INTRODUCTION

Healthcare professionals are expected to work and make decisions in high-pressure environments while monitoring, evaluating and modifying their emotions constantly (Thompson, 1994). Holmes et al. (2006) suggest that feelings of disgust can violate these limits, adding to the emotional labour of healthcare professionals. Disgust can be a powerful experience, the reaction being swift, automatic and involuntary (Miller, 1993), leading to physical as well as psychological distancing of the self from the other (Curtis & Biran, 2001). Healthcare professionals spend a lot of time working in environments inundated with physical disgust elicitors, such as bodily fluids, foul smells, death and ‘envelope violations’, a term which refers to cases in which the normal exterior of the body is ruptured or altered (Curtis & Biran, 2001). Despite this, healthcare professionals have to act against the automated response of avoidance (Jackson & Griffiths, 2014). A comprehensive literature review (Hadjittofi et al., 2020) has identified that even though disgust is recognized as a prominent emotion for healthcare professionals, little is known about its experience and impact on clinical care. Interestingly, even...
though disgust has been identified as one of the most relevant emotions for healthcare in both professionals and patients (Davey, 2011), research to date has focused on the experience of the service user and not the professional carer.

### 1.1 Physical and moral disgust

Disgust is a powerful emotion, first theorized by Darwin, who posited that fear of contamination leads to the disgust reaction, which then initiates withdrawal behaviours and cognitions in order to avoid contamination (Darwin, 1872). The disgust reaction is swift, automatic and driven by fear (Miller, 1993), and when triggered leads to a distinct facial expression (Ekman & Friesen, 1986), a physiological response (nausea) and a behavioural response (avoidance) (Douglas, 1966). Disgust was initially seen as a reaction to physical stimuli that assault the senses (Miller, 1997), such as foul smells, bodily fluids, envelope violations and death (Angyal, 1941). However, more recently, socio-moral disgust has been identified as another facet of the disgust experience (Curtis & Biran, 2001). Curtis and Biran (2001) suggested this is an extension of physical disgust which has evolved to alert us to social ‘parasites’ and therefore avoidance of others that have in some way violated a moral code. Literature suggests that moral disgust is accompanied by other distinct primary emotions such as anger and contempt (Olatunji et al., 2012). These arise when we attribute agency to the external party that has violated a moral code, therefore triggering feelings of indignation (Lee & Ellsworth, 2013). Physical disgust, on the other hand, seems to be linked mainly to feelings of fear (Marziller & Davey, 2004).

The question arising therefore is whether moral and physical disgust refers to the same concept, since often the term ‘disgust’ is used by people to describe both aversive physical stimuli and immoral behaviours (Lee & Ellsworth, 2013). Some researchers suggest that moral and physical disgust are variants of the same theme but triggered by different elicitors (Lee & Schwartz, 2011; Schnall et al., 2008; Wheatley & Haidt, 2005). In support of this, Chapman et al. (2009) found that immoral acts elicit the same facial expression as physical disgust does, as well as triggering similar neural pathways (Borg et al., 2008), suggesting that even though triggers might be different, the response to the experience is similar. However, other research suggests that physical disgust is associated with different emotions (fear) to moral disgust (contempt and anger), but also shows different self-reported emotional responses, different time courses and gender effects (Simpson et al., 2006), therefore suggesting two separate emotional experiences.

Even though this is an ongoing debate, researchers recognize that an added difficulty in establishing a distinction between the two is that in real-life situations, both physical and moral disgust may co-occur, making it hard to differentiate between the two (Lee & Ellsworth, 2013).

The powerful response to both moral and physical disgust has, from an evolutionary perspective, aided survival as it guided avoidance of contamination from bacteria and viruses (Curtis et al., 2004). Through history however, this response has also been employed by humans to label outgroups as dirty, unhygienic and morally flawed in order to justify often brutal actions such as violence, genocide and class divisions (Taylor, 2009). Accumulating evidence in literature has shown that disgust can interfere with our ability to empathize, leading to dehumanization of the other, causing attributions that others are less than human (Harris & Fiske, 2006). Projecting disgust onto an outgroup is an effective mechanism to create avoidance as well as provide a perceived elevated social status for the in-group (Nussbaum, 2001). An example is Hitler’s propaganda in Nazi Germany which portrayed Jews as disease-carrying rats that needed to be cast out from society (Bloom, 2010).

### 1.2 Disgust in healthcare

In the literature so far, disgust within healthcare has been described as ‘the hidden side of nursing’ (Wilkes et al., 2003), a taboo topic (Muggleton et al., 2015) and a ‘hushed stressor’ for nurses (van Dongen, 2001). This, alongside findings from a literature review (Hadjittofi et al., 2020) which found that professionals struggle to talk about their experience of disgust, can help explain the scarcity of research in this area.

In terms of physical triggers to disgust, Sowinski (1991) explored how disgust plays a role within nursing homes and found that it can often trigger and fast track end-of-life decisions as it makes the decaying body more visible. Feelings of disgust can be experienced both by the professional and the patient, which can often make healthcare professionals work faster (Sowinski, 1991), as well as stay further away from the patient in order to cope (Lindahl et al., 2005).

In a qualitative study, Lindahl et al. (2005) conducted interviews with nurses caring for people with malodorous wounds and found that striving to be a good nurse was more difficult when the management of the wound was more challenging. Lund-Neilsen and colleagues (2005) also identified that when nurses underestimate the impact of malodour on themselves and fail to reflect on it, it can lead to miscommunication and maltreatment of patients.

Researchers have in the past suggested that feelings of disgust in conjunction with a tired, overworked healthcare professional can result in ‘disgust-conditioned violence’ in nursing (Ringel, 2003; Winter & Matzawrakos, 2009). This received more attention and momentum following the Francis Inquiry report (Francis, 2013), which recognized how, among other factors, feeling repelled by patients might make healthcare professionals more prone to neglect and even abuse of patients.

Apart from the physical triggers to disgust, research has also identified a socio-moral facet in the experience of disgust for healthcare professionals, alongside explicit and implicit negative attitudes towards patient groups they care for. For example, registered nurses were significantly more likely to agree that caring for obese patients is physically exhausting, uncomfortable, stressful and disgusting, compared to student nurses (Poon & Tarrant, 2009). Similarly, midwives are having to manage an unconventional emerging trend around eating,
encapsulating or burying the human placenta (Dickinson et al., 2017). Even though the instant reaction of midwives to these practices can sometimes be disgust, supporters of these practices appear to overcome the disgust reaction by reframing the experience as a natural, empowering practice of motherhood (Dickinson et al., 2017).

In order to cope with disgust, healthcare professionals have developed a range of strategies. Jackson and Griffiths (2014) found that familiarity with the patient reduces nurses’ feelings of disgust as they perceive patients as nicer. A comprehensive literature review (Hadjitoffi et al., 2020) summarized the current knowledge on how healthcare professionals cope with disgust into three main categories. First, by recruiting empathy, professionals can prioritize the patient’s needs, recognizing the need to provide them with relief and dignity. Second, professionals talk about emotional suppression of disgust, whereby they avoid thinking about their feelings in the moment and ‘get on with’ the task at hand. And finally, using practical strategies such as cleaning, looking away and using protective measures (gloves, masks and aprons) can help them manage feelings of disgust.

Pope and Tabachnick (1993) suggest that when it comes to professionals experiencing feelings of disgust in their clinical work, it is extremely difficult to acknowledge these and even more difficult to find an appropriate professional model and space to discuss them. Part of this might be due to training programmes not equipping students as well as supervisors with tools to deal with this (Pope et al., 1986). Even though professionals said that this gets better over time and with more experience (Lindahl et al., 2005), it is unclear from the literature how this is experienced at the very beginning of one’s career, when students are being exposed to novel situations and are developing their professional identity.

Becoming socialized to the role of a nurse or a midwife is a complex, interactive process in which content around the professional role, values, attitudes and goals are learned and internalized to develop a professional identity (Goldenberg et al., 1993). The literature around identity formation can help us to understand the complexity in nurses’ responses to experiencing and managing disgust. Social identity theory (SIT; Tajfel, 2010), in particular, can help us understand the ways in which nurses manage experiences that challenge social identities and what happens when these are threatened. Student nurses and midwives are in the process of developing a new professional identity, which will integrate organizational content around the professional role, values, attitudes and goals are learned and internalized to develop while still allowing for comparisons across participants (Smith et al., 2009). The female interviewer had received specialized training in Qualitative Research Methods at postgraduate level—including training in interview skills and interview data analysis.

1.3 | Rationale and aim of this study

The aim of this study therefore is to explore how nursing and midwifery students experience, understand and cope with disgust in their clinical work. Given the exploratory nature of the study, interpretative phenomenological analysis (IPA: Smith et al., 2009) through in-depth interviews was felt to be a suitable methodology as it allows the development of an idiographic approach and understanding of what it means for participants to experience disgust within their individual social realities (Bryman & Burgess, 1994).

2 | METHOD

2.1 | Design

The study followed an IPA design (Smith & Osborn, 2003) which allowed for the interviewing and analysis of the experiences of a small, purposive sample of participants (Smith & Osborn, 2003). This design is well suited to the open research question and its exploratory nature, as it allows for the complexity in each individual experience to develop while still allowing for comparisons across participants (Smith et al., 2009). The female interviewer had received specialized training in Qualitative Research Methods at postgraduate level—including training in interview skills and interview data analysis.

2.2 | Participants

2.2.1 | Recruitment

A volunteer sample of nursing and midwifery students was recruited from a university in the south of England through posters placed on campus as well as posting on relevant student Facebook groups. Participants that expressed interest were sent an email containing a participant information sheet, a consent form and a topic guide so they could make an informed decision. The participant information sheet provided information about the researcher as a female clinical psychology trainee, completing her doctoral thesis. For interested parties, arrangements were then made for interviews to be carried out on campus.

2.2.2 | Sampling strategy

A sample of six participants was interviewed, in line with IPA research recommendations (Pietkiewicz & Smith, 2012), allowing for
in-depth analysis of accounts (Reid et al., 2005) and preservation of the individual ontological aspects of the data (Larkin & Thompson, 2012).

A homogeneous sample was recruited, consisting of midwifery and general nursing students. Drawing on two nursing fields increased the number of participants while allowing exploration of the concept of disgust in a sample where this has personal relevance and significance (Pietkiewicz & Smith, 2012). The literature does not suggest that different nursing specialisms affect attitudes in student nurses. Both general nursing and midwifery students undergo a process of professional identity development, which integrates organizational values with their own personal values and morals (Salvage, 1990). To ensure homogeneity of sample in terms of past experience, all participants were recruited from the same university, and if they were first years, they were required to have pre-training clinical experiences to allow them to draw on professional practice examples.

2.2.3 | Sample

All participants were female and currently undertaking either their nursing or midwifery course at a University in England. Four participants were on the midwifery course, of which one was in the first year, one was in the second year, and two were in their third year. Two participants were on the general nursing course, both of which were in the third and final year. It is important to mention that students ranged in terms of their age from 21 to 31, with some being mature students who came unto their respective courses with varying amounts of personal and professional experience.

2.3 | Interviewer characteristics and reflectivity

Interviewees were aware that the interviewer was a female doctoral student at the time of the interviews and of similar age to most participants, which enabled a good rapport to be developed with participants. The researcher aimed to be as transparent as possible with this research project and in order to ensure this, a reflective log was kept throughout the process, to identify biases and assumptions. Furthermore, the discussion of these with research supervisors allowed this to remain transparent and open to feedback and critique.

2.4 | Ethical considerations

Favourable ethical approval was granted for this project by the Faculty of Health and Medical Sciences Ethics Committee (number 1362-PSY-18). On arrival, participants read the information sheet, poster and consent form again. This ensured participants understood their data would be anonymized and kept in a secure location only to be accessed by the research team and then destroyed under the Data Protection Act 1998 in due course.

2.5 | Data collection

In-depth reflexive IPA style interviews (Smith et al., 2009) lasting between 34 and 122 minutes were audio-recorded and transcribed on the university campus. Interview questions focused on experiences of disgust as a nursing/midwifery student, thoughts and feelings around it, institutional understanding of disgust and what support participants use to cope with disgust.

2.6 | Data analysis

An IPA approach to analysis of the transcribed interviews (Smith & Osborn, 2003) drew on reflexive practice throughout data collection to sustain a reflexive engagement with the transcripts in an interpretative, idiographic process. In order to maintain the respondent’s confidentiality, appropriate aliases were assigned to each participant.

2.6.1 | Single-case analysis

Each transcript was read in-depth several times, allowing the researcher to familiarize themselves with the material. During this process, significant utterings and emergent themes were identified separately for each transcript and the same process was repeated for each interview.

2.6.2 | Emergent themes

Themes emerging from the data were initially listed on a paper in chronological order of occurrence, followed by a more theoretical re-ordering as the researchers made sense of the data by identifying connections between the themes, organizing them into potential clusters and hierarchies. The themes were then organized into subordinate and superordinate themes, which were then tabulated with identifiers from each transcript.

2.6.3 | Cross-case analysis

Once all transcripts were analysed, a final table of superordinate themes was constructed. This required collecting all the themes in a table and slowly reducing them, based on the richness of data, prevalence and how illustrative they were. This also meant looking out for similarities as well as differences between emerging themes in different transcripts. As the analysis continued, the researchers kept returning to the transcripts to ensure that as abstraction continued at higher levels of convergence, themes remained true to the data. Discussions between authors enabled the selection and condensing of the themes to ensure a thorough analysis. A sustained attempt was made to remain sensitive to the context, transparent and coherent in the process (Yardley, 2000) as well as applying rigour to
the collection and analysis of data, while keeping in mind personal background and research lenses.

3 | FINDINGS

Four superordinate themes and eight subthemes were identified and summarized in Table 1. From these, two themes and one subtheme were selected on grounds of relevance, novelty and contribution to the existing body of knowledge.

3.1 | It is never acceptable to show disgust to our patients

This subtheme explores the challenge of balancing acceptance of the very human visceral experience of disgust against the culturally strong professional value of never expressing to patients and about how it is expressed to other professionals. Through the language used to describe this experience and the comments made about the term disgust itself, participants convey the dissonance between ones’ internal experience of disgust and the masked or filtered external expression of it. All participants agreed that it is not professional to express or show disgust to the people they care for. Within their talk, there is a clear expression of professional identity, which dictates the expectations placed on them as professionals and which mandates acceptable behaviour. Sue and Laura talk about how the expression of disgust could be a ‘barrier to trust’ at it might come across as judge-

ment. All participants spoke about the detrimental effects of expressing disgust and how it can often cause the patient to experience embarrassment and discomfort, compromising their ‘dignity’. Within this subtheme, the researcher’s observations are also incorporated, as they are thought to further illustrate aspects of this subtheme.

Katie talks about how ‘you should ideally keep it to yourself’ and feels that expressing disgust openly could actually have a great impact on your career: ‘if you were kind of just saying it, it could be seen as gossip, I actually think that it could be something that you get stuck off for. That’s how strict they are’. Similarly, Mary links the suppression of disgust to the professional role of how a nurse needs to behave and how showing disgust relays a sense of judgement:

I think as a nurse we should be able to respond to everything that’s thrown at us. If we suddenly think “Actually no, that’s disgusting” and we’re meant to be non-judgmental, people would be like, you shouldn’t be having judgements. You shouldn’t judge people, but sometimes as a human, you can’t really help it. You’ve just got to keep it to yourself.

Tanya also summarizes it well when she points out that:

I think it’s more the embarrassment for the patient you’re trying to avoid. I’d feel horrendous if I was in hospital for something and being looked after by someone and they turned around to me and said “you smell or you’ve done something that smells”. You’d feel really bad and I think it’s an embarrassment thing [...] You have to be professional don’t you? There’s no way around it.

3.2 | It’s easier to talk about moral disgust

This master theme relates to how many participants made a clear distinction between physical and moral disgust and the differences in the ways that they are talked about. While participants did not explicitly say that it was easier to talk about moral disgust, it was apparent by looking at the way and the length at which they talked about each one. Moral disgust appeared to relate to how others acted, both professionals and patients, in a way that might be morally questionable. These moral transgressions would then initiate feelings of disgust, which were then tied in with a sense of responsibility.

For example, Jess talks about moral disgust at length, and about how ‘unfair’ it is to be talked down to and how as students ‘you’re the lowest of the lowest’ and how she finds that the ‘most disgusting bit’ and goes on to give further examples. When it comes to talking about physical disgust though, she talks about it like a silenced part that does not get talked about much: ‘No one enjoys that aspect of care. But there’s no point talking about it ‘cause you just have to get on with it’.

Similarly, when Katie was asked about physical triggers to disgust her response quickly moved back to moral aspects of disgust:

When things can go wrong, ehm, yes. I mean. Ehm. Yes. There have been a few times in surgery, so I mean, I suppose there’s they physical side of it. You do have quite a few people that faint and so, yes you’ve got that. But personally, it makes me feel really uncomfortable when professionals are not nice to pa-

ents. I mean come on, that’s basic professionalism. So that makes me feel more disgusted.

Similarly, Tanya explains how

Dealing with something that isn’t great, it doesn’t bother me. It took us a while, every time we went into the hospital, to actually get over that [sagging sound] [laughs] when you first get in there because it was gross, really bad. [chuckles]. Yes okay, when I’ve worked over here certain things have got me and I’ve had to stop myself from retching, but I think that comes with a healthcare professional’s job. But it’s totally different when people treat you or their patients like rubbish. That’s absolutely disgusting to watch, and unlike gross smells, that’s not something that goes away.
### TABLE 1 Master themes and subthemes with descriptions

| Master theme | Subthemes | Description |
|--------------|-----------|-------------|
| We are not supposed to express disgust as professionals. | But we do experience it—it’s a normal reaction | All participants talk about experiencing disgust and how it is a very immediate, visceral and automatic response yet it is unwanted. Most participants normalize it as a human experience which cannot be helped, but stress the importance of not letting it interfere with the care of patients. |
| | It is never acceptable to show disgust to our patients | Participants considered it highly unprofessional to express or show disgust to patients. The use of language shows a strong sense of professional identity which dictates expectations placed on professionals and what good care looks like. Expressing disgust is seen as a ‘barrier to trust’ and could lead to patients experiencing embarrassment or discomfort, compromising their sense of dignity. Participants stress the importance of being empathetic to patients as a means to overcome disgust. |
| | We use euphemisms or other words to express it | Participants felt that even using the word disgust is taboo, describing it as a ‘bold’, ‘strong, judgmental word’. One participant (Mary) says that ‘disgust and nursing aren’t words that normally match’. Participants appeared to steer away from using the word disgust and instead used words like ‘difficult’, ‘challenging’ or ‘gross’. |
| | It’s more acceptable to use the term within a personal context | Three of the participants made particular reference that the term disgust feels different and more acceptable if used in personal environment. Using it with family members means it can be used in a humorous, jovial way. Jess uses the example of telling her nephew that picking his nose is ‘disgusting’, but that she wouldn’t use the term if he was ill, as his symptoms in that case would not be deliberate. |
| We have ways of managing disgust | We just get on with it | Participants described the practical, immediate behaviours that they engage in to cope with the disgust reaction. These responses allow the creation of boundaries and distance, for example putting gloves and aprons on, cleaning or covering up. Participants minimize and suppress their own emotional responses to triggers and comment on the need to ‘get on with it’. |
| | We normalize it for ourselves and our patients | Participants emphasized how important it is to normalize the experience of disgust through discussions with trusted colleagues as well as the use of humour. Additionally, they note how normalizing the disgust-eliciting events to patients as well can help reframe intimate care as a privilege. All participants made significant reference to the personal and professional importance of remaining empathetic as a means to overcome disgust reactions. |
| | We all react differently which allows us to work as a team | Participants explained that disgust-eliciting experiences differ between professionals, with some finding triggers (sputum, vomit, malodour) more aversive than others. Participants describe how this can be a strength in teams so that colleagues can help each other out. However, participants also describe how experiencing intense disgust reactions can have an impact on the care delivered and how, if left unaddressed, can mean that nurses avoid spending time with the patient and use dehumanizing language to describe them. |
| | We get used to it over time | All participants talked about how over time and exposure, a lot of triggers that might cause them to feel disgust lose their potency and become normal parts of care, describing how their ‘disgust threshold increases’. |
| It’s easier to talk about moral disgust | | Participants appeared to make a clear distinction between physical and moral disgust reactions and their different elicitors. Moral disgust appeared to be triggered by other peoples’ actions, both professionals and patients, when they are perceived to be morally questionable. Participants would then talk about subsequent feelings of disgust which were tied in with attribution of responsibility to the person exhibiting these behaviours. From the transcripts, it appeared to be easier for participants to talk about moral disgust. Participants appeared to find it easier to talk about moral disgust as they spent more time describing examples in detail, their own feelings and thoughts during these events and their thoughts around other peoples’ reactions to it. |

(Continues)
3.3 ‘We’ respond to moral disgust by distancing ourselves from ‘them’

This master theme relates to how most participants said that they respond to moral disgust by creating distance, either physical or emotional between themselves and the ‘immoral’ other.

For Jess, it is evidenced in the way that some professionals further up the hierarchy treat the hospital setting ‘almost like their stamping ground. That makes me feel disgusted’. She goes on to say that in order to cope ‘we have to almost sideline them and distance ourselves from those professionals and still do our thing. It maybe feels a bit underhand but ultimately you are doing it for the right reason’. Similarly, when Laura experiences bad practice from others she talks about ‘not wanting to be a part of it’. Yet feeling ‘like you’re under that umbrella with them as a professional. That’s when we’re all like “ugh, that’s disgraceful” and that feeling makes you want to learn and be different’.

Mary makes reference to the relevance of agency, moral disgust is relevant where the individual has choice in how they behave-

staff members talking in a particular way to patients or other staff, that’s deliberate. And it makes me feel disgusted. You don’t have to be doing that and you can change that. I think that’s what makes it less acceptable and more disgusting.

Similarly, Tanya talks about how disagreeing with practice and feeling morally disgusted forms your ‘opinions on people who you’re disgusted by’ and as a result she will ‘go away and I’ll think “I don’t want to practice like that. I don’t want to act like her”’. Tanya recognizes that one of her coping strategies is to socially and physically remove herself from the situation: ‘If I saw something particularly disgusting in terms of how a member of staff spoke to another member, I would probably walk away rather than get involved and deal with it’. This is an interesting comment, as she avoids taking any action against what she is witnessing, but instead feels that as ‘time goes on, you just tend to deal with it better or maybe turn a blind eye’.

4 DISCUSSION

The experience of disgust by healthcare professionals is greatly under-researched (Curtis et al., 2011; Holmes et al., 2006) even though it is recognized as a commonly triggered emotion (Davey, 2011) with potentially severe consequences on healthcare provision (Goergen, 2001). In an effort to address this significant knowledge gap, this study aimed to explore how nursing and midwifery students experience and cope with disgust and how this experience affects their clinical practice. Given that theoretical frameworks relating to the experience of disgust within healthcare are limited, this paper makes a unique contribution to the literature by situating the findings within the context of intergroup theories of identity, namely SIT (Tajfel & Turner, 1979b) providing a robust lens through which the results can be understood and integrated and forms a basis for the application of findings to improve quality of care.

Overall, the key superordinate themes identified through analysis show that participants feel that We are not supposed to experience disgust as professionals, however We have ways of managing disgust. In addition, it appears that It’s easier to talk about moral disgust and that ‘We’ respond to moral disgust by distancing ourselves from ‘them’, that is other people who fracture the ‘moral order’ in some way. Together with the eight sub-themes, these themes show that the experience and expression of disgust in a healthcare context are a complex and ambiguous process, inextricably linked with the participants’ professional identity. Nursing has historically struggled to establish a professional image (McAllister et al., 2014) and so has midwifery (Foley, 2005), as they were both historically seen at the periphery of medicine and thus constantly had to negotiate their own identity and professional boundaries (Foley & Faircloth, 2003). Such views still permeate society, alongside strong narratives which see nurses and allied professionals as self-sacrificing and altruistic (Gordon & Nelson, 2005), which in turn might make participants more vulnerable to social desirability bias in order to portray a positive self and group image (Tajfel & Turner, 1979). The implications for this study are that in order to protect their professional identity from the potential dissonance, participants may have struggled to admit to an experience that is deemed inappropriate.

One of the main findings was that participants experience physical disgust and their descriptions of it are in line with existing literature, in that participants talked about an often quick response which consisted of a specific facial response (Ekman & Friesen, 1986), a physiological visceral response (nausea) as well as the behavioural response of avoidance (moving away, looking away or distracting) (Douglas, 1966; Rozin & Fallon, 1987). The triggers to these reactions as described by the participants can vary, with smells and bodily fluids being the most commonly mentioned aspects. These triggers are in line with literature which suggests that physical disgust is most often triggered by things that are warm, wet, sticky, soft, slimy and
remind us of our animal nature (Angyal, 1941; Miller, 1997). The mechanisms and coping strategies that participants most talked about all seem to relate to building and maintaining a barrier, whether perceived (distracting self and patient) or physical (wearing aprons, gloves, cleaning, moving away) between themselves and the trigger.

One important finding is that participants are then faced with the dissonance between experiencing disgust, yet the need to suppress or modify their expression of it. They unanimously agree that it is not appropriate for them to show disgust to patients and therefore engage in strategies and processes in order to cover it up and suppress it. This appears to be dictated by the professional identity of what it means to be a nurse/midwife and all participants say it would be ‘unprofessional’ to show disgust. Traditionally, caring professions have been expected to preserve professionalism by minimizing their own reactions, while still remaining available and warm towards their patients (Hochschild, 1983). Social identity theory (SIT; Tajfel & Turner, 1979b) suggests that a sense of belongingness is crucial for everyone and that following self-categorization in a group (nurse/midwife), people engage in social identification where they adapt to the identity of their chosen group. In this case, this identity incorporates aspects around how to present oneself to patients, integrity to practice and appropriate care of patients (Hewison, 2001). This then creates a robust internal construct of group membership, with participants actively engaged in the process of maintaining a positive self-image and group image (Abrams & Hogg, 1990). When the in-group experiences identity threat (disgust), they can engage in a range of behaviours to restore a sense of stability and favourable opinion of their group (Hogg, 2016), which could take the form of avoiding talking about the topic, minimizing it or using euphemisms to allude to it.

The experience of disgust, therefore, might be contrary to a salient professional identity of being a nurse or midwife and as Mary puts it, ‘the words disgust and nursing aren’t words that normally match’. When considering the salience of the professional identity, it is also important to think about the wider narratives of the National Health Service (NHS) in which they are embedded. The NHS has undergone several restructures since its inception and has been seen as the ‘nearest thing this country has to religion’ (Warner & O’Sullivan, 2013, p. 7), suggesting a certain national pride in the NHS. In addition to this, the introduction of NHS values nationwide (Dixon, 2000) with the aim of providing high standard of healthcare sets the scene for what the professional ethos is (Hewison, 2001). Although these values provide a compass with which clinicians and managers navigate their work, it can also cause confusion, tension and difficulty making decisions (Wall, 1993). This has been argued to be in part due to the often unachievable level of expectation being placed on clinicians, given the current economic and political climate, where providing a universal and equitable service to those in need is currently impossible (Maynard & Williams, 2018; McKenna, 2018). However, this does not stop these values from becoming embedded into the narrative of what it means to be an NHS employee and in the context of this study, adding to the challenge of trying to maintain these values while experiencing disgust.

These findings also contribute knowledge to our understanding of emotion management in healthcare by showing that disgust can be an additional, yet silent, cognitive burden for participants which interferes with empathic abilities. Literature suggests that even though suppressing disgust might decrease its behavioural expression, it also prolongs its experience (Gross, 2002; Holmes et al., 2006; Richards & Gross, 1995), which in turn uses cognitive recourses which can potentially impact performance on other tasks (Gross & Levenson, 1997). Experiencing disgust has been shown to decrease ability to empathize (Gilbert, 2005) which in turn can contribute to sub-optimal care via not recognizing or neglecting the needs of others (Muggleton et al., 2015). Given that healthcare professionals are often stretched for time, tired and experiencing compassion fatigue (Austin et al., 2009), the impact of the experience of disgust could compound that further. More importantly, suppressing it does not guarantee that patients do not detect it, since patients are often aware that their symptoms might trigger disgust (Bland, 1996), they experience shame and embarrassment about it (Ousey & Roberts, 2016) and they can often read the body language of professionals who inadvertently ‘leak’ their emotional reactions (Lindahl et al., 2005). From what participants said, making effort to acknowledge the patient as a person and therefore as someone in need, can help them overcome the disgust reaction. This is in line with findings from a literature review, which identified empathy as a key component to dealing with disgust in healthcare (Hadjitoffi et al., 2020).

More importantly, as some participants point out, experiencing disgust can impact on the care being delivered by teams, as patients are actively then avoided. This, although a difficult realization, is important as it suggests that disgust can indeed play a role in how patients are treated, as shown by the Francis Report (2013). The question then is, if disgust itself is a taboo topic to talk about for healthcare professionals, how does one talk about its impact on care? Taboos are very hard to deviate from (Fiske and Philip, 1997), they come with a social cost of being outcast from the in-group (Romer, 1984), and due to their nature, they might be hard to consciously identify (Spain, 1988). Therefore, given the findings in this study, it is important to consider how to encourage deviating from the taboo in such a way that benefits both the professionals as well as the patients.

Another key finding was that participants made a distinction between moral and physical disgust and additionally found it easier to talk about moral disgust, rather than physical disgust. This might have been because participants experience more of it, compared to physical disgust. However, looking at the number of examples of each provided and the discourse when discussing them, this does not seem to be the case. Instead, it appears that moral disgust is easier to talk about and this can be understood in terms of the purposes which it might serve. Curtis and Biran (2001) suggest that similarly to physical disgust, moral disgust alerts us to social ‘parasites’, which can then result in ostracizing people that have violated a socio-moral code of conduct (see Haidt (2003) for further expansion on moral emotions and their purpose). Moral disgust assumes that the ‘other’
has agency and control over their actions (Lee & Ellsworth, 2013), whereas with physical disgust, it is harder and less appropriate to assume people have responsibility over their physical symptoms (Lindahl et al., 2005). Interestingly, feelings of moral disgust towards others seem to heighten feelings of self-efficacy (Smith & Ellsworth, 1985), which might explain why it was easier to talk about. In addition to showing that identity as a professional may offer a powerful explanatory mechanism for understanding the experience of disgust, this study also suggests that moral disgust is also a prevalent aspect of healthcare which was not identified through the literature review (Hadjittofi et al., 2020) and is therefore an original contribution to our knowledge.

The findings are also pertinent to the debate as to whether moral and physical disgust are related to the same concept or not. All participants made a distinction between the two, in that physical disgust is elicited by different stimuli to moral disgust, which is consistent with findings in the literature (Lee & Schwartz, 2011). Participants, however, described the two experiences using the same term (disgust), exhibited the same facial expression when describing their experiences and described similar responses for both physical and moral disgust (avoidance and distancing). This therefore suggests that even though moral and physical disgust might have differences, they also have significant overlaps (Simpson et al., 2006). Given, however, that participants found talking about moral disgust easier, it is important for future research to keep the distinction between the two and to further explore what it is about physical disgust that makes it harder to talk about and whether using the same umbrella term for both is useful.

One of the key findings is that participants have ways of coping with disgust. Even though some might not be as successful (suppressing it) or helpful (walking out), participants see the value in using them. One of the most effective strategies used is normalization through their peers and mentors. Participants talked about the comfort offered in knowing others are experiencing something similar and how they can learn from that.

### 4.1 Limitations of current study

This study has helped to improve our understanding of the experience of disgust by midwifery and nursing students and has shown that this is a complex experience with strong implications for their professional identity. Although this is a novel exploratory study with a purposive and intentionally small sample which invites only tentative interpretations, there are good reasons to rely on the credibility of findings. Even though the sample is small, it enabled detailed engagement with each idiographic account, ensuring all voices were captured (Smith et al., 2009).

It is recognized as with all IPA studies that interpretations were made through the personal lens of the researcher and are open to re-interpretation. However, the fact that the data both resonates with previous findings from a literature review (Hadjittofi et al., 2020), as well as adds to our understanding of professional identity does more than confirm the assumption of relevance. Additionally, from interviewing students from two separate practitioner courses, it also allows tentative parallels to be drawn about similarities within their experiences. Indeed, findings cannot be generalized to the general nursing and midwifery population, as they relate to the specific experience of these six participants, who are also students. It does, however, provide a strong basis for further research.

Even though the researcher drew on literature from SIT (Tajfel, 2010) as a productive framework to interpret findings, this is not the only theory that could be used to understand the participants’ experience. Other theories such as Kristeva’s theory of the Abject (Kristeva, 1982) and more psychodynamic understandings of disgust as a primal rejection of the foreign (Juni, 1984) could be used to interpret data, alongside more recent theories, like the three systems of affect regulation (Depue, 2005; Gilbert, 2005). SIT was thought more pertinent though as it has much better conceptualization of group memberships, their narrations and influences on behaviour, compared to other theories. Since its inception, SIT has developed a robust and comprehensive evidence base which integrates theories of the self as well as having a strong explanatory power for intergroup behaviour (Hogg & Smith, 2007). Like all identity theories, SIT has received criticisms, with authors suggesting that one of its main limitations is that it does not adequately take into account the wider social environment of group memberships, norms and identities (See Prislin & Wood, 2005) as it mainly focuses on attitudes and individual cognitions, and has neglected the wider social context (Hogg & Smith, 2007). Including literature therefore on the NHS context and societal climate is thought to add weight to the interpretation of these findings.

### 4.2 Clinical implications and future research

The study’s findings suggest that there are several future directions for research as well as clinical applications for this knowledge. First, participants showed that talking about disgust can be hard; however, with normalization from peers and mentors, it can be discussed and addressed. It is therefore important to consider ways of introducing this practice on placements as well as in teaching. As Alavi (2005) also points out, student nurses are not well-prepared to work with patients that they might feel disgust towards and there is a real lack of a confidential space for nursing and midwifery students to explore this further without feeling judged. The findings therefore are most pertinent to the current nursing and midwifery training courses, as these need to begin considering how to incorporate further teaching on this topic. This could take the form of pedagogy, or it could take the form of reflective group discussions with older students or clinicians and mentors who can talk about their own experiences. This will hopefully provide an opportunity to further develop education around the emotion of disgust during training by encouraging students as well as managers and mentors to provide support.
practice groups have been proven to be very helpful to students as they enhance normalization of experiences and create an open atmosphere where students can integrate theory and practice (Mann et al., 2009). Additionally, seeing others model an open approach to it might help students feel more comfortable to break the taboo.

Even though findings are tentative, and within a specific population of nursing and midwifery students, it is important to begin thinking about how this experience might be relevant for other clinicians within the healthcare system. Further research, therefore, could take a more nomothetic approach, looking at the extent to which these factors affect healthcare across settings.

Even though participants were interviewed prior to the COVID-19 outbreak in the UK, it is important to connect findings about the experiences of disgust healthcare professionals have, to the current crisis experienced by healthcare systems across the world due to COVID-19. Emerging research already agrees that disgust sensitivity drives contamination avoidance behaviour of COVID-19 (Waqs et al., 2020). With healthcare professionals being in close proximity to COVID-19 patients knowing that they could also be putting their loved ones at risk, naturally increases worries of infection (Brooks et al., 2020), which could change the care delivered if it’s not addressed.

5 | CONCLUSIONS

The current study has contributed three major findings to our existing knowledge. First, nursing and midwifery students experience disgust, yet they believe it unprofessional to express it to their patients and have thus developed ways of coping with it, based on their professional identity. Second, participants have made a distinction between moral and physical disgust and have demonstrated that both are highly relevant to the environment they work in and may have an impact on patient care. Finally, participants find moral disgust more acceptable to talk about, especially when directed towards people that might be perceived as outgroup members. Even more importantly, within these findings, participants’ discourse and body language showed how hard it is to open up about this topic, especially given the perception that they might be sanctioned for feeling this way towards their patients.

Although these findings are tentative, given the small sample and exploratory nature of the study, they do suggest that we might consider how training courses as well as healthcare foundations and services can provide a safe space for professionals to address, discuss and normalize disgust. The study also raises concerns around what might happen if we keep stretching our healthcare professionals, increasing their caseloads without further support within an already stretched and struggling healthcare system (Campbell, 2016). As we already know, emotional management can often be a difficult and neglected aspect of being a healthcare professional and therefore finding ways to support it is crucial, as this will then enable professionals to engage empathically with their patients, maximizing the quality of the care they can deliver.

CONFLICT OF INTEREST

None.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ORCID

Marilena Hadjittofi 🐦 https://orcid.org/0000-0002-8122-6591

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