**tableTemplate – Empirical research – Qualitative**

*[Please include wording as appropriate under every heading. For details please see the Author Guidelines]*

**ABSTRACT** [300 words; no abbreviations or detailed statistics, please]

**Aims:**

This is the second of two papers conceptualising emotional labour in the emergency department (ED). This paper aims to understand the environmental 'moderators' of ED nurses emotional labour.

**Design:**

Ethnography, through an interpretivist philosophy, enabled immersion in the ED setting, gathering the lived experiences and narratives of the ED nurses.

**Methods:**

Observation and semi-structured interviews over a 6-month period. Two hospital sites (one district general and one major trauma center based in the UK.

**Results:**

Over 200 hours of observation plus 18 formal / semi-structured interviews were completed. Environmental, institutional and organisational dynamics of the emergency department instrumented the emotional labour undertaken by the nursing team. Time and space were found to be 'moderators' of ED nurses' emotional labour. This paper focusses on the relevance of space and in particular, 'excessive visibility' with little respite for the nurses from their intense emotional performance.

**Conclusion:**

Emotional labour is critical to staff wellbeing and the way in which healthcare spaces are designed has an impact on emotional labour. Understanding how emotional labour is

moderated in different clinical settings can inform organisational, environmental and workforce related decision making.

**Impact:**

- **What problem did the study address?**

We know little of how nurses emotional labour is moderated. This paper helps us to understand how nurses emotional labour is moderated in the ED setting, focusing specifically on the relevance of space for the intensity of nurses emotional experience.

- **What were the main findings?**

We found that physical space moderated nurses emotional labour, particularly through the excessive visibility staff experienced (through being 'on-stage'). The lack of 'off-stage' space for staff intensified the management of emotion.

- **Where and on whom will the research have impact?**

This research will have impact for relevant for policy makers, clinicians, academics and patients. Most crucially, it is important for those involved in managing and designing healthcare environments.

**Key words:** [Max 10, including 'nurses', 'nursing', 'midwives' or 'midwifery'. Advice on Search Engine Optimization can be found here.]

Nurses; emergency; workforce; wellbeing; emotions; workplace; healthcare environments.

**Main paper**

## INTRODUCTION

***[Note: there should be wording under both Introduction and Background headings]***

Emergency Departments (EDs) are struggling to meet demand, with increasing patient attendance over the last 70 years (The King's Fund, 2018) and intense government targets, often a direct consequence of, or are entwined with, the broader pressures affecting the

National Health Service (NHS). There is an increased need for efficiency and quicker throughput through the services (whilst still meeting the expectations of patients and their relatives). These challenges have been exacerbated further by the Covid-19 pandemic.

In spite of these issues, we know little of how the emergency environment influences the management of staff emotion. Surprisingly, an exploration of ED nurses' emotional labour (taken from Hochschild's original theory, 1983), is missing from current understanding. This paper is the second of two aiming to fill this void; both explore the emotional labour of emergency nurses (see Kirk et al, 2021, for paper one conceptualising ED nurses feeling rules.) This paper seeks to understand the 'moderators' of emotional labour in ED.

**Background**

Emotional labour in nursing

The concept of emotional work, and specifically the theoretical concept of emotional labour, products of Arlie Hochschild's *The Managed Heart (1983)*, offered those studying the workplace a lens through which to explore workers' emotions. Various examinations of emotional labour since Hochschild's introduction have highlighted theoretical application and application to the fields of social psychology, organisational sociology and human resource management (Ashkanasy and Humphrey, 2011, Grandey and Gabriel, 2015; Barry, Olekalns and Rees, 2019.)

The emotional labour of various professional groups has also been examined. Perhaps unsurprisingly, this has included those within healthcare and nurses; generically, it is well established within academic literature that nurses do emotional labour routinely in their practice (Smith, 2012 and Theodosius, 2008). When nurses' feelings do not align with what is expected, they 'do' emotional labour in response, McQueen (2004, pp.103-104) states:

> When nurses do not feel as they think they ought to feel in particular situations, they engage in emotional labour to manage, control, or alter their emotional status to correspond with what they believe is appropriate for the situation.

The nurse acts as a social performer (Bolton, 2001), adapting to meet various needs. These terms align strongly with Goffman's (1959) 'presentation of self' and impression management, in which employees adopt a specific outward appearance of the expected emotions for the 'stage' whilst their true emotions remain supressed and out of sight (Huynh, Alderson and Thompson, 2008; Bolton, 2001).

## Emotional labour in ED

Despite this extensive body of literature, we know little of how nurses emotional labour is moderated and how emotions are managed in the ED environment. This oversight is amplified when considering the distinctive nature of ED. Here nurses must manage a target driven culture (e.g. the four hour wait and ambulance turnaround times) whilst striving to maintain care standards. At the same time, the patient population served is uniquely challenging, with an array of diverse presentations and no 'cut off' to the number of patients who may present (24 hours a day). Exposure to traumatic cases and violence is also frequent, ED staff experience rates of both physical and verbal abuse that are significantly above the national average, when compared to other healthcare workers (NHS Security Management Service, 2010). It is perhaps unsurprising that ED nurses are especially vulnerable to experiencing anxiety, depression and burnout (Adriaenssens et al., 2015) – Despite these observations, thus far, the relevance of emotional labour in the ED has only been touched upon within a broader study (Bailey et al, 2011). The research acknowledged the emotional labour undertaken by ED staff in the management of patients receiving end-of-life care in EDs. Despite this insightful paper and other contributions to emotional labour theory, there remains a compelling space to understand the management of emotion in the ED.

### Moderating emotional labour

Theorists (Grandey and Gabriel, 2015 and Lee et al, 2010) have explored factors which shape how, and to what degree, emotional labour is performed. They have identified the 'moderators' of emotional labour – physical and non-physical elements which affect the emotional performance in terms of intensity, frequency and, therefore, the personal impact of the labour. This examination of moderators has often focussed on relational considerations (Grandey and

Gabriel, 2015), for example, an individual's psychological traits (emotional abilities or /values) (e.g. Diefendorff et al. 2011). The dominant perspective shows the negative implications of emotional labour will be less for employees who embody organisational values (Schaubroeck & Jones 2000). At an organisational level, scholars have investigated contextual factors which influence experiences of emotional labour including; job status; the degree of autonomy in work; the financial rewards for the emotional labour undertaken; and the degree of social support available to employees (Grandey and Gabriel, 2015). This resource-based perspective acknowledges argues that emotion regulation will be less depleting (in terms of wellbeing) for an individual in a work setting in which has more resources available (Grandey and Gabriel, 2015). For example, the perception of strong organisational support systems helps to mitigate the negative effects of emotional labour and in particular, its influence on job satisfaction (Duke et al, 2009).

We might assume that environmental structures may also moderate employees' experiences of emotional labour. Despite this, a thorough exploration of various structural 'macro' elements (such as space and time), and their part in the moderation of emotional labour, is limited. Noting the pressures facing the ED, including overcrowding and a lack of resources, it is likely that these and other environmental elements act as moderators of ED nurses' emotional labour. This paper will concentrate on the exploration of these moderators in the ED environment.

## THE STUDY

### Aims

This study aimed to explore emotional labour in the ED with a specific focus on the theorisation of specific environmental 'moderators' of nurses labour.

### Design

The ED offered a fitting case study to explore and contribute to the concept of emotional labour. Ethnography, through an interpretivist philosophy, enabled immersion in the ED setting, gathering the 'life world' (Gherardi, 2015) and narratives of the ED nursing team. Data was

collected by the main author and ethnographer (KK). The observation was non-participatory to manage clear professional / ethical boundaries (as KK is a registered nurse). KK undertook direct and first-hand observations, using an ethnographic approach. This allowed room for the dynamism of the setting, workload and pace. Semi-structured interviews were also undertaken with ED staff and the wider 'well-being' team. Two departments were used for a rich and illuminative dataset.

**Sample/Participants**

Observation at two UK EDs (this observation totaled 200 hours):

> One district general (approx. 150,000 patients) / number of nurses on a single shift = 15
>
> One large teaching hospital, university affiliated (approx. 230,000 patients per year) / number of nurses on a single shift = 23

18 formal / semi-structured interviews with ED nurses (varying levels of seniority). Interviews were completed with ED nursing staff (a mixture of staff nurses, sisters / charge nurses). Respondents needed to be actively working in the ED setting, but the sampling criteria did not stipulate age, level of experience or other demographic. Respondents were initially recruited via social-media, email and poster advertisement in the EDs – a 'snowballing' (Robinson, 2014) approach aided the latter half of recruitment, as participants shared their experience of interview with colleagues, prompting further involvement. See Table 1 and Table 2 below for participant demographic.

**Data collection**

> Data was collected over a 6 month period. Interviews followed a semi-structured format using a predefined topic guide. In addition to a standard approach to interview questioning, metaphorical terms were also drawn out of the observational data and taken 'into' the interview room. These terms (including: assembly line; juggling; A&E Swan; warzone) acted as a prompt for participants and helped them to explore and

describe the emotional component of their work. Metaphors in qualitative research are established providing new insights into conventional and familiar ways of speaking about our experiences (Gowler & Legge, 1989). It is also important to note that participants were actively encouraged to challenge interpretations made by the researcher.

Considering the hectic nature of the ED setting, participants were encouraged to select a time and location which was most convenient for them. KK knew 4 of the 18 participants (from previous clinical work). Interviews were recorded via Dictaphone and then transcribed verbatim. All aspects of 'rigor' including KK's clinical experience will be acknowledged within the rigor section of this paper.

Observation (200 hours +) was split throughout the different clinical areas in the ED (see Table 3 in Findings below). KK wore plain clothing and a hospital ID badge at both sites. All of these areas were observed to witness the variety of work completed by staff. The formal observation was restricted to the adult ED, although paediatric staff shared their experiences during the informal interviews. This included the minor injuries areas, assessment areas, resuscitation area and the 'majors' area of the ED (a space in which those patients who were not appropriate for minor injuries or resuscitation care were treated). All areas within the ED were observed from close-up or more-distant vantage points when appropriate, in order not to interfere with the flow of care delivery (Kusenbach, 2003). It is important to note that the observation was completed both during the day and at night (in a 24-hour timeframe). Notes were taken by hand and electronically, sometimes in bullet form to keep pace with the activity. These notes were then 'worked up' into more comprehensive accounts after the period of observation.

**Ethical considerations**

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

**Data analysis**

NVivo 11 was used to manage the data. This included all observational notes together with interview transcripts adopting a 'triangulation' approach (Mason, 2017), bringing together data sources. In line with the studies ontology, a deeply reflexive approach adopting interpretivism was used to analyse the data (Mason, 2017). The process of analysis was iterative (see Hammersley and Atkinson, 2019) and began during data collection when notes were sumarised and reflected upon. The formal process of analsyis began with coding and was non-cross-sectional, establishing preliminary themes (Mason, 2017). As re-reading took place, by the wider research team, codes were refined and a cross-sectional approach aided the reduction of nodes. After the team had established a final set of nodes and sub-nodes, the data was displayed visually through diagrams and charts, this prompted further analytic thinking, relating to relationships between nodes. Conceptual abstraction was achieved through progressive focusing (Hammersley and Atkinson, 2019). Throughout the process of analysis, the team worked collaboratively; critical for assumptions and interpretations to be challenged.

The data analysis process ultimately led to two overarching concepts—'Moderators of ED nurses emotional labour' and 'Specialty specific feeling rules' (see Kirk et al, 2021). For the purpose of this discussion, we will focus on the moderators. To further aid transparency, Figure 1: Refinement of Nodes: Moderators of Emotional Labour (Appendix A) shows how this concept was reached.

**Rigour**

Trust and rigor were achieved in this study through ongoing critique and transparency (Lewis et al, 2014). Drawing upon the 'Sociological Imagination (see Mills, 1959) offers the opportunity to prioritise self-awareness. This stance is particularly helpful considering the positionality of the researcher; KK is a registered nurse with ED experience. It is important to note this, as with all ethnographies, the researchers past experiences, values and beliefs are intrinsic to the data generated, what is included and any omissions (Law & Singleton, 2013).

At the same time, the status assigned to KK during the research process and her interactions with participants, this changed depending on past relationships and their perception of whether KK was an 'insider' or 'outsider'. Stepping away from these dichotomous positions

(Thomson & Gunter, 2011) and seeing this position as changeable, enhanced the process of reflexivity. Refelexivity has been fundamental to this study and striving for rigor. This reflexive stance has underpinned pragmatic steps (Mason, 2017) taken to ensure assumptions are challenged, both within and outside of the research team.

Interviews were treated as an interpreted social event (Hammersley and Atkinson, 2019). These recounted experiences were socially constructed narratives (Silverman, 2017), not descriptions of the actual events (Mason, 2017). The accounts were the result of the 'complex negotiation' conducted within the interview discussion (Gherardi, 1995, p.15). The opportunity to examine the ED nurses' experiences of emotional labour was offered when the data showed recurring themes (Mason, 2002).

Gherardi (1995, p.23) argues that 'plausibility is the validity criterion for ethnographic research'. However, due to the subjectivity of the interpretation process, it is crucial that the researcher outlines all aspects of the methods involved and the data collected (Gherardi, 1995). Achieving quality judgements in ethnographic research requires transparency with respect to these judgements, decisions and theorisation (Lewis et al, 2014). In response, examples of some mechanisms utilised for 'testing' assumptions were through combined data collection and analysis methods, ongoing team member checking and visual mapping.

## FINDINGS

Our earlier paper (see Kirk et al, 2021) argued that emotional labour is a routine, prominent and essential component of nursing in the ED. The study unearthed and conceptualized four feeling rules born from this context, underpinning the labour of ED nurses. The data presented for this paper works alongside these feeling rules, showing that physical and non-physical resources – in particular, time and space – moderate emotional labour in the ED. In this second paper we focus on an exploration of space as a moderator of ED nurse emotional labour, showing the intensity of the emotional performance expected is exacerbated by the physicality

and design of the ED space. Central to this argument is the excessive visibility of staff and the minimal opportunity for 'off-stage' reprieve.

It is important to note here that the ED is a distinctive clinical environment. Irrespective of size, EDs are most often split into different areas or spaces based on the clinical need of the patient (e.g. minor injuries, majors and resuscitation). There is therefore a group of individual environments and spaces that together form the ED. This collection of spaces and the staff within them treat and manage a diverse range of illnesses, injuries and complaints. These spaces have competing priorities, different audiences and different environmental constraints.

Excessive visibility and center stage

An area of the ED where the relevance of space can be seen most prominently is in the majors area, the largest physical space within the ED. This area cares for a wide variety of patients with a vast range of complaints – medical, social and psychological (including cases of domestic violence, safeguarding and vulnerable adults, in addition to patients with mental health problems). These are not patients with minor injuries, nor are they patients who need the care of the resuscitation department.

> The space in its entirety is large and open plan. As a consequence, there are no visible options for staff to escape the intensity of the environment except the sluice (a small room used to dispose of contaminated waste); staff appear to use this room infrequently and for seconds rather than minutes. Staff are visible at all times in the space: only when they are behind curtains with their patients are they out of sight, so there is no opportunity for 'offstage' time. This spatial element (excessive visibility), specifically the lack of offstage opportunities, proves significant for the nurses' emotional labour…
>
> (Teaching ED, observational notes)

The majors spaces offers little opportunity for time 'away' from patients. As such, the nurses must maintain their 'social performance' (Bolton, 2001), sustaining expected emotions for their patients (and colleagues) whilst their true emotions remain suppressed and out of sight (Huynh, Alderson and Thompson, 2008). A role within the majors space which amplifies this labour further still, is that of the nursing coordinator. This nurse is 'central' to the running of majors, coordinating both colleagues and patients. They are also central to the space in physical terms, standing at a central hub, and visible to all within the space. Here, a nurse manager introduces the role and offers insight into the pressures and skill (emotional labour) of being able to 'control' yourself and perform the appearance of 'cool' and 'calm':

> It's a very stressful job, actually. I would struggle to do that particular role [laughs]… I think that takes a very special person… it's *about controlling yourself*, being an excellent communicator… because they've not only got to be able to speak to and communicate with healthcare assistants, their team and doctors, there'll be the site manager, who's at them saying: 'Where are we? What are we doing?' There'll be matron and me popping in five minutes later asking them to repeat everything they've already just said, and they'll say it with such patience and tolerance to us… Then they've got ambulance crews arriving all unplanned, unless the red phone's gone to say that there is a stroke coming in or a significant patient with exceptional resus needs… And *they still look quite fresh towards the end of the day* generally, and *generally have kept their calm and cool*…
>
> (ED Senior Nurse Manager Shelly, District ED, Formal Interview)

The nurse coordinator manages the staff and patients in the majors area. There is an expectation that (even when they *feel* stressed, those who are good at their job, must *control* and ultimately suppress their true emotion through their emotional labour. What amplifies the need and intensity of this emotional labour further is the excessive viability of the coordinator role. Their physical placement in the majors area means that they must not only suppress any tension to those immediately around her / him, but also other staff and patients in the ED. The layout of the space and excessive visibility puts the coordinator on 'central' stage. ED Sister Evie

shares first-hand experience of her work as a nursing coordinator and how spatial elements of the space intensified her experiences:

> …. Sometimes you just feel like you just don't know where to start… in the environment where it's overcrowded like that, *you can feel very enclosed* and it can feel quite pressurised… you're there as a person who can be seen *like on stage*; it can feel quite daunting… you feel *like everybody is looking at you*, so I think sometimes practitioners and doctors *get to escape* that because they are sitting in the office. As a nurse… you're there *on show all the time*… you would torture somebody with the same sort of amount of pressure and noise and sort of four people at once asking you what, asking you something; it's stressful.
>
> (ED Sister Evie, Formal Interview, Teaching ED)

Here Evie explains how the layout of the environment amplifies her experiences of suppressing stress (her emotional labour). The majors space means that she and her nurse colleagues were constantly visible and 'on stage' – there were no offstage spaces for her to 'escape'. As a result, there was little or no opportunity for reprieve from the suppression of her emotion (pressure and tension), which must be sustained for the duration of the shift. Evie's emotional labour was intensified as a result of the excessive visibility, a product of the ED majors space.

> (Restricted) space 'between' patients
>
> There are elements of the job where you do need to have resilience and be tough because sometimes when you're faced with aggressive patients or a particularly tragic – sounds a bit melodramatic – but a particularly sad situation… *yes you can wear your emotions on your sleeve, but if they're always on show*, then you might find that it can potentially *interfere* because you'll have this [patient], that [patient]… *and five minutes later you'll have to go in to another patient and see them*… From my perspective, I

> wouldn't want my nurse coming to me crying and they'd be like: 'Well, why are you crying?' '*Oh, it's nothing to do with you…*', but trying to sort me out with tears running down their face…
>
> (S/N Adam, District ED, Formal Interview)

The 'space' (or lack of) between patients also moderates the ED nurses emotional labour. There is little physical space (distance) or space (in terms of opportunity / time) for the nurses to process emotion. This limitation on opportunity to process emotion from one distressing patient case, before moving on to the next, arguably intensifies the labour required *for* the 'next' patient, as articulated in the extract above from Adam. The lack of space between patients can result in intense emotional labour as the nurse attempts to hide sadness (in the example above, tears) from the new case.

ED S/N Becky shares a specific experience of this. Here she felt void of any space to work through her emotional experiences of one distressing case, before the next patient arrived under her care. Moving her attention immediately to another patient was a significant source of emotional labour for Becky, requiring her to suppress her emotional experiences and 'present' the expected front to the next – she did not have the space to process the case until the drive home. Here the lack of space between cases moderated (intensified) her emotional labour:

> … he was a medical patient [moved] into one of my bays… He obviously wasn't well… he was quite an obese man and he'd asked me like twice if I could help change him and I kept going: 'I'll come back to you. I promise I'll do it. I promise I'll do it', and then I had to go on my break and handed his care needs over… Went on my break. Came back. Obviously, he hadn't been changed… it was really busy in resus. His obs had got worse. So, I went to go and find a doctor to come and like just have a look at him, and that might have taken about 15 minutes. Came back with a doctor into the bay and he'd died and arrested like in that time… I didn't know a thing… *I just felt really rubbish.* So, I

> cleaned him up. Put him in the viewing room *and the next patient came in… I felt really bad.*
>
> *… Do you stop thinking about it immediately?*
>
> *I did because the next patient was also really unwell.* So it wasn't 'til driving home thinking about it. I still remember him really clearly… and no one came to ask if we were alright or anything…
>
> (ED S/N Becky, Teaching ED, Formal Interview)

Off stage, seeking unconventional spaces

The ED space in its entirety offers few spaces for staff to show, process or release intense emotions. Opportunities for emotional downtime or performance reprieve are restricted; consequently, staff are forced to use clinical areas but those few 'off-stage' and out of direct sight of patients and colleagues. ED S/N Alison introduced this (she used 'the back' – a store room and kitchen area – to remove her 'mask'):

> …you deal with a lot of things. *Really tough things*. And then sometimes, it's the littlest thing that can then just *tip you over* and make you upset… it isn't that one thing, but it's just everything else that you've had to deal with. Like pharmacy not delivering a medication quickly enough and patients getting a bit annoyed, which is normally fine one day but because yesterday you'd dealt with a death or something that's upset you. *This just tips you over and you feel yourself getting stressed and upset. Sometimes… you just kind of run into the back, maybe have a few tears, then get back on with it.*
>
> (ED S/N Alison, Teaching ED, Formal Interview)

In the absence of protected off-stage spaces for the nurses, they seek out unconventional spaces to vent and for reprieve from their masked performance, these are often 'backstage' but

still clinical. Ironically, the sluice room is often used for tears and other restricted emotional displays – an offstage space. This is a small space largely reserved for the disposal of waste products. It is a small, cramped and unpleasant-smelling room that to a certain degree is seen as less visible (and most certainly out of patient sight). Here, bodily waste is disposed of, along with staff members' emotional baggage. It provides an opportunity to vent and discharge away from the gaze of others. For some nurses, their emotional retreat and release are saved for spaces outside of the ED completely to 'let these emotions out': the hospital chapel or the car journey home alone.

## DISCUSSION

This discussion will detail the key findings of this paper namely how the lack of space 'between' patients in the ED, and the excessive visibility of staff in the ED, moderates (and intensifies) staffs experiences of emotional labour.

### Application to ED: Space 'between' patients

Physical space within the ED is a social production that is lived, experienced and maintained by the staff (Tyler and Cohen, 2010). Viewing the ED as a system, and as a collection of spaces, fits with the organisational description offered by Halford and Leonard (2003, p.661), seeing it as a 'configuration of multiple, distinctive and differentiated spaces offering different potentials for subjectivities.' Emphasis is placed on moving patients through and out of the space and preventing a build-up of patients within the ED – this spatial element adds to the sense of the ED as a conveyor belt that must keep moving, limiting the 'space' between patient interactions, moving from one, immediately to the next. Staff have no time to process one emotional experience before moving onto the next, this moderates their emotional labour as staff have to suppress emotion from previous cases to ensure they present the expected display to the next patient in their care. As argued by Peter and Liaschenko (2004), nurses in particular may desire to flee, but their place in the system, both geographically and morally (and in contrast to other health care professionals), prevents it.

### Application to ED space: Excessive visibility

The lack of offstage space and subsequent opportunity for reprieve from undertaking the described degree of emotional labour is of significance. These findings strongly relate to the work of Goffman (1959), where employees choose their performance based in part, on where they are located ('front stage' or 'backstage'). This is critical to ED nurses' emotional labour as the ED has little clinical backstage space away from the patient audience. This is most prominent in large, open spaces where there is constant visibility from the patient audience and, most notably, their relatives. For many of the nurses, particularly those in charge of a specific space (e.g. the majors or resuscitation spaces), there is little if any respite or offstage/backstage opportunity - presenting a professional version of the 'self' (Goffman, 1959) is constant, irrelevant of stress experienced. This sociological understanding of emotion works with the idea that individuals consciously manage their emotions to follow the values and beliefs within a specific situation or community (Bolton, 2001). Goffman (1959) described this as 'face-work', in which individual actors have direct control over their 'performance' and the management of their emotional performance (Bolton, 2001). The performer is a 'harried fabricator of impressions involved in the all too human task of staging a performance' (Goffman, 1959, p.220). This fabricator is the 'character' with qualities to be shared – the performance is designed to evoke and display these qualities (Goffman, 1959).

The ED nurse suppresses a myriad of feelings in to maintain the expected 'performance' and qualities (fearlessness, calmness and stoicism, amongst others, see Kirk et al, 2021) to those around them. Most crucially, the visibility of the nurse to the various audiences increases the intensity of this emotional labour – a factor that was previously missing from exploration but is now seen as especially relevant to both physical and emotional work (Boyd, 2012). Rather than the duration of an individual interaction (Morris and Fieldman, 1993), the intensity of emotional labour is impacted significantly by the duration of front-stage period.

### Implications of excessive visibility and future research

Considering that we already know of the links between emotional labour and burnout / emotional exhaustion and intention to leave (Bartram et al, 2012), these findings are critical to contemporary nursing. This point is emphasised further still when we consider them against the

workforce ‘crisis’ backdrop: record breaking stress, burnout, and absenteeism - compounded by the Covid-19 pandemic: sickness absence rates in the NHS are higher than in the rest of the economy (The Kings Fund, 2020). The wellbeing of UK nurses is amongst the worst in the world (Aiken, 2012). Where nurse staffing is short and / or skill mix is poor, patient mortality is increased (Aiken et al, 2014; Griffiths et al, 2019).

The relentless nature of the ED nurses workload and the target driven culture of their practice result in little or no ‘space’ between emotive interactions (and emotional health is fundamental for nurses wellbeing.) A likely remedy is a reduction in workload for ED nurses, which would offer up more ‘space’ to process emotional experiences. Considering the challenges of contemporary practice and workforce challenges, this solution will not offer immediate relief.

This argument is also relying on the assumption that staff have ‘off stage’ spaces where they can seek emotional reprieve (given the opportunity) as a remedy to excessive visibility. Further research is required to understand how these spaces might be designed, however, the findings from this paper suggest how important the physical design of healthcare facilities are for staff, as well as the patients receiving care. Staff need offstage spaces which are incorporated into clinical areas (rather focusing upon break rooms or rest areas alone, which are often even harder to access). Here they may retreat in-between patients, for non-contact patient tasks. As argued by Leonared and Halford (2003) in the absence of offstage spaces, nurses create ‘internal private and personal spaces for themselves, free (or freer) from the ever-possible demands of others’.

**Limitations**

This study generated an abundance of data and insights into the emotional labour undertaken by nurses in the ED setting. Despite the extensive nature of data collected, ethnography is limited for direct application to other settings (Seymour & Sandiford, 2005). However, it is anticipated that findings will still be of great academic and practical value including healthcare settings outside of the ED environment.

**CONCLUSION**

Emotional labour is critical to staff wellbeing and the way in which healthcare spaces are designed has an impact on emotional labour. This paper argues that the ED calls for an extensive spectrum of emotional labour from the nurses working there. This labour is moderated by space in particular and most crucially, the lack of time 'between' patients and the excessive visibility experienced by staff. This results in extensive periods 'on stage' with little or no 'off stage' reprieve. Understanding how emotional labour is moderated in different clinical settings can inform organisational, environmental and workforce related decision making, particularly in the design of healthcare environments.

**Conflict of Interest statement**

None

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