

*A Place for Emotion:
How Space Structures Nurse-Parent Interactions in West African Pediatric Wards*

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ABSTRACT: A wide range of workers are regularly tasked with managing their own and others' negative emotions. Existing literature provides a number of strategies for doing so, but is based largely on organizational settings that share certain key characteristics. Using observational and interview data from a very different setting, high-mortality pediatric hospital wards in West Africa, I find that despite widely-shared norms to the contrary, nurses are twice as likely to respond to emergencies and patient deaths with public displays of anger and frustration toward the parents of their patients than to comfort or reassure them. Combining literatures on emotion management and on the impact of place and space on social life, I show that two features of these hospital wards – the absence of private, back stage areas and the presence of visibility without control – shape nurse-parent interactions and influence how nurses express and manage emotions. My findings extends our understanding of emotional labor and workplace emotion management to environments that provide little space for processing emotions behind the scenes, but do provide a place for anger and frustration.

Emotions infuse our working lives. From hospitals to restaurants, airplane cabins to police interrogation rooms, a wide range of workers are tasked with managing their own or others' emotions. Though emotional labor can impose a burden on workers (Bono and Vey 2005; Boyle 2005; Hochschild 1983; Meerabeau and Page 1998) it can also, in some cases, help them to protect and sustain their own well-being, or to derive pleasure or meaning from work (Bolton 2000; Korczynski 2003; Stenross and Kleinman 1989; Wharton 1999). In particular, the skilled management of negative emotions can be essential for advancing organizational goals and meeting the needs of both internal and external actors (Geddes and Callister 2007; Lewis 2005; Martin 1999; Pierce 1995; Sorensen and Iedema 2009; Stayt 2009).

Existing literature points to three ways in which workers manage negative emotions. First, individuals who work in particularly intense or challenging emotional environments – including those who regularly confront the realities of life and death, such as coroners, combat soldiers, and some health professionals – may cope by cultivating distance or detachment from their colleagues, patients, or clients (Lewis 2005; Maben, Latter, and Clark 2006; Menzies 1960; Sorensen and Iedema 2009; Stayt 2009; Sutton 1991). This distance can help buffer them from their own or others' negative emotions. Second, workers may strive to align the emotions that they feel or express with those prescribed by the organizationally-, professionally-, or situationally-defined “feeling rules” governing their interactions (Hochschild 1983). This effort has been called *emotion work* in the private spheres of life, and *emotional labor* in the workplace (Hochschild 1998; Steinberg and Figart 1999; Theodosius 2008). Third, workers may come together to collectively process their emotions and to support their colleagues to do the same (Korczynski 2003; Lewis 2008).

In most organizational settings, these three explanations largely capture the ways in which workers deal with negative emotions at work. My field sites, however, present a very different set of conditions. Most prior studies have examined organizations with available backstage spaces, where social actors are protected from the audience of clients or customers and are thus free to step out of character and contradict their front stage persona (Goffman 1959). In such settings, workers ranging from nurses (Theodosius 2008) and paramedics (Boyle 2005) to police (Martin 1999) and debt collectors (Sutton 1991) take advantage of backstage and offstage areas to process difficult emotions. In the rare cases where such areas are lacking, and workers must instead manage emotions front stage, there tends to be a high degree of organizational control to ensure that workers adhere to the feeling rules dictated by their organizations or professions, even if they experience dissonance between those rules and their felt emotions. In contrast, the nurses in this study work in hospital wards that lack backstage areas and have extremely low levels of organizational control. The nurses are also highly constrained from using offstage areas for emotional processing. Although these conditions are relatively rare in the United States, they are common in other parts of the world. We therefore need to expand our theory of how workers manage negative emotions to account for these alternative settings.

In this article, I draw from extensive observational and interview data from three hospital wards treating critically ill children in a West African country, and I show that in intensely

public spaces like these hospital wards, the absence of protected, backstage areas push nurses to publicly display negative emotions that they may have otherwise processed behind the scenes. These include genuine expressions of anger and frustration with patients' families, as well as angry outbursts that help nurses cope with grief, anxiety, and other difficult emotions. I use this extreme case to extend existing theory and build a model for how certain features of space and place shape the ways that workers express and manage their emotions.

MANAGING NEGATIVE EMOTIONS: DISTANCING, EMOTIONAL LABOR, AND COLLECTIVE PROCESSING

A rich tradition of scholarship on the sociology of emotions and on emotion and organizations has highlighted at least three distinct but interrelated strategies by which workers manage their own negative or potentially disruptive emotions, while also striving to control or contain the emotions of clients, customers, and colleagues. The first strategy emerges from literature on workers who regularly confront the darker aspects of life and death. The emotional burden for these workers can be substantial; particularly in caregiving organizations, workers may experience direct and vicarious trauma (Kahn 2003) and “cumulative grief,” and may become fixated on death or begin to doubt their capabilities or professional identity (Stayt 2009) or overwhelmed by a sense of futility (Good et al. 1999).

To cope, these workers often cultivate distance or detachment from their clients or patients (Lewis 2005; Maben et al. 2006; Menzies 1960; Sorensen and Iedema 2009; Stayt 2009; Sutton 1991). Individuals employ “distancing tactics” (Stayt 2009:1272) to protect themselves, and organizations embed these defense mechanisms in their structure, culture, and routines. Hospitals have been shown to facilitate detachment by assigning nurses to carry out specific tasks for multiple patients, thereby limiting the time they spend with each, or by moving nurses between wards, hospitals, or patients frequently and with little notice (Menzies 1960). Although some find emotional engagement unavoidable (Field 1984) or desirable (Margolis et al. 2008), many of these workers are taught during training that getting too involved with patients or clients can exact an emotional and psychological toll (Sorensen and Iedema 2009; Sutton 1991); instead they must walk a “tightrope... between closeness and distance” (Meerabeau and Page 1998:297). This distance can help buffer them from their own or others' negative emotions.

The second strategy, highlighted by literature on emotion work and emotional labor, is helpful when workers experience dissonance between the emotions they actually feel and those

they perceive are required in a given situation (Rubin et al. 2005). To resolve this dissonance, they may strive to align their felt and expressed emotions with the applicable feeling rules (Hochschild 1998; Theodosius 2008). This may involve workers feigning emotions they do not feel, which Hochschild called “surface acting,” or actually changing their inner feelings to match what is expected, which is called “deep acting.” In the case of negative emotions, workers are often required to suppress or avoid negative emotions that are considered inappropriate to express (Geddes and Callister 2007), but may also be expected to generate expressions of negative emotions in certain situations (Martin 1999; Pierce 1995; Sutton 1991).

Scholars have studied emotional labor in a diverse array of occupations, ranging from flight attendants and bill collectors (Hochschild 1983; Sutton 1991) to call center workers (Korczynski 2003; McCance et al. 2013) and nurses (Bolton 2001; Huynh, Alderson, and Thompson 2008; Lewis 2005, 2008; Mann 2005). Following Hochschild and others who emphasize the deleterious effects of emotional labor (Bono and Vey 2005; Hochschild 1983; Rubin et al. 2005), many studies have focused on the burden that such expectations place on workers (Boyle 2005; Meerabeau and Page 1998; Stayt 2009). Others have challenged this perspective, arguing that workers are guided by a variety of motivations and selectively deploy different emotion management techniques, some of which may be enjoyable or rewarding (Bolton and Boyd 2003; Bolton 2000; Lopez 2006; Stenross and Kleinman 1989). One paper argued that workers’ varied responses to their workplaces’ emotional expectations are contingent on both individual and environmental factors (Grant, Morales, and Sallaz 2009).

Finally, workers may come together to collectively process their emotions and to support their colleagues to do the same (Korczynski 2003; Lewis 2008; McCance et al. 2013). Hochschild (1983) described flight attendants providing one another with emotional support, and called this collective emotional labor. Similarly, workers in a variety of settings have been shown to develop “communities of coping” (Korczynski 2003) in which “undesirable” emotions “such as hurt, frustration, anger and grief can be vented or expressed” (Lewis 2005:579). Workers also use shared laughter to defuse anger or other difficult emotions (Sutton 1991).

These three strategies are neither exhaustive nor mutually exclusive. Collective processing can be considered a type of emotional labor, or a means to facilitate emotional labor. Detachment can reduce the need for the other strategies, although it is not likely to replace them entirely. Moreover, there are alternatives to emotional labor which are largely overlooked by this

literature and are rare in most organizational settings, due to strong norms or even sanctions against them (Rubin et al. 2005), but do sometimes occur. These include withdrawal, passive-aggression, escapism, hostility, or even physical violence (Martin 1999; Rubin et al. 2005). Various factors will determine which strategy or strategies workers use when they experience negative emotions at work. In the next section, I consider one set of factors: the nature and availability of space.

THE SPATIALITY OF EMOTION MANAGEMENT

In recent decades, a few scholars have called for a rediscovery by sociology of *space* and *place* (Baldry 1999; Gieryn 2000; Kornberger and Clegg 2004). Space and place, like time, are ever-present but often invisible (Markus 2006), a “medium through which social life happens” (Gieryn 2000:467). Space and place both structure and are structured by human interaction (Bourdieu 1989; Lefebvre 1991). Scholars conceptualize space and place in diverse and sometimes contradictory ways, but in this article I borrow Gieryn’s definition of place as a geographic location with material form, invested with meaning and value, and with independent and measurable effects on social life (Gieryn 2000). Place encompasses space, but is much broader and more complex; it is “space filled up by people, practices, objects, and representations” (Gieryn 2000:465). Places, which range in size from a nation or city to one corner of a room, are not only vessels for social interaction but also both reflect and constitute systems of power and meaning (Chanlat 2006; Muetzelfeldt 2006).

Our understanding of how space and place affect micro-social interactions is perhaps most strongly influenced by the work of Erving Goffman, who divided the world into front stage areas, where the performances that constitute social life take place; backstage, where social actors are protected from the audience and thus free to step out of character and contradict the impression they seek to convey front stage; and a residual offstage space (Goffman 1959). Front and backstage may be delineated using physical boundaries, such as cabinets dividing a nurses’ station from the rest of a hospital ward (Lewin and Reeves 2011) or curtains drawn around a hospital bed to conceal a dead or dying patient (Costello 2006), or with devices that obscure individuals’ identities, like surgical masks (Tanner and Timmons 2000) or online pseudonyms (Ross 2007). Sometimes, the mere presence, absence, or level of (in)attention by certain audiences may designate an area as front or backstage (Goffman 1959).

Front stage areas may be more obvious to observers, but backstage areas serve a variety of purposes. Organizational actors' behaviors are often more relaxed, informal, and egalitarian backstage (Goffman 1959; Lewin and Reeves 2011; Tanner and Timmons 2000), and professional boundaries may blur in ways that can boost morale and group cohesion (Tanner and Timmons 2000). Backstage areas can also be used to prepare for front stage performances (Goffman 1959) and may provide safe places for productive risk-taking (Ross 2007). In the healthcare setting, backstage communication can improve patient care by allowing health workers to speak more candidly and with fewer interruptions (Lewin and Reeves 2011) and can be important for the socialization of medical and nursing students (Lewin and Reeves 2011; Oliver, Porock, and Oliver 2006). Potentially tainted activities like preparing a body (Sudnow 1967), judging the behavior of patients or family members (Heimer and Staffen 1995), or investigating and assigning blame for a patient's untimely death usually take place backstage, and nurses may use "concealment rituals" to create temporary backstage areas that hide a dead or dying patient from others on the ward (Costello 2006).

Most importantly for this paper, the structuring of space across front, back, and offstage areas is important for shaping how workers manage emotions. Studies have examined, for instance, how nurses (Theodosius 2008), police (Martin 1999), and paramedics (Boyle 2005) manage emotions differently across front, back, and offstage regions. Others have shown how workers construct or reconstruct space through performance and interaction; for instance, nurses transformed a neonatal ward into a "differential space" at night by performing expressive, philanthropic emotion work not allowed in the daytime space (Lewis 2008). Workers in various organizational settings wait to express or otherwise process negative emotions in private, backstage areas, away from customers or clients, or at home or otherwise off stage (Boyle 2005; Freund 1998; Korczynski 2003; Meerabeau and Page 1998). For example, bill collectors talking to angry debtors on the phone often created a backstage by pressing mute, and then vented their own anger through words and gestures that they would have been punished for by managers if the caller could see or hear them (Sutton 1991). Frequently, workers use private backstage areas for collective coping and mutual support (Lewis 2005), though they may also cope individually or with the support of family members (Boyle 2005).

The structuring of space can also facilitate surveillance and control of organizational actors. For Foucault, the architectural structure of the Panopticon, whereby cells are arrayed in a

circle around a central watchtower so that guards can observe inmates at all times but inmates cannot see into the watchtower, “assures the automatic functioning of power” by inducing “a state of conscious and permanent visibility” among inhabitants (Foucault 1977:201; McKinlay and Starkey 1998). Other studies have also found that the structuring of space to maximize visibility – for instance, a shop floor organized like a “fish bowl” of “voyeurs and their objects” (Salzinger 2003:52, 57) – can strongly influence workers’ behaviors, though sometimes in paradoxical ways (Bernstein 2012; Sewell and Barker 2006).

In this study, I examine organizational settings that have a very high degree of visibility and little backstage space, but extremely weak levels of organizational control. In so doing, I address an important gap in existing theory, and extend our understanding of workplace emotion management, largely developed in service organizations in the United States and Western Europe, to a very different social, cultural, and organizational environment.

THE STUDY: BACKGROUND, METHODS, DATA

This article is based on inductive, qualitative fieldwork with nurses treating pediatric patients in public hospital wards in West Africa.¹ The hospitals, which I will call Capital and Provincial Hospitals, were selected to be representative of how under-resourced healthcare systems care for severely ill patients. I focus on nurses and pediatric patients because these groups are of central importance to public health scholars and practitioners. Nurses comprise nearly 75% of the clinical healthcare workforce in the country where this research took place, and outnumber doctors 20 to 1. Nurses are also perhaps the prototypical emotion managers (Theodosius 2008). Finally, the busy hospital wards that I study have a high rate of severe illness and inpatient mortality, and therefore provide an excellent opportunity for observing how health workers, and specifically nurses, manage life-or-death situations.

Context and Research Sites

My research sites are government hospitals located in one of the poorest countries in the world, where more than half of the population lives in severe poverty, and nearly twenty percent of children die before the age of five. Still rebuilding from a civil conflict in the 1990s, the country’s governance structures, public services, and infrastructure are extremely weak. Despite considerable public investment in recent years, health facilities remain under-resourced, skilled medical staff are sorely lacking, and there are significant performance problems among nurses and other health workers.

Both hospitals are publicly-funded referral and teaching hospitals staffed by civil servants. Capital Hospital, which treats more than 11,000 inpatients per year, is within walking distance of approximately one million impoverished city dwellers. Provincial Hospital is in one of the country’s largest district capitals, and treats around 8,000 inpatients per year.² I conducted preliminary interviews and observations in all inpatient wards of Capital Hospital, but later focused my data collection on three wards, chosen to reflect the typical experience of nurses: a general medical ward and a step-down unit for more severely ill patients at Capital Hospital, and the pediatric inpatient ward in Provincial Hospital. Details about the focal wards are in Table 1.

INSERT TABLE 1 ABOUT HERE

Death is a constant presence on these hospital wards. The vast majority of patients are under the age of five and suffering from preventable and treatable – but nonetheless frequently fatal – conditions such as malaria, pneumonia, malnutrition, and diarrheal diseases. In 2012, Capital Hospital admitted more than 11,000 patients and lost nearly 13%, or more than 120 infants and young children each month, not including those who are dead on arrival or immediately thereafter and are never officially admitted. Comparative data for Provincial Hospital is not available, but the mortality rate is likely similar. Each nurse will be aware of a high proportion of these deaths , not least because deaths are usually marked by very visible public mourning, as described in Appendix 1.

These wards differ substantially from facilities in wealthier countries. They are often dirty and chaotic, with hospital staff, patients, visitors, and vendors selling food, diapers, or household goods wandering in and out at will. There are no electronic monitors or high-tech equipment, except for a few oxygen concentrators in Capital’s step-down ward and in the “TV room” (IVR) in Provincial Hospital.³ Wards are crowded with non-staff adults, because each child is accompanied at all times by a caregiver, usually a mother, grandmother, or sister. Nurses delegate responsibility to these caregivers for the children’s feeding, bathing, and most other daily care, as well as for monitoring their condition and alerting nurses if they develop diarrhea or a fever, have trouble breathing, start to convulse, or show other signs of deterioration. Caregivers sleep in the hospital, usually in their child’s bed, which is sometimes also shared with other patients. For the most part, time moves very slowly; staff and patients sit idly for hours in

the tropical heat, waiting for something to happen. Nurses spend much of the day at the nurses' station, chatting with one another or, occasionally, with patients, and catching up on record-keeping. These periods of suspended animation alternate with sudden bursts of activity: medication rounds, doctor's rounds, waves of new admissions, and emergencies heralded by a caregiver's cry and attended by a flurry of activity.

The wards are intensely public spaces. Only waist-high walls divide the large, open wards in Capital Hospital, while in Provincial Hospital, shown in Figure 1, five extremely crowded rooms hold dozens of beds, overflow patients lie on beds in the corridor, and the sickest children occupy the tiny IVR, a low-tech intensive care unit crammed with staff, children, and their anxious parents. There are no curtains or private patient rooms in either hospital, and thus patients and staff alike share the same spaces. Beds and exam tables, some holding two or three children, are often just inches apart. There are very few designated spaces – be they physical, temporal, or virtual – for nurses to speak privately among themselves. The nurses' stations are within eyeshot and earshot of many members of the public, and lack the physical barriers that help create privacy for nurses in other hospitals (Lewin and Reeves 2011). The Capital and Provincial nurses sometimes tried to create a barrier around their station by sitting with their backs to the ward, but this only possible in rare moments when there were no patients waiting nearby for admission, discharge, or treatment. Nurses also occasionally sought privacy in the nurse changing room on each ward, but they were discouraged from doing so during their shifts. More often they simply disappeared, to wander around the hospital grounds, talk with friends on other wards, or otherwise escape the ward.

INSERT FIGURE 1 ABOUT HERE

Methods and Data

I collected the core data for this article during two phases of field research in 2012, and I also incorporate historical data from 2008-2011, during which time I lived in the country and worked in Capital Hospital as part of a technical assistance and capacity-building team.⁴ My work at Capital Hospital involved analyzing why it was failing to provide an adequate standard of care, and how that might be improved. Thus, while not formally conducting research, I did engage in active observation and analysis, and wrote personal notes and memos, public

reflections, and reports and proposals for my colleagues. These writings document, among other issues, problems of poor performance by hospital staff and instances of conflict between staff and patients. They provide important background to help me interpret data from my later study.

These earlier observations and experiences helped motivate and inform the design of this project, which strives for a balance of distance and involvement (Anteby 2012). When I re-entered Capital Hospital in 2012, I did so with this background, but in a very different role. Due to high turnover, only a small number of the nurses knew me from before, but I took care with all nurses to distinguish this project from my earlier role. I had no prior experience with Provincial Hospital and the nurses there knew me only as a researcher.⁵

As summarized in Table 2, I use four types of data: interview, observational, archival, and historical. First, I conducted 23 relatively formal, semi-structured interviews with 29 nurses or trainee nurses, plus dozens of informal ad hoc interviews and conversations with many more. Nurses were selected to reflect a diversity of backgrounds, levels of experience, and observed behavior. Availability of nurses was also a factor, particularly for informal conversations, which took place as and when the nurses' workload allowed. I created a spreadsheet with basic demographic and professional information about all the nurses I had met or observed, updated this each night from my field notes, and used it to select future interviewees. I also approached nurses whose interactions with patients and families had been particularly positive, puzzling, or problematic. Interviewees were not compensated for their participation, but on my last days in the field, I bought candy or soft drinks for all the nurses as a token of gratitude.

INSERT TABLE 2 ABOUT HERE

My interview protocol covered a range of topics related to the nurses' training, experience, motivations, and professional identity, including how they thought other people viewed the nursing profession. Most relevant for this article, I asked nurses at length about their perceptions of and experiences with patients and their families, and how they managed difficult emotions and challenging situations with families. Specifically, I asked them what they did when they got frustrated, angry, or upset about something that happened at work, and what they felt and did when patients died. With few exceptions, all interviews were conducted in the local creole language, which I speak fluently. Nearly all formal interviews were digitally recorded, and

the others were transcribed immediately following the interview based on detailed notes. For ad hoc interviews, I either took notes during the conversation, using a small field notebook, or immediately thereafter.

The second type of data come from 164 hours of direct, first-hand observation of nurses at work, and include extensive field notes and tables tracking nurse activities over space and time. More than 80% of my observation was focused on the three focal wards, described above, where I spent approximately 4-6 hours per day and five days per week during the second phase of research. Various practical and ethical considerations prevented me from taking part in the nurses' tasks, and thus my participation was limited primarily to spending time with the nurses, chatting and establishing trust and rapport, while also observing their behavior, particularly their interactions with one another and with patients, family members, and other visitors. Nurses spend large parts of their day sitting at the nurse's station (up to 50 percent of their time according to data from six representative days), so it was straightforward for me to observe and talk with them.

In total, I have data on approximately 150 nurses from my observations and interviews, reflecting the demographic and professional diversity of nurses in both hospitals, including all tiers of trained, trainee, and untrained nurses. All but a handful of nurses were female, with a wide range of ages, ethnicities, birthplaces, and training schools.

The third and fourth types of data are archival (photos, artifacts, and hospital data on patient numbers and staffing levels) and historical (from minutes, reports, and other written materials from 2008-2011). These primarily serve to inform my analysis of the interview and observational data.

Data on Patient Deaths and Urgent Cases

In this article, I focus primarily on 29 emergency incidents. Thirteen involve the death of a patient, five of whom were dead on arrival to the hospital, while sixteen are urgent, life-or-death situations in which, as far as I know, the patient survived. I also incorporate more limited data from two cases in which I saw the body after death but did not see the child die, and six deaths that happened in recent days and that I heard nurses or doctors discussing. I include as urgent cases all situations in which a child was having seizures or convulsions (12 cases) plus four cases in which the child was not convulsing but the nurses' or doctors' behavior or conversation made clear that the situation was life-threatening.

I first transcribed my field notes into a narrative account of each incident. I translated direct quotations from the local creole language into English, while keeping note of any terms in the original language that were particularly evocative or difficult to translate. I then created a table of the 29 incidents, with columns specifying details about each case including the interactions (if any) between nurses and patients' family members and whether nurses expressed sympathy, sadness, anger, or blame to me or to one another. I also recorded features of the ward and of individuals, including demographic and socioeconomic data on the nurses, patient, and family; information about the busyness and overall mood of the ward at the time of the incident; and whether there were any other deaths or urgent cases earlier in the shift, among others.

I used the table to analyze the cases, looking to identify patterns in the observed incidents and to develop and test theories about what might be driving the nurses' emotional expressions and emotion management. Many factors that I suspected might explain the variation proved not to matter. The nature of nurse-parent interactions were not a function of individual difference; some of the nurses whom I observed being unusually committed and compassionate one moment behaved with callousness or aggression in the next, while nurses whom I had seen harshly shame patients' families on one day were comforting on another. Moreover, nurses were no more likely to shout or publicly scold parents who were of a particular ethnic, religious, or socioeconomic status, either in absolute terms or relative to their own. The age of the patient also did not matter, nor did the overall mood of the ward that day, the nurse-patient ratio, or other measures of the busyness of the ward.

One thing the data did seem to suggest was the importance of space. As discussed earlier, existing scholarship has shown that workers often wait to express or otherwise process negative emotions in private, backstage areas or at home or otherwise off stage. In analyzing my field notes, I realized that nurses in Capital and Provincial Hospitals largely lack this option, and I began to suspect that space may be shaping nurse-parent interactions and influencing how nurses expressed and managed emotions during emergencies. To test this emerging theory, I moved down a level of analysis and divided each of the 29 incidents into composite actions and interactions. This allowed for greater variation in the availability of backstage areas, including the type and composition of the audience for each interaction. I defined each action or interaction in terms of the individuals involved. A single interaction lasted as long as a dyad or group was interacting without interruption, and a new interaction started when the group broke or interacted

with someone new. I also included actions involving a single nurse, such as a nurse preparing an injection or checking a patient’s chart, but I excluded actions and interactions that did not involve at least one nurse, such as an interaction between two mothers on the ward.

In the end, I had a set of 161 actions or interactions involving nurses across 29 incidents. I coded each of these for the availability of backstage, which was overall very low but varied across interactions, from those that are actively observed by a crowd of parents or other bystanders to semi-private conversations between nurses or with me. In total, I coded 71 interactions as having little or no backstage space, 19 as having a high availability of backstage space (relative to the overall low availability in this context), and 65 as being in between. In five of 161 interactions, I had insufficient information to code the backstage availability. One example of an incident broken down into interactions and coded for the availability of backstage space is included in Table 3.

INSERT TABLE 3 ABOUT HERE

I then coded the emotions expressed, if any, in each interaction, and whether the nurses shouted or were otherwise aggressive toward patients. I used truth tables (Becker 1998) to systematically count the occurrence of different configurations of space and emotional expression, and then created a series of graphs to help visualize the rhythm of interactions. These showed that the availability and use of backstage space ebbed and flowed both within and across incidents, and that nurses sometimes seemed to use this space to “cool their hearts” (a local expression) during emergency incidents. I describe these findings in detail in the next section.

EXPRESSION AND MANAGEMENT OF EMOTION IN URGENT SITUATIONS

Anger and Frustration with Patients’ Parents

Although largely absent from the literature on nurses and other healthcare workers, negative emotions, including anger, are certainly part of these workers’ lived experience (Meerabeau and Page 1998; Theodosius 2008). In Capital and Provincial Hospitals, I heard nurses privately express anger or blame towards parents in nine of 29 urgent incidents. On sixteen occasions across ten incidents, five of them fatal, I saw nurses shout at or publicly scold parents. As shown in Table 4, scolding was twice as likely to occur than any effort to comfort or

reassure parents. In one case, a nurse used physical violence and public humiliation to berate a mother who failed to call the doctor when her baby started convulsing.

INSERT TABLE 4 ABOUT HERE

There are many reasons the nurses might be angry or frustrated at work, including challenging working conditions, low pay, and limited control over their postings. The nurses' anger and frustration specifically toward *parents* can be understood, in part, by the fact that parents in this setting often do share the blame for the severity of their child's illness. In one extreme case, I saw one baby die after developing sepsis from being left too long in a dirty diaper. More generally, hospital statistics and interviews with health workers suggest that parents frequently wait too long to bring their children to the hospital, and arrive too late to be saved.⁶ This is consistent with findings from around the world that poor families often wait to seek care for sick children, or seek care first from a pharmacy, drug peddler, or another source, turning to a public facility only when that treatment fails (Mota et al. 2009; Nyamongo 2002; Ryan 1998; Scott et al. 2013; Spry 2012). Staff at Capital and Provincial Hospitals express frustration about these delays, saying that parents "sit down and wait" and then arrive expecting a miracle, sometimes even lying about how long their children have been sick.

Another understandable source of frustration is parents who leave the hospital prematurely. The word used to describe this behavior, both colloquially and in official hospital records – "absconding" – even sounds accusatory.⁷ Nurses' accounts of absconded patients are often framed as a battle of wits between the authorities (nurses and doctors) and unruly inmates (the patients' families). Absconding infuriates health workers because they work hard to save a child, only to have them deteriorate again when their parents bring them home too soon. Not only is this a "work loss" (Glaser and Strauss 1964), but it also means parents may return, demand that health workers save the same child yet again, and blame them if they cannot. As one nurse told me, "You're treating a patient, they start to get better, and then they leave. And when the child gets worse and comes back and passes off (dies)" they blame the hospital.

Sometimes, nurses' anger toward parents may serve to displace or cope with other uncomfortable and potentially threatening emotions, such as grief, guilt, anxiety, or shame (Katz 1999; Meerabeau and Page 1998). Nurses often experience the death of a patient as a threat to

their own skill and competence; as one highly skilled nurse manager said, “[When a patient dies, it suggests that] maybe you don’t know anything.” Patients who come too late to save can make the nurses’ work seem futile; as one nurse said, “late arrival . . . makes you feel bad, because your efforts go in vain.” Nurses also feel that some parents blame them for failing to save their children, and although these accusations confer no legal or professional sanctions, they do carry an emotional and social weight and can exacerbate negative stereotypes of nurses as incompetent, corrupt, or cruel. Blaming parents, in turn, can help deflect blame from the nurses themselves, and shield them from some of the taint and stigma conferred by their association with death (Ashforth and Kreiner 1999).

An Elusive Backstage

Thus, there are many possible reasons for the nurses’ anger and frustration. But why do they so often express these emotions publicly and during urgent, life-or-death situations? To understand, I turn to characteristics of the hospital wards as *places* with meaning as well as material form (Gieryn 2000) and which both structure and are structured by human interaction (Bourdieu 1989; Lefebvre 1991). Specifically, I focus on two characteristics of the Capital and Provincial Hospital wards: the absence of backstage areas, and the weakness of control.

Nurses in Capital and Provincial Hospitals lack the backstage space that workers often use to express or otherwise process negative emotions. As described earlier, the wards are extremely open and public spaces, often crowded, and with virtually no privacy for staff or patients. Nearly all the nurses’ actions and interactions take place in full public view, including behaviors that would elsewhere occur behind closed doors (Heimer and Staffen 1995; Sudnow 1967). This likely exacerbates nurses’ negative emotions. Studies have shown that a lack of control over one’s privacy can be a workplace stressor (Sutton and Rafaeli 1987), while specifically having a patient’s family witness resuscitation attempts can increase the stress of health workers and surface strong emotions (Rattrie 2000).

Privacy is especially lacking during emergencies. Every urgent incident and patient death that I observed occurred before an audience of multiple nurses, sometimes doctors, and other patients and their families. In the absence of electronic monitoring equipment, a child’s decline is nearly always announced by a terrified mother’s wrenching cries, or her collapsing to the floor in fear and shock. Everyone knows what those cries herald, and other parents and visitors turn to watch or gather nearby. The nurses have no way to conceal what transpires: beds lack curtains

and also often hold multiple patients lying side by side. In the IVR at Provincial Hospital – the location of the sickest children and thus of most emergency cases – beds are crammed together, as shown in Figure 1, with barely enough space to move between them. Fatal outcomes, in particular, are very public (Manning 2008).

Because of this, the Capital and Provincial nurses have few spaces at work to express their emotions privately, or to engage in the kind of collective coping that has proven valuable for workers in other settings. In addition, the nurses are constrained by professional norms from using “offstage” areas – their homes, churches, or other places outside the hospital – for this purpose. When asked how they managed anger or frustration (“vexation” in the local language), several said they would step away from the ward, leave the hospital, or stay home in order to “cool their heart.” However, when I asked whether they sought support from friends, family members, or members of their church or mosque, the nurses looked at me quizzically. One admitted she sometimes spoke with her sisters and asked them to help her pray for specific cases, and a few said they spoke to God, but most asserted emphatically that would never discuss their patients with anyone outside the hospital, citing training on medical ethics. Even when I probed further, saying that surely they could talk about their own feelings without revealing patients’ names or other details, they did not budge.

Despite this extremely low level of backstage overall, I found that nurses did occasionally try to create a small measure of protected space, even during urgent situations. For instance, I once saw a nurse, after realizing that a newly-arrived patient was already dead, shoo away a large group of mothers who had gathered to watch the dramatic events unfold. Another nurse chased out onlookers who had crowded into the tiny IVR upon the arrival of a newborn; the baby passed away a few moments later. Once, a large group of nurses crowded around the front exam table in the step-down unit, on which a doctor was trying to resuscitate a toddler. This crowding created a modicum of backstage, but one that was both short-lived and incomplete, as the mother of that child and two other parent-child pairs were sharing the table and thus inside the nurses’ barrier.

These efforts to seek or create backstage areas, though both partial and rare, did sometimes seem to provide nurses with a chance to process their own difficult emotions, and to avoid open expressions of anger toward parents. One time, when I was having a relatively private informal interview with a nurse on the step-down ward, a child on the adjacent emergency room died and her mother collapsed, wailing. Unprompted, the nurse began to speak

to me, quietly but with obvious emotion, about how those deaths made her feel. “It’s not easy. When I first came, I cried every day,” she said, using the unusually private moment to process her own grief. A few times, including the incident in Table 3, nurses on the step-down unit crossed to the adjacent emergency room in the midst of dealing with an urgent situation, thereby entering a kind of backstage away from their own patients, even as they remained front stage on the other ward. Once there, they chatted and laughed with their colleagues, perhaps as a way to defuse their negative emotions.

In another case, described in detail below, a doctor and several nurses furiously and very publicly blamed a mother for contributing to her child’s condition, but then withdrew to the nurse’s station, creating a partial backstage far from the mothers on the other side of the ward. With this time and space, the staff members gained control of their anger and, in the local parlance, “cooled their hearts.” When the child later died, they showed no reaction

The staff were focused on a baby girl with an extremely distended stomach and what looked like a nasty diaper rash. According to one nurse, Maribel, the baby had sepsis from being left in dirty diapers for too long. While another nurse, Jeneba, worked to pass a nasogastric tube on the semi-conscious child, the doctor and nurses loudly scolded the girl’s mother for not showing the rash to the doctor sooner.⁸ The mother said she did show the doctor, and blamed him for doing nothing. Maribel and the mother argued about whether the child could have urinated recently. When the mother insisted she had, Maribel replied angrily, “That’s a lie.”

The doctor and nurses, clearly furious at the mother, retreated to the nurse’s station. The baby’s mother sat on the bed near her child, while other mothers gathered a few feet away, gossiping in hushed voices. It seemed battle lines had been drawn, and the tension was palpable.

The doctor asked Jeneba to check the septic child’s vital signs. “Just a minute, let me hang this blood (for another child) first,” she said. More than ten minutes later, she still had not checked the vital signs, and the doctor had left for the emergency ward without following up. Suddenly, a wail erupted. The mother collapsed to the floor, and the doctor returned to confirm what her scream had already told us. The baby girl was dead.

None of the health workers betrayed any reaction, nor did the other mothers on the ward. The doctor quickly returned to the emergency ward, and Jeneba returned to the nurse's station and set up her phone to charge, chatting pleasantly with another nurse as if nothing has happened. Meanwhile, the mother fled the ward and her distraught wailing could be heard from the hall outside.

These examples of backstage processing are rare exceptions to the overall trend. In the vast majority of cases, the spatial characteristics and dynamics of the situation left nurses with little choice but to manage their emotions publicly.

Weak Organizational Control

In addition to their lack of backstage or offstage space for collective coping, these wards are also characterized by extremely low levels of organizational control. In contrast to prior literature that links surveillance to control of workers (Foucault 1977; McKinlay and Starkey 1998; Salzinger 2003), what I find at Capital and Provincial Hospitals is visibility without control. The structure and crowding (Tuan 1977) of these three hospital wards means that nurses are constantly observed by their colleagues and by patients and their families, and yet this visibility does not constrain behavior because the accompanying organizational control strategies are absent or nonfunctioning.

Although organized as hierarchical bureaucracies, with rigid tiers of nurses designated by differences in uniforms and insignia, the system lacks the ability to punish noncompliance or reward compliance with organizational rules (Barker 1993). Supervisors are few in number and frequently absent from the hospital wards; they are bound by an inflexible and largely dysfunctional civil service, and thus lack the power to suspend, fire, or otherwise punish workers; and the country's weak institutional environment means that there are very few legal or occupational restrictions on workers' behavior. As a result, even nurses with long stretches of absenteeism or repeated failure to meet basic job requirements usually face no repercussions. Only in very rare cases do supervisors submit negative reports about individual workers to the bureaucracy overseeing the health workforce, and even then it will often take months or years for consequences – such as suspended pay for workers who repeatedly fail to show up for work, or who refuse a posting to a new facility – to be effected. High performers can only be promoted if they return to school and retrain at a higher level, thereby robbing supervisors of an important device of bureaucratic control: an internal labor market (Simpson 1985).

Also largely absent are non-bureaucratic forms of control. Nurses do not actively police themselves or one another, as workers often do in other settings (Barker 1993; Simpson 1985). Parents are disempowered by their poverty, lack of education, limited alternatives, and a weak institutional environment, and thus do not speak up against the nurses' behavior or express their dissatisfaction by choosing another health facility. Absent these constraints, nurses have largely free rein to interact with parents in whatever way they choose.

In my experience, counterfactual cases in which the nurses are subject to any noticeable organizational control were extremely rare. I can find only three such cases during any of the urgent incidents. In one, a nurse trainer from the local university was on the ward to check in with her trainee nurses; in the other two, a British doctor volunteering at Provincial Hospital was present and involved in the incident.⁹ (The hospitals' matrons and nurse managers were not present for any of the 29 urgent incidents.) Neither the nurse trainer nor the foreign doctors had any formal authority over the nurses on staff, but they did likely hold some informal authority, and exercised normative control. Indeed, the nurses did not shout or express open frustration toward parents in the presence of these informal authorities; in one case, a nurse privately blamed the mother for her child's death, but did not express this publicly or to the mother.

It is also worth noting that my presence, as a white foreigner, may have served as a form of informal normative control. One study in Sierra Leone found that the mere presence of a white foreigner significantly increased the pro-social contributions made by players in "dictator" behavioral games (Cilliers, Dube, and Siddiqi 2013). During my field work, I went to great pains to reduce this risk, by making it clear that I was not there to police the nurses but rather to understand the challenges they faced and why they did what they did, and by emphasizing my local language fluency and long years living in the country, which gave me a measure of insider status. However, to the extent that my presence did suppress counter-normative behaviors – including shouting at patients – it follows that the evidence presented in this paper is actually conservative, and these behaviors are more common than I observed them to be.

Prior studies from other organizational settings reinforce the role of organizational control in preventing expressions of anger and frustration, and enforcing what one theory calls the "dual thresholds" of expression and impropriety (Geddes and Callister 2007). For instance, debt collectors were expected to maintain a neutral and calm tone when speaking with angry debtors, and managers used various mechanisms of control – none of them available to the

managers at Capital and Provincial Hospitals – to ensure adherence (Sutton 1991). They selected new collectors with this norm in mind, and closely monitored collectors' conversations with debtors, rewarding and punishing them accordingly. Collectors who lost their tempers were reprimanded or even fired (Sutton 1991). Incidents of collectors shouting at debtors did still occur, but thanks to these control mechanisms, were relatively rare.

Thus, the behavior of nurses in Capital and Provincial Hospitals is not qualitatively different from what we see in other organizational settings. Rather, it is a matter of degree: the extreme lack of both control and privacy in this setting means that open expressions of negative emotion that are elsewhere very rare, are on these wards very common.

Public Blaming and Shaming: Angry Interactions with Patients' Parents

Faced with a lack of backstage space and with very low levels of organizational control, nurses in Capital and Provincial Hospital frequently express negative emotions openly and publicly during interactions with parents. As mentioned earlier and in Table 4, I saw nurses shout at or publicly scold parents in ten incidents, five of them fatal. One nurse used physical violence and public humiliation to berate a mother who failed to call the doctor when her baby started convulsing. As I wrote in a field memo:

I looked over to find the nurse slapping a woman, likely the child's mother, on the back and arm. The woman was very young, her hair loose and frazzled [a sign of extreme distress] and she wore the standard attire of the city's poor: a second-hand shirt, cotton sarong, and plastic flip-flops. Clearly confused and ashamed, she kept looking around the ward to see who was watching. Indeed, she was in full view of two wards' worth of doctors and nurses, several dozen mothers or caregivers, and her own child – all witnesses to her shame.

Shouting and gesturing rapidly, the nurse made the woman use her tank top to clean the exam table and her child. The nurse then wiped her own hands on the tank top, which the woman was still wearing. Only after this striking public humiliation did the nurse explain to the mother what she meant by a convulsion; I could see her pantomime tight fists and vibrating arms. Before that, the mother likely had no idea what the nurse was talking about, let alone how serious a symptom this was.

Though extreme in its use of physical violence, this case otherwise mirrored other incidents of public scolding.

It is important to note that this behavior is arguably less shocking in this country than they would be in other cultural contexts. People in this country, as in much of the region, frequently express emotions vocally and forthrightly, sometimes shifting abruptly from calm, polite conversation to an outright shouting match, and then returning to amiable interaction. A level of verbal conflict that might elsewhere damage the parties' relationship is here often temporary, and later brushed off with surprising ease. In the local creole language, to allow this flash of negative emotions is to "blow" or "blast", and many people find it helpful and appropriate to "blow" for a moment when they are angry or frustrated, so they can then move on.

That said, neither patients nor the nurses themselves consider these behaviors appropriate. In the terms of one theory governing the expression of anger in the workplace, both their peers and their clients see nurses as having crossed the "threshold of impropriety" when they shout at parents (Geddes and Callister 2007). Members of the public in this country frequently complain of rudeness or harsh treatment by health workers, and the nurses emphatically denounce such behavior, to one another as well as to me. In formal interviews, informal conversations, and in their interactions with one another, nurses endorsed clear and consistent expectations for what emotions nurses should express (or not) around patients' families, and for how they should help manage the emotions of others. These feeling rules dictated, first, that nurses suppress any grief they may feel at the death of a patient and instead display stoicism and a neutral affect. As one explained, "I don't want them to see me cry... It would make them cry more. I need to encourage them." Nurses considered it a core professional skill to be able to cultivate empathy for patients and their families, and to reassure them when they are stressed or upset. One supervising nurse equated this with "love of the job," and said that, "you must have that love to help people, particularly when they're in distress, when they're in pain." The expectation that nurses reassure patients is also evident in the language used in the nightly report book on Capital Hospital's step down ward. Nurses use these books at night to document any deaths, emergency incidents, or significant changes in patients' conditions. During one period, every single entry ended with the phrase, "Nursing care duly rendered and relatives reassured," a clear signal of what they understand to be the organization's feeling rules.

Consistent with these expectations, the vast majority of nurses specifically and emphatically asserted that nurses should not shout, argue, or express anger with patients or family members and should instead “reassure” and “encourage” them. During training, the nurses explained, they are taught to be polite and patient with patients and their families. As one senior nurse at Provincial Hospital put it, “You have to comport yourself... Because if [a patient or family member] confronts you, and you get in an argument with him, the job won’t go on well.” A more recently trained nurse chimed in to agree, “It’s not ethical.” Another day, I asked a supervising nurse if it was ever acceptable for nurses to speak harshly to patients’ families – for instance, when families failed to obey nurses’ instructions. “It is *not* necessary and it is *not* appropriate,” she asserted emphatically and without exception. Other nurses independently agreed. “If you holler, it means you don’t know your job,” said one, and another said that one of her least favorite parts of the job was when her colleagues shouted at patients. Nurses not only denounce shouting when speaking with me, but also in conversations among themselves. For instance, two nurses were left on the step-down ward one night, awaiting the night shift’s arrival. They gossiped, within my earshot, about their colleagues, and one recounted with disapproval a nurse who yelled at a woman whose child had died. She must have never lost a close family member, the two nurses surmised, shaking their heads, or she would have shown more empathy.

Thus, the behaviors that I observe – in which nurses are twice as likely to shout at patients as they are to comfort or reassure them – directly contravene the norms that nurses themselves articulate. When asked to give accounts of these behaviors by their colleagues, nurses generally attribute it to individual differences: that some nurses have a “warm heart,” meaning a quick temper, or lack the experience that would allow them to empathize with patients. In very rare cases, nurses sought to explain their own or others’ harsh interactions in terms of the patients’ best interests. For instance, one highly skilled and dedicated nurse manager at Capital Hospital told me that shouting at mothers was sometimes necessary to prevent dangerous behaviors. After she told me that she sometimes grew angry at parents who left the hospital against medical advice, I asked what she did when she felt that way. She recounted a case in which the mother left and later returned to the hospital, her child much sicker than when she left, and the nurse shouted at her, telling her she had been “careless with [her] child.”

Q: So after you yell [vex] at a patient like that, do you feel better?

A: *I feel better, because I'm just trying to make her understand... So the next time, when they put her child on treatment, she'll say, 'Oh, let me take [the pills]... When I [didn't], the nurse got angry at me.' She'll have it in the back of her mind. If she wants to be careless, when she remembers 'that nurse got angry at me,' that will motivate her.*

Thus, from this nurse's perspective, shouting at a parent can serve an educative purpose, and hopefully protect the child in the future. The target of this education sometimes includes other parents on the ward, rather than or in addition to the parents of the affected child. As one nurse told me, "Some of [the parents], I tell them, 'If this child dies, you're responsible. It's your carelessness that made the child die'... Then I can call the other patients and say, this one is an example to you, that when you have your child at home, the moment when your child [starts behaving differently or complaining of pain]... you come with him" to the hospital. One night I saw this kind of group warning in action:

Suddenly, a woman rushed to the nurse's station with a toddler in her arms. A crowd formed: staff, visitors, and the mothers of other patients. Before I knew what was happening, one nurse was holding the girl upside down by her ankles and slapping her on her back. "Was she feeding her?" someone asked, and I realized she must be choking. With each slap from the nurse's open palm, the toddler's body whiplashed, her head snapping through the air.

Meanwhile, another nurse began yelling at the assembled crowd. "This is why you should not hand feed your children," she shouted, "and why you should holler if they begin to choke!" Gesturing wildly, she recounted another case, when a grandmother refused to follow the nurse's advice on how to feed her grandchild, and as a result, the child died. That death was the grandmother's fault, the nurse said, just as this young girl's mother was to blame for the fact that her daughter's life was slipping away. Listening silently, the crowd gazed from the angry nurse to the child, still hanging upside down from the first nurse's right hand. A moment later, the nurses declared the child dead and laid her on a table.

I never saw the child's mother, though she was almost certainly nearby, but the nurse's angry speech had made her cautionary tale for the other mothers on the ward.

Unfortunately, by shouting at parents, nurses likely contribute to the very behaviors by parents that frustrate them and put their patients at risk. A growing body of evidence from this and other countries around the world shows that disrespect and abuse by health workers deters women from seeking needed healthcare (Hill 2010:25; Jewkes, Abrahams, and Mvo 1998; Moyer et al. 2013), leading them to arrive only after long delays, when they or their children are often too sick to save.

DISCUSSION

This study provides an important extension of our understanding of how workers manage negative emotions. By using an extreme case with very different conditions than those present in most prior studies of emotional labor – specifically, a setting with extremely limited backstage space and very low levels of organizational control – I build a model for how space and control both shape the ways in which workers express and manage difficult emotions. This model, shown in Figure 2, illustrates that workers who experience anger and frustration in settings with readily available backstage areas are generally able to process their emotions collectively or to otherwise cool down. When there is a low level of backstage but high levels of organizational control, workers are likely either to engage in front stage emotional labor, thereby suppressing their anger, or to use passive aggression or other behaviors less likely to attract organizational sanction. In cases where there is both low backstage space and low organizational control, as I observe in Capital and Provincial Hospitals, workers will likely abandon emotional labor and openly express their anger and frustration. They will then develop accounts and disclaimers to help explain and make sense of this norm-violating behavior.

Although these conditions are relatively rare in prior studies of emotional labor, they are quite common around the world. Even in the United States or Western Europe, there are organizational settings in which these conditions will hold to a greater or lesser degree. As a result, this study provides important contributions to our understanding of how workers in a wide range of organizations manage negative emotions. Sociologists have shown that emotions are not just an internal “feeling,” but something constructed in interaction (Katz 1999). The resulting expressions of emotion are influenced by broader collective representations – feeling rules – that dictate what individuals should feel and should express in a given situation (Hochschild 1979) but these are filtered through specific situational factors, including what Eliasoph and Lichterman have called “group style” (2010). I extend this theory by exploring the influence of

space and place. Just as the drivers in Katz's study of anger (1999) are affected by the spatial configurations of their own cars in relation to others on the road, the nurses in Capital and Provincial hospitals are pushed by the absence of privacy, and enabled by the absence of control, to express negative emotions publicly that they might otherwise have processed behind the scenes.

This study also offers important insights for the literature on the influence of space and place on social life (Bazerman and Gino 2012; Hurdley 2010; Lebaron and Urgen 1997; Zhao 1998). The importance of backstage areas for workers trying to gain control of negative and disruptive emotions adds to a growing literature on the sometimes surprising benefits of safe and private settings within organizations (Bernstein 2012; Kellogg 2009).

Future Research

This article answers a call for “contextually rich, ‘real time’ emotion studies of organizational life” (Fineman 2000:14) and provides an important, if troubling, counterpoint to recent scholarship on compassion in organizations (Rynes et al. 2012). Future research should explore further the ways that workers manage negative, potentially disruptive emotions and emotional expressions that violate organizational feeling rules. This will lend greater insight into how workers experience and resolve emotional dissonance.

Field experiments to test changes in the spatial arrangements and other aspects of place would not only facilitate greater understanding of mechanisms but also lend insight for managers and policy makers. Future research could also disentangle the factors identified by this study, and further elaborate on the counterfactual cases suggested in Figure 2. Workers who lack private, back stage areas but do face strong organizational controls on behavior, for instance, might be more likely to express or process difficult emotions at home (Boyle 2005), or to cope with suppressed emotions with alcohol, drugs, or sex. Organizations that lack control but provide physical or temporal space, on the other hand, may find greater individual and group variation in where and how workers manage emotions.

Finally, future research should explore how these dynamics might vary for different professions and organizational settings. The experience of nurses treating critically ill children is a particularly heightened case of emotion management; these are prototypical emotion managers, and they are dealing with some of the most emotionally fraught situations experienced in organizational life. It remains to be seen how these findings would differ for professions that are

not usually identified with emotion management, but nonetheless find themselves confronted with their own or others' difficult emotions; this might include journalists assigned to cover a tragic event, or bankers tasked with foreclosing on people's homes. Exploring how those professionals enact and manage their emotions, in interaction with sources or clients, would providing an important contrast to the experiences of nurses and others we expect to be master emotion managers.

APPENDIX 1: A Blue Bundle

Excerpt from a blog post from May 2008, describing an incident observed at Capital Hospital (Manning 2008).

A children's hospital.

Down the concrete ramp from Ward 2 (general inpatient) to the main entrance comes a group of six young men. Barely more than teenagers, they walk in a loose V formation like soldiers – in uniforms of t-shirts and jeans – to battle. They carry an air of solemn concentration, duty-bound, and the cloud of silence around them pushes back the din of the hospital to a dim distant hum.

One of the boyish men, a few steps in front of the others, carries in his arms a child-sized bundle wrapped in a blue blanket. He doesn't look at the bundle. His eyes are dry.

Behind this group come two women, also young. Their gaze is riveted on the men in front of them, oblivious to their surroundings. One of the women wails and clutches her breasts, grasping for the child who nursed there. Her face is haggard, and you know she has been crying for hours or days.

The procession passes through the doorway and into the glare of the courtyard. Past parents toting sick children. Past student nurses gathered in the shade. Past security guards and drivers and curious onlookers.

For the small group of mourners, however, all that is far away. The traffic of the hospital and of the street beyond belong to the world of the living. Theirs is the grim task of accompanying the dead.

A dented white pick-up truck waits for them just outside the entrance. The father climbs into the front seat with his precious bundle. The child is small enough to lay across his lap, even

with the bulky blanket. I find myself wondering how old she is – was – but shake my head and push the thought aside. Too young.

The rest of the men – brothers, cousins, comrades-in-arms – climb into the back of the truck. They reach down to the mother, to help her up behind them, but she is trembling with grief. Her leg buckles when she steps on the bumper. It is all too much.

As the truck drives away, I can still see the small blue bundle through the front window. I imagine where they are going, what comes next. A tiny casket. A simple gravestone. A memorial service. A lifetime of sorrow. “I had three children, and two are alive.”

REFERENCES

- Anteby, Michel. 2012. “Relaxing the Taboo on Telling Our Own Stories: Upholding Professional Distance.” *Organization Science* 1–29.
- Ashforth, Blake E., and Glen E. Kreiner. 1999. “‘How Can You Do It?’: Dirty Work and the Challenge of Constructing a Positive Identity.” *The Academy of Management Review* 24(3):413–34.
- Baldry, C. 1999. “Space - The Final Frontier.” *Sociology* 33(3):535–53.
- Barker, James R. 1993. “Tightening the Iron Cage : Concertive Control in Teams.” *Administrative Science Quarterly* 38(3):408–37.
- Bazerman, Max H., and Francesca Gino. 2012. “Behavioral Ethics: Toward a Deeper Understanding of Moral Judgment and Dishonesty.” *Annual Review of Law and Social Science* 8(617):1–44.
- Becker, Howard S. 1998. *Tricks of the Trade: How to Think About Your Research While You’re Doing It*. Chicago: The University of Chicago Press.
- Bernstein, Ethan S. 2012. “The Transparency Paradox : A Role for Privacy in Organizational Learning and Operational Control.” *Administrative Science Quarterly* 57(2):181–216.
- Bolton, Sharon C. 2000. “Who Cares? Offering Emotion Work as a ‘Gift’ in the Nursing Labour Process.” *Journal of advanced nursing* 32(3):580–86.
- Bolton, Sharon C. 2001. “Changing Faces: Nurses as Emotional Jugglers.” *Sociology of Health & Illness* 23(1):85–100.
- Bolton, Sharon C., and Carol Boyd. 2003. “Trolley Dolly or Skilled Emotion Manager? Moving on from Hochschild’s Managed Heart.” *Work, Employment & Society* 17(2):289–308.

- Bono, Joyce, and Meredith A. Vey. 2005. "Toward Understanding Emotional Management at Work: A Quantitative Review of Emotional Labor Research." Pp. 213–34 in *Emotions in Organizational Behavior*, edited by Charmine E. J. Hartel, Wilfred J. Zerbe, and Neal M. Ashkanasy. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.
- Bourdieu, Pierre. 1989. "Social Space and Symbolic Power." *Sociological Theory* 7(1):14–25.
- Boyle, Maree V. 2005. "'You Wait Until You Get Home': Emotional Regions, Emotional Process Work, and the Role of Onstage and Offstage Support." Pp. 45–65 in *Emotions in Organizational Behavior*, edited by Charmine Hartel, Neal M. Ashkanasy, and Wilfred Zerbe. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.
- Chanlat, Jean-Francois. 2006. "Space, Organisation and Management Thinking: A Socio-Historical Perspective." Pp. 17–43 in *Space, Organizations and Management Theory*, edited by Stewart R. Clegg and Martin Kornberger. Liber & Copenhagen Business School Press.
- Cilliers, Jacobus, Oeindrila Dube, and Bilal Siddiqi. 2013. *"White Man's Burden"? A Field Experiment on Generosity and Foreigner Presence*.
- Costello, John. 2006. "Dying Well: Nurses' Experiences of 'Good and Bad' Deaths in Hospital." *Issues and Innovations in Nursing Practice* 594–601.
- Eliasoph, Nina, and Paul Lichterman. 2010. "Culture in Interaction." *American Journal of Sociology* 108(4):735–94.
- Field, D. 1984. "'We Didn't Want Him to Die on His Own'--Nurses' Accounts of Nursing Dying Patients." *Journal of Advanced Nursing* 9(1):59–70.
- Fineman, Stephen. 2000. "Emotional Arenas Revisited." Pp. 1–24 in *Emotion in Organizations*, edited by Stephen Fineman. London: SAGE Publications.
- Foucault, Michel. 1977. *Discipline and Punish*. Random House of Canada.
- Freund, Peter E. S. 1998. "Social Performances and Their Discontents: The Biopsychosocial Aspects of Dramaturgical Stress." Pp. 268–94 in *Emotions in Social Life: Critical themes and contemporary issues*, edited by Gillian Bendelow and Simon J. Williams. London: Routledge.
- Geddes, Deanna, and Ronda Roberts Callister. 2007. "Crossing the Line(s): A Dual Threshold Model of Anger in Organizations." *Academy of Management Review* 32(3):721–46.
- Gieryn, Thomas F. 2000. "A Space for Place in Sociology." *Annual Review of Sociology* 26:463–96.
- Glaser, Barney G., and Anselm L. Strauss. 1964. "The Social Loss of Dying Patients." *American Journal of Nursing* 64(6):119–21.

- Goffman, Erving. 1959. *The Presentation of Self in Everyday Life*. New York: Random House.
- Good, Mary-jo Delvecchio, Esther Mwaikambo, Erastus Amayo, and James M. Imunya. 1999. "Clinical Realities and Moral Dilemmas: Contrasting Perspectives from Academic Medicine in Kenya, Tanzania, and America." *Daedalus* 128(4):167–96.
- Grant, Don, Alfonso Morales, and Jeffrey J. Sallaz. 2009. "Pathways to Meaning: A New Approach to Studying Emotions at Work." *American Journal of Sociology* 115(2):327–64.
- Heimer, Carol A., and Lisa R. Staffen. 1995. "Interdependence and Reintegrative Social Control: Labeling and Reforming 'Inappropriate' Parents in Neonatal Intensive Care Units." *American Sociological Review* 60:635–54.
- Hill, Kathleen. 2010. "Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth Report of a Landscape Analysis." *Public Health* 1–57.
- Hochschild, Arlie Russell. 1979. "Emotion Work, Feeling Rules, and Social Structure." *American Journal of Sociology* 85(3):551–75.
- Hochschild, Arlie Russell. 1983. *The Managed Heart: Commercialization of Human Feeling*. Berkeley and Los Angeles, CA: University of California Press.
- Hochschild, Arlie Russell. 1998. "The Sociology of Emotion as a Way of Seeing." Pp. 3–15 in *Emotions in Social Life: Critical themes and contemporary issues*, edited by Gillian Bendelow and Simon J. Williams. London: Routledge.
- Hurdley, Rachel. 2010. "The Power of Corridors: Connecting Doors, Mobilising Materials, Plotting Openness." *The Sociological Review* 58(1):45–64.
- Huynh, Truc, Marie Alderson, and Mary Thompson. 2008. "Emotional Labour Underlying Caring: An Evolutionary Concept Analysis." *Journal of advanced nursing* 64(2):195–208.
- Jewkes, R., N. Abrahams, and Z. Mvo. 1998. "Why Do Nurses Abuse Patients? Reflections from South African Obstetric Services." *Social science & medicine* (1982) 47(11):1781–95.
- Kahn, William a. 2003. "The Revelation of Organizational Trauma." *Journal of Applied Behavioral Science* 39(4):364–80.
- Katz, Jack. 1999. *How Emotions Work*. Chicago: University of Chicago Press.
- Kellogg, Katherine C. 2009. "Operating Room: Relational Spaces and Microinstitutional Change in Surgery." *American Journal of Sociology* 115(3):657–711.
- Korczynski, M. 2003. "Communities of Coping: Collective Emotional Labour in Service Work." *Organization* 10(1):55–79.

- Kornberger, M., and Stewart R. Clegg. 2004. "Bringing Space Back in: Organizing the Generative Building." *Organization Studies* 25(7):1095–1114.
- Lebaron, Curtis D., and J. Urgan. 1997. "Built Space and the Interactional Framing of Experience During a Murder Interrogation." *Human Studies* 20:1–25.
- Lefebvre, Henri. 1991. *The Production of Space*. Oxford: Blackwell Publishers.
- Lewin, Simon, and Scott Reeves. 2011. "Enacting 'team' and 'teamwork': Using Goffman's Theory of Impression Management to Illuminate Interprofessional Practice on Hospital Wards." *Social Science & Medicine* 72(10):1595–1602.
- Lewis, Patricia. 2005. "Suppression or Expression: An Exploration of Emotion Management in a Special Care Baby Unit." *Work, Employment & Society* 19(3):565–81.
- Lewis, Patricia. 2008. "Emotion Work and Emotion Space: Using a Spatial Perspective to Explore the Challenging of Masculine Emotion Management Practices." *British Journal of Management* 19(s1):S130–S140.
- Lopez, Steven H. 2006. "Emotional Labor and Organized Emotional Care: Conceptualizing Nursing Home Care Work." *Work and Occupations* 33(2):133–60.
- Maben, Jill, Sue Latter, and Jill Macleod Clark. 2006. "The Theory-Practice Gap: Impact of Professional-Bureaucratic Work Conflict on Newly-Qualified Nurses." *Journal of advanced nursing* 55(4):465–77.
- Mann, Sandi. 2005. "A Health-Care Model of Emotional Labour: An Evaluation of the Literature and Development of a Model." *Journal of Health Organization and Management* 19(4/5):304.
- Manning, Ryann. 2008. "A Blue Bundle." *Dispatches from Sierra Leone*, May 16.
- Margolis, Joshua D., George Benson, Cecily Cooper, and John Galvin. 2008. "Navigating the Bind of Necessary Evils: Psychological Engagement and the Production of Interpersonally Sensitive Behavior." *Academy of Management Journal* 51(5):847–72.
- Markus, Thomas A. 2006. "Built Space and Power." Pp. 129–42 in *Space, Organizations and Management Theory*, edited by Stewart Clegg and Martin Kornberger. Liber & Copenhagen Business School Press.
- Martin, Susan Erlich. 1999. "Police Force or Police Service? Gender and Emotional Labor." *Annals of the American Academy of Political and Social Science* 561:111–26.
- McCance, A. Silke., Christopher D. Nye, Lu Wang, Kisha S. Jones, and Chi-yue Chiu. 2013. "Alleviating the Burden of Emotional Labor: The Role of Social Sharing." *Journal of Management* 39(2):392–415.

- McKinlay, Alan, and Ken Starkey. 1998. "Managing Foucault: Foucault, Management and Organization Theory." Pp. 1–12 in *Foucault, Management and Organization Theory: From Panopticon to Technologies of Self*, edited by Alan McKinlay and Ken Starkey. London: SAGE Publications.
- Meerabeau, Liz, and Susie Page. 1998. "'Getting the Job Done': Emotion Management and Cardiopulmonary Resuscitation in Nursing." Pp. 295–312 in *Emotions in Social Life: Critical themes and contemporary issues*, edited by Gillian Bendelow and Simon J. Williams. London: Routledge.
- Menzies, I. E. P. 1960. "A Case-Study in the Functioning of Social Systems as a Defence against Anxiety: A Report on a Study of the Nursing Service of a General Hospital." *Human Relations* 13(2):95–121.
- Mota, Ruben E. Mujica, Antonieta Medina Lara, Esthery D. Kunkwenzu, and David G. Lalloo. 2009. "Health Seeking Behavior after Fever Onset in a Malaria-Endemic Area of Malawi." *The American journal of tropical medicine and hygiene* 81(6):935–43.
- Moyer, Cheryl A., Philip B. Adongo, Raymond A. Aborigo, Abraham Hodgson, and Cyril M. Engmann. 2013. "'They Treat You Like You Are Not A Human Being': Maltreatment During Labor and Delivery in Rural Northern Ghana."
- Muetzelfeldt, Michael. 2006. "Organizational Space, Place and Civility." Pp. 113–28 in *Space, Organizations and Management Theory*, edited by Stewart Clegg and Martin Kornberger. Liber & Copenhagen Business School Press.
- Nyamongo, I. K. 2002. "Health Care Switching Behaviour of Malaria Patients in a Kenyan Rural Community." *Social science & medicine (1982)* 54(3):377–86.
- Oliver, Debra Parker, Davina Porock, and David B. Oliver. 2006. "Managing the Secrets of Dying Backstage: The Voices of Nursing Home Staff." *OMEGA: The Journal of Death and Dying* 53(3):193–207.
- Pierce, Jennifer L. 1995. *Gender Trials: Emotional Lives in Contemporary Law Firms*. University of California Press.
- Rattrie, Elizabeth. 2000. "Witnessed Resuscitation : Good Practice or Not ?" 14.
- Ross, D. a. R. 2007. "Backstage with the Knowledge Boys and Girls: Goffman and Distributed Agency in an Organic Online Community." *Organization Studies* 28(3):307–25.
- Rubin, Robert S., Vicki M. Staebler Tardino, Catherine S. Daus, and David C. Munz. 2005. "A Reconceptualization of the Emotional Labor Construct: On the Development of an Integrated Theory of Perceived Emotional Dissonance and Emotional Labor." Pp. 189–212 in *Emotions in Organizational Behavior*, edited by Charminie E. J. Hartel, Wilfred J. Zerbe, and Neil M. Ashkanasy. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

- Ryan, G. W. 1998. "What Do Sequential Behavioral Patterns Suggest about the Medical Decision-Making Process?: Modeling Home Case Management of Acute Illnesses in a Rural Cameroonian Village." *Social science & medicine* (1982) 46(2):209–25.
- Rynes, Sara L., Jean M. Bartunek, Jane E. Dutton, and Joshua D. Margolis. 2012. "Care and Compassion through an Organizational Lens: Opening UP New Possibilities." *Academy of Management Review* 37(4):503–23.
- Salzinger, Leslie. 2003. *Genders in Production: Making Workers in Mexico's Global Factories*. Berkeley and Los Angeles, CA: University of California Press.
- Scott, Kerry, Shannon McMahon, Fatu Yumkella, Theresa Diaz, and Asha George. 2013. "Navigating Multiple Options and Social Relationships in Plural Health Systems: A Qualitative Study Exploring Healthcare Seeking for Sick Children in Sierra Leone." *Health policy and planning*.
- Sewell, Graham, and James R. Barker. 2006. "Coercion versus Care: Using Irony to Make Sense of Organizational Surveillance." *The Academy of Management Review* 31(4):934–61.
- Simpson, Richard L. 1985. "Social Control of Occupations and Work." *Annual Review of Sociology* 11:416–36.
- Sorensen, Roslyn, and Rick Iedema. 2009. "Emotional Labour: Clinicians' Attitudes to Death and Dying." *Journal of Health Organisation and Management* 23(1):5–22.
- Spry, Emily. 2012. "Treatment-Seeking Behaviour of Caregivers of Children under 5 Years Old with Fever in Freetown: A Cross-Sectional Survey."
- Stayt, Louise Caroline. 2009. "Death, Empathy and Self Preservation: The Emotional Labour of Caring for Families of the Critically Ill in Adult Intensive Care." *Journal of clinical nursing* 18(9):1267–75.
- Steinberg, Ronnie J., and Deborah M. Figart. 1999. "Emotional Labor Since The Managed Heart." *Annals of the American Academy of Political and Social Science* 561:8–26.
- Stenross, Barbara, and Sherryl Kleinman. 1989. "The Highs and Lows of Emotional Labor: Detectives' Encounters with Criminals and Victims." *Journal of Contemporary Ethnography* 17(4):435–52.
- Sudnow, David. 1967. *Passing On: The Social Organization of Dying*. Englewood Cliffs, NJ: Prentice-Hall, Inc.
- Sutton, R. I., and A. Rafaeli. 1987. "Characteristics of Work Stations as Potential Occupational Stressors." *Academy of Management Journal* 30(2):260–76.

- Sutton, Robert I. 1991. "Maintaining Norms about Expressed Emotions: The Case of Bill Collectors." *Administrative Science Quarterly* 36:245–68.
- Tanner, J., and S. Timmons. 2000. "Backstage in the Theatre." *Journal of advanced nursing* 32(4):975–80.
- Theodosius, Catherine. 2008. *Emotional Labour in Health Care: The Unmanaged Heart of Nursing*. Oxon, UK: Routledge.
- Tuan, Yi-Fu. 1977. *Space and Place: The Perspective of Experience*. Minneapolis: University of Minnesota Press.
- Wharton, Amy S. 1999. "The Psychosocial Consequences of Emotional Labor." *Annals of the American Academy of Political and Social Science* 561:158–76.
- Zhao, Dingxin. 1998. "Ecologies of Social Movements Student Mobilization during the 1989 Prodemocracy Movement in Beijing." *American Journal of Sociology* 103(6):1493–1529.

TABLES AND FIGURES

Table 1: Research Sites¹			
	General Medical Ward (Capital Hospital)	Step-Down Ward (Capital Hospital)	Pediatric Inpatient Ward (Provincial Hospital)
Beds and patient load	35 beds. Sometimes 2 children / bed.	~ 8 beds. Often 2-3 children / bed.	~ 36 beds in general wards, some 2 children / bed. ~ 6 beds in IVR, usually 2-3 children / bed.
Severity of patient illness	Patients should be relatively stable, but may deteriorate without being transferred.	Patients sicker than in the general ward, but less than in the adjacent ER or ICU.	Patients divided: more stable in 3 general wards, critical cases in the “IV room” (IVR), a low-tech ICU.
Patient-nurse ratio²	Average 7.4 patients / nurses (Range 4.1-9.2)	Average 4.1 patients / nurses (Range 1.9-8.0)	Average 7.2 patients / nurses (Range 1.3-10.0)
<i>Notes:</i>			
¹ The three sites are not meant to be comparative cases, but to test for similar findings across different settings.			
² The patient-nurse ratios were calculated each day based on my notes on the numbers of patients and nurses actually present on the ward for a given shift. I varied whether this was the afternoon or morning shift.			

Table 2: Data and Methods	
Overall	Two phases of research in 2012 Data on ~150 nurses, reflecting diversity of nurses in both hospitals. Professional diversity: State Registered Nurses (SRNs), State Enrolled Community Health Nurses (SECHNs), Untrained nursing aides, and Trainee nurses Demographic diversity: Mostly female but also a handful of male nurses; wide range of ages, ethnicities, birthplaces, and nursing schools
Interviews	23 semi-structured interviews with 29 nurses or trainee nurses Dozens of informal, conversational interviews
Observations	164 hours of direct, first-hand observation; ~ 4-6 hours of ward observations per day & ~ 5 days per week in June-July 2012 Additional observations in January 2012 Observed nurse behavior and interactions with one another and with patients, parents, visitors Narratives and discourse: how the nurses spoke about their jobs, patients and families, and workplaces
Archival	Photos, artifacts, hospital data Used primarily to inform analysis of the interview and observational data
Historical	Minutes, reports, personal and public writings from 2008-2011 Used primarily to inform analysis of the interview and observational data

Table 3: Example of Incident Breakdown and Coding		
Details of actions / interactions	Level of backstage	Notes
Convulsing child, dad calls N12. She comes over, feels the child's body, tells the dad to pull all the child's clothes...	3 (Med)	
Then N12 takes a side trip to the ER front desk, to laugh with Ns there. Then returns to step-down...	4 (High/Med)	Seeking backstage away from own ward, even if front stage on other ward
Dad says to N12, politely but scared “nurse...” N12 says “I’m coming”, putting on gloves, then actually jogs across the ward to get something and comes with glucometer & thermometer	2 (Low/Med)	Running makes her more noticeable, more front stage
N10 and N21 talking about results of the child's tests and what to do. N12: temperature is 100.7. N10: Did you give paracetamol? N12: [inaudible]. N10: [inaudible, something about blood sugar]. Then N10 gives the chart to N12 and says to go show the doctor.	4 (High/Med)	
N10 to N11 (at the child's bed) – “is he still convulsing?” ...	2 (Low/Med)	Calling across ward makes this even more front stage
N12 at front desk with N10, discuss patient. N12: “His body is warm.” N10: “His mother wrapped him” [in too many layers of clothes]	4 (High/Med)	Create backstage by speaking at desk, though Dad & patient not far away (at one of the nearest beds)
N12 went to bed to check child. Touched, then...	3 (Med)	
N12 called to N11 (who was across the room) “what’s his blood sugar?”	2 (Low/Med)	Front stage bc yelling across the room, but the technical question may help create slight backstage
Dad calls to Ns again. N11 and N12 go with diazepam [medication] and the convulsions finally stop.	2 (Low/Med)	
Notes: Each row is a separate action / interaction. Numbered codes (e.g., N11) denote individual nurses. Backstage is code from 1 (virtually no backstage) to 5 (fully backstage).		

Table 4: Nurse-parent interactions		
Behavior	Example	Frequency
Reassuring	Nurses told a mother, “you have	5 of 29 cases

	to bear it,” “don’t make yourself sick”	4 of them fatal 2 also shouted at
Rebuking	Shout or publicly scold parents; lecture sometimes directed at onlookers	10 of 29 cases 5 of them fatal 1 mother physically slapped by nurse

Figure 1: Pediatric Ward in Provincial Hospital

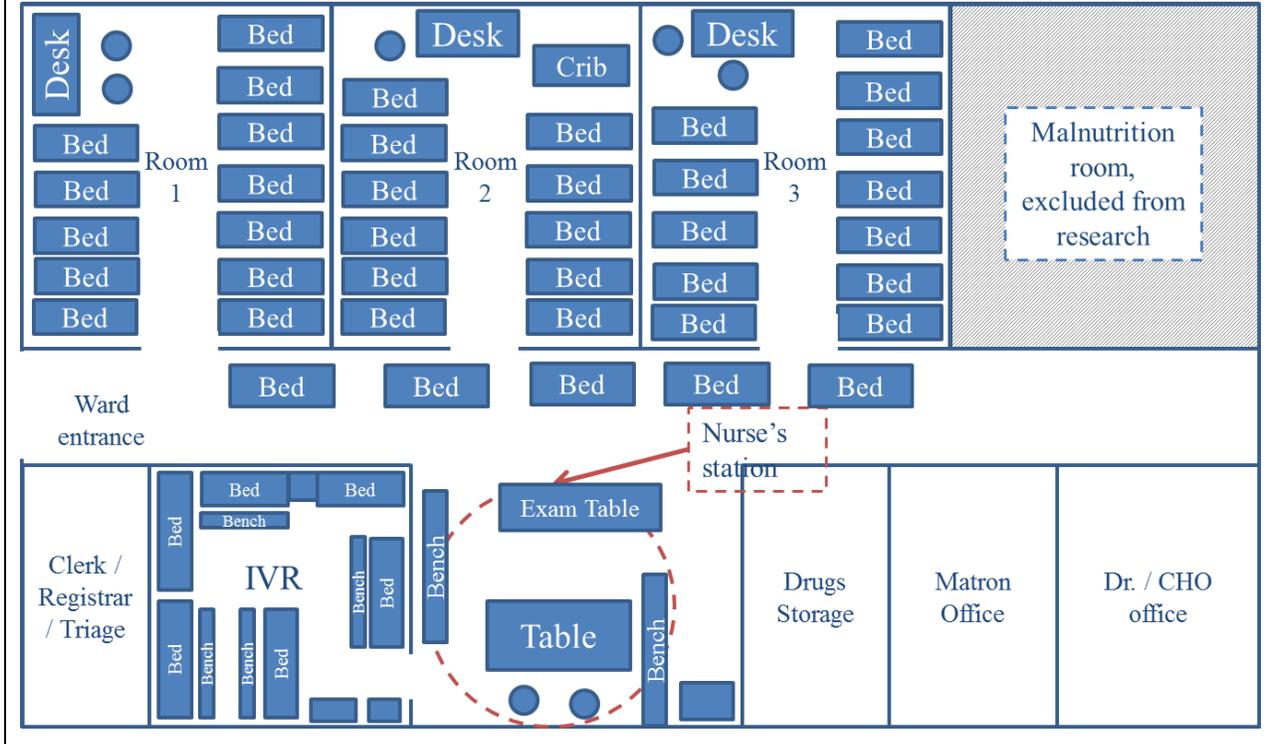
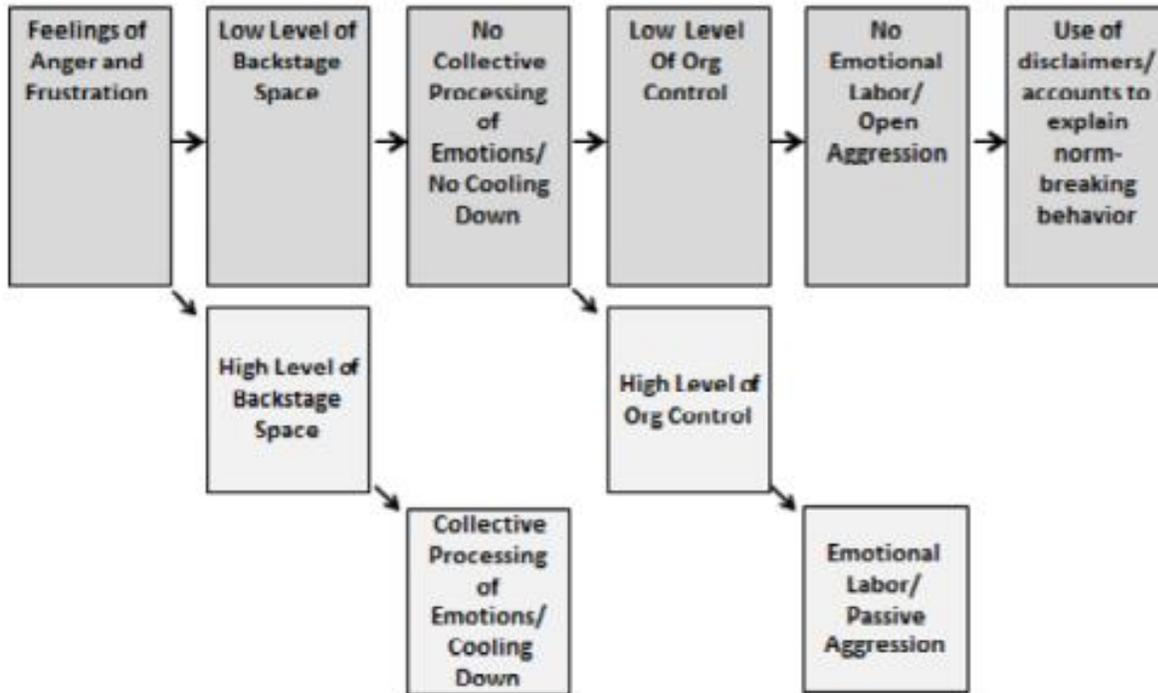


Figure 2: How Space and Control Shape Emotional Expression and Management



¹ To protect the confidentiality of my research participants, I will not identify the specific country or hospitals involved. All names are pseudonyms.

² Numbers for Capital Hospital come from hospital reports. Similar data were not available for Provincial Hospital, so I estimated this based on daily admissions during my stay, adjusted for seasonal variation and under-reporting.

³ These machines are used in the place of compressed oxygen cylinders; they transform normal ambient air into more oxygen-rich air for patients who are having trouble breathing.

⁴ My role at that time was a manager and technical advisor, but I had prior training and experience in research methods, and had recently completed a large qualitative study of communities around the country.

⁵ I explained that I was conducting academic research, and provided no technical or managerial support while in the field. The similarity of findings between the two hospitals suggests that my prior role at Capital Hospital did not alter the nurses' behavior or other aspects of my data.

⁶ The reasons for parents' delays are complex and multi-fold, including poor understanding of illness and medicine; perceived or real financial barriers; constraints related to distance, transportation, or work or familial obligations; and lack of trust in hospital-based care.

⁷ Parents may abscond for many of the same reasons that they delay seeking care. In addition, they may be frightened by things they observe on the ward, tired of the hospital's unpleasant living conditions, unhappy with the treatment they've received, or believe their child is getting better and can safely go home.

⁸ A nasogastric tube is passed through the nose and into the stomach, often to deliver food or medication.

⁹ The presence of either of two British doctors (both white, one female) also served to attract more attention from bystanders, thereby thrusting the nurses assisting them more firmly front stage. This was particularly true in Provincial Hospital, where white people were a greater curiosity than they were in Capital Hospital. I was also aware of this scrutiny (as a white, female foreigner) but because I was not involved in the care of patients, the effect was not necessarily to increase visibility of the incident itself. If anything, I may have distracted from what the nurses were doing.