Witnessing the Ward: On the Emotional Labor of Doing Hospital Ethnography

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Abstract

This paper examines the emotional labor performed by researchers when undertaking ethnographic research in hospitals. Drawing on emotion work theory to situate emotions at the center of qualitative and interdisciplinary research, I provide a methodological reflection based on a 20-week long ethnography at a Canadian pediatric hospital I conducted in the context of a research project examining risk communication of antimicrobial resistance. I argue that the emotional labor in which hospital ethnographers engage starts long before the fieldwork and carries on throughout the project and into the data analysis and writing of results. I divide these instances of emotional labor into four categories: gaining and maintaining access to the field site, resolving ethical concerns, managing relations with participants, and witnessing human suffering. This paper addresses a gap in the literature regarding the various barriers that hospital ethnographers encounter as I reflect upon the challenges I faced and the emotional labor I intuitively engaged in and provide advice for researchers on how to navigate these barriers.

Keywords

emotional labor, hospital ethnography, interdisciplinary research, qualitative research, reflexivity

Introduction

There is a growing body of literature examining researchers’ emotional experiences and emotional safety while conducting research on sensitive topics (c.f. Dickson-Swift, 2017; Lalor et al., 2006; Tolich et al., 2020); however, studies on the emotional labor performed by hospital ethnographers is very limited. While hospital ethnography is a well-established methodology and a field of study in itself (cf. Finkler et al., 2008; Strauss et al., 1963; van der Geest & Finkler, 2004), there is a gap in the literature regarding the various levels of ethical, institutional and legal barriers that hospital ethnographers encounter and the emotional labor involved in this process. In this paper I reflexively examine the emotional labor I engaged in while doing ethnography in a pediatric hospital in Canada. The study that provides the backdrop for this paper involved doing ethnography focused on risk communication of antimicrobial resistance, healthcare professionals’ risk perceptions and infection prevention practices. In this paper I reflect upon this experience and the challenges I faced to address two questions: 1) what kind of emotional labor does the hospital ethnographer perform at various stages of the research project? and 2) what are the ethical and institutional challenges for conducting hospital ethnography? Drawing on emotional labor theory and fieldnotes documenting my experience as a hospital ethnographer, I discuss the methodological intricacies of accessing a health institution as a field site and of doing ethnography in a pediatric ward, particularly in relation to moments when as a researcher I had to do emotional labor, understood as face-to-face interactions that produce an emotional response and that require the management of one’s own emotions (Steinberg & Figart, 1999).

In order to conduct ethnography there has to be mutual interest in order to build a relationship between researchers and participants; hospitals, however, are highly structured, closed and excluding institutions (Foucault, 1975). The “defensiveness of hospital authorities and their hesitation in allowing observers enter their workplace” (van der Geest & Finkler, 2004, p. 196) has been recognized by many scholars as practical reason why there are few hospital ethnographies conducted in Western countries. Despite being closed and hierarchical institutions, Strauss et al. (1963) noted that hospitals

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have a “negotiated order,” an implicit level of organization in daily negotiations among doctors, nurses, aides, administrators, and patients (p. 148). These negotiations can lead to tacit agreements or understandings, however influenced by power relations that enable and constrain interactions and negotiations (Liberati, 2017; Nugus, 2019; Strauss et al., 1963). I use the concept of negotiated order to examine how various actors in the hospital, including the ethnographer, navigate hierarchical relations, institutional regulations, and epistemological and methodological disciplinary differences.

I argue that there are many instances throughout the research process in which the ethnographer must perform emotional labor, including the early stages of the research project, the observation in the ward, data analysis, and writing process. I first review the scholarship on emotional labor in qualitative research. Then I discuss the hospital as a space with strict hierarchy and regulation, but also a site for constant negotiation and reorganization. Next, I examine the various ethical institutional challenges when doing ethnographic research in hospitals and reflect on the implications of the researcher’s emotional labor on data collection and analysis. This paper also aims to shed light on the intricacies of conducting ethnographic work in health institutions. The current SARS-CoV-2 pandemic has strained hospital resources in Canada as well as healthcare workers’ physical and emotional wellbeing, and in this context, it can be assumed that barriers and challenges for hospital ethnographers have also intensified, particularly in relation to infection prevention and control measures. The reflections presented in this paper will also help researchers navigate the institutional and ethical challenges of conducting a hospital ethnography in the midst of a global pandemic.

**Emotional Labor**

In conducting qualitative studies, researchers are expected to be aware of their participants’ emotions and prevent any emotional harm to them, and these protections are highlighted in ethical codes (Nutov & Hazzan, 2011). However, researchers themselves report the various emotions they experienced in conducting their research at different stages, such as joy, loneliness, frustration and apprehension (ibid). Emotions are a central component of social research (Dickson-Swift et al., 2009), including the researchers’ emotions. “Emotional labor” or “emotion work” denote face-to-face interactions that produce an emotional state in another person, while at the same time managing one’s own emotions (Steinberg & Figart, 1999).

Emotional labor is part of the wider concept of emotional intelligence, defined as “an individual’s ability to identify her/his own emotions and emotions of others, and thus to form favorable relationship with others” (Wen et al., 2019, p. 121). Emotional intelligence involves three specific abilities: (a) emotion evaluation; (b) expression and regulation of emotion; and (c) use emotion to solve problems (ibid).

Emotional labor involves following specific “feeling rules” (Bellas, 1999; Diefendorff & Gosserand, 2003), such as not expressing emotion in professional or academic contexts. Following these display rules “may require the use of emotion regulation strategies such as faking an unfelt emotion or suppressing an inappropriate felt emotion” (Diefendorff & Gosserand, 2003, p. 945). A related concept is that of emotion management, which supposes “an effort by any means, conscious or not, to change ones feeling or emotion” (Hochschild, 2002, p. 9). In her classic study on emotional labor, Hochschild argues that emotional labor can have “human costs” such as feeling “burnout” or “self blame,” as well as detrimental consequences for psychological well-being (Hochschild, 1983).

Emotion management can be achieved through surface acting and deep acting (Diefendorff et al., 2005). Surface acting refers to adjusting the visual display of emotions to fit the emotion rules of the organization (Hochschild, 1983). Deep acting refers to instances in which the individual’s inner feelings do not match the performance required by the organization, so through a deep psychological process that seeks to stimulate positive emotions while suppressing negative ones, the individual is able to experience emotions that match the organization’s emotional performance requirement (Grandey, 2000). Therefore, emotional labor is a useful analytical tool to examine intersectional power dynamics, for example in healthcare settings where workers are expected to comply with emotion rules set by employers and managers, and junior physicians and nurses should manage their emotions according to professional standards and to gain the respect of senior colleagues (Haas & Shaffir, 1991).

Qualitative research in public health, such as hospital ethnography, can be a highly emotional experience that elicits a wide array of feelings in the researcher, from anger and frustration to sadness, anxiety, guilt, and occasionally relief (Dickson-Swift, 2017; Lalor et al., 2006). This type of research can also lead the researcher to reflect on his or her own life experiences and reliving some traumatic experiences (Dickson-Swift, 2017; Dickson-Swift et al., 2009). Qualitative research on sensitive topics, such as pediatric illness, in which there are frequent face-to-face encounters with people in disheartening situations is associated to feelings of emotional exhaustion, a key component of “burnout” (Dickson-Swift et al., 2009). There are, however, no studies examining the emotional labor performed by hospital ethnographers, and this paper addresses that gap in the scholarship.

Academic research is embedded in an ideology of scientific objectivity, in which researchers are trained to suppress emotions while conducting studies (Campbell, 2002; Dickson-Swift et al., 2009). However, many scholars have argued that qualitative researchers no longer perceive themselves as objective spectators documenting other people’s lives, but instead are aware of the way in which their own emotions impact their research (Gilbert, 2001). Hence, it is valuable and appropriate for qualitative researchers to consider the emotions of participants and their own when designing, carrying out, and writing up their research, and to understand emotional and intellectual functions as inseparable from each other during the research process (Dickson-Swift et al., 2009; Harris & Huntington, 2001).
Furthermore, some qualitative research involves not only emotion work, but also embodied emotion work. Emotions have physical expression, such as watery eyes or plain crying, broken voice, face flushing, feeling nausea. It can be difficult for researchers conducting qualitative studies on sensitive topics to maintain emotional distance, particularly when the topic of research relates to their personal experiences. Researchers can experience physical manifestations of emotion while conducting their studies, but they often engage in emotion management so that their posture and bodily display do not reveal what they are actually feeling (Dickson-Swift et al., 2009).

**Background**

The pediatric hospital where this study was conducted is a 167-bed tertiary care pediatric hospital and university teaching hospital in Canada. The hospital is associated with the faculty of medicine at a local university, which means that there are 3rd- and 4th-year medical students doing their 6-week long pediatric rotation at all times. The hospital also offers a 3-year residence program as well as fellowships in various specialties. All physicians in the hospital hold faculty positions at the university, and many of them are researchers with the hospital’s affiliated research institute. I conducted ethnography in this hospital as part of my doctoral dissertation research, to examine how the risk of antimicrobial resistance is constructed through prevention practices and discourses that affect healthcare providers’ daily work and how they negotiate their own risk of infection in the ward. My research was given clearance by the university’s and the hospital’s research ethics boards. I was embedded in the inpatient unit doing observation for 10 weeks and in the oncology unit for 6 weeks, followed by 8 weeks of interviews. I did approximately 300 hours of observation, during which I would stand in the hallways and observe doctors and nurses in the ward, follow medical teams as they performed rounds, and observe meetings and casual conversations between doctors, nurses, and students. Occasionally I would ask questions to my participants when a clarification was needed. While I was allowed to follow the medical team on rounds (after asking for individual consent from all members), my ethics clearance did not allow me to be there if a patient or their family participated in the meeting. While observing in the wards I would take notes with thick descriptions of the setting, actors and interactions, about participants’ behaviors and conversations, and my own reflections on what I was witnessing.

There were three medical teams at all times in the inpatient unit and one in the oncology unit. These teams were composed by one pediatrician or oncologist and between two to six residents and medical students. Additionally, each floor of the inpatient unit and oncology unit had team of between six to 10 nurses, a head nurse coordinating the work on the floor, and occasionally nursing students. Pharmacists, therapists, teams of specialists, lab technicians, healthcare aides, and cleaning personnel would also walk in and out of the ward constantly throughout the day and interact with the doctors and nurses in the units.

**Gaining and Maintaining Access to the Field Site**

Hospitals are highly closed institutions and access to them as fields of study is protected to preserve workers’ and patients’ privacy. There are many layers of approvals that must be obtained to gain and maintain access to the field site. I began this process ten months before I started my observation in the ward, and once one stage of access was cleared a new barrier arose with new unforeseen requirements, making this a slow and at times frustrating journey. At each stage of this clearance process my project and methodological choices were scrutinized, as a qualitative research project seemed out of place at a health institution used to biomedical research. Moving from one clearance to the next required adapting institutional frameworks and relying on other people’s interest and actions, while identifying spaces for negotiation in this very prescriptive institution.

Conducting research at this hospital can only be done in association with a researcher of the affiliated research institute, who becomes the de facto principal investigator for the project. My collaborator and PI for my hospital ethnography had no previous experience doing qualitative research in a hospital setting but they had a deep interest in having an ethnographer in the wards. Having read many hospital ethnographies, the PI was enthusiastic about the data I would gather in my observations, particularly regarding prescription practices and infection prevention and control routines. When I first approached the PI, they immediately considered that my project would offer valuable insight to the institution. Once the PI had agreed to collaborate in this project, the next step was finding out who were the hospital officers that needed to approve it, which took a few weeks. Written permissions from the medical heads of the inpatient and oncology units as well as the units’ managers were required. Obtaining their signatures could only be done by the hospital’s PI, which placed a considerable burden on them. The PI, who is also a physician in the hospital, had to explain the research project to their colleagues, who had concerns about potential reputational damage and privacy, and advocate for it. Once all the approvals were secured, I submitted an application to the institute’s Research Ethics Board. The board provided me with an application template designed for biomedical research and clinical trials, asking for example how I would handle patient information and what statistical analyses I would perform. I had to adapt this template to my qualitative research project and to the fact that my participants were hospital workers and not patients, and this negotiation with various officers at the research institute was the first step for bending the framework that regulates all research at the hospital.

While waiting for the REB approval, the office of human resources sent me a package which included a confidentiality agreement, links to various online trainings I had to complete, and I attended an orientation session. I also had to undergo a
medical exam, a TB skin test, and provide an up-to-date immunization record. I was given a badge with my photo and a green strap that identified me as a researcher with the Research Institute, and which gave me unrestricted access to the wards. Six weeks later, the hospital’s REB approved my project. A data transfer agreement (DTA) between me and the PI was mentioned by the REB applications, stating that I could not remove my fieldnotes or signed informed consent forms from the hospital until such agreement was signed. I carried on with the project as I knew the negotiation of a DTA would take time, and it seemed like a simple process that would be handled by hospital lawyers.

As I was about to start my observation period in the ward, some hospital managers expressed concerns to the PI regarding the reputational risks that my project could pose for the institution. This was the first instance of pushback against the project and the emotional toll it was having on my collaborator was noticeable. I quickly realized that the PI would have to perform emotional work in advocating for my research project with their colleagues who would make my collaborator anxious about the project. Reducing my collaborator’s anxiety was crucial so that they could reassure the hospital administration that all ethical concerns and reputational risks had been considered and dealt with. This trust-building process involved constant, open communication with the PI, which continued throughout the research and even after the writing of results. The following note illustrates an instance in which I sought to reduce anxiety about my research project:

[PI] called, some people are concerned about informed consent and hospital reputation […] This makes [the PI] uneasy. I sent [them] an email clarifying my and my doctoral committee’s expertise in this type of research, hoping this would put [their] mind at ease (6 months before observation started).

Despite these concerns and not having a signed DTA, I was allowed to start non-participant observation in the inpatient unit as a volunteer researcher with the research institute in September 2018. All hospital workers in the inpatient and oncology units received an email about my study the week prior to the start of my observation clarifying that they could choose whether to participate or not in the study. After 7 weeks of observations in the ward I received a draft of the DTA, which gave exclusive data ownership as well as publication rights to my collaborator. The document, which was a template designed for data generated from clinical trials, prescribed the nature of any collaborative relation between a hospital researcher and a researcher from another institution, giving full control of the study to the hospital researcher, and did not reflect the understanding the PI and I had. I received this news while observing rounds in the ward and my observations could not be compromised by how upset I was feeling. I decided to write down a note as I took deep breaths to avoid showing facial expressions indicating anger, including tears. As I noted:

[Hospital] lawyers sent a data sharing contract template that doesn’t apply at all to my study. Then, the research coordinator emails saying they want a supervisory role and authorship in every publication [for the PI]. I’m feeling very overwhelmed. (Week 7)

It became clear, again, that the institutional mechanisms to support our collaboration did not exist in the hospital, and so we embarked in an arduous process of negotiating an ad hoc DTA, a process in which hospital and university lawyers were involved. The main challenge during this negotiation was the reluctance of the hospital officers to modify their template to fit my research project. In an institution of biomedical research in which data is constituted by patients’ information, the hospital negotiators could not understand that my study focused on hospital workers and not patients, and they were reluctant to give me full access and ownership of the data. What is customary for biomedical research was not adequate for an ethnographic study.

Negotiating the data transfer agreement was a source of much anxiety for me. I kept going every day to the ward while not knowing if I would ever have access to my data, which was kept in the PIs office, or if I should be thinking of an alternative dissertation research project. Several meetings were postponed and communication with hospital officers was intermittent for several months, making me feel powerless as a researcher vis-à-vis a large, powerful, closed and slow institution.

In the meantime, I held various meetings with my dissertation supervisor, university’s Research Ethics Board and lawyers, in which we discussed the practical, legal and ethical challenges I was facing. These meetings provided spaces for emotional release, where I could express my fear and frustration over the potential failure of my project. After 3 months of delays and several conversations between both legal teams, a meeting was decided in which the university, the research institute, the hospital, and the hospital’s REB would participate. Setting up the meeting was also a slow and frustrating process as the hospital team canceled it on various occasions. As I logged in my notes after 3 months of observation in the wards:

Contract meeting delayed AGAIN by [hospital] lawyers—It’s so upsetting and emotionally draining! (Week 12)

Finally, the meeting was held, and all parties engaged in an open discussion about multidisciplinary practices and how to reach an agreement that would allow the project to move forward. The meeting was a highly emotional experience for me as this ethnography is the core of my doctoral dissertation research. We discussed data ownership, publication rights, data storage, and ensuring participants’ confidentiality. All parties recognized the importance of the project and we were able to reach an agreement and a specific DTA was written to reflect this agreement. This meeting was a moment of negotiation in which both the university and the hospital bended their institutional structures and a new order emerged in which ethnographic research was possible. Once my observation period in the hospital was over, the PI and the research institute asked me
to provide them with feedback on my experience as an outside researcher collaborating with them, which they would use to adapt some of their regulations in order to facilitate future collaborations with other researchers, particularly for qualitative studies.

Experiences of emotional labor are deeply influenced by race and gender. While women tend to engage in more intensive emotion regulation than men (Hochschild, 1983), women of color must perform additional emotional labor as a result of confronting not only gendered power relations, but also racist interactions and race-based inequalities (Cottingham et al., 2018). Being a junior researcher and a woman of color made me very aware of the fact that I had to negotiate strongly but calmly and regulate my emotional display, not show my frustration and anxiety. Power relations were evident during the meeting as the hospital team kept addressing my white, male supervisor instead of me, while my supervisor kept redirecting the questions to me. Despite these moments of intense negotiation and anxiety, it was very pleasing when I was asked to provide feedback on the process. In my feedback I addressed the need to make forms and contracts flexible enough to be used in non-biomedical research. I also referred to data storage and ownership as well as publication rights, which vary greatly across disciplines. It was very rewarding to see the hospital and research institute invested in creating more spaces for collaborative, interdisciplinary and qualitative research.

Managing Relations With the Hospital’s PI

Collaborative work requires more emotional labor than individual work (Bellas, 1999) as the researcher needs to manage personal emotions and collaborators’ expectations. Key aspects in managing my relationship with the PI supposed recognizing their own emotional work in advocating for the project while also facing pushback from the legal team and hospital board, and in advocating their own interests (reputation, authorship, data ownership). My relationship with the PI, was amicable and based on a spirit of collaboration, despite recurring disagreements regarding methodological and practical issues. This implied at times discussing and negotiating methodological issues and publication practices of two very different academic fields.

While I designed and conducted the study, with the advice and guidance of my supervisor and committee members, at the hospital my collaborator was considered the principal investigator. I was expected to conform to these perceptions for which I performed, sometimes unsuccessfully, much emotional regulation. For example, 1 day in the ward, two physicians asked me questions regarding informed consent, but instead of listening to my answer they said they would ask the PI. At that moment, their decision seemed illogical given that I was the person best suited to answer their questions, so I clarified to them that I had designed the research project. My reply was perceived by these doctors as disrespectful and later told the PI that I had deauthorized them in front of other doctors and students. This encounter made me realize that the hierarchical relations in the hospital are part of implicit rules that I was not aware of, for example, that I was not expected to question senior physicians or even discuss the project without the PI’s authorization.

Studies have shown that there is a steep and implicit hierarchy in medical teams (see for example Bould et al., 2015; Doja et al., 2018), and in the process of managing relations with my collaborator and hospital officers, the negotiated order of the hospital became evident. I also learned the implicit hospital “feeling rules” (Bellas, 1999), i.e. when it was acceptable to express feelings, such as frustration or anger, and when emotional management was required in order to preserve the relationships. These observations made me acutely aware of the PI’s emotional labor as they advocated for my project, worked on reducing their colleagues’ anxieties about it, and maintained their position of power and respect in the hospital.

Ethical Concerns

There are various ethical considerations for hospital ethnographies, including who are the participants, whether they are a vulnerable population, how will informed consent be acquired, how will the data be managed and stored, and how will participants’ privacy be protected. My ethnography studied how the risk of antimicrobial resistance affected the work of doctors and nurses in the wards, therefore patients and their families were not observed or included in field notes. This also meant that I had to make sure that patient information would not be revealed in my notes.

I discussed the process of obtaining informed consent from doctors and nurses with my collaborator on several occasions. Many hospital ethnographers seek institutional consent, i.e. a blanket consent provided by hospital management to observe hospital workers in predetermined areas, so as to not interfere with the setting. Healthcare providers get a notice that the study is taking place and they are able to withdraw consent if they wanted to. This approach for obtaining informed consent, however, has been criticized as “studying down” or observing research subjects with the approval from management and as a form of exploitation. Gusterson (1997) argues in favor of reducing the authority of the ethnographer over participants, allowing them to be part of the data analysis and writing process (p. 117). Feminist approaches to ethnography emphasize principles of reciprocity, honesty, accountability, responsibility, and equality to ensure treating participants with respect (Buch & Staller, 2007; Skeggs, 2001), which “enables an acknowledgement that their time is important and establishes the intention of non-exploitation” (Skeggs, 2001, p. 13). I decided to take this approach to ethnographic research and sought individual consent from each research participant, which allowed me to build a rapport with them and give them the chance to ask me questions about the project. This initial conversation also gave me the opportunity to explain consent as an ongoing process, rather than just the signing of a form, and that their participation was confidential, so no disciplinary
measures would be taken against them\(^1\) for things they did or said while I was around.

Obtaining informed consent from participants in this manner was a challenge as the inpatient unit—and to a lesser extent the oncology ward—is a space characterized by the constant flow of people (specialists, medical students, nurses, therapists, patients and their parents, visitors, cleaning staff, healthcare aides, nursing students, administrators, pharmacists, lab technicians, kitchen staff, etc.). Every day I would introduce myself to new participants, briefly explain my project, and answer their questions. I explain this process in the next section. This process involved waiting for the appropriate time, not interrupting, and keeping track of who had given consent and who had not. Not everyone on the floor was being observed, however. For example, some teams of specialists walked into the ward and straight into a patient’s room, so I was not able to observe anything relevant and therefore they were not included in any field notes. Other times, I focused on observing one of the two medical teams on the floor, thus I did not ask for consent from the second team nor were they included in the field notes.

Although consent was always obtained before making any notes about a participant, sometimes I could witness a conversation or interaction before having a chance to ask for consent. Medical work in a pediatric ward is usually time sensitive and I chose to wait and not record potentially valuable interactions instead of interrupting conversations at inconvenient moments. Most participants understood this to be a natural methodological constraint in this setting. However, two participants expressed concerns to the PI, which led to discussions that required me to defend my choice of asking for individual consent while reassuring them that no interactions were recorded unless appropriate consent was given.

**Managing Relations With Participants**

Pediatric wards are closed to the public, meaning that only hospital workers or patients and their families can access them. Doing ethnographic work in this context means that the ethnographer immediately jumps out of the background with people wondering “who is this person lurking in the hallway?” It is therefore impossible as an ethnographer to maintain the site “undisturbed” as my mere presence was inevitably changing the environment. Doing participant observation in hospital is not possible (van der Geest & Finkler, 2004) and I was inevitably a novelty in the ward for the first few days until participants got used to seeing me around.

While doing observation in the wards I had to negotiate my space there. Establishing a rapport with participants can be emotionally exhausting as every day I had to introduce myself to new participants and ask for their consent, i.e. for permission to witness their daily work and record any relevant observations and conversations. This process required making participants feel safe and comfortable with the research, so when I approached them for the first time, I would begin by briefly explaining that I was a PhD student, and I was there doing research for my dissertation on how the risk of AMR is communicated in the wards and experienced by doctors and nurses. I also explained that while I had an ID from the research institute, my research was not mandated by the hospital, but I would communicate my results to the PI. Then I would ask them if they would be willing to let me observe their daily activities and take notes, assuring them that their identity would be confidential so that my notes could not be traced back to them. If at that point they expressed interest I would then go over the content of the informed consent form and explain to them that even though they were signing, consent would be an ongoing process, so that they could ask to be removed from the study at any point and that they could ask me to not take notes on what they were saying or doing at any given time, or not to include a specific comment or event. I needed to make this process as brief as possible, however it was important to make sure they knew that I would protect their identity and that they were facing minimal risks by participating.

Reducing participants’ anxiety required me to earn and maintain their trust throughout the research process while projecting confidence. I also needed to overcome my own anxiety, as a person who is not an English native speaker and having a very perceptible accent, of approaching strangers and explaining my dissertation research in a few seconds, making sure that I was being understood. At first some doctors and nurses were suspicious, they kept their distance, even those who had agreed to participate. While senior doctors were more open to participating, as they are researchers themselves, residents and medical students would look around to see whether their peers had consented. Similarly, nurses were not always open to participating, and some of them refused to participate or assumed I was spying for their managers. The following fieldnote illustrates this situation:

> Walked into ward and [hospital worker] asked me in front of nurses if I would be “spying” on them again, they immediately turned around and looked at me. She was joking but not a great start. (Week 7, day 1)

This made me immediately aware of the badge strapped to my neck identifying me as affiliated with the research institute and how this impacted nurses’ perception of me as a researcher being imposed on them. I tried to mitigate this perception by emphasizing that the ethnography was part of my doctoral dissertation and that their participation was voluntary and that they would not face any retaliations for participating or not. However, whenever a doctor signed a consent form, the nurses and medical students around them would also agree to participate. Similarly, if a senior doctor refused to participate, the rest of their team would be more hesitant to do so. The power relations were evident from the start and this is one of the drawbacks of asking for individual consent. For example, some male physicians refused to participate even before I told them what the research was about. This was problematic as others around them would also start to hesitate. On one occasion an attending physician did not consent to the study, he dismissed
me with a hand gesture and after that the entire team of residents and medical students, who had consented to participate the week before, became elusive with me, albeit none of them withdrew consent. It was clear that the new attending doctor’s refusal to participate had a deep impact on his subordinates. Upon reflection I realize that after being quickly dismissed by a few male doctors I became more cautious when approaching other male doctors. This also made me reflect about my own positionality as a junior researcher and how this could impact both the way I approached them and their response.

As the days went by doctors and nurses started to feel more comfortable around me and to have open and spontaneous conversations with me, some would even joke. At some point I started exchanging pleasantries with nurses and health care aides. I also progressively became a resource in the ward as doctors and nurses started asking me if I had seen a specific person, or whether I knew if the staff doctor had arrived, or if I could hand them a piece of equipment. For example, one time a nurse standing at a patient’s door and wearing gown and gloves, asked me to bring her a scale as she could not leave the isolation area. Other nurses would joke with me and even tell me to write things down in my notepad, such as how hard they were working or how efficient they were. For example:

Nurse approached me, told me that since Epic [new patient management system] was introduced nurses are given 4-patient assignments instead of 3. She explains how hard it is to take care of 4 patients particularly if they are very young or have respiratory issues. She asks me if I could make a recommendation to go back to 3-patient assignments. (Week 9, day 2)

Nurse approached me and said: “Well, now I’m also doing translations, so add that to your notes” (Week 10, day 3).

Some doctors would ask me how my research was going and residents and medical students would tell me about their aspirations and next steps in their careers. I developed a relationship with many of the recurrent doctors, nurses, residents, medical students, pharmacists, and cleaning staff. Their initial suspicion evolved into trust and their anxiety was reduced.

**Witnessing Human Suffering**

Going into the inpatient unit for the first time I was filled with excitement. My badge opened the doors to the unit. Three hallways illuminated by potent white lamps make a U-shape with the nurses’ station in the middle. The ward was busy with doctors and nurses coming in and out of patients’ rooms, computers on rolling stands being wheeled in all directions, and patients’ relatives bringing food, bags, and toys in and out of the unit. But as the days went by, I started to also notice the children’s constant crying, the angst in their parents’ faces, and the long-term patients that are hospitalized for months at the time. Soon enough I was feeling strong empathy for the parents and the children, relating their experiences to my own experience as a mother and activated my parental anxiety. For example:

During rounds I would listen to the medical team discuss the various cases of infants and children admitted to hospital in varying degrees of distress and the challenging therapies they had to endure. During my 1st weeks in the ward, I was deeply affected by the cases I heard during rounds, I felt sad and apprehensive, and the following day I would be anxious to hear if the tests had come back with encouraging results or not. At this point I was forced to engage in emotion management as I could feel my face getting flushed, a lump in my throat and tears filling my eyes when listening to particularly complicated or tragic cases being discussed. I tried to control my emotions, or at least not display them, by looking down and pretend to take notes until I could regain composure. As the weeks went by, I became more skillful at controlling strong emotions and emotion display in the ward.

Some researchers allow themselves to become emotional while interacting with participants, and found the process of acknowledging their own feelings enriching for the study, for example crying with the interviewee instead of remaining emotionally neutral (Dickson-Swift et al., 2009). While connecting emotionally with participants can be productive during interviews, it is less frequent while doing observation in the ward, where doctors and nurses and deeply engaged in their own emotional regulation. Workplaces have implicit emotional rules that specify which emotions can and should be expressed in different situations and that compel employees to do emotional labor in order to conform to the accepted emotional display (Diefendorff & Gosserand, 2003). The medical profession and the hospital as a workplace have a set of implicit emotional rules that limit the healthcare professionals’ expression of emotions, for example frustration when a course of treatment is not working, sadness if a patient has a negative outcome, angst if a patient has a complicated family situation, or get too emotionally attached to patients who are in emotional distress. While doctors and nurses may express all these emotions in private conversations and interviews, they perform emotional labor to reduce emotional display in the ward. So, I tried to control my emotions as much as possible in the ward, while trying to find safe spaces to vent them (e.g. home, meeting with supervisor, discussing with peers).

Healthcare providers constantly engage emotion management to project emotional neutrality, a practice that is recognized as part of their professional culture. Hass and Shaffir (1991) explain that as part of their professionalization “[m]edical students learn to adopt a symbolic-ideological cloak of competence” (p. 55), including how to communicate authoritativeness through “body language, demeanor and carefully managed projections of self-image” (p. 80). Donning a cloak of
competence also involves not expressing emotional reactions to patients (p. 85). While emotional labor and management is a temporary situation for the ethnographer in the ward, for hospital workers emotional management and performativity gradually becomes part of the profession, the expected way to deal with complex situations. It becomes an implicit rule. Thus, trainees conclude that if they become emotionally involved with patients, their colleagues and superiors will not see them as professionally competent (p. 94). This does not mean that doctors do not feel a wide array of emotions regarding their patients, but rather that they perform intense emotional labor to regulate the display of those emotions in order to project competence. On occasion, however, doctors and nurses would have emotional expressions, for example:

Pediatrician said to resident after talking with patient’s mom: “Can you imagine how strong this mom is? Her perfect little [child] suddenly paralyzed and she’s still smiling.” (Week 3, day 1)

Resident, visibly frustrated, talking to medical students about parents of [infant patient] who left the hospital without letting the team know and now patient has been alone for hours: “They went home, they said they were tired. Of course they’re tired, they have a baby!” (Week 2, day 4)

These examples not only reveal the emotions that these doctors were managing while interacting with patients but felt comfortable enough to share with colleagues, but they also reveal what these physicians deemed desirable emotional display by parents of sick children. In the first example the doctor is praising a mother for being brave and stoic, while in the second example the resident is criticizing a patient’s parents for leaving the hospital for a few hours, without considering the burden of physical and emotional exhaustion those parents are probably feeling. These examples show that patients’ parents are also expected to perform emotional labor in the wards. Although patient-physician communication was a dynamic I did not assess in my study, it can be assumed that if these expectations of “appropriate” emotional performativity were communicated to parents, directly or indirectly, they would have a negative impact on an already difficult experience.

As the weeks went by, I also felt the need to display emotional competence and became more skillful at controlling emotion display in the ward. While I recognized that my emotional experience would impact my ethnographic work, from what I chose to note down to my interpretation of results, I also felt compelled to engage in the same kind of emotional work that the medical team performed. I felt like I had no right to become emotional and that I would lose the respect of the people around me if I did not conform to the emotion rules of the ward. So I engaged in deep emotion regulation and sometimes deep acting strategies, i.e. attempting to change how one feels so that the appropriate emotions can be displayed (Diefendorf & Gosserand, 2003, p. 954), for example by using relaxation techniques and creating a sense of calmness before going into the ward and encountering very tragic situations.

Ethnographers can become deeply involved in their participants’ lives, especially if there is sustained contact with them (Bellas, 1999). While I did not become emotionally involved with my participants, because medical teams changed on a weekly basis, I did with the stories of some patients. After a few days in the ward I would know each patient’s story (why they were hospitalized, diagnosis, treatment, family and social situation, etc.). Some of those stories touched me deeply and although I did not have contact with the patients, I would see them or their parents walking down the hallway. At some points I would feel physically sick when listening to doctors talking about these patients or if I could hear them crying in their rooms, and I would inevitably visually scan the unit in search for their nurse. On one occasion I alerted a nurse about an infant crying for a long time alone in their rooms behind closed doors; on another, I approached a resident and urged her to contact the specialist seeing her patient as the information she had gotten from a medical student was inaccurate. Although this way beyond my role as researcher in the ward, potentially posing an ethical dilemma regarding how much I should interfere, I felt that the responsibility to minimize these children’s suffering came first.

My role at the hospital was researcher, but occasionally I would interact with patients and their families when approached by them. For example, many times toddlers in hospital gowns and attached to IV lines would walk down the hallways followed by a parent pushing an IV pole, and the children would smile at me and wave or say “hi!” I instinctively reacted and waved back or smiled back and complimented them. Other interactions included parents and visitors sometimes asking me to buzz them out of the unit, or the location of the washroom, they would ask me where to get food and other practical information. They saw me wearing a hospital badge and assumed I was a hospital worker. Other times parents would approach me and start talking about random things, like the weather or the price of gas. I interpreted these interactions as moments of much needed distraction for the parents. I was familiar with their children’s diagnoses and treatment and could understand the immense anxiety they were feeling. I was always open to these hallway conversations even if they distracted me from my observation.

**Emotions, Reflexivity, and Data Analysis**

Doing observation in the wards was emotionally challenging. Witnessing distressing and sometimes tragic situations involving children and engaging in emotion suppression had a profound impact on me, as I tried to also keep those experiences from affecting my personal life. Once the observation period was over and I was allowed to take my fieldnotes from the hospital, I transcribed them and did two levels of analysis: thematic and interpretative. I did not anticipate that in the process of transcribing and analyzing the data I would relive the emotions I had felt in the moment. While the data were anonymized, I could remember where every event had taken place and who were the actors involved, and I would feel the same anxiety or sadness or any
My relationship with research participants was brief and characterized by my negotiating a place in the ward and them negotiating what they would allow me to witness. My relationship with hospital administrators was more stable but contingent on certain conditions ranging from specific behaviors (e.g., not observing patients and adhering to infection prevention rules); ethics practices (e.g., storing data appropriately, granting data access to collaborators, ensuring participants’ confidentiality); completing human resources trainings and medical examination; and legal obligations.

Conclusion

As shown in this paper, gaining access to hospitals as fields sites can mean navigating institutional, epistemological, and ethical barriers. In my case, these barriers led to considering the role of emotional labor in qualitative research as well as reflecting on the ways in which researchers can negotiate access to sites that do not share the same epistemological and methodological assumptions. By having to dwell in the emotional and embodied entanglements of professional life in hospitals, this research also advances ways for understanding these methodological hurdles as a key aspect of the broader production of knowledge. This paper also highlights the need for universities and healthcare institutions to engage in common efforts to improve the working conditions for researchers, particularly junior researchers. The various instances and forms in which emotional labor is necessary for ethnographers could be examined in future research on ethnographic methodologies and student mentoring to develop the psychological competences required when doing qualitative research in healthcare environments. The reflection presented in this paper provides insight and guidance for researchers seeking to engage in ethnographic endeavors in hospitals during the COVID-19 pandemic, particularly highlighting the importance of gaining collaborators’ trust and interest, and the need to acknowledge the emotional work performed in various instances by the researcher, collaborators, and participants, and how it shapes the collection and analysis of data.

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Note
1. I had, however, the obligation to report any incidents I witnessed in which a child was being endangered in any way. This never happened but that was the only caveat to the confidentiality clause.

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