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EXAMINING THE REPERCUSSIONS OF EMOTIONAL LABOR AMONG MEDICAL DOCTORS - AN EXPLANATORY SEQUENTIAL MIXED-METHOD DESIGN

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ABSTRACT
Emotional labor prevails in a variety of fields. However, degree of emotional labor practiced by medical professionals, during the COVID-19 pandemic, is considerably higher. This study adopts an explanatory sequential mixed-method approach, where a survey-based quantitative study was conducted on 406 doctors working across Pakistan; followed by an interview-based qualitative study, conducted on 15 doctors. Quantitative analysis reveals that surface and deep acting both lead to high emotional exhaustion and low well-being, whereas genuine emotions lead to low emotional exhaustion and high well-being. No significant impact of emotional job demands is found on well-being via emotional exhaustion. Results from qualitative study reaffirm that due to high emotional job demands, doctors tend to heavily engage in emotional labor, which leads to emotional exhaustion, and compromises their well-being. The research highlights the contextual nature of emotional labor construct and investigates lesser-explored facets of psychological and physical well-being. The study also adds to the scant mixed-method literature, specifically an explanatory sequential design entailing structural equation modeling and thematic analysis.
Keywords: Emotional Job Demands, Emotional Labor, Emotional Exhaustion, Psychological/Eudaimonic Well-being, Physical Well-being, COVID-19.

INTRODUCTION
Emotional job demands and emotional labor are invaluable yet challenging aspects of the healthcare profession (Andel, et al, 2022: Gulsen & Ozmen, 2019: Heijden, Mahoney & Xu, 2019). Apart from its medical and infrastructural challenges, the emotional toll brought about by COVID-19 outbreak is monumental (Creese et al, 2021). The emotional and psychological repercussions of the pandemic not only include stress, depression, and anxiety (Ofei-Dodoo, Loo-Gross & Kellerman, 2021) but also sleep disorders, panic attacks, and physical illness (Karakose & Malkoc, 2021). Workers directly involved with COVID treatment units also struggle with post-traumatic stress disorder (Khattak et al, 2021).

The present research aims to empirically investigate the impact of emotional job demands and emotional labor on exhaustion and well-being of doctors. The study employs a mixed-method design with an aim to comprehend the nature of emotional work in healthcare sector from two perspectives. Firstly, to examine the variables objectively and draw conclusions from data based on precise quantitative assessment. Secondly to dig into the subjective reality behind emotional labor by examining the context of participants and allowing them to share their unique narratives on how they cope with emotional challenges at work (Creswell, 2014).

REVIEW OF LITERATURE
Service interactions require the frontline workforce to display positive emotions in front of customers. These emotions are embedded in the very nature of job and are termed emotional job demands

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(Muhammed et al, 2022). During the COVID-19 pandemic, the need to project the right emotions has become critical (Bhuyan, 2020). However, emotional job demands are generally considered to have detrimental effects like turnover intentions (Eriksson, Jutengren, Dellve, 2021), burnout, and exhaustion (Rhéaume, 2022). However, emotional demands may also improve service quality (Geisler, Berthelsen & Hakanen, 2019) and job satisfaction (Tarabeih & Bokek-Cohen, 2020).

Emotional labor refers to regulating and projecting certain emotions at work (Ashforth & Humphrey, 1993). Frontline employees like doctors heavily engage in emotional labor and regulation practices (Costakis, Gruhlke & Su, 2021). Emotional labor is found to strongly affect organizational outcomes including employee commitment and engagement **(**Sezen-Gultekin, Bayrakcı & Limon, 2021), customer relationship management (Grandey & Sayre, 2019), turnover intentions (Heijden, Mahoney, & Xu, 2019) and emotional exhaustion (Gulsen & Ozmen, 2020). Three widely discussed dimensions of emotional labor are surface acting, deep acting (Hochschild, 1979), and genuine or natural emotions (Ashforth and Humphrey, 1993). Literature shows varying effects of aforementioned strategies. Surface acting is usually found to have negative results including high turnover and burnout (Costakis, Gruhlke & Su, 2021). Hiding one's true emotions at work may also lead to decreased job satisfaction, self-efficacy, work engagement, and positive affect (Burić, Kim, & Hodis, 2021). Furthermore, surface acting also causes work-family conflict and depressive symptoms among those who practice it (Suh & Punnett, 2021). Conversely, deep acting, and genuine emotions are found to have pleasant effects like higher job satisfaction (Costakis, Gruhlke & Su, 2021), reducing work-family conflict, stress, burnout (Kim, 2020), and turnover intentions (Öngöre, 2020).

Emotional exhaustion is the depletion of one's affective or emotional reserves, resulting in strain and burnout (Maslach and Jackson, 1981) leading to high turnover intentions, and low well-being (Heijden, Mahoney, & Xu, 2019). Emotional exhaustion is the common outcome of emotional job demands (Rhéaume, 2022) and emotional labor (Adams & Mastracci, 2020). For instance, surface acting has been found to increase emotional exhaustion (Gulsen & Ozmen, 2020). Similarly, deep acting has been found to raise emotional exhaustion levels through increased psychological effort (Yang & Jang, 2022).

Psychological well-being entails living a meaningful life involving a purpose, positive relationships, and personal growth (Ryff, 2018). Challenges in healthcare profession put employees' psychological well-being at risk. Job stress, the stigma of disease, and well-being concerns lead to declining psychological well-being resulting in burnout and absenteeism (Gavin et al, 2020). Under such circumstances, emotional support from the organization can considerably improve employees' well-being and quality of life (Baker & Kim, 2020). Doctors may rely more on deep acting through which their psychological empowerment would increase thereby reducing the likelihood of outcomes like stress and burnout (Kotze, 2021).

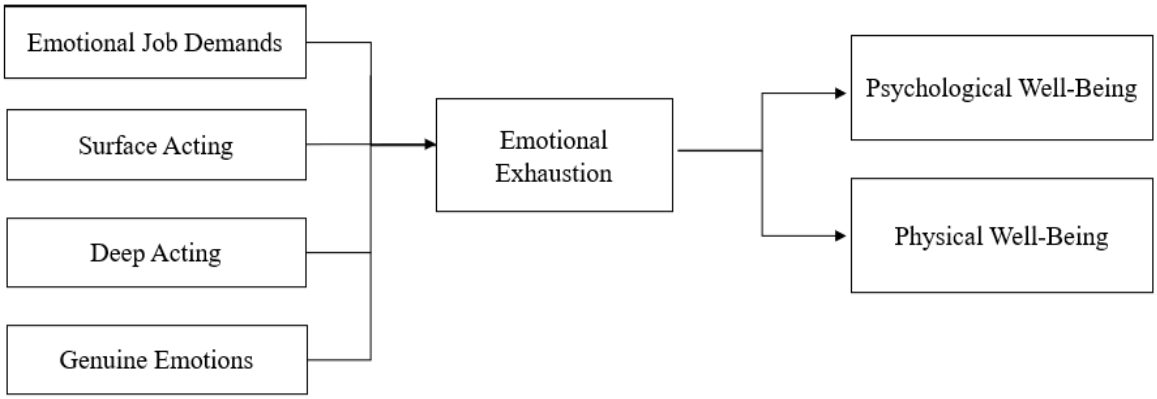
Physical well-being refers to one's physical health and fitness (Best, Downey & Jones, 1997). Among doctors, lack of exercise and outdoor movements take a toll on workers' well-being by compromising their physical fitness and sleep quality. Caregiving burnout, patient awareness, counseling, high infection probability, and hectic working hours lead to deterioration of doctors' physical health (Adams and Mastracci, 2020). This further translates into poor psychological well-being, if remains unchecked (Trabelsi et al, 2021)

This study's research model is based on the Conservation of Resource Theory (Hobfoll, 1989), which states workers strive to build emotional and psychological resources to better cope at work. The theory further postulates that workers strive to conserve these resources during service interactions (Hobfoll, 1989; 2011). However, high emotional job demands may place pressure on workers, thus depleting these resources thereby leading to exhaustion and low well-being. Based on this supposition, our research model hypothesizes that high emotional job demands cause high exhaustion levels in doctors, subsequently lowering their psychological and physical well-being. Similarly, emotional labor strategies of surface and deep acting are both straining since the former entails the element of pretense whereas the latter involves internalizing the displayed emotions. Therefore, both are hypothesized to elevate emotional exhaustion and lower well-being. Since genuine emotions involve the authentic display of emotions, they are thus hypothesized to lower emotional exhaustion and raise the well-being levels of doctors. Figure 1 illustrates the hypothesized relationships.

H1: High emotional job demands decrease psychological and physical well-being via the mediating role of emotional exhaustion.

H2: Surface acting decreases psychological and physical well-being via the mediating role of emotional exhaustion.
H3: Deep acting decreases psychological and physical well-being via the mediating role of emotional exhaustion.
H4: Genuine emotions increase psychological and physical well-being via the mediating role of emotional exhaustion.

Figure 1. Research Model



Sample Size, Scales and Methods

Based on non-probability snowball sampling method, 406 doctors across Pakistan participated in the survey. Construct of emotional job demands is measured using 7-item scale developed by Best, Downey and Jones (1997). Emotional labor is gauged using two scales, for surface and deep acting, a 6-item scale built by Brotheridge and Lee (2003) is used, and for genuine emotions, a 3-item scale by Diefendorff, Croyle, and Gosserand (2005) is used. Psychological well-being is measured by borrowing 9 items from Ryff (1989) psychological well-being scale. Physical well-being is measured through the "Perceived Well-Being Scale" developed by Recker and Wong (1984). A five-point Likert scale ranging from strongly agree to strongly disagree was employed to gauge survey responses. Structural equation modeling is used for quantitative analysis.

For the qualitative study, one-to-one semi-structured interviews with 15 doctors were conducted. The interview guide was designed, altered, and refined based on previous literature and initial interviewee responses. (Kallio et al, 2016: Saunders, Lewis & Thornhill, 2007). Within the qualitative domain, the phenomenological approach is employed, whose purpose is to understand a social phenomenon by studying the experience of subjects in a given context (Flick, 2007a).

This study seeks a comparison of quantitative and qualitative research based on the methodological integration method. Specifically, a *between-methods* approach is used by employing survey and interview both for empirical investigation (Jick, 1979). Furthermore, explanatory sequential model is used for integration of quantitative and qualitative results, where the latter complements the former (Creswell, 2014). Findings obtained from both studies are compared using *Dominant/Less Dominant* design where one study dominates the other (Creswell, 2014). Here, the quantitative study (sample: 406) is deemed dominant and qualitative study (sample: 15) is deemed less dominant. Overall, the two studies in relation to each other remained complimentary (Flick, 2007b).

Frequencies of Demographic Variables

Table No. 1 Demographic Information of Survey Participants

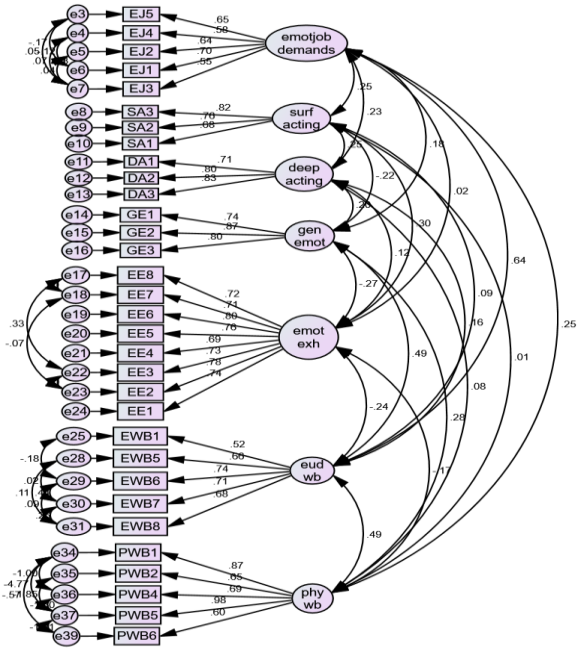
Variables	Options	Frequency	Percentage
Gender	Male	176	43
	Female	230	56
Age Group	<30	172	41
	31-40	140	35
	41-50	42	10
	>50	52	13
	Surgery	78	19

Variables	Options	Frequency	Percentage
Area/Field of Expertise	General Physician	56	14
	Internal Medicine	46	11
	Gynecology	40	10
	Dentistry	38	9
	ENT	22	5
	Dermatology	22	5
	Cardiology	2	2
	Other	102	25
Experience	<1 year	48	12
	1-5 years	180	43
	6-10 years	78	18
	>10 years	100	25
Sector	Public	107	26
	Private	299	74
City	Islamabad/Rawalpindi	199	49
	Lahore	116	29
	Peshawar	41	10
	Karachi	14	3
	Bahawalpur	11	3
	Other	25	6
Total		**406**	**100**

Confirmatory Factor Analysis

Confirmatory factor analysis establishes model fitness and checks multicollinearity. The initial model comprised 40 factors out of which 8 were removed on account of <0.5 factor loadings (Hair et al, 2009). The final model contains a total of 32 factors. Covariances among all latent variables were found to be less than 0.7, thereby eliminating the problem of multicollinearity (Hair et al, 2009). Figure 2 shows the final CFA model.

Figure 2. CFA



EJ/emotjob demands: Emotional job demands
SA/surf acting: Surface acting
DA: Deep acting
GE/gen emot: Genuine emotions
EE/emot exh: Emotional exhaustion
EWB/eud wb: Eudaimonic well-being
PWB/phy wb: Physical well-being

The fitness indicators alongside their respective values are shown in table 2. Based on Hair et al (2009) recommendation, fit indices are within recommended ranges. CFI value is above the threshold of 0.9, and RMSEA value is below the threshold of 0.08. CMIN/DF value is less than the upper limit of 3 or 5 both, thus warranting fitness (Hair et al, 2009). Values for AGFI, GFI, and NFI, albeit not above 0.9, are still acceptable for being above 0.8 (Baumgartner & Homburg, 1995: Forza & Fillipino, 1998).

Table No. 2 Model Fitness Indices

Model	CMIN/DF	GFI	AGFI	NFI	CFI	RMSEA
First Model- 40 factors	2.359	0.826	0.796	0.783	0.861	0.058
Final Model- 32 factors	**2.264**	**0.868**	**0.834**	**0.846**	**0.906**	**0.056**

CMIN: Chi-Square Statistic
DF: Degrees of freedom
GFI: Goodness of Fit Index
AGFI: Adjusted Goodness of Fit Index
NFI: Normed fit index
CFI: Comparative Fit Index
RMSEA: Root Mean Squared Error of Approximation

Correlations

Table 3 depicts correlations among the variables, which indicate that emotional job demands positively and significantly affect psychological and physical well-being. Both deep acting and genuine emotions are significantly correlated with both well-being dimensions. Emotional exhaustion has a negative correlation with both psychological and physical well-being. No considerable correlation is found between surface acting and well-being. Similarly, there hasn't been found a noticeable association between emotional exhaustion and emotional job demands.

Table No. 3 Correlations

	Mean	S.D	α	EJD	SA	DA	GEs	EE	EWB	PWB
EJD	1.91	0.7	0.748							
SA	2.67	0.98	0.796	0.248***						
DA	2.7	0.94	0.824	0.230***	0.255***					
GEs	2.36	0.92	0.843	0.184**	-0.216***	0.199**				
EE	3.21	0.93	0.91	0.017	0.302***	0.120*	-0.270***			
EWB	2.13	0.74	0.811	0.637***	0.093	0.164*	0.492***	-0.238***		
PWB	2.42	0.76	0.729	0.254***	0.012	0.081*	0.276***	-0.174***	0.493***	

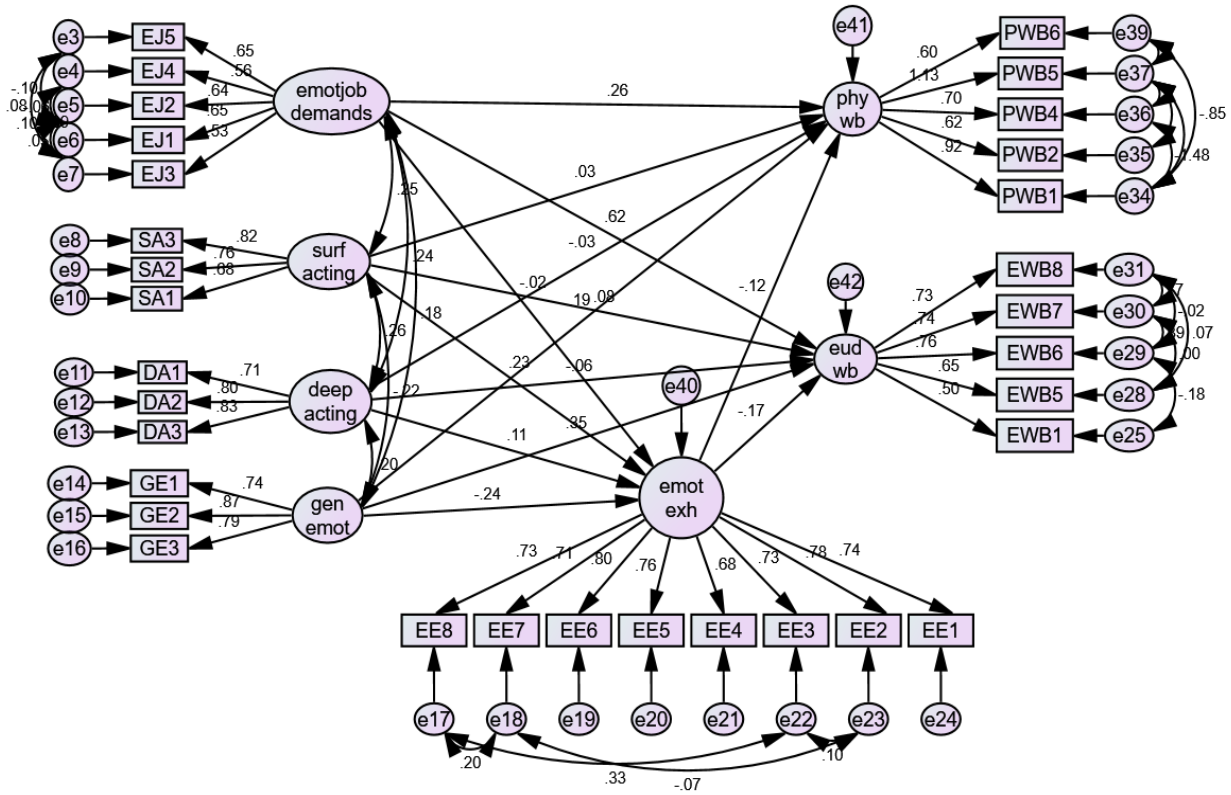
***Correlation is significant at 0.001 level
** Correlation is significant at 0.01 level
* Correlation is significant at 0.05 level
EJD: Emotional job demands
SA: Surface acting
DA: Deep acting
GE: Genuine emotions
EE: Emotional exhaustion
EWB: Eudaimonic well-being
PWB: Physical well-being

Structural Mediation Model

The structural mediation test is run in AMOS using the latent mediation estimand. A bootstrap sample of 2000 was chosen to run the mediation test. Coefficients for both direct and indirect effects can be

observed in figure 3. Direct paths in the model show significant but positive effects of emotional job demands on psychological (0.62) and physical (0.26) well-being. No direct impact of emotional job demands is found on emotional exhaustion. Out of the three emotional labor strategies, surface acting has been found to increase emotional exhaustion (0.25), while genuine emotions tend to reduce it (-0.24). No significant association between deep acting and emotional exhaustion is found. Moreover, emotional exhaustion is found to lessen both psychological (-0.17) and physical (-0.12) well-being among the doctors.

Figure 3. Structural Mediation Model



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The structural model reveals no negative effect of emotional job demands on psychological and physical well-being via emotional exhaustion among doctors, thus H1 is not supported. Surface acting has been found to increase emotional exhaustion, thereby decreasing the psychological and physical well-being of doctors. This lends support to H2. The impact of deep acting on well-being is also negative via emotional exhaustion but is only significant for psychological well-being, thereby leading to partial acceptance of H3. Finally, genuine emotions are found to enhance both psychological and physical well-being by lowering emotional exhaustion. Thus, H4 is also supported. Estimates and p-values for structural mediation model are included in table 4.

Table No. 4 Mediation Paths

Path	Estimate	P-Value	LLCI	ULCI	Decision
EJD→EE→EWB	0.003	0.722	-0.020	-0.033	Reject
EJD→EE→PWB	0.003	0.656	-0.023	0.039	Reject
SA→EE→EWB	-0.023	0.004	-0.055	-0.006	Accept
SA→EE→PWB	-0.026	0.023	-0.067	-0.003	Accept
DA→EE→EWB	-0.014	0.047	-0.040	-0.0001	Accept
DA→EE→PWB	-0.016	0.055	-0.056	0.0001	Reject

GE→EE→EWB	0.027	0.004	0.009	0.059	Accept
GE→EE→PWB	0.031	0.023	0.004	0.076	Accept

LLCI: Lower Limit of Confidence Interval
ULCI: Upper Limit of Confidence Interval
EJD: Emotional job demands
SA: Surface acting
DA: Deep acting
GE: Genuine emotions
EE: Emotional exhaustion
EWB: Eudaimonic well-being
PWB: Physical well-being

Thematic Analysis

In the qualitative part of the research, interviews are deciphered using thematic analysis. The study is structured based on guidelines provided by Creswell and Poth (2018). Based on the phenomenological paradigm, the preliminary interview guide was developed around existing literature and theory (Kallio et al, 2016) and codes and themes were extracted through deductive approach. Interviews were conducted to the point of saturation where no new findings were emerging anymore. Table 5 depicts some of the questions asked during the interviews.

Table No. 5 Sample Interview Questions

Can you identify the most common types of emotions (variety) you need to exhibit as part of your job?
How long does it take you to appease or handle such a patient?
When do you think you have to pretend to be considerate when you are feeling differently?
How often do you truly feel concerned for your patients?
Describe those instances at work where you are completely authentic and natural without putting on an act or façade to please colleagues or patients.
Does your work affect your mental and physical health? Describe an instance to elaborate.
What makes you feel exhausted at work? Describe an instance to elaborate.

Thematic analysis has been performed manually by extensively studying the transcriptions. For the sake of understanding the context and communicating it as it is originally meant, the codes and themes were deliberately determined manually. For ensuring confidentiality, the interviewees are assigned dummy names. Table 6 shows the characteristics of the sample subjects for the qualitative study.

Table No. 6 Demographic Information of Interview Respondents

Doctors/ Participants	Gender	Age	Years of Experience	Field of Specialization	City	Sector
Suleiman	M	36	10	Nephrology	Faisalabad	Private
Kanwal	F	26	1	General Physician	Islamabad	Private
Aijaz	M	28	4	General Physician	Renala Khurd	Public
Amber	F	28	4	General Physician	Rawalpindi	Private
Asim	M	64	38	Psychiatry	Mirpur Azad Kashmir	Private
Aliya	F	38	10	Gynecology	Rawalpindi	Private
Raheel	M	28	3.5	General Physician	Islamabad	Public
Faiz	M	70+	53	Orthopedics	Lahore	Private
Rida	F	32	4	Otolaryngology	Peshawar	Private
Sawera	F	34	6	Pharmacology	Peshawar	Private
Rizwana	F	62	32	Maternal and Child Health	Islamabad	Public
Sania	F	33	5	Dentistry	Rawalpindi	Private
Tahir	M	35	11	Orthopedics	Lahore	Private
Maria	F	34	8.5	Anesthesia	Islamabad	Public
Hina	F	28	4	General Surgery	Rawalpindi	Private

For bringing richness to the transcribed text quality, all interview transcripts are explicated through transcription notation. The notation refers to highlighting non-verbal cues present in the interviews like voice tone, pitch, degree of emphasis over a word, and pauses. This step assists in precise interpretation of interviews (Flick, 2009: Flick, 2014). Table 7 depicts the symbols indicating non-verbal signs.

Table No. 7 Transcription Notation

	Non-Verbal Component	Transcription Notation
1	Increased Pitch/Loudness	**Bold**
2	Decreased Pitch/Tone	↓
3	Pause	^
4	Emphasis	Underlined

Keywords were used to identify and distinguish codes and themes. For instance, empathy denoted deep acting, pretense denoted surface acting, stress, or strain denoted exhaustion, etc. A total of 23 codes were identified based on repetition and prominence. A coding frame can be quite extensive however, only three major themes are discussed here that are most relevant to the research area (Flick, 2014). Thematic maps for each theme feature the theoretically anticipated as well as organic sub-themes.

Theme 1. Medicine: A Challenging and Thankless Profession

The commonly recurring theme emerging from the interview transcriptions was the general feeling of being underappreciated. The following accounts convey how doctors perceive the status of their profession.

Aliya-38-10 *"[Chuckles] I just feel that it's a thankless job."*

Kanwal-26-1 *"The return or the payback is less as compared to the amount you invest, the age invest, The time you invest, and the intellect you invest."*

Tahir-35-11 *"In OPD we see^^ one doctor seeing more than 50 patients in a **day**.^ We don't have time to have a cup of tea. When we take a break and [Chuckles] we are having tea, the patients who are sitting there for about 5 minutes would push the door and enter^ saying are you just coming here for tea, gossiping, etc. But they don't know that the same doctor is seeing 50+ patients, and is also standing for 24 hours in emergency."*

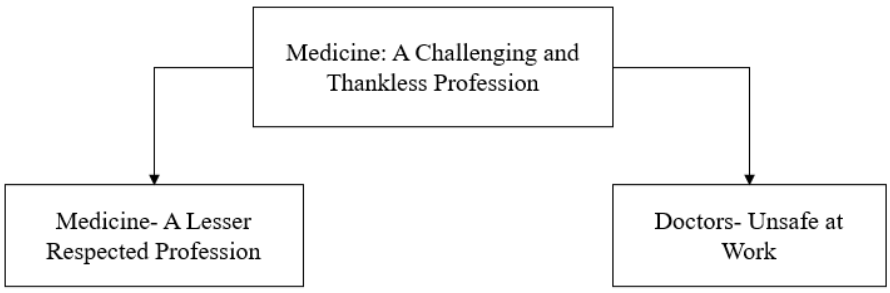
Almost all the interviewees agreed that practicing medicine involves responsibilities that are monumental compared to other professions.

Faiz-70-53 *"It's stressful, all other careers are also stressful. But **here** the^ irreversibility of the losses and^^ problems makes it more difficult than others. Once you make a mistake, somebody pays such a high **price^** that you can't **forgive** yourself."*

Rida-32-4 *"It's a^ matter of life and death. It's a profession where there is no margin for a non-serious attitude. Mistakes and losses in other fields are bearable but in medicine, life is at stake. That's why it is a distinguished profession. You can give a **new life** to someone, and you may also become the cause of someone's demise."*

The following two sub-themes explicate further challenges experienced by doctors, including lack of respect from patients, attendants or society, and lack of safety and security at the workplace. Figure 4 depicts thematic map for theme 1.

Figure 4. Thematic Map Theme 1



Sub-Theme I. Medicine- A Lesser Respected Profession

Majority of respondents shared that the profession of medicine has lost the respect and nobility, it once carried.

Kanwal-26-1 *"Doctors were like the Messiah of society and everybody used to^* ***trust*** *them* ***blindly.***

Lack of respect and due appreciation, undue coercion, and unpleasant encounter with patients are just some of the factors that add to doctors' emotional responsibilities at work. For instance:

Sawera-34-6 *"I feel like at times^ we are underappreciated. We get* ***blamed*** *for things that are not our fault. Somehow, they put everything on the doctor. When somebody dies, it is our fault. But when somebody heals, they never come and appreciate you."*

Raheel-28-3.5 *"There are times when,^ the patient themselves or an attendant might be unduly condescending, or sarcastic or rude. You might not even be responsible for a patient and they'll just^ come up to you and^ start belittling, start talking trash to you, start scolding you,^ just because they have frustrations and they need to vent them out."*

When asked how do doctors deal with problematic or challenging patients, they had varying responses. Dr. Aijaz and Dr. Suleiman suggest ignoring the troublesome ones and going about one's day.

Aijaz-29-4 *"Patients misbehave.^ How I deal with it is that I try to ignore them and continue the treatment."*

Suleiman-36-10 *"If I feel that,^ he or she is not getting into any proper organized, constructive conversation with* ***me****, so I just try^ to avoid them. I just don't give them much time."*

On the other hand, 62-year-old Dr. Rizwana emphasizes the need to talk to patients and provide them with adequate counseling. Similar views were reinforced by Dr. Tahir.

Rizwana-62-32 *"Just^ a few sentences make the patient calm.↓ ^ Unless they are very^ bad mannered,^^ otherwise the patients become^ polite after few words, few^ sentences^ and your gestures and your^ behavior and your^ sympathy with them."*

Tahir-35-11 *"It is our duty^ to counsel the patient. If they do not get counseling, then the most^ reasonable person among their attendants is called and we talk to him^ about the disease and the aggression or mood. And that attendant handles the issue with us."*

Sub-Theme II. Doctors- Unsafe at Work

Doctors' accounts also reveal a lack of safety and security at work. Doctors' tense encounters with patients, attendants, or visitors may sometimes even translate into abusive behavior. The following accounts further elaborate.

Amber-28-4 *"There are certain types of people, they come^ and they show their authority or^ give you threats like^ we will do* ***this*** *to you or* ***that*** *to you if you don't treat our patients.^ So we always ask our^ administrators or consultants and they^ politely ask them to leave^ or take their patients to some other hospital↓ if they are not comfortable."*

Kanwal-26-1 *"There is no,^ no security, no safety by the department you're working in. In the government sector, there is literally no respect and people are like,^ they think that the doctor can be pressurized."*

Apart from disease, diagnosis, or treatment-related conflicts, instances of sexual harassment and assault were also reported by doctors.

Maria-34-8.5 *"I had a colleague in gynae, and an attendant came into her room and^ she was taking a nap because you have to sleep during long on-call duties like 24- or 36-hour duties.^ The room was not secure enough, I guess.^ I guess she would have been tired and she^ did not lock the room. So an attendant^ barged in and↓ he grabbed^ her chain.^ He snatched it and he ran away. But this girl, she was strong enough, she instantly woke up and followed him and she snatched the chain back and gave him a beating [Laughs]. She was like how dare you! She also scolded the*

*security for not giving proper protection to the doctors. But^ just **look** how daring that guy was."*

Theme 2. Emotional Labor/ Emotional Display

Respondents agreed that high emotional job demands, and laboring away affective resources are embedded in the very nature of the medical profession. Here, communication with patients for awareness and reassurance becomes a vital part of the job. Dr. Aliya and Dr. Raheel discuss the importance of positive verbal and non-verbal communication with the patients, as follows.

Aliya-38-10 *"In our profession^ we have to show them care. We have to show them love and we call it tender loving care."*

Aliya-38-10 *"**Listening** is very important. If you are listening to the patient, they feel good about it. Over half of the^ illness is gone, when you're listening to them properly."*

Raheel-28-3.5 *"Body language^ as well as^ the tone in which we speak^ matters a lot to our patients.^ So^ you definitely need to^ pass a smile, have a frown, show some concern, things like that.^ If a^ patient is^ uncomfortable in^ talking,^ you have to^ show, you have to tell them that^ they can open up, their privacy will be assured. You can lean in a bit."*

Investing emotional resources at work is likely to take a toll on doctors' well-being, as Dr. Aijaz and Dr. Faiz explain here.

Aijaz-29-4 *"Irritation yes is one of the^ negative emotions that doctors show in our setup. And I experience them too sometimes. For instance, during Covid,^ often when patients cough near you and they know they have the symptoms^ or fever,^ and in presence of such^ good media campaigns, government campaigns, social media campaigns, and electronic media campaigns^ even then if the patient is not wearing a mask then I get a little irritated."*

Faiz-70-53 *"I^ sometimes^ can be quite rude^ when I lose control^ or when I am stressed and overburdened by too many things^ or for some other personal reasons."*

Majority of respondents stated that the choice of any one of the emotional labor strategies is contingent upon the context, as the following accounts show.

Amber-28-4 *"It depends upon the patient and his condition.^ You have to be natural sometimes or you have to^ fake it."*

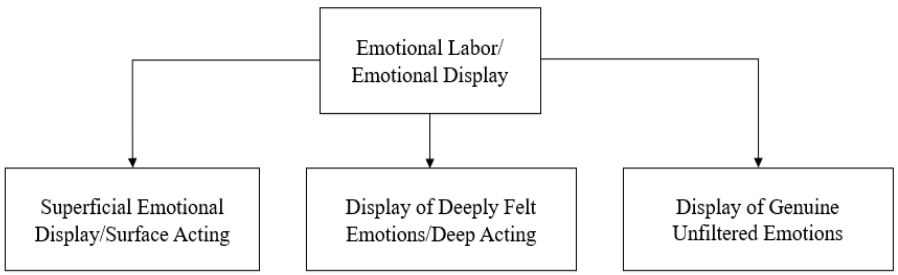
Hina-28-4 *"If I am in a good mood,^ I would be smiling a lot and^ encouraging them. But if I have^ a bad day^ or if I'm tired,^ and it is the end of the day,^ I would just^ go by and I would not be showing any emotions.."*

Here, Dr. Raheel describes the need to switch from one emotional labor strategy to another.

Raheel-28-3.5 *"I would say that^ one should be^ acting genuine,^ at work, but,^ one should always be flexible and tailor themselves according to the^ situation.^ There are some days **it just might not be possible** for you to^ feel happiness or empathy or concern for anyone other than yourself. So^ you don't **have to** take the burden that day."*

Figure 5 highlights the thematic map for the theme of emotional labor. The sub-themes explore the usage of three emotional labor strategies.

Figure 5. Thematic Map Theme 2



Sub-Theme I. Superficial Emotional Display/Surface Acting

When inquired about surface acting, doctors maintained that it is not so much acting, but rather an ideal demeanor every doctor must display as part of the profession. It may aid in shielding doctors from getting personally and emotionally involved with their patients.

Faiz-70-53 *"I **don't** say that we **pose,** but we try to maintain a certain amount of^ good service attitude, even if we don't feel anything about it. But^ you cannot call it hypocrisy.↓ It's part of my training, it's my professional job.^ I must be attentive, I must look **sincere**."*

Raheel-28-3.5 *"I wouldn't call it^ **faking** per se,^ but we have to adjust our^ tone and our mannerisms to^ make the patient^ feel that we^ realize how^ big of a deal it is to the patient."*

Aijaz-29-4 *"Being a doctor, I will^ prefer pretending to be nice. A doctor shouldn't feel anything so much in the first place. if the patient is critical then^ doctor will show on the surface that everything is fine and understandably wouldn't share too much."*

Dr. Rida shares her experience with critical patients, saying that pretense is indispensable when dealing with terminally ill patients. Under such circumstances, doctors cannot possibly be completely honest.

Rida-32-4 *"I feel it happens when a patient comes to us who has stage 3 carcinoma which is widely spread and^ you can't say to the patient that^ the survival rate is 5 to 10 percent. You are getting this feeling inside that chemotherapy is a **waste of time** but still, you have to show them^ hope of life.^ At times like these I feel like I am acting.↓"*

Sub-Theme II. Display of Deeply Felt Emotions/Deep Acting

Talking about deep acting, doctors emphasized that emotional display may be internalized and is healthy if it involves empathy.

Kanwal-26-1 *"I^ have that compassion, I have that empathy, whenever I see a patient. Because I think^ he could be me and I could be him."*

Asim-64-38 *"Without empathy, I can't^ **deal**, I can't^ **communicate** and I can't^ **face** my patients. Empathetic attitude usually **helps** me^ and gives me a sort of^ relaxation and relief."*

Maria-34-8.5 *"If I am not empathetic, I have opted for the wrong profession."*

Dr. Aijaz stressed that empathy must not transform into sympathy. Distinguishing between the two, he says,

Aijaz-29-4 *"A trained doctor should^ have empathy rather than sympathy. He should understand the pain, suffering, and condition of the patient, but he doesn't share that pain and suffering with the patient."*

Dr. Raheel emphasized that empathy must carry a certain level of care and compassion, otherwise the doctor may become too detached and mechanistic while dealing with patients.

Raheel-28-3.5 *"If you^ cannot^ put yourself in the shoes of^ the person^ that you're treating and^ the family of the person that you're treating,^ your treatment and your^ judgment of the patient will be purely analytical. And^ that^ is not a very good thing when you're dealing with^ living, breathing people."*

Sub-Theme III. Display of Genuine Unfiltered Emotions

When asked about showing unfiltered genuinely felt emotions at work, most of the respondents shared that it is not usually the option. Dr. Hina (surgeon) and Dr. Maria (anesthetist), both exclaimed jokingly that the only time they can be natural and authentic is the time when the patient is unconscious. Similar views were expressed by Dr. Faiz.

Faiz-70-54 *"We can't act naturally because if we start acting naturally, we will hurt people. Doctors do not have the liberty to act natural. I don't say that we are posing most of the time^ but our rights at work are very limited. The **patient's** rights are^ preferred. We can't really^ let our emotions^ run^ amuck."*

However, at times showing natural emotions becomes necessary. Dr. Kanwal pointed out that doctors don't have the time for maneuvering artificial emotions when dealing with emergency cases.

Kanwal-26-1 *"In emergency^ when patients^ come, burden is^ very much over there and I have to be my authentic self. So, you actually are yourself over there in emergency^ because you don't have enough time for pretense."*

Theme 3. Exhaustion and Low Well-Being

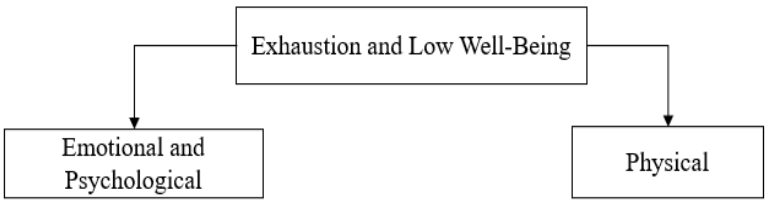
As discussed earlier, investing emotional resources in any job causes strain, exhaustion, and low well-being. Doctors reinforced that stress and exhaustion are common outcomes of excessive patient counseling, dealing with emergency cases, placating difficult patients or attendants, or the emotional toll of a patient's demise.

Suleiman-36-10 *"Counselling of the patients^ exhausts me a lot.^ But in our profession, you have to do it^ for the betterment of the patients. You just cannot avoid it."*

Asim-64-38 *"When^ we are seeing^ a long list of patients at times **or** taking^ classes in a row^ then,^ we become exhausted and tired and,^ also have,^ these^ problems,^ emotionally and mentally."*

As a result of the aforementioned factors, doctors reported feeling emotionally, psychologically, and physically drained. These facets are shown as sub-themes in figure 6.

Figure 6. Thematic Map Theme 3



Sub-Theme I. Emotional and Psychological Exhaustion/ Well-Being

The respondents reported that the strenuous nature of work drains them, worsening the emotional and psychological state of doctors.

Maria-34-8.5 *"It is not always the sunshine.^ There are some days when^ life gets tough. And **then** you have to come to work and you have to treat your patients. So this↓ obviously, it emotionally **drains** you."*

Raheel-28-3.5 *"Not many people actually^ care about^ our^ mental state^ or what we^ go through. It is very^ **easy** at least in our society to^ pass an opinion or a criticism on^ doctors but^ most people don't even know what we go through. In the long-term,^ it so happens that^ doctors are^ very commonly found to be^ suffering from clinical depression and anxiety. And^ the very reason for that is that ^ they are listening to everyone's troubles but^ pretty much no one is listening to their troubles."*

Dr. Raheel further stated that too much faking and pretense create dissonance and thus cause psychological and emotional distress.

Raheel-28-3.5 *"If you're forcing yourself to work and wear a smile on your^ bad days^ that will obviously lead to^ stress.^ And^ **again**, it just leads to that balance point again.^ You^ need to know where your own limits are. If you're^ forcing yourself beyond those limits, then it's definitely going to be stressful and^ impact you quite negatively."*

Use of deep acting does not warrant curbing the stress and exhaustion. Dr. Hina warned about getting too attached to the patient and how it may bring emotional burdens and baggage.

Hina-28-4 *"Getting yourself attached to a patient would^ affect your mental health because if the patient is not getting well,^ you would be worried for the patient all the time. And^ God forbid if the patient^ passes away or^ expires,^ then^ that stigma or that^ thing that you couldn't^ do anything to^ save that patient would stick with you. So that is why we have to keep our personal and professional life separate^ and^ not bring the worries home."*

Sub-Theme II. Physical Exhaustion

Interviewees agreed that physical strain, tiredness, and exhaustion are closely associated with emotional and psychological exhaustion. Dr. Kanwal vociferously communicated the issue of the poor physical state of doctors. She reported working under fever numerous times, and often taking liquid diets for time conservation.

Kanwal-26-1 *"There is no biological rhythm, like 15 days of the month you are awake^ all^ 12 hours of the night. How will your body remain healthy?^ If you are not^ being^ used^ in the **capacity** of a human being, you are being used like a robot, then you will never ever remain healthy."*

Lack of time for workouts and exercise also negatively affects doctors' well-being. Dr. Maria shared that despite aiming for regular exercise, she never finds the time and strength due to her hectic and inflexible job routine.

Maria-34-8.5 *"I don't get time for exercise^ [Chuckles] because I feel so tired^ because of duties."*

Dr. Raheel talked about the effects of standing or sitting for long time periods with bad posture, leading to back aches and spine issues. He further shared how doctors indulge in unhealthy eating habits including comfort eating, to cope with exhaustion, subsequently leading to poor health.

Raheel-28-3.5 *If you're in the OPDs you^ generally tend to have a very bad posture,^ you are either looking down or^ crouching over the^ table, things like that.^ It is really bad for your neck, it's bad for your back. And^ when you are really tired^ or exhausted, then you might want to have^ a sort of^ let's say, a **binge meal** or something like that. You want to just^ get takeout, get something really oily or spicy, or something **just** to lift your mood. So^ physical health **definitely** gets^ quite negatively impacted in this field."*

In a nutshell, concerns pertaining to physical fitness and well-being of doctors are intertwined with emotions. One of the respondents, Dr. Sawera narrated an incident when she stabilized a patient after working for 16 consecutive hours. However, the patient's attendant told her that he would never let his child become a doctor given how corrupt and dishonest doctors are. Dr. Sawera shared that the remark lowered her morale, especially because she had not had a glass of water for the last 16 hours. She recalls her reply as follows.

Sawera-34-6 *"Yes uncle we're very dishonest, because I haven't even had a glass of water since last 16 hours. Because I'm **that** dishonest."*

The above discussion concludes a crossover between emotional, psychological, and physical wellness of doctors.

DISCUSSIONS AND CONCLUSION

Results from quantitative analysis supported our assumption about the straining nature of surface and deep acting emotional labor, specifically in Pakistan's healthcare context. Their negative impact on well-being via emotional exhaustion also resonates with COR theory (Hobfoll, 1989) which emphasizes that affective resource depletion leads to strain and exhaustion. Thus, engaging in surface or deep acting requires laboring away affective/emotional resources, subsequently leading to emotional exhaustion and low well-being. Similarly, the positive effect of genuine emotions on well-being through lowering emotional exhaustion again supports the notion that conserving resources through authentic emotional display reduces exhaustion and improves both psychological and physical well-being. These findings coincide with Burić, Kim, and Hodis (2021), Costakis, Gruhlke and Su (2021), Öngöre (2020).

Unlike expected, impact of emotional job demands on well-being remained insignificant. This may be due to individual differences in perceptions of emotional job demands and how they may be context driven. It should be noted that the majority of respondents expressed that they deliberately chose medical profession and do not regret it. During the interviews, doctors reported that they experience contentment and satisfaction from their work. This may seem contradictory to their accounts of experiencing and coping with emotional job demands and emotional labor. Such contradictions are likely prevalent due to the contextual nature of the variables, with doctors responding to emotional job demands differently at various points in time (Tarabeih & Bokek-Cohen, 2020). Workers may even playfully redesign their tasks according to the expected demands, making the job easily manageable and less straining (Scharp, Breevaart & Bakker, 2021).

Employing a phenomenological stance assisted in expounding the existing research and added in-depth context to the quantitative study. Through interview accounts, doctors shared their perceptions about medical profession which in view of the conservation of resource theory (Hobfoll, 1989) may later shape their degree of receptiveness towards meeting emotional job demands and help build up emotional resources for emotional labor. As is signified by the descriptive data provided in table 2, doctors face high emotional job demands (mean=1.91). Interviews assisted in exploring instances when and why certain emotional labor strategies are used or transitioned from. Respondents stressed upon the importance of providing good service to patients, therefore they frequently engage in surface acting (mean=2.67). Deep acting (mean=2.7) is especially preferred since it entails empathy, care, and sensitivity towards patients. Furthermore, doctors shared their limitations in displaying genuine emotions in front of patients given the need for emotional composure and professionalism (mean=2.36). However, exhibiting genuine emotions is highly contingent upon situations as well as their synchronization with emotional job demands. The qualitative study remained flexible in discussing the consequences of emotional job demands and emotional labor, and explored exhaustion and well-being, in addition to stress, depression, anxiety, and work-life balance. Moreover, interviews also revealed grave issues like sexual harassment and assault faced by female doctors at work, an issue that makes the job even harder for them relative to their male counterparts. Overall, our study concurs with Yang and Jang (2022), Karakose and Malkoc (2021), Khattak et al (2021), Ofei-Dodoo, Loo-Gross and Kellerman (2021), Suh and Punnett (2021), Wang, Hall and Taxer (2019)

Our study adopted an explanatory sequential mixed-method design with the purpose to compare and reflect upon both (Flick, 2009). For similar reasons, results from both studies were not quantitatively triangulated, given the preciseness of explanatory study with respect to specific constructs and scale operationalization; while qualitative study was more open-ended with doctors discussing issues outside of the quantitative model like stress, work-life balance, depression, etc.

Practical Implications

Based on the findings, it is imperative to investigate ways to equip doctors with necessary awareness and training. In this regard, recruiting individuals who possess traits of empathy, tolerance, patience, listening, emotional composure, and miscellaneous people skills may aid in meeting emotional job demands smoothly. Organization-wide training programs may also be initiated that provide doctors and medical staff ways to conserve their affective resources for practicing emotional labor and fulfilling emotional job demands, whilst avoiding exhaustion and low well-being. Such programs may include trainings for stress management, work-life balance, and managing work-family conflicts. The issue of doctors' safety and security at work must also be given utmost priority by healthcare administration.

Future Research Avenues

Research limitations call for a longitudinal study examining the impact of the COVID-19 pandemic in terms of its waves, whilst understanding the desensitization of the masses towards the disease and its subsequent effects. The magnitude of both misinformation, panic, scarce medical research, and mounting mortality rates during the earlier COVID waves starkly differs from the latter waves of the pandemic. This maturation of circumstances changed emotional labor practices in healthcare. For qualitative inquiry, a case-based approach can be employed by selecting an organization and controlling for certain variables. Given the inconsistencies and contradictions in the emotional labor literature, a sector-wise comparative study can also be useful in this regard.

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