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## Bending the Rules of “Professional” Display: Emotional Improvisation in Caregiver Performances

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### Abstract

Organizational norms of emotional expression are open to negotiation through improvised performances, as employees may bend or break emotion rules to gain more leeway in expressiveness and participate in the development of their own role identities in the workplace. In this ethnographic study, a dramaturgical perspective is used to analyze the processes and outcomes of emotional improvisation as observed among nurses, technicians, and physicians in a cardiac care center. It was found that the emphasis on maintaining a “professional” appearance in caregiving largely constrains actors to perform along their scripted roles. Results are discussed in terms of practical implications for training/education for health care providers and recipients. This study complements Goffman’s (1959, 1961) emphasis on external role-playing by considering actors’ internal feelings in relationship to observable emotional displays.

**Keywords:** organizational emotionality, emotional improvisation, emotion rules

Even as grievances are voiced against the “medicalization” of daily life by alternative organizations espousing holistic approaches to health, the emphasis on science, technology, and rationality remains largely intact within Western models of caregiving (Goldstein, 1999). Traditional health care organizations, in turn, support and reward an organizing approach that reflects and maintains the rationality ideal (James, 1993; Smith & Kleinman, 1989). Consequently, those who practice medicine in traditional settings often must align

their personal experiences and expressions of emotion with expected organizational and occupational norms of appearing unemotional if they want to be perceived as "professional." Medical students, for example, are socialized toward nonemotionality through a number of means, from the more obvious use of "techno-scientific" language (Hafferty, 1988), to the unspoken mastery of showing "detached concern" for the patient (Lief & Fox, 1963). Although the degree of emotional distance expected likely varies across practitioners and organizations, scholars maintain that health care personnel are still largely constrained to exhibit "professional detachment" (Lupton, 1994), "instrumental rationality" (Good, 1994), or "emotional neutrality" (Smith & Kleinman, 1989) as they perform their work roles. Associated with this emphasis on rationality is a seeming obsession with certainty in the medical sciences, which pressures health care personnel to arrive at "objective" conclusions (Atkinson, 1995; Daly, 1989) and don a "cloak of competence" to appear professional (Haas & Shaffir, 1982).

Performing along the role expectations of certainty, objectivity, professionalism, and neutrality is likely to be emotionally demanding for caregivers (Hearn, 1993). Such culturally appropriate emotional displays are formed as explicit and implicit rules of conduct, and become normative in that the resulting emotional order can reinforce or punish behavior and, thereby, shape future interactions (Hochschild, 1983). However, the fluid, socially constructed nature of display rules indicates that workers can and do play a role in shaping these expressive norms. These "emotion scripts" are not immutable but, instead, open to improvised performances (Fineman, 2000).

In the past, scholars have referred to the clash between organizational and individual interests in expressive norms as emotional "ownership" (Hochschild, 1983) or "control" (Tolich, 1993), but few have considered the implications involved in the struggle to shape the emotional order. We argue that actors work to negotiate the emotional order through improvised performances that directly oppose or otherwise depart from the scripted organizational emotion rules. Although this idea may be easy to grasp conceptually, it becomes quite difficult to locate empirically. Therefore, in this study, we take a first step toward locating, describing, and interpreting the process of emotional improvisation in a health care setting. In so doing, we consider how emotional improvisations work to alter or maintain emotion norms and role identities. Ultimately, we hope to reveal how the concept of emotional improvisation can be instructive in the twin concerns of theory and practice in applied communication research by addressing the general conceptualization of organizational emotionality and the specific education processes for health care providers and patients.

Specifically, we focus this investigation on the negotiated performances of emotionality of medical personnel conducting heart catheterizations in a cardiac care center. Emotional improvisation, in this sense, refers to how technicians, nurses, and physicians perform along and against organizational constraints to alter emotion rules (such as "detached concern") as they construct individual and collective role identities. In this setting, doctors and staff experience an ongoing, almost ritualistic exposure to emotionally demanding situations in which a patient undergoes a delicate, anxiety-ridden procedure. Primarily a diagnostic tool, the catheterization procedure is permeated by a great deal of ambiguity as to

the severity and urgency of the patient's heart condition. Several times a day, these nurses and doctors perform emotion collectively, just as they perform procedures together.

In constructing role identities, emotional improvisations become extremely important to organizational actors, for changes in emotional role boundaries come about through testing and altering emotion rules. Organizational members can bend or break emotion rules to perhaps create a wrinkle in the dominant emotional script, so that an alternative emotional order might be expressed and validated (Fineman, 1993, 1996). Successful improvisations, therefore, can be considered those performances that are convincing to the dominant culture and, at the same time, expand role boundaries to allow for more latitude in emotional expressiveness. As emotional latitude increases, so do members' control in constructing their identities in the organization. Greater member participation in this process reduces the systematic distortion of what appropriate feelings and displays are, thereby supporting human development in the organization and, ultimately, in society (Deetz, 1992). As medical power must be continually reestablished in medical encounters (Fox, 1994), there always exists such opportunities for emotional improvisation by patients, family members, and medical personnel (James, 1993).

Because of our emphasis on improvised performances, we use a dramaturgical perspective to guide this study. Specifically, Goffman's (1959, 1961) conception of communicators as performers helps us portray the constraining and enabling factors of the actor as both character and audience. Within this framework, emotions are taken to be historical acts that involve intentions, cultural influences, and social judgments of situated actors (Sarbin, 1986), such that emotional role-playing can be viewed against other, multiple role demands of organizational actors (Goffman, 1961). While only a handful of researchers have used a dramaturgical perspective to explore organizational emotion explicitly (Hopfl & Linstead, 1993; Zurcher, 1982) or implicitly (Haas & Shaffir, 1982; Rosen, 1985), other scholars have been clearly concerned with emotional performances, and how they connect with actors' inner feelings (Hochschild, 1983; Van Maanen & Kunda, 1989). A more overt use of a dramaturgical perspective would give researchers a terminology for describing the socially constructed elements of emotional experience, expression, and interpretation (Ashforth & Humphrey, 1995; Harré, 1986; Shott, 1979). In the present study, for example, dramaturgy provided us with the means to investigate how actors, sometimes forming a "supporting cast" to avoid social embarrassment (Goffman, 1963), used interpretive license to perform creatively within and around constraining emotion scripts, and how various audiences judged those performances in the end (Goffman, 1959, 1961).

Performances communicate on a number of meaning levels simultaneously; they are both the means and ends of social reality, and thus, capable of bringing about change (Turner, 1986). This perspective highlights, in a humanistic, creative, and vivid manner, the struggle between different role identities as actors strive to construct convincing performances with expectant audiences. On a practical level, a dramaturgical approach is useful in documenting the dynamic nature of emotional expression in both individual and collective performances. In addition, practitioners and patients can benefit from this view as they come to see their health care interactions as open to individual improvisation.

To explore the concept of emotional improvisation, we begin by reviewing relevant research in health care emotion management and performance. We then describe the scene

of the research setting and how observations and interviews were conducted and analyzed. Finally, we present our interpretations and offer theoretical and practical insights gained from the study.

### Literature Review

Three themes that emerge in the body of organizational emotion literature (Waldron, 1994) are paralleled in emotion studies conducted in health care settings. The first theme of regulated emotion is revealed in studies that consider the emotion work involved in display norms of certainty and neutrality in health care, and the resulting negative consequences of emotional dissonance on individual performers. To begin, researchers describe how the first signs of emotional dissonance appear during the schooling of health care professionals. For instance, Smith and Kleinman (1989) discovered that medical students were concerned about becoming overly desensitized, and thereby, estranged from their feelings. Hafferty (1988) also found that medical students had the ability to recognize and even worry about the changes that occurred from abandoning the emotional identity of a layperson and accepting the emotional proscriptions of the medical professional.

Once on the job, caregivers' experience of emotional dissonance highlights the struggle between individual and organizational ownership of emotion (Hochschild, 1983). In a hospice setting, for example, James (1992) found that nurses' ideology of caring clashed with the organization's emphasis on curing. In a case study of a nursing home, Putnam and Mumby (1993) found that when fundamentally different approaches to emotionality collided in the workplace, high incidents of stress and burnout became commonplace. For physicians, too, displaying the expected "professional" demeanor can be at odds with personal feelings. For example, Clark and LaBeff (1982) found that doctors who had to deliver news of a patient's death to family members would outwardly follow the organizational expectation of rational appearance by calmly detailing the chronology of events leading to death, while inwardly suffering with pangs of guilt.

Interestingly, studies of emotional labor in health care settings often note the imbalance of power when it comes to emotion work demands. For example, while doctors clearly perform emotional labor, they also tend to pass along the comforting responsibilities to others. Clark and LaBeff (1982) found that after death-telling, doctors often had nurses stay with the family to answer questions and lend emotional support. James (1989, 1992) also argued that divisions of emotional labor fell unequally among health care staff according to gender and status, as lesser paid, mostly female nurses were left to attend to the patients' emotional needs. The emotional burden, in essence, is often passed down the hierarchy, even extending to family members (Clark & LaBeff, 1982; James, 1992). James (1993) argued that the staging of emotion is set by the rational communication of doctors, and the division of emotional labor implies that others must carry out the emotion work within this impersonal context.

The second theme of social influence research reveals how health care professionals' expressions of neutrality may be a way to influence patients to show a similar "detached" approach to their conditions. Sugrue (1982) told the story of how doctors and nurses attempted to persuade a patient to become more detached from her body and her feelings

by telling her to relax, stop exaggerating, and not to concern herself so much with what the staff was doing to her. This form of emotional control can be a form of social control (Lupton, 1996; Shott, 1979). For example, Treweek (1996) illustrated how care assistants used their emotion management skills to create order in a residential home for the elderly. An emotional social order is created and maintained as care providers and recipients perform according to their culturally scripted roles (Lupton, 1996).

The final theme of organizational culture research is probably best shown in studies that highlight medical and nursing students' uses of cultural forms to negotiate feeling and display rules. These studies underscore how education regarding emotional experience and expression is an implicit, informal process that is taught through observation of and participation in symbolic activity (Smith & Kleinman, 1989). Hafferty's (1988) study of "cadaver stories" demonstrated how joking rituals were observed by medical students and reenacted among themselves as both a distancing technique and a coping strategy. In that study, students internalized a professional identity in which authority was akin to being unemotional. Haas and Shaffir (1982) likewise studied how medical students performed their "professionalization" by strategically tailoring emotional displays toward certain audiences (e.g., acting sympathetic in front of family members), while maintaining the culture's rational ideal as the appropriate internal feeling. O'Hara (1989) described "degradation rituals," in which nursing students exhibited willingness to serve, while displaying (often feigning) eager anticipation for the surgeon's orders. Such performances indicate the strong influence of organizational culture on the emotional socialization of health care providers.

In sum, the studies conducted in health care settings emphasize that the emotional labor involved in caregiving can be both a burden and a source of control. Individuals who perform emotional labor may suffer from stress or burnout (Miller, Birkholt, Scott, & Stage, 1995) and may develop a concern about becoming "desensitized" to their patients. The social influence studies, on the other hand, underscore how caregivers can make use of dominant emotion rules to maintain the reciprocal roles of doctor/nurse and a compliant, dependent patient (Lupton, 1996). Finally, the cultural approaches to these settings indicate the power of socialization as students learn, in an unguided and unspoken way, how emotional distancing, or "professional detachment," serves a real and important purpose (Lupton, 1994) and yet can degrade others in lower status positions (O'Hara, 1989). However, what is not always evident in these studies is the fact that role boundaries can be altered that allow for new emotion rules to develop: "The role is organizationally led, but can be subject to individual negotiation, particularly when there are social changes that facilitate this negotiation" (James, 1993, p. 111). Negotiation of emotion rules through improvisational performances can alter the roles people play and, in turn, alter the emotional expectations that go along with those roles.

In this project, we begin to unpack what it means to be an emotional organizational actor, and how individual and collective emotion performances are improvised through the intersection of inner feelings, outer displays, organizational mandates, and role-identity management within the context of a catheterization center. To do this, the following research questions were designed to guide this investigation:

RQ1: What are the existing emotion rules in the catheterization center?

RQ2: How do nurses, technicians, and physicians attempt to negotiate these emotion rules through improvised performances?

RQ3: What characterizes successful versus failed emotional improvisations?

## **Methodology**

Viewing organizations through a dramaturgical lens demands that the methodology employed be at least partially ethnographic, as performances need to be observed and evaluated (Hopfl & Linstead, 1993). Ethnography, in its traditional form, represents a way of investigating and describing others' experiences through their own perspectives (Lindlof, 1995; Patton, 1990). It is necessarily grounded in the natural world, as the researcher makes claims about how symbols are enacted, maintained, resisted, or co-opted by actual people in actual time (Conquergood, 1991). This project represents an organizational ethnography, as we focused on describing the ways a certain reality (in this case, emotional experience) is created and understood by organizational members (Morgan, 1986). A principal aim of organizational ethnography is to "uncover and explicate the ways in which people in particular settings come to understand, account for, take action, and otherwise manage their day-to-day situation" (Van Maanen, 1979, p. 540). The experience of everyday work life is carefully examined, explained, and consequently, validated, through this approach.

### ***Participants and Setting***

The participants in this study made up a diverse "cast of characters," including cardiologists, nurses, and technicians in a physician-owned catheterization center. There were 14 cardiologists (13 males, 1 female) who performed procedures in the laboratory. The least-experienced physicians had to begin working for the other doctors before they could buy into the ownership of the catheterization center. The catheterization lab manager, a registered nurse by training, was also included in the study. He was selected by the physicians to perform the administrative and financial duties associated with the center.

A core staff of eight people (four registered nurses, two licensed practical nurses, and two technicians), ranging in age from 26 to 42, remained in the catheterization center full time, admitting patients, performing procedures, and aiding in the recovery process. Other nurses and/or technicians from a nearby hospital rotated into the lab schedule as needed to help perform procedures. Of the full-time staff, the technicians worked solely in the lab, whereas the licensed practical nurses (L.P.N.s) worked only in the pre- and post-procedure recovery area. One registered nurse (R.N.) worked only in the recovery area; another worked primarily in the lab. The two remaining R.N.s alternated days between lab work and recovery work. One of the R.N.s was male, and the rest of the staff members were female. The overall professional tenure of the core staff ranged from 3 to 15 years. Most of the employees were previously employed in a hospital-based lab. All but two employees had been working at the catheterization center since it opened in 1997. This group, collectively referred to as the "staff" in this essay, was the central focus of the study.

In this particular setting, exploratory or diagnostic heart catheterizations were performed to detect any blockages in the arteries and determine a course of treatment, such as angioplasty or stents in milder cases, and open-heart bypass surgery in more extreme cases. Most of the patients in the lab under study were not expected to have very serious heart conditions that would require immediate medical attention once catheterized; in fact, close to half of the patients observed did not require any further treatment. Emergency situations were a rarity in the stand-alone lab. This is not to say that the catheterization procedure itself was free from risk. For example, there was always a danger of the patient developing an irregular rhythm during the 30-minute procedure. If medication couldn't restore the rhythm, and the patient lost consciousness, a defibrillator would have been used to "shock" the patient back to a regular heartbeat. Other patients experienced chest pain during the procedure and were given nitroglycerin to ease the pain. Finally, there existed a very remote possibility that a catheter could tear arteries or the aorta. Most of the catheterizations, however, were performed without incident. To illustrate the emotional significance of the procedure, we next describe a typical patient visit to the catheterization center.

#### *Heart Catheterization Procedure*

About an hour and a half prior to the catheterization procedure, a nurse shaves around the patient's groin area to create a sterile environment for the entry point of the catheter. The patient is given Valium to help calm his or her anxiety. Once the patient is brought into the lab, he or she is moved onto a flat, gray table. Two to three staff members work on the patient at the same time, putting on a blood pressure cuff, hooking up the monitor, and stabilizing the person's arms by tucking them close to the body with a sheet. A staff member sponges on iodine soap around the groin area and the two potential entry sites for the catheter. The patient's gown is removed and replaced with a plastic sheet that has openings over the entry sites. Once the patient is readied, a dose of Versed is injected intravenously, which relaxes the patient and produces mildly amnesiac aftereffects. After Versed is administered, the nurses and technicians converse among themselves—often about family and social events—while waiting for the doctor to arrive, which could be anywhere from 5 to 30 minutes and occasionally more. During the procedure, Versed affects patients in different ways; many fall asleep, whereas others ask questions or talk gibberish. One patient actually sang a song (complete with three verses) and received a round of applause from the doctor and staff upon finishing.

After the doctor "scrubs in," he or she begins the procedure by numbing the entry site with a local anesthetic. The doctor then injects a needle into the main artery. This process may take a couple of tries, but once the artery is struck, the doctor immediately places a sheath in the opening. The sheath has a one-way valve in it to prevent the patient from bleeding out. Some doctors may inject Heparin, a blood thinner, through the sheath at this point to prevent clotting during longer procedures. A guide wire is then inserted through the sheath and up toward the heart. Once the catheter is inserted, the guide wire prevents the tubing from looping back on itself. Dye is injected that makes the blood vessels visible. Lesions can be detected by those arteries that appear narrowed or pinched at one end. Immediately following the procedure, the doctor informs the patient about the results of



the test in a truncated fashion, such as whether the person has blockages, and whether he or she will need surgery. Because of the amnesiac effects of Versed, many of the patients say something similar to, "That's all there is to it? That wasn't so bad," as they are being wheeled out of the lab and into a recovery room.

In the recovery room, a nurse pulls out the plastic sheath and then must maintain pressure on that area, usually manually, to stop any bleeding. Using both hands, the nurse stands stiff-armed over the patient to apply pressure to the groin area for about 10–15 minutes. Once the bleeding stops and the patient begins bedrest, the nurses periodically check on him or her and do what they can to make the patient comfortable. The patient is again instructed to keep his or her leg straight so that the entry site does not start bleeding again. Family members are allowed to stay with the patient in a private recovery room before the procedure and during bedrest. After three to four hours of bedrest, the patient is free to go home.

### *Procedures*

This study, developed from the first author's dissertation research under the direction of the second author, represents a fusion of insider/outsider perspectives toward data collection and analysis. As the "inside" investigator, the first author used the main data-collection procedures of participant observation and interviews. Observation was an important first step in describing performances as they occurred naturally in the catheterization center. In this investigation, the primary observational phase lasted for two months. Observation periods were conducted 4 days a week, at various times of the day, for 2–4 hours at a time. In the setting, the first author took handwritten field notes and attempted to document key phrases of conversation verbatim. Notes also were taken regarding the physical setting, technical information, and of her emotional inventory as she engaged in the process. She remained as silent as possible and tried to physically position herself toward the periphery of a given scene, whether it was at the side of the nurses' station, the back of the observation booth, or the corner of a patient's room. With no formal medical background or training, the first author had to absorb and learn a great deal through her observations as a lay audience. The advantage of this emic orientation was that she entered the scene with few pre-determined ideas or assumptions about the setting or its characters, which allowed her to more openly receive the emotional drama as it naturally developed.

Nine formal, individual interviews were conducted in a private office onsite with staff members and a nurse manager. Interviews generally lasted between 30 and 45 minutes, and were audio-recorded. Field observations were brought back to the interviewees for their insights into what they were feeling and how they displayed (or repressed) those feelings during specific interactions. Therefore, structured interviews were used to delve into deeper role-acting considerations. Following Hopfl and Linstead's (1993) lead, participants were asked what an actor who was preparing to "play the part" of his or her job would need to feel and act in order to play the role convincingly for different audiences. Participants were also asked about times when their displays were inappropriate for a situation, perhaps due to clashes with either subgroup or organizational role expectations, and how they handled that situation. Positive and negative consequences of their actions were also explored during the interviews.

In addition to these procedures, the first author facilitated a "feedback session" to check the researchers' perceptions with those of the participants. In an informal meeting, the five staff members in attendance were asked if they thought we were mostly accurate in our conclusions. They largely agreed with our interpretations, and provided some additional perspective and feedback. Information from the feedback session was entered into the data set for analysis and is reflected in the findings when appropriate.

### ***Data Analysis***

Once observations and interviews were conducted, patterns of performances were identified (Polkinghorne, 1983). The process of identifying patterns occurs when the data sufficiently become repetitive or "saturated" (Glaser & Strauss, 1967). Recurring patterns were then organized around a set of dramatic performances involving the playing of roles, writing of scripts, descriptions of settings, and audience reactions (Lindlof, 1995). The observational data were sorted into "scenes" in both onstage and backstage areas of the catheterization center. Four main performances/settings emerged as primary: the procedure room or lab (onstage), the observation booth (backstage), the patient's room (onstage), and the nurses' station (backstage). Interview themes were similarly layered into a dramaturgical framework that highlighted various emotional performances for different audiences. By using this process, we could further refine what the usual "scripted" staff performances would be for doctor, patient, and coworker audiences, and when staff members would improvise their way around these norms. The second author's "outside" vantage point provided an important perception check when we analyzed the data. We were able to discuss and debate various possible interpretations of the data until reaching a consensus on the most reasonable explanations.

To illustrate this procedure, the first author originally looked for instances of emotional deviance, or "interruptions," in expected behavior (Fiebig & Kramer, 1996). Anything that initially struck her as odd or out of place at the time of observation was considered a possible improvisation. She would take note if it appeared that staff members or doctors were bending or breaking an emotion rule. Later, away from the scene, both researchers reflected on how the organizational members were perhaps attempting to etch out more emotional leeway for themselves, and sometimes, for others as well. We discussed whether actors' improvised performances led to changes in the emotional order, or if they simply followed the standard emotional script. Attempting to analyze such subtle and complex processes as emotional experience and expression presented us with many challenges; however, we feel that we have offered credible interpretations based on our triangulation of methods and researcher discussions (Patton, 1990). The interpretations that emerge are certainly not the only ones possible but are those we feel best reflect the nature of emotional improvisation for these particular actors in this particular setting.

### ***Analysis and Interpretation***

In this section, we address the nature and scope of emotional improvisation according to the emotion rules observed within various "scenes" in the catheterization center. We consider the nature of successful and failed emotional improvisations and how they might

alter or maintain emotion rules and, therefore, role boundaries/identities of the participants. In the final portion of this section, we indicate how the actors were greatly constrained to follow or bend, rather than break, the emotion rules. These scenes indicate how actors would appropriate organizational emotion rules for personal ends. For the scope of this study, we analyze a handful of episodes that were the most striking as emotional improvisations.

### *Emotion Rules*

The staff's emotion rules for the patient audience involved treating patients equitably and with politeness, no matter how strange or demanding the audience became. A professional, confident demeanor was also perceived as a necessary display, mainly for minimizing patients' anxieties. One nurse explained during her interview how patients looked to the staff to be their "rock" in the preprocedure wait; if the nurses did not appear to be calm and self-assured, then the patients might become even more agitated than before. Although the staff members generally believed they should feel for their patients, they mentioned how this "line" should not extend too far into their own emotions so that a professional distance could be maintained (Lupton, 1994). In this sense, nurses and technicians were conscious of their emotional investment in their role (Kahn, 1992). Crying, for example, while considered a natural "work feeling" (Putnam & Mumby, 1993) by staff members, was something they felt must be controlled for the benefit of the patients. By not "giving back" their full and true emotions to patients, staff members also benefited from maintaining a safe emotional boundary through role distancing (Goffman, 1961). In addition, a couple of nurses mentioned how performing their jobs "professionally" prevented patients from questioning their medical competency. This vote of confidence from the patient audience had the technical consequence of helping nurses to complete their tasks more easily and the symbolic consequence of heightening the nurses' status as caregivers.

Regarding the physician audience, staff members said they also had to display a professional appearance. However, many of the staff members claimed that the doctors' "professional" portrayals varied from actor to actor on the basis of personality, mood, and/or the situation at hand. For example, the staff discussed the differences between the younger generation doctors and the "old school" doctors. This distinction also became evident in observations of the procedure. The more established physicians were steadfast about creating a solemn, rational, all-business environment; the younger doctors, by contrast, were more improvisational in their approach, encouraging the staff to engage in personal discussions and humorous storytelling. For the staff, the "professional" emotion rule in relationship to the doctor audience was fairly fluid, within an acceptable range of behaviors. Dissonance was created for staff members when it appeared that the physician stepped out of what they considered to be acceptable professional behavior. For example, staff members openly disparaged the female physician who had yelled at a nurse for placing the foot pedal in the wrong place. Whereas doctors have more latitude to break emotion rules without consequence (Goffman, 1961; James, 1992), lower status staff members are often constrained to maintain the "standard" professional display (e.g., not yelling back), and defer authority to the physicians in the process. According to the staff, adjusting to the doctors' displays was absolutely essential in giving a "convincing" performance in the lab

or the recovery room. Beyond this, demonstrating one's technical knowledge or proficiency was an acceptable display for the doctor audience, while discussing the patient's emotional condition rarely happened. As with studies of emotion conducted in medical training programs (Hafferty, 1988; Smith & Kleinman, 1989), the "professional" emotion rule reveals an emphasis on rational appearances and technological displays of competency as appropriate behavior.

Finally, the emotion rules involved with a coworker audience gave staff members the opportunity to drop their professional masks with each other. This does not mean that emotion rules were not in effect, however. Indeed, whatever the group was expressing during a given situation became the norm to which others were pressured to conform. In general, a positive disposition was favored by a dominant subgroup among the staff members. They were practical jokesters who favored a jovial way of working. During venting sessions of bitching and/or mocking rituals, participation was encouraged and rewarded by this subgroup. The remaining staff members were limited to expressing emotion according to the norms of the current ritual (Rafaeli & Sutton, 1987).

Interestingly, while acting "professional" was key in front of both patient and doctor audiences, something quite different was preferred with the coworker audience. Perhaps staff members felt that the emotion work they did for the other audiences should decrease when they were around each other. Their coworker performances took place in an emotion-safe "zone" (Fineman, 1996) where their true feelings could be expressed and validated. This zone included the rule that coworkers were supposed to let each other know "where they stood" if they were upset about a certain issue.

### *Successful Improvisations*

Generally speaking, we believe that *successful emotional improvisations* are those that go "unpunished" by the other party and work to alter the emotional order, even if only temporarily. These improvised moments are convincing to the audience and yet manage to reveal the actor's interpretation of the script. Successful improvisations appear to garner some emotional space for the negotiator, perhaps to reveal his or her personal work feelings as valid. Some improvisations, such as the accepted joking behavior between staff and doctors, may also work cumulatively toward altering the overall emotion rules, such that emotional behaviors once considered "inappropriate" may become the "proper" way of doing business (Fineman, 1996).

It seems imperative that successful emotional improvisations first involve an intuitive awareness of what an audience judges as appropriate. Given the influence of "technorationality" in such an environment (Smith & Kleinman, 1989), it seems likely that the doctor audience, for example, would be convinced by improvisations that were performed closer to their "professional" expectations. Staff members who revealed their "rational" side to doctors in the observation booth, for example, may have become successful over time in building more credibility into their perceived work role. It may depend on the audience, however, as to how effective these subtle attempts at negotiating rationality may be. If the doctor is oblivious to what is going on, or is more consumed by showing his or her own expertise, the potential recognition will be lost.

Less subtle departures from expected emotional display were, therefore, more successful in having an impact on the actors involved. For example, one catheterization procedure, which normally involved displaying a rational, professional appearance, was particularly striking. The doctor and staff were working on the case as a group of staff members had gathered in the observation booth. The door between the booth and the procedure room was open as usual. The doctor then did something uncommon or risky with the catheter. Everyone in the booth was cheering for the doctor by yelling things like, "Whoa, way to go," and applauding his supposedly extraordinary maneuver. The doctor responded by saying, "Yeah, most guys wouldn't attempt this!" The four people in the booth were so loud with their cheering that the patient, who was very groggy, actually turned her head toward the booth to see what was going on.

This scene represents a clear "interruption" from normal expressive behavior during a procedure (Fiebig & Kramer, 1996). The doctor, youthful and casual in demeanor, appeared to be a staff favorite. It was perhaps easier for the staff members to express themselves in a more raucous fashion because of this relationship dynamic with the doctor. The lab manager also cheered along with everyone in the booth, likely making it safer for staff members to join in. The doctor's response indicated his own improvisation with the emotion rule of displaying calm, professional behavior. Following the doctor's cue, the staff members could safely continue applauding and encouraging the doctor to continue his performance. The doctor, as a "lead actor" possessing the greatest power, was able to legitimate this departure from the normal performance and, thereby, allow those of lesser power to join in (Goffman, 1961). Even if the emotional order was changed only temporarily, the improvisation was successful in the sense that it was accepted by all as a dramatic turn of events in which emotional display was open to a wider range of individual expression.

A more striking improvisation stemmed from a patient who had been kept waiting a long time, and finally "unloaded" emotionally on the doctor. The patient, a prominent businessman, became increasingly agitated the longer he waited for the doctor to come visit him. He had finished his test hours earlier and wanted the results so that he could return to work as soon as possible. The nurses took turns placating him as he became increasingly hostile. He simply did not accept what the nurses told him—that the doctor was perhaps in an emergency situation at the hospital. In the patient's view, the doctor had told him when he would return and simply failed to deliver on that promise. When the doctor finally arrived, the patient was irate, and let the doctor know it. The patient shouted, "If I ran my business the way you ran yours, I would be out of business!" The doctor was visibly stunned by the patient's display. He was first quiet and then, bumbling for a response, apologized in the end. The patient used a consumerist discourse quite literally, in taking the well-known business attitude of "time is money" to express his frustration.

This interaction reveals that patients can and do negotiate discourses and doctor authority in medical encounters, although great persistence may be required to do so (Fox, 1994). As an emotional improvisation, however, the performance became muddled by the consumerist approach. Even though the situation was highly emotional, the content of the patient's message focused more on the rational aspects of running a business and less on his feelings about being left alone with his uncertainty. In general, a consumerist discourse

may tend to devalue or disregard the *content* of the patient's emotional experiences in certain medical encounters (Lupton, 1996). However, what makes this specific improvisation ultimately successful was the *display* of emotion that upset the order of the dominant "compliant patient" role. The patient abandoned the "script" of the calm, compliant patient (which calls for a great deal of emotion work) to, instead, display his full frustration and outright anger. The dominant social order became challenged to the point that the doctor's self-defined role as "healer" was laid bare in this encounter (Fox, 1994).

With regard to the staff's emotional performances, one clear improvisation stood out as successful. An L.P.N. who worked with an inoperable patient negotiated leeway to express her own feelings and show her concern. After the doctor had explained that the patient's condition was too poor to do surgery, the nurse was left in the room to remove the sheath and apply pressure. The nurse started making conversation with her usual small talk, asking the patient where she was from, how many children she had, and what she thought about the recent ice storm. However, it was clear the patient was not holding up her end of the conversation. The patient was visibly shaking as she started to sob. Suddenly, the nurse changed the focus of the discussion by asking, "Are you upset by what the doctor told you?" There was no answer—the patient just kept crying. The nurse proceeded to show her own sadness, as tears welled in her eyes when she continued to ask questions that addressed the emotional state of the patient. Even though this nurse's actions may not be considered overly nurturing by some standards, her performance was, nonetheless, a departure from the more rational displays common to this particular scene. Usually, the emotional performance in the recovery room involved displaying proficiency while focusing attention on tasks such as providing food, water, and pillows for the patients' comfort. Her improvisation of the emotion script involved a turn away from displaying strictly "professional" competency and detachment, toward displaying heartfelt concern for the patient's feelings. The verbal discussion mirrored this change, as the nurse shifted the talk from banal topics to the patient's emotional state—a move not witnessed at any other time in the cardiac center. Certainly the gravity of the patient's condition, as an unexpected plot twist, set the stage for such an improvisation to take place. The nurse simply used the break in the script to negotiate the standard emotional order through her improvisation.

Through this interaction and other key performances with her patients, we noted how this particular nurse may serve as an exemplar of Goffman's (1961) "role-embracer," as she negotiated her own feelings into the work role. It appeared that she allowed naturally emerging "work feelings" to become a valid part of doing her job (Putnam & Mumby, 1993). In turn, the patient had the potential to expand her emotional boundaries, by openly expressing her fear and sorrow through crying. The patient was simply too distraught to verbalize how scared or upset she was, but her silent sobbing was validated by the nurse's displays. In her interview, the nurse reflected on how upset this interaction made her feel, and how she didn't try to hide her sadness while soothing the patient. Because the nurse negotiated the emotion rule of keeping a "professional distance" (Lupton, 1994) to show personal concern for the patient, the patient had license to show more emotion, with perhaps less fear of feeling embarrassed or judged (Goffman, 1963). Just as caregivers are constrained by the rule of detachment, patients are similarly bounded to the script of nonemotionality, if they wish to be well received by the practitioner audience (James, 1993;

Sugrue, 1982). Therefore, in this specific scene, the nurse temporarily altered the emotional order of detachment and, in turn, cleared the way for the patient to perform emotion according to the newly revised script.

Clearly, emotional improvisations that are direct, pointed, and even startling to the receiving party can be successful in shaking up the dominant order a bit. It is as if the actor becomes so unnerved by someone's deviation from the script that he or she "corpses" in his or her own role performance (Hopfl & Linstead, 1993). For example, the previously mentioned patient who abandoned his "compliant" role to express his frustration left the physician stammering, out of character, not quite knowing how to save face (Goffman, 1967) before ultimately apologizing for his lateness. Other times of pointed improvisations may have occurred when staff members claimed to have "stood their ground" with doctors and coworkers, using surprise tactics to create a wrinkle in the normal emotional order. In such situations, masks likely dropped away to the point that everyone—including actors and audiences—became aware of the contrived nature of their previous performances (Mangham & Overington, 1987).

Common and consistent strategies could help staff members make a number of small "wins" that might eventually lead to a construction of an alternative emotional order. For the most part, however, the dominant ideology, based on rationality, certainty, and "biomedical" aspects of disease (Baker, Yoels, & Clair, 1996; Good, 1994) held very strong in dictating the "professional" display as most appropriate (Haas & Shaffir, 1982), as demonstrated in failed emotional improvisations.

### ***Failed Improvisations***

*Failed emotional improvisations* are those that are judged harshly or simply go unnoticed by the other party and, therefore, fall short of altering the emotion rules in any way. Small resistance behaviors, for example, were largely ineffective as emotional improvisations. One case of failed resistance involved a nurse who had explained during her interview how she would often not perform little "favors" for doctors she thought were acting like "little jerks." It bothered her that the female doctor, in particular, would throw towels on the floor rather than in the nearby bin where all other doctors managed to discard their towels. She refused to pick up the towel, hoping to change what she perceived as disrespectful behavior on the part of the doctor. However, the nurse doubted whether her actions had an impact, as she said she just wanted the doctor to "explain herself, and maybe she would then feel, I don't know, bad." However, the doctor's behavior remained unchanged. If the staff's improvisations are too heavily veiled in isolated or infrequent resistance behaviors, little change in emotion rules will come about, if at all.

It seems likely that the more power an actor has in the organization, the less often emotional improvisations will fail. In the case of this setting, physicians had the most interpretive license (James, 1992, 1993). However, in one instance, a doctor failed to negotiate his emotional role in front of a patient audience. He had been looking at the chest film in the observation booth, and was uncertain about how to proceed. He talked to another cardiologist on the phone, and asked the opinion of another doctor who happened to be passing by. The doctor brought the uncertainty that he had expressed in the backstage area of the observation booth (an emotion-safe zone) with him to the onstage area of the patient's

room. Specifically, the doctor improvised against the expected "certain and rational" physician role, to show more skepticism and caution in front of the patient audience. The doctor explained that he wanted "a lot of eyeballs" to look at the patient's chest film, and wondered aloud if they should "not even knock on the door" of surgery. He continued to say that he could prevent one artery from closing down. However, the patient's family verbally criticized the doctor; they did not appear satisfied with his answer, probably because it really was not an *answer*. The husband of the patient retorted, "Well, put your heads together and then tell us." The daughter of the patient added that waiting was the hardest part. If the doctors were going to do anything, she wanted to get it "out of the way" by the next morning.

This interaction was striking in that as the doctor dropped his "certainty" mask, the patient's family judged this performance harshly. The improvised performance, thus, failed to alter the rationality norms inherent in the professional emotion rule in particular, and in the "empiricist vision of illness" more generally (Good, 1994, p. 180). The patient audience, by judging the doctor's performance harshly, quickly dismissed the improvisation, returning the scene back to the standard emotional script. Although patients may sometimes express frustration with doctors' "know-it-all" behavior, it is often they who, at least in part, constrain the doctors to act in just that way. Perhaps because of their culturally formed expectations of doctors to be "god-like" (Lupton, 1994), patients participate in perpetuating the obsession with certainty in biomedicine (Atkinson, 1995). Patients may expect doctors to exhibit certainty to quiet their own emotional turmoil stirring below the surface. To do this, patients unwittingly guide physician performances of emotion toward the rationality norms they have come to expect from medical personnel.

Finally, there was one backstage improvisation among coworkers that failed to alter the emotional order. Although a few nurses indicated that they could openly share their feelings, particularly sadness, with each other backstage, this was not observed first-hand at the nurses' station. In fact, the same nurse (an L.P.N.) who had allowed the inoperable patient to express her feelings seemed to be chastised by a fellow nurse (an R.N.) for showing too much concern. On this particular day, the L.P.N. had expressed concern about when and how the patient's family would get a chance to eat, as the patient was to be walked immediately over to the hospital. The R.N. replied by saying the family could simply eat first and then meet the patient in the hospital. Unsatisfied, the L.P.N. wanted to schedule a way for the family to walk with the patient to the hospital so they could all be together. When the L.P.N. finally thought of a solution, the R.N. replied with mock concern, "Do you think that will work?" The rest of the staff members standing nearby collectively said, "Oooh," indicating that a biting remark had been made. It seemed that the L.P.N., at least in the eyes of the R.N., had gone too far in accommodating the patient's family. The R.N. therefore cut short the emotional improvisation by mocking the L.P.N., and, in turn, upheld the "appropriate" emotional display of detachment for this scene. This time, the L.P.N.'s display of naturally occurring feelings failed to make even a momentary impact on an emotion rule that a few nurses had defined in their interviews: there is a "line" of showing concern for the patient that should not be crossed.

In many cases, then, the staff's improvised performances failed to sway the dominant emotional order of this work setting. Societal influences are indeed strong, and as has been



shown, patients participate in maintaining the social order (Treweek, 1996). Small rebellions that are perhaps designed to release a strongly felt emotion are ineffective in changing the status quo, particularly if the audience is unaware of their occurrence. Other improvisations, such as the doctor who expressed uncertainty and the L.P.N. who expressed concern, were direct and yet perhaps unconscious performances that went against the emotional norm. Their emotional improvisations were recognized by others, but, in the end, were deemed by the audience to be inappropriate performances of emotion. Possibly to avoid negative social judgment, staff members mostly performed emotion within the emotion rules and, at times, appropriated them for strategic purposes. In the next section, we summarize how the staff performed emotion largely by the rules for each audience.

### *Sticking to the Script*

In the onstage areas of the center (procedure room and recovery room), the doctor's presence largely constrained the staff members' opportunities to improvise their performances of emotion. Behavioral resistance may have played a role in negotiating emotional freedom but was of little impact precisely because it was so subtle. Because nurses and technicians were so tightly constrained onstage to remain in their professional roles, they had to make subtle maneuvers in attempting to alter the emotional order, if at all. If a rule were to be broken, a physician or some other actor with enough relative power and interpretive license had to initiate the move so that other staff members could follow.

When it came to the patient audience, staff members, as well as physicians, most often made use of the dominant emotion rules to maintain the social order and secure the dependent nature of the doctor/nurse-patient relationship (Lupton, 1996). When this happened, patients would show deference to the staff's professional performances and taper their emotional responses toward the preferred behavior of the "good," compliant patient role (Treweek, 1996). For example, several female nurses shared how they often had to endure sexual harassment, especially during the shaving process. They talked about how they would strategically use their professional demeanor to gain compliance, by telling harassing patients to stop their deviant behavior. Other examples involved doctors using their "professional" display to effectively silence patients' questions or Versed-induced small talk. The doctors would gain compliance by explaining that they needed silence to focus on the technical procedure, ultimately guiding the patient back to performing the "correct" role. These instances were clearly not improvisations; instead, the doctors and staff members were using the organizational emotion rules to their advantage (Tolich, 1993). Certain actors, at times, appropriated the rules of rationality, professionalism, and detachment as a means of restoring their status in the relationship. In these instances, the dominant emotion rules were extended into the interactions to return the role-playing back to the "proper" script and the preferred emotional order (Conrad & Witte, 1994).

The backstage areas of the center were not all that similar when it came to emotional improvisation opportunities. Whereas the observation booth was a prime improvisation site, the nurses' station was probably the least open for improvised performances. The key difference was that the booth played host to impromptu scenes between actors of varying status and authority, whereas the nurses' station showcased well-rehearsed performances of a close-knit cast. Both sites, however, provided a unique perspective into the role of

emotion in employee relationships, as the patient audience was removed from the immediate scene.

Away from patients, doctors in the observation booth, for example, were freer to improvise the staunch technical precision of their onstage performance by revealing their uncertainty or even their excitement about a case. In turn, staff members were able to perform the rational/technical side of their roles with doctors by revealing their competence in reading chest films and discussing diagnoses. For other emotional episodes, humor or sarcasm became an acceptable way for staff members to let the doctor know how they felt on a given issue. However, staff members appeared to use humor to couch their anger or frustrations, as it was a "safe" way to display feelings in the backstage areas. The unfortunate result of these "safe" performances is that they helped maintain the very emotional order that constrained the staff.

In terms of their coworker relationships, staff members indicated that they let each other know "where they stood." However, this was already an emotion rule within this subgroup and therefore, was not an improvisation of a rule per se. They also perceived themselves to be equal in status, for the most part. At the nurses' station, then, few improvisations were necessary or even warranted, perhaps because staff members already respected each other's roles and intuitively understood their coworkers' feelings and emotional demands.

## Discussion

In this study, we found that emotional improvisations were not made very often, and only a handful of those were deemed successful. It may well be that there were attempts that simply went undetected, as the process of improvisation often demands subtlety as part of its strategic design. It is also possible that certain improvisations that failed in a particular time and place may in the future combine with other performances such that the cumulative effect would work to negotiate emotion rules (Fineman, 1993). Instead of locating multiple improvised performances, however, we more often found examples of employees creatively using the already established organizational rules to their advantage, such as nurses using professional displays to gain compliance from uncooperative patients (Lupton, 1996; Treweek, 1996).

The finding that most of the staff's emotional performances fit within the constraints of the emotion rules suggests that the predominance of rationality in the ideology of the biomedical model holds very strong in the cardiac center. The power of emotion rules that influences medical personnel to display "detached concern" (Lief & Fox, 1963), "professional detachment" (Lupton, 1994), or "instrumental rationality" (Good, 1994) seemed to solidify role identities along those lines. Certainly, the routine nature of the catheterization procedures, performed on relatively "healthy" patients, contributed to the strength of the detachment rule in this particular, traditional, medical setting. Other, more residential or long-term care environments would likely espouse a different emotional value system. In the cardiac center, however, those few employees who expressed more of their own feelings within the organizational system, and actively worked to create an alternative identity

for "what it means" to be a caregiver, generally have yet to be validated by the organization, or by patients for that matter.

For substantial alterations to come about in the emotional order and in role identities, it may be necessary for a new discourse to prevail that promotes an ideology focused on caring for a "whole person" (Cassell, 1991) that directly counters the "empiricist" visions of illness (Fox, 1994; Good, 1994). As researchers, patients, and caregivers alike continue to question the underlying assumptions of the biomedical model, the greater the chance for other ideologies to be expressed and validated regarding emotion in health care. For example, participative, dialogic, patient-centered ideologies have emerged in recent years as an important step toward acknowledging patients' emotional experiences (Geist & Dreyer, 1993). If traditional health care organizations were to embrace this ideology, as some alternative organizations have already done, a new emotional order would likely surface that would no longer be considered "alternative." Because the study of emotional improvisation through a dramaturgical lens involves viewing interactive performances embedded in their cultural and social contexts, researchers who use this approach can likewise contribute to developing ideologies of caring by critiquing dominant emotional value systems in health care. It has not been the expressed purpose of this study to critically examine ideology; however, it became clear to us through the course of the project that the potential for ideological critique is ripe in dramaturgical studies of organizational emotion. Future critical studies could certainly work to draw distinct parallels between underlying cultural/organizational assumptions and overt communicative behaviors in health care settings. In the remainder of this essay, we explore further theoretical and practical insights gained from our experiences in this study.

### *Theoretical Implications*

By examining the negotiation of emotion rules through improvised performances, the relationship between the expression of emotion and social control is highlighted more clearly in this study than in past communication-based research. In a health care setting, the power of doctors and nurses to not only manage their own emotion but the emotion of their patients is evident. This study, thus, underscores the connection between emotionality and the maintenance of the social order (Shott, 1979; Treweek, 1996) via the "scripted," reciprocal roles of patient and caregiver (Lupton, 1996). By displaying a "professional" or "competent" demeanor, for example, nurses manage their own feelings, keep an appropriate distance, and gain compliance from the patients. The status quo of authoritative and power differences are upheld throughout the course of these interactions, promulgating the culturally defined images of how patients and personnel should act in a health care setting (Lupton, 1995).

The theoretical enrichment that lies in the connection between face-to-face interactions and a larger ideology working "behind the scenes" is quite striking, especially as a feature of role-identity construction in a health care setting. The methodology of dramaturgy, combined with the idea of a negotiated order in organizations, may extend work in this area. Dramaturgy provides a useful framework and terminology for investigating emotion holistically, as it considers how feelings are socially constructed and displayed (Ruane, 1996).

Using dramaturgy as a theoretical and methodological guide offers a fresh view of organizational emotionality—in any applied setting—as a complex, fluid, socially created process that has been too often missing in past research.

As a direct extension of Goffman's (1959, 1961) dramaturgical perspective, we investigated "role-embracing" as an emotional improvisation strategy. Again, much has been researched about the role-distancing behaviors in which organizational actors engage (Hochschild, 1983; Sutton, 1991), but little is known about how employees might fully invest themselves into their roles (Kahn, 1992) or even what such behaviors would look like (Waldron, 1994). In this study, one nurse in particular was described as a likely role-embracer, as she was able to successfully negotiate the emotion rule of "professional distance" (Lupton, 1994) through improvised performance and, in turn, alter the emotional order for a time. In a practical sense, a role-embracer, especially if located in a position of leverage, may make small adjustments in role development that could possibly trigger a more systemic expansion of role boundaries for actors across the organization. The nurse in this setting may not have had enough status in the organization to bring about systemic change; a more prominent actor with greater interpretive license would likely have greater influence on others' roles (Goffman, 1961).

We also complemented Goffman's emphasis on external role-playing by considering actors' internal feelings about emotional events. Through the interviewing and feedback processes, we were able to gather staff members' perceptions about their own role performances, and include these within the whole of the interpretation. As researchers, we could glimpse into how actors played their roles as well as how they chose to play their roles. Sometimes an actor's improvisation of emotion scripts involved very subtle, perhaps undetectable maneuvers, and yet was based on a conscious choice. This added dimension to Goffman's perspective, then, more strongly accentuates the often deliberate and strategic elements of emotional role-playing (Bailey, 1983; Sarbin, 1986).

### *Practical Implications*

In terms of patient interactions, emotional improvisations made by doctors and staff have significant consequences for patients in their care. Generally speaking, it seems that when doctors or nurses place limits on their own emotional displays, they limit patients' responses as well. For example, when certain doctors expressed their unwillingness to tolerate patients' questions or Versed-induced chatter in the procedure room, patients became silenced, disallowed from expressing their feelings. Conversely, when doctors or nurses revealed more of their own feelings away from what was normally expected, it appeared patients had more leeway to do the same. The doctor who expressed uncertainty or the nurse who allowed her own feelings to guide the interaction, for instance, permitted their patients to respond in kind. In the doctor's case, the patient's family used the opportunity to vent their frustration, whereas the nurse's patient felt free to silently cry. Possessing the greater script-writing power in patient interactions, doctors and nurses can partially guide emotional communication toward a freer exchange of emerging feelings. By negotiating dominant emotion rules through improvised performances, doctors and staff can create a space for patients to express themselves more openly, without fear of losing face (Goffman, 1963).

If patients were to express themselves emotionally, health care providers would likely benefit by learning more about their patients' total state of health. Unfortunately, the biomedical model often directs communication almost exclusively toward talking about physical symptoms, even though patients experience their conditions holistically, as amalgams of thoughts, feelings, preconceived notions, social comparisons to others, and physical signs (Mechanic, 1999). Therefore, when caregivers focus on verifiable symptoms of patients, they are left unaware of all those other aspects of illness, including emotional experiences, which could provide important information for effectively treating patients. Knowledge, then, of patients' thinking and feeling states would allow health care workers to gain a more accurate, complete picture of patients' conditions and, at the same time, to minimize their own uncertainty during the diagnostic process (Cassell, 1991).

In turn, patients who express their feelings, and are appreciated for doing so, may gain a more responsive audience in their health care providers. Humanizing themselves in the interaction, patients would likely receive more holistic care than if they were to adhere strictly to the detached "compliant patient" role. New display and feeling rules may emerge as a result, as both practitioners and patients improvise their own experiences against the dominant emotional order (James, 1993). Over time, perhaps, role identities of "what it means" to be a caregiver or patient could also be constructed along those new lines of expressiveness.

Finally, it appears that both health care providers and recipients could benefit from specific, more formalized education regarding emotion management and improvisation in medical settings. Medical education should address the emotional aspects of caregiving, as too often during training, emotional socialization progresses without formal direction or dialogue regarding work feelings (Smith & Kleinman, 1989). Students could benefit from a frank debate of the positive and negative consequences of displaying "detached concern," for instance. As noted in this study, there are certainly times when performing a detached role is advantageous, especially in the presence of an unruly patient. The point is that students *themselves* might locate a comfortable position between the extremes of feeling overly detached or overly concerned, as opposed to internalizing the professional/organizational emotion rules as their own (Rafaeli & Sutton, 1987). If emotional issues were brought to their awareness, students could then perform emotion in ways that are respectful of both their own emotional experiences and their patients' feelings.

Fruitful discussions could likewise center on staff-doctor or staff-staff interactions. Students could discuss how emotional environments might vary from setting to setting. They might explore different organizational cultures to better understand emotional expectations, and how these expectations translate into coworker relationships. If medical and nursing students could understand and discuss how and why emotions are performed in interactions with various audiences, they could perhaps regain some personal control in their expressiveness. Students could have a dialogue about how improvisational acting along and against the organizational script of regulated emotion could enhance their "autonomous" emotion management abilities (Tolich, 1993).

For caregivers already in the workplace, performances can be used as an instructional tool.<sup>1</sup> Some consulting and training companies already use actors to dramatically illustrate communication processes, such as conflict and decision making in organizational settings.

Role-plays could be conducted in medical settings that call for various emotion management and improvisational strategies, so that caregivers could explore different ways of performing emotion for various audiences. For example, patients' stories could be dramatically retold through a type of playback theatre (e.g., Salas, 1996) so practitioners could witness firsthand patients' (often hidden) experience of emotion as it unfolds in performance.<sup>2</sup> Nurses and physicians could then develop their empathic communication skills by acting out how they would have responded to various patients as portrayed in the playback scenes.

After receiving more directive training regarding emotional communication and improvisation, caregivers may be able to lessen emotional dissonance to not merely cope but thrive in a health care environment. Medical practitioners, again, may negotiate expressions of feelings according to what they are more personally comfortable displaying, to potentially reduce workplace stress and burnout (Maslach & Leiter, 1997; Putnam & Mumby, 1993). Furthermore, through participation in interactive training performances, caregivers may come to understand the dual nature of emotional experience and expression, for they manage patients' emotions at the same time that they manage their own (Tracy & Tracy, 1998). Once they recognize the weight of the emotional burden they bear, caregivers may begin to take steps, perhaps collectively, to reduce or reframe emotionally trying experiences.

Performances could also be used in health promotion efforts at the community level. In this way, patients could begin to view the medical encounter as a site of improvisation and an opportunity to reassert their power (Fox, 1994). Too often, bureaucratic rules combined with cultural emotion rules restrict patients as a social force in medical situations (Kreps, 1990). Performance-based training, such as forum theatre (e.g., Boal, 1995), could reveal the ways in which patients are typically scripted into submission, and how they might rewrite their medical interactions.<sup>3</sup> Through training and practice, patients could learn to assert their feelings into their improvised performances and precipitate a fundamental change in the emotion script of medical encounters. Clearly, as a process of improvisation, emotional scenes must be dynamically altered, or rewritten, by both practitioners and patients for true changes to come about in the well-worn script of emotional neutrality in traditional health care dramas.

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## Endnotes

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2. Playback theatre, generally speaking, involves the reenactment of a story. The storyteller is allowed to speak freely and fluidly, as actors create the scene the storyteller describes. The actors gather initial information about characters before beginning but then improvise the scene as the story progresses. After the performance, the storyteller comments on whether and how the scene was reflective of his or her experience. Through the performance, the audience members are able to grasp the storyteller's internal thoughts and feelings as they connect to external displays during a certain event.
3. Forum theatre involves role-playing a variety of different reactions to a singular event. The idea is to set aside the "standard" or "expected" performance (as in the good, compliant patient role) so that alternative responses may be constructed. Role-plays are improvised as participants "try on" different approaches to a communication event and challenge their previously taken-for-granted assumptions and behaviors.

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