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EMOTIONAL MANAGEMENT OF HEALTHCARE PROFESSIONALS IN PALLIATIVE CARE SETTINGS

Palliative care has developed in Russia since the 1990s as an adopted Western institutional form within the ideological framework of a 'good death,' which suggests a holistic approach to patient suffering. The development of palliative care was not linear and has received systematic governmental support only over the last ten years. Psychological care and quality of life were only legally included in palliative care in 2019. As a consequence of the existing structural constraints in most organizations, all of the emotional labour is done by medical professionals often lacking training in the management of emotions. In this case, a key role is played by the leaders of the organization. The main objective of this work is to demonstrate how the management of emotions at the level of personal interactions is connected with the management of emotions at the organizational level. Emotion management in palliative care settings is analysed based on empirical evidence collected during the periods 2018–2019 and 2020–2021. During the research thirty-four interviews with specialists in the field of palliative care were collected. Materials are analysed through dramatic and cultural theories of emotions and theories of rituals. Key emotion management mechanisms in palliative care settings at the organizational level include team building and coordination; maintenance of collective emotions and collective solidarity; and the management of the space of the organization. At the individual level, emotional labour is carried out in accordance with the ideological framework of a 'good death.' Emotional labour is most often done through deep performance and is aimed at overcoming negative emotions such as anger, fear, or disgust. Management

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of emotions at the organizational level allows, first, to overcome the existing structural limitations; second, to adjust the volume and content of the emotional labour of employees.

Key words: palliative care, emotional management, medical professionals, emotional labour, good death

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Hospices as an institutional form emerged in the 1970s in England in contrast to the existing impersonal model of care for the dying implemented in hospitals (Stolberg et al. 2017). The basic idea was to reproduce 'family care' and the 'home' environment, and to include emotions as a prerequisite for caring for the dying (James, Field 1992). The emotional component permeates all social interactions between patients and their loved ones and professionals in palliative care (PC) through feeling rules and display rules, consistent with professional ideas of 'good death' (Steinhauser et al. 2000).

A common understanding of the concept of 'good death' can be found in the works of Cecilia Saunders (1981), the founder of the modern PC model, who emphasized a holistic approach to patient suffering. By 'good death' she means the creation of the most comfortable conditions for the patient's dying and the relief of physical, social, psychological and spiritual suffering of patients, both in the home and in the hospital environment (Walsh, Saunders 1984: 204). In practice, the concept of 'good death' acts as a general framework for describing ideas about what is good and right in the dying process as understood by specific professionals for the patient, their loved ones and caring professionals. Research shows the dependence of representations of 'good death' on the cultural context, organizational context, and social groups to which PC is exposed, which accounts for their variability (Cain, McCleskey 2019). Although the topic of emotion in PC is a well-studied one, the organizational level of emotion management has often fallen out of focus. Only in recent decades have researchers paid attention to emotions at the organizational level (Fineman 2000).

Palliative care in Russia began to develop in the 1990s as an institution borrowed from Western countries along with dominant views of 'good death.' They vary from organization to organization, but the holistic approach to patient experiences is a key aspect. This approach has been implemented in Russia since the 1990s with the involvement of various specialists, including psychologists, social workers and representatives of religious organizations. After 2006, due to a wide range of external and internal factors, organizations became more standardized, bureaucratized, funding for institutions decreased, as a result, opportunities for individual approach to patients and for performing emotional labour decreased. Development of PC received a new round only after 2011, when it was allocated in Federal Law 323 as a separate type of medical care and received systematic state support. However, it was specified

as intersectoral – involving various professionals – with the legislation passing only in 2019 (Federal Law 2011).

Studies indicate that with the development of the 'New Professionalism' based on competencies and performance as well as team models of care delivery (Light 2010; Kuhlmann 2006), opportunities to involve non-medical professionals in the delivery of care within medical settings are developing (McKinlay, Marceau 2008). The role of the interdisciplinary team in PC is to respond to individual patient needs and to include attention to all causes of patient suffering (pain). The allocation of responsibilities within the team acts as a way of managing emotion through calculating the availability of emotional energy and the risk of spontaneous interactions (Summers-Effler 2004).

Opportunities to form interdisciplinary teams in Russia exist only in some PC organizations that possess resources and opportunities to involve non-medical professionals. In organizations that lack opportunities to form interdisciplinary teams, the entire volume of emotional labour falls on medical professionals. Existing structural constraints make it difficult to perform emotional labour. Current training for PC professionals is represented by professional development programmes, which often do not adequately address competencies related to emotion management. In addition, there are no institutional forms of psychological support for professionals. Because of this, professionals need to acquire emotion management skills on their own or with the help of supervisors and experts. This reinforces the already significant role of organizational leaders in emotion management.

Unlike most medical specialties, in PC, patient death is the inevitable end of treatment, requiring a significant amount of emotional labour in relation to patients and efforts to maintain one's professional identity (Arbore et al. 2016). Terminal cancers can have manifestations that are uncomfortable for patients and have an impact on bodily health, such as 'dirty dying' (Lawton 1998). The care that professionals perform for the patient's body is described through the category of dirty work that is often taboo and invisible (Lawler 2006). Existing research suggests a high risk of professional burnout for professionals engaged in the care of the dying, which is explained by (1) the phenomenon of 'mutual suffering' which implies that the suffering of patients and their relatives leads to the worries and suffering of employees (Graham et al. 2005; Chan et.al. 2016) and (2) the phenomenon of 'disenfranchised grief' (Doka 1989), as professionals act as a support resource, and have to leave their negative emotions outside the interaction with the patients. Moreover, the risk of professional burnout increases if emotional labour is performed in a disrespectful environment (Jeung et al. 2018). In these cases, peer support, recognition of professional experiences (White et.al. 2004), and development of interdisciplinary teams (Swetenham et.al. 2011) reduce the risk of burnout.

Research shows that the problem of burnout in the PC field does not arise more often than in other specialties, which is explained by the special compe-

tences of these professionals in emotion management (Chan, Tin 2012; Chan et.al. 2016). The main objective of this paper is to show how emotion management in PC at the level of personal interactions combines with emotion management at the organizational level. Presumably, the ideological framework of 'good death' integrates emotion management at the personal interaction level with the organizational level and allows them to coordinate with each other.

Emotions, Emotional Management and Professional Burnout

Emotion management is an integral part of many modern professions functioning in a market environment, including the medical profession. In 1983, Arlie Hochschild introduced the term 'emotional work' which implies that emotions can be controlled by the individual (2003: 216–217). Emotions are controlled on two levels – deep and surface acting. Surface acting is the expression of feelings that do not correspond to inner feelings. In contrast to surface acting, deep acting involves working on feelings and meanings. The acting is performed according to the feeling rules and display rules. The feeling rules determine 'which emotions and with what intensity should be experienced and felt in a given situation' (Simonova 2011: 117). Using the example of the analysis of gender ideologies, Hochschild shows that ideologies determine the feeling rules and the display rules (1990).

PC professionals experience a variety of emotions as they work. At the basic emotion level (Ekman 1972), these are fear, anger, joy, sadness, disgust, and surprise. At the secondary emotion level (Plutchik 2001), employees feel pity for patients and their loved ones. In accordance with the good death ideology's feeling rules and the display rules, professionals carry out emotional labour. Presumably, staff members exercise emotional labour predominantly through deep acting due to the presence of a strong 'good death' ideology and extended time of interaction with patients.

The organization can be viewed at least from two perspectives: organization as process of organizing and organization as work context (James 1992). This paper examines both the role of organizational leaders in emotion management and organization as a space. Managers of PC organization aim to implement emotion management mechanisms that are designed to reduce the risk of professional burnout and improve performance (Hayward, Tuckey 2011: 1502). They are the main experts in emotional labour and the main emotion managers within the institution (Smith, Gray 2001), and they are also responsible for selecting employees who fit a certain type (Hochschild 2003: 97), they monitor and control compliance with rules and implement emotion management mechanisms at the organizational level (Simonova 2011: 139). Positive emotions of the employees of the organization are manifested as a result of communication with patients, good relations with the work team, good relations with managers, aligned work of the human resources service, the atmosphere of the institution,

corporate philosophy and compliance with standards of quality of care (Imdorf 2010). In the case of PC organizations as well, it might be assumed that the key role in coordinating employees' emotional labour is played by organizational leaders, who set feeling rules and display rules according to the ideological framework of 'good death' and monitor compliance with them.

At the organizational level, emotion management also occurs through the construction of interaction rituals and the control of 'emotional energy.' Communication serves as a potential resource of 'emotional energy' (Collins 1990; Wharton, Erickson 1995: 277) that contributes to successful emotional labour performance. Randall Collins writes that the 'outcome of successful build-up of emotional coordination within an interaction ritual is to produce feelings of solidarity <…> the long-term result is the feeling of status group membership' (Collins 2004: 108). The development of solidarity within the work team contributes to the formation of collective emotions and the maintenance of shared notions of feeling rules and display rules. These rituals form and maintain collective solidarity and collective emotions, that is, 'emotional states shared within the group' (Simonova 2011: 107). This theory is further developed by adding to the analysis the behavioural strategies (Summers-Effler 2004). It can be assumed that the activities of organizational leaders are aimed at building and maintaining the collective solidarity and collective emotions that are necessary to ensure a common adherence to the ideological framework of 'good death.'

Managing Emotions in Palliative Care Settings

The main empirical data of the study include fourteen interviews with hospice staff, six audio recordings of home visits by the hospice outreach service, and hospice observations collected between November 2018 and April 2019 at a hospice in a major city. The study materials are supplemented by data collected for regions of the Russian Federation between October 2020 and June 2021: eleven interviews with staff of NGOs in the field of PC, nine interviews with doctors of regional institutions. The analysis of empirical data allows us to answer the following questions: what is the role of PC organization managers in emotion management? What emotion management mechanisms are used by managers at the organizational level? What is the role of the institution in which cases do PC professionals perform emotional labour? How does emotion management combine together at the organizational and individual levels?

Managing Emotions by Organizational Leaders

The organizational level includes emotion management through leadership and coordination of employees and through the organization of the space of the institution. Managers of PC organization have a key role in managing emotions at the organizational level. They turn to a variety of emotion management mechanisms to ensure compliance with feeling and display rules in

the patient care setting. The first emotion management mechanism is the selection of a team that shares the notions of 'good death' prevalent in a particular institution and that has the necessary competencies. Interviewees describe suitable candidates in such categories as 'our, hospice person' (*nash, hospisnyj chelovek*). More generally, supervisors look at three components when selecting professionals: professional experience, personal experience, and emotional labour skills.

Managers focus on the professional experience of candidates and give preference to specialists who have had experience working with oncology or 'difficult' patients. Personal experience also determines one's ability to perform emotional labour. It is assumed that an employee who has had personal loss experience has the necessary emotional labour skills. However, informants reported that there is an informal rule that restricts hiring employees who have experienced the loss of a loved one within the past year because it is assumed that the employee will not be able to control unconscious or partially conscious emotions and therefore will not be able to perform emotional labour well.

When interviewing, supervisors pay attention to candidates' emotional labour skills. Emotional labour skills are operationalized through an understanding of feeling rules that include empathy for patients and their loved ones, acceptance of all patient emotions and 'healthy' estrangement and through an understanding of display emotion rules that include expressing certain emotions when a patient or loved one needs support and expressing negative emotions only in interaction with colleagues, psychologist or managers. A common rule in PC also deals with limiting the expression of negative emotions relating to work at home. However, more detailed rules may vary depending on the organization's perceptions of 'good death.' During the probationary phase, the employee determines if he or she is willing to follow the existing rules, and the supervisor tests the employee's emotional labour skills in practice.

The second emotion management mechanism is coordination of staff activities through scheduling, assignment of work duties, and inclusion of non-medical professionals (psychologists, social workers, representatives of religious organizations, volunteers, etc.). Coordination is accomplished through scheduling and assigning tasks based on individual staff needs and interests and creating opportunities for unscheduled leave. In some institutions, part of the emotional labour is performed by non-medical specialists, and interdisciplinary teams are created. Conditions are also created for comfortable interaction between professionals and patients (no time constraints, special rooms, etc.), which allows employees to feel satisfied with the quality of their work, since the situation when specialists do not have the opportunity to perform their work in accordance with the corporate philosophy or meet quality standards in the current environment (having conversations, establishing trusting contact) is described by employees as psychologically difficult.

The third is the management of emotions through the formation and maintenance of collective solidarity and collective emotions. 'Five-minute'

(*pyatiminutki*) or 'morning conferences' where the on-duty shift hands over patient management to the on-call shift, serve as a ritual of interaction that builds collective emotion and maintains solidarity (Bruce et al. 2006), just like any other collective event. Expanded Sanitary Regulations (*SanPiny*) and decreased opportunities for collective activities in public institutions over the past decade have made it more difficult to build collective solidarity and increased the risks of professional burnout among employees.

The space management of the institution allows to adjust the amount of necessary emotional labour. Creating comfortable conditions for both staff and patients, which means creating common spaces for patients; restrooms for staff that patients do not have access to; easy access to common spaces (exit to the street from the room, ramps and the ability to take the bed outside; availability and convenient location of toilets and bathrooms); availability of elements that create comfort (flowers, pictures, smell of coffee, etc.). Managing privacy and accessible information includes directing patient flows within the facility and minimizing unnecessary intersections.

In institutions where staff work in spaces designed to look like other institutions, they improvise to control the privacy and amount of information available to patients. For example, screens are used to enclose patients, creating personal spaces or hiding deterioration or death from other patients and their relatives. The described emotion management mechanisms at the organizational level allow adjusting the amount and content of emotional labour at the individual level through training, distributing emotional labour volumes, maintaining collective emotion, and reducing emotional labour by forming interdisciplinary teams.

Emotional Labour of Palliative Care Professionals

Professionals exercise emotional labour at the individual level in the organizational context. The need to control negative emotions in employees occurs more often than the need to control positive emotions that are expressed in accordance with the rules, so this section will look at how professionals control negative emotions. Here is one of the interviewee's answers to the question 'How do you deal with it, when is it hard to enter the ward?':

> Breathe in and out, of course, there are other psychological moments. I can switch somehow, I can pull myself together all the same. This is my job, I chose it myself (Nurse, I2).

In this excerpt, the nurse describes her emotions related to her interactions with the patient. She experiences emotions that do not conform to the feeling rules and display rules accepted in the institution, so she resorts to deep acting through body control ('*breath in and out*') and meanings ('*this is work*'), which allow self-estrangement and the gaining of control over her own emotions not as conforming to established rules, but as a personal choice of dying-related work ('*I chose it myself*').

Employee commitment to the organization's 'good death' ideology and their acceptance of feeling rules and display rules lead them to resort to deep acting rather than surface acting. Through deep acting they redefine the meaning of situations, such as when it is necessary to control anger at a patient: transferring negative emotions from the patient to the illness; accepting the patient's emotional response as part of the treatment; justifying the emotional state by explaining the causes of negative emotions to patients or their relatives, with the employee's negative emotions being replaced by sympathy.

When it is necessary to control pity, the following categories are mentioned: '*Work is work*,' '*Pity should not interfere with work*,' i.e. the employee redefines the situation, which allows them to estrange. To overcome disgust or fear, the manifestation of which is considered unprofessional and unpleasant for patients (Muggleton et al. 2015), i.e. not in line with established feeling rules and display rules, employees also turn to deep acting and shift their focus. For example, they re-focus from tumour to patient through conversation during bandaging or redefine the meaning of the situation: '*This is what is hard – bandaging is scary, tumour collapse. It's hard to emotionally tune yourself out, to suppress your squeamishness <...> no one will do it but you, so you tune yourself out*' (Nurse I13).

Conclusion

Working in the PC field carries a high risk of professional burnout. Professional burnout is dangerous both for the employees themselves and for the patients, whose quality of care is considerably reduced in this case. However, PC specialists manage to overcome the problem of professional burnout quite successfully due to special competences related to emotion management. Despite the lack of sufficient support from the state (insufficient resources to form interdisciplinary teams; insufficient attention to competencies related to emotion management in educational programs; lack of systematic support programs for PC specialists) managers are able to form these competencies among specialists in the process of work.

Materials of our empirical research show that management of medical professionals' emotions in PC institutions is a complex and multidimensional phenomenon implemented at the organizational and individual level. At the organizational level, emotion management is aimed, first, at the quality and efficiency of medical care provision; second, at maintaining compliance with the existing ideological framework 'good death'; and, third, at reducing the risk of professional burnout of employees. Managers of PC organization implement such emotion management mechanisms as team building and coordination, collective solidarity, collective emotions and space management. Emotion management is carried out in accordance with feeling rules and display rules defined by the ideological framework 'good death.'

PC professionals perform emotional labour in situations where emotions do not conform to the accepted feeling rules and display rules of the organization. More often such situations arise in the presence of negative emotions. Professionals address mainly deep acting by changing the body state or the meaning ascribed to the situation.

The management of emotions at the organizational and individual level is carried out in accordance with the ideological framework 'good death.' At the organizational level, conditions are created and maintained from the very beginning in which it is possible to adjust the scope and content of emotions, aimed ultimately at facilitating the performance of emotional labour at the individual level.

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