CHAPTER I
INTRODUCTION

In today’s world, the important characteristic for most of the jobs is to perform emotional labour. Emotional labour is defined as “the process where employees regulate their emotional display in an attempt to meet organizationally based expectations specific to their roles.” (Brotheridge and Lee, 2003, p.366). In the service industry, the employers or the managers always want their staff or subordinates to interact with employees properly and display certain kind of emotions during the interactions. These emotions can be that of cheerfulness, friendliness, warmth, confidence, enthusiasm, etc. Managers act on the presumption that the good nature of the employees will be strongly correlated to customer satisfaction and thereby boost customer commitment, customer loyalty, etc. This will have a huge impact on profits as happy customers provide more business to the organizations. Employees look up to their managers and supervisors for support and consider them as role models. In this context, the contagion effect of the emotions has also been widely studied and validated. It is therefore, essential for both employers and managers to control employees’ actions and supervise “emotional expressions” to make sure the end results is that of superior value of job and performance.

The term was coined by A.R. Hochschild in 1983. Since then, quite a number of studies have been done to study the various effects of emotional labour among service employees. It has been proved that emotional labour varies with the kind of jobs done and can have both good and bad effects on employees. Researchers eventually concentrated on this idea and tried to study the various forms of emotion management. Thoits (1996) and Francis (1997) were among the first to categorize emotion management in to two different forms. The forms were named as “self-
focused” emotion management and “other-focused” emotion management. The concept of self-focused or intrapersonal emotion management is same as Hochschild’s (1979, p.552) descriptions of people who manage their own emotions while interacting with others. On the other hand, the concept of other-focused or interpersonal emotion management is common for people who work in healthcare and other therapeutic based organizations where “individuals attempt to care for people by helping them cope with and manage their felt emotions.” (Erickson and Grove 2008, p 706). Bolton (200, p 87) suggested in his paper that, nursing is one such profession which requires extensive amount of emotion work given the nature of the job. This triggered the thought and idea to study emotional labour in nurses given the unusual context of the organization i.e. hospitals (for e.g.) and the nature of the service of nurses. The motivation which led me to take forward this idea and shape it into a thesis has been described in the next section.

1.1 Motivation for this study.

I was highly motivated to study emotional labour process in nurses and therefore chose this topic for my thesis. It is mainly because of the fundamental reason that health care presents a strikingly dissimilar context for experiencing emotional labour than the other counterparts in the customer service industry which differs from social, cultural, and interactional level. Most remarkably, employees working in other service sectors do not face the challenge of facing issues dealing with life and death (of customers) as a daily feature of work life. Studies have proved that as and when professionals in the healthcare industry gradually realize that there are certain expectations from them given the challenging nature of the work, which again is very different from the other human service industries, they start experiencing more emotional dissonance and start performing less authentic care work with patients to overcome their stress.
Therefore, the study of emotional labour in nursing becomes necessary as it is perceived to be important to those involved in the “delivery of health care and to the patients who receive that care.” (Phillips, 1996, p 142). Mitchell and Smith (2003, p 110) explained in their review that, EL has always been “part of the image of nursing”. The authors further provided support for making such statement quoting Smith and Gray (2000) in their report, saying that nurses are forced to adopt certain strategies to manage their emotions. The situation in the hospitals can take various forms. Sometimes there is uncertainty in the nature of the treatment of patients. At other times, nurses have to face the repressed feelings or antagonistic reactions from the patients as well. In such situations, nurses themselves feel that it is their duty to repress the negative emotions such as disgust, irritation and anger, the expression of which would not be favourable to the patient. The desire to feel certain emotions can lead to emotional labour, especially on occasions when nurses are unable to genuinely offer appropriate emotions (perhaps because of distractions from their personal lives, or due to depersonalisation effects of burnout: Mann 2005, p 308). To make the patient feel that taking care of them is of utmost priority, the negative emotions must be controlled or suppressed (McQueen, 2004, p 103). Thus, when nurses do not feel as they think they should in a particular situation, they experience emotional labour in order to match their emotional displays with the patient or the social expectation (display rules). This can be explained with a situation explained by de Castro (2004, p 120). In hospitals any kind of interactions with irritated, aggressive or stubborn patients can be emotionally charged and therefore demand nurses to suppress or modify their emotions. As one nurse commented in Smith and Gray’s (2000) report that, “some patients are really horrible and even disgusting, which means you have to really emotionally labour”. Nurses readily admit the significance of emotional labour to their job role which requires “taking care of
In a qualitative study by Smith and Gray (2001, p 42), the authors gave a narrative of nurses’ experiences of emotional labour. They said that almost all the nurses acknowledged emotional labour as a principal component of their job in making patients feel “secure”, “relaxed” and “at home”. Bolton (2001) described that nurses should be called “emotional jugglers” as they were capable of matching the face with the situation, sometime failing to match it with the feeling. She also talked of nurses capable of presenting a “sincere face” to match feelings with the face, or a “cynical face” to disguise feelings which should not be displayed (during a tensed interaction, for example). In another study, reactions of 45 nurses were studied and the faces/expressions were distinguished in to a “professional face”, the “smiley face” and the “humorous face”. The author felt that these were used by the nurses to manage most of the emotional demands (Smith and Gray 2001, p 235). It became quite clear that in the caring professions, it is not always helpful to express genuine emotion response – in some cases performing emotional labour may be more helpful to the patient. For example, one particular nurse working in the maternity department said “You have to have a rational detachment otherwise you could become involved and then it would not benefit yourself or this woman (patient)” Henderson (2001, p 132). McQueen (2004) said in his paper about another nurse who stated, “If one is overcome with emotion, cognition and behaviour can be adversely affected”. As a result, slowly, performing emotional labour became a essential sign of growing burnout in nurses (Fineman 2005, p 9). From the organization point of view, the detached and burned-out healthcare providers evidently did not offer high-quality care. This eventually will pose threat to the organizations as such care providers can weaken the chief goal of hospitals in serving the patients properly which in turns can hamper the organizational image.
If one takes a closer look at the current scenario in India among nurses, it is no different. The healthcare industry is undoubtedly India’s largest business sectors in terms of employment and revenue. This industry includes hospitals, telemedicine, medical tourism, health insurance, medical equipment etc. The hospitals are categorised into two major components - public and private. The public sector includes providing essential healthcare facilities in the form of primary healthcare centres (PHCs) in rural areas. On the other hand the private sector includes all the secondary, tertiary and quaternary care institutions with major focus on the tier I and tier II cities. This private sector has become the building force in India’s health care industry helping it gain both national and international reputation. Huge investments by private sector players have added considerably to the growth of India’s healthcare industry. This is evident from the fact as the private sector comprises of about 74 percent of the country’s total health care industry outflow. The reason for such fast growth can be attributed to the media coverage, services etc. On the other hand, medical tourism is currently on rise in the country. “The vast pool of medical professionals, expanding private health-care infrastructure, growing technical expertise, cheaper medical procedures, world class health-care infrastructure and government support are likely to boost the number of medical tourists arrivals in India to a projected level of 4 lakhs by 2018,” said Sharad Jaipuria, president, PHD Chamber.\(^1\) The Indian medical tourism industry is presently estimated at US$ 3 billion per annum, with tourist arrivals estimated at 230,000 per annum. Inspite of such good statistics which gives an indication of good growth, the scenario is not that much favourable for hospitals given the shortage of nurses. In an article in 2014 in the Economics Times, Dr. Devi Shetty, health entrepreneur and founder of Narayana Health pointed out that there is acute shortage of nurses in the private healthcare sector .The numbers went

\(^1\) http://www.livemint.com/Home-Page/NX5iFoYztnkCFz4vztt5N/India-medical-tourism-industry-to-reach-6-billion-by-2018.html
dwindling from 1.65 million nurses in 2009 to about 1.56 million. It is a given fact that these private players are successful in attracting patients from both India and worldwide given their reputation in providing top class medical facilities and treatment. But when it comes to retaining the nurses, almost all the private players are facing problems. According to human resource experts, attrition rate among nurses is the highest, varying from 28 per cent and 35 per cent as compared to the average 10.1 per cent attrition rate for 2005. (Express Healthcare, 2012) They also face problems when it comes to work. Opposing to what is allowed in other countries, “in India even a nurse with 20 years ICU experience cannot administer a simple painkiller or give an injection unless a doctor is around” (The Business Standard). The nursing profession in our country lacks high professional status, offers low and unattractive salaries and has little incentives for quality performance (Gill 2009, p 53). Information on the attrition rate of nurses in a typical Delhi private hospital is almost up to 55% as per various (recent) reports. Dr.Harit Chaturvedi of Max hospitals Delhi reported “Before you know a fresh batch of nurses will join the hospital and the management has to restart its training programme once again”. In such a scenario, it also becomes a challenge for the management of the hospital to ensure the safety of the patients where most of the nurses are new recruits with very little experience. This is of course apart from the fact where they are trying their level best to make the working environment compatible for the nurses which will in turn motivate and encourage them to stay with the organization.

With this being said, it has also been acknowledged by researchers in their study that teaching emotions and its expressions within health-care education definitely emerged to be

2 http://archivehealthcare.financialexpress.com/201005/healthcarelife01.shtml
undependable. A gynaecological nurse in Northern Ireland remarked in Mc Creight’s paper (2005, p 542) that she was not taught things related to techniques by means of which she could deal with her own as well as her patient’s emotions and as a result felt that she incompetently geared up for her job. And coincidentally this is the case almost all around the world- nurses are trained how to take actions and apt forms of medical intervention during situations such as miscarriage, but not trained how to react in the emotional aspects. The assumption in most of the cases is that displaying emotions should come naturally hence is not paid attention to in the training module. In another case, a psychiatrist reported in the British Medical Journal that “much of medical training seems to be focused on how to deal with things . . . rather than how to cope with people” (Persaud, 2004, p 89). During the course of collecting data, I also happened to connect with Dr. Usha Ukande, President of the Nursing Research Society of India and I quote her here, “True, the basis of nursing is concerned with being emotionally sensitive to patient's emotions under their care, yet be detached. A difficult situation for the nurses. It is not that they are not formally taught about this, they have a subject of psychology in the very first year, mainly to sensitize them about this aspect. But learning to use emotions with wisdom takes long years of experience of being with the patients.” Other researchers subsequently pointed out that identification of moderator variables might help to ease out the process and later hospital management can concentrate in building up their training programmes revolving around these issues.

With this background and information given, it is very important to study the cumulative effects of emotional labour on the nurses in India. It also thus becomes imperative to understand the various implications it can have on their working conditions especially in these private hospitals.
The root cause for their emotional labour and henceforth their reason to leave the organization might be known through this study. After careful analysis; results might throw some light in to this aspect. Harini (2013, p 128) in her paper had suggested that except for a few studies in certain fields, the literature on emotional labour in India is very limited. An extensive research is needed to understand the importance of emotional labour. Presence of few empirical papers also makes it important to study how nurses perform emotional labour. The objectives of this study has been further clarified after an extensive literature review on the subject and identifying the relevant research gaps.

1.2 Dissertation Layout

This thesis has seven chapters. Following the first chapter, a brief literature review on the topic of emotional labour has been presented. In the third chapter the gaps in the literature have been identified and the hypotheses have been formulated with explanation. The fourth chapter explains the methodology followed by the fifth chapter in which detailed analysis of the sample and factor analysis results have been presented. The sixth chapter thereafter consists of the discussion of regression results which tries to elaborate the findings. Finally the thesis ends with the seventh chapter which discusses the implications that the results and findings can have both from an academic perspective and a managerial perspective with a special impact on nurses and the healthcare sector. Future direction for research has also been discussed in the final chapter.