall outside the scope of biomedical observation. When people have symptoms that fall outside clear-cut medical diagnoses, doctors tend to either classify the symptoms as psychological in nature or ignore the patients' physical symptoms altogether (see Sabo *et al.* 2000). Hence, patients with MUS challenge GPs' traditional approach to diagnosis and intervention and what it takes to be a 'legitimate' patient in a context constituted by medical credibility. Credibility refers to a GP's ability to create an explanatory framework that categorises patients in a specific sick role through the legitimisation of their complaint, even when a medical diagnosis is absent.

This article presumes that when MUS patients turn to GPs for assistance they risk being classified as illegitimate; in turn, in the patients' eyes, the GPs can be seen to be lacking in credibility as medical practitioners if they cannot state what is wrong with them. This article provides a sociological insight into contemporary understandings of 'the sick role' (Parsons 1951: 436) when the patients in question are defined by the lack of a clear-cut medical diagnosis. We also demonstrate how GPs classify symptoms described by MUS patients and create opportunities to treat this group of people as legitimately sick individuals. In this article we address these questions by firstly, examining how different explanatory models reported by GPs relate to their construction of what it is to be a legitimate patient. Secondly, we focus upon how

GPs struggle to define 'legitimate patients' relates to the (problematic) socio-economic status, general life stories and personality traits of patients with MUS. In our present study, however, we exclusively focus on the GPs' point of view.

Classification of illness

There has been much research on the tools of classification in biomedicine (see Bowker and Starr 1999) and how diagnostic practices can be a potent way to create a social order for medicine, the patient and the doctor. In other words, diagnosis structures become a reality for individuals. Jutel (2009) writes how 'being diagnosed gives permission to be ill. What was previously a complaint is now a disease' (2009: 278). But what happens when doctors cannot give such permission because there is no clear correspondence between the patients' complaints and physiological function? Previous research problematises the dichotomy of illness and disease (see Mol 2002) and questions, for example, the utility of classifying illness narratives as either fact or fiction (Bury 1991). Recently, Michailakis and Schirmer (2010) addressed the distinction between being diagnosed and considered to be ill as a medical matter and being so diagnosed as a political matter. This focus follows Parsons' (1978) original work, which posited that society has a functional interest in minimising illnesses because the sick role effectively inhibits the fulfilment of all other social roles.

Parsons' (1951, 1978) initial thoughts on the institutional expectations of the sick role thus inspired this article. We focus on GPs' classification of patients with a similarly strong focus on how the sick role is merged with society's expectations of its citizens. We do not depart from a dualistic approach that distinguishes between (factual) disease and (fictional) illness narratives of patients. We address the ways in which GPs approach patients who hold the sick role in cases where the patients challenge the ability of the GPs to offer a clear-cut diagnosis. We try to understand how GPs primarily attend to the (problematic) social situation and (problematic) personality of patients with MUS by recognising patients with MUS as legitimate patients and

thereby entering them into the sick role. The sick role gives moral legitimacy to the claim that patients cannot perform normal responsibilities and hence that this ‘condition’ prevents them from performing other social roles (see Parsons 1978: 436).

A number of recent empirical studies have examined patients living without a diagnosis, including patients with MUS, and thereby brought prominence to the interdependent relation between the patient, the doctor and the reported complaint. Nettleton (2006), for example, shows how 18 neurology outpatients in England needed (but were not given) permission to be sick. Wilemana *et al.* (2002) explore GPs’ attitudes towards the management of patients that have MUS in primary care consultation. Focusing on the relationship between doctors and patients as well as on problems of control and authority in consultations, the authors discuss the need for more training for GPs on how to manage patients with MUS. In a study on diagnosing depression in primary care, McPherson and Armstrong (2009) show how doctors struggle at first to identify certain patients but then begin to construct a category for such patients that is characterised by non-medical features – for example, by deviant features such as emotional difficulties or manipulative tendencies. Werner and Malterud (2003) use patient experiences in primary care to explore what it takes to be a legitimate patient in the eyes of a doctor when a biomedical diagnosis is unclear (in their terminology ‘a credible patient’). Similarly, Gill *et al.* (2010) focus on how patients take an active part in the interpretation of their own symptoms.

Classification, while it occurs in the context of the medical consultation, is a complex embedded institutional process. Other studies have addressed how the medical system and the public in general deal with patients with MUS by analysing, for example, the documents of support groups and health professionals that deal with fibromyalgia syndrome (Madden and Sim 2006), patient associations and media portrayal of Morgellon (Fair 2010), Internet newsgroup postings and public debates on chronic fatigue syndrome and multiple chemical sensitivity (Dumit 2006), encounters between genetic counsellors and clients ‘without a label’ (diagnosis) (Brookes-

Howell 2006) and audio-recorded consultations between GPs and patients with medically unexplained physical syndrome (Ring *et al.* 2005). However, none of these studies addressed how MUS influences the GPs' classification and recognition of legitimate patients.

Theoretical framework

This article is inspired by a theoretical approach to the negotiation of the sick role that relates to GPs' ideas of what it takes to be a legitimate patient. Research into how symptoms are recognised and classified by GPs is affected not only by medical discourse but also by the different social contexts in which the negotiation of the sick role takes place. For this reason, we employ a theoretical approach that takes into account the different contexts in which identity construction (Goffman 1959, Mead 1934) and negotiation of dominating categories take place.

The explanatory models provided by doctors become highly relevant when we take a symbolic interaction approach (Goffman 1990b, Jenkins 1996, Mead 1934) to the construction of a legitimate sick role. The symbolic interaction approach pays particular attention to the external validation of identities (see, for example, the 'generalised other' in Mead 1934: 151), in our case, the GPs' explanations of the legitimacy of the sick role. Doctors' external classifications are always related to issues of identification and identity (Jenkins 1996: 113; 120–1). Classification practices are here assumed to influence not only how GPs work and think but also how patients with MUS are perceived and valued in the doctor–patient relationship. The external categorisation performed by GPs gives information about the boundaries around what can be said to constitute a narrative of complaint and grounds the definition of the medical situation.

Shilling (2003) proposes the term 'the body project' to emphasise that there is a tendency in our modern, uncertain environment to see the body as 'in a process of becoming; a *project* which should be worked at and accomplished as part of an *indi-*

vidual's identity' (2003: 4; emphasis in original). It seems reasonable to suggest that, in regard to the categorisation of patients with MUS, the body can be seen as an important workable project. The bodies of patients with MUS are examples of 'malleable entities, which can be shaped and honed by the vigilance and hard work of their owners' (2003: 5). Patients with MUS must work laboriously to make their symptoms socially visible, real and physically present (Werner and Malterud 2003). These people, however, cannot do this work alone. Patients with MUS are in strong need of others (Mead 1934), such as GPs, to define their bodies as entities that need repair and, hence, qualify them for the sick role.

A sociological focus on the process in which deviant bodies are repaired in medicine is not new (see Parsons 1951, 1978). As classic work has shown, medicine has a normalising function (see Canguilhem 1989, Foucault 1977). Medicine restores defective organs to health and corrects bodily dysfunctions. Our question, however, is the following: what does medicine actually normalise for patients with MUS? According to the scholars just mentioned, medicine not only restores and repairs parts of the body that are malfunctioning (for example, a broken leg or an infected blood vessel); medicine also seeks to restore patients' abnormalities that go beyond pathological illness and seeks to deal with norms that define 'normal' health in the surrounding society and its institutions. Doctors can in this way be seen as 'moral entrepreneurs' (Becker 1997: 147) because they legitimise and label illness.

In our empirical analysis we show how this insight becomes relevant when the GPs, influenced by common sense psychology, repeatedly transmute patients with MUS into objects of inspection and discourse set outside a traditional biomedical vocabulary (Balint 1964, Rose 1985, 1999a). This common sense perspective includes ideas about responsible citizenship and ideal social values (Rose 1999b, Dean 2002) that recently were shown to exist in a Scandinavian context also (Michailakis and Schirmer 2010). The observation that patients are the targets of governing conduct is well known in the literature (see Armstrong 1983, Rose 1999a). However, what is

significant about our findings, as we demonstrate later, is how GPs provide these patients with legitimacy through an interest in their social and personal profiles.

Our primary concern with the ‘making up’ (Hacking 1986) of a legitimate patient in the eyes of GPs leads to a focus on the constructive element of identities in institutions. We try to understand how institutional selves (Gubrium and Holstein 2001, Holstein and Gubrium 2000) rely heavily on the social context from which the categories in question derive.

Data and methods¹³

In order to gain a deeper insight in how GPs classify and recognise patients with MUS, 21 GPs were interviewed¹⁴. All interviews has been taped and transcribed. For ethical reasons the identities of the interviewees quoted in this article have been concealed. Participants in the study were made aware in advance that they would participate anonymously. In Denmark there are strict rules for processing and securing data. For example, we removed personal security numbers and last names from the interviews before sending them to transcription and we stored the data so only the research team could gain access to it. Besides these general rules for processing and storing the data and participant acceptance (based on descriptions of the research), no formal ethical approval to conduct a research project like this, is required in Denmark. We have, however, followed the guidelines given by the British Sociological Association on how to conduct research in an ethically responsible way.

¹³ This research is part of a larger study consisting of a national survey of welfare officers working in the area of sickness benefits in Denmark’s 98 municipalities, 41 qualitative individual interviews with people with MUS, 15 group interviews with welfare officers ($N = 52$) and three individual interviews and eight group interviews with GPs ($N = 21$) (Mik-Meyer 2010, 2011).

¹⁴ We initially planned to conduct only group interviews with GPs. However, in three cases, only one GP was present (the others were either sick or too busy to participate as promised). We have, however, decided to include both the three individual interviews and our group interviews in our analysis.

Individual and group interviews with GPs (N = 21)

We¹⁵ contacted the participating GPs for this study by randomly selecting and calling GPs across Denmark during their daily consultancy hours, between 8 AM and 9 AM¹⁶. Approximately half the GPs contacted declined to participate in the study either because they were too busy or because they found the research project irrelevant. The participating GPs, however, decided to participate after being introduced to the study first on the telephone and later after having received written information on the study. The large number of GPs who declined to participate led us to reflect on our sample of participating GPs. During our initial telephone contact and later interviews, it became clear that one dominant reason for GPs to participate was that patients with MUS were perceived as extraordinary time consuming, medically challenging and often a demanding group to work with.

We could expect the GPs in our sample to have experience with MUS for two reasons. Firstly, citizens in Denmark can choose their own GP. Secondly, in an interview study with 41 patients with MUS we found that most change their GP if their current GP did not accommodate them as suffering individuals. Another common feature among the participating GPs was that they expressed the view that having MUS prevent individuals from fulfilling work-related obligations.

These reflections aside, conducting a research project based mainly on interview material produces certain possibilities and limitations for analysis. As such, the interview material should be seen as the result of active encounters between the interviewer, with her theoretically motivated research agenda, and the interviewees, confronted with this agenda (Holstein and Gubrium 1997, Järvinen 2000). The interviews were semi-structured and maintained a focus on the interviewees' perspective and

¹⁵ This research project's methodological design, data collection and processing were conducted solely by Nanna Mik-Meyer and a research assistant, but to harmonise the writing style in this article, we have decided to write 'we' throughout our discussions in this methodological section.

¹⁶ Unlike in other countries such as the UK, it is still possible in Denmark to get in personal phone contact with GPs during the daily consultancy times.

subjective experience. We paid close attention to their involvement in the process by asking open-ended questions. In the actual interviews, for example, we often listened to longer disquisitions on the (problematic) social background of individuals with MUS that was believed to have a negative effect on their ability to get well. As a consequence, more discussion was elicited on this issue than we had initially prepared for. Thus, our research design was also adjusted during the interview process to better reflect issues of importance to the GPs.

The interviews with the GPs consisted of eight group interviews with 18 GPs and three individual interviews. Just as individual interviews can be seen as active encounters between interviewers and interviewees (Holstein and Gubrium 1997), group interviews also give special importance to the social context and the interactions among the interviewed participants in the story that is produced (Kitzinger 1994). In this case, the GPs could spur each other on to discuss various matters during the interview; this would result in discussions of central themes and sometimes parting in disagreement. The analysis has been thoughtfully conducted and the quotes presented in this article carefully selected, that is, we have not presented quotes containing extreme opinions that are only shared by a few GPs. We have also been very attentive to shorter discussions among GPs that could be seen as examples of ‘spurring each other on’ and, as a result, have excluded these opinions from the analysis. In most cases, the group interviews with respectively three GPs (two groups) and two GPs (six groups) were conducted in a very similar fashion to the individual interviews with a question-and-answer structure. The GPs would give answers in turn and occasionally discuss the question posed among themselves. Systematic thematic readings of the data, however, did not reveal clear differences in the positions and attitudes of the GPs who were interviewed individually and those who participated in small groups. The three individual interviews conducted with three GPs (Peter, Martin and Monica) contained the same types of reflections as the groups in relation to the GPs’

explanation of the main problems of patients with MUS and the problem of labelling the patients' complaints.

The eight group interviews each lasted approximately 1–2 hours, and the three individual interviews each lasted approximately 1 hour. All interviews, except one that was conducted at the university department, were conducted at the GPs' workplaces. We began the analysis by reading the material in its entirety and listing the themes the interviewees talked about. We then systematically grouped the responses into themes and attitudes according to their relevance to our research questions. The following questions were used in our thematic reading: (i) what characterises this group of suffering people, according to the GPs? (ii) what labels and symbols are used to describe patients with MUS? (iii) what models of explanation are used to account for symptoms and complaints?

The sick role and social problems

As discussed earlier, the classical literature has particularly focused on systems of classification and labelling and the effects of these systems on patients (Becker 1997, Foucault 1977, Goffman 1959). This approach is important because it shows how any classification system, including that of medical diagnosis, can be seen as a social construct that reflects and is produced by the given social context. However, in our analysis we attempt to understand how GPs categorise symptoms and complaints and we examine the effects of GPs' classifications.

A patient whose arm is crushed in a rolling machine in a bookbinding factory does not automatically play a legitimate sick role. Brian, one of the GPs, makes the following observation about an encounter with a former pressman:

He got his arm stuck in a roll. The arm went all the way in. He crushed all his muscles and the arm swelled up to the size of a thigh, but he healed well; he didn't undergo surgery and he regained full mobility. Now he turns up claiming that eve-

rything is wrong, but, you see, he can manage everything with his arm. He has moved apartment seven times; he has built five houses, but he claims that he cannot do anything at all.

As this GP emphasises, the patient's arm was completely healed. However, there is a discrepancy between the objective findings of the GP and the subjective complaints expressed by the patient. Similarly, another case reveals that it is not enough to have been involved in a traffic accident to be classified as legitimately sick when no physical evidence of damage is revealed in a computed tomography scan. As one of the GPs mentions, a 'minor involvement in traffic accidents leads automatically to medical contact' (Mary) or as another GP (Martin) explains:

When somebody crashes her car accidentally into something, which causes complaints of neck pain, then all others symptoms easily follow . . . manually you only find a little stiffness in the neck of the patient . . . the rest is just a retelling of the person's own complaints . . . chronic pain, headache, concentration and memory problems, tinnitus, sexual difficulties and so on and so forth.

Instead, what the suffering individual must show to be recognised as a legitimate patient can depend on the GP's emphasis on certain social background parameters. With MUS it is important to understand the categories through which GPs interpret patients' complaints and how this classification proceeds from their perceptions of their patients' (problematic) social background. As we will show, MUS cannot be separated from two important dimensions of social context: the individuals' social problems and their (problematic) personality traits.

Despite differences in their responses, many GPs share the opinion that patients with MUS are 'not born with a silver spoon in the mouth', as one GP (Paul) explains. A violent family history, weak family ties and a lack of social resources can sometimes be enough to lend support to the sick role. Paul further elaborates that a young woman in her thirties who was married to a violent husband who 'beats her nearly to

death but looks like a dream for any mother-in-law but from whom she managed to escape; of course, she now has a condition'. This condition, Paul continues, lends the patient enough legitimacy to be declared 'dysfunctional'. Paul ends his description by stating that such a patient is 'somebody who, despite her young age, will never again return to the labour market . . . she just can't manage it'. In addition to a violent husband who has changed a seemingly healthy woman into a 'totally dysfunctional' patient with unexplained pain symptoms, Brian (GP) explains that other social background factors, such as growing up under the wing of a distressed mother who was prescribed Valium, can justify medical attention.

Most often, GPs mention socially defined problems when characterising patients with MUS. These patients have few (if any) 'resources' (Brian), they are 'non-educated' (Diana), react to 'problematic life circumstances . . . and have no motivation' (Paul). They 'don't function' (Michael), have 'unacknowledged conflicts in their private life' (Peter) and they are believed to have had a 'problematic childhood' (Susanne) in which they experienced 'violence' (Paul) and carried a 'heavy load of desertion and neglect' (Martin). A convincing picture emerges from our analysis of the interviews. As one of the GPs (Diana) explains, 'these patients accommodate something social-wise'. In other words, patients with MUS are pictured as having many social problems due to their problematic upbringing, current social situation and social capacities.

To provide a more coherent description of GPs' perceptions of patients with MUS, we quote Michael (GP), who gives the following description of a typical encounter with this type of patient:

In the beginning, [patients with MUS] are very focused on the somatic problems . . . and you begin to examine their complaints. And you start some treatment for a bit of rheumatic disease and you give them some medicine to cure their pains . . . and

you talk to them . . . and then it usually becomes apparent that they represent types of people that are disadvantaged.

Martin (GP) continues in the same line of thought:

They have experienced violent disturbances in their past. . . . All kinds of things which possibly can go wrong in life, have somehow also turned out wrong for this group of people. . . . At a moment in their life this social past is converted into somatic symptoms . . . pain, dizziness, headache, myalgia . . . classic somatic symptoms.

In our study, GPs appeared to construct a category of patients characterised by deviant social factors that differentiated them from ‘normal’ healthy people. The transformation of a suffering individual from a patient with somatic complaints into a patient with social problems, as shown in the above quotes, demonstrates a general pattern found in the interview material. Through this transformation, a legitimate institutional identity can be constructed despite the lack of physical evidence of any illness or physical disorder.

Broadly understood, to be a legitimate patient in the eyes of GPs is to be recognised as one who suffers (Cassell 2004). There is no doubt in our material that GPs see patients with MUS as individuals who suffer, but it is less obvious *what* exactly they suffer from. Is it a malfunctioning body, a hypersensitive nerve system or poor genes? Or do they actually suffer from social problems related to a problematic childhood, an abusive partner or a bad economic situation? And, perhaps more importantly, can the latter – social problems of whatever kind – be united with the sick role? In other words, can you – medically speaking – suffer from social problems? Or do you need to suffer from more than social problems to be a legitimate patient?

The sick role and problematic personality

Our analysis so far has shown that to be a legitimately sick patient, the complaints of a patient with MUS must be explained with reference to particular social aspects of that person's life. But as the question just posed suggests, social problems might not be enough of a burden to qualify. The legitimacy of a patient – or the 'permission to be ill' (Nettleton 2006: 1167) – only becomes truly manifest, as we will show below, if social background parameters are combined with the personality of patients with MUS in the classification process.

As Monica (GP) explains, this patient group's symptoms stem from a 'combination of physical things . . . and a personal shortcoming'. Many GPs have the opinion that patients with MUS suffer from some sort of physical pain, but few discuss pain using a medical model that focuses on, for example, what kind of new diseases the pain might reflect. Of course, GPs regularly use medical terminology in their descriptions. For examples, GPs say patients with MUS are 'symptoms producers' (Brian), are 'chronically tired' (Paul), have a 'pre-morbid psyche', have 'a sensitive nervous system' (Monica) and 'have a dysfunctional disorder' (Michelle). However, GPs typically relate these vaguely medical descriptions to the patients' problematic social backgrounds and deviant personalities regardless of their physical complaints.

In our data, GPs often provide explanatory models for 'somatisation' that are grounded not only in physical distress and social problems but also in the specific personality types of patients with MUS. This awareness of the problematic personality traits of patients with MUS may be another way that GPs shift their attention away from physical complaints that cannot be observed and towards other aspects of these patients' situations. Susanne (GP), for example, explains that

it is very often patients who have a certain type of personality. They don't necessarily have a low social status or just moderate abilities, but it is presumably a question of personality types.

And Brian (GP) adds that ‘somebody just happens to be bowled over and just lies there . . . it has a lot to do with personality’.

As we read through the interviews, it became clear that, as Susanne (GP) points out, ‘there are certain kinds of personality types who easily turn into this kind of a patient’. Despite the fact that a social group such as patients with MUS can be seen as an ‘ill-defined, fuzzy, practical and symbolic construct’ (Jenkins 2010: 13), these individuals transform into a clinical workable whole by GPs’ ascriptions of problematic personalities. Here is another example illustrating this phenomenon, where two GPs discuss in some detail the personality of patients with MUS:

Brian: Even on days when I’m full of positive energy . . . in other words my tank is totally full . . . then I enter the waiting room and there – Bang – there she is, now she sits there again . . . it is heavy.

Ann: They are infectious.

Brian: Yes, they are indeed infectious, aren’t they?

Ann: I used to say that one can feel when some of them show up at the clinic, how their energy seems to be withdrawn and tugged out from their big toe and is spilled out on the floor, don’t you think? One can feel them down there; there is no energy present, no drive at all.

Ann’s acknowledgement of the patients as infectious is supplemented by another female GP, Diana, who explains, ‘When they fall off the treadmill, they can’t get on again’. Peter (GP) has a similar observation concerning personality in relation to coping capabilities: ‘They see half-empty glasses’. Or, as Brian (GP) says, ‘They see problems instead of tasks to fulfil’. Lisa, a female GP, believes that ‘a lot of them have a wandering personality, which gets them into all kinds of trouble’. What might, from an outsider’s point of view, seem to be very offensive images of a particular patient group is, however, also supplemented by more emotionally loaded descriptions

and verbs. For example, Diana (GP) and others point out that patients with MUS are very 'sensitive', they are 'tired' (Michelle), 'they don't display any happiness; they are rather joyless' (Brian), 'they have a low threshold of frustration . . . a low threshold for adversity, stress and demands' (Susanne), their 'lives simply hurt' (Martin) and finally, Michael concludes that they are 'inept at living . . . whiners . . . pitiable people'.

Despite the variety of the metaphors used by the GPs ranging from lay to professional terminology, there is a common pattern in their utterances: the metaphors' ability to produce associations that characterise a certain type of personality. Together, the list of (problematic) social background parameters and the different (problematic) personality types make up a common pattern that patients with MUS can be fitted into. The GPs are then able to recognise a familiar pattern in the patients' complaints, a pattern that enables the GPs to proceed in the emerging diagnostic process and reach a sort of final point in the process that forms the basis for further intervention.

GPs' professional identities as doctors depend on their ability to construct patients out of people complaining about pain. They must provide a diagnostic trajectory, which may result in an improvement of the patients' situation. That is, not only do patients with MUS need to be conceptualised as legitimate in their complaints but also the GPs are in need of legitimate patients in the encounter to be judged as credible or infallible professionals (Jutel 2010). According to our findings, GPs discover in patients with MUS some kind of fundamental human weaknesses on both a social and personal level, which can constitute a useful pattern for further interventions. When GPs focus on the social background and personality traits of patients with MUS, they are able to treat individuals with MUS as legitimate patients.

Discussion

In this article we have explored the negotiation of a legitimate sick role for patients with MUS in primary care. We have analysed what it takes from the GPs' perspective

for a sick role to be seen as legitimate. Our findings show that the GPs' evaluation of the legitimacy of individuals with MUS, who are suffering and therefore unable to work and take on daily duties, relates first and foremost to an assessment of the social background and particular personality type of patients with MUS. When a problematic background combines with a problematic personality as a series of rather distinct elements, GPs can accept patients' medical legitimacy as suffering individuals and try to accommodate their particular complaints.

Other studies on MUS in medical practice have analysed patients' perspectives (Dumit 2006, Nettleton 2006, Werner and Malterud 2003), primarily examining how patients experience their encounters with GPs and how they work to be understood and taken seriously as patients. However, little research has been done on how the sick role of patients with MUS is negotiated from the doctors' point of view or on the explanatory models used by doctors in this process. This study attempts to shed light on these problems by focusing on the external side of the identity-formation process in which the sick role is negotiated; that is, how formal classification practices among doctors produce legitimate patients.

The lack of patient voices might appear to be a weakness in the article. Other studies, for example, show how patients do not trust doctors with discussions of emotional aspects of their problems and instead choose to hide those aspects behind somatic symptoms (Peters *et al.* 2008) or how doctors fail to respond to hints of the patients' desire for emotional support (Salmon *et al.* 2008). We have, however, deliberately left patients' voices out because our theoretical perspective favours 'the others' – the external validation – in the social process of identity work (Gubrium and Holstein 2001, Mead 1934). The role of a legitimate patient, in other words, is not a role a suffering person can just take – this sick role is a position that can be given to an individual by doctors only if the suffering individual's story and situation resemble, in GPs' eyes, the story and situation of paradigmatic patients with MUS. Legitimation is thus an institutionalised matter. Patients with MUS and their specific illnesses

are in this way assembled and legitimised as much in virtue of their own experience of illness as in virtue of GPs' perceptions of what it takes to be a legitimate patient.

The GPs' explanation of legitimacy in the medical encounter turns patients with MUS into objects of recognition (Foucault 1977). As noted by Atkinson (1995: 149), a general feature of modern medicine seems to be 'the dislocation of the case from the patient's bedside' and indeed from the patient's physical presence. Our analysis of how GPs classify and recognise patients with MUS demonstrates how the patient is transmuted into an object of careful inspection and discourse that is both set outside a traditional biomedical vocabulary and is physically dislocated from the patient. The lack of a traditional medical diagnosis of patients with MUS leads GPs to create a new kind of category, a social diagnosis, which resembles a clinical diagnosis in its function as an explanatory model for further intervention but is different from a clinical diagnosis in its lack of attention to pathological components. A possible effect of social diagnosis-making may be that GPs in some cases regard the suffering of patients with MUS as simply manifestations of the social.

GPs' discussions of the sick role show that a legitimate patient identity is closely tied to social responsibilities and to the performance of certain societal obligations. We now conclude by suggesting how the current sick role might be intimately connected to social obligations, as proposed in the work of Parsons (1951: 1978). The socio-political treatment of individuals by GPs is largely infected by their role as professional experts. When framing or establishing a legitimate patient, GPs not only stabilise their own professional identity as doctors; they might also take into account general societal norms about the obligation to participate in the labour market if one doesn't have a medically explainable physical or psychological defect. It becomes part of the GP's job to help patients with MUS be responsible citizens in relation to socioeconomic and political demands of labouring, such as obligations to wake up in the morning, to hold down a job and to manage the daily tasks in one's life. In other words, medicine could be seen as a profession that is engaged in translating and rear-

articulating contemporary norms in society concerning what it takes to be a responsible citizen in modern western societies (Dean 1998, 2002; Michailakis and Schirmer 2010). In the words of one GP, 'The trick is to help these patients to be able to take on a job', a sentiment echoed by other GPs. The GPs' evaluation of a patient's legitimacy, in other words, relates, perhaps primarily, to an evaluation of the possibility that the individual could return to the labour market. This evaluation seems to be very focused on the social background and personality types of patients with MUS. The evaluation of legitimate patients, that is, individuals who are unable to support themselves at a given moment, might be intimately connected to what is perceived to be the social obligations of citizens.

How to respond to patients suffering with MUS, however, is one of the fundamental dilemmas of contemporary medical practice in primary care (Wainwright *et al.* 2006), which leaves the GPs adrift in an uncertain domain. As Griffiths *et al.* (2005) have shown, GPs prefer problem formulations, such as diagnoses, that have simple solutions as a way to create order in the midst of the chaos and confusion that their patients present. On one hand, doctors might find themselves frustrated by their inability to come up with a clear-cut diagnosis in medical encounters with patients classified as MUS. On the other hand, this particular patient group is in need of a diagnosis to validate their diffuse symptoms, which pervade most aspects of their lives.

Our findings demonstrate that GPs are prepared to set aside the traditional search for objective findings to confirm the subjective complaints of patients with MUS. This happens by constructing and negotiating a sick role even when there is a lack of a clear-cut medical diagnosis and it is difficult to label a particular illness. As Parsons (1951) argued, this process give patients access to the sick role and give medicine its power to legitimise or construct illness. But this construction of the sick role also, perhaps unintentionally, determines that patients with MUS are individuals who suffer from a combination of social problems and problematic personality traits. To be a legitimate patient, then, does not come without side effects. GPs become co-

producers of novel sick roles that might have consequences for the everyday life of these people, including their social relations with their family, employers and the welfare state in general.

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Chapter 9: Conclusion

'One must recognise empathy as a modern combat weapon on human terrain'

(Human Terrain)¹⁷

Above quote refers to practices of mapping the combat terrain of modern warfare. According to the American frontline journalist, Sebastian Junger (2010), 'human terrain' is often mistakenly conceived as the opposite of 'physical terrain'. The latter refers to mountains, deserts, vehicles, weapons, maps, and so forth. Human terrain refers to the messy social aspects of war. This includes how professional soldiers engage in social relationships with other human beings to fulfil their mission in an efficient way. Even though military officials tend to divide their concerns into conceptual slices and deal with them separately, the physical terrain and human terrain interact in so complex ways that it is hardly possible to separate them in practice. Soldiers can occupy a hilltop in human terrain much like they can occupy it in 'hard' terrain. For instance, they may hire local people to work for them and thus protect them from attacks while exposing themselves to others. This is also the function of a strategic hilltop position, where the position itself functions as a kind of protective shield. However, there is an important difference between the two kinds of terrain: no matter how many physical hilltops the soldiers have occupied, they still cannot win the combat if they mess up in relation to the human terrain. For instance, if the steady presence of male soldiers in small villages means that local women cannot leave their houses, human terrain is lost. Another way to lose human terrain is by committing too many accidentally killings. The two terrains are depicted through extremely detailed data gathering. The human terrain is covered through genealogical data and flowcharts of

¹⁷ Human Terrain (2009). A documentary by James Der Derain, David Udris and Michael Udris

economic, social and cultural activity, and maps of religious relationships, language conditions and regional manners. Maps of the physical terrain are, on another hand, rendered from satellite data and show population centres, vegetation and landscape elevations. A precondition for occupying new territory is then to combine the two kinds of information and on this background develop an elaborated ‘master plan’ to provide the means to regulate action within both terrains.

This may seem a surprising way to begin a conclusion of a thesis focusing upon the relationship between emotions and professional conduct in a cancer clinic. However, there are a number of reasons for turning to ‘concerns of terrain’ in this conclusion. I began this thesis by presenting an observation from the cancer clinic of the presentation and understanding of empathy in clinical practice. The observation had to do with the question of how to label, regulate and measure emotional transactions which are taking place between health care employees and patients. It also pointed to the way employees are seeking to engage in practices ranging from displaying ‘genuine’ care and taking action upon patients’ feelings, to training of communication style to evaluating and auditing in the service of the production of a tightly knitted cancer trajectory. The metaphor of ‘mapping terrains’ can be used to understand how current attempts to organise cancer treatment into accelerated, streamlined, measurable production flows also involve a systematic ordering and cultivation of human conduct. If we accept this analogy we see how ‘knowledge of the whole terrain’ (Elias, 2000: 398) becomes a precondition for not only social order, but also for effective clinical production. The object of ‘empathy’ becomes a tactic weapon to engage oneself with others both in- and outside work spaces. The complex of practices that make up ‘empathy’ or ‘empathic behaviour’ involves strategising, cunning, clever tricks and wicked manoeuvres, as well as war-like elements such as surveillance and quantification of particular sites. Tied to issues of quantification and calculability, the mapping practices of the terrains within health care are expanding. Like the mapping of terrain and combat zones in modern warfare, diverse programs

within health care try to transform health care workers' job into a terrain where activities and individuals are mapped in detail, enumerated, compared, evaluated and contained. Accelerated cancer care is in this light an example of the medico-administrative programs, which produce a 'regulated subjectivity' in the heart of medical practice, working through sophisticated emotion codes, standards and constraints (Rose, 1991; Rose and Miller, 1992).

Let me next follow up on these preliminary concerns by summing up how the thesis has explored the metrics and tactics of the 'human terrain' in accelerated medicine.

Theoretical intent and contribution

I set out to do three things in the thesis: 1) to review and discuss the way emotions have generally been addressed in the social sciences; 2) to discuss the way in which emotions have specifically been studied in relation to health care organisations and conducts of doctors therein; and 3) to empirically explore the role of emotions in 'accelerated medicine', more particularly, the introduction and use of accelerated, standardised treatment packages in a cancer clinic. I will now turn to the way these three tasks have been accomplished and how they may inform each other.

First, I have commented upon the concept of emotion as a slippery entity in social science studies. I have examined emotions in peoples own experiences and understandings in a cancer clinic and beyond, and the framing of emotions in policy documents, management discourses and training programs, as well as identifying some of the sociological underpinnings of 'questions of emotion'. Despite these exercises, emotions still remain somewhat elusive. This is, however, perhaps no surprise given to the fact that the role and expression of emotions vary across contexts. The complex interweaving of personal biographies, interpersonal relationships, power relations, institutional settings and socio-historical processes give meaning to emotional display. From that insight follows that emotions are of many types and have different intensities in human conduct. 'Questions of emotion' includes asking questions about

how individuals' activity and experience are interlinked with codes of conduct that are themselves historical and socio-cultural grounded. Thus the area of emotion research is an area contesting the lines of the classic sociological concern with the relationships between 'individual' and 'society'. In a wider perspective, and interesting for me at least in light of this thesis, are the ways we seek to identify emotions as operational within social life and how we try to make sense of – and express – our emotional experiences as part of a continuous project of improving human relationships in work and organisations.

Second, I have illustrated that how one chooses to approach emotions in the field of studying and understanding health care organisations relies upon one's theoretical grounding of emotions. I have explained how a kind of 'conceptual trapping' of emotions, tied to tropes of interiority and irrationality leads to all kinds of problems. This is typically brought forward in two types of arguments. The first type promotes the idea of 'colonised emotions': that emotions, intimate relations and production and economic activity are opposed to each other and that one can occupy the other. I previously touched upon the issue of inner/outer distinctions in Chapter 4 ('Theories on emotions'), in which selected emotion studies within health care were reviewed. The weaknesses of some of those studies could be addressed to their way of putting down inner feelings of individuals as something sacred to hostile attempts of polluting intimate relations – hence the idea of 'colonising emotions'.

The second group holds the idea of 'disappearing emotions': that emotions and intimate relations have been lost in bureaucratic processes of effectivity and efficiency, and now must be brought back into human services. This idea also leads to another dichotomous image, which is the image of private and public spheres: emotions are situated in the private 'untamed' sphere while reason or rationality is set in the public sphere as something collectively manipulated and controlled. In the hands of researchers within emotion studies who tie emotions to tropes of interiority,

we see how a trapping occurs when emotions are thought to be private and mysterious and hence rarely seen as systematic or structured. This thinking places emotions in contrast with an image of the 'rational' organisation or rationalised work procedures. From this follows that emotion are foremost seen as an adjunct to work and emotional expression is understood as rarely compatible with more instrumental processes and consequences of organising social life. These ideas are way different from the perspective employed throughout this thesis, theoretically informed by Weber and Elias, which approaches emotions and the constitution of an emotional person – such as the 'compassionate' doctor - as the direct outcome (opposite a precondition) of socially organised forms of training and practices.

Third, I have empirically investigated the management of emotions in a cancer clinic and a GP's practice. Due to the shifting state of these relationships, definitions of emotion and emotional expression have been demonstrated to be subjects for various modes of governance. This is manifest in particular organisational attempts of directing and regulating the conduct of doctors in a cancer clinic and beyond. More specifically, I have followed these attempts in relation to, what I called the 'framing', 'training' and 'performance' of emotions in accelerated medical relationships. I wanted to explore how the organisation of cancer illnesses and their treatment into accelerated, standardised treatment flows not only was directed at regulating technical aspects of medical activities but also included a cultivation of emotions and emotional transactions within these activities. I coined the phrase 'conduct of doctors', which is the trained manners in which doctors behave and manage their emotions in particular situations (Du Gay and McFall, 2008). Programs of accelerated cancer treatment was showed to frame how doctors are expected to behave in certain ways and take responsibility for managing their own and patients' emotions. I found that doctors are met with two strands of interconnected emotional injunctions: a) one which requests doctors to bring in compassion or feelings into clinical activities, encouraging an 'emancipation' of emotions in medical relationships,

and b) one which urge doctors to make themselves ‘emotionally available’ in a particular way. However, I also showed that this was not simply a call for ‘setting emotions free’, but entailed a call for very particular forms of emotions. The injunctions could be viewed as rather standardised forms of emotional engagement in medical relationships. Let me specify this chapter by chapter.

As I argued in Chapter 5, current trends of ‘bringing back’ compassion or feelings in health care workers public activities may be seen as a trend where emotional restraints are cast off in favour of more liberated emotional expressions of ‘empathy’, ‘authenticity’, ‘engagement’ and ‘responsiveness’. However, instead of a relaxation in the control of emotions, the development is more accurately understood as a tendency of what Elias called ‘controlled de-controlling of emotions’ (Elias and Dunning, 1986: 44). More particularly, the complexity of medical activities in accelerated cancer pathways and discourses of ‘compassionate’ care and more ‘human’ engagement result in increasing emotional control rather than loosening ways of doctors’ behavior in the public health care sector. Increasing emotional control can, for instance, be considered from the perspective of the central question posed in Chapter 6 – precisely how do we see that doctors are equipped or trained to act in a certain emotional way or as a certain kind of emotional available persons? Let me try to answer this question by once again paying attention to the analysis of the training workshop in empathic communication.

In Chapter 6, I explored how new reform initiatives within health care not only enroll doctors as the focus of standardised, measurable clinical activities. They also make claims to enroll doctors as engaged and responsible selves. This involves the emergence and development of technologies by which this can be achieved. A returning issue in both the accelerated cancer pathway descriptions (reform documents) and in the doctors own debates about possible improvement of their services in the cancer clinic, was the issue of communication. In generally, the assumption was that effective communication between cancer patients and doctors not only im-

proves patients' satisfaction within the provided services, but also facilitates the accelerated clinical procedures in the pathways. By claiming that problems in accelerated interactions between patients and doctors were merely technical in nature, I demonstrated how techniques in communication were diagnosed and employed to reskill the doctors and equip them to act in certain ways in patient interactions. The training of communicating emotionally through the use of a standardised language was showed to involve the management of disturbing emotions and uncertainties in the interactions. Thus communication was considered to be an emotional skill in medical practice through which doctors can engage in collaborations with patients through 'skills in instilling coordination and recognition' (Illouz, 2008). The idea of effective communication was mobilised at the medical training facility as means of 'cultivating on the conduct of the doctor' (May et al. 2006). Employment of effective communication skills may be a subtle way of health care workers to present themselves to others as compassionately engaged while they display emotions in extremely regulated and controlled ways.

This insight reached forward to a central finding of Chapter 7. Namely, that the doctors of the cancer clinic experienced it as continuous work to establish a proper presentation of 'doctor' in emotionally challenging situations. In order to be a detached observer and sustain affective neutrality in patient-doctor interactions, doctors need to carry out important micro-regulated tasks of emotion management to maintain composure in these interactions. In situations where there is very limited time to practise this kind of work, this become difficult and presents a number of problems. To sum up, the challenge of doctors is to regulate their conduct, not only by professional ideologies, clinical guidelines and standards, but also by a deliberate and strategic expression of 'emotions'. As these emotional expressions are further cultivated it may lead to increasingly more complicated and more standardised modes of 'empathic' self-presentation in medical relationships. As I have written previously,

a possible outcome of this could be a higher risk of job burnout or morale fatigueless within the profession of medicine.

The insights from Chapter 8 are connected to central findings of Chapter 7. As we saw earlier, this chapter was occupied with GPs in primary sector health care and it dealt likewise with the management of emotions in clinical ‘core’ situations. More specifically, the chapter explored how doctors try to make sense of emotions in negotiating meanings of patients’ stories in everyday practice. Far from being an example of bio-medical reductionism, this negotiation became an example of how doctors respond emotionally in medical encounters, when they are faced with diffuse symptoms of unexplained illnesses. The chapter demonstrated how practices of emotion management are placed at the heart of medical diagnosis making. In the process of giving patients with MUS a patient position, doctors not only used objective bio-medical diagnostic tools, they also diagnosed through feelings. They heavily drew on personal opinions and evaluations of the patients’ particularities when deciding if a suffering person should be given credibility from the position of a patient or not. The presentation of doctors’ experiences and understanding of various ‘difficult’ patients demonstrated that it takes work to constituting feelings and bringing these into being in response to awareness of the social norms underpinning the medical encounter about what the doctor should be feeling in particular situations and how she should be attending her suffering patients. On this background, I suggest that the subtleties of medical relationships are looked at more detailed to register what is actually happening and whether change in the management of emotions and the manners in which professionals meet patients or clients are supported from evidence from these relationships.

We are left with an important question: what can we take away with us from this investigation of questions of emotion? I have described some key answers to these questions and addressed four concerns at work:

- It seems that emotions and the management of emotions play a significant role in organisational structures that systematically both accelerate and reduce human interactions in public meetings, while intending to make these interactions more ‘human’.
- The more ‘hard’ dimensions of medical services are standardised, the more we also see a standardisation of ‘soft’ dimensions of these services.
- These ‘soft’ dimensions – such as the provision of empathy, responsiveness and engagement in interactions between doctors and patients – are increasingly established through subtle ‘metrics’, in other words standards which are profoundly involved in the constitution of the entities they aim to measure.
- In clinical practice, the navigation between these ‘hard’ and ‘soft’ dimensions entails various challenges to doctors. Not least because the time frame of average consultations is very condensed and the amount of physical encounters between doctors and patients is reduced due to aims of acceleration and efficiency.

The described key points indicate, I suggest, a need for detailed studies of the kind of micro-organisational issues and challenges that are connected to contemporary forms of accelerated medical care. This would direct our attention to important questions of how ‘hard’ and ‘soft’ dimensions of care are organised in practice, and how health care workers on a daily basis, together with patients, try to coordinate and make sense of those dimensions. The crucial point here is that the task of future research, as explained through the thesis chapters, is not only to explore how emotions are getting excluded from production units, such as hospitals, because they hinder effective transactions. It is also necessary to explore how emotions are organised as part of formal organisation structures and how this affects the workers within these structures.

Practical concerns

The findings from this PhD project have implications for how we critically think about emotions in organisations and processes of organising. Different forms of organising entail different ways of putting emotions to rational use, which concurrently provide different challenges to the conduct of doctors. The development of accelerated cancer pathways can be viewed as a mode of organising that neglects to address the way the management of emotions are indispensable in skilful medical activities. Instead, the organisation of cancer illness and their treatment into standardised production flows builds upon the assumption that physical terrain and human terrains can be separated and compartmentalised into isolated activities or steps that subsequently can be distributed among different practitioners in different work settings. The very organisation of cancer illnesses and their treatment assumes that ‘soft’ relationships and emotional aspects can and should be separated from technical aspects of the patient pathways and that it leads to better patient care if each one individually is standardised and streamlined into separate entities. It remains unclear whether this increased fragmentation and ‘work of purification’ (Latour, 1993: 31) can be reconciled by anyone other than the patients and what costs this work might entail. The increased separation of rational transactions and psychological and social support elements provides new opportunities but also greater challenges to the construction and experience of continuity in the pathways. This form of organising medical services attests for a need for further exploration, because the divisions of terrains within specific services may both influence patients experiences of continuity and collaboration when they undergo treatment, and it may affect the motivation and job satisfaction of the health care workers involved.

One central feature of the rearranged cancer pathways is the reduction of the time available for concrete, physical interactions between medical professionals and patients. Every sequence of the pathway has been optimised and unnecessary slack has been cut off, including a reduction of face-to-face interactions and an accel-

eration of technical tasks. Accordingly, and as effect of the speed, patients are left with a lot less time to cope with their feelings, when they are faced with a diagnosis of cancer and the mutilating bodily interventions, which often accompany this kind of diagnosis. Also the time available for doctors to make themselves emotional available and engage with patients in the technical and psychological intimacies involved in medical relationships, and to manage the often strong emotional responses of patients, is strongly reduced.

Another central feature of the rearranged cancer pathways are that these ‘intimacies’ are increasingly focused upon as matters of importance and improvement. A doctor (Sarah) in the cancer clinic makes this reference to the changing organisational context and its possible effects upon her daily activities in an interview conducted for the thesis. She explains:

‘The better we get at taking care of the patients and discharging them effectively from the clinic, the more we preclude them from our “softer” services, which we know that they find important – as demonstrated in various patient studies and surveys. Also social interventions, which we ourselves believe in are necessary for a good healing process, are now rendered mission impossible because of the developments of the treatment regime’.

The so-called ‘softer’ services, the doctor emphasises in the quote, involve the psychological and social dimensions of medical care. However, the point here is that the speed-ups of the cancer pathways influence the forms and expression of emotional engagement between medical professionals and patients.

In Denmark, at least, there has been little attempt to engage systematically with the questions of whether professionals’ behaviour and everyday manners have been shaped by organisational changes, either specifically in relation to specific po-

litical or institutional changes or in the wider sense of being governed by modern forms of rules, such as elaborated technologies for the regulation of professional conduct. On the basis of this thesis I propose a move towards engaging directly with how the conduct of individuals are getting reframed in relation to the organising and managing impulses of contemporary society and what kind of problems this entails.

Future research

This thesis has of course its obvious limitations. However, instead of talking about what I should have done differently throughout my research, I will point to some further research suggestions, which can substantiate the analysis of the existing work.

This research was based on a general type of contemporary speculation. This means that I have not covered here historical work that links changes of the ‘psychological make-up’ of doctors with changes of the socio-economic health apparatus over time. There are well-documented studies that show how societal changes bring about changes of the identity of doctor. Armstrong (2002) for instance shows how the identity of doctor since the 1960’s has changes from that of an observing doctor, subsuming the doctor’s identity to that of her professional group, to that of a subjective doctor, who can be externally inspected in relation to her ‘personality’. The psychological presence of the doctor involved that it became natural both within the medical profession and the political-administrative system to debate the doctor’s personality traits, such as her psycho-social capabilities and her way of emotionally connecting to patients in the medical encounter. We see how it is in these historical shifts to this ‘personal’ doctor-patient relationship, that real problems emerge. Suddenly previous boundaries defined by professional codes of conduct and ‘doctor-centred’ concerns became diffuse and complex and the possibilities for involvement and detachment correspondingly multiple and ill defined. This existing research on the management of the emotions in accelerated medical relationships could positively benefit from historical accounts of ‘what makes doctor’ in order to capture the socio-

historical changeability of emotions and emotional display. A part of that account would also include paying attention to changes in the control or management of emotions and in the relative importance of specific emotions and emotional display in different periods.

Another important issue to be dealt with here is the question about ‘whose emotion management’. I have throughout the thesis only focused on doctors’ activities. However, doctors cannot handle cancer illnesses, their treatment and psycho-social dimensions of care all by themselves. They need others for it, such as nurses, patients, secretaries, administrators, relatives, IT devices and so on. Apropos the nursing profession, a general assumption is that doctors merely deals with technical aspects of patient trajectories and hence tend to be forgiven their poor emotion management skills as, in the gendered division of health care labour, nurses are tasked with picking up the emotional mess the doctors leave behind (see for example Theodosius, 2008). We might also recollect the presence of this assumption in the nurse’s view upon doctors’ work in the introductory observation from a staff meeting in the cancer clinic. Indeed, there is some truth to the argument. In the cancer clinic we see for instance how nurses follow up on doctor-patient conversation in order to make sure that the patients have understood the central content of this conversation. The individual nurses in the cancer clinic also have their own agenda in relation to how they present themselves in encounters with patients. An issue to be dealt with for future research is thus the emerging issue of ‘conflict’ and ‘coordination’ in cases where psycho-social dimensions of cancer illnesses and their treatment are organised across work units and professions.

This brings me to the final issue in this conclusion, namely the presence of emotions in our time. ‘Presence’ is perhaps the wrong term to suggest here, because I am not going to propose a diagnostic of the present. Empirical attention in this thesis has

been focused on standardised forms of organising emotional engagement in a cancer clinic. However, these reflections can also be transferred to sites outside the clinic.

The specific ways of organising the ‘emotional’ and the ‘rational’ are reproduced in the increased presence of so-called ‘emotion programs’, where social and psychological aspects of medical care are organised in separated entities outside the hospital organisation to better supplement the accelerated procedures inside the hospital corridors. A concrete example in relation to the treatment of women with breast cancer is the development of so-called ‘emotion agencies’, which are organisational entities that are created for the specific purpose to supplement the delivery of effective, standardised transactions in health care organisations by providing emotional support to cancer patients. The emergence of rehabilitation centres, gym classes, mindfulness meditation programs, illness coaching, therapeutic self-help support, relaxing kayak courses, and etcetera in both private and public domains is an example of these kinds of agencies.

Several important socio-historical trends concerning the management and expression of emotions are related to the contemporary valuation of emotions. One trend is the move towards the emancipation of emotions and ‘informalisation of manners’ (Wouters, 2011: 140). Emotions which have previously been denied or repressed now regain wider acceptance in social life. Another trend is the tendency of revealing and articulating emotions and one’s emotional state to others. Accordingly we see the emergence of social arrangements which can meet this interest. What this suggests is that processes of standardisation and rationalisation are followed by an interrelated intensely specialised emotion culture, which plays a crucial role in the ways individuals act and understand themselves. If the study of emotions teaches us anything it might be that it offers us a lesson about how emotions work to constitute both subjects and social formations.

English summary

The introduction of ‘cancer packages’ in the Danish healthcare system has led to a reorganisation of cancer diseases and their treatment into accelerated, streamlined patient pathways. This development involves not only that technical work activity in the pathways, for example to take a biopsy, to book a patient for surgery or to prescribe preoperative medicine, increasingly becomes standardised. It also involves that political and managerial light is cast on the psychological and social activity involved in cancer care and that these aspects are made objectives to processes of standardisation and cultivation.

The thesis has as its point of departure the assumption that new forms of organising influence how intimate interactions between doctors and patients are structured and directed in the health care system. The assumption gives rise to examine more specifically the relationship between emotions in a cancer clinic and types of professional conduct therein. An ongoing interest in the thesis chapters is the interest in so-called ‘questions of emotion’. The attention to these questions – or more specifically to behaviour, feelings, gestures, impressions, sentiments, manners, affects, expressions etc. and the codes, norms and values directing and regulating them – can help us understand how individuals emotionally express and experience themselves in specific historical moments, organisational contexts and social situations.

More precisely, I ask how emotion is ‘framed’, ‘trained’ and ‘performed’ by doctors in accelerated medical relationships. The connection between these questions is investigated through detailed empirical analyses of how notions of ‘compassion’ and ‘authenticity’ emerge in the heart of accelerated, standardised medical services, and moreover, how doctors get to know about and manage people’s feelings and make themselves emotionally available to others in social interactions.

Traditionally, both in the sociology of emotions and in particular in studies of emotions in health care practice, there have been a tendency to relate the man-

agement of emotions to the work undertaken by the nursing profession. However, practices and techniques of emotion management cannot be monopolised to a single profession. Doctors too are involved in this kind of labour in their daily routine interactions with patients. Reconsider for instance the actual work doctors must take on to be perceived as empathic and responsive beings in their engagement with patients. Or the concrete medical situations doctors find themselves in when they have to disclose serious diagnoses of cancer to anxious and alarmed patients; inform about bodily mutilating treatment plans, or provide support to gravely ill younger women with metastatic cancer disease.

This thesis is based on a qualitative study of doctors' management of emotions in a cancer clinic in Denmark in which accelerated cancer treatment regimes have been a part of the formal structure since 2008. Through a focus on doctors' interactions with patients in these regimes, the thesis explores the role and function of emotions, and furthermore how emotions are met with intense political and institutional attention, evident in the development of various quality and improvement strategies. This implies that emotions, for instance empathy, compassion and responsiveness, are framed, trained and performed in increasingly standardised ways that subsequently can be measured and evaluated.

The questions of emotion are guiding the thesis and framing the individual chapters. The thesis is divided into two parts – a frame (Chapter 1-4 + 9) and four articles (Chapter 5-8). The frame begins with a description of the organisation of cancer illnesses and their treatment in the Danish health care system. Accordingly, Chapter 2 introduces the concept of 'accelerated medicine' and it explains the development of the so-called 'cancer treatment packages'. It further introduces the issue of emotions in accelerated cancer care and it pays attention to how questions of emotion arise from the empirical context.

Moving on from here, Chapter 3 deals with theories on emotions in organisations. In this chapter, both classic sociological literature and more recent theories on emotions, social order and organisations are addressed. In addition to this, the chapter contains a review of texts that focus especially on emotions in health care practice and discusses how some of these texts fall short in their approach to emotions because they tend to elevate emotions to the disregard of rationality and rationalistic activities. The chapter then moves towards a preliminary draft of my own theoretical approach, which is further developed in the remaining chapters of the thesis.

Chapter 4 explains a number of methodological challenges which accompany my qualitative study of emotions in a cancer clinic and its surroundings. It describes the situatedness of my PhD project and my access to the clinic and its occupants, and it explains how my object of inquiry developed over time – from foci to a developing focus on emotions. It also contains a relatively clean description of the conducted fieldwork; of the qualitative methods and the extent of materials used for this research, and it describes how each analysis in the thesis takes smaller parts of the empirical material as its point of departure. Finally, it discusses problems of ‘involvement’ and ‘detachment’ (Elias, 1987) in the study of emotions, and it pays attention to a kind of ‘methodological vocation’ which is described as the vocation of researchers to approach emotions without sentimentality.

Chapter 5 explores how exactly emotions are framed in medical relationships and it addresses how this framing equips doctors to act in certain ways in particular situations. Using the development of accelerated cancer pathways and a wide range of health care reform documents as an empirical case, the chapter explores how doctors are encouraged to become more emotionally available to patients. As the chapter demonstrates, this call for emotionality is accompanied by increasing demands on doctors to manage the emotions of others in recordable, measurable and standardised ways. To be a compassionate doctor involves an exhibition of a particular emotional behaviour in medical relationships, what Elias calls a ‘controlled de-

controlling of emotions' (Elias and Dunning, 1986: 44), namely that of a 'sincere' or 'authentic' behaviour which doctors are required to enact and to be committed towards. What this points to, I argue, is a set-up where health care reform documents encourage room for personal and unique concerns in medical relationships while expecting maximum acceleration and standardisation of these relationships.

Chapter 6 continues the investigation of questions of emotions through a discussion of how empathy and responsiveness, as specific techniques of emotion management, arise as the outcome of well-structured forms of training and practice in the cancer clinic. The chapter focuses on a training workshop in 'empathic communication' through which doctors from the clinic learn to recognise and control the emotional frame of doctor-patient interactions. It addresses how the training and practice of communicating empathically in these interactions rely on standardised scripts, which in turn direct and cultivate the conduct of doctors. In line with the argument in the previous chapter, it concludes that humanistic values increasingly become the target for techniques of micro-management such as qualitative measurement and performance audit. In other words, the chapter argues that attempts to improve 'soft' dimensions of medical services entail a further standardisation of these aspects.

Chapter 7 addresses the question of how doctors relate emotions to their understanding of professionalism and principles of standardisation and speed in the treatment of cancer illnesses. In a present work environment of reforming and rationalisation drives, the chapter directly asks 'how doctors feel'. This question is explored through doctors' personal biographies of emotional experiences and challenges in relation to their routine and everyday situations. The chapter explains how emotions and emotional display are frequently performed in a rationalised way to help doctors ensure the progress and efficiency of the accelerated treatment regimes. However, the chapter scrutinises how the rearrangements of cancer illnesses and their treatment into 'accelerated packages', and attempts to separate social and psychological dimensions of medical services from technical dimensions of these services, com-

plicate doctors' ability to incorporate emotions into their practices in a 'proper' way. What this points to, is the need for researchers to investigate how different forms of organising technical tasks within health care entail different ways of organising emotions and emotional practices within this field, and how this generates organisational problems of various kinds for both patients and doctors.

Chapter 8 completes the shift from the 'framing' and 'training' of emotions to concrete 'performances' of emotions in medical relationships. It addresses questions of emotion through a study of how general practitioners (GPs) approach patients with medically unexplained symptoms (MUS) in primary care. Concerns about the role and function of emotions in the core of the medical enterprise come under closer scrutiny here because the chapter explores how GPs are diagnosing with feelings. Accordingly, the chapter explores how GPs diagnose MUS patients as legitimately sick patients. What makes this classification procedure difficult is that MUS patients fall inside a particular residual category in the eyes of the doctors. This defies the doctors' capacity to decipher the patients' intentions and motives, making it hard to empathise with them. To confirm the subjective complaints of patients, the GPs must rely on their personal opinions and evaluations of a patient's particular circumstances when deciding whether the patient is legitimately sick or not. These different strategies for managing the complaints of patients are connected to ways of dividing individuals into certain categories of persons characterised by deviant features such as unpleasant personalities and manipulative appearances. The chapter emphasises how the affective connection between the patient and the doctor becomes paramount to the outcome – the diagnosis – of the clinical encounter.

In the concluding chapter, the main arguments of the thesis is summed up and their implications for understanding the relationship between emotions in a cancer clinic and forms of professional conduct therein and, more broadly, the active, shaping influences between individuals and social, medico-scientific and political worlds, are indicated. It is demonstrated how a central feature of the rearranged can-

cer pathways is the reduction of the time available for concrete, physical interactions between medical professionals and patients. Every sequence of the pathway has been optimised and unnecessary slack has been cut off, including a reduction of face-to-face interactions and an acceleration of technical medical tasks. Accordingly, and as an effect of the speed, patients are left with a lot less time to cope with their feelings, when they are faced with a diagnosis of cancer and the mutilating bodily interventions which often accompany this kind of diagnosis. Also the time available for doctors to make themselves emotionally available and engage with patients in the technical and psychological intimacies involved in medical relationships, and to manage the often strong emotional responses of patients, is strongly reduced. The point here is that the speed-ups of the cancer pathways influence the forms and expression of emotional engagement between medical professionals and patients. The conclusion points to the fact that a contemporary focus on ‘effective’ and ‘standardised’ supply of medical services is accompanied by an increasing focus on ‘soft’ and ‘intimate’ relationships. The latter includes an interest in how these relationships should be structured and directed. Unlike previous ways of organising cancer care and health care workers’ management of emotions, the increased separation of ‘production’ and ‘human’ creates new opportunities but also increased challenges in the Danish health care system – not least in relation to the individual doctor and the ways in which he or she is called upon to act as a certain kind of ‘doctor’.

Resume af afhandling

Introduktionen af 'kræftpakker' i det danske sundhedsvæsen har ført til en reorganisering af kræftsygdomme og deres behandling. Disse udføres nu i stigende grad i accelererede, strømlinede patientforløb. Denne effektiviseringsproces indbefatter ikke kun, at tekniske arbejdsopgaver i patientforløbene, fx det at tage en biopsi, at booke en patient til operation eller at ordinere præoperativ medicin, ensartes. Det indbefatter også, at psykologiske og sociale aktiviteter ensartes og standardiseres. I afhandlingen arbejdes med en antagelse om, at nye former for rationel og standardiseret organisation har betydning for, hvordan "bløde" mellemmenneskelige relationer defineres og varetages i sundhedsvæsenet. Antagelsen giver anledning til at undersøge mere specifikt, hvordan forholdet er mellem følelser i en kræftafdeling og forskellige former for sundhedsprofessionelle handlemåder. En gennemgående interesse i afhandlingens kapitler er således en interesse i såkaldte 'følelsspørgsmål'. Mere præcist spørger jeg *hvordan følelse dikteres, trænes og udføres af læger i accelererede kræftbehandlingsforløb*. Disse spørgsmål løber som en rød tråd igennem afhandlingens kapitler.

Traditionelt set er der både i følelssociologien samt i specifikke studier af følelser i sundhedsorganisationer en tendens til at koble følelsesarbejde sammen med det omsorgsarbejde, der udføres af sygeplejersker. Følelsesarbejde kan dog ikke monopoliseres til kun at omfatte den sygeplejefaglige profession. Også læger udfører i høj grad følelsesarbejde i deres rutinemæssige, daglige interaktioner med patienter. Tænk blot på det konkrete arbejde læger skal udføre for at fremstå empatiske, lydhøre og engagerede, når de modtager patienter i konsultationen. Eller de helt konkrete, medicinske situationer læger befinder sig i, når de skal overbringe en alvorlig kræftdiagnose til en oprevet patient, informere om en, oftest kropslig mutilerende, behandlingsplan eller yde støtte til en alvorligt syg, angstpræget yngre kvinde med metastaserende kræft.

Afhandlingen bygger på en kvalitativ undersøgelse af lægers følelsesarbejde på en brystkræftafdeling i Danmark, hvor accelererede kræftforløb blev indført i 2008. Ved at følge lægers interaktioner med patienter i disse forløb, undersøges den rolle og funktion følelser har og ydermere, hvordan følelser i forhold til tidligere bliver genstand for øget opmærksom gennem forskellige kvalitets- og forbedringsstrategier. Dette indebærer, at følelser – som eksempelvis empati, lydhørhed og engagement – iscenesættes, trænes og udføres på stadig mere standardiserede måder, der kan måles og evalueres på linje med andre kliniske og administrative aktiviteter. Afhandlingen er struktureret i to dele: En ramme (Kapitel 2-4 samt Kapitel 9) og fire selvstændige artikler (Kapitel 5-8). Den første del indledes i Kapitel 2 med en beskrivelse af organiseringen af kræftsygdomme og deres behandling i det danske sundhedsvæsen. Kapitlet introducerer til konceptet 'accelereret medicin' og det forklarer udviklingen af de såkaldte 'kræftpakker'. Endvidere stiller kapitlet skarpt på, hvordan særlige 'følelsspørgsmål' udgår fra den empiriske kontekst.

Kapitel 3 kobler sig direkte på disse spørgsmål og ved hjælp af en teoretisk diskussion af diverse følelssociologiske teorier, giver kapitlet forslag til, hvordan man kan forstå og undersøge følelsspørgsmål i moderne organisationer. Kapitlet adresserer både klassisk, sociologisk følelsesteori samt nyere teori om følelser, social orden og organisationer. I forlængelse af dette gennemgås studier, der særligt har beskæftiget sig med følelser i sundhedspraksisser. Kapitlet diskuterer, hvordan flere af disse studier kommer i problemer, fordi de antager at rationalitet, eller rationelle organisatoriske aktiviteter, analytisk kan adskilles fra følelser og mere 'autentiske', individuelle aktiviteter. Afslutningsvist gives et bud på en teoretisk forståelsesramme, som videreudvikles i løbet af afhandlingens kapitler.

Kapitel 4 forklarer, hvilke metodologiske udfordringer der har ledsaget afhandlingens studie af følelser i en kræftafdeling. Kapitlet beskriver vejen til ph.d.-projektet, adgangen til kræftafdelingen og det forklarer, hvordan forskningsobjektet tog form over tid. Det indeholder også et udførligt overblik over det udførte feltarbej-

de; det beskriver de metoder, som er taget i brug for at indsamle det empiriske materiale og det redegør for, hvordan hver enkelt artikel gør brug af udvalgte dele af materialet. Endelig diskuteres problemet om henholdsvis 'detachment' og 'involvement' (Elias, 1987) i studiet af følelser, og det bringer et metodologisk kald på banen, nemlig et kald til følelsesforskere om at studere følelser uden sentimentalitet.

Afhandlingens første analyse præsenteres i Kapitel 5. Kapitlet tager afsæt i udviklingen af accelererede kræftforløb og et bredt udsnit af sundhedspolitiske dokumenter som empirisk case og undersøger, hvordan læger opfordres til at stille sig følelsesmæssigt til rådighed for patienter. At være en medfølelse læge indebærer således en fremførelse af en særlig form for 'ægte' eller 'autentisk' følelsesadfærd i patient-læge interaktioner, eller hvad Elias kalder 'kontrolleret de-kontrollering af følelser' (Elias and Dunning, 1986: 44, min oversættelse). Dette peger i retning af et foretagende, hvor sundhedspolitiske dokumenter på den ene side opfordrer til, at der i interaktioner mellem læger og patienter skabes plads til den enkelte patient, der har unikke behov, som lægen må tilgodesee på den bedst mulige vis. På den anden side forventes, at disse interaktioner skal udføres med maksimal hastighed og at alle enkeltaktiviteter i processen skal reguleres og standardiseres.

Kapitel 6 fortsætter undersøgelsen af følelsesspørgsmål gennem en diskussion af, hvordan empati og lydhørhed – forstået som specifikke følelsesstyringsteknikker, opstår som en effekt af velstrukturerede former for træning og praksis i kræftafdelingen. Kapitlet fokuserer på en træningsworkshop i 'empatisk kommunikation', hvor læger i afdelingen gennemgår træning, der skal sætte dem i stand til at genkende og kontrollere den følelsesmæssige ramme for læge-patient interaktioner. Det adresserer, hvordan træning i at kommunikere empatisk bygger på det at være i stand til at efterleve et sæt standardiserede manuskripter. Disse virker som et indirekte middel til at kultivere lægers handlemåder. I forlængelse af argumentet fra Kapitel 5, konkluderer dette kapitel, at humanistiske værdier i medicinsk praksis i stigende grad bliver genstand for mikro-styrings-teknikker som eksempelvis kvalitetsmåling

og præstationsaudit. Med andre ord viser kapitlet, at forsøg på at forbedre 'bløde' dimensioner af medicinske ydelser involverer en yderligere standardisering af disse.

Kapitel 7 adresserer, hvordan læger relaterer følelser til deres forståelse af professionalisme og principper for standardisering og hastighed i deres daglige arbejde. Kapitlet spørger direkte 'læge, hvordan føler du' i en kontekst præget af kontinuerlige reform- og rationaliseringstiltag. Dette spørgsmål undersøges via lægers personlige beretninger om følelsesmæssige oplevelser og udfordringer i forbindelse med deres arbejdsrutiner i afdelingen. Kapitlet viser, hvordan følelser typisk mobiliseres af læger på en rational måde for at skabe fremdrift og effektivitet i de accelererede behandlingsforløb. Imidlertid gransker kapitlet, hvordan reorganiseringen af kræftsygdomme og deres behandling i 'accelererede pakker' og forsøg på at adskille sociale og psykologiske dimensioner fra tekniske dimensioner af medicinske ydelser, i stigende grad gør det vanskeligt for læger at indarbejde følelser i deres aktiviteter på en hensigtsmæssig måde. Dette peger i retning af, at der er brug for yderligere at undersøge, hvorledes forskellige måder at organisere tekniske opgaver inden for sundhedsvæsenet også nødvendigvis medfører måder, hvorpå man samtidig organiserer følelser og muligheder for at udføre følelsesarbejde. Dette har konsekvenser for modtageren af ydelserne (patienten) samt for afsenderen af ydelserne (lægen), som får sværere ved at udføre følelsesarbejde som en naturlig integreret del af det øvrige kliniske og administrative arbejde.

Kapitel 8 tager læseren med ud af kræftafdelingen og adresserer, hvordan praktiserende læger håndterer følelser i lægekonsultationen, når de møder patienter med 'diffuse lidelser'. Problemet med patienter i denne patientkategori er, at de falder uden for almindelige, klassificerbare sygdomskategorier. Kapitlet undersøger, hvordan læger forsøger at skabe mening i patienternes diffuse sygdomsbillede og give dem en diagnose. Dette arbejde besværliggøres af, at disse patienter oftest vækker en masse modstridende følelser i lægen, hvilket samtidig gør det svært at imødekomme patienternes forventninger og empatisere med deres motiver. Kapitlet demonstrerer,

hvordan lægerne udstyrer disse patienter med en sygdomsdiagnose ved at klassificere dem som mennesker, der lider af en problematisk personlighed og under en svag social baggrund. Endvidere understreges hvordan den følelsesmæssige relation mellem læge og patient bliver afgørende for resultatet af mødet mellem dem.

Afslutningsvist i Kapitel 9 oprulles afhandlingens hovedkonklusioner og der peges frem mod nye forskningsfelter. Det fremføres, at samtidens fokus på 'effektive' og 'standardiserede' leveringer af sundhedsydelser ledsages af et stigende fokus på 'bløde' relationer mellem mennesker og hvordan disse skal organiseres. Hvor tekniske og psykosociale aspekter af medicinsk praksis tidligere blev håndteret 'organisk', dvs. som dele der organisatorisk hang sammen i patientens indlæggelsesforløb, fører den stadig skarpere rendyrkelse af effektive transaktioner (fx at informere effektivt om behandlingsplanen; at foretage et kirurgisk indgreb skånsomt; at udskrive patienten hurtigt) til en øget opmærksomhed på og krav om at kvalitetssikre og standardisere intime relationer (fx at være anerkendende lyttende i patientmøder; at fremstå empatisk og medfølelse). Til forskel fra tidligere måder at organisere kræftbehandling og sundhedsprofessionelles følelsesarbejde, giver den øgede adskillelse af 'produktion' og menneske nye muligheder, men også øgede udfordringer i det danske sundhedsvæsen – ikke mindst i forhold til den individuelle læge og de måder, hvorpå han eller hun nu skal være læge på.

Appendix A: Interviews in the cancer clinic and its surroundings

Name	Interviews	Position	Semi-structured interviews, length: 30 minutes	Explorative inter-views Length: 30 min. – 1.30min.
Mary	1	Medical staff	X	
Lucy	1	Medical staff	X	
Paul	1	Medical staff	X	
Erving	1	Medical staff	X	
Deborah	1	Medical staff	X	
Susan	1	Medical staff	X	
Michael	1	Medical staff	X	
Eva	1	Medical staff	X	
David	3	Head of research	X	XX
Sarah	1	Medical staff	X	
John	1	Medical staff	X	
Monica	1	Medical staff	X	
Brian	1	Medical staff	X	
Jan	1	Retired professor		X
Stewart	1	Professor		X
Susan	2	Head of nursing		XX
Ann	1	Clinical teacher		X
Sylvia	1	Pathway coordinator		X
Rachel	1	Researcher		X
Beth	1	Consultant		X

Appendix B: Observations in the cancer clinic and its surroundings

Observation type	Location	Frequency
Morning conferences (mono-disciplinary)	Staff meeting room, the cancer clinic (CC), The University hospital (UH)	8 conferences
Morning conferences (inter-disciplinary)	Staff meeting room, CC, UH	3 conferences
Patient-doctor consultations	Outpatient unit, CC, UH	15 days
Breast cancer surgery	Operation theatre, surgical unit, UH	4 operations
Ward rounds	Inpatient ward, CC, UH	4 rounds
Radiology conferences	Department of Radiology, UH	5 conferences
Multidisciplinary conferences	Department of Pathology, UH	2 conferences
Management meetings	Administrative unit, UH	1 meeting per week in three years
Training workshop	Education unit, UH	1 day

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