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**The Nuffield Trust**

*The Maureen Dixon Essay Series on Health Service Organisation*  
*Number 3*

**COLOURING THE KALEIDOSCOPE**  
**- *Emotion in Health Care Organisation***

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*This paper is written in memory of Maureen Dixon who would have described her contribution to healthcare organisation in terms of the rational process - anyone who knew her however, would have understood that it was her passionate commitment to health care and the founding principles of the NHS which drove her work forward; her emotions formed the backbone for her work. Maureen may not have entirely agreed with the propositions set out in this paper, but she would have recognised the need for constructive thinking about the future of healthcare in the UK, and this work it is hoped provides some ideas to inform this debate.*



## Foreword

Maureen Dixon played a major part in developing a systematic approach to organisation design. This essay series has been established in order to place her contribution in context and the essays are intended to contribute to informing the debate about the organisation and design of work, whilst at the same time stressing the importance of values in health care organisation and management. The Nuffield Trust is grateful to Andrew Wall, Series Editor and the author of the first paper in this series, who conceived the idea for this set of papers.

*Colouring the Kaleidoscope. Emotion in Health Care Organisation* by Annabelle Mark is the third in the series. She examines emotion in health care organisations, endeavouring to give legitimacy to feelings that are often considered inappropriate. Drawing on her experience of analysing the complexity and unpredictability of health care organisations, she realised that as with much research and writing about organisations, the issue of what role emotion plays has been marginalised and often ignored. This essay redresses the balance and examines some of the ways that emotion can bring to health care organisation experience and may help show what may be missing and how understanding it can improve the future.

This publication is appearing just at the same time as the Sir Kenneth Caiman, H.M. Queen Elizabeth the Queen Mother Fellow, with his lecture and publication *A Study of Story Telling, Humour and Learning in Medicine*. He explains that one of the most potent aspects of story telling is in the establishment of leadership. 'Good leaders tell good stories and their power, at least in part, rests on this ability. It must be supplemented of course by knowledge and other skills but the ability to describe where you want to go and how to get there is critical. This is where power resides - in the capacity to convince others that your story is likely to be more effective than that of someone else.' Caiman's principal hypothesis is that people change behaviour because they have been infected by the ideas or values of another. It is argued that this contagion, passed on through transmits (transmitted ideas) can be a very powerful mechanism and may even change the lives of a large number of people. People are thus the agents of transmission of change and the phrase 'caught not taught' as a way of thinking about teaching, illustrates the point. Words, feelings, written, spoken or delivered in many other ways gain access via the senses especially sight, hearing and touch. They are transmitted. Emotions and feelings are also important.

Trust is at the heart of the patient/doctor relationship and thus at the centre of the organisation of health care. This publication addresses emotion as an explicit issue in health care, its history, current context and future opportunities. Habitually health care organisations have sought rational solutions but in the event rationality alone has proved to be inadequate. What is now needed is better recognition and explicit discussion of the role that emotion plays in ensuring that we actually get what we need both as individuals and as a community.

John Wyn Owen, CB  
London: December 2000



## **Colouring the kaleidoscope**

The image of a kaleidoscope provides a way of describing both the complexity and unpredictability of health care organisations in the UK over the last 50 years. We only just begin to observe and understand the relationships between interlocking parts when they can all suddenly shift into a new pattern. What then happens is that commentators, be they policy makers or academics, rush around trying to describe and analyse these changes before the same process is repeated.

Something however always seems to be missing from such analysis, and when I first started to think about this I realised that, as with much research and writing about organisations, the issue of what role emotion played had been marginalised and often ignored. So it is time to redress the balance and to examine just some of the ways that colouring this kaleidoscope, with the vivid brilliance that emotion can bring to our experiences, may help to show what we may be missing, and how understanding it can improve the future.

It is only possible here to explore some aspects of the issue but they should provide some insight into the importance and complexity that the subject can reveal. This will be undertaken by thinking about:

- the past, in particular how the NHS as an organisation has developed;
- the present, by looking at the dominant groups involved in health care;
- some major themes which are part of the fabric of the organisation,

and issues for the future.

## **Monochrome mindsets**

A well-recognised symbol for management in health care, which represented it for many years, was 'men in grey suits'. This monochromatic metaphor which suited the past, described the dress code associated with what was a male dominated group of professionals, but also illustrated the lack of feeling often associated in the public eye

with those fulfilling this role. However with the appointment of a woman chief executive, Maureen Dixon, in the 1980s to run the Institute of Health Services Management (the professional health managers' association in the UK), together with the election over the next few years of a number of women to the president's role, a major shift in the gender balance of this management group was being demonstrated. Today women make up a much higher proportion of health management and at least some of the changes to the way the organisations are run can be attributed to this fact. The demise of grey suits is symbolic not just of a change in gender but also a change in how the organisation of health care is undertaken.

The failure of the competitive market approach of the 1990s was not perhaps just political, but exemplified the need to move from male models of dominance and competition towards behaviours more associated with women, such as co-operation and collaboration (Tannen 1992). This is because the issue for the organisation is not just one of the current policy agenda, but also increasingly what will deliver effective healthcare. Some of the changes to the organisation can of course be traced to prevailing political philosophies, or the effects of global markets in health care. Nevertheless the wider role of women in society and within the controlling professional groups, is affecting the way both the organisation delivers healthcare and indeed what healthcare is delivered. Gender is thus a powerful way for understanding changes in healthcare organisation, and symbolises what is often characterised as the rational male/emotional female divide. This divide has in the past expressed the division in the roles in healthcare, male doctors & female nurses, but this has long since ceased to be representative of the structure of the workforce. It does however leave a long tail in terms of the rational/emotional divide for the organisation and it is this legacy which increasingly needs to change.

What is also highlighted by this perspective is the need for new representations of healthcare organisations which portray something more akin to the lived experience of all those who are involved with them (Ackroyd & Thompson 1999).

Healthcare is first and foremost about people, people as patients, people as professionals, people as politicians, but most of all people as participants in the dialogue about what health is and how it can be attained. The first and most obvious differences between people are those of gender, then of race, creed, colour and so on. However difference is only half the story; as it is also what they share, albeit in different proportions and varying degrees, that provides ways of understanding how they can work better together. Emotions are critical to these shared experiences, but their relevance in understanding why things happen has been underestimated, sometimes purposefully ignored or seen by organisations as uncivilised, invalid, too powerful and even shameful (Ralston 1995) to be part of any formal organisational process.

The colour that these emotions bring can complicate as well as illuminate the view and requires greater understanding - and this often acts as a disincentive for those who wish to continue to see action through the simplicity provided by a monochrome world. This is understandable; anyone who remembers the arrival of colour television can no doubt recollect those who claimed to still prefer black and white. It was simpler, what they were used to, their response represented a defence against a changing interpretation of reality, but was also an assertion of personal independence. In the same way what is needed now is a way of moving from the present monochrome to full colour in a graduated way which, somewhat ironically, will take account of such emotionally led responses without being bound by them.

### **Increasing the Spectrum**

Emotion and rationality are often described in terms of left-brain/right-brain activities within each individual, but even this is an oversimplification of what actually exists within the brain (Hellige 1993). It does nevertheless provide an appropriate starting point for analysis. Similar oversimplification, through stereotyping, takes place when we sort people into boxes from which we can attempt to interpret and predict them. This allows organisations to colour the individuals as doctors or nurses or followers or

leaders, and thus their reactions are often predicted, by others, in relation to their roles, not their feelings. Medicine, seen as the most senior branch of the medical organisation, has its own hierarchy of specialities, which reflect very profoundly the division between knowing and feeling or reason and emotion. Neurology, the physical study of the brain and nervous system has a higher status than psychiatry which is concerned with diseases of the mind (Turner 1995a, Cassell 1998). The NHS has historically reinforced this hierarchy in both its funding and the management attention given to different specialities. The leading profession in the provision of health thus helps to shape the attitude of the organisation, which has been thereafter reinforced through the budgetary allocations and investments in each speciality. Changes to these patterns of funding and professional hierarchy have been slow and not always successful.

We start out therefore using this simple if rather crude rational/emotional axis, because as a perspective it has a number of advantages:

- it allows the gradual introduction of a more colourful view
- it contrasts with the prevailing reliance on rationality
- such contrast highlights why and how rationality alone fails

In more general terms, exploring emotion in the study of people and organisations is experiencing serious attention, and is no longer seen as being only of importance in the creative arts. Indeed it is what artists have already explored which is now informing many aspects of organisations and their development; for example the growing interest in what Shakespeare has to tell us about power and leadership (Egan 2000).

It seems that organising healthcare has so far failed to take proper account of its uniqueness of purpose at an emotional level in dealing with individuals who are often at their most vulnerable. This vulnerability makes their perception of professionals and the organisation very important. If arts-based disciplines are now being used to

inform our understanding of this, it redresses an imbalance in what have been the reference points for management until now.

What the history of the NHS as an organisation highlights, is a failure to connect the organisation to the unique task it performs within society, and the emotional as well as rational consequences of this. Perhaps this is because there is some confusion about what that task is, or should be in the future, and perhaps in the absence of such understanding other pressures and solutions have been introduced. Now however it is necessary to reassess this connection of the "organisation to its task. This is because patients continue to feel disempowered by the system as currently provided as now acknowledged in the NHS Plan (DoH 2000), yet look to it to provide healthcare into the 21<sup>st</sup> Century. Understanding these connections, at both rational and emotional levels, will be critical to the future welfare of the organisation, as well as the people it serves.

To provide an understanding of the organisation we need to take a closer look at some aspects which will highlight important issues.

Health care organisations can be very dramatic places to work, as many television programmes confirm, and this drama is most powerfully symbolised in the continuing use of the term 'operating theatre'. Role playing as part of this dramaturgy (Downing 1997), is also at the heart of the relationship between patients and professionals, but its emotional content and context has only recently become the subject of analysis. An important contribution to our thinking about this is Hochschild's book *The Managed Heart: the commercialisation of feeling* (Hochschild 1983) which has given us the concept of 'emotional labour'. In health care this involves managing emotions to achieve professional and organisational goals. This 'management of emotions for a wage' (Grandey 2000) also incorporates the notion of what she terms 'surface' and 'deep' acting. In surface acting one regulates emotional expression; for example the doctor does not express views about a patient's injuries and how they may have been acquired. Whereas in deep acting one consciously modifies *feelings*, which are our individual internal experiences, in order convincingly to express the desired emotion;

for example the nurse who shows sympathy and empathy for patients while on duty but can switch off from them when the shift is finished. Both are strategies with a twofold purpose to maximise patient confidence, and minimise staff stress. Role play is thus a critical activity of healthcare provision and is derived from the 'display' or 'feeling' rules for the organisation or job (Goffman 1959, Hochschild 1983).

Of course such strategies may have other purposes; the role play can have a political or cultural component, but for the purpose of immediate and observable interactions the role and purpose of surface and deep acting provides a useful insight into what is going on. Problems however can occur when there is confusion or a lack of clarity about what the 'display' or 'feeling' rules of the organisation are; this can happen when there are organisational or role changes. The emergence of new display rules, becomes critical to the continuation of successful relationships and encounters, because as communication theory suggests 'emotion is constructed on-line as part of the developing relationship emerging from a real-time encounter between people' (Parkinson 1995). This must be contrasted with our individual feelings, which as our subjective internal experiences, may or may not be on display during these encounters, depending on whether we are indulging in surface or deep acting. Some attention has been given to this aspect of roles or jobs within healthcare, but with an emphasis on the changing roles of professional groups. Much less attention has been given to this sort of research into organisations and the part it plays in encapsulating and transmitting these rules. The past history of the NHS does seem to show that this lack of attention has indeed presented problems.

### **Past Patterns**

To understand how we need to approach the future we must ask ourselves "what do we know and how can we learn?" from the past (Dawson 1999). Any discussion about healthcare in the UK is within the context of the National Health Service (Rivett 1998) which has shaped the delivery of services in this country for the last 50 years. As an organisation it was considered by many to be the envy of the world. This was

because it has, at least economically, delivered good health as measured in terms of the outcomes, which can be counted. Yet its founding principles had little to do with such economic considerations but were rather based upon the political belief that removing the fear of ill health and infirmity was the mark of a civilised society. Self interest was best served by a shared community interest in the provision of healthcare. Like many such visions, a rational justification had to be found and this was soon to appear when the NHS was analysed at both national and international levels. The economics of nationalised health care and the science of medicine could be shown, together, to have improved the health of the nation when counted in terms of many comparative health indices of the past and of other countries. This constant resort to economic and scientific rationality as a method of sustaining the NHS was, however, made at the expense of an understanding of the role emotion plays in both the justification and delivery of health care. In so doing it has not only increased the potential workload in healthcare (Stewart Brown 1998) but also has also ignored the original purpose of the NHS which was to reduce fear and provide pathways to happiness through health.

The purpose of emotion and healthcare organisations have been and remain very much the same, as both in their different ways provide protection and fulfilment for individuals and communities; their relationship is therefore important.

Healthcare in the UK at the beginning of the 21<sup>st</sup> Century is no longer just about meeting needs but is having to explore new boundaries between the provision of health and the improvement of lifestyle for individuals and communities. Identifying where these are, and how the health budget should be allocated between products and treatments which provide for both, is a key challenge as the recent debate over Viagra has revealed. Much of the discussion around them is emotionally based so rational solutions alone will no longer suffice in providing answers.

**Black and White makes 'Gray'.**

So what do we mean by rationality and what do we mean by emotion?

The dominance of rationality has a long and persuasive pedigree, but our first concern here is with emotion, and its definition is not easy. Lupton (Lupton 1998), suggests that definitions of emotion themselves fall into categories specific to the discipline exploring them. So for my purposes I have defined emotion at this stage as only an instinctive feeling as opposed to reason, which has much in common with Aristotle's description of them as 'feelings that so change men as to affect their judgements'(Harre & Gerrod Parrott 1996). This definition does not require a description of what are and are not emotions, or emotional states, but it does provide confirmation of how we need comparisons to begin to understand such basic ideas. Furthermore, in health care the dualism between reason/rationality and emotion/affect is the basis upon which so much of the discussion with professionals begins.

A brief literature review reveals that much of the relevant material on emotion in healthcare organisation is found by looking for specific emotional responses (Wilkinson 1995), like happiness, fear, anger and depression, (Kempner 1987). What this analysis demonstrates is the separateness of these experiences for individuals, rather than the relationships between them; yet for the organisation of health care it is the relationships between these emotional states, which really matter.

In contrast, rationality and its English manifestation as empiricism (Locke 1690), is the view that self-evident propositions are the sole basis of all knowledge. Where this English view differs from the Cartesian rationality of "I think therefore I am", is its very practical reliance on evidence derived from sensation and reflection. Locke was himself a medically trained doctor and this may in part have informed his view. Its focus is on the external world and not the instinctive world of emotions. This perspective has informed medicine to the present day and could be seen as the philosophical basis of the Evidence Based Medicine movement that currently has such credence in the UK health care system (Gray 1996). Challenges to this view are increasing (Stenmark 1995, Fitzgerald et al 1999), but the focus of this challenge while identifying the problems, may not have grasped why EBM is a necessary but

not sufficient response. It is not a question of either rationality or emotion for patient care or organisational arrangements but rather a need to understand these distinctive worlds of meaning and experience, which constitute the practice of medicine (Good 1994), and how they influence each other, in a 21<sup>st</sup> Century organisational context. This will enable a better understanding of health, its costs, its organisation and social context, (Stewart Brown 1998, Taylor-Gooby 1998, Fineman 1993, Williams et al 2000) to be found. Inherent within all these aspects is the notion of trust, *a feeling* that is metaphorically the light we need on the lens of the kaleidoscope, and through which the colours and patterns will be revealed.

### **Trusting colours**

The conundrum for effective healthcare is that it is based on a feeling of trust between the patient and professionals and organisations involved, whatever the information and evidence available. Ultimately the patient must believe in the professional as an individual as well as the role he or she occupies. This trust is based within the emotions and analysing its origins is like trying to capture and hold the best combination of colours and patterns in a kaleidoscope. Its absence however makes the view black, so when we see that it has disappeared, we need to know how to bring back the full spectrum of colour. These emotional colours can only be found within individuals who recognise and use them to colour their own kaleidoscope of interactions. We do have ways of describing these abilities. Much trust is built through the emotional intelligence (Goleman 1996) of professionals; this implies self-awareness and the ability to effectively manage emotions, including an ability to empathise and utilise them in a positive way in oneself and in others. The presence of these skills in individuals, or the training to develop them, has not overtly informed the development of managers, or for that matter doctors or nurses until relatively recently. However, their presence or absence has often been the factor that has separated success from failure for all healthcare professionals.

Other forms of intelligence, notably knowledge intelligence, have been more highly valued as a measure of success within health care organisations and the professions they employ. The management of this knowledge has also received increasing managerial attention (von Krogh & Roos 1996). Knowledge relies largely on abilities that relate to the intelligence quotient (IQ) of individuals and involves understanding things or objects (Rowe 1994). But, as Rowe suggests, IQ is not sufficient especially when dealing with people; what is also required is an understanding of what she has termed their WQ or wisdom quotient, which has much in common with Goleman's description of emotional intelligence. The consequences these different component parts of IQ and WQ have on people relationships, are set out below together with Rowe's interpretations of the consequences, and may help in understanding the varieties of behaviour that we find in the healthcare.

*Figure 1*

<i>IQ HIGH</i>	Good at Understanding  Persecuted	Trying to do Good  Can be Useful  Can be Dangerous	Powerful  Cruel  Very Dangerous
<i>MEDIUM</i>	Fair at Understanding  Persecuted	Means Well  Can be Confused	Supporting Power and Cruelty
<i>LOW</i>	Simple Understanding  Frustrated	Caring but Confused, Prejudiced and Dogmatic	Not Understanding  Used By Others  Destructive
<i>WQ</i>	<i>HIGH</i>	<i>MEDIUM</i>	<i>LOW</i>

***Interpretation***

*High IQ & WQ* have a good understanding of themselves and other people and the world they live in. Unless they are very careful they are persecuted.

*Medium IQ & High WQ* have a fair understanding of themselves and other people. Unless they are careful they are persecuted.

*Low IQ and High WQ* (quite common among people with learning difficulties since they have not had their minds cluttered with 'expert theories') have a very simple and direct understanding of the people around them, but as they cannot marry this understanding to more intellectual matters, and since they are often treated with disregard by the 'normal' people around them, they are often hurt and frustrated.

*High IQ & Medium WQ* try to do good, and this can be useful and effective, but if they are convinced that they know what is best for other people, they become dangerous.

*Medium IQ & Medium WQ* mean well, but they do not see issues clearly and can be used by those with a high IQ and medium WQ and those with a high IQ and low WQ.

*Low IQ & Medium WQ* can be very caring, but they are also likely to be confused, prejudiced and dogmatic.

*High IQ & Low WQ* are powerful and cruel, very dangerous people.

*Medium IQ & Low WQ* are also dangerous, for their support power and cruelty.

*Low IQ & Low WQ* have little understanding of what goes on around them. So they are thoughtlessly destructive and are easily led by those with a high or medium IQ and low WQ.

© Rowe, D. Reproduced with permission from, *Wanting Everything - the art of happiness*, 1992 edn, HarperCollins, London.

Such analysis could also be used as a template to describe organisations, but what it also shows us is that individuals can demonstrate a range of behaviours. These may also vary according to other influences such as their ethnicity, their professional background, their personality and the context in which they work. Patients are also of course affected by all these factors, and the success of the communication process between patient and professional will additionally be influenced by both parties' capacity in both IQ and WQ. However, the patient is more often driven by emotion in the interaction because it is he or she who has the problem. So the expectations and outcomes sought between patients and health care professionals are different, even when the relevant personal skills and attributes are present on both sides. The clinician's primary concern is directed at defining the problem, and the effects of treatment; has it made the patient better? This contrasts with the patient's first concern, which is that they should *feel* better, before questions of effectiveness and harm arise. Thus a disparity in the starting point for the relationship can exist. Such conflicts between what patients want and what professionals give are often generated by this rational (professional) response to what has become an emotional (patient)

problem. The bridge between such disparity is the trust of the patient, that the professional will seek to move these disparate points closer together (Tudor Hart 1996). Where this fails to happen outcomes can be compromised; for example patient compliance with treatment may be jeopardised. Where such trust is damaged, for example as revealed in the Bristol Royal Infirmary paediatric cardiology public enquiry, or the Harold Shipman trial, alternative ways of managing the future for organisations are often sought via some form of monitoring or control. However such approaches fail to account for the fact that the essence of the problem lies outwith such devices. If trust is to be regained what is required is not just a way of dealing with an unknowable future, but furthermore a demonstration that the organisation can help to deal with the emotional detritus of the past experience.

Trust is at the heart of the patient-doctor relationship and thus at the centre of the organisation of healthcare - yet trust itself is a feeling which all the supporting evidence cannot of itself engender. The potential for damage to this relationship is not new; throughout the history of the NHS it can be demonstrated that such trust has been repeatedly put to the test and indeed has been found wanting, as any survey of Health Service Ombudsman reports can testify. When seeking explanations of these failures of trust, what is often found is a miasma, from which, as I have already suggested, only the actionable and rational are extracted to explain and guide the future. This compounds the problem because it often leaves the real causes ready to damage the next set of vulnerable circumstances. For patients and their families it is not enough; the emotional damage to victims of organisational and clinical error rests significantly upon the failure to manage sensitively the consequences of these acts. Yet the organisation continues to look to changes in structure and process rather than behaviour to solve these problems. While regulation, essentially a rational process, has a role to play in reducing risk and demonstrating safety as part of quality provision (Sally & Donaldson 1998), there is also a need to recognise how emotion colours the picture. This may then allow the organisation to identify more comprehensively how such problems are being generated and why.

### **Filling in the colours**

Habitually organisations look only at the patterns created by the lines which connect its structures, processes and agents. Whatever a rearrangement of these produces, it still fails to fill in the emotional colours to show how and why appropriate responses are constrained or curtailed. Furthermore both organisations and individuals often adopt strategies for neutralising emotion (Ashforth & Humphrey 1995) by ignoring key behavioural issues which appear as emotional responses such as anger or fear. Revealing the colours may therefore not be a simple process of recognition, it will require investigation. The outcomes of these responses can be seen across all levels of the organisation, for example from official complaints to the levels of violence which occur in Accident and Emergency departments. The solutions are often focused on containing events rather than understanding the emotional causes; it is time to change this partial response to include a full spectrum of colour. If the emotional aspects of problems are identified and monitored it could allow a continual emotional audit and improve the satisfaction of both patients and professionals. So why is it that the emotional basis of many problems is so often ignored? There may be a number of underlying reasons:

- it is difficult to find new descriptors appropriate to the task which are not based on former constructs that have not been rooted in the black and white past of rationality
- emotional audits can reveal both organisational and professional failures so why should professions and healthcare organisations provide politicians with another stick to beat them with?
- the heterogeneity of both patients and the healthcare workforce means that no meaningful measures can be established
- we do not have the skills or research base to undertake such work, so where do we start?

In addressing these issues we first need to find new descriptors. It is a challenge already being addressed by organisational research. The increasing integration of arts disciplines into an understanding of organisations, and indeed healthcare itself, is helpful here. The standardised templates of emotional language are extensive, (Johnson-Laird 1989) and limiting their use may distort the colours and patterns unique to each organisation. Because of this organisations need to be able to choose those descriptors (of emotional behaviour) which they feel are most appropriate. Metaphors are valuable in helping organisations to describe emotions. As I hope my own metaphor of colouring the kaleidoscope shows, they provide new ways of seeing and thinking. This is because metaphors (Sontag 1991) themselves are often the key to unlocking emotional process (Gordon 1961) which then helps an organisation to understand its own complexity, or metaphorically, its range of colour.

The second reason for suppressing emotion in organisations is the fear of consequences and retribution which, ironically, is in itself an emotional response. Arguably, fear has no place in organisations that wish to be successful. Fear may activate and control activity but it cannot sustain or enrich the creative process so necessary to survival. Despite this, the NHS while it initially removed the fear of illness, especially from those who could not be covered by insurance schemes, has subsequently often resorted to fear as a motivator to sustain its strategy and structure (Webster 1998). Even the introduction of the internal market (Parliament 1990), which sought to relocate the economic dynamics of the system, did not explicitly explore the behavioural changes required by the move from consensus to competition. The structural and cultural changes in the organisation of health care during the '80s and '90s, led by politicians, cast aside attempts to provide a caring organisational context, and set up emotive dissonance (Hochschild 1983) for many of those giving and receiving health care. This dissonance, or mismatch between what is experienced and what is desired and expected, is the emotional impact of redrawing the political map of healthcare policy in the UK without reference to its social and emotional role and context as an institution. The benefits of introducing a market approach did highlight the role of the patient consumer or consuming patient as increasingly

important, but the emotional costs of this damaging transition could have been reduced.

The problems of healthcare organisation are usually interpreted within economic terms, yet have almost always been addressed by organisational solutions. These solutions based largely on structure with some reference to change in organisational culture, leave the emotional territory untouched; except perhaps as a negotiating ground orchestrated between the patients and politicians through the media. This logical fallacy of providing rational organisational solutions to both emotional and economic deficits, diverts attention from the issue of how much the UK should spend on healthcare, which is the responsibility of politicians, to how this finite resource is delivered, which is the responsibility of managers. Cash, when it is injected, is given to maximise political rather than patient advantage and the emotional consequences are ignored or dismissed as irrelevant.

The third problem is that the diversity of perspectives within and without the NHS makes it very difficult to understand what is going on. Here new technology can help but it will need a much greater commitment to research into its effects and its uses to overcome the initial cost and process obstacles (Mark & Dopson 1999).

Finally, as far as research methods are concerned, research constructs themselves can offer a variety of opportunities. For example the use of postmodernist and post structuralist approaches have already contributed to thinking and methods for research in organisations (Hassard & Pym 1993). They now need to be taken further through the development of new interdisciplinary theoretical approaches (Genosko 1998) challenging existing boundaries. Such new perspectives need to concentrate on making sense of the whole rather than an analysis of its parts. For example, the laws of closure, well understood in the psychology of perception, have demonstrated how, by filling in the gaps to our sensory inputs, we are able to see incomplete objects as complete. Research methods may now also need to concentrate on the whole picture, to identify its dominant tones and colours.

Already the growth in holistic approaches to medicine has demonstrated the value of understanding the inter-relatedness of one part to another and the consequences of their interaction. This search for inter-connectedness contrasts with postmodernist approaches to organisational research, which are concerned with the collapse in meaning across our multicultural society (Kilduff & Mehra 1997). Their interpretation has reinforced the sense of fragmentation which may well reflect the lived experience in UK healthcare in recent years (Dent 1995). The limitation of the postmodernist approach is that it does not help our understanding of how emotion helps in *linking* events for the individual (Goleman 1996) to make sense of experiences (Weik 1995). Post-structuralism as an alternative, does allow for an exploration of a variety of meanings in a way that provides some useful tools for analysis (Cropper 1999, Lupton 1998). Such approaches, while not providing complete answers, will reveal new perspectives, will shake our kaleidoscope (Turner 1995b).

Until now healthcare organisations have tended to use other forms of research; these, as we shall see, also have much in common with the elements important to our understanding of the emotions.

### **Purple professions**

After the 1960s and the revolutions produced by the 'white heat of technology' (Rivett 1998), the relationship between professionals and patients changed. Although the essential separation of patient from professional was still maintained, it was through different forms of what psychologists call 'distancing'. This distance is expressed metaphorically by the gap between the lens we look through, and the mirrors that create the kaleidoscopic pattern. Without it we cannot see what is in front of us because being too close or too far away blurs our vision. Distancing has a number of functions for individuals including being indicative of the amount of difficulty experienced when interactions do occur, as with many patient-professional interactions. Distance however also has social psychological functions like those founded upon the hierarchy and class differentials between doctor and patient. In the

post '60s world differentiated knowledge between patient and clinician overtook class and hierarchy alone (Perkin 1989), to provide the power distance between patient and professional.

For those whose work can be described as what Hochschild has called 'emotional labour', managing distance is important because it reinforces a series of messages about the roles of class, knowledge, power and emotions between individuals. It also has important implications for the culture of the organisation. Hofstede's work (Hofstede 1980) within one large multinational company, described how 'power distance' influenced the differences between the cultural values of separate nationalities (Hofstede & Bond 1988), as did the differences between assertiveness and nurturing roles which were activated differently by different nationalities. His approach could be equally applied across other types of organisational groups, to compare cultural norms. These factors listed below are significant because they reveal behaviours, all of which are predicated on emotional responses. They are:

- Power distance - the extent to which differences are accepted and sanctioned
- Individualism collectivism - the loose (individual) or tight (collective) bond between individuals and groups
- Masculine/feminine traits- embracing success assertiveness versus nurturing & solidarity
- Uncertainty avoidance - the search for structure versus freedom
- Long versus short term orientation - future versus present & past in tradition and social obligations

This analysis is important in our attempt to understand organisational cultures but also has further significance in managing the different responses which are likely to appear in multicultural groups, professions and organisations, of which healthcare is a primary example. So gender is just one issue which must be joined by nationality, professional training and socialisation; all will affect the individual's emotional responses.

Further analysis of the power distance idea provides insight into how other groups, often external to it, can affect the organisation of healthcare. Politicians create distance between themselves and problems by identifying solutions whose success or failure rests with others. Such distancing is also adopted at professional and managerial levels in healthcare and is aimed at reducing the emotional heat. Given the feelings of patients, this attempt to reduce the impact of their experience may prove to be alienating. Distancing used in this way, separates emotion and action so that the latter can be reinvented as rationality. Rationality appeals to management, the scientific community of the NHS and the fiscal interests of the taxpayer, as it provides what are seen as independent justifications for action or inaction. However, taxpayers readily shed this coat of rationality when they become patients, exposing emotions such as fear and anxiety and becoming distressed that the organisation seems so often to have no adequate way of responding.

Distancing is thus not a static state but very much a movable attribute between individuals, groups and the organisation; it shifts in much the same way as a kaleidoscope does because it is a response to the changing emotional colour in relationships.

Allowing the intersection between emotion and rationality to occur does not always have deleterious consequences. For example, professional clinicians often see their interventions primarily in terms of what we might call 'the cool blue' of rationality distancing themselves from the 'hot red' of emotions. What they fail to appreciate is that they are thereby losing the third colour. That colour, as the kaleidoscope shows, is purple and supplies another emotional response combining the best of blue and of red but adding something extra to their perspective which affects their potential to respond appropriately and their ability to achieve satisfactory outcomes.

This acceptance of an increase in the colour spectrum improves the capacity of politicians and professionals to respond to the growth of multiculturalism in our society and in our organisations. Hofstede's analysis perhaps demonstrates even more complexity than we first thought. The growth in multiculturalism has not been the

only issue to affect health care in the UK. During the 1970s, '80 and '90s the organisation of healthcare in the UK was influenced by the mores of the private and commercial sectors and even non-European managerial ideas. However the changes of the 1970s were still largely rearrangements of existing hierarchies compared, to what the '80 and '90s had in store with the move towards a market approach. Before this was revealed, the Thatcher government, elected in 1979, set its sights on changing the professions, especially what Mrs Thatcher called the traditionally 'immune targets' of law, medicine and the clergy (Perkin 1989). Attempts to reform the medical profession were considerably helped by the introduction in 1984/85 of a general management rather than an administrative culture. Control was to be shifted from the clinicians to professional managers. Objection to this, and the compromises eventually arrived at by giving doctors managerial responsibilities, was preceded by a fight-back by the doctors (Klein 1995) who employed tactics which drew upon the emotions of those engaged in the debate and the feelings of the onlookers. Nevertheless the methods deployed were to be those which had proved successful in the recent past; that is an exaltation of the rational benefits of medical knowledge to health within the community. The voices challenging the virtues of medicine (Cochrane 1972, McKeown 1976, Illich 1977) remained only marginal to the debate.

Government attempts to relax the grip the professions had on the organisations in which they worked, had a further purpose by creating a vacuum which they wanted the new managers to fill. The professional status of many of these managers was politically weak, but they had the support of government whose agenda they were now able to implement and for which they were to be rewarded financially. The management model was based on control and command, not a management approach necessarily appropriate to the complex and sophisticated nature of health organisation at the end of the 20<sup>th</sup> century. Accountability became very explicit and hierarchical in the worst sense (Wall 1999). A blame culture developed based on fear and this resulted in more than a few public and sudden removals of managers from key posts who were said to be unequal to the demands of the job. This generated a level of organisational anxiety which as its effects filtered downwards, was used to control the system. The alleged carrot of private and personal reward for performance, was less

evident than the stick of sudden and sometimes devastating punishment. The climate of fear that ensued did much to stifle the creativity essential to future successful organisational performance and so the downward spiral continued. This legacy, some would suggest, still pervades parts of the NHS today. Success and failure of the organisational changes were rarely reviewed in terms of the appropriateness of feelings, attitudes and behaviour, but usually focused on individual actions and errors.

### **Introducing new colours**

The introduction of the so-called internal market in UK healthcare (Parliament 1990) concentrated on the economic role of markets and took little account of the more interesting aspect of the marketing discipline which takes emotion as crucial to its operation. Markets were introduced partly to distance politicians from healthcare provision, and also to realign healthcare to be more responsive to consumers. Nevertheless the delivery of this responsiveness remained within a command and control environment.

The changes moved some aspects the organisation forward into potentially new perspectives, but the failure to recognise these for what they really had to offer was a mark of the distance between the rational and the emotional view. Yet the emotions which drive consumer actions (Elliott 1998), and the interplay between these and economics are now understood as critical to future success (Earl & Kemp 1999) for all organisations.

Inside the NHS however little seemed to be changing; if managers and doctors colluded unwittingly or otherwise in their use of rationality to justify their activities, the nurse's role remained more expressive of the emotional content of health care. However, nursing continued to be undervalued especially where its emotional content was high; for example Health Visitors were marginalised and even abolished by some health authorities. The development of the professional graduate nurse through Project 2000 was an example of an attempt by the nursing profession to remove nurses from

the apparent stigma of only being a 'feely' role to a discipline underpinned by knowledge and rational processes.

While the NHS overtly valued knowledge it was not averse to using emotions to achieve organisational objectives (Ashforth & Humphrey 1995) to both maintain control of its providers and increasingly its users (Mark & Elliott 1997). The consequences of this for providers working within the organisation has led to increasing confusion over the 'display' or 'feeling' rules of the organisation.

The fear generated by increasing and often unpredictable changes to the organisation, like changes in competitive or collaborative contexts, now threatens the NHS because of what research has also revealed as the emotional dysfunction of many of its key players (Williams, Michie, & Pattani 1998). The emotional health of the organisation is jeopardised. Yet patients, however they may perceive the problems of healthcare in general, when faced with a personal encounter with the system, must start from the assumption of a state of wellbeing in those providing care. As we have seen there are increasing reasons why this assumption may not be justified. Even economists now acknowledge that trust is crucial for patients placed in situations, of "ignorance or uncertainty about unknown or unknowable actions of others." (Mannion & Smith 1997).

### **Primary Colours**

What is needed now is to redress this imbalance and review the significance of emotion within organisations. To do this we need to think through in more detail what emotions are. Definitions as we know are difficult and may be spurious (Ortony & Turner 1990) but locating the emotional colours in the kaleidoscope (Turner 1995b) of health care organisation will include:

- identifying which emotions are important,
- how they can be identified,
- where they appear,

- why they appear,
- how they are dealt with,
- and what can be done to ensure that this process continues as an aspect of organisational activity.

Specifying emotions individually is not always the best place to start as it implies a fixed set of responses to a known set of categories and is too rational an approach. Rather more helpful is the idea of primary and secondary emotions where some primary emotions when combined together can be seen to generate a range of new secondary or complex emotions (Huang 1998). These changes are often unpredictable, and form new patterns and new colours all the time, in much the same way as a kaleidoscope does.

The NHS as an organisation was predicated on what Kempner (Kempner 1987) would describe as primary emotions, and these he defines as being constituted as only four from which all others appear as secondary states. These four are satisfaction/happiness; fear; anger; and depression. If we use this template for the organisation as a whole we can say that the NHS removed the fear of the problems of affordability (Rivett 1998) for individuals, which are still apparent in market led systems like the US (Gold 1999). The NHS has struggled instead with the issue of access, which has led to problems of anger and depression; but neither UK or US approaches have found a way to guarantee satisfaction or happiness.

Some support for this view of the role of primary emotions in organisations can also be found in their representations as one of the four main dramaturgical plots of organisational life. These Downing (Downing 1997) has defined as the Quest (expressing satisfaction/happiness), the Downfall (expressing fear), the Scam (expressing sadness/depression) and the Contest (expressing anger), which become Romance, Tragedy, Irony and Melodrama when given their dramatic form. Combinations of these plots help to structure more complex stories, but there is a tendency in organisations for plots to create emotional momentum through one dominant story line. If management pursues the Quest without reference to a more

dominant storyline, they will fail. Interestingly the private sector always takes its focus as the Quest. This suggests that there is a transfer away from a response of the fear of affordability, and the depression and anger caused by problems of access familiar to the NHS, into meeting needs for happiness.

## **Secondary hues**

What we find in healthcare therefore are a whole range of emotional dramas being played out. The curtain goes up when the patient first encounters the system. The overall organisational drama is often complicated by the simultaneous presence of a whole range of emotional states or mini-dramas manifested by individuals and groups in the organisation as a whole (Ashforth & Humphrey 1995, de Vries & Miller 1984). Emotional states in individuals and organisations are not the same, but the purpose of the organisation itself, which in this instance is the delivery of healthcare, can act as an integrator of the dramas or a blender of colours in our kaleidoscope. The presence of emotion, as integral to both purpose and its implementation, can be used to show where both individual and organisational dysfunction are occurring, as a study of a London teaching hospital has already suggested (Holden 1991). Therefore, developing an understanding of the shared meaning of emotion, as something more than the dualistic opposite of rationality at the heart of the scientific basis of knowledge (Czarniawska 1997), is also becoming essential to an understanding of why current practices in medicine only provide part of the story. Research has shown that looking at a clinical intervention, and ignoring its organisational and behavioural context, fails to achieve the successful outcomes required (Bradley et al. 1999).

There is also a need to understand the interplay between emotional states, as manifested physically and psychologically, and emotional action. The transition process remains unclear; for example what makes people worry enough to seek advice, then get angry when there is a delay in receiving it? Some of this will be learnt behaviour as described by the social constructionist approach (Suttie 1988). Some will be based on physical responses and the use of past experience to

understand the present, the cognitive theory approach (Frijda 1988). But all involve the interplay between rational and emotional process. Sorting these factors is complicated because the patient and organisational perspectives have also been coloured by some corruption of emotions as a signalling device (Mestrovic 1997). The utilisation of emotions for instrumental purposes, like political or commercial gain, takes place outside the organisation, within the wider society, (Hochschild 1983) and (Mestrovic 1997) has had a corrupting effect on how people respond to what they recognise as insincerity. The "have a nice day" greeting at the supermarket checkout, jars because it is so obviously role-play for instrumental purposes. Such experience is carried by the consumer (Mark, Pencheon, & Elliott 2000) between the external world and the health system, and the consequences of this may in part be seen in the breakdown of trust in general between the public and those seeking to persuade and influence them (Beck 1992). Its as though someone has changed the lens on the kaleidoscope and distorted the view so although the colours are the same and even the pattern is similar, the view is distorted, unreal and uncomfortable.

The mistake has perhaps been, not so much in acknowledging and understanding the world outside the NHS, but in adopting practices from outside, without really thinking through their interpretations and consequences either at an emotional level within the organisation, or at the interface with patients. Further areas of concern which have also influenced the way healthcare organisations must now respond are the international and scientific context of healthcare, the former changing expectations for provision and the latter changing expectations for intervention. Both are driven by fear as well as a desire for happiness and fulfilment. These are emotions which are utilised to advantage by commerce and by professional groups in promoting their agendas. Healthcare organisations may find it more difficult to use emotion to promote what are, by their very nature, more mixed agendas.

### **Future Colours and Patterns**

My contention is that the NHS can no longer concentrate solely on matters of efficiency and economy, but must incorporate the other more neglected dynamics

experienced through emotions, and thereby acknowledge the crucial influence derived from people's experience of healthcare either as patients or staff.

The first, and possibly the most important place to begin, is at the point of access to the system. Patients demonstrate both rational and emotional responses by how they access healthcare. Some find alternative therapies are more sensitive to their emotional needs which suggests not only a degree of rejection of modern medicine but also often a desire to have a more personal relationship with providers. This is because in organisations, as Gutek (Gutek 1997) suggests, we are moving from relationships to encounters, the former based on trust while the latter are based on standardised procedures such as clinical protocols.

RELATIONSHIPS	ENCOUNTERS
Participants are known to each other	Participants are strangers: maybe anonymous
All providers not equivalent	Providers interchangeable, functionally equivalent
Based on trust	Based on rules
Elitist: individuals treated differently	Egalitarian: individuals treated alike
Customized service	Standardized service
Difficult to start	Easy to enter
Difficult to end; loyalty a factor	No obligation to repeat interaction
Fosters knowledge of other	Fosters stereotyping of other
Creates weak ties, networks	Does not foster networks
Does not need infrastructure	Is embedded in infrastructure
Fosters emotional involvement	Often requires emotional expression not felt
Inherent feedback loop	Feedback loop thro' management not thro' consumer/provider
Become more effective over time	Designed to be more operationally efficient

**Table 1** Differences between Relationships and Encounters in Health Care (based on Gutek 1997):

Gutek, B. 1997, 'Dyadic Interactions in Organisations ', in *Creating Tomorrow's Organisations-a handbook for future research in organisational behaviour*, C. Cooper & S. Jackson, eds., ©John Wiley & Sons Ltd Reproduced with permission

These interactions, which are in part a response to the pace of life and its discontinuity and complexity, are furthermore being mediated by technology, for example NHS Direct which uses telecommunication systems and evidence based decision support systems to provide health care. Emotions in these circumstances, as Gutek points out, are increasingly managed in a more transitory and impersonal way. Understanding the

emotional as well as the clinical impact of these developments will be crucial to their success, as unlike many other service and sales industries developing similar strategies, in healthcare the patient is the product. There is a need to acknowledge that the emotional content of the encounters between providers and patients is felt to be satisfactory by all parties.

We have already seen that trust has both rational and emotional elements. New technology is another area that may threaten the delicate balance of the doctor-patient encounter. As the genetic revolution takes off (Jones & Zimmern 1999), the signs which prompt the lay perspective to engage with healthcare professionals will be joined by new definitions of demand where clinical intervention is created (Mark, Pencheon, & Elliott 2000) based on signs apparent only to clinical professionals. Individuals will be able to be diagnosed with health problems which may not appear for some time, but for which early treatment will be advised. This is different from the emotional investment required for immunisation programmes, so easily disrupted themselves by scare stories. The difference is between accepting a pre-existing problem and the possibility of a problem developing. The patient will have no outward symptoms and therefore has to accept the doctor's word on trust. As we know from the anti-smoking campaign, younger people in particular find intimations of morbidity or even mortality often difficult to grasp. This scenario therefore implies, it seems, a higher reliance on the emotions and more particularly the emotional intelligence of clinicians.

Further integration of the rational and emotional aspects of health provision is also occurring through the developments of new roles; these blur the boundaries between *cure:rational:male* and *care:emotional:female*, an example of this is the development of the Nurse Practitioners' role. Many existing roles are also being re negotiated and eventually perhaps those remaining within only one context, rational or emotional, will be seen as the exception rather than the rule. The organisation itself will need to reflect these changes. Some evidence of this may already exist when and where emotion is accepted as a driving force of the organisation. It increases motivation, improves understanding, enriches job performance, reduces stress and enhances

relationships; but examples of such organisations in healthcare are still rare and often transitory developed only to meet a given set of circumstances.

One further aspect of the integration of rationality and emotion will be acceptance of the idea that knowledge based on reason is also implicitly valued in the organisation for its *emotional* role, as essential to the maintenance of trust between patient and professional. Reason is, in this context, the third party agent used as a justifiable tool to persuade both organisations and individual patients to set aside potentially negative emotional responses such as fear, to allow extraordinary interventions to occur.

The current separation of what are also described as objective and subjective feeling states (Ashforth & Humphrey 1995) has in the past been reinforced and maintained because medicine has long been able to relate emotion to physiological process, thereby defining its relevance as fundamentally biological. This perception of emotion in medicine, as reducible to rational analysis has organisationally and professionally been ratified. The simulation of these physiological responses, which the creative arts, and now virtual reality and the emotional labour process all facilitate, have also highlighted the need to connect emotion and its outward display to the internal world of feelings (Damasio 1999). Nonetheless the link between emotion and its manifestation can be unreliable if the physical response alone is used as an indicator of the presence of an emotion, and its relationship to consciousness is only just beginning to be explored (Damasio 1999).

As far as the future for users of healthcare are concerned it is increasingly necessary to provide better emotional support across the full spectrum of patient experiences, at entry, during treatment and when leaving the system. Perhaps better attention to those final colours will ensure a happy disengagement from the kaleidoscopic organisation thus ensuring that trust is maintained for the individual who may return to the system later on, and who will certainly relate their experiences to others.

Within the health system itself more attention will need to be given to the emotional impact of the organisational processes and activities, especially as they affect those new to the role and the organisation. This should provide a framework to guide future

entrants where none currently exists. Managing the negative outcomes, which are necessary transition points in organisational and clinical life, involves addressing the emotional impact on oneself and others. Organisations currently structure this around specific processes like accident reporting and stress counselling. Clinicians have only relatively recently developed methods of peer review and support, but even some of these do not pay enough attention to the emotional content of such activities. Neglecting the emotional impact may place even the rational elements of this process in jeopardy if it is seen as just a matter of defence against criticism. The capacity to manage emotion positively is developed implicitly through the socialisation processes for professionals and for organisations through the informal organisation or shadow systems (Stacey 1996). Now a greater ability to understand and characterise emotion explicitly within organisations is becoming necessary both ethically and legally.

To understand why these issues are of concern at both an ethical and legal level, the organisation must be considered in its wider environment. The social context is one where peer group (Mestrovic 1997) rather than political or organisational control is paramount, where the organisational structure is transitional and where there is increasing cynicism (Fineman 1997) about the manipulation of emotion to serve organisational purposes. If the peer group is located through a professional rather than an organisational group, as many are in health care, attempts by the organisation to challenge professional role boundaries (DoH 2000) may be doomed. This is because the strategies to protect them will be largely external. Peer groups are based on a fundamental emotional need to belong as a result of what Maslow (Maslow 1954) termed our affiliation needs. Peer groups are therefore relatively impervious to organisational attempts to control them (Mark & Scott 1992).

The prevalence of peer groups acting within their cultural norms has implications for how patients will respond to the different providers of care. The extent of the emotional connection between patient and provider will dictate the success or otherwise of health interventions. A recent example of this problem can be seen in the case of the Siamese twins Jodie and Mary, who were brought to the UK because of the special care they would require. However their clinical needs, which were

themselves the subjects of differing medical opinion, were more significantly a point of contention between the law, and religious beliefs of the parents (Orr 2000), who objected to the proposed treatment because it meant the death of one twin and a challenge to what the parents believe is God's will. The parents and indeed their beliefs were not derived from a UK environment so the imposition of UK law may have seemed a heavy price to pay for gaining access to what they had imagined was appropriate healthcare. They were alienated and isolated until their peers within the Roman Catholic church in the UK rallied to support their view, and countered what seemed to them as morally wrong, whatever medico legal opinion said.

### **The next pattern**

What I have tried to do in this paper is to address emotion as an explicit issue in health care organisation, its history, its current context and future opportunities. Habitually healthcare organisations have sought rational solutions, but in the event rationality alone has proved to be inadequate. What is now needed, I am suggesting, is better recognition and explicit discussion of the role that emotion plays in ensuring that, combined with rationality, we actually get what we need both as individuals and as a community. Notwithstanding, I have to accept that the use of the commanding metaphor of the kaleidoscope may have limited my perception. One twist of it will reveal other patterns and other interpretations all of which will have something to offer, but whatever these are they should now include the colour of the emotions which complement, contrast and coalesce with each other to show us what is really happening.

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