Studies in Continuing Education

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/csce20

Feeling rules for professionals: medical students constructing emotional labour in fiction talk

Anja Rydén Gramner

To cite this article: Anja Rydén Gramner (2022): Feeling rules for professionals: medical students constructing emotional labour in fiction talk, Studies in Continuing Education, DOI: 10.1080/0158037X.2022.2051474

To link to this article: https://doi.org/10.1080/0158037X.2022.2051474

Published online: 17 Mar 2022.

STUDIES IN CONTINUING EDUCATION
https://doi.org/10.1080/0158037X.2022.2051474

Routledge
Taylor & Francis Group

Feeling rules for professionals: medical students constructing emotional labour in fiction talk

Anja Rydén Gramner

Department of Behavioural Sciences and Learning, Linköping University, Linköping, Sweden

ABSTRACT

Although there is a large body of research about emotional labour in workplace settings, such as the health professions and the service industry, less is known about the empirical processes through which emotional labour is taught in higher education and professional education. Using medical education as an example, a discursive psychological (DP) approach is used in this paper to detail how the feeling rules of the physician's profession are constructed by students and tutors in fiction, film, and poetry seminars. From a data set of 36 video- and audio-recorded fiction seminars from two medical schools, 29 sequences of discussions about emotional challenges for physicians were found. These examples have been transcribed in detail and analysed using DP. Analysis shows that students and tutors construct feeling rules as fluid, negotiable and changeable. Feeling rules are defined as the calibration of emotion to suit different situations as well as different physicians with different levels of emotionality. Students deploy constructions of feeling rules to manage student identities, and students and tutors construct emotion as a separation between subjective experience and observable behaviours, where the subject-side experience should be managed or controlled in the way it manifests externally.

ARTICLE HISTORY
Received 1 February 2022
Accepted 4 March 2022

KEYWORDS
Medical education; discursive psychology; emotional labour; professional identity; higher education

Introduction

Within the varied field of research on professional identity and emotion (e.g. Timoštšuk and Ugaste 2012; Swanson and Kent 2017; Pickering 2018), medical education research has in the past few years increasingly focused on the processes through which medical students form their professional physician identities (e.g. Cruess et al. 2014; Wald et al. 2019), where emotion forms a central aspect. Indeed, some researchers argue that professional identity is in itself affective, and that a recognition of emotions as central for professionalism and identity development can provide opportunities for self-development and growth (e.g. Zembylas 2003). In medical education, students are expected to learn not only how to perform a physician's tasks, but also to slowly adopt the identity of a professional (McNaughton 2013), forming the beliefs, thoughts and

CONTACT Anja Rydén Gramner anja.gramner@liu.se Department of Behavioural Sciences and Learning, Linköping University, Campus Valla, Johannes Magnus väg 21, 581 83 Linköping, Sweden @Agramner

values which will shape their future working life (Schrewe et al. 2017). This interactional process is contingent on the teachers, students, patients and future colleagues whom students encounter (Monrouxe 2010; Schrewe et al. 2017). The ability to handle emotions, both the physician's own emotions and the emotions of patients and relatives, is an important part of a professional physician identity (Helmich et al. 2014).

One way of conceptualising emotion in professional development courses in medical education is by using fiction, poetry, film, and art. This practice of using fiction for educational purposes such as reflection and emotional self-awareness is also common in other fields such as law, nursing and higher education (e.g. Jarvis and Gouthro 2019). Researchers within the fields of medical humanities and narrative medicine stress how fictional works can provide opportunities for medical students and physicians to develop important professional skills such as empathy and emotional self-awareness (Montgomery Hunter, Charon, and Coulehan 1995; Charon 2001; Bleakley 2015).

In contrast to the explicit curriculum of medical education, which highlights emotional engagement and empathy as important aspects of the clinical encounter, the hidden curriculum implicitly conveys the opposite message, even sometimes functioning as an 'empathy-disabling curriculum' (Hopkins et al. 2016, 2). These processes might lead to a repression of emotional responses (Gaufberg et al. 2010), and a dehumanisation and objectification of patients (Holmes, Miller, and Regehr 2017), which are sometimes attributed to an emphasis on intellect and theory over emotion in medicine (Coles 1989). Thus, when medical students form their professional identities in interaction with others, their understanding of the emotional aspects of the medical profession is shaped through both the explicit goals of the curriculum and the implicit values of the hidden curriculum. This means that students' understanding of the emotional aspects of the medical profession may be confusing and contradictory, creating a tension between feeling empathy for patients and keeping emotional distance – the latter being perceived as the professional stance (Toivonen et al. 2017). This paper contributes to research about how emotion can be conceptualised in medical education by detailing how students and tutors in fiction discussions co-construct understandings of the kind of emotional challenges a physician might face, and how those challenges should be handled.

Emotion in the health professions

In the early 2000s, researchers claimed that medical education fostered a culture of emotional distance, which was detrimental to the teaching of compassion and humanism for future physicians (Coulehan 2005). More recently, however, some studies suggest that there is an increased focus in medical education on emotional engagement and on the emotional aspects of communication between patient and physician – a change which is also visible in the way communication and emotion are taught in medical education (Vinson and Underman 2020). Hochschild's term emotional labour (1983) encompasses how emotions are intrinsically linked to workplace behaviours and expectations on employees. Emotional labour as a concept is used to understand how working life is filled with tasks where the individual is asked to perform emotionally in the 'correct' way for the benefit of others (Hochschild 1979). This entails both moderating one's

own emotional behaviour in accordance with the norms of a specific situation, and ensuring that the receiver of work, be it a patient or a client, feels as happy and as content as possible. According to Hochschild, in caring and nurturing professions such as medicine, employees are asked to handle both their own emotions as well as the emotions of, for example, patients, in a way which is acceptable and fits into the feeling rules of said occupation (Hochschild 1979). Originally a term used by Hochschild in analysis of flight attendants, emotional labour has since been used to understand the emotional aspects of various professions, such as teaching in higher education (Berry and Cassidy 2013), and customer services (Totterdell and Holman 2003). Research on emotional labour in medicine has focused on nurses (e.g. Gray 2009), midwifery students (e.g. Gleisner 2013) and practicing physicians (e.g. Kerasidou and Horn 2016). Emotional labour as an aspect of professional and vocational education, however, has been less explored, with a few exceptions (e.g. Bredlöv 2021), while research on emotional labour in medical education is even less common.

In medical research, Hochschild's terms 'surface acting' and 'deep acting' are used to uncover the two aspects of emotional or empathetic behaviour in physicians. Here, surface acting refers to the performance of behaviours perceived by patients as caring and empathetic, while not necessarily experiencing those emotions inside, and deep acting refers to the performance of these actions while also self-reflecting on one's own emotional reactions, using them as tools to deepen the response (Larson and Yao 2005). Thus, there is a separation between what an individual is supposedly experiencing or feeling, and which emotional expressions the individual performs. These things are not necessarily the same.

Although there is a body of research detailing how empathy is conceptualised empirically in interaction with medical students (e.g. Vinson and Underman 2020) and in how empathy is made relevant in physician-patient interaction (e.g. Frankel 2017), more empirical work is needed to understand how emotional aspects of the medical profession are taught to medical students (Bolier et al. 2018). This paper helps expand knowledge of how emotional labour can be co-constructed by students and tutors in fiction, film, and poetry seminars. By using the analytical tools and theoretical stance of discursive psychology (DP), it is possible to make sense of how psychological concepts such as emotion are jointly constructed in in-situ interaction, and how these aspects of emotion are deployed, negotiated, and shaped by participants of discussions.

Emotion in interactional research

Within a discursive psychological framework and other interactional research, emotion as a phenomenon is regarded not as a reflection of cognitive models or personality traits, but rather as a psychological and social phenomenon which is co-constructed by participants of interaction, and sometimes used as an interactional device (Edwards 1999). In institutional contexts, interactional research on emotion has covered settings such as the police force (Howard, Tuffin, and Stephens 2000), politics (Augoustinos, Hastie, and Wright 2011), child protection helplines (Hepburn and Potter 2007) and preschools (Cekaite and Ekström 2019), as well as medical education (Rydén Gramner and Wiggins 2020).

In the current paper, the focus lies not on how students construct their own emotional reactions such as being 'angry' or 'upset', but rather on how these students and tutors in fiction seminars construct the phenomenon of emotion as it exists in the imagined future when students have become physicians. The aim of this paper is to uncover how emotional labour is constructed in-situ by tutors and students during medical education fiction seminars. The research questions are:

- How do students and tutors in fiction, film and poetry seminars construct emotional labour and the feeling rules of the medical profession?
- How do students and tutors construct the subjective experience of emotion and the observable behaviour related to the subjective experience, in a fictive clinical encounter?

Materials and methods

The data analysed for this paper comprise video and audio recordings of 36 fiction seminars conducted with 20 groups of students and their tutors at two medical schools in Sweden. Group sizes ranged from six to 16 students, and one or two tutors per group. Different types of fictional works were used, such as short stories, films, autobiographies, and poetry. The fiction seminars were part of the regular curriculum of each medical school and were either held during the first two semesters of the students' education, during the middle part of their education, or towards the end. Usually, though, they were placed within courses focusing on professional development, ethics, and patient treatment. Tutors were either practicing physicians or academic scholars, and apart from getting information about the aims of the fiction seminars to contribute to emotional awareness and identification, they received no formal training, but volunteered for this teaching assignment because of their own interest in fiction.

All fiction seminars were recorded with two cameras and/or one or two audio recorders. They were then roughly transcribed, and notes were made on topics and issues that students and tutors oriented to. One recurring topic was talk about emotional reactions that physicians might have in clinical encounters with patients. From the entire data set, 29 sequences were identified of discussions about emotional reactions for a physician. These sequences were taken from 25 different seminars – 18 seminars from the beginning of medical education (year 1), three seminars from the middle and four seminars from the end of their education.

The 29 examples were all transcribed using the Jeffersonian transcription system (Hepburn and Bolden 2012), and then analysed using discursive psychology (Edwards and Potter 1992; Wiggins 2017) in a turn-by-turn manner to find patterns, ambiguities and deviant cases. The analysis progressed by moving back and forth between the detailed transcription and the video clips. Notes were made on each line, focusing on the psychological phenomenon in play – by asking the question 'What does x do?'. As analysis deepened, focus returned to the video recordings, and further details were added in the transcripts. This iterative process between video clips, transcripts and analysis was conducted several times. Four excerpts were

chosen as representative examples of the range of findings regarding how emotional labour was conceptualised in the data. In the transcripts, tutors' names are capitalised. All names are anonymised.

Findings

The analyses below detail how students and tutors in this data co-construct an understanding of what emotional labour might entail for physicians in an imagined future. This discussion is quite abstract for most of the students, as 18 of the 25 seminars in the data for this paper include first-year students who have had limited patient interaction. The characters and events in the fictional works therefore function as a kind of levy or platform, which is used to launch discussions about what the students think they will do and feel in different imagined situations in their future profession. Often, seminars follow a pattern where the discussion first focuses very closely on characters and events in a book or film, and then the tutor or a student introduces an imagined scenario about a patient or a challenging situation for a physician, loosely inspired by the fictional work, where topics about professionality and emotion are presented. In this latter part of the discussion, the fictional work is seldom explicitly mentioned or referred to. In the discussions about how physicians should handle their own emotions as well as patient's emotions, students and tutors construct the emotional labour for physicians as a set of 'feeling rules' (Hochschild 1979) which are sometimes contradictory, and where the expectations of physicians are ambiguous.

In discussions about imagined patients and emotions, there is also a distinction made between the inner experience of emotions within the physician, an idea related to Hochschild's concept of deep acting (1979), and the behaviours which are perceived by patients as emotional, an idea related to the concept of surface acting. The feeling rules are constructed as something negotiable and fluid; something which is unknown and is brought into being through the discussion.

Below are analyses of four examples where emotional labour for physicians is constructed in terms of how physicians should or could feel or behave, in order to be professional. The excerpts detail how the feeling rules for physicians are constructed as calibrations of emotion, contingent on the needs of the patient, the situation of the clinical encounter, and the physician's own self-knowledge about being an 'emotional' or 'non-emotional' person, as well as a deviant case which depicts the construction of feeling rules for 'negative emotions' about patients. The first example concerns how a physician must balance between emotional distance and emotional closeness.

The balance between cold heart and warm heart

In this excerpt, students and tutors orient to the task of finding a balance between emotional opposites – described by Lindberg (2012) as an ideal where the right amount of emotion is not too much or too little, but somewhere in between. Below, tutor LIV constructs this balance as having both a cold heart and a warm heart. These first-year students and their tutor have been discussing different books during their seminar, and LIV then moves the discussion to their future occupation and asks the

students how think they would react if they would appear teary-eyed in front of a patient. One student, Eva, says that she would find it difficult because she does not like to show emotion in front of other people.

Excerpt 1: 'If I break down completely I can't help her'

1 LIV: it sounds like you are very aware [th]at you can
2 Eva: [mm]
3 LIV: can kinda .hhh have (0.3) cold (.) cold £heart or£
4 Eva: yeah yeah mm
5 LIV: warm hear-yeah I don't know how to express it but
6 Eva: mm yeah
7 LIV: we all know what we mean you can (.) block
8 yourself [agai]nst things like that
9 Jonna: [yeah]
10 Kim: yeah that's true
11 LIV: and tha-sometimes you need to do it 'cause the patient
12 maybe (.) needs that I: (.) that tha-I mean she maybe
13 sh-needs to see that I can deal with this situ-if it's
14 very dramatic she tells me something really awful (.)
15 Jonna: mm
16 LIV: then (.) I can show my emotions of course but if I
17 (0.2) £break do[(h)wn hahah] £if I £completely
18 ss: [hahahahhaha]
19 LIV: break down£ then ha-then I can't help her and
20 she will become anxio:us I think
21 Kim: mm
22 ss: yeah mm
23 LIV: but that you still show that it moves you (.)
24 Kim: mm mm
25 LIV: that (.) that I think that-that can't be wrong
26 Jonna: no:o

LIV uses Eva's assessment of herself as a starting point in defining the concepts 'cold heart, warm heart' (lines 1–3) (see Appendix 1 for transcription symbols). She constructs these concepts as subject-side skills (Edwards and Potter 2017) which are part of the physician's putative personality traits. These concepts are constructed as problematic through the delivery which is marked by cut-offs, pauses, audible breathing and repairs, all signs of a 'delicate object' (Silverman 1997) which is troublesome to talk about. This troubles-talk continues in the next line, where LIV makes a stake inoculation (Potter 1996) that she does not 'know how to express it' (line 5). Thus, LIV refutes the potential claim that she has a stake in her statements – rather, they are presented as ad-hoc reflections, open to negotiation. LIV's way of positioning herself as a non-expert, although she is a practicing physician with experience of emotional labour,

invites the students to join in and co-construct these concepts, instead of LIV presenting students with the correct answer.

Continuing, LIV uses a fictive patient as an illustration of the importance of finding the balance between emotional distance and emotional closeness. The whole sequence is marked by 'turbulent talk' (Silverman 1997) with pauses, cut-offs, repeats, smiley voice, emphasis and audible breathing. The subject-side internal skill of being able to 'block yourself' from emotions (line 7) is constructed as a necessity for the benefit of the patient, who needs a physician in control of their emotions when faced with a 'very dramatic' situation (line 14). LIV then constructs the opposite, of using the 'warm heart' in that situation, as something which will harm the patient who will become 'anxious' (line 20) because it would entail a 'break down' (lines 17–19) by the physician. The laugh particles (Potter and Hepburn 2010) in the word 'break down' as well as the intense laughter by LIV and students, constructs this extreme emotion as both troublesome and laughable – a reaction which is exaggerated (Holt 2011). Directly after, LIV states that showing some emotion, 'that it [the situation] moves you is not wrong' (lines 23–25), but this statement is also delivered with cut-offs and hesitation. Thus, the balancing act of warmness and coldness is constructed as problematic and, simultaneously, subject to negotiation and challenge.

Excerpt 1 thus illustrates how feeling rules are constructed as a balance between emotional closeness and emotional distance, where emotion should be controlled and sometimes concealed in a clinical encounter – similarly to how higher education teachers talk about concealing their emotions for the benefit of students (Constanti and Gibbs 2004). The next excerpt details the construction of the feeling rules which should guide the relationship between physician and patient.

The physician-patient relationship – closeness and distance

In the following excerpt, feeling rules are constructed as careful calibrations of the physician-patient relationship, where a physician by necessity forms a closeness or friendship with patients, but must also preserve some form of distance, to maintain the hierarchy of the clinical encounter. In this excerpt, a group of eight first-year students and tutor DAN, who have had one previous seminar together, are discussing the novel *My Sister's Keeper* (Picoult 2003). This novel depicts the story of a family where the first-born daughter Kate is severely ill with leukaemia. The family decides to have another baby, Anna, specifically because the baby's umbilical cord blood could be used to save Kate's life. The procedure is at first successful, but after a few years, Kate's cancer returns. When Anna is asked to donate her kidney to Kate, through a major operation which will severely affect Anna's life and might not even save her sister, she refuses, and goes to court to gain medical emancipation. It is then revealed that it was Kate who asked Anna to go to court in this matter. The story ends tragically. A student, Ann, then reflects on the types of emotional situations a physician might encounter.

Excerpt 2: 'Too much like a friend'

1 Ann: we have to kinda go into a relationship wi:th patients
2 and next of kin [(.)] e::h (0.2) and you (.) c-can
3 DAN: [mm]
4 Ann: experience sometimes that you might become a little
5 like a fri[end] (.) but then you have to guard
6 Jim: [mm]
7 Ann: yourself a little so that you kind of don't become too
8 much like a friend [.hhh] so that it becomes instead that
9 Nina: [no]
10 Ann: patients or relatives kinda be-begin to kinda (.)
11 protect us from (.) what is hard and such but
12 (0.3) e:h (0.6) .tsk it really is important to
13 keep I mean professional doesn't have to
14 be that you are unfeeling or stuff but that
15 you keep (0.4) hhh don't know if you should
16 call it distance but that you

In contrast to research about nursing students, who defined themselves as needing to learn how to care and show care (Smith and Gray 2001), Ann constructs herself and the group not in need of learning how to care, but in need of learning how to care less or not too much – the aspect of emotional labour where emotions of the individual must be controlled or suppressed and not shown – for the benefit of patients. Interestingly, Ann does work to position herself and the group of students as part of the professional community (Wiles 2013) by using the pronouns 'we' and 'us' (lines 1, 11, 27) when she talks about the risk of physicians developing an unprofessional friendship with patients – similar work is done in Nikander's paper (2007) where caregivers displayed conscientiousness and professionality by explicitly mentioning the possibilities of letting decisions become tainted by personal emotions. Notable here is the practical separation from professional practice: these students are in their first term, and while they have experienced some patient interaction, they are still in training.

The action of becoming too close to a patient is framed by Ann as something that can happen to physicians, who can become 'too much like a friend' (lines 7–8), a process which physicians need to be wary of ('you have to guard yourself', lines 5–7). This experience is constructed as a subject-side assessment (Edwards and Potter 2017), meaning that it is attributed to the putative inner experiences of the physician. This subjective experience, however, is constructed as noticeable by patients who might be harmed because the expected hierarchy of the clinical encounter is flipped, and patients 'begin to kinda protect us from what is hard and such' (lines 10–11). The emphasis on the word 'us' brings into focus the professional community which Ann includes the group of students in, and the future, when they will be physicians and not students.

Similar to excerpt 1, the negotiation of feeling rules is constructed as problematic. The task of creating a distance between physician and patient, which Ann tries to define in lines 12–16 as an ideal way to behave, is constructed as especially troublesome. Ann uses different formulations of uncertainty ('professional doesn't have to be' lines 13–14, 'don't know if you should call it distance' lines 15–16), which together with the 'turbulent' delivery work as a kind of stake inoculation (Potter 1996) against the potential claim that Ann has a stake in what she is saying. So, 'distance' is constructed as an ideal but also framed as something that Ann is not invested in or proposing. Altogether, this works to position Ann both as a regular student with no expert knowledge and, simultaneously, as a good student who has understood the complexity that emotional labour entails for physicians – a way of 'self-policing' her knowledge display so as not to appear better or smarter than the others. This is in line with findings by Benwell and Stokoe (2005) that students in higher education orient to knowledge displays as troublesome, and that they co-construct cleverness as problematic, making 'average' the correct way of doing 'being a student'. This way of talking about the problematic aspects of becoming too intimate with patients, paradoxically, functions as a discursive tool in marking a conscientious physician-to-be who is aware of her own emotions, similarly to how the problems of letting emotion interfere with decision-making is used as a discursive display of sound reflective professionality in emotion talk in meetings (Nikander 2007).

Moving on to excerpt 3, analysis shows how the calibration of feeling rules is constructed as something personal and contingent on each individual physician's level of emotionality.

Different rules for different people

This excerpt contains an 'instruction-like' sequence where the tutor constructs the feeling rules as an ongoing adjustment of emotion that physicians need to manage depending on how they are as individuals. During their second seminar together, SOPHIE and the students have discussed the short story 'The Death of Ivan Ilyich' (Tolstoy [1886] 2008). This story begins with Ivan's death, and then details the previous 30 years of his life where he increasingly focused on living according to the rules of bourgeois society, and eventually became emotionally distant from his family. Finally, on his death bed, Ivan understands that his past way of living was morally wrong, and he dies in peace. The group move from discussing the short story to a discussion about how people respond emotionally to situations in various ways. The student Fia talks about herself as easily becoming emotional, and finding this an important quality in a physician, while the student John claims that he seldom feels moved by events and that he sometimes wishes he 'felt more'. Tutor SOPHIE introduces the idea that a person's level of emotionality can be controlled through a strategy of 'keeping the door open or closed' to their emotions.

Excerpt 3: 'Look for this small thing'

1 Annika: now so-or you could think like that (.) individually
2 like this now I'll [try] to keep the door closed but
3 John: [hhe]hh
4 Annika: now I'll try to keep it open (.) but
5 Annika: they're [so (0.2)] they're so different
6 SOPHIE: [yeah no it]
7 Annika: base positions (0.2) how we
8 Vera: how you're raised I mean how
9 Annika: yeahh:
10 Vera: how your parents shape you °incredibly much°
11 Jeff: yeah
12 SOPHIE: i:t if we go back to la-or [to the] last meeting (.)
13 Vera: [thheh]
14 SOPHIE: discussion and the part about selfkno:wledge to
15 know about it (.) that you might go [off] a lot
16 Jeff: [hhih]

17 SOPHIE: emot[ion]ally when you see a patient and to know that
18 Fia: [mm]
19 SOPHIE: now it's my emotions and now I kinda must (.) I
20 can't bring that in (.) to the room too much (.)
21 and you mi:ght (.) be a bit more like there isn't that
22 much emotion so you might have to lo-look for
23 this small thing that you still feel somewhere 'cause
24 it might in a (.) in a patient-doctor situation
25 be very important (.) 'ca-cause sometimes it's
26 like a mirror [th]at the emotion you get is

Annika disagrees with SOPHIE, claiming that although a person could try to actively be more or less emotional ('try to have the door closed', line 2), emotionality is something involuntary, innate within each person ('base positions', line 7). Vera aligns with this, adding that parents and upbringing play a part in a person's level of emotionality (line 10). In response, SOPHIE begins a short monologue, using Fia and John and their own reflections on emotionality as examples. SOPHIE's main point is that self-awareness or 'self-knowledge' (line 10) is an important skill for these students when they become physicians – it is the tool with which the feeling rules of the medical profession can be fulfilled. She directs herself to Fia (personal 'you', lines 15, 17,) and to John (personal 'you', lines 21–23, 26, 29–31). Interestingly, in both these examples, SOPHIE moves from talking to the student to talking 'as' the student, when she switches from 'you' to 'I' (lines 19–20, line 33). This works as a kind of reported speech (Holt 2000), but not by repeating what someone has already said, but rather by saying what the student, according to the tutor, would

say or think to themselves in that situation – a sort of tutor-constructed knowledge display attributed to Fia and John.

The examples function as opposites, but both are constructed as subject-side experiences of emotion which are controllable as objects when they are made observable by others. In this construction, self-knowledge allows the professional to not bring emotion 'into the room too much' (line 16) but also to find that emotional 'small thing' (lines 23, 33) which is needed in the clinical encounter. By using the two students and their assessments of themselves as emotional or non-emotional people, SOPHIE constructs the feeling rules of the medical profession as a calibration of emotions which is contingent not only on the needs and expectations of the situation and the patient, but also on the putative traits of the individual, who might need to 'tone down' or 'amp up' their own emotional reactions in order to give good care.

The way SOPHIE uses Fia's and John's own assessments of themselves as examples could be understood as a threat to their positive face (Brown and Levinson 1987), meaning their self-image, as she is potentially criticising them for 'doing emotion the wrong way' if they do not follow the feeling rules and adjust their emotional reactions correctly. This can be seen in SOPHIE's use of the hedging phrase 'you might' throughout her turn (lines 15, 21, 24, 28) which softens her assessments about the students. These strategies by tutors of 'negative politeness' (Brown and Levinson 1987) to help students' face-saving mechanisms have also been noticed in research on interaction in university tutorials (Benwell and Stokoe 2002). SOPHIE's conclusion is that 'nothing is better or worse' (lines 36–37) also lessens the potential face-threatening aspect of what she is saying, while enforcing the construction of feeling rules as something fluid, which changes and develops depending on each individual physician.

The last excerpt is a deviant case in that it illustrates that some types of emotion are more problematic than others – namely, the difficult emotions toward patients who have committed horrible crimes.

Putting 'bad' emotions to the side

The fourth excerpt is the only excerpt in the data set where the emotions described are constructed as 'negative' or 'bad'. The group consists of first-year students: eight students and tutor GABRIEL, and in their second seminar, they are discussing the short story 'Dimensions' by Alice Munro (2009). The story is about Doree, a woman who marries young. She and her husband Lloyd have three children, but the marriage is unhappy, as he is very controlling over her. Eventually, Lloyd kills their three children and ends up in prison. After a discussion about this atrocious event, the tutor GABRIEL asks the group about situations in their future occupation, and whether they think they could give good care to a person who has done bad things, for example a paedophile. GABRIEL formulates this as a situation where the physician's ethics might clash with someone's personal ethics about what is right or wrong.

Excerpt 4: 'You don't want to become a robot'

1 Ben: yea: (.) it's better to not become emotionally
2 involved (.) and keep your professionality kinda
3 (0.9)
4 Ina: yeah however I think that professionality could be to
5 (.) to (0.3) a-as humans we have we form
6 an opinion (.) as you say I mean pure intu- (.)
7 intuitive £yeah.hh don't know how to
8 say it£ in swedish a:h so it can be
9 kinda this case with a paedophile then that I (.)
10 also feel that kinda a: it probably would have been
11 a bit harder (.) and I think that the professionality
12 is to take those emotions which are (.) woken 'cause
13 they will as you [(.)] we aren't perfect (0.2)
14 GABRIEL: [mmm]
15 Ina: and put them to the side to give someone good care (.)
16 but also to be able to (.) .tsk eh we talked a little
17 about it last time that hrm hhhm hhrrm .tsk that e:hm
18 (.) you don't want to become a robot kinda
19 Elsa: mm
20 Ina: when it comes [to] the professionality that
21 GABRIEL: [mm]
22 Ina: you want to think that I can't show emotions or I
23 can't mix in my emotions because I don't think that's
24 true of the physician profession (0.2) bu:t (.) ah just
25 to be able to put them on the shelf when it's needed

In the first line, student Ben introduces the ideal, professional way of handling negative emotions as 'not becoming emotionally involved' (lines 1–2), framing emotion as an experience which can be avoided. This statement is then refuted by Ina who in contrast constructs the formation of emotions as involuntary, expected and a subjective experience ('those emotions that are woken 'cause they will as you we aren't perfect', lines 12–13). At the same time, Ina constructs this emotional experience as something which can be controlled – to 'put them [emotions] to the side' (line 15) or 'on the shelf' (line 25). She also uses a reference to a previous seminar to construct the absence of emotion, even negative emotions, as something problematic – becoming 'a robot' (line 18) is constructed as undesirable.

In all of the excerpts presented where a student 'holds the floor', analysis has shown that students orient to doing 'being a student' (Benwell and Stokoe 2005), which is a balancing act between constructing themselves as 'average' and fulfilling the aims of the task at hand. Ina manages this by introducing her argument through a stake inoculation ('don't know how to say it in Swedish', lines 7–8), which allows her to argue for her understanding of a physician's emotional labour while not claiming to be an expert or

above her peers, and by delivering her claim with cut-offs, hesitations, repairs and pauses typical of 'turbulent talk' (Silverman 1997).

Throughout this excerpt, tutor GABRIEL is very quiet, only giving confirmatory 'mm's while students speak. Although he asked the question which prompted the discussion, he remains passive and does not guide the students or try to unpack the concepts of being 'objective', 'professional' or 'showing emotion'. By being so passive, GABRIEL leaves it to the students to make sense of what emotional labour might mean for them in their future occupation.

Discussion

Analysis of fiction seminar data in this paper has shown how these students and tutors construct feeling rules as fluid, negotiable norms, where the physician is expected to calibrate their own emotions according to the situation, the patient and the physician's own perceived personality traits. Emotions are consistently constructed as subject-side experiences within the physician, but simultaneously as controllable, object-side 'things' when they are manifested as behaviours. This separation between what a person feels and how they behave is similar to the concepts of 'surface acting' and 'deep acting' where a physician can behave in an empathetic way without experiencing the emotions connected to the behaviour (Larson and Yao 2005), and this view seems to permeate how these students and tutors construct emotional labour. Similar to the way the explicit curriculum and the hidden curriculum communicate conflicting values and goals regarding emotion, this discursive construction of emotion as a set of behaviours separate from subjective emotional experiences creates the risk of an instrumental view of emotion where emotional awareness is used to self-police and to control emotional reactions instead of deploying them as part of a holistic professional identity.

In the excerpts, feeling rules are constructed as problematic, 'delicate objects' (Silverman 1997) through the way they are delivered, with pauses, cut-offs and other markers of hesitation, as well as stake inoculations constructing the feeling rules presented as uncertain and 'talked into being' rather than common knowledge. Students who talk about feeling rules and how physicians should behave work to frame themselves as non-experts, as part of the group, who do not claim to know the right answer but are simply 'thinking aloud' while inviting others to join in. Talking about feeling rules in this way allows students to construct themselves as part of the professional community (Wiles 2013), fulfilling the goals of the seminar of professional development and emotional awareness, and simultaneously, to 'do being students', and to discursively form the rules and boundaries of student behaviour as doing well, but not too well, in academic tasks. This interactional business that the students engage in is in line with earlier research on students in higher education (Benwell and Stokoe 2005; Stokoe, Benwell, and Attenborough 2013).

All the tutors in this data orient to the construction of feeling rules as problematic in different ways. LIV in excerpt 1 positions herself as just as unsure or searching for the correct answer as the students, and SOPHIE also deploys markers of hesitation in her short monologue. The other two tutors, DAN and GABRIEL, take a more passive role, giving continuers, but mostly remaining quiet. Perhaps the purpose of this neutral attitude is to let the students experience the uncertainty of their future emotional

experiences, and to challenge the students to reflect on their own way of dealing with these situations – an uncertainty which has been claimed to be important in students' formation of a professional identity (Bebeau and Monson 2012). So, both talking about the feeling rules and conforming to the feeling rules pose challenges for students. The difficulty that medical students experience in coming to terms with emotional labour is very similar to the findings of Toivonen et al. (2017), where students struggled to find a balance between empathy with patients and professional distance.

In conclusion, this paper contributes to existing work on higher education, emotion, and professional identity by showing how the feeling rules of the physician profession can be constructed as calibrations of emotion which needs constant adjustment in relation to patients, situations, and the physician's own way of being, and where both emotional closeness and emotional distance need to be deployed simultaneously. This paper also contributes to research on discursive psychology by illustrating how students in higher education can use subject-object relations to construct emotional labour while managing student identities, and how feeling rules can be constructed as 'delicate objects' through the way they are formulated and deployed. More work is still needed to understand how emotional labour is conceptualised in medical education and how it relates to the explicit curriculum with its focus on emotional awareness and professional identity. Discursive psychology has proven a fruitful perspective to uncover how concepts of emotional labour and feeling rules can be interactionally achieved in-situ in higher education settings, and how these can be deployed to achieve interactional goals. I therefore conclude with a call for more research using DP in studies about emotional labour in higher education such as medical education, as well as DP research illustrating the different ways that fiction talk and discussions about fictional events can lead to emotion talk in higher education.

Disclosure statement

No potential conflict of interest was reported by the author(s).

ORCID


Anja Rydén Gramner http://orcid.org/0000-0002-4074-1802

References

Augoustinos, Martha, Brianne Hastie, and Monique Wright. 2011. "Apologizing for Historical Injustice: Emotion, Truth and Identity in Political Discourse." *Discourse & Society* 22 (5): 507–531. doi:10.1177/0957926511405573.

Bebeau, Muriel J., and Verna E. Monson. 2012. "Professional Identity Formation and Transformation Across the Life Span." In *Learning Trajectories, Innovation and Identity for Professional Development*, edited by Ann McKee, and Michael Eraut, 135–162. Dordrecht: Springer.

Benwell, Bethan, and Elizabeth Stokoe. 2002. "Constructing Discussion Tasks in University Tutorials: Shifting Dynamics and Identities." *Discourse Studies* 4 (4): 429–453. doi:10.1177/1461445602004004020 1.

Benwell, Bethan, and Elizabeth Stokoe. 2005. "University Students Resisting Academic Identity." In *Applying Conversation Analysis*, edited by Keith Richards, and Paul Seedhouse, 124–139. London: Palgrave Macmillan.

Berry, Karen, and Simon Cassidy. 2013. "Emotional Labour in University Lecturers: Considerations for Higher Education Institutions." *Journal of Curriculum and Teaching* 2 (2). doi:10.5430/jct.v2n2p22.

Bleakley, Alan. 2015. *Medical Humanities and Medical Education: How the Medical Humanities Can Shape Better Doctors*. London: Routledge.

Bolier, Melissa, Karolina Doulougeri, Joy de Vries, and Esther Helmich. 2018. "'You Put Up a Certain Attitude': A 6-Year Qualitative Study of Emotional Socialisation." *Medical Education* 52 (10): 1041–1051. doi:10.1111/medu.13650.

Bredlöv, Eleonor. 2021. "Becoming an Emotional Worker and Student: Exploring Skin and Spa Therapy Education and Training." *Studies in Continuing Education*, 1–15. doi:10.1080/0158037X.2020.1865300.

Brown, Penelope, and Stephen C. Levinson. 1987. *Politeness: Some Universals in Language Usage*. Cambridge: Cambridge University Press.

Cekaite, Asta, and Anna Ekström. 2019. "Emotion Socialization in Teacher-Child Interaction: Teachers' Responses to Children's Negative Emotions." *Frontiers in Psychology* 10 (1546). doi:10.3389/fpsyg.2019.01546.

Charon, Rita. 2001. "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust." *JAMA* 286 (15): 1897–1902. doi:10.1001/jama.286.15.1897.

Coles, Robert. 1989. *The Call of Stories: Teaching and the Moral Imagination*. Boston: Houghton Mifflin Company.

Constanti, Panikkos, and Paul Gibbs. 2004. "Higher Education Teachers and Emotional Labour." *International Journal of Educational Management* 18 (4): 243–249. doi:10.1108/09513540410538822.

Coulehan, Jack. 2005. "Today's Professionalism: Engaging the Mind but Not the Heart." *Academic Medicine* 80 (10): 892–898.

Cruess, Richard L., Sylvia R. Cruess, J. Donald Boudreau, Linda Snell, and Yvonne Steinert. 2014. "Reframing Medical Education to Support Professional Identity Formation." *Academic Medicine* 89 (11): 1446–1451. doi:10.1097/ACM.0000000000000427.

Edwards, Derek. 1999. "Emotion Discourse." *Culture & Psychology* 5 (3): 271–291. doi:10.1177/1354067X9953001.

Edwards, Derek, and Jonathan Potter. 1992. *Discursive Psychology*. London: Sage.

Edwards, Derek, and Jonathan Potter. 2017. "Some Uses of Subject-Side Assessments." *Discourse Studies* 19 (5): 497–514. doi:10.1177/1461445617715171.

Frankel, Richard M. 2017. "The Evolution of Empathy Research: Models, Muddles, and Mechanisms." *Patient Education and Counseling* 100 (11): 2128–2130. doi:10.1016/j.pec.2017.05.004.

Gaufberg, Elizabeth H., Maren Batalden, Rebecca Sands, and Sigall K. Bell. 2010. "The Hidden Curriculum: What Can We Learn from Third-Year Medical Student Narrative Reflections?" *Academic Medicine* 85 (11), doi:10.1097/ACM.0b013e3181f57899.

Gleisner, Jenny. 2013. "Negotiating the Normal Birth: Norms and Emotions in Midwifery Education." PhD diss., Linköping University.

Gray, Benjamin. 2009. "The Emotional Labour of Nursing – Defining and Managing Emotions in Nursing Work." *Nurse Education Today* 29 (2): 168–175. doi:10.1016/j.nedt.2008.08.003.

Helmich, Esther, Sanneke Bolhuis, Roland Laan, Tim Dornan, and Raymond Koopmans. 2014. "Medical Students' Emotional Development in Early Clinical Experience: A Model." *Advances in Health Sciences Education* 19 (3): 347–359. doi:10.1007/s10459-013-9477-1.

Hepburn, Alexa, and Galina Bolden. 2012. "The Conversation Analytic Approach to Transcription." In *The Handbook of Conversation Analysis*, edited by Jack Sidnell, and Tanya Stivers, 57–76. Oxford: Wiley-Blackwell.

Hepburn, Alexa, and Jonathan Potter. 2007. "Crying Receipts: Time, Empathy, and Institutional Practice." *Research on Language & Social Interaction* 40 (1): 89–116. doi:10.1080/08351810701331299.

Hochschild, Arlie Russell. 1979. "Emotion Work, Feeling Rules, and Social Structure." *American Journal of Sociology* 85 (3): 551–575.

Hochschild, Arlie Russell. 1983. *The Managed Heart: Commercialization of Human Feeling*. Berkeley: University of California Press.

Holmes, Cheryl L., Harry Miller, and Glenn Regehr. 2017. "(Almost) Forgetting to Care: An Unanticipated Source of Empathy Loss in Clerkship." *Medical Education* 51 (7): 732–739. doi:10.1111/medu.13344.

Holt, Elizabeth. 2000. "Reporting and Reacting: Concurrent Responses to Reported Speech." *Research on Language & Social Interaction* 33 (4): 425–454. doi:10.1207/S15327973RLSI3304_04.

Holt, Elizabeth. 2011. "On the Nature of 'Laughables': Laughter as a Response to Overdone Figurative Phrases." *Pragmatics* 21 (3): 393–410. doi:10.1075/prag.21.3.05hol.

Hopkins, Laura, Lana Saciragic, Joanna Kim, and Glenn Posner. 2016. "The Hidden Curriculum: Exposing the Unintended Lessons of Medical Education." *Cureus* 8 (10): e845–e845. doi:10.7759/cureus.845.

Howard, Christina, Keith Tuffin, and Christine Stephens. 2000. "Unspeakable Emotion: A Discursive Analysis of Police Talk about Reactions to Trauma." *Journal of Language and Social Psychology* 19 (3): 295–314. doi:10.1177/0261927X00019003002.

Jarvis, Christine, and Patricia Gouthro, eds. 2019. *Professional Education with Fiction Media: Imagination for Engagement and Empathy in Learning*. Cham: Palgrave Macmillan.

Jefferson, Gail. 2004. "Glossary of Transcript Symbols with an Introduction." In *Conversation Analysis – Studies from the First Generation*, edited by Gene H. Lerner, 13–34. Amsterdam: John Benjamins.

Kerasidou, Angeliki, and Ruth Horn. 2016. "Making Space for Empathy: Supporting Doctors in the Emotional Labour of Clinical Care." *BMC Medical Ethics* 17: 8. doi:10.1186/s12910-016-0091-7.

Larson, Eric B., and Xin Yao. 2005. "Clinical Empathy as Emotional Labor in the Patient-Physician Relationship." *JAMA* 293 (9): 1100–1106. doi:10.1001/jama.293.9.1100.

Lindberg, Ola. 2012. "'Let Me Through, I'm a Doctor!': Professional Socialization in the Transition from Education to Work". PhD diss., Umeå University.

McNaughton, Nancy. 2013. "Discourse(s) of Emotion within Medical Education: The Ever-Present Absence." *Medical Education* 47 (1): 71–79. doi:10.1111/j.1365-2923.2012.04329.x.

Monrouxe, Lynne V. 2010. "Identity, Identification and Medical Education: Why Should We Care?" *Medical Education* 44 (1): 40–49. doi:10.1111/j.1365-2923.2009.03440.x.

Montgomery Hunter, Kathryn, Rita Charon, and Jack L. Coulehan. 1995. "The Study of Literature in Medical Education." *Academic Medicine* 70 (9): 787–794.

Munro, Alice. 2009. *Too Much Happiness: Stories*. London: Chatto and Windus.

Nikander, Pirjo. 2007. "Emotions in Meeting Talk." In *Discursive Research in Practice: New Approaches to Psychology and Interaction*, edited by Alexa Hepburn, and Sally Wiggins, 50–69. Cambridge: Cambridge University Press.

Pickering, Kristin. 2018. "Learning the Emotion Rules of Communicating Within a Law Office: An Intern Constructs a Professional Identity through Emotion Management." *Business and Professional Communication Quarterly* 81 (2): 199–221. doi:10.1177/2329490618756902.

Picoult, Jodi. 2003. *My Sister's Keeper*. New York: Atria Books.

Potter, Jonathan. 1996. "Interests and Category Entitlements." Chap. 5 in *Representing Reality: Discourse, Rhetoric and Social Construction*. London: Sage.

Potter, Jonathan, and Alexa Hepburn. 2010. "Putting Aspiration into Words: 'Laugh Particles', Managing Descriptive Trouble and Modulating Action." *Journal of Pragmatics* 42 (6): 1543–1555. doi:10.1016/j.pragma.2009.10.003.

Rydén Gramner, Anja, and Sally Wiggins. 2020. "Enacting Emotion: Embodied Affective Stance in a Medical Education Fiction Seminar." In *Discursive Psychology and Embodiment*, edited by Sally Wiggins, and Karin Osvaldsson Cromdal, 221–245. Cham: Palgrave Macmillan.

Schrewe, Brett, Joanna Bates, Dan Pratt, Claudia W. Ruitenberg, and William H. McKellin. 2017. "The Big D(eal): Professional Identity through Discursive Constructions of 'Patient'." *Medical Education* 51 (6): 656–668. doi:10.1111/medu.13299.

Silverman, David. 1997. *Discourses of Counselling: HIV Counselling as Social Interaction*. London: Sage.

Smith, Pam, and Benjamin Gray. 2001. "Reassessing the Concept of Emotional Labour in Student Nurse Education: Role of Link Lecturers and Mentors in a Time of Change." *Nurse Education Today* 21 (3): 230–237. doi:10.1054/nedt.2001.0541.

Stokoe, Elizabeth, Bethan Benwell, and Frederick Attenborough. 2013. "University Students Managing Engagement, Preparation, Knowledge and Achievement: Interactional Evidence from Institutional, Domestic and Virtual Settings." *Learning, Culture and Social Interaction* 2 (2): 75–90. doi:10.1016/j.lcsi.2013.01.001.

Swanson, Steve, and Aubrey Kent. 2017. "Passion and Pride in Professional Sports: Investigating the Role of Workplace Emotion." *Sport Management Review* 20 (4): 352–364. doi:10.1016/j.smr.2016.10.004.

Timoštšuk, Inge, and Aino Ugaste. 2012. "The Role of Emotions in Student Teachers' Professional Identity." *European Journal of Teacher Education* 35 (4): 421–433. doi:10.1080/02619768.2012.662637.

Toivonen, Asta Kristiina, Sari Lindblom-Ylänne, Pekka Louhiala, and Eeva Pyörälä. 2017. "Medical Students' Reflections on Emotions Concerning Breaking Bad News." *Patient Education and Counseling* 100 (10): 1903–1909. doi:10.1016/j.pec.2017.05.036.

Tolstoy, Leo. [1886] 2008. *The Death of Ivan Ilyich and Other Stories*. Reprint. London: Penguin Classics.

Totterdell, Peter, and David Holman. 2003. "Emotion Regulation in Customer Service Roles: Testing a Model of Emotional Labor." *Journal of Occupational Health Psychology* 8 (1): 55–73. doi:10.1037/1076-8998.8.1.55.

Vinson, Alexandra H., and Kelly Underman. 2020. "Clinical Empathy as Emotional Labor in Medical Work." *Social Science & Medicine* 251. doi:10.1016/j.socscimed.2020.112904.

Wald, Hedy S., Jordan White, Schmuel P. Reis, Angela Y. Esquibel, and David Anthony. 2019. "Grappling with Complexity: Medical Students' Reflective Writings about Challenging Patient Encounters as a Window into Professional Identity Formation." *Medical Teacher* 41 (2): 152–160. doi:10.1080/0142159X.2018.1475727.

Wiggins, Sally. 2017. *Discursive Psychology: Theory, Method and Applications*. London: Sage.

Wiles, Fran. 2013. "'Not Easily Put Into a Box': Constructing Professional Identity." *Social Work Education* 32 (7): 854–866. doi:10.1080/02615479.2012.705273.

Zembylas, Michalinos. 2003. "Emotions and Teacher Identity: A Poststructural Perspective." *Teachers and Teaching* 9 (3): 213–238. doi:10.1080/13540600309378.

Appendix 1. Transcription symbols

Adapted from Jefferson (2004) and Hepburn and Bolden (2012).

Symbol	Definition and use
[yeah] [okay]	Overlapping talk
(.)	Brief interval, usually between 0.08 and 0.2 seconds
(1.4)	Time (in absolute seconds) between end of a word and beginning of next
Word	Underlining indicates emphasis Placement indicates which syllable(s) are emphasised
Wo-word	Cut-off of word which is then repeated or reformulated
Wo:rd	Elongated vowel
°word°	Degree sign indicates syllables or words distinctly quieter than surrounding speech by the same speaker
.hhh	Inbreath. Three letters indicate 'normal' duration. Longer or shorter inbreaths indicated with fewer or more letters.
Hhh whhord	Outbreath. Three letters indicate 'normal' duration. Longer or shorter inbreaths indicated with fewer or more letters. Can also indicate aspiration/breathiness if within a word (not laughter)
w(h)ord	Indicates abrupt spurts of breathiness, as in laughing while talking
£word£	Pound sign indicates smiley voice, or suppressed laughter
~word~	Tilde sign indicates shaky voice (as in crying)
(word)	Parentheses indicate uncertain word; no plausible candidate if empty
ss	Several students responding the same way, for example through laughter