They just don't really get it, this is a vocation and I wanna do it: Exploring the Wellbeing of 'Customer Service' Workers in Healthcare

Submitted by Lilith AREVSHATIAN and supervised by Dr. Rachel LEWIS

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Note:

This thesis investigates the personal topic of wellbeing. Please be aware that this thesis contains emotionally distressing material which may be upsetting to sensitive readers.

Abstract

This thesis tells the tale of a special group of healthcare 'customer service' workers called the Patient Advice Liaison Service (PALS). It looks at how their job is designed and explores the impact this has on their wellbeing by using a mixed-method research design which includes one quantitative and one qualitative study. The starting occupational level study is based on quantitative data from 138 participants using a questionnaire that measures global wellbeing, job satisfaction and psychosocial work conditions. A high incidence of strain is reported, statistically higher than that of other customer service employees and more comparable to social workers. Psychosocial conditions at work are revealed to be dire and in need of urgent action; and yet, the same group of workers report satisfaction with their job. To further unwrap the complex lived experience of PALS workers, an individual level study was conducted. Interpretative phenomenological analysis was undertaken with nine participants. Four emergent themes affirm that when it comes to their job, others *just don't really get it*, especially the extent of their emotion work. Changing the NHS is compared to *changing a super tanker's direction* and participants confess to having had a *breaking point*. Nevertheless, PALS staff declare that *this is a vocation and I wanna do it*. Reflexive interpretations suggest that some customer service employees actually engage in rather complex work that is not easily captured by the broad 'customer service' label. For individuals engaged in this type of relational work emotion work was found to be both a source of distress and motivation. Comparisons between these healthcare workers and other public sector relational workers are made and the new discourse of expertise services is proposed. Theoretical and policy implications are discussed.

Acknowledgements

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Dedication

To the spinal cord of the NHS – with thanks.

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Foreword

This thesis is submitted for the degree of Doctor of Philosophy (PhD) which is an independent piece of research that makes an "original contribution to knowledge" proportionate to the length of registration (Kingston University, 2011, p.53). This PhD submission is a critical investigation and evaluation of the wellbeing of the Patient Advice and Liaison Service (PALS) employees working in healthcare and contributes to the body of knowledge of psychology and healthcare management as well as public policy. Because of its trans-disciplinary approach, it navigates information from different fields and quilts together concepts from different disciplines into one narrative.

This thesis tells a story spanning between 2010 and 2013; and although it began in 2010, it was then quite a different story. It started as an inspection of how information contained within patient complaints was used (or not used) by National Health Service (NHS) managers in their decision making processes. It was during that year, while reading for the literature review, that a more pressing PhD emerged; one focussing not on the operational process of complaints management but on the people tasked with taking in these complaints. The research since then transformed and became about the relationship between people's work and how they feel. But this is not an exploration of just any generic employee – it is about a special group of 'customer service' employees known as PALS staff who work in the world's fifth largest employer, the NHS (Alexander, 2012). This research combines an occupational level broad investigation with an in-depth individual level phenomenological exploration using a Pragmatic approach to link both studies.

These public servants are special because, as this thesis will evidence, they are unique to the NHS; and their function, as envisioned by the Department of Health (DH), is an abundant assortment of assignments, which this thesis argues makes them quite different from other generic customer service workers. What this research does in essence is explore the interactive relationship between PALS employees, their work, and how they feel. This relationship is important for many reasons; how PALS employees feel influences their behaviour at work which in turn impacts on the NHS and ultimately on patient care and patient safety.

As with many other academic concepts, for example job satisfaction, wellbeing has various definitions. Researchers working in this area may be exploring a variety of different experiences under the umbrella of the 'same' concept (although the possibility of objective 'sameness' can

also be questioned). In an effort to try and make sense of the vast body of literature on wellbeing, this thesis will begin by introducing the concept of wellbeing and positioning it in the wider psychological literature. Then it will focus on how the design of one's work can impact on wellbeing outcomes. This introductory chapter is a literature review that will construct the conceptual framework of this thesis and convey the overarching information needed to begin this research (Table 1).

Table 1 Thesis Structure

Chapters	Description
1-2	Introduction and Literature Reviews
3-6	Occupational Level Quantitative Study One
7-11	Individual Level Qualitative Study Two
12-13	General Discussion and conclusions
14-15	References and Appendices

Following on, chapter two will then focus on PALS employees. It will provide a fleshed out appreciation of the phenomena that are likely to be pertinent to their wellbeing. It introduces the reader to the complexities of the healthcare organisation and the public sector context where PALS staff work. It discusses how people work can impact on employee wellbeing and then dig down into the customer service role to determine the transferability of previous research findings.

Chapter three will then commence the first quantitative study that initiated this research, detailing its specific focus and describing how data was collected. Results will be reported in chapter four and findings will be discussed in chapter five. Chapter six will then build on this work and explore the next emerging research question.

Chapter seven will describe the methodological steps taken to conduct this second idiographic study, building on the former. Chapters eight to 11 report and discuss its findings with each chapter being dedicated to one super-ordinate theme. Chapter nine will narrate a cohesive discussion of the whole research by looking at the thesis as a whole. Chapter thirteen will then conclude by noting some of the limitations that stood in the way of this project and propose possibilities for future researchers. A reference list and appendices can be found at the close of this thesis.

1. Introduction

1.1 Review Approach

Three aspects of this research are important: (1) its theoretical framework, (2) its context, and (3) its occupation. In order to cover all this knowledge ground the literature review has to bring together theories and research from different fields; hence, this work can identify itself as trans-disciplinary and eclectic. This is a key advantage as trans-disciplinary work can achieve a more complete understanding (Stokols, 2006) and reach a wider audience (Magill-Evans et al. 2002). For each field, a different approach was needed to access information making a systematic literature review inappropriate.

First, to gain information about the theoretical framework of wellbeing, the review engages with the discipline of psychology. Within this field literature is reviewed from different branches, such as occupational psychology and positive psychology. Here it explains what wellbeing means and why it is an important consideration at work. It shows how the concept evolved from its early philosophical roots to its present standing as a psychological construct (Drakulic, 2012). The review then considers literature onhow work is designed in order to understand the sorts of conditions that impact on employee wellbeing. Known broadly as work design (Nicholson 2010) or job design (Fried et al. 2007), this type of research is based on the premise that some jobs can be damaging to the doer's health (Parker et al. 2001). By engaging with work design research, the review links conditions at work with employee wellbeing and proposes that some work factors (e.g., high demands) can be detrimental for wellbeing whereas others (e.g., social support) can be helpful (HSE, 2012).

The second aspect that is important about this study is the context of healthcare. Government commissioned reports as well as policy documentations are sourced to elucidate contextual specifics concerning the National Health Service (NHS).It is important that neither wellbeing, nor work design, are seen in isolation within a closed system; but rather, that they are understood as positioned within a wider exo-system. The NHS is a public sector organisation and thus heavily influenced by social, economic and political factors. These contextual variables external to the organisation can either constrain or enable work design (Morgeson et al. 2010).

And finally, this study engages with a particular king of customer service worker: the Patient Advice and Liaison Service (PALS). This means that in addition to psychology, the review also extends to the fields of marketing and healthcare management. First the literature review exposes that customer service is a high strain job (Johnson et al. 2005) and that worker wellbeing may be at risk (e.g., Bakker and Schaufeli, 2008; Grebner et al. 2011; Sprigg, Smith and Jackson, 2003). Then it builds an argument to differentiate between types of customer service workers and shows that largely research has been conducted on samples of generic mass production workers (e.g., Belt, 2002; Holdsworth and Cartwright, 2003; Holman 2002; Houlihan 2002, Jenkins et al. 2010; Mulholland, 2002; Zapf et al. 2003). This suggests that the wellbeing of high level service workers such as PALS staff remains unknown. The review then teases out the particular work conditions that may play an influential role in generating wellbeing outcomes; e.g., working in a highly political environment (Bentley et al. 2005; Xanthos, 2008), adopting different role identities (Abbott et al. 2006)and experiencing conflict of interest (Mulcahy and Lloyd-bostock, 1994). The preconception put forward is that PALS employees perform an important organisational function and that certain job design characteristics in their work may be concerning for their wellbeing. This warrants investigation as wellbeing impacts on performance and the consequences of making a mistake at work are serious in healthcare.

Overall, the material reviewed consists of academic peer reviewed journals, but also of government commissioned reports and policy documents. Sourcing was open-minded and it was not feasible to constrain searching at the start by setting strict inclusion/exclusion criteria. At times, wellbeing knowledge had to be gained by looking at research on comparable occupations, e.g., complaints staff (Xanthos, 2008), NHS managers (Mulcahy and Lloyd-Bostock, 1994), ombudsmen (Kolb 1988); and reflecting on the transferability of these findings to PALS employees. It is simply not possible to review *all* published material on this topic, rather a sample had to be drawn to highlight what is already known about PALS staff wellbeing and what remains to be discovered. A literature search was conducted on EBSCO, PsyINFO and other academic search engines and keywords such as customer service, call centre, and wellbeing were used to generate results. Articles were numerous and studies ranged from emotional work (e.g., Jenkins et al. 2010; Lewig and Dollard, 2011) to professional identity (e.g., Huws 2009;Pritchard and Symon, 2011) – in essence the topics of investigation were simply too broad. Most of the studies sampled call centre workers (e.g., Bakker and Schaufeli, 2008; Belt, 2002; Brannan 2005; Grebner et al. 2011; Holdsworth and Cartwright 2003; Holman, 2002; Houlihan 2002; Lewig and Dollard 2003; Mahesh and Kasturi 2006; Mulholland 2002; Wegg et al. 2010; Zapf et al. 2003), while only a few, such as Boles and Babin (1991) involved face to face customer service. However, their sample of restaurant workers perform a job that is too different from PALS staff to make any valuable inferences. It was then that a decision was made to restrict the review to studies that (1)

sampled call centre workers as their customer service role was believed to be, at the time, the most comparable, and (2) measured wellbeing as the composite and global concept consistent with this thesis' conceptual framework.

In summary an open and flexible approach was taken for this literature review that is presented in two chapters covering three core areas of importance: wellbeing as a theoretical construct, the context of healthcare, and the occupation of PALS staff. This first chapter focuses on the broad conceptual framework while the second moves on to the contextual and occupational specifics. As a literature sampling guide, two primary questions led the synthesis: (1) what is already known about wellbeing at work covered in chapter one; and (2) what is already known more specifically about the wellbeing of PALS employees to be discussed in chapter two.

1.2 Defining Wellbeing

This study adopts a composite and global definition of wellbeing (Figure 1) inspired by Danna and Griffin's (1999) framework. Wellbeing is viewed as comprised of both life satisfactions and dissatisfactions, work related satisfactions and dissatisfactions, and psychological and physiological health. The latter is seen as a "sub-component" of wellbeing (Danna and Griffin, 1999, p.359) and includes both psychological (e.g., anxiety) and physiological indicators (e.g., blood pressure). Wellbeing outcomes result from influencers across different life domains, from work and non-work events.

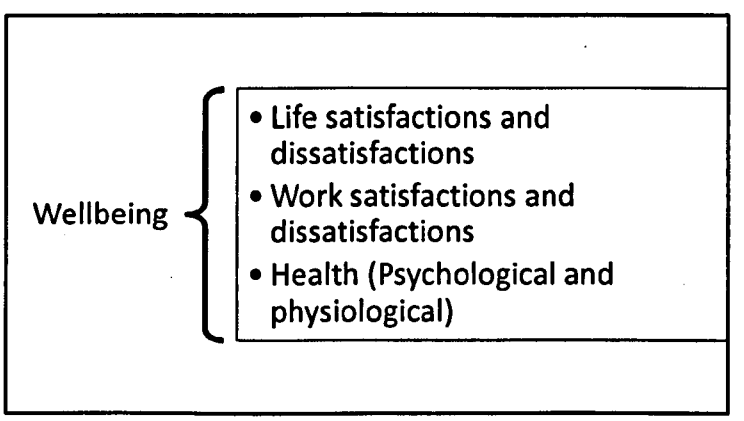

Figure 1 Wellbeing: A Composite and Global Construct

In taking a composite and global perspective on wellbeing, this study critiques two prominent psychological concepts: stress and subjective well-being (SWB). Discussions on these phenomena can be broadly understood as endorsing the psychopathological or the positive psychology discourses. Psychopathology is preoccupied with dysfunction while positive psychology considers

what is good (Fineman, 2006). The latter thus offers an attractive alternative to the negative focus of stress. However both discourses have their limitations and this review proposes that emancipating either the negative or the positive can only provide a partial picture of wellbeing. Rather an eclectic whole rounded perspective as suggested by this study is more suitable to understanding the complexities of human experience. It does however acknowledge that contrasting these two approaches is simplifying a rather complex debate in the literature. The intention is not to dichotomise and present an either/or argument but rather to position this study's conceptual framework in the wider debates taking place in the discipline.

Stress researchers aim to identify stressors and recommend ways to minimise strain by uncovering the environmental hazards most likely to lead to strain (Leka & Houdmont, 2010). The focus here is largely on the negative, on hazards and strain. Theoretical interest in stress originated quite some time ago; the earliest proposed is by Cannon in the 1920's who described stress as a fight or flight response to threat(Cox and Griffiths, 2010).His work was mostly focused on the neurological mechanisms that lead to the display of aggressive behaviour or escapism. Selye's later research in the 1950's developed on his predecessor's work by unpacking the fight or flight response into three stages: First, the threat triggers alarm, then the resistance stage sets in where the individual restores, followed by the exhaustion phase if the stimulus continues.

Since then, more modern conceptualisations of stress have been developed. Engineering interpretations view stress as a stressor. Stressors can be broadly understood as environmental hazards that lead to strain (Spector, 1998). Researchers endorsing this perspective measure stress as an independent variable in the external environment (Cox et al. 2000). Alternatively, it can be taken as the individual's response to the stressor known as strain (Jex and Beehr, 1991) and measured a dependent variable (Cox et al. 2000). Strain responses can be physical e.g., increased blood pressure; psychological e.g., bursts of anger; or behavioural e.g., smoking (Mazzola, Schonfeld, and Spector, 2011). Academically, scholars distinguish between stressors and strain, but lay interpretations appear mixed; in a UK study of mixed industries, 47% of participants conceptualised stress as their response to the situation while 33% understood it to mean the situation itself (Kinman and Jones, 2004). This might further confound stress research findings as researcher and participant might be interpreting the term differently.

Stress has been found to be the leading reason for long term work absence (Brockett, 2011) costing the UK economy an estimated £28 billion each year (NICE, 2009). Excessive hazards at work combined with stresses from daily living and personal issues can eventually take its toll on the individual and lead to a number of undesirable outcomes (Kerr et al. 2009a). For the organisation, this means more cases of absenteeism, an obvious and costly consequence (Arnold

et al. 2005), but also less overt repercussions such as tired employees with poor concentration, a difficulty in prioritising and confusion with making judgements (Kinman and Jones 2005). For the individuals it could lead to high blood pressure, increased cholesterol levels, precipitated heart rate, and other life threatening conditions such as coronary heart disease which have been well documented in the behemoth series of Whitehall studies (e.g., Marmot, et al. 1991). This is because strain can lead to a number of neuro-endocrine responses as illustrated by Figure 2.

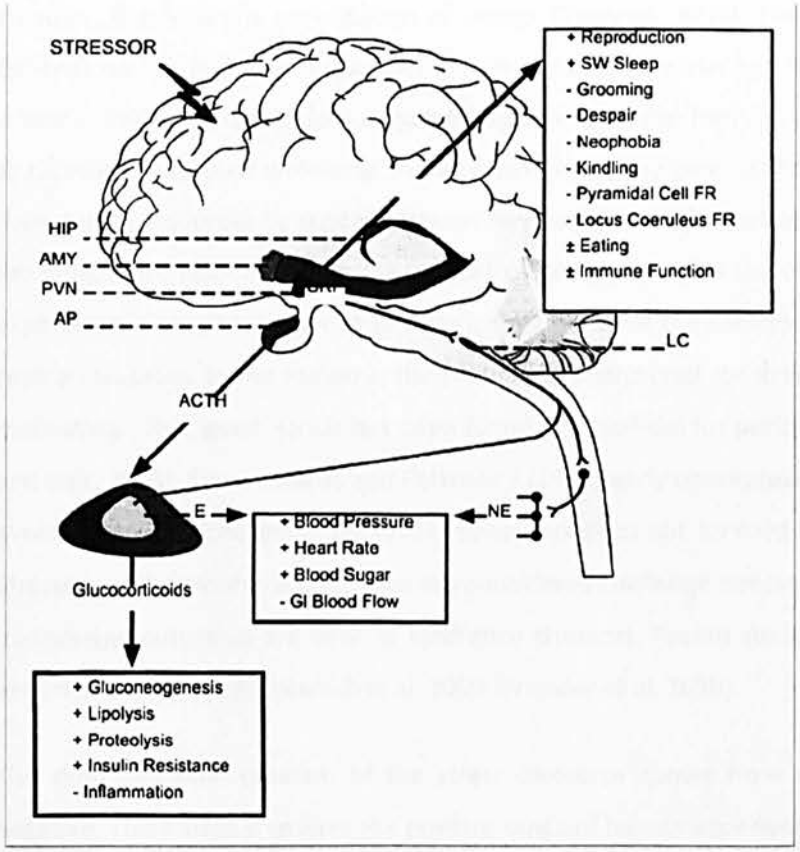

Figure 2 Neuro-endocrine Response to Stressors *(Source Gutman et al. 2000)*

When faced with stressors individuals may experience elevated cortisol levels and decreased serotonin (Cowen 2002). Heart rate may increase leading to palpitations and sleep may be affected – all rather unpleasant. Additional undesirable reported outcomes include tension, worrying, anxiety, insomnia and apathy (Kinman and Jones, 2005). These emotions are bothersome in themselves and potentially more so for people who are working in an already tense environment with patients who are likely to be upset and expecting them to exhibit empathy.

Now three key criticisms are put forward concerning the use of the stress discourse. The first criticism is that while these biochemical perspectives help further understanding of what occurs physiologically during times of stress, being rather reductionist they do not adequately account

for the meaning people associate with these physiological experiences. Stating that poor wellbeing is due to high cortisol levels does little in the way of explaining the experience of poor wellbeing; any more than stating that high oxytocin is responsible for bonding can explain affection or love. Furthermore, as these explanations are rooted in bodily functions they fail to adequately explore individual variations in responses.

The second criticism is that 'stress' itself is a natural and normal reaction to a stressor i.e., stimulus, requiring the mobilisation of energy (Theorell, 2003). The type of strain experienced depends on the individual's appraisal of the situation (Lazarus and Folkman, 1984). In occasions where individuals experience a negative response to stress, they are appraising a particular event as threatening to their wellbeing. In these instances, they perceive these events are either taxing their coping resources by stretching them beyond perceived capability, or as exceeding them, by requiring more resources than they perceive they possess. On the other hand, when individuals experience a positive response to stress, they perceive themselves as endowed with sufficient coping resources. In this instance, the stimulus is interpreted constructively and the strain can be motivating. This 'good' stress has been found as beneficial for performance (Le Fevre, Matheny, and Kolt, 2003). Since Lazarus and Folkman's (1984) early conceptualisations, this distinction has evolved into the 'challenge-hindrance' stress model as put forward by Cavanaugh et al. (2000). Stressors with favourable outcomes are considered challenge stressors whereas those leading to undesirable outcomes are seen as hindrance stressors. Recent studies are beginning to provide empirical support (e.g., Pearsall et al. 2009; Webster et al. 2010).

The third and final criticism of the stress discourse comes from its one sided focus on the negative. This means it ignores the positive range of human experience thereby only telling half a story. Partly as a response against psychopathology's fervent fascination with dysfunction, the 1960's birthed the positive psychology moment, and researchers began to pursue the conditions that lead to happiness (Seligman and Csikszentmihalyi 2000). Within this discourse, it is the relationship between positive emotions and positive health that is explored (Spreitzer et al. 2005). Of notable research interest have been resilience (e.g., Sutcliffe and Vogus, 2007; Rutter, 1993), employee engagement and positive organisation behaviour (e.g., Bakker and Schaufeli, 2008), flourishing and positive subjective wellbeing (e.g., Diener, Suh, Lucas, and Smith, 1999), flow (e.g., Csikszentmihalyi, 1990), self-actualisation (e.g., Maslow, 1998) and job satisfaction (e.g., Locke, 1990). In contrast to stress, positive aspects are associated with desirable outcomes (Danna and Griffin, 1999) such as increased job satisfaction, employee morale, and productivity as well as decreased turnover with an estimated cost saving of £250 000 a year[1](NICE 2009). Put quite

[1] Cost saving calculated for organisations with approximately 100 employees (NICE, 2009)

simply, while stress research magnifies what is not working well, positive psychology research highlights what is working well.

While psychopathological discourses engage with the concept of stress, positive psychology scholarship engages with the concept of SWB. SWB is a singular and positive concept (Frey and Stutzer, 2013)characterised by life satisfaction, positive emotions *and* the absence of negative emotions (Diener and Chan, 2011). Quite simply, it is another term for happiness (Frey and Stutzer, 2013). While there are many definitions of SWB, they usually tend to have three defining characteristics: (1) it is a subjective experience; (2) it includes the presence of positive emotions and the relative absence of negative emotions; and (3) it is a global judgement about life overall (Wright and Cropanzano, 2004). On the one hand SWB results from global life satisfactions and on the other it also depends on more transient moods in everyday life. Distinctions can be made between eudemonic elements (e.g., experiencing meaningfulness in life) and hedonistic states (e.g., feeling good in the now). The former has its roots in Aristotelian *eudaimonia* broadly translated as the actualisation of one's virtuous and good potential in life (Ryff and Singer 2006). It concerns longer term evaluations such as a sense of purpose in life, whereas hedonistic states are more fleeting, concerning daily pleasures. Generally people seem to experience both at the same time and self-report ratings on eudemonic and hedonistic happiness appear to be equitable (Berridge and Kringelbach, 2011). On the whole, feeling good and experiencing meaningfulness go hand in hand.

SWB has roots that can be traced back to the days of ancient philosophers although today it has metamorphosed into a psychological construct going through a number of transformations along the way (Figure 3).

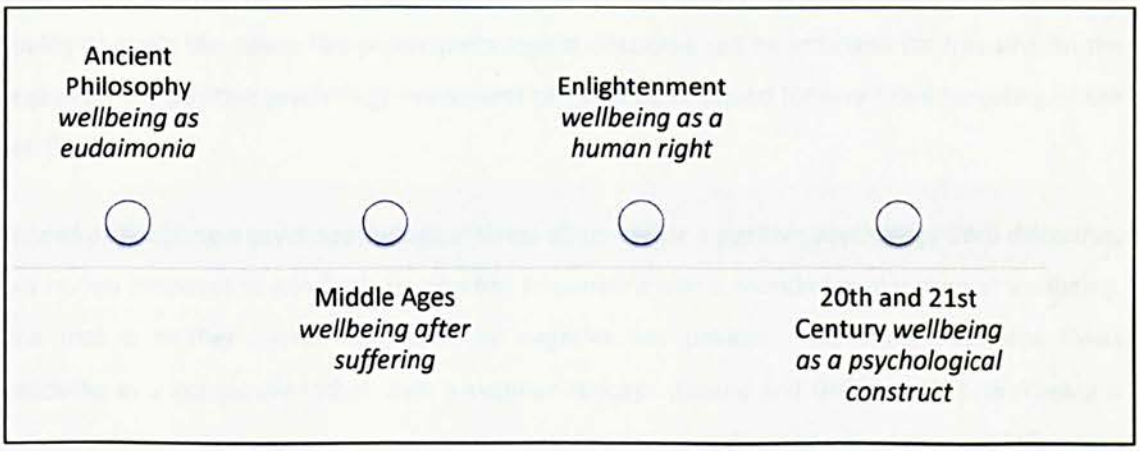

Figure 3The Emergence of Wellbeing as a Psychological Construct

The belief that happiness is a sort of 'human right', a necessary requirement of life, is largely a western construction emerging from countries like England, France, Italy and North America during the period of Enlightenment (Drakulić 2012). Voltaire (1694 – 1778) wrote that the only human concern was to be happy and the period of Enlightenment generally furthered the idea that people were born to be free and happy. It was only at the beginning of the 20th century that SWB began to be perceived as a psychological construct (Drakulić 2012). Some of these conceptualisations were related to philosophical ideals and engaging in meaningful work (Csikszentmihalyi, 1990).

Modern philosophers such as Zizek (1949 -) critique the "pervasive, unconditional injunction to enjoy – the command that we must experience pleasure in all aspects of experience" (O'Dwyer, 2013,p.34). It appears that psychological views on SWB consider happiness a human necessity and individuals who are unhappy as 'deviants' from the norm: people must be happy and those who are unhappy have something wrong with them.It can be questioned why today happiness is taken to be an absolute and necessary condition of human experience and negative emotions perceived as states to be avoided, as something intrinsically 'bad'. Some negative emotions may actually be beneficial; for instance suffering can temper a person while the physical pain of training can lead to winning a marathon.

The positive psychology movement has done much to put positive emotions on research agendas but similar to psychopathology it is limited by providing only a partial understanding. First, it is rather one sided in its focus on simply happiness. One may question the value of dichotomising the positive and negative and seeing wellbeing as simply composed of the former. If that is the case, then why differentiate between wellbeing and happiness at all? It seems unnecessary to further confound an already complicated area of research. Also, if wellbeing is simply about being well, then it ignores the influential power of negative emotions in forming judgements about the quality of one's life. Much like psychopathological discourse can be criticised for focusing on the negatives, the positive psychology movement can also be critiqued for one sided targeting of the positives.

Instead of adopting a psychopathological stress discourse or a positive psychology SWB discourse, this review proposes to join both approaches to permit a whole rounded exploration of wellbeing. One that is neither overtly tempered by negative nor positive. This study therefore views wellbeing as a composite rather than a singular concept (Danna and Griffin, 1999). Wellbeing is understood as comprised of an assortment of satisfactions *and* dissatisfactions that are influenced by a variety of affective states ranging from happiness to stress. It is recognised that how an individual feels is made up of both positives (e.g., joy) and negatives (e.g., resentment). Focusing

reservedly on either stress or SWB can only tell a partial story of human experience. People can feel many different ways about many different things but these might influence each other. An employee can feel happy at getting a promotion but sad that this means a change of office. Both together will influence the worker's wellbeing overall – not just one or the other.

A second defining characteristic of this approach is seeing wellbeing as a global appreciation influenced by various life domains e.g., work, family, leisure, health etc. (Diener et al. 1999). In this perspective, it is acknowledged that experiences at work may spill over into other domains of life, and vice versa (Diener 2000). For example, the same individual who is happy about their promotion at work and sad about the office change, could be annoyed at a loved one at home. How they feel overall is not only made up of their emotions regarding their experiences at work but also about their home life. In this approach, people's work and non-work lives are not seen as distinct and separable but rather as interknit and intervolved.

In summary, this study views wellbeing as comprised of general life satisfactions and dissatisfactions, work related satisfactions and dissatisfactions, and general health (Danna and Griffin 1999). This conceptualisation of wellbeing enables a more holistic understanding of human experience than permitted by either stress or SWB research. It combines both psychopathological and positive psychology viewpoints and allows the exploration of both the 'good' and the 'bad'. While its holistic and whole rounded approach is a key strength, it is also a disadvantage as it makes wellbeing a broad umbrella concept that is challenging to operationalise and measure. Usually, SWB is measured by self-report scales which contain both an affective component (i.e., hedonistic appraisal of how individual feels) and a cognitive component (i.e., judgement about how life compares with expectations) (Hoorn 2007); but in adopting a composite and global interpretation measurement becomes more complex. This discussion is developed in greater depth in chapter three when describing the process of constructing the questionnaire.

1.3 Explaining Wellbeing: Work Design

This research focuses on the relationship between people's work and their wellbeing. It acknowledges that work experiences are simply one domain of an individual's life. Its purpose is to magnify this area to better understand its particularities. On average, British employees work 36.3 hours a week (Office of National Statistics 2011). Some may perceive their work as simply a job, focusing on the financial benefits of working (Wright and Cropanzano, 2004). Others may see their work as an end in itself and view it as a vocation or a calling (Elangovan et al. 2010).

Whatever the personal case may be, the simple matter is that Westerners spent a significant portion of their life working. Hence, although work experiences are simply one domain of life overall, it is arguably one quite large domain and deserves in-depth investigation.

Work design has generated much academic attention with promising organisational initiatives(Nicholson 2010). It is within this organisational predictor of wellbeing that this review will focus. But there are far too many theories that attempt to explain wellbeing at work and a truly exhaustive review is simply beyond the scope of this research. Due to the colossal landscape, this literature review will focus on the most influential theories discussed in the report commissioned by the European Agency for Safety and Health at Work as this evidences European Union (EU) good practice: the Person-Environment fit model, the Vitamin model, and the Demand-Control-Support model.

Proposed by French (Edwards, Caplan, & Harrison, 1998), the Person-Environment (PE) fit model appraises the match between an individual and their work environment. The model posits that an appropriate fit between employee and work environment is imperative for wellbeing. If their skills, abilities, and resources suitably match the demands of their remit and the work environment meets their needs, then wellbeing is likely to ensue. Conversely, if either of those is not adequately matched, then strain could result due to work demands exceeding resources or needs exceeding job supply. A great advantage of the PE fit model is that it provides an intuitively acceptable explanation – even toddlers learn from an early age that a cube cannot fit into a round hole, and one can easily understand that a certain amount of 'fit' or 'suitability' is required for effective synthesis. However the model's disadvantage stems from this very simplicity in that it assumes fit to be a static and stable occurrence and fails to take into account the dynamic and changeable nature of both individuals and their environment. In many occupations, job demands may not be monotonous and whilst on one occasion an employee's skills may be sufficient to complete the task at hand, in others, they may fail them. In addition empirical support for the PE fit model has been minimal (Mark and Smith 2008).

Warr (1987) proposed the Vitamin model and used the metaphor of how vitamins work for the human body to explain the interaction between external work environment and individual. For example, much like vitamin C, certain job characteristics such as salary and significance of task are argued as having beneficial effects on employees when they 'dose up'. However, once the optimum threshold is breached, they fail to produce an effect, whether negative or positive. Alternatively, like vitamin A, some job characteristics such as demands, autonomy, and feedback, have an inverted U effect – too little or too much are hypothesised as harmful to wellbeing (Figure 4).

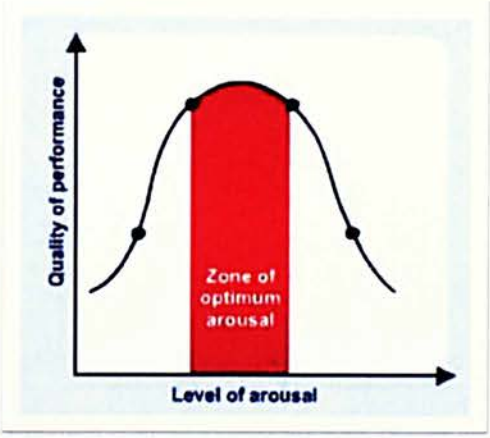

Figure 4 Inverted U Diagram

Much like the PE fit model, the Vitamin model provides an easy to understand, 'user-friendly' and simple explanation. Their use of the inverted U illustration does somewhat explain how the same stimulant can have a different outcome depending on the situation. It also links well with theories of *eustress*, colloquially referred to as 'good' stress (Hargrove et al. 2013). Here, when individuals experience a positive response to stress, or *eustress* (originating from the Greek *euphoria*), they perceive themselves as endowed with sufficient coping resources. In this instance, the stimulus is interpreted constructively and the strain can be motivating. This optimum amount of stress is beneficial for performance (Le Fevre, Matheny, & Kolt, 2003). However, in spite of its colourful metaphor, empirical support for Warr's Vitamin model remains inconclusive (Mark and Smith, 2008).

Lastly, Karasek (1979) developed and tested the Demand-Control model which he later modified to the Demand-Control-Support (DCS) model. The model attempts to predict that strain may result from the interactive influence of work demands and job control. He conceptually distinguishes between two dimensions of the work environment. First, the work demands that an employee must address (e.g., workload and/or intellectual requirements of their job remit) and second, the discretion at their disposal on how to meet these demands (e.g., amount of control over's tasks and the autonomy to determine how to complete these tasks). The two key features of the Demand-Control model are the strain and buffer hypotheses. The strain hypothesis posits that the lowest levels of wellbeing will be experienced by employees who are faced with high work demands but have low job control whilst the buffer hypothesis puts forward that high job control will moderate the negative effects of high work demands. Karasek (1979) reasons that high work demands on their own are not sufficient to lead to strain, but rather it is the combination of high demands with low decision latitude that leads to a toxic environment which places the employee at risk of harm. In these instances, the employee has little discretion on how

to meet work demands; their control over their work and the autonomy awarded to them is at the lower end of the spectrum.

The key feature of the Demand-Control model is the role of job control with the premise that high work demands coupled with high job control can actually be beneficial and motivate the employee to develop new skills and behaviours (Figure 5). These types of jobs, that he terms *active jobs* are associated with greater authority and skill, more active learning, and greater internal locus-of-control (Theorell & Karasek, 1996).

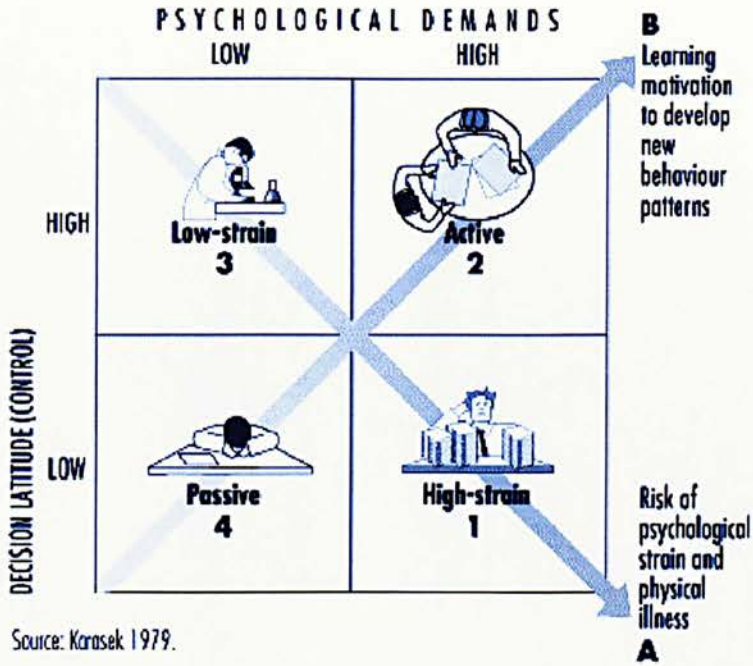

Figure 5 Karasek Demand-Control Model *(source Karasek 1979)*

Karasek's (1979) framework has proved to be influential in managing wellbeing in an organisational context as it does not solely attribute strain to stressors but rather to the interaction of job control with demands. Additionally the strain hypothesis has received much empirical support, notably from the cohort of Whitehall studies; for example, high strain jobs have been linked with cardiovascular disease (DeJonge and Kompier, 1997), coronary heart disease (Bosma et al. 1997), and high blood pressure even after work (Steptoe and Willemsen, 2004).

In contrast, job control has been associated with positive outcomes. For example, Bond and Flaxman (2006) in their meta-analysis note that job control may lead to improved performance ratings, decreased absenteeism, and less intention to leave the organisation. However, in spite of

the strain hypothesis' success, the buffer hypothesis has generated much controversy and the assumption that job control is somehow an antidote to occupational stress has been refuted by many researchers. A significant criticism falls on the statistical techniques used in the studies that have found support for the positive mediation effect of job control. For one, correlations instead of regressions have been used (Terry and Jimmieson, 1999) in cross-sectional designs (de Lange et al. 2003). Moreover, critics also question the operationalisation of concepts in supporting studies. Another prominent criticism is the model's inability to account for individual differences. One may wonder whether job control is a favourable solution for all employees. For example, Schaubroeck, Jones, and Xie (2001) found that high job control was associated with ill health for individuals with low self-efficacy – in these employees job control was source of frustration instead of a means of coping. Employees with low self-efficacy may actually prefer to have low decision latitude and may be threatened by job re-design initiatives which increase their job control. In these cases, it is not the lack of job control that may be detrimental to health but rather the presence of it.

As a means to understand this inconsistency, Karasek and Theorell (1990) reconceptualised the original model and included the additional variable of organisational social support leading to the development of the Demand-Control-Support model. This led to the development of the iso-strain hypothesis which predicts that employees are at greater risk of stress when faced with high demands, low job control, and low social support; and the new buffer hypothesis which proposes that social support moderates the negative impact of high strain work.

Cohorts of studies have since investigated the predictability of the Demand-Control-Support model. De Jonge and Kompier (1997) in their examination of empirical studies categorise them into four groups: epidemiological, cross-sectional, psychological, and intervention studies. They note that whilst the epidemiological studies provide the most support for the model, the hypothesised interaction effects are seldom found and often interventions were not evaluated. They echo previous critiques on the operationalisation of demands and control. It can further be argued that most research conducted has used a survey method and thus subtle complexities that may be best uncovered by qualitative methods have been heretofore largely ignored. Hence there remains a need to explore such subjective processes at the individual interpretation level, for instance by conducting in-depth qualitative studies. At times, it appears that the organisational discipline foregoes understanding the individual's complex experience in favour of linear and causal models. This is a shame as it misses out on the intricate complexities, paradoxical contradictions and individual differences of human experience. The same can be said of the more positive emotions in the human repertoire – for too long psychopathology has taken favour (Seligman and Csikszentmihalyi 2000).

One way of understanding positive wellbeing at work is the Job Characteristics model (Oldham et al. 1976), developed by Hackman and Oldman. In contrast to the models discussed so far, it provides a greater appreciation of why employees may experience positive wellbeing at work. The Job Characteristics model focuses on job aspects that have a motivational pull and the resulting satisfaction for the employee. The original model hypothesised that five work aspects would increase worker satisfaction (Figure 6).

Figure 6 The Original Job Characteristics Model *(adapted from Oldham, Hackman and Pearce, 1976)*

For instance, the variety of skills that an employee may use, their identification with the task, its significance, and feedback they may receive are viewed as providing the employee with opportunities to experience a sense of meaning and responsibility in their work. Positive or negative job characteristics are then hypothesised as leading to certain mental states which influence cognitive outcomes such as motivation and job satisfaction, and behavioural outcomes such as absenteeism (Mark and Smith, 2008). A notable proposition is that *task significance*, the degree to which one's job improves the wellbeing of others, can contribute to employee motivation (Loher et al. 1985). Primarily, it is argued that when employees perceive their jobs as meaningful, they are more likely to be motivated to do it. Although the Job Characteristics model focuses more on how employees react to the structural properties of their work, it does show that making a positive difference in the world can be an influential job characteristic. It thus regretful that scholars today have disregarded further research into how making a positive difference can impact on employees (Grant 2007).

The job characteristics model proved to be influential in job re-design initiatives by proposing enhancements to the external environment (e.g., job enrichment initiatives). Although there are some criticisms (e.g., limited number of work characteristics), supportive findings have been plentiful. Most notably, the recent meta-analysis which considered 259 studies and found that

work characteristics generally explain 43% of the variance in employee attitudes and behaviours (Humphrey et al. 2007). The foremost contribution of this study is the development of the original job characteristics model while incorporating additional variables (Figure 7).

Work Design Characteristics	Mediators	Work Outcomes
•*Motivational Characteristics* •Autonomy (3 types) •Skill Variety •Task Variety •Significance •Task Identity •Feedback from job •Information Processing •Job Complexity •Specialisation •Problem Solving •*Social Characteristics* •Interdependence •Feedback from others •Social support •Interaction out of organisation •*Work Context Charactertics* •Physical Demands •Work Conditions •Ergonomics	•*Critical Psychological States* •Experienced meaningfulness •Experienced responsbility •Knowledge of results	•*Behavioural Outcomes* •Objective performance •Subjective performance •Absenteeism •Turnover intentions •*Attitudinal Outcomes* •Job satisfaction •Supervisor satisfaction •Coworker satisfaction •Compensation satisfaction •Growth satisfaction •Promotion satisfaction •Organisational commitment •Job involvement •Internal work motivation •*Role Perception Outcomes* •Role ambiguity •Role conflict •*Wellbeing Outcomes* •Anxiety •Stress •Burnout/exhaustion •Overload

Figure 7 Extended Work Design Model *Adapted from Humphrey, Nahrgang and Morgeson (2007)*

The model contains the following modifications. Firstly, the work design aspects have been expanded to differentiate between motivational characteristics (a more varied inclusion of the Job Characteristics model), social characteristics such as support at work, and contextual elements such as work conditions. Notable improvements include the distinction between work scheduling autonomy, methodological autonomy and decision making autonomy. In other words, there is a difference between employees who are free to choose between when they work and how they work. Also whereas Oldham, Hackman, and Pearce (1976) hypothesised that each psychological state would act as an independent mediator, Humphrey, Nahrgang and Morgeson (2007) found that *experienced meaningfulness* was the most influential mediator. In other words, the degree to which the employee believes their job is valuable and important is the strongest mediator between work characteristics and wellbeing. Upon testing the extended model, the

authors found that motivational characteristics explain 34% of the variance in job satisfaction and that social characteristics explain a further incremental variance of 17%. Work context appears to have the least strong influence with an explanatory power of only 4% of the variance.

As can be seen the extended version provides a greater appreciation of the sorts of things that may influence satisfaction with one's job, however what is disappointing is that work context only considers physical demands, conditions, and ergonomics. Arguably, such aspects are easier to measure than the more implicit and intangible contextual factors such as organisational culture, power hierarchies and organisational discourses, but the latter variables could change the meaning awarded to the other, more tangible, attributes. Particularly for public sector workers such as PALS employees, the political climate may play a crucial role in determining the meaning allocated to their job. Alas, the extended model proposed by Humphrey et al. (2007) comes across as too much of a closed system (i.e., focuses solely on the work system) without due consideration to the impact of external variables (e.g., political agenda, media attention etc). The problem with viewing organisations as such closed systems is that ultimately, they are not, as matters outside the organisation will play a role in determining matters within the organisation. For public sector organisations such as the NHS, largely funded by the public resources, this influence is probably greater than in the private sector where senior decision makers are less accountable to the public and less susceptible to media scrutiny.

1.4 Chapter Summary

Conceptualising wellbeing as composite and global allows a more whole rounded exploration than permitted by either stress or SWB discourses. By using Danna and Griffin's (1999) wellbeing framework both the positives and the negatives can be investigated without emancipating half the spectrum of human emotions. In this way, a more holistic understanding of wellbeing can be gained as opposed to a partial representation offered by psychopathology and positive psychology.

Work design research illustrates the work characteristics that impact on wellbeing. Of notable interest have been job control (Karasek, 1979), social support (Karasek and Theorell, 1990), and experienced meaningfulness (Humphrey et al. 2007). The respective hypotheses posit that job control, social support, and experienced meaningfulness can alter the effect of work design characteristics on wellbeing. The next chapter now focuses on the particular case of PALS staff. It

introduces the healthcare context in which PALS work and the customer service function they perform for the organisation. It evaluates previous research on customer service and transparently develops preconceptions regarding PALS wellbeing.

2. The Wellbeing of PALS Workers

PALS staff, who are customer service public servants working in healthcare, are in a particularly challenging position. First, the healthcare industry reports one of the highest rates of work related stress with health professionals and caring services coming in the top three most stressed occupations (HSE, 2013). Such public sector employees, of whom PALS staff form part, take an average of 9.7 sick days, at a cost of £784 per employee per year – that is approximately £100 above the national average (HSE, 2010). Second, Johnson et al.(2005) categorise customer service as a high strain job role; and since 1992, the service industry has risen from employing 68% of the British workforce to 80%, taking up a fair chunk of the workforce (Office of National Statistics 2011). It seems that PALS staff, both from an industry and occupational perspective, are in a dire placement.

2.1 The Context of PALS Workers

This thesis initially began as an operations management investigation of how patient feedback was used in NHS managerial decision making. It was while reading for the literature review that interest in PALS workers was piqued, their working life questioned and inferences made regarding their wellbeing. The first clue came in the form of semantics. In trying to enumerate the sources through which patient feedback is collected, it was realised that within the NHS two primary groups of employees perform this task. The first group may be identified as the complaints department, and much like their private sector counterparts, staff who manage complaints follow the formal complaints procedure. For instance, these complaints can be in writing and could involve the chief executive (NHS, 2013). Different to the private sector, the NHS also has strict time deadlines and healthcare providers are mandated to work within these mile stones (Britnell and Behan, 2009). For example, a patient must receive an acknowledgment to their complaint within three working days. Complaints management thus appears to be a linear and strictly

defined process, with requirements clearly stipulated, and protected by law, at each stage. The task then for the complaints employee is to do their specific part in the wider chain (Figure 8).

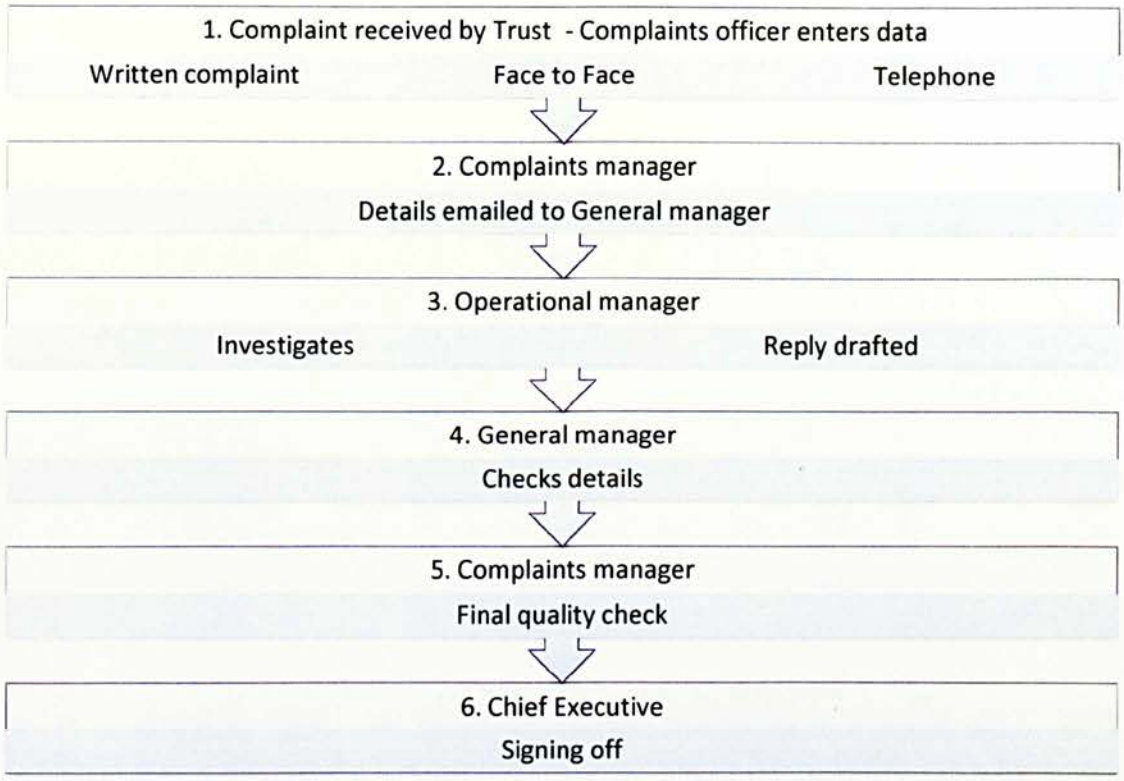

Figure 8Formal NHS Complaints Process*Adapted from Department of Health (2002)*

Legislation in Statutory Instruments, Local Authority Social Services and National Health Service Complaints, England, Regulations (2009), stipulates that complaints must be properly investigated and dealt with efficiently. Complainants must be treated with dignity and respect and receive reasonable assistance and support in lodging complaints. A timely outcome response must be provided and, if necessary, action taken. Healthcare providers are, by law, required to designate an individual responsible for handling complaints and one to ensure adherence to legal standards.

Complaints employees in the NHS are interesting due to the rigid and pre-defined nature of their job; however they are not unique as many different industries may employ complaints staff, who are likely to be placed within a call centre. What is however unique to the NHS is the second group of employees that collect patient feedback: PALS staff. This group is rather interesting as not only are PALS exclusive to the NHS, but their function in the organisation is really rather peculiar. PALS staff manage informal concerns as opposed to formal complaints, and they are expected to provide both immediate resolutions and promote organisational change (Department of Health, 2002). Their role is much speedier than for their complaints colleague (Figure 9).

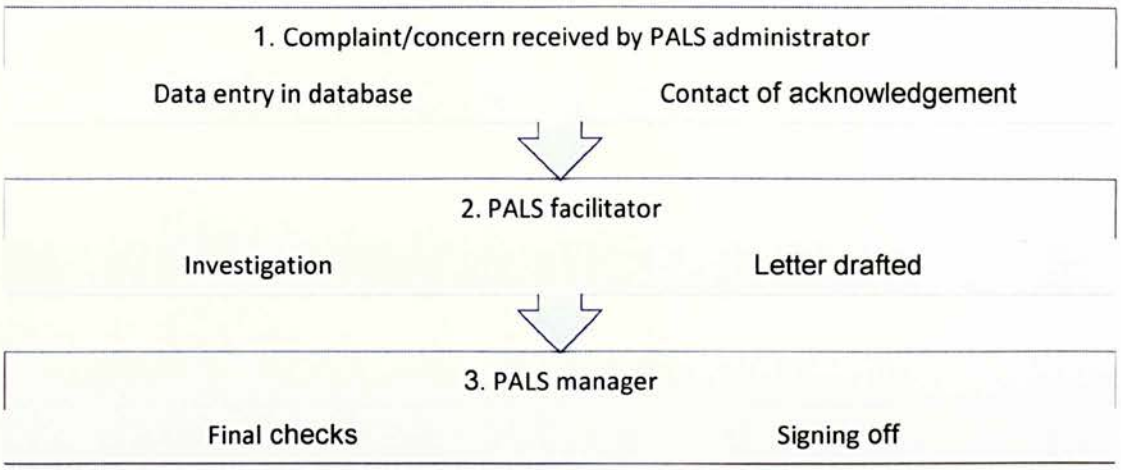

Figure 9 PALS Procedures

(Adapted from Department of Health, 2002)

As can be seen, an administrative grade PALS officer is envisioned as taking in the concern and entering the information in the database. The Department of Health (2002) further proposes that a higher grade PALS official may perform investigative duties and draft a response letter to the complainant which is then reviewed and approved by the PALS manager.

Additionally, their function appears to be somewhat of an assortment of skills as it consists of administrative duties, customer service tasks, higher order problem solving and organisational change (Figure 10).

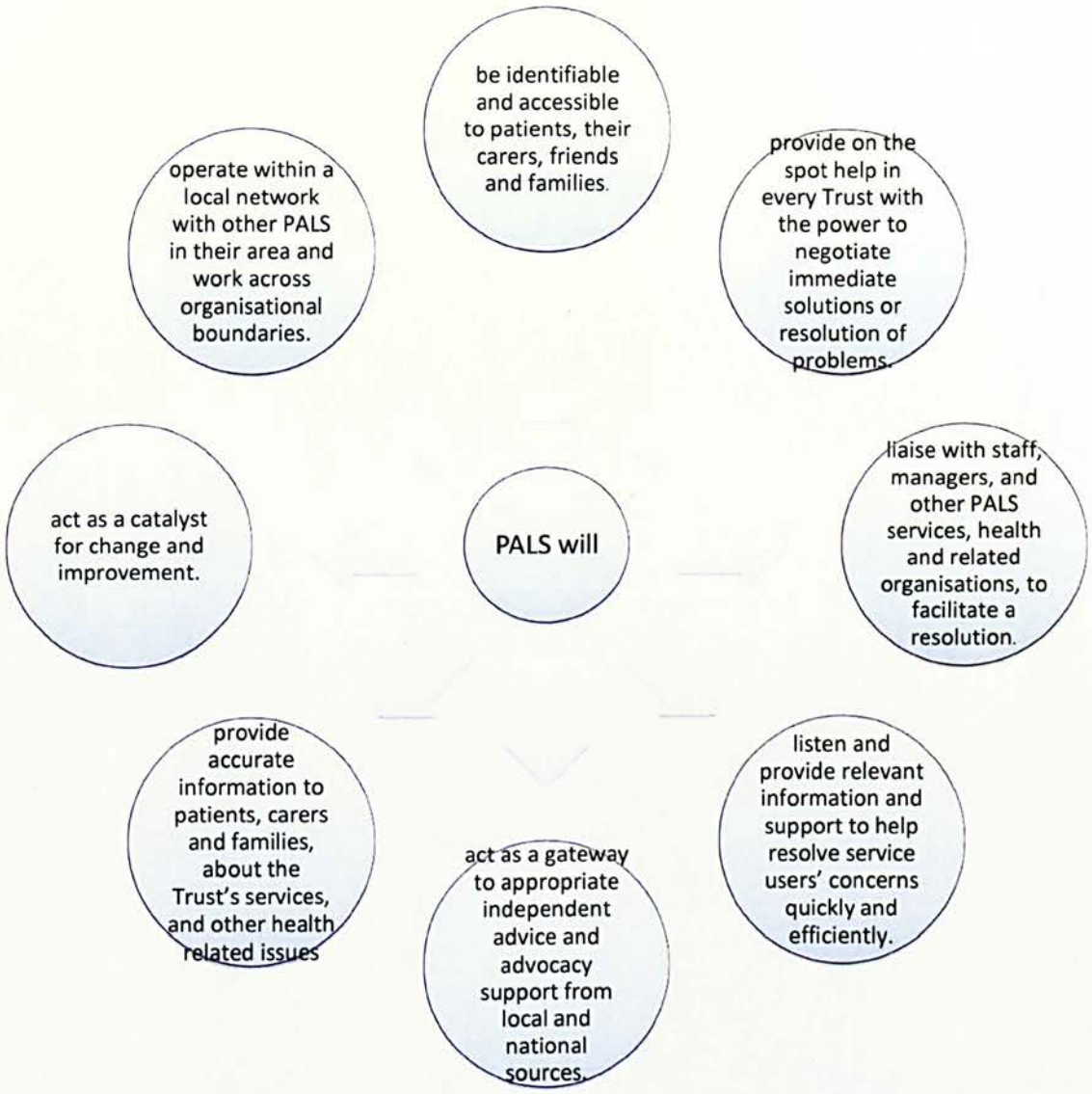

Figure 10 Core Functions of PALS (Adapted from Department of Health, 2002)

Firstly it is not quite evident where complaints ends and PALS begins. The difference between a complaint and a concern is arguably vague and even the Department of Health (2002) avoids delving too deep in this distinction and rather opts to leave it to the 'common sense' of the employees involved. As a psychologist, this intra-group uncertainty was the first issue of. Secondly, and possibly more importantly, the portfolio as envisioned by the Department of Health (2002) appears to be a miscellany of different roles and levels and one may question whether it was sensible to brew such a mélange of tasks under one remit. For instance, whether the employee competent to perform customer service duties is equally capable of initiating organisational change, and whether colleagues perceived them as administrators, potentially with limited power, or managers, perhaps better equipped with status.

These questions are important because PALS workers perform a crucial organisational function. They hold within their power the ability to revert a disgruntled patient into a satisfied customer, to defuse situations which may lead to litigation costing the firm a considerable amount of money, and minimise the damage to NHS' reputation. Also PALS staff may dilute negative word of mouth and enact an ethical role for the organisation – that of setting right a wrong. Within the healthcare context, which in the United Kingdom (UK) is public sector, this role is somewhat more complex for the following reasons. First, the NHS is funded from public resources; and perhaps this may pre-empt a sense of entitlement from patients who are in essence funding the organisation. Second, the NHS has in recent times undergone a new marketing appeal where it has pledged to empower patients who are now being perceived as *customers*. This change in discourse, reflective of the private sector influence on public sector organisations, further propels the patient into a position to judge the quality of the care they receive. And finally, the stakes of errors are high in healthcare and a mistake resulting in a complaint could quite possibly be the difference between life and death. Put simply, the quality of services is linked with patient safety. For example, if a customer contacts Virgin Mobile to complain about the loss of WIFI, the employee in this instance could easily rectify the problem by offering a refund. But in the case of PALS, the cost of a misdiagnosed illness may be irreplaceable. Currently, the political climate is such that the Conservative/Liberal Democrat coalition government have proposed major restructuring to how healthcare was being provided under the former Labour administration. Hence, NHS PALS, who were largely supported by the former government, are facing a time of uncertainty in the midst of broader organisation wide change.

As their role is really quite particular and the present time rather salient for wellbeing research, it is rather surprising that research heretofore has neglected PALS. Perhaps this is due to the relative 'newness' of their inception and the comparatively long waiting times that it takes academic research to be disseminated in publications. At present, it seems that an ample amount is known about medical professionals when faced with complaints (e.g.,Cunningham, 2004; Gallagher, 2003) but little about the experiences of those who take in those complaints and attempted to resolve them. In addition to the novelty of the role and publication red tape, it may be that PALS have been academically ignored as their function is devalued. For instance, during an early presentation of this research an audience member asked 'so what? How much does it cost to replace a doctor and how much does it cost to replace this customer service person?'. And perhaps herein lays the answer; if one is to take such a utilitarian perspective, then indeed training a doctor, hiring a doctor, paying his or her wages, and finding a replacement is certainly much more costly. Traditionally human resource perspectives consider employees with a limited and specialised skill set as more valuable and unique (Truss, Mankin, and Kelliher, 2012). Through commitment-based practices such as support and engagement, organisations attempt to attract

and retain these more 'valuable' resources. However, customer service workers, as they command lower salaries and have less specialised skills, are perceived as having limited 'value' and 'uniqueness'. For this group of staff, the organisation may utilise a compliance-based employment mode where their expectation is that employees conform to rules. As the cost associated with this group is lower than the highly skilled specialised group, retention is less important as they are allegedly 'replaceable'. Indeed, some organisations revert to outsourcing such staff by making use of call centres where their customer service function is performed. This trend can be seen in the last two decades in the recent mushrooming of call centres to mass produce customer service (Holdsworth and Cartwright 2003). Hence the answer to the second part of the audience member's question is unequivocally that, yes, doctors are more costly, however in response to the first part of the question, there is no doubt that the wellbeing of those who earn less and the wellbeing of those who earn more is just as equally important.

As a means of making sense of these intriguing burgeoning questions, a literature review was conducted to assess the present state of knowledge on wellbeing and PALS staff. From this engagement with the literature, the research questions which guide this work emerged. The next sections now narrate this literature review.

2.2 Working with People and Wellbeing

In the introductory chapter, the discussion was somewhat on the conceptual level; now the focus will be on understanding wellbeing at an occupational level. This is important because employee wellbeing is not the same across occupational groups – some professions report lower wellbeing than others. Over the years, the 'usual suspects' of poor wellbeing are often found to be nurses and social workers (Kahn, 1993), healthcare workers (Cooper, Clarke, and Rowbottom, 1999), ambulance drivers (Sterud, Ekeberg, and Hem, 2006), and teachers (Kyriacou, 2001). Today, in the UK, workers in caring, leisure and service occupations report significantly higher rates of injury and illness than other occupations (The Health and Safety Executive 2012a). Individuals employed in health and social services, public administration and education are significantly more likely to have ill health than individuals employed in other industries.

Academically, a prominent study on wellbeing across occupations, cited over 224 times, was conducted by Johnson et al.(2005) where workers in 26 different occupational groups were tested for wellbeing, physical health, and job satisfaction. By using the General Health Questionnaire 12

(GHQ 12) by Goldberg et al. (1997), a multi-dimension job satisfaction scale (Warr et al. 1979) and questions pertaining to physical health, the researchers were able to present a hierarchical list of occupational scores (Table 2). As can be seen, healthcare focused occupations such as nursing and social services, educational groups such as teachers and teaching assistants, as well as service workers such as customer service workers tend to report considerably poor physical health, wellbeing and job satisfaction. Overall, ambulance workers, teachers, social services, customer service, prison officers, and police score worse than other occupational groups in all three respects.

Table 2 Top 15 occupational groups scoring low on physical health, wellbeing and job satisfaction

Ranking	Physical Health	Wellbeing	Job Satisfaction
1	Ambulance workers	Social services	Prison officers
2	Teachers	Teachers	Ambulance workers
3	Social services	Fire fighters	Police
4	Customer service	Ambulance workers	Customer services
5	Bar workers	Vets	Social services
6	Prison officers	Lecturers	Teachers
7	Private sector management	Clerical and admin workers	Nursing
8	Clerical and admin workers	Private sector management	Medical/dental staff
9	Police	Prison officers	Allied health professionals
10	Teaching assistants	Academic researchers	Bar staff
11	Head teachers	Police	Private sector management
12	Secretarial/business support	Customer services	Fire fighters
13	Academic researchers	Public sector directors	Vets
14	Lecturers	Allied health professionals	Clerical and admin workers
15	Senior police workers	Bar workers	Public sector management

The common denominator of these high scoring jobs is believed to be emotional labour (Johnson et al. 2005). What they have in common is that workers interactwith customers, manage the emotions of their audience, and display mandated emotions of their own (e.g., interest versus disinterest). Today emotional demands are appreciated as noteworthy factors intrinsic to some occupations involving a broad range of 'people work' (Brotheridge and Grandey, 2002).The

earliest recognition of this was proposed by Hochschild (1979)who conducted her seminal work on flight attendants and explored the interaction between employee and customer. In her research, she notes that environmental aspects of the job such as working in small confined spaces and cognitive aspects such as remembering health and safety regulations did not sufficiently or exhaustively explain the full spectrum of work demands facing flight attendants. She notes that a large proportion of their role consists of dealing with customer emotions and expressing normatively acceptable emotions of their own. For example, flight attendants are required to be polite even when customers are rude or disrespectful and must remain friendly even when they are upset. She thus proposes the term *emotional labour* as the process of managing one's emotions to display certain facial or bodily expressions. Her interpretation is influenced by Goffman's dramaturgical perspective stemming from what is known as *symbolic interactionism.* Within this tradition, the work place is considered a stage, employees are performers, and customers are the audience – the interaction between them is the play. Performers must thus manage impressions and employ expressive devices to achieve the organisation's aim of rendering a service.

Two key lessons can be learned from emotion labour theory: (1) that workers are expected to behave in accordance with display rules, and (2) that they may at times have to act to do this. Each is now considered. Hochschild (1979) proposes that how an employee ought to act is governed by certain normative rules – certain emotions are permitted whereas others are not acceptable. For example, there are certain "unsaid rules" about the acceptability – or lack thereof – of expressing certain emotions at work (Harkness et al. 2005, p.128). In a qualitative discourse analysis study of 22 clerical workers, participants explained that office norms stipulated that having emotions at work *in general* was not acceptable, especially negative emotions. For those who are unable to maintain such a stronghold on their emotions, there are repercussions. For example, one participant shares that, unable to silence her distress, she broke down and cried at her desk. Unfortunately she believes that "that particular incident sort of put a major blackmark by my name ... [after that] they reprimanded me for very silly things"(Harkness et al. 2005, p.128). Implicitly there seemed to be some association between showing negative emotions (such as crying) and being weak. Perhaps by showing negative emotions she has revealed herself as someone who is not able to cope, someone who cannot do the job. Participants explain that "we're not supposed to have emotions in the workplace" and point out that the unwritten rule dictates "be happy or else" (Harkness et al. 2006, p. 128).

It is these 'unsaid rules' that Hochschild (1979) terms display rules. She believed that they were largely governed by the organisation and was very critical of its power and control over employee emotions. Her argument was this removed emotional autonomy from employees and

commoditised emotions. For public servants such as PALS workers, it is more complicated. Government policy, legislation, and even the public may play a role in influencing display rules. Senior decisions makers such as Trust directors, line managers, and colleagues may have differing and individual interpretations of how patients ought to be treated. These multiple pressures and potentially tensions may place PALS workers in a complex dynamic which is graphically displayed as Figure 11.

Figure 11 Display Rules

Critical perspectives argue that organisations are constructions of pluralist perspectives as opposed to a uniform whole (Hatch and Cunlifee, 2006). Different people may hold different beliefs about what is and what is not acceptable behaviour. For example patients may approach PALS staff expecting retribution. Senior managers, perhaps fearing litigation and public backlash, may discourage PALS staff from apologising in writing. The PALS worker's own line managers may pressurise that the case be closed lest it affects their targets and so forth. Hence each different group is demanding different emotive and behavioural reactions from PALS staff.

The research of Morris and Feldman (1996) contributes by distinguishing display rules dimensions. For instance, they propose that frequent emotional displays, may overtax employees and lead to exhaustion; in contrast less frequent displays may be easier to manage resulting in minimal negative impact on their wellbeing. The more an employee needs to be attentive to display rules,

the more effort is required to carry out their tasks. This, they hypothesise, will depend on the duration and the intensity of the encounter. Short interactions are more likely to be scripted and thus require less emotional effort on the part of the employee. On the other hand, longer and more repetitive contact on the same case is less scripted and therefore requires more effort from the employee. In longer encounters, it may become more difficult to act out 'fake' emotions as the employee is more involved with the same customer. In situations where exhibiting intense emotions is needed, more effort will be required; the higher the variety of emotions to be expressed, the more taxing the work.

Applying Morris and Feldman's (1996) proposals to PALS workers, it could be argued that because healthcare complaints are complex and serious in nature, the variety and intensity of expressed emotions is likely to be high. For example, a complaints manager in retail may only need to express slight concern at the customer's dissatisfaction with the product, however PALS workers in healthcare need to mobilise higher levels of empathy in response to the death of a complainant's loved one or the misdiagnosis of their child's illness. Here the level of empathy that the employee must manifest is much stronger, requiring greater intensity due to its psychologically 'heavy' nature. Due to the variety of healthcare complaints, PALS workers may need to individualise their reactions, hence the encounter could be less scripted than in traditional call centres.

Hochschild (1979) believes that all direct face to face or verbal contact with customers constitutes an interaction where the employee is required to elicit an emotional response from their audience by managing their own. For example, PALS staff may need to portray that the complainant's concerns are understood and appreciated and that the organisation empathises with their woes. PALS staff must thus play the role of a compassionate and empathetic listener while ensuring that the complainant audience is feeling taken care of and valued. However, the role of a compassionate listener may require investing emotional effort if the performer does not genuinely experience empathy for the complainant – the worker must then act. Through *surface acting*, the employee engages in simply altering outward emotive expressions, they are in essence faking. For example, serial users and repetitive complainants take up a disproportionate amount of PALS workers' time (Buchanan et al. 2005). In these instances, PALS staff are still required to deal with the complainant and treat the concern as if it were not "bogus" (Buchanan, et al. 2005, p. 321). Hence, they must nevertheless communicate the required emotion of concern by feigning an empathy which they do not genuinely feel. This discrepancy between emotions expressions and emotions experienced is known as *emotional dissonance* which has been linked to emotional exhaustion, a core component of burnout (Brotheridge and Grandey 2002). However if the employee is able to modify their internal state to match their outward expressions, then they are

said to be *deep acting* or 'faking in good faith' (Grandey, 2003). In these instances, PALS staff may try to genuinely empathise with the patient and experience a sense of concern internally which they then express outwardly.

Yet not all workplace behaviours necessarily require mobilising effort nor are unpleasant for the employee. Some may be routine, easy to perform, and thus not at all taxing (Ashford and Humphrey, 1995). Grandey (2000) elaborates that surface acting is simply a response; it requires no cognitive effort from the part of the employee. During surface acting, employees are simply automatically responding to cues; there is no effort and hence no strain. In contrast, deep acting necessitates deploying cognitive resources to modify one's internal states. In other words, when PALS staff are surface acting, they are simply automatically responding to the cue; but when they need to deep act, cognitive resources are used to actually alter how they feel, hence the latter requires effort. Grandey (2000) further theorises that individual differences such as gender, affectivity, emotional intelligence, and organisational factors, such as social support and job control, will impact this process.

Perhaps the greatest limitation of emotional labour theory is that it misses one important possibility: that emotion work could have a positive outcome. Ashford and Humphrey (1993) vaguely touch on this briefly when they propose that adhering to organisational standards would increase employee self-efficacy as this would mean that they are effectively performing their duties. They do however insist that mechanical adherence is not sufficient and that the employee needs to convey genuine emotions. It seems that the consensus in the emotional labour literature is that empathy mostly leads to negative outcomes for the individual empathising. This is sadly quite a pessimistic view of human interaction and paints a rather bleak picture for service workers. However, even early researchers in altruism realised that not all instances of 'serving' customers needs to lead to undesirable outcomes. For example, research in the catering industry shows that waiting staff who smile more broadly receive more tips than those who only smile faintly (Tidd & Lockard, 1978). In this case, the outward behavioural expression of emotional labour (i.e., smiling) actually incurs positive gains. Similarly, a much more recent study found that smiling at customers had a number of reciprocally beneficial outcomes, for example, making customers smile more which in turn moderated the relationship between the employee's display of positive emotion and their actual experience of positive mood (Kim and Yoon 2012). Equally, in a longitudinal qualitative study with 27 PALS personnel one employee recounts how she was "so chuffed" by her role in actively mediating a complex situation between staff members and the complainant's family; she expresses that "it was very, very hard, but it was good. My God it was good!" (Abbott, et al. 2006, p. 143).

If using the wellbeing ethos of seeing experience as composed of multi-dimensional states, both positive and negative, then it could be argued that emotional labour theory is making the same mistake as stress theories by assuming an all negative outlook. For example, not all stress is necessarily harmful. At times, it can constructively stretch employees and be beneficial for performance (Le Fevre, Matheny, and Kolt, 2003). Similarly, it could be that emotional labour theory is limiting itself by perceiving emotion work as solely taxing and/or draining. Having discussed the nature of 'people work' and the emotional demands such occupations place on employees, discussion will now turn to a specific group of people workers: PALS workers as NHS customer service employees.

2.3 PALS as Public Sector Customer Service

PALS staff work in the sensitive context of healthcare provision. They deal with patients as customers, people who are ill or who are distraught because they are visiting someone who is ill. In this setting, something dissatisfying and upsetting has occurred; emotions are likely to be high and rectifying errors in such a large bureaucratic organisation is likely to be slow. For example, if one takes the telecommunications industry as an example of another service provider and considers the complaints received by its independent regulator, Ofcom, the gravity of healthcare complaints can be easily contrasted. For instance, whilst Ofcom (2010) complaints target shows such as X Factor or Big Brother, healthcare complaints target people – that is, clinicians, nurses, and other medical staff (The Information Centre for Health and Social Care, 2010). In addition, whilst the subject matter of telecommunications complaints contain references to mis-selling, early contract termination charges, and loss of service (Ofcom, 2010), NHS complainants protest at the medical treatment they have received, the attitude of caring staff, appointment delays and cancellations, and patient privacy and dignity (The NHS Information Centre, Worforce, and Facilities Team, 2013). In all aspects, the stakes are higher in healthcare.

Moreover, complaints in healthcare systems may lead to significant financial losses for the organisation – an organisation subsidised by public funds. Although few patient complaints escalate to litigation (Cave and Dacre 2008)those that do can be very costly. For example, between 2010 and 2011, the NHS Litigation Authority received 8 655 claims of clinical negligence costing £863 million – an £76 million increase from the previous year (Adams et al. 2012). With an estimated increase in claim by 30% a year, the cost could exceed £1 billion in the not too distant future. This figure only includes defence and claimant legal costs and damages paid – it does not

consider other financial outgoings such as potential redundancy packages, recruitment costs, and training for new staff.

Due to the severity of healthcare complaints, the information contained within user feedback may be used to enhance patient safety. The National Audit Office (2005)estimates that if providers had learnt lessons from previous error reporting approximately 50% of occurring safety incidents could have been averted. In their report *To Err is Human*, the Institute of Medicine(2000)concluded that most adverse events are not as a result of reckless actions, but rather originate in faulty systems, processes, and conditions that either lead healthcare professionals into making mistakes or do not effectively prevent them from avoiding them. Amongst other strategies, the Institute of Medicine (2000) recommend developing an effective reporting system so that organisations may learn from mistakes. PALS services are a means by which errors are reported and effective management – one where the source of the problem is identified and addressed – may lead to organisational learning and thus potentially prevent similar errors from re-occurring thereby improving patient safety. As noted by the Department of Health (2010b), patient experience is considered as one of three dimensions of service quality, thus the information acquired by PALS staff serves as a crucial source of patient experience data along with satisfaction surveys, feedback cards, and other measures. By assessing the contents of feedback, PALS staff may determine the organisation's strengths and areas of development (i.e., what the organisation is able to do effectively or needs to work on). When this information is then fed-back into the system, quality improvements on products and practices can be made. In this way, PALS staff play an integral role in ensuring that complainants and users are satisfied with the services they receive by being a key intermediary between them and organisational decision makers.

PALS staff, have to listen, help, and resolve often difficult situations and sometimes distressing subject matter (Healthcare Commission 2007). They have to be attentive, provide information, and guide service users with often complex needs and concerns who are likely to be emotionally upset as a result of a dissatisfying hospital experience. Their duties include advice and support to patients, their families, carers and to listen to their concerns and suggestions (Department of Health, 2002). During these interactions, the patient could be emotional, upset, or even angry, and PALS staff must remain calm, professional, and compassionate. They must elicit a sense of trust from the patient and make them feel heard and understood - that their concern is appreciated and taken seriously. They must play the role of an empathetic and compassionate listener. Indeed, person specifications for PALS personnel include interpersonal, communication, and listening skills as an essential requirement for the job (Department of Health, 2002) while

those for complaints staff stipulate good stress management skills and an ability to work in a highly pressured environment (St George's Healthcare Trust, 2011).

In a qualitative study which explored the needs and wants of the public, 32 service users were interviewed and reported that listening, understanding, and an ability to 'hear' what was not said was crucial for PALS personnel. One participant explains that "listening skills are of vital importance. You have to hear what the person is saying...you have got to listen to them, and try and understand where they are coming from. If you are not doing that, there is no point doing the job, really" while another confesses that she/he "just wanted somebody to confirm to me that I wasn't going mad" (Abbott et al. 2005, p.131). A typical encounter with a patient may consist of first calming them and creating an atmosphere of openness, and then drawing out the details of the concern in a coherent fashion. This may then require further emotion management and impression creation as the patient may be upset or angry, or unable to remember details and names of persons. PALS staff may then need to professionally explain possible investigative channels and stages – which in the case of formal complaints could take up to weeks. This may further aggravate a patient who is expecting an instant response and PALS staff must yet again manage the emotions of their audience.

In addition, PALS workers as public sector customer service workers may encounter quite context specific work experiences, for example, working in a highly political environment, bureaucratic constraints, and public scrutiny; and especially in this period of financial austerity, having to do more with fewer resources. Understanding the wider macrosystem that embodies the patient feedback function is important to appreciate the extent of external pressures imposed on PALS staff. In essence, PALS workers are 'sandwiched' between Department of Health stipulations exerting pressure from above and patient/public expectations pushing from below.

The proverbial 'rock and hard place' is as a result of the last 20 years which have seen a great transformation in the wider paradigm of healthcare. The traditional medical model where patients were perceived as weak and ailing recipients of authoritative care provided by unquestionable and powerful medical professionals has been replaced by a consumer model. Healthcare is now perceived as a service and terminology favours 'client', 'customer', and 'service user' – endowing them with the power to shape the market and greater choice in where, and how, they receive their care. Although a change in discourse does not necessarily reflect a change in practice, the evolution of government policies clearly evidences that there has been a real change in the power allocated to patients. No longer a meek and unquestioning recipient, the patient is now a powerful service user, an evaluator of quality, safety, and performance – a judge

who not only compares healthcare services to other providers but with other industries as well expecting similar standards of service quality (Ozborne, 1995).

Previously, the NHS had been criticised for its centralised control, paternalistic culture, and undemocratic approach (South, 2007). However when the former Labour government came into power, patient and public involvement (PPI) made up much of the healthcare governance agenda. Policies stipulated strengthening user voice and public involvement in the delivery and planning of healthcare services which resulted in major changes in both organisational structures and approaches to service delivery with greater user participation. The ideological transformation coupled with a growing public dissatisfaction over complaints processes brought with it a significant reform to complaints systems (Allsop and Jones, 2008). Although complaints functions were present in hospitals since the mid 1980's, they were mostly discretionary internal processes, and it was only with the private sector model influence on public services that grievances began to be perceived as opportunities to rectify errors. In 1991 social services were mandated to have clear and accessible complaints procedures (Simons, 1995); and thereafter, in quick succession, the Department of Health (1998; 2000) white papers pledged to put patient needs at the centre of the NHS and embarked to design services around their needs.

Since then a series of changes have reflected this shift in paradigm, for instance, the creation of PALS to provide independent advice and support to patients acting as a direct gateway for patient led change. In this way, PALS was incremental to the dissemination and application of wider government reforms endowing the user with greater power. Even policy titles embraced the new patient empowerment discourse and used words that made reference to the service user and alluded to a union between recipient and provider of care – in this instance a change in language occurring due to a change in practice: for example green paper *Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England*(The Department of Health 2005)and white paper*Our health, our care, our say: a new direction for community service*(The Department of Health 2006).

In 2010 the Conservative and Liberal Democrat coalition government took office and furthered the agenda of patient empowerment through choice. In July of the same year, the now crucial role of the patient in the delivery and improvement of services was further fortified when *Equity and excellence: Liberating the NHS* gave patients the power to rate provider performance and encouraged providers to be open about their mistakes. The new policy highlights the importance of patient complaints as a source of feedback which ought to be a "central mechanism" for providers to evaluate quality of services (The Department of Health, 2010, p.19). Additionally a

new independent customer champion, HealthWatch England, is being set up to strengthen patient voice, provide support in lodging complaints, and ensure that patient feedback is used in a 'bottom up' approach to commissioning decision making. In essence, the patient has become the NHS judge on quality, safety, and performance – and thus, what the patient thinks and perceives, now more than ever, is of utmost importance.

The above explanation of the healthcare context is important to this study as it frames the macro and exo-system within which the PALS microsystem operates. It describes the external pressures placed on PALS staff who are pivotal to the government reforms and the patient involvement agenda. Additionally, it sets out the expectations of patients whom PALS staff face in their day to day tasks as growing more demanding. These external pressures are argued as increasing the emotional demands already inherent within the PALS job role. Hence the pressing need to explore the wellbeing of PALS staff.

For this purpose, a variety of keywords such as PALS, complaints, managing complaints, complaints management and patient feedback were used on search engines such as PsyINFO, Google scholar and Business Source Premier with very limited results. For example, searching *Patient Advice and Liaison Service* on Business Source Premier yielded only four publications. Hence searching had to be open-minded; allowing for internal reports and small scale projects as well as peer-reviewed articles.

Table 3 documents material found. Studies generally either consider complaints employees or PALS workers distinctly. From these publication dates, it can be observed that research on PALS in particular is still in its infancy.

Table 3 PALS and Complaints Peer Reviewed Research

Complaints Specific Literature	PALS Specific Literature
Kolb (1988)	Abbott, et al. (2005; 2006)*
Resnik and Harmon (1983)	Bentley et al. (2005)*
Mulcahy and Lloyd-bostock (1994)	Buchanan et al.(2005)*
Xanthos (2005; 2008)**	South (2007)
	Evans et al. (2005; 2006; 2008) ***

*Publications resulting from same study

** PhD and resulting publication

*** Some publications are reports and thus not peer-reviewed

As can be seen only a handful of researchers have approached PALS workers as a population group and most of this literature is largely empirical, within minimal reference to theory. In addition studies have either used samples of complaints staff or PALS employees.

As indicated by the single asterisk in Table 3 over half of the PALS publications result from one large study. In addition, the Bentley et al. (2005) paper is simply a collection of researcher observations while the South (2007) article is not an empirical study but rather a narrative critique. While this is a positive observation for publication opportunities from an academic's perspective, it also evidences that conclusions made on PALS staff basically stem from two independent studies: the final Evans et al. (2008) government commissioned evaluation report (and resulting publications of 2005 and 2006) and the large study that was the source of single asterisk publications (e.g., Abbott et al. 2005; Abbott et al. 2006; Bentley et al. 2005; Buchanan et al. 2005).

Regarding complaints specific literature (left side of table),studies conducted were undertaken prior to the 2009 procedures change. This means that explanations may be somewhat outdated as the complaints processes are now different. Presently, the NHS complaints procedure consists of two possible stages (NHS, 2013). The first part consists of local resolution where complainants are encouraged to raise the matter directly with their service provider. The aim is to rapidly resolve issues to the satisfaction of all parties concerned. If the complainant is not satisfied with the outcome of the investigation, they may then approach the Parliamentary Healthcare Ombudsman for an independent review in act two. Prior to April 2009, complainants had to direct their concerns to the Healthcare Commission before approaching the Ombudsman. Thus the current two staged procedure is argued as simplifying the complaints process for patients. If the matter runs smoothly in during local resolution, there is no need to take it further. As such, the local resolution events taking place with PALS for instance can be argued as crucial to the process. In addition Kolb (1987), the earliest example found, used a sample of ombudsmen, who at the time performed a melange of Human Resource (HR) functions and internal employee complaints; thus not quite the same role as today's PALS. Similarly the sample of Mulcahy and Lloyd-Bostock (1994) consisted of managers tasked with complaints duties and not complaints managers per se. Whilst these two studies did not research PALS or complaints employees per se, the scarcity of research in this particular area has necessitated a broader exploration of 'similar enough' job roles.

Furthermore, *none* of the studies listed in Table 3above explored wellbeing. Table 4below indicates their topics of investigation. While some of these topics are related to wellbeing, for

example role conflict (Xanthos, 2008) and change (Buchanan et al. 2005); wellbeing as a concept, prior to this PhD, was not yet investigated in this largely untapped employee group.

Table 4Topics of investigation

Study	Topic
Abbott et al. (2005)	Development of patient centred criteria to assess PALS
Abbott et al. (2006)	Role of PALS in interacting with service users
Bentley et al. (2005)	Support at work
Buchanan et al. (2005)	User driven change
Evans et al. (2005; 2006; 2008)	National evaluation of PALS
Kolb (1987)	Conflict resolution by corporate ombudsmen
Mulcahy and Lloyd-Bostock (1994)	Dispute handling by managers
Resnik and Harmon (1983)	Complaints services in social services
South (2007)	Critique of PALS
Xanthos (2004, 2008)	Role conflict and ambiguity in NHS complaints managers

As previous to this present study the wellbeing of PALS workers was not yet investigated, there are no papers to source that discuss this very point. Instead attention was turned to the broader category of customer service workers to see whether those findings would be transferrable to explain PALS workers wellbeing. A literature search was then conducted on wellbeing, as understood by this thesis' conceptual framework, in samples of call centre workers. The three notable studies found are listed in Table 5 below.

Table 5 Wellbeing in Call Centre Samples

Study	Context
Grebner et al.(2011)	Swiss unidentified organisation/industry
Holman (2002)	UK based organisation with 3 call centre sites: banking, mortgage, and loans
Sprigg, Smith and Jackson (2003)	UK based 36 call centres from various industries

In alphabetical order, the first study is conducted by Grebner et al. (2011) in Switzerland. Unfortunately the authors do not share the nature of the industry, making it difficult to judge

whether the context there and the context in the NHS would be similar enough to transfer results. The second and third are UK based projects, one funded by the ERSC and led by Holman (2002) and the other an HSE funded report led by Sprigg, Smith, and Jackson (2003). These two studies make use of a diverse portfolio of industries thus providing a broad appreciation of what wellbeing levels may be like in general amongst call centre employees. These are now discussed below.

2.4 Wellbeing in Customer Service Call Centres

The literature search has identified three studies that have specifically measured wellbeing as a composite and global concept in call centre employees. Grebner et al. (2011) measured wellbeing used Warr's job specific scale and Mohr's psychosomatic scale in a sample of 234 call centre agents exclusively dealing with inbound calls in French and German speaking areas of Switzerland. Their results were compared to norm groups consisting of traditional occupations such as cooks, sales assistants, nurses, bank clerks and electric technicians – although it is worth pointing out that ascertaining comparability is difficult as the study's industry is unknown. Analyses show that although their call centre sample reported a higher incidence of psychosomatic complaints, they nevertheless scored lower on strain. Hence, when it comes to psychosomatic complaints, their call centre sample report poorer wellbeing, but regarding strain, they report better wellbeing than comparison groups. However the transferability of these findings to NHS PALS is highly questionable. First and possibly most obviously, the study was conducted in Switzerland and thus transferability to the UK cultural context may be limited. Second and rather surprisingly, the authors do not divulge the industry from which they sampled their participants, hence comparability is difficult to judge. And lastly, their sample consisted solely of agents taking inbound calls, whereas PALS workers also execute outbound calls and are thus proactive and reactive. For these three primary reasons, the Grebner et al. (2011) findings are argued as not transferable to PALS workers.

The next potential source of information is the study led by Holman (2002) which is without a doubt a stronger piece of research. First, it was a mixed method design comprised of 557 questionnaires and 50 interviews within three call centres of a UK bank. The highly corporate banking culture could be argued as far too different from the bureaucratic public sector culture of the NHS, hence casting some doubt on the transferability of these findings. These employees were engaged in tasks related to banking, mortgages and loans and spent the majority of their time answering inbound calls – which yet again different from PALS staff who both take in

inbound calls and make outbound calls. Using the same job related wellbeing scale developed by Warr (1980), Holman (2002) compared results to both shop floor manufacturing and clerical groups. Analyses revealed that while agents performing bank duties scored lower on wellbeing, those engaged in mortgage and loans tasks report similar or higher wellbeing than comparison groups; suggesting that agents who specialised in banking fared worse on their wellbeing than their mortgage or loan colleagues. Although the Holman (2002) study is a more robust piece of research than the study by Grebner et al. (2011) due to its mixed method approach, its focus on the banking industry (which is a strength where the study itself is concerned as it allows in-depth investigation) is unfortunately a disadvantage for its transferability, which was one purpose for the literature review. Employees working in a private sector bank are likely to experience different work situations to PALS staff working in the public sector NHS; for instance a customer complaining about their debit card not working requires a different level of empathy to a patient complaining about their chronic illness medication is not working. Put bluntly, the stakes of making a mistake in healthcare are higher; thus the management of resulting complaints take a more serious tone. For the dissimilarity of industry, findings from Holman (2002) are argued as not transferrable to the NHS PALS.

The next project is funded by the Health and Safety Executive and led by Sprigg, Smith and Jackson (2003). It also had a mixed method design where the researchers conducted 22 interviews and a survey questionnaire with 36 UK call centres with a sample of 1141 workers. Industries included within the sample consist of telecoms, IT, financial services, hotel, public service, transport, emergency, and outsourcing; with employees engaged in various inbound and outbound calls. Also, there was a public service organisation within their sample. Results were compared to benchmark groups comprised of clerical/secretarial, technical support staff, maintenance engineers, supervisors, shop floor staff, professional workers, managers, and ancillary staff – a rather comprehensive benchmarking group. This is the first study that included both inbound and outbound agents with a sufficient variety of industries to be considered as a potential 'candidate' for transferability. Analyses in this case conflict with the two previously discussed studies; here, call centre workers report *lower* wellbeing than benchmark groups. In particular, the job was found to be more stressful when call handlers did not make full use of their skills, had a high workload, were unclear about their role, and were faced with conflicting demands. These findings echo Van Den Broek's (2003) research to be discussed shortly.

The difference of results may be explained by the measures of wellbeing and the scale of the projects. First, the studies Grebner et al. (2001) and Holman (2002) used Warr's wellbeing scale – which is a *job related* scale; Sprigg, Smith and Jackson (2003) on the other hand also used the

GHQ12 which is a *global* measure. A global measure is argued as more suitable for exploring wellbeing as the concept itself is a global concept (Danna and Griffin,1999), in other words, it does not place a strict barrier between work events and other life events – in fact, one may question the very notion of having a distinction between *life* and *work*. In addition the scale of Sprigg, Smith and Jackson's (2003) project is simply much larger and their sample contains a melange of industries. For instance, it could be that call centre workers *in general* report poor wellbeing; but employees working in the Swiss organisation and the UK bank fare better than their counterparts due to context specific factors. Perhaps these sites have effective supportive measures that allow their employees to cope better than the general call centre population group.

Furthermore it is difficult to infer conclusive remarks about the wellbeing of call centre agents as there was variability in the benchmarking comparisons as well. For instance, Grebner et al. (2011) used data from the *Work Experience and Quality of Life in Switzerland* project, while Holman (2002) and Sprigg, Smith and Jackson (2003) both used Mullarkey's (1999) benchmarking manual. However, Holman (2002) only used the clerical and shop floor comparison groups, and it is not quite evident why these comparison groups were selected, while Sprigg, Smith and Jackson (2003) compared their sample to a wider variety of occupations, allowing better comparability.

In summary, the literature review has noted three studies that have specifically attempted to measure the construct of wellbeing in call centre workers. Results are inconclusive. Whilst in a sample comprised of a wide range of industries agents reported lower wellbeing than benchmark groups (Sprigg, Smith and Jackson (2003), in studies of single organisations findings are mixed (e.g., Holman, 2002). However, possibly the biggest deterrent of transferability is the assumption made by Sprigg, Smith and Jackson (2003) that call centre workers are a homogenous population group. Although some commonalities such as the use of scripts may be shared amongst agents, it is erroneous to assume that call centre workers are entirely homogenous in the functions they perform. This argument is developed below.

2.5 Within-Group Differences in Call Centres

Whilst reading for this literature review, it soon became apparent that call centre workers are not a uniform homogenous group but rather perform different functions in their organisations. In Australia, van den Broek (2003) distinguishes between *routine mass production* models, which maximise volume and minimise cost; and *professional services*, where workers maintain discretion. Employees working in the former, for example directory inquiries, are likely to require

relatively limited skills; whereas the latter, for example healthcare professionals, do need qualifications. As a means of illustrating these functions, they have been grouped into different skill levels; with a proposition to include the additional *expertise services* instead of van den Broek's original *hybrid*as the terminology is more expressive (Figure 12).

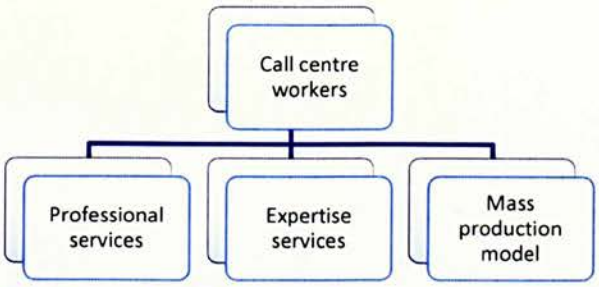

Figure 12 Types of call centre workers by skill level*(Extended from van den Broek (2003)*

Call centre workers in *expertise services* engage in work that requires specialised knowledge and/or experience, for instance the education provider sample in the Houlihan (2002) study. While employees in this sub-group are not necessarily professionally qualified, they nevertheless require specific knowledge of the service provided to perform their role. Call centre workers in *professional services* engage in what can be construed as 'high skilled' professional work, for instance shared services HR professionals studied in Pritchard and Symon (2011) and NHS direct nurses sampled in Weir and Waddington (2008). In contrast, employees in *mass production models* perform comparably 'low level' skill work, for example cancellation of contracts (e.g., Grebner et al. 2011) and sending out technicians to customers (e.g., Holdsworth and Cartwright, 2003). In other words, the last sub-group engages in more generic customer service tasks that neither requires professional qualifications nor expert knowledge. Sprigg, Smith and Jackson's (2003) demographic reports show that these roles are largely occupied by young to middle aged white females who are at least educated to GCSE level. While most of their sample had three to five years' experience in the call centre industry/organisation, only 51% had aspirations of remaining in the industry for more than five years. These demographic details provide evidence for researchers such as Belt (2002) who compare call centres to 'female ghettos' which offer little room for either job satisfaction or career progression.

Overall, when reviewing the literature to identify the skill level of the samples used, the outcome is somewhat unclear. Some authors, such as Houlihan (2002)vaguely specify the types of tasks their sample may perform, others such as Mahesh and Kasturi (2006) and Mulholland (2002) ignore it or mention it too briefly to provide sufficient information from which to make inferences. This is somewhat problematic as it assumes a wrongful homogeneity. In essence, call

centre workers are not simply one population group characterised by phoned based work, but rather, there are distinct job roles embedded within this wider grouping.

These differences are important to note as it may impact on wellbeing. For example, call centre agents in professional services may have greater decision making autonomy due to their high level of skill than compared their generic services colleagues. Similarly those working in expertise services may engage in greater creative problem solving than generic services operators who are strictly bound by scripts. Hence the level of skill required may impact both on the demands imposed on the agent and on the job control allocated to them. Furthermore, in the public sector, political agendas may influence the power given to human service workers in call centres. For example, nurses in Quebec, having historically enjoyed legitimate authority in providing health care, have input in designing their call centre software while nurses in the UK, with limited autonomy, had little or no input in designing their technology (Colin-Jacques and Smith, 2002).

van den Broek (2003, p.3) raises the important question of whether the provision of human services, such as healthcare, can "comfortably" conform to the "logic" of the mass production model. Indeed, in her research with Childline she seems to find evidence to argue otherwise. Childline is an Australian government call centre which houses qualified social workers. Most employees were qualified at degree level (e.g., social work, social welfare or psychology) and had over ten years' experience in community health. Employees worked day, afternoon and nights shifts to ensure children were protected from abuse. Their job description, similar to PALS, seems to be a mélange of skill levels. For example, Childline workers would respond to general queries, refer clients, provide afterhour's crisis response, perform initial assessments, and undertake investigations.

van den Broek (2003, p.6) interviewed five Childline workers and two union officials and found that staff required both "rational" and "emotional" decision making skills and employees were required to make complex decisions rather quickly about children at potential risk. They had to decipher urgent cases from less pressing concerns, assess risk, and effectively communicate with a number of parties at different levels. However, in spite of these professional requirements, van den Broek (2003) found that a supervisory managerial culture undermined their skill. For example, team leaders would walk around and direct instructions to work quickly. Childline workers felt considerable time pressures, for instance call waiting time and number of calls in the queue. They shared concerns that the quantitative aspects of customer service were given prominence over the qualitative aspects of human care. As a means of dealing with this conflict, workers would resort to Machiavellian tactics such as taking in the details of a caller at the end of a queue and

calling them back simply to reduce the number of calls waiting. Workers lamented that their reports were rushed and often put aside until the end of the day when details were forgotten. Overall, participants felt that social work was being 'de-skilled' by Childline adopting a mass production call centre model.

Although not a statistically large sample, this study clearly evidences the conflict that may occur when human services of a professional nature adopt a private sector mass production model. In mass production models 'measurable' outputs are favoured over the more interactive aspects of services; however as evidenced by participants in van den Broek's (2003) study, it is with great discord that less tangible attributes are set aside. As pointed out by van den Broek (2003) most call centre research is conducted with private sector low skilled workers; it thus follows that relatively little is known about customer service workers in professional services and expertise services.

Furthermore, a particularly noteworthy distinction to make is between the provision of a service and working *specifically* with customer feedback as done by PALS or complaints staff. It is now posited that working specifically with customer feedback embodies three distinct characteristics that differentiate it from other forms of customer service: (1) the purpose of the service encounter is focused on the receipt of feedback; and (2) the emotions conveyed by the customer are likely to be negative, requiring a greater level of emotion management by the PALS worker. Finally, (3), as the role also requires the PALS worker to solve the issue, this particular job type may require a higher level problem solving than simply generic customer service. These premises are now justified below.

In the first instance, the primary purpose of the service encounter is argued as different when comparing generic customer service with PALS. Within the PALS scenario, a dissatisfying event has already occurred prior to PALS staff encountering the customer. The purpose of the service encounter is for the dissatisfied customer to voice their concerns. As such, the emotions within this type of encounter are likely to be negative from the onset. In essence, the customer is upset. As a result, the employee response needs to be tailored to these negative emotions, for instance by enacting empathy and compassion while effectively managing the negative customer emotions to reach a satisfactory resolution. Additionally, PALS staff are simultaneously attempting to appease the dissatisfied customer while minimising the organisational blame; as a result they are engaging in high level problem solving while navigating an already complex emotive situation. Drawing on Morris and Feldman's (1996) conceptualisation of emotional labour, it can be argued that the feedback service encounter is emotionally taxing on PALS staff due to the intensity of

emotions displayed, the variety of emotions that need to be displayed, and the dissonance experienced as a result.

The only study found in the literature search that considers call centre agents who specifically deal with complaints is done by Bakker et al. (2003)who sampled TeleAdvisors and TeleConsultants as a sub-group of their sample consisting of four different job types in a Dutch Telecom call centre. TeleAdvisors are tasked with taking in customer complaints while TeleConsultants solve them. However, Bakker et al. (2003) did not explicitly undertake research on complaints staff per se, but rather, these employees formed part of their overall sample consisting of other call centre roles as well (TeleOperatives who simply give out number information and Supervisors tasked with supervisory duties). In addition, the aim of their study was not to investigate wellbeing but rather to test the Job Demand Resource Model. Findings do however indicate that TeleConsultants, tasked with solving customer complaints, score the highest on emotional exhaustion and repetitive strain injury and report more sickness absence. While these findings are merely scratching the surface, they do nevertheless suggest that call centre employees tasked with solving customer complaints engage in significant emotion work which places them at a greater risk of emotional exhaustion.

To summarise the argument so far, findings from Sprigg, Smith and Jackson (2003) indicate that call centre workers in their large sample of 1141 participants report lower wellbeing than a variety of benchmarking groups. Results from Bakker et al. (2003) suggest that those engaged with solving customer complaints may actually experience greater emotional exhaustion than colleagues. While these findings may aide in developing preconceptions, they do not fully explain the situation with PALS staff who work in the specific context of the NHS, taking both inbound and outbound queries, through a variety of media e.g., email, phone, face to face). Additionally, the job role of PALS is argued as residing within the expertise services cadre of customer service as opposed to generic customer service. As most studies are conducted on relatively low skilled call centre workers (van den Broek, 2003), the wellbeing findings from call centre samples that have been discussed so far in this thesis are argued as not transferrable to PALS staff. In essence, the wellbeing of PALS in the healthcare context is simply not known. As PALS perform a crucial customer service and change function in the NHS that is not only necessary for the patient involvement agenda but for quality care and patient safety, it is important to explore the work experiences of PALS that may be associated with their wellbeing.

2.6 PALS Work Experiences

Although the studies catalogued in table 3 did not investigate wellbeing, they did unearth PALS staff occupational experiences that can help understand the phenomenon of their working life. Table 4 from section 2.4 is now reproduced below for ease of reference:

Table 4(reproduced)

Study	Topic
Abbott et al. (2005)*	Development of patient centred criteria to assess PALS
Abbott et al. (2006)*	Role of PALS in interacting with service users
Bentley et al. (2005)*	Support at work
Buchanan et al. (2005)*	User driven change
Evans et al. (2005; 2006; 2008)	National evaluation of PALS
Kolb (1987)	Conflict resolution by corporate ombudsmen
Mulcahy and Lloyd-Bostock (1994)	Dispute handling by managers
Resnik and Harmon (1983)	Complaints services in social services
South (2007)	Critique of PALS
Xanthos (2004, 2008)	Role conflict and ambiguity in NHS complaints managers

By engaging with the literature above, two key pieces of information can be discerned: (1) that PALS workers may experience conflict of interest; and, (2) that PALS workers operate in a complex political environment. Each of these premises is now developed in turn.

In as early as the 80's, studies had identified a certain conflict of interest in the role of individuals who received complaints. For instance, Resnik and Harmon (1983) found that 45.5% of corporate managers in receipt of consumer complaints cited satisfying the customer as their primary objective while 41% rated protecting their organisation as their dominant goal. The authors conclude that these goals "need not be mutually exclusive" (Resnik and Harmon, 1983, p.91) and perhaps rightly so as one may lead to the other, however it can also be argued that they are interpreting their findings perhaps too optimistically. Kolb (1987) provides some evidence that this may be the case by pointing out that these two goals may lead to a conflict of interest: on the one side supporting the complainant and on the other protecting the organisation being complained about. Although her study was conducted on a rather small statistical sample of

seven corporate ombudsmen, her findings do demonstrate an inherent role tension. For example, one participant warns that:

> *"you have to be careful not to be too supportive because there is always the danger that you will support the wrong person and hurt the company" (Kolb, 1987, p.681).*

whilst another cautions that:

> *"you have to take into account the impact of your actions on the system. You cannot always think of the individuals" (Kolb, 1987, p.681).*

Based on these statements, it appears that ombudsmen were cautious of taking the complainant's side; from what they say, it seems that standing by the organisation is their preferred stance. Indeed, one ombudsman sums it up as: "mercy is important, but I am a manager of this company and my actions have to reflect this" (Kolb, 1987, p.681).

As a means of addressing this conflict, Kolb (1987) interpreted that participants were likely to adopt various identities in their investigations. For example, ombudsmen with *helper* identities attempted to design individualised solutions and went out of their way to resolve the issue. Kolb (1987) suggests that this propensity to help complainants is a means of coping with the tension experienced – perhaps a subconscious sense of guilt. In contrast, *fact-finders* were more likely to adopt an objective stance and perceived themselves as "an investigator to find the truth" (Kolb, 1987, p.684). These participants were concerned with following protocols and ensuring procedures were appropriately implemented. Unsurprisingly Kolb (1987) found that adopting these different identities impacted on how they investigated the complaint. For example helpers were more prone to transferring complainants to another location whereas fact finders were more likely to discipline the target of the complaint.

This role duality evidenced in ombudsmen has also been found in healthcare managers. The first researchers to explore this phenomenon were Mulcahy and Lloyd-Bostock (1994) who published two papers as a result of this particular piece of work. As the articles were published as 'sister' papers, it was somewhat difficult to make sense of the overall methodology as each paper made reference to the other but the whole picture, methodologically, was arguably vague. It appears that, on the whole, the researchers interviewed 25 NHS senior managers in receipt of complaints. Similar to Kolb (1987) they too found that managers adopted different roles as a means of managing the conflict and ambiguity experienced in their role. For example, managers who adopted *gate keeping* duties were more likely to deflect the complaint at the source before these could progress through official channels whereas managers who preferred a *dispute handler* role were more prone to evaluating the merits of each case and communicating with the complainant.

Depending on the nature of the complaint and the gravity of the situation, which staff members were involved and their relationship with the complainant, managers adopted different roles in complaints handling. Their own perceptions of whether the complaint was justified, their personal style, and what resources they had at their disposal also influenced this selection. The greatest determiner of role adoption was the nature of the complaint. For instance in complaints where inference to medical negligence was found, the legal department or experts were sought out and this would elicit the adoption of a much more defensive strategy – possibly to avoid blame. Indeed, the NHS has oft been criticised for its blame culture (Bann 2004). Perhaps for this reason, managers were well aware of the 'public relations' aspect of complaints. Participants noted that phrasing a case in favour of the staff member might not be as easy as phrasing one in favour of the complainant (Mulcahy and Lloyd-Bostock, 1994). Possibly in case the media got involved. At times, it was best not to establish the rights/wrongs of the case, but rather to adopt a *peacemaker* identity and support both complainant and staff member as "a way of saving faces" (Mulcahy and Lloyd-Bostock, 1994, p.202).

One important variable that was likely to influence which identity a manager would adopt was their relationship with the clinician in question. For example, traditionalist managers from another era were more likely to be appeasing towards clinicians; new style executives (perhaps with something to prove) were more likely to adopt a confrontational stance. Managers were also likely to take up a confrontational stance with complainant should they be complaining about an issue that the manager him/herself is responsible for. This was more prone to happening with senior managers as they were more likely to be responsible for policies or efficiencies. In these cases, when managers were targets of complaints, they were likely to adopt *opposer* identities which was rather defensive. Here, they could revert to avoidance tactics, such as failing to return complainant calls or referring complaints to other staff members. One participant confesses that:

> *"memory has a wonderful ability to embellish and exaggerate and suddenly accounts of events change dramatically. The most effective way to deal with this threat would be to adopt a name with fourteen letters and no vowels and then nobody would feel comfortable writing to you" (Mulcahy and Lloyd-Bostock, 1994, p.203).*

Such defensive behaviours when faced with complaints has also been found in retail managers (Harris and Ogbonna 2009). In some instances, they would go against company policy of recording all complaints and simply deal with the issue on the shop floor thereby not logging it formally. Similarly, they would fail to record telephone complaints. In other rarer cases, they would remove the complaint from the log book. Some motives were altruistic and complaints were concealed to

protect friends or family. Other motives were more instrumental and aimed at personal gain or simply the prevention of extra work.

A significant contribution of the Mulcahy and Lloyd-Bostock (1994) study is the importance of the organisational context. As managers operate within an organisational macrosystem, variables beyond their control such as budget allowance and resources influence how they will choose to manage the complaint. In addition, socio-political aspects such as promotion prospects, organisational culture, relationship with colleagues involved, and internal politics impact on complaints management. These variables contribute to PALS role identity as well. Abbot et al. (2006) conducted a similar qualitative study to Mulcahy and Lloyd-Bostock (1994) with 27 London PALS personnel and the researchers report a similar propensity to changing identities depending on the situation. In some cases, PALS staff play the pivotal role of feeding back information between patient and staff members. One PALS officer admits that:

> *"staff were very good at getting that resolved themselves. All we needed to do was to flag up that there was a problem and they were there, getting it sorted it." (Abbott et al. 2006; p. 142).*

In this *messenger* role, PALS staff act as a catalyst for change as envisioned by the Department of Health by reporting patient concerns to the responsible staff member. As such, they also function as an *information provider*, where they keep and share large amounts of resources and information – they both provide details and also explain them. In order to do this effectively, they have to tailor their approach to the audience. One participant comments that "it's communication really [...] at least they feel that somebody has listened to what they've said" (Abbott, et al. 2006, p. 141). PALS staff also perform *supporter* duties by providing emotional support for service users to act independently. For example one PALS officer recounts that a patient was:

> *"very nervous, but I went into clinic with her and once she started, she just spoke for herself. And I didn't even have to do anything really – it's just like being given permission, or just having the back-up there" (Abbott et al. 2006, p.142)*

Another PALS participant provided a patient with support in drafting a letter. Linking these behaviours with emotion work theory, it appears that PALS staff perform poignantly, acting as a go-between patients and organisation, providing emotional support to patients and also engaging in instrumental negotiations with staff members. The concern with this emotively active front stage is what may be lurking in the back stage. Based on the findings from Kolb's (1987) ombudsmen, Mulcahy and Lloyd-Bostock's (1994) managers, and Abbott et al.'s (2006) PALS samples, it can be inferred that if individuals in receipt of complaints adopt different identities, then they could experience role conflict and role ambiguity as a result. Role conflict in this context

can be understood as the simultaneous presence of pressures where complying with one makes it more difficult to comply with the other (Shumate and Fulk, 2004). Perhaps one role would force the employee to behave in a way that may conflict with their personal ethics.In some cases, employees may not know which role to adopt, and possibly, these possibilities may not even be conscious to the employee. Here role ambiguity makes the requirements of each role somewhat vague and difficult to interpret.

The only researcher who explored the impact of role conflict and ambiguity specifically on NHS *complaints* managers is Xanthos (2004, 2008) who submitted a doctoral dissertation and published two articles as a result. In her opening chapters, Xanthos (2004) highlights the scarcity of research in this area and in the last few years circumstances have not improved much. In her sample of 30 NHS complaints managers, she found similar evidence of role conflict and ambiguity; particularly when "the complainant is saying one thing, and the nursing staff are saying another thing" (Xanthos, 2008, p.e1). In these occasions, complaints managers were placed in an automatic dilemma and found it difficult dealing with conflicting accounts. The manager then had to choose who to side with and if the complainant's story was accepted over the staff member's, then that could affect the manager's popularity with the rest of the staff. Employees who placed their duty to the public over and above their loyalty to the organisation where perceived as 'troublemakers'; and it is thus not surprising that over one third of participating complaints managers admitted that they would side with the organisation:

> *"it's a thorny one...the bottom line is – you give staff the benefit of the doubt in the absence of other information" (Xanthos, 2008, p.e1).*

Now this is a really intriguing finding. If the preferences of complaints managers from the Xanthos (2008) study are compared to general managers from the Mulcahy and Lloyd-Bostock (1994) research, a very interesting difference can be perceived. *Complaints* managers preferred to side with the organisation for fear of being perceived a troublemaker by other staff. *General* managers on the other hand were afraid that siding with the organisation would have a negative ripple effect on public relations. They rather opted to make peace without affirming the rights and wrongs of the case. This could imply that complaints managers feel less authority and independence to provide patients an objective outlook; general managers in contrast, perhaps because of the inherent power their job title awards, were less worried about what other staff members thought and more concerned about what the public would think. As such, contextual power variables could be quite salient in influencing behaviour.

While Xanthos' (2008) sheds some much needed light on the complaints group, for example how whistle blowers may be perceived, her study made exclusive use of telephone interviews. Perhaps

this may have made participants more comfortable to share sensitive information however it could also miss out on crucial embodied cues for instance office space and body language.

In summary, this section has shown that the job design of dealing with complaints when the handler is a member of the organisation in receipt of the complaint may be inherent with conflict of interest. Research has shown that PALS staff may adopt different roles in order to perform their job role. This finding is of interest to this study as role conflict and ambiguity are known to have a detrimental impact on wellbeing.

To measure the effects of role conflict and role ambiguity Rizzo, House, and Lirtzman (1970) in their seminal work (an article cited over 2800 times) developed a 30 item scale. Their questionnaire measured both individual outcomes, such as anxiety and discomfort, and also organisational outcomes, such as intention to leave. Their results evidence that role ambiguity has a higher correlation with what they term 'satisfaction' variables. These consist of job security, personal recognition, and autonomy for example. In other words, role ambiguity is more likely to influence the relationship with satisfaction variables than role conflict. Role ambiguity was further found to be positively associated with anxiety while role conflict was more likely to lead to somatic tension. This means that PALS employees who are unsure about which identity to adopt are more likely to experience anxiety while PALS employees who are made to behave in ways that conflict with one another are more likely to have physical tensions (e.g., sore back, muscle tension etc.). In circumstances where supervisors provide structure, facilitate teamwork, and tolerate freedom, role conflict and ambiguity were likely to be low. This shows that supervisors can play an important role in decreasing the negative impact on wellbeing.

Since then, critiques have questioned the construct validity of Rizzo, House, and Lirtzman's (1970) scale. For example, in the 80's, Tracy and Johnson (1981) argued that their questionnaire did not measure conflict or ambiguity but rather stress. More recently Kelloway and Barling (1990; 2011) note that the questionnaire items which measure the construct of role ambiguity actually reflect the absence of ambiguity as opposed to its presence. On the other hand, items measuring the construct of role conflict test its presence, hence they critique comparisons. Although they proceeded to test the construct validity of the scale, they found little support for their criticisms. With a cautionary word on negatively worded questions, they conclude that their findings uphold the robutness of the questionnaire.

Since then, researchers have theorised that role conflict and ambiguity are notable sources of occupational stress (Stamper and Johlke, 2003). Work by leading researchers has lead to three

comprehensive meta-analyses: Fisher and Gitelson (1983); Jackson and Schuler (1985); and Tubre and Collins (2000). Overall, results appear somewhat mixed. Although the earlier meta-analyses found an association between role conflict and ambiguity with tension and low job satisfaction, they observed a weak relationship with job performance. These findings indicate that employees who experience role conflict and ambiguity may experience lower job satisfaction and more tension than their counterparts however this may not actually impact on their performance. In contrast, Tubre and Collins (2000) used more sophisticated statistical analyses and a greater sample size of research articles and found that while role ambiguity had a negative relationship with performance there was no meaningful relationship between role conflict and performance. In other words, PALS staff faced with role ambiguity may exert poorer performance but PALS staff in conflict perhaps not. The researchers propose two theoretical bases for their finding. According to cognitive theories, they argue that role ambiguity results from a lack of information about which behaviours are expected and thus could lead to detrimental performance as the individual does not quite know what to do. Similarly, in line with motivation theories, role ambiguity could lead to a decrease in the link between effort, performance, and expected rewards, as the individual is unsure on what they receive; and thus could negatively impact on performance. However, the researchers are unable to provide an explanation for the lack of effect of role conflict on performance. This may be because in ambiguous situations, individuals refrain from acting as they are unsure what to do, however in conflicting situations, although faced with a dilemma, individuals nevertheless choose a behavioural option, hence, whether liking it or not, they are still acting. The answer is not clear. However, what is clear based on research evidence is that PALS employees adopt different identities when performing investigations, that this could lead to role conflict and role ambiguity, that conflict and ambiguity impact on wellbeing and perhaps on performance too. As already mentioned, one important variable in determining the identity that PALS staff would adopt is the macrosystem within which they work; and for the NHS, this is a complex political environment.

2.7 Working in a Complex Political Environment

In addition to the emotional component of their job role and the inherent conflict of interest, PALS staff have to communicate with various colleagues, first to resolve the concern and then to instigate organisational change as a result. This may involve liaising with targets of patient complaints such as doctors or nurses, and with their managers such as department heads or matrons. In order to perform this "catalyst for change" role effectively, the Department of Health (2002, p. 32) clearly stipulates that PALS staff require "direct access to the Chief Executive" as it is

this link which will signal the organisational status awarded to PALS staff. Research evidence supports this premise and indicates that a complaints manager must be of an appropriate status in the organisation in order to perform their job role effectively. For example, one high status manager explains that a complaints manager needs to have:

> *"sufficient level in the organisation to carry some clout – either reporting directly to the Chief Executive, or pretty close. I think if you had somebody who was sort of in an admin grade and maybe pretty young and inexperienced, I think it could be quite daunting – especially when you are dealing with consultants. I mean they can be very arrogant and difficult creatures, and I'm of sufficient status and age and experience – I talk to them at the same level, you know" (Xanthos, 2008, p.e1).*

Similarly, a PALS research participant argues that PALS workers "must be given power, or access to power, or else trust staff will not see change as necessary" (Abbott et al. 2005, p. 133). Another participant explains that:

> *"it's trying to be a bottom-up culture change, instead of a top-down one, which – I don't know how successful that will be with such a large organisation" (Abbott et al. 2005, p.133).*

In particular, Evans et al. (2008) found that PALS champions who were senior organisational members were particularly useful in supporting the PALS agenda and their influence. For instance, one PALS employee confesses that their champion "ensured that they've got access to the chief executive because I think that's important" whereas another "is a great PALS champion, he really does believe in it, he's great, he really is interested in it" (Evans et al. 2008, p. 79). Additionally, in sites where PALS champions would support the agenda, the PALS team was more likely to be well resourced and integrated in the organisation as a whole.

From the literature above, it can be summarised that both policy and research evidence seem to indicate that appropriate status is imperative for PALS employees to perform their job roles effectively. However, the chart below (Figure 13) depicts that most PALS personnel are of band 3 - this means their post is matched with customer service officers, clerical officers, and secretaries. In other words, it is matched as an administrative grade.

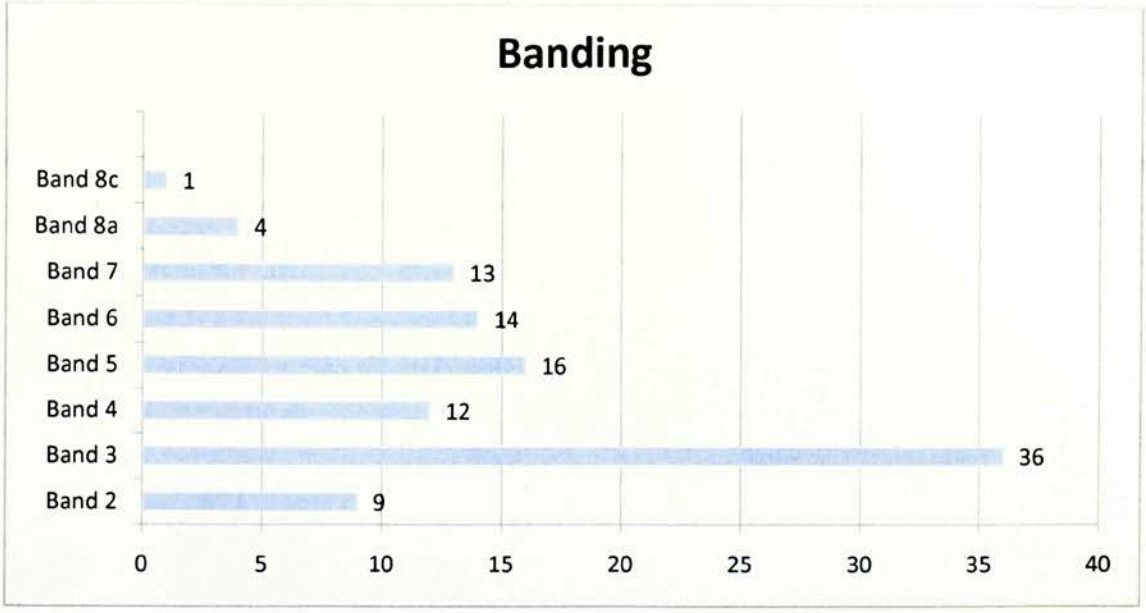

Figure 13 PALS Banding(*Adapted from PALS Professional Development Work Stream; PALS, 2006*)

The representation above is taken from the PALS (2006) Professional Development Work Stream. This information was requested in 2006 as part of the Agenda for Change initiative and is not a formal research project. However, more robust figures are not obtainable as the NHS does not collect data specific to PALS or complaints staff. In this sample, 145 responses were received from 20 Strategic Health Authorities. The chair of the Professional Development Work Stream, who compiled the summary sheet, notes that there were 37 different job titles and 14 pay brackets. Responses indicate that out of 36 PALS employees who were graded at band 3 (the most common banding in the sample) only three were satisfied with this outcome (PALS, 2006). This could be reflective of dissatisfaction with pay (as banding is linked to pay) but also with status as bands 3 are matched with an administrative grade. The chair of the Professional Development Work Stream suggests that a lack of professional qualifications "is not helping the banding process" and that "the general feeling" is that employees ought to be banded higher than they are (PALS, 2006, p.3).

While understandably higher bandings are expected to take on greater responsibilities, Bentley et al. (2005) evidence that PALS are often small departments – with some providers running a one person office. In addition, it has been suggested that the banding process fails to take into account the extensive diversity of the job portfolio and that generally posts are mismatched to their allocated band (PALS, 2006). It has been argued that PALS staff do not simply perform generic customer service but rather engage in a higher level expertise function that require greater problem solving skills and negotiation abilities. Evidence above seems to support this argument and it appears that perceptions of the post are not an accurate reflection of job

responsibilities. Comments from PALS employees echo these sentiments; some exclaim that this is "one big kick in the teeth" and confess feeling "undervalued, deflated, demoralised, concerned, insulted, not appreciated, apprehensive, unhappy" (PALS, 2006, p.3). Research from other industries simulate these emotions and depicts that clerical workers may generally feel undervalued, unappreciated, replaceable, and not respected (Harkness et al. 2005). In a study of 22 clerical employees, participants confided that "people don't respect admin" and "invisible is the message that came to me from society" (Harkness et al. 2005, p. 128/129). Some participants suggest "admin is seen as we didn't make it" and they interpret the perceptions of others are equating administrative roles to a "subservient type of occupation" (Harkness et al. 2005, p.129).

In summary, one may question whether colleagues perceive PALS staff as endowed with sufficient status in the organisation to perform the pivotal change agent role; particularly when research already evidences that complaints managers fear being labelled a 'trouble maker' (Xanthos, 2008). Indeed some participants in Abbott et al.'s (2006) study were not overtly optimistic about the openness to a bottom-up culture change as envisioned by Department of Health. In addition, PALS staff reflect the general feelings expressed by the administrative participants from Harkness et al.(2005) who report a similar lack of appreciation. This can also be compared with the lamentations that social work was being de-skilled by introducing a mass production call centre model into Childcare (van den Broek 2003). In addition, there also appears to be an impression that the PPI agenda is given "more status" than the employees themselves (PALS, 2006, p.3). This could be reflective of the misconception that PALS staff perform generic customer service as opposed to the expertise service as argued by this thesis and that in some Trusts the patient empowerment agenda is at risk of tumbling into a 'box ticking' exercise.

2.8 Chapter Summary

This literature review chapter, a crucial section in a research project (Levy and Ellis 2006), set out to enlighten the scene. It aimed to show what is known about wellbeing at work focussing specifically on PALS worker wellbeing, and highlighted important gaps in this knowledge. In doing so, it has earnestly explored theories and models and critically engaged with a sample of research findings to paint a picture of this knowledge. It has portrayed that wellbeing, a holistic and global concept made up of both stresses and happiness, can impact the employee (e.g., anxiety or

engagement) and the organisation (e.g., absenteeism or productivity). In particular, in occupations where the biggest portion of one's time is spent dealing with people, employees report lower levels of wellbeing due to the heaviness of the emotional load that comes with managing their own emotions and the emotions of others. For PALS staff, a large proportion of the emotions that they have to manage are likely to be negative due to the nature of their role. The subject matter of these complaints and concerns are likely to be severe as they relate to the sensitive topic of medical care. PALS as NHS customer service representatives then have to calm and appease the patient and resolve the matter. However, research shows that complaints managers may fear being seen as troublemakers by other staff members.

Tentative data suggests that most PALS staff are of an administrative grade. This could be indicative that PALS workers are not awarded the authority necessary to perform their change agent role effectively. This could be partly due to PALS being viewed as 'customer service' as opposed to the argued 'expertise service'. Having to circumspect a complex political arena abound with media scrutiny, PALS staff may have to adopt different roles in performing their duties. This chameleon effect could have a detrimental influence on their wellbeing if not managed appropriately, for example by supervisor support. However, these assumptions at this stage, are merely speculations. In order to address this important knowledge gap, this research needs to investigate (1) what is the wellbeing of PALS workers in healthcare, (2) how this compares to other comparable occupations, (3) what work experiences may contribute to this wellbeing, and (4) whether these experiences are better or worse than the experiences of the UK general working population.

Some studies may make a more blatant contribution to knowledge by evidencing findings that are counter-intuitive and thus exciting to discover; others may make a less ostentatious contribution by confirming what may be obvious to some. This first quantitative study is an example of the latter. It is not a far stretch of the mind to imagine that employees engaged with complaints would experience impoverished wellbeing, however before this piece of research, that assumption would be a mere guess. And while inferences can be made from research evidence as to why they might experience low wellbeing, these too, at this stage, are simply inferences as no one has asked PALS staff how they feel and why. Although this research does focus on a sensitive domain and a very particular group of people, it does not mean that its findings are not useful for others. For example, while this study may assist job design interventions for PALS, there is no reason why this knowledge cannot be transferred to complaints staff more broadly, for example ombudsmen. Also, findings from this study may help advance the realisation that not all customer service workers engage in generic customer service, some actually perform professional level

services and others an expertise function. This distinction, of course, has serious implications for recruitment and selection, remuneration and staff development, and of course, the extent of support required to perform the role.

The second qualitative study also makes its own contributions by furthering knowledge on the positive aspects of wellbeing and motivation – although, at the current literature review stage, this was still unknown. At this point in time all that was known were the preconceptions listed above; for now the questions asked are simply:

RQ1: What is the wellbeing of PALS workers in healthcare?

RQ2: How does this wellbeing compare to other relevant occupational goups?

RQ3: What work experiences are associated with this wellbeing?

RQ4: How do these experiences compare with the experiences of the general UK working population?

To answer these questions the following study was done.

3. Methodology

Faced with the uncertainty around the wellbeing of PALS workers in healthcare, this study embarks on an assessment of how they feel at work. In order to achieve its objectives, it is first necessary to reflexively introduce the methodological decision making that took place prior to the commencement of empirical research. Following this, the steps taken during field work will be narrated; the participants, measures and processes will be detailed.

3.1 Introduction

Much like a doctor might do a white blood cell count to test for disease, researchers attempt to capture a psychological construct by measuring its indicators. So for example, to assess physical health, doctors may ask about diet, exercise, smoking etc. Similarly, to assess wellbeing, which is a latent and unobservable phenomenon, researchers need to ask symptomatic questions about its indicators, from which inferences can be made about wellbeing. In order to operationalise wellbeing, there is a need to return to the conceptual framework so that the chosen scale measures the same construct.

Chapter one has provided an interpretation of the term wellbeing and explained how the concept is employed in this thesis. In their recommendations for research, Danna and Griffin (1999) propose that wellbeing at work studies ought to explore both health aspects and broader satisfactions. This conceptual framework exposes that wellbeing is a composite and global concept. It is composite in that it includes both positives and negatives, and global in that it captures overall judgements as opposed to only domain specific feelings. Hence the chosen wellbeing measure needs to capture both of these conditions. In addition, as comparisons are made between PALS staff and other groups of workers, the measure ought to be comparable to the measures previously used in customer service research. For example if previous research in this field mostly uses questionnaire X but this study uses questionnaire Y then comparing responses may be affected as differences may simply be due to the scale. And finally, the measure also needs to have a certain amount of face validity – it needs to 'look' right. Measures ought to be read to see which items best capture the conceptual framework. Such *face validity* is often assessed by judging the fit of a measure to its relevant concept to see whether a questionnaire

appears to measure what it claims to measure (Bryman and Bell, 2007). In this case, face validity was appraised by wellbeing expert, Dr. Lewis, who is also this PhD's supervisor.In summary, the selection criteria for the measure are as follows: (1) theoretical: measures both composite and global wellbeing; (2) empirical: has been used in previous customer service research, and (3) pragmatic: good face validity.

Returning to the list of available measures depicted in chapter one (McDowall, 2006), the above selection criteria can be applied:

(1) The health opinion survey (Macmillan, 1957)
(2) The twenty two item screening score of psychiatric symptoms (Langner, 1962)
(3) The affect balance scale (Bradburn, 1965)
(4) The positive and negative affect scale (Watson, Clark, and Tellegen, 1988)
(5) The life satisfaction index (Neugarten and Havighurst, 1961).
(6) The Philadelphia geriatric center moral scale (Lawton, 1972)
(7) The general wellbeing schedule (Dupuy, 1978)
(8) The RAND mental health inventory (Ware, 1979)
(9) The health perceptions questionnaire (Ware, 1976)
(10) The General Health Questionnaire (Goldberg et al. 1997)

From the sample of 10 wellbeing measures, some are immediately not applicable. Number 1 as it is more of neurotic measurement, number 2 because it is a mental illness measure, number 3 because it is a coping measure, number 5 because it is aimed at an aging population group, number 6 same as 5, and number 9 because it measures beliefs as opposed to current state. To the remaining measures, the inclusion/exclusion criteria can be applied (Table 6).

Table 6 Wellbeing Measures

Measure	Composite	Global	Previous research	Face validity
The positive and negative affect scale	X	X		
The general wellbeing schedule	X	X		X
The RAND mental health inventory	X	X		X
The general health questionnaire	X	X	X	X

The General Health Questionnaire (GHQ) (Goldberg et al. 1997) is one of the most widely used mental health measures in occupational research and reports good validity and reliability (e.g., Hardy, Shaprio, Haynes, and Rick, 1999). It is a self-administrated test that explores participants' ability to carry out their normal functions and their experience of new events. Mental health is an individual and personal condition whose standards are influenced by culture (Jahoda, 1958). Western conceptualisations tend to consider the individual's attitude, their realisation of potential, functioning, independence, perceptions of the external world and ability to master life. It is a shortened version of the original GHQ60; Goldberg (1972) then omitted items that were specifically pertinent to physically ill individuals and the remaining 12 items made up the commonly used and shorter GHQ12 (Goldberg et al. 1997).Because wellbeing researchers are interested in long lasting affect (as opposed to brief transient passings) (Diener et al. 1999), the GHQ12 seeks to capture deviations from 'normal' and routine functioning. For example, after a particularly difficult one to one appraisal at work, an individual may experience sleep disturbance later that night. However, this sleep disturbance could simply be an exception; on all other nights, the individual may sleep fine. For this reason, the GHQ12 does not ask about current states (which could be transient and fleeting) but rather it aims to explore states that are different from what is 'usual' for that individual.

The GHQ12 (Goldberg et al. 1997) is a global measure as it investigates general mental health as opposed to domain specific mental health e.g., mental health at work. It is a composite measure as it captures both positive and negative mental health.In a sample of 9204 UK participantsHu et al. (2007)researchers conducted both Exploratory Factor Analysis and Confirmatory Factory Analysis using AMOS and conclude that the GHQ12 (Goldberg et al. 1997) measures two independent factors: - positive and negative mental health (Hu et al. 2007).The GHQ12 (Goldberg, et al. 1997) was previously used by Sprigg, Smith and Jackson (2003) in their evaluation of call centre wellbeing and work design. In this literature review this paper was identified as the most robust and rigorous investigation in the articles sampled. Finally, the measure was judged as having good face validity. It asks questions about the individual's ability to concentrate, make decisions, and face problems – phenomena that are known to be problematic during times of stress (e.g., Kinman and Jones (2005). Equally, it has items which capture enjoyment, usefulness perceptions, and confidence – positive indicators of sound mental health.

The GHQ12 (Goldberg et al. 1997) can capture psychological functionning, but an additional scale is needed that questions participants satisfactions with their work in specific. It is not sufficient to simply ascertain how someone is doing, but it also necessary to ask what the individual thinks of their own state. For this reason, it is important to also ask about job satisfaction; simply put, to

find out whether PALS workers are actually satisfied with their job. Amongst organisational scholars, job satisfaction is comically known as the Holy Grail (Landy, 1989). The reason why job satisfaction has been so attractive for theorists and researchers alike is its ability to explain the link between an employee's attitude and their subsquent performance at work. The interest in this link can be traced back to the Hawthorne studies (i.e., Mayo, 1949) where productivity increased as a result of being researched as participants felt important and enjoyed the attention. This impact has now been canonised as the Hawthorne Effect and evidences that how an employee feels can determine his/her performance. For the construct of job satisfaction, its awarded power comes from the happy-productive hypothesis. This is the belief that workers who are happy are more likely to be productive than workers who are unhappy (Brief, 1998). And job satisfaction has been the preferred operationalisation of happiness at work, with most organisational researchers using job satisfaction measures as an indication of happiness (Wright and Cropanzano, 2004). Certainly this decision can be questioned, for if wellbeing is a composite of eudaimonic elements and hedonistic aspects, then it follows that satisfaction would be an indicator of eudaimonia whereas happiness would be hedonistic. Although there are linked, it may not be necessary that job satisfaction on its own is a reflection of overall happiness, but rather a part of wellbeing.

Traditionally, job satisfaction scales have belonged to two camps: those that measure global satisfaction and those that discern between dimensions (Warr et al. 1979). Generally, there seems to be a tendency to shy away from simple 1-item global measures even though these were validaded decades ago (Scarpello and Campbell 1983). Some have criticised internal reliability as one cannot measure internal consistency in 1-item measures; others were not convinced by reported correlations between 1-item measures and dimension measures (Wanous et al. 1997). Others yet were perhaps uncertain about its face validity; afterall it does seems somewhat optimistic that one simple question could provide sufficient information. However, this time, it appears that one simple question does in fact provide no less information than multi-question dimension measures – a sort of reversed *lex parsimoniae* or Occam's Razor. Whereas Occam's Razor states that the simplest solution is often best, in this case, the simplest question is best. Since Scarpello and Campbell's (1983) positive conclusions, somewhat more recently Nagy's (2002) work confirms that 1-item job satisfaction scales are no worse than dimension measures. In fact, they may even be better for busy respondents where speed is important, and have been used in healthcare contexts to measure physician professional satisfaction (e.g., Haas et al. 2000). Hence Nagy's (2002) simple yet effective 1-item job satisfaction measure was selected to seek self-reflective information from participants. In summary, scores of GHQ12 (Goldberg et al. 1997) and job satisfaction interpreted together can reveal some information about participant wellbeing.

Further to this, a second objective of this study is to attempt to understand what sorts of work related experiences contribute to PALS worker wellbeing. In order to do so, a second measure was required; one that was domain specific, work focussed and able to capture the psychosocial conditions that influence wellbeing. In the UK, the Health and Safety Executive (HSE) act as the national watchdog for work related health; they are responsible for policy and the functional running of occupational health issues (HSE, 2013). When faced with alarming statistics on the cost of work related stress, which at time was estimated to be up to £381 million per annum, the Health and Safety Commission and the HSE spurred into action (MacKay, Cousins, Kelly, Lee, and McCaig, 2004). After a 'bottom up' qualitative consultation with numerous stakeholders in the spring of 1999, the consensus was to develop clear standards of good practice to prevent poor mental health through effective work design and sound management practices. The overall project methodology was a mix of qualitative approaches, such as workshops and discussions, and quantitative techniques such as factor analysis (Cousins et al. 2004). At the end of the process, the HSE compiled what is now known as the Management Standards to help educate organisations about the sorts of hazards one may find at work and how to manage these effectively as to minimise employee harm.

The Management Standards are guidelines to support organisations and assist them in meeting certain standards of wellbeing. From this guidance list, the HSE then constructed the Management Standards Indicator Tool so that organisations could measure their adherence to the standards and works towards meeting it. This tool thus aids organisations to assess their performance against the desired standard and to benchmark their state against other firms. Key to this approach is employee involvement; potential risk is assessed by evaluating the degree of agreement amongst employees. This not only ensures that identification of organisational hazards is reliable for "that particular group, at that particular time, and in that particular context" but also invites employee participation (Mackay et al. 2004, p.106). Hence although the HSE Management Standards Indicator is a quantitative tool, it is nevertheless context sensitive and participative in a bottom up fashion.

According to the HSE (Kerr et al. 2009b), there are six key areas of working life that ought to be managed appropriately in order to facilitate employee wellbeing (Figure 14 HSE (2013) Management Standards) The demands placed on employees, the control they have over said demands and the support they receive while fulfilling their obligations are said to job content standards (think back to the Demand-Control-Support model); while role at work, relationships with colleagues and organisational change pertain to the context of one's job.

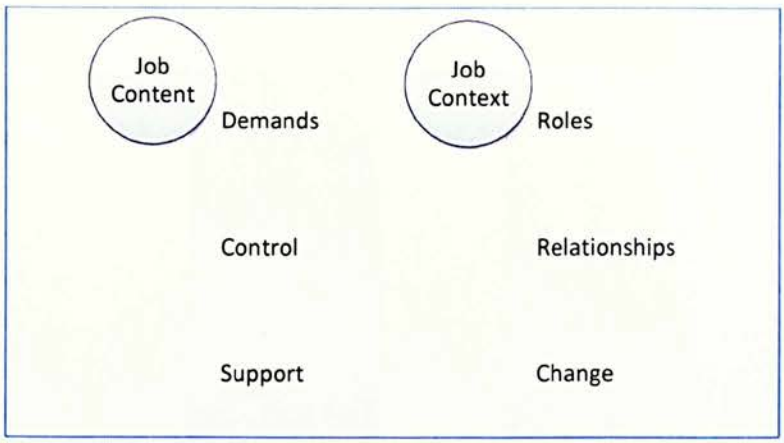

Figure 14 HSE (2013) Management Standards

As can be seen from the diagram above, the HSE Management Standards distinguish in a rather user-friendly manner the two key compositions of work life: job contents and job context. When considering the job content variables that are likely to impact on employee wellbeing, the HSE Management Standards include assessing workload and work patterns, the say employees have over the way they work, and the encouragement and supportive resources provided by the organisation to assist them in doing their work (Cousins et al. 2004). For example, it is advisable that up to 85% of the participating sample indicate that they are both able to deal with their workload and that systems are in place to address concerns should they arise. Regarding job context variables, the HSE Management Standards propose that organisations ought to promote positive behaviours and address unacceptable behaviour, ensure that employees understand their role and those requirements are not in conflict, and finally that organisational change is managed appropriately and communicated to staff. For example, in this case, it advisable that up to 65% of the participating sample indicates that they are consulted about change and permitted to participate, and that systems are in place to raise concerns.

A key methodological strength of using the GHQ12 (Goldberg et al. 1997) and HSE Management Standardsin a questionnaire is the option of benchmarking. This involves comparing and evaluating one's position against the position of referential others to see how one is doing (Al-Zoubi, 2012). The management literature is rife with recommendations for companies to use benchmarking (e.g., Dattakumar and Jagadeesh 2003, Voss, Ahlstrom, and Blackmon, 2013; Watson, 1993) while the psychological discipline has long made use of such comparisons for mental ability and personality testing (Mullarkey et al. 1999). Raw scores from questionnaires can explain the state of what is being investigated, but its informative power is limited until that state is compared to the state of similar others. So for instance, an individual may score 4 and think they are doing rather poorly, but to understand the meaning of '4', what it means to be at that

level, their score ought to be compared with the score of other indivdiuals. In one instance, others may be scoring 10, in which case the individual is indeed doing rather poorly. But in another setting others may be scoring 1.5, in which case, the meaning of scoring '4' takes on a different interpretation, one where scoring '4' actually means doing rather well when compared to others who are doing the same thing. In a way, although benchmarking from questionnaire data is largely a quantitative feat, the ontology behind it seems to be social constructionist as the meaning of scores is generated through social comparisons and what social groups agree to be high or low.

Using benchmarking comparisons with GHQ12 (Goldberg et al. 1997) data, PALS wellbeing scores can be analysed against other occupations. For instance, the literature review has argued that PALS staff do not simply perform mass customer service, but rather engage in high level problem solving and negotiations more similar to professional and expertise services. By benchmarking, it will be possible to tell whether PALS workers experience better or worse wellbeing than customer service employees and whether their wellbeing is more comparable to professional occupational groups. It has also been posited that PALS staff engage in high levels of emotion work due to the sensitive nature of their job role. Hence, it would be useful to compare their scores against the scores of benchmark groups such as social workers for instance. By doing this, the study will be able to discover how the wellbeing of PALS staff fares when compared to the wellbeing of other occupations (i.e., whether they feel better or worse than comparison groups).

Similarly, the HSE Management Standards indicator tool allows for benchmarking against the UK general working population. This will be able to discern how PALS staff are responding when compared to other UK workers in general. So for example, as public servants, PALS employees work in a highly political environment under media scruitiny, hence they might score particularly high on job context factors such as relationships at work. The one key disadvantage here is that while the GHQ12 (Goldberg et al. 1997) discerns between occupational groups, the comparable data provided by theHSE Management Standardsrefers to the UK general working population. This is a disadvantage as finer differences such as private versus public sector would have been insightful. Although this information was collected, it is accessible through paid consultancy routes and thus could not used in this PhD project.

In summary, in accordance with the conceptual framework of this thesis, wellbeing has been operationalised as health and satisfaction (Danna and Griffin, 1997). The GHQ12 (Goldberg et al. 1997) measures both positive and negative mental health and captures psychological and physiological symptoms. In complement, Nagy's (2002) job satisfaction will measure broader

satisfaction with work. To explore the second objective, work experiences have been operationalised as the HSE Management Standards to be measured by their indicator tool. Overall this questionnaire hopes to discover a number of things: First, it will find out how responding PALS staff feel. Then it will compare their scores with that of other workers and see how PALS fare against other occupational groups such as customer service employees. Finally, it will decipher the psychosocial work conditions that are associated with their wellbeing and benchmark their experiences against the UK general working populations.

3.2 Participants

As this piece of research is specifically concerned with PALS, the primary sampling strategy is purposive sampling; participants are not randomly selected but rather deliberately invited for their likely contribution to the subject matter (Bryman and Bell, 2007). In this study, participants were purposefully invited to partake in the research based on their job role: that of being a customer service agent engaged with feedback duties in the NHS. Three complimentary sampling approaches were employed to recruit participants: championing from the National PALS Network (NPN), cold calling and snowball technique.

The primary sampling consisted of championing from the NPN[2]. The NPN was a not-for-profit membership organisation supporting PALS and PALS work (National PALS Network, 2011). The organisation was contacted and their endorsement was sought. The chairperson, at the time, kindly uploaded the questionnaire on the NPN website. An email was then sent to their members with the invitation letter and a URL link to their website where the questionnaire could be accessed. A week before the questionnaire was due to close (26 March 2012), a reminder email was re-issued. In 2011, the NPN had a registered member list of 1 358 individuals consisting of 1 146 females and 212 males. This reported figure is unreferenced as the NPN does not collect a formal census and this data was kindly provided at the researcher's request in a personal email. However, this figure is not necessarily representative all PALS staff currently employed by the NHS as (1) guest registrations are available to interested parties, and (2) PALS memberships are not necessarily cancelled when leaving the NHS. This means that this study is unable to determine the response rate of this sampling technique as it cannot compute the ratio of the acquired sample compared to the population.

[2] The NPN has now shut down due to lack of funds

The other two sampling strategies include a combination of manual purposive sampling and snowball sampling. Email addresses of PALS staff were sourced by compiling a list of NHS Trusts in the UK and sending 'cold call' emails. A similar 'cold call' strategy was used by Ashforth, Kulik, and Tomiuk (2008) to invite service agents to participate in their study. The email contained an introductory invitation with an anonymous link to the questionnaire (see appendix 1) and a research summary explaining the overall project and its purpose (see appendix 2). Within the same email, participants were asked to forward the invitation to their colleagues in a similar patient feedback role. This is known as snowball sampling and consists of researchers making additional contacts through initial recruits (Rogelberg, 2004). Disadvantages of both strategies described above stem from its non-probabilistic nature, as such it cannot be determined whether wellbeing levels reported by the sample are experienced by all PALS staff in the NHS. However, as the questionnaire was made available to PALS nationally, was championed by their governing organisation, and was divulged by three different complimentary strategies, the study has sought a personalised and pluralist promulgation for participation.

Although it would now be customary to report response rates for the questionnaire, this study employed complementary sampling strategies simultaneously. As such it is not possible to decipher neither how many participants were recruited from each approach nor how many people received the invitation. This also means that analyses cannot differentiate between cohort effects. When data was being collected, there were 168 acute Trusts and 28 Strategic Health Authorities in England (The King's Fund, 2012). Hence, if at least one PALS employee worked in each, then there would be just under two hundred PALS staff employed in England in one year. So a sample of 100 would survey almost half of that population group. It is further unfortunate that the Health and Social Care Information Centre (2013), the national body that gathers the NHS census, does not singularise this particular group in their non-medical workforce list. This is a loss as PALS staff may fall under any number of sub-categories of support staff, and from the data provided in the workforce consensus it is not possible to determine their actual headcount.

In total, 138 PALS staff across England responded to all three invites and completed the questionnaire (Table 7). Out of 138 participants, 122 were female (89.1%) and 15 were male (10.9%). This finding is largely comparable to the general NHS gender ratio where 80.9% of non-medical staff are female and 19.1% are male (The Health and Social Care Information Centre, 2012). As such, the gender ratio of PALS staff is largely reflective of the greater number of women employed by the NHS overall; which provides support for the sample's representativeness. The implications of having a greater female to male ratio of staff in the largest employer in Europe

(NHS, 2013) could be considered however that discussion, albeit interesting, is beyond both the scope and theme of this study.

Table 7 Questionnaire Participant Demographics

	% participants
Gender	
Female	89
Male	11
Age	
Not disclosed	>1
20 – 29 years	6
30 – 39 years	14
40 – 49 years	32
50 – 59 years	42
60+	5
Band	
Not disclosed	4
Band 1	1
Band 2	0
Band 3	1
Band 4	19
Band 5	26
Band 6	26
Band 7	19
Band 8a	6
Band 8b	2
Years of experience with patient feedback	
Not disclosed	2
<5	33
5 – 10	45
11 – 20 years	20
Contract Type	
FT	110
PT	29
Not disclosed	1

As can be seen, most participants, at 42% of the sample, were between 50 and 59 years, followed by PALS workers aged between 40 and 49 years of age at 32% of the sample. The least represented age group was PALS employees aged between 20 and 29 years of age at a mere 6%; however this is somewhat reflective of the wider NHS age profile as less than 10% of administrative and support staff are under 24 years of age (Yorkshire and Humber 2010). This is also a positive indication for the sample's representativeness. The majority of PALS staff who responded to this questionnaire were either of bands 5 or 6 (25.7% each) which means they were

earning between £21 176.00 and £34 189.00 per annum[3] (NHS Terms and Conditions Handbook, 2011). Forty four percent of participants had between 5 to 10 years' experience of working with patient feedback and 20% had between 10 and 20 years' experience. Finally, 79% reported working more than 35 hours a week and 17 PALS staff from those indicated working more than 37.5 hours per week. A fair proportion, at 17%, worked part-time between 20 and 35 hours a week.

Table 8 Most Common Survey Participant

Gender	Female
Age	50-59 years
Band	5 or 6
Earnings	£21 176 - £34 189 p/a
Experience	5 – 10 years
Contract type	Full time
Hours worked	35 to 37.5 hours p/w

In summary (table 8), PALS workers who responded to the questionnaire were more likely to be women aged between 50 to 59 years at bands five or six earning between £21 176 and £34 189 per annum with five to 10 years' experience with patient feedback in full time contracts working between 35 to 37.5 hours per week (Table 8).Having discussed the sampling and participant profile, the next section will now discuss the measures used in greater detail.

3.3 Measures

As this research topic deals with the sensitive topic of mental health and asks for participants to share private and perhaps distressing information about themselves, it was important for the research ethos to actively involve participants in the methodological decision making process. While a questionnaire, by virtue of being prepared prior to participant involvement is a 'top down' tool; it is nevertheless possible to engage the population group in the development of the

[3]*Figures reflective of tax year April 2011 to April 2012 when this data was collected*

questionnaire, source their opinion and seek feedback. In this manner, some power may be awarded to participants; they are, after all, the experts of their condition. With these principles in mind, preliminary research was conducted prior to formally beginning this study. This preliminary stage was very much exploratory and intuitive; it is perceived as different from the literature review stage as primary data was actively sought out. The information gathered in this way coupled with the theoretical rationale explained in the introduction forms the overall justification for the measures used in this study.

In an iterative manner, unstructured interviews were conducted with nine PALS staff in eight anonymous London and Greater London trusts. Unstructured interviews take the form of a free flowing dialogue consisting of open ended general questions and award directional power to the interviewee (Firmin, 2008). Three discussions were face to face and six were conducted over the telephone. Willing participants were recruits through convenience sampling via professional networks, contacts and 'cold calls'. The aim of these unstructured interviews was to assess the overall practical significance of the project. In addition, two national conferences for PALS were attended and discussions were initiated with delegates. The aim of this ethnographically inspired approach was to figure out whether PALS staff did indeed want someone to investigate their wellbeing; did they believe this research question was warranted? This authentication was important as many of the preconceptions formed during the literature review were just that – preconceptions; and it was believed that in order to assess the underlying pragmatic value of the project, it was necessary to seek out actual PALS workers and source their opinions. While it is acknowledged that this piece of research is foremost a doctoral submission, and as such, an academic undertaking; it was nevertheless important that it still added value to organisations and employees in practice; its impact factor per se.

During this open and unstructured process, insight was gained into the job role by talking to actual PALS workers; the information obtained in this way was authentic and when combined with scientific evidence, made for rich data. For example, it was by engagement with PALS job descriptions that a preconception was formed about the emotion work inherent in the role; however it was through discussions with PALS staff that it was confirmed and authenticated via anecdotal evidence, initiating the imperative to explore it scientifically. Hence, issues pertinent to PALS staff as informed by PALS staff were noted. Together with theoretical backing and research evidence, these 'real life' issues helped to select which standardised measures would be included the overall questionnaire. The three measures described in the introduction were compiled into one questionnaire on the Qualtrix software: the GHQ12 (Goldberg et al. 1997), the HSE (2013)

Management Standards, and the 1-item JS scale. The reader is already somewhat familiar with these tools; now, example items are shown below.

GHQ12

The GHQ12 (Goldberg et al. 1997) is comprised of six positively worded and six negatively worded questions with responses rates on a four point Likert scale (Hu et al. 2007). The six positively worded items measure positive mental health, for example:

Have you recently felt capable of making decisions about things?	More so than usual	Same as usual	Less than usual	Much less than usual

And the six negatively worded items, test for negative mental health(Hu et al. 2007). For example:

Have you recently lost much sleep over worry?	More so than usual	Same as usual	Less than usual	Much less than usual

By using all 12 questions, global levels of overall wellbeing can be measured; by separating out the positive and negative scales, a distinction between positive and negative mental health can be made. Both the longer GHQ60 and the shorter GHQ12 (Goldberg et al. 1997) are validated measures of mental health (e.g., Banks et al. 1980; Hardy, 1999) with the advantage of the GHQ12 (Goldberg et al. 1997) being its shorter length making it quicker to complete. Internal consistency is computed at the higher end of the spectrum; past recommendations have ranged between 0.9 and 0.7 (Clark and Watson, 1995). In this study Cronbach's alpha = 0.93 which means that approximately 90% of the composite score would be considered as a true score. This is largely comparable to values reported in this field; on the lower end of the range are values such as 0.78 reported by Salama-Younes, Montazeri, Ismaïl, and Roncin (2009) and the one higher end are values between 0.82 and 0.90 (e.g., Guidi, Bagnara, and Fichera, 2012a).

HSE Management Standards

The 35 item HSE Management Standards Indicator Tool was included to measure the specific dimensions of (1) demands, (2) control, (3) support, (4) relationships, (5) role and (6) change. This is in line with Danna and Griffin's (1999, p.364) recommendation that organisational wellbeing research use both "generalised job related experiences" and "facet specific dimensions". The HSE (2012) recommend that the Management Standards indicator tool is incorporated into surveys; the measure itself has been psychometrically validated by Edwards, Webster, Van Laar, and Easton (2008). Responses are rated on a five point Likert scale, either conveying frequency, for example:

I have to work very fast	Never	Seldom	Sometimes	Often	Always
	☐	☐	☐	☐	☐

Or agreement:

I have some say over the way I work	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
	☐	☐	☐	☐	☐

A total of 35 items measure six different dimensions; internal consistency is reported below (Table 9):

Table 9 HSE Dimensions and Internal Consistency

Dimension	Items	Cronbach's alpha
Demand	3; 6; 9; 12; 16; 18; 20; 22	0.86
Control	2;10;15;19;25;30	0.83
Manager Support	8;23;29;33;35	0.92
Relationships	5;14;21;34	0.74
Role	1;4;11;13;17	0.86
Change	26;28;32	0.78

As with the previous measure, the HSE Management Standards Indicator Tool shows steady internal consistency: demands α= 0.86; control α = 0.83; manager support α = 0.92; relationships α = 0.74; role α = 0.86; and change α = 0.78. This is congruent with previous research where reported value range from 0.78 to 0.92 (Kerr et al. 2009a).

JS

Job satisfaction was measured using Nagy's (2002) 1-item measure on a 7 point Likert scale:

How satisfied are you with your job in general?	Extremely dissatisfied						Extremely satisfied
	☐ 7	☐6	☐5	☐4	☐3	☐ 2	☐1

A benefit of using a 1-item job satisfaction measure over a longer questionnaire is permitting participants to respond in less time without affecting psychometric properties (e.g., Nagy 2002;

Scarpello and Campbell, 1983). Such 1-item job satisfaction scales are being increasingly used by researchers (e.g., Main, Glozier, and Wright, 2005). In particular for this study, during the pilot stage (see section 3.2.3 procedures) the length of the questionnaire was highlighted; pilot participants noted that busy NHS staff would be more likely to complete a shorter questionnaire and that the pre-pilot version was too long. This means that the issue of time was found to be particularly pertinent for this population group making the use of a 1-item scale both theoretically sound and pragmatically justified.

3.4 Procedures

As briefly mentioned in the previous section, a pilot was conducted to assess the questionnaire's comprehension, user-interface and user-friendliness. Pilots are recommended to ensure that research tools function appropriately (Bryman & Bell, 2007); specifically for self-report measures, this step is particularly useful as researchers are not present when participants complete them. For this reason, it is helpful to pilot out a questionnaire so that potential hiccups are highlighted and addressed. The pilot stage, chronologically illustrated in Figure 15, began two years ago.

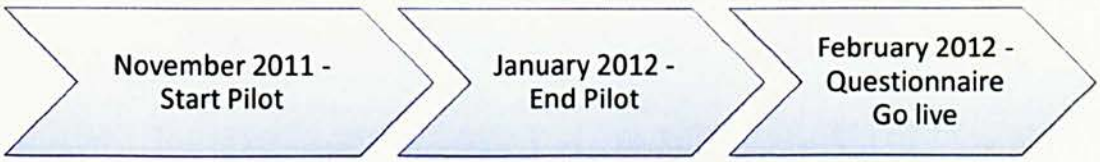

Figure 15 The Pilot Process

During the month of November 2011, a four part questionnaire was constructed consisting of a demographic section, the GHQ12 (Goldberg, et al. 1997), the HSE Management Standards Indicator Tool, and the Warr Job Satisfaction measure – a longer measure of job satisfaction. A qualitative pilot was conducted with four PALS workers who completed and commented on the questionnaire. PALS staff were recruited based on convenience and access – criteria generally used for selecting a pilot (Yin, 2009). PALS staff were contacted by email; two were sourced through professional networks and two were previous participants from the unstructured interviews. All PALS workers were asked to provide feedback specific to the questionnaire, for instance whether it was too long/too short and if the instructions were clear. Pilot participants were also encouraged to openly share their thoughts on the research overall. A psychometric pilot was deemed unnecessary as each measure has been independently validated in previous

research (e.g., Banks, Clegg, Jackson, Kemp, Stafford, and Wall, 1980; Edwards, Webster, Van Laar, and Easton, 2008; Goldberg, 1997; Nagy 2002; Scarpello and Campbell, 1983; Hardy, 1999).

The pilot was completed in January 2012 and three prominent areas of development were highlighted: (1) length, (2) clarity of instructions, and (3) repetitiveness of some sections. First, pilot participants noted that the questionnaire was too long to attract busy NHS staff. As the GHQ12 is already a shortened version and the HSE Management Standards tool is designed to measure different constructs of importance, it was the Job Satisfaction scale that was replaced with a 1-item measure to reduce the time needed to complete the questionnaire. Additionally, some demographic questions, for example those pertaining to ethnicity, were removed as theoretical justification for inclusion was not warranted. Finally, a completion bar was added to the questionnaire to better guide participants through the sections and signpost the end.

The second area of development noted by the pilot participants was the clarity of some instructions. Each instruction was then revisited and re-worded to enhance clarity. For example, prior to the recommended GHQ12 instructions, additional information was provided about the purpose of the measure by including the statement: *The following questions will ask you about your wellbeing*. Furthermore, additional signposting was included to explicitly guide the participant through the different measures. For example, between sections where the Likert scale changed format, instructions were added to highlight the new scale format by including statements such as: *Please select the option that best describes your working conditions from 'never' to 'always'*.

Finally, pilot participants advised that some sections were repetitive. These repetitions however form part of the measures in question and it is not possible to remove them without affecting the psychometric properties of the scales. To address this, encouraging comments such as *Thank you for your patience* were added between sections. Reflecting back, it may seem that many of the noted areas of development, for example the completion bar, should have been obvious; however at the time, they simply were not. The strength of the pilot in this case was providing a learning opportunity and gaining experience. There were still some points that were not flagged up during the pilot but that emerged later, for example, the fact that the questionnaire asked about a 35 hour working week assuming that this was the norm. As a result, a disproportionate number of respondents selected above 35 hours, but the meaning behind this choice was redundant as it did not necessarily imply that they were working above the weekly average. This, for instance, is something that could be done differently if the study was repeated now with more research experience than was the case in 2011.

Based on the feedback received from the pilot process, the final questionnaire was compiled and consisted of four parts (see appendix 3).The prelude to the questionnaire consisted of a welcome message, informed consent, demographics and Nagy's (2002) 1-item job satisfaction measure. As this scale consisted of simply one question, it was not deemed necessary to provide it a separate section on its own but rather it was included at the end of part one.

Following this, part two was introduced by signposting the participants and the recommended GHQ12 instructions. This part consisted of 12 items. Part three was signposted as 'final part', participants were thanked for their participation so far, and the HSE instructions were included. This part consisted of 35 items. The questionnaire was closed by thanking participants once again, offering researcher contact details for a final report should they wish one, and inviting them to participate in the qualitative study. Lastly, participants were provided with a comment box to share any additional comments. The final version of the questionnaire went live in February 2012.

Upon receipt of the completed questionnaires, the data was first cleaned as to keep only useable questionnaires. Participants who simply completed one or two questions were deleted. The total number of deleted questionnaires is 21 as information provided was simply not sufficient. It is difficult to determine why participants chose to leave the study; perhaps the questionnaire was exhausting or too personal and participants changed their minds. Two participants who completed the GHQ12 but not the HSE Management Standards were considered as 'usable' as all questions in the first measure were answered. Basic descriptives were then computed for demographic data and the job satisfaction scale. The latter required no recoding as the 7 point Likert scale is simple – the higher the score the higher the indicated job satisfaction. Basic frequencies were computed for this measure. Then, the values for the GHQ12 (Goldberg et al. 1997) and the HSE Management Standards were recoded. The details of the GHQ12 (Goldberg et al. 1997) scoring are first discussed, followed by the HSE (2013) Management Standards.

The GHQ12 (Goldberg et al. 1997) may be used to measure both positive and negative mental health (Hu et al. 2007). It can be scored in two primary different ways: binary and Likert (Stride, Wall, and Catley, 2007). Each of these has modifications, respectively C-GHQ and modified Likert. The method recommended by its author Goldberg et al. (1997) is the binary scoring (Hardy 1999) also known as the GHQ scoring (Charbotel et al. 2009) and caseness method (Spriggs, Smith and Jackson 2003). The GHQ binary scoring method treats each item as a possible symptom that is either present or absent while the Likert scoring method discriminates between frequency changes in symptoms (see Table 10). In other words, the binary coding can assess whether or not

a symptom is present while the Likert scoring can determine the extent to which it is present (e.g., 'rather more' versus 'much more' compared to the usual experience).

Table 10 GHQ Distress Scoring Example

Have you recently lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
GHQ binary scoring	0	0	1	1
Likert scoring	0	1	2	3

In the example above, the GHQ binary scoring is able to determine whether the participant is losing sleep over worry compared to their usual experience. By using the 0-0-1-1 coding, the measure may tell whether or not the participant is losing sleep over worry (i.e., whether the symptom is present) but cannot ascertain the degree to which it is present as it collapses columns. In order to determine the degree to which the symptom is experienced, the Likert scoring may be used as this distinguishes between categories of answers by coding 0-1-2-3. Additionally, the Likert scoring method is more sensitive to chronic cases as it will pick up instances of persistent symptoms unlike the binary system which collapses *'not at all'* with *'no more than usual'*. Banks et al. (1980) suggest using the Likert scoring when using parametric tests as the data is represented in more even distribution of scores. Obviously, high scores are indicative of high strain.

For positive wellbeing on the other hand, the binary coding collapses all options other than an increase in frequency (Hu et al. 2007); while the Likert scoring may be reversed to compute parametric tests (Table 11). In this version, high scores are indicative of happiness.

Table 11 GHQ Positive Wellbeing Scoring Example

Have you recently felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less than usual
Positive Wellbeing Binary	1	0	0	0
Positive Wellbeing Likert	3	2	1	0

While some authors (e.g., Mullarkey, et al. 1999; Stride, Wall and Catley, 2007) note that there is little difference between binary scoring and the Likert method when it comes to identifying cases, others (e.g.,Hankins, 2008) have however noted some error in the negatively worded items and false negatives (e.g., Whaley, et al. 2005). Critics argue that because the questionnaire asks participants to compare their present state with 'recent' experiences, chronic cases of persistent symptoms may not be reflected in scores (as what the individual is recently experiencing are similar to previous experiences, albeit on the poor end of wellbeing). To address this critique, studies tend to adopt both binary and Likert scoring methods (e.g., Charbitel et al. 2009; Spriggs, Smith and Jackson 2003) and as such this research also reports findings interpreted from both scoring perspectives. For this research, these scores were then compared to benchmarking data provided in Stride, Wall and Catley (2007) which is the benchmarking manual. By conducting basic t tests and assessing the Standard Error of Measurement (SEM), significance levels between this sample and the benchmarking samples were computed using PASW.

The recommended threshold for indicating caseness (e.g., the individual is experiencing a symptom either 'rather more' or 'much more' than usual) varies in the literature. For example, Goldberg et al. (1997) suggests 1/2, Picardi, Abeni, and Pasquini (2001) advise 3/4, while Whelan et al. (2008) used 4. Makowska, Merecz, and Kolasa (2002) found that a cut-off point of 3/4 has the lowest misclassification error rate; and hence this study opts for the 3/4 threshold as not to pathologise participants. For analysis, overall wellbeing scores were computed to determine global wellbeing level of the sample (i.e., using all 12 items). Then, differences between happiness and distress scales were measured. Having explained the GHQ12 (Goldberg et al. 1997) analysis technique, now the HSE Management Standards scoring will be discussed.

The HSE Management Standards is measure of six occupational areas that influence wellbeing: (1) demands, (2) control, (3) managerial support, (4) peer support, (5) relationships, (6) role, and (7) change. Questions pertaining to 'demands' and 'relationships' were reverse coded so that high scores would indicate favourable conditions while low scores undesirable hazards [1→5; 2→4; 3=3; 4→2; 5 →1]. The mean for each dimension was then calculated and compared to benchmarking data from the HSE manual (HSE, 2004). As observed by Packham and Webster (2009) mean scores between constructs are not comparable. In other words, the mean for 'demands' cannot be compared to the mean of 'control'; instead each construct needs to be compared to itself either in different time periods or between organisations. The sample scores were then benchmarked against the HSE recommended organisational data (The Health and Safety Executive 2010). In addition to this, statistical explorations were conducted on PASW to explore the data and its relationship with the GHQ12 (Goldberg et al. 1997) scores.

First correlations were conducted to examine bivariate relationships amongst the variables. Following this hierarchical multiple regressions were computed to examine the variance explained in each dependent variable (i.e., wellbeing, job satisfaction) and independent variable (Management Standards dimensions) while controlling for gender. In hierarchical regressions the variables are entered based on theory and research (Pallant, 2004); in this case, gender was used as a control variable based on research precedence (e.g., Guidi, Bagnara, and Fichera, 2012; Kerr et al. 2009; Main et al. 2005). First, as per Field's (2009) recommendation, assumptions were checked. Data exhibited neither heteroscedasticity nor non-linearity; plots of *ZRESID and *ZPRED displayed assumptions as met. Histograms and P-Plots represented normally distributed data. After this, box plots were checked for outliers to assess whether any case differed so substantially from the remainder of the data that it distorted it; no outliers were found. Cook's distance was then verified to ensure no cases were greater than 1; as all values were < 1 it was ascertained that no cases would pressure undue influence on the results. Independence of errors was inspected by the Durbin-Watson test; values less than 1 and greater than 3 can be concerning (Field, 2009). In this sample, there was no evidence of auto-correlation. Finally, multicollinearity was assessed by VIF values; as no variable presented with the recommended greater than 10 threshold (Myers, 1990), it was deduced that a disproportionately strong correlation was not present amongst variables. For these reasons, it was concluded that assumptions were met.

To address each research question, different computations were conducted. To determine the level of wellbeing of PALS workers, happiness and job satisfaction scales were analysed, followed by distress. These two calculations provide a global appreciation of wellbeing levels comprised of both happiness and distress. Next, to understand how PALS worker wellbeing compares with the wellbeing of other workers, data from this study was benchmarked against various occupational groups (e.g., customer service, social workers etc). To compare the wellbeing scores of PALS to other occupational groups from the benchmarking manual, the Likert scoring is used as this is recommended for parametric tests such as t tests (Stride, Wall and Catley, 2007).

Lastly, to address the final research question of trying to uncover the reasons why PALS staff may experience the wellbeing they report, the relationship between variables were then explored in greater depth by performing hierarchical multiple regressions. As recommended by Field (2009) gender was first recoded (1→0; 2→1) then entered into a regression model predicting wellbeing (Likert scoring) as Step 1; this was followed by the HSE Management Standards dimensions in Step 2.Having explained the methodological steps and their governing decision making processes, the next section will now announce the results.

3.5 Research Ethics

Before embarking on this research project, ethical approval was sought from and granted by the Kingston University ethics committee (see appendix 4). During this process the university's research ethics committee went over the project proposal as well numerous supporting documentation that explained the research design. Compiling this application was extremely useful; it allowed deep reflection about the project, planning for the unexpected and the possible impact it may have on participants.

Informed consent was rendered at the start of the questionnaire, on the welcome screen. Here, participants accepted to partake in the research and gave their permission for their anonymous responses to be used for research purposes (Figure 16). The welcome screen informed participants that their engagement was entirely voluntary and that their responses would be strictly anonymous. It also detailed an approximation of how long it would take to complete the questionnaire and gave a brief description that it would question their wellbeing, work and feelings about their work. This was only a very synoptic message at the start of the questionnaire, before reaching this stage participants were already introduced to the project in the email (appendix 1) and given the more detailed research brief (appendix 2).

Welcome. Thank you for your interest in our research. This questionnaire will explore the occupational wellbeing of front line service professionals such as yourself who work in the crucial role between service users and service providers. Your participation is entirely voluntary and all information provided is strictly anonymous.

The questionnaire will take about 15 minutes to complete and consists of different questions about your wellbeing, your work, and your feelings about your work.

I would like to participate in this research:
YES
NO

Figure 16 Informed consent

Should anyone not wish to participate, the software provided an 'opt-out' option where they would be taken to an alternative screen and thanked for their time. It would have been useful to have included additional information on the right to withdraw and data storage; not in the questionnaire as this could make it cumbersome to navigate, but in the research brief. It is also worthwhile to point out that when the project was being conceived, the original idea was to

conduct focus groups after the questionnaire. As this thesis will soon reveal, interviews were conducted instead. It is difficult to guess how one might avoid such changes in research procedures; certainly in projects that span a few years a few amendments are likely to be unavoidable. At times, it may be necessary to be flexible, and after acquiring more knowledge, develop one's initial ideas.

3.6 Summary

The previous chapter showed that customer service workers are not a homogenous group. It extended van den Broek's (2003) argument by explaining that some call centre workers, similar to PALS staff, engage in expertise services that require higher levels of problem solving and award greater autonomy to the employee than generic customer service which is characterised by routine tasks (e.g., sending out technicians). While writing the literature review, the methods sections of empirical papers were carefully read to pick out sample characteristics and their tasks were catalogued. From this attention to detail came the evidence that the majority of studies reviewed measured wellbeing in groups of mass production call centres workers – employees who engage in rather different tasks than PALS employees. Due to this quite significant dissimilarity in role (please return to section 2.4 for the more comprehensive discussion on this difference), it was then argued that customer service wellbeing findings are not transferrable to PALS staff. Hence, to address this notable gap in the literature, the first research question posed by this study asks the open and exploratory:

RQ1: What is the wellbeing of PALS workers in healthcare?

Only one paper by Bakker et al. (2003) was found where employees with complaints duties were sub-sampled as part of the largest overall sample. Their results indicate that this sub-group scored higher on emotional exhaustion, repetitive strain injury and sickness absence. However this group was only one of four employee types being sampled and the overall research was not about measuring wellbeing, hence it would be too imprudent to generalise based on such limited evidence. To explore this tentative preconception further, the second research purpose questions:

RQ2: How does this wellbeing compare to other relevant occupational goups?

Then the literature review moved on to discuss evidence gathered in the new emergent field of healthcare management. Through this inter-disciplinary review, it was found that PALS staff adopt different identities in their interactions with patients (Abbott et al. 2006) placing them at risk of

role conflict and ambiguity which can hamper performance (Tubre and Collins, 2000) and impact wellbeing (Stamper and Johlke, 2003). By considering research on NHS complaints managers, it was found that status in the organisation played a role in supporting or inhibiting investigations (Xanthos, 2008) and by looking at PALS (2006) documentation it was discovered that PALS staff report feeling undervalued. The interest to unravel such factors that influence PALS worker wellbeing led to the development of the third research question:

RQ3: What work experiences are associated with this wellbeing?

And finally, as to assess how the psychosocial conditions of PALS staff fare in comparison to other UK workers, the last research question asks:

RQ4: How do these experiences compare with the experiences of the general UK working population?

4. Results

Wellbeing is a global concept (Lutterbie and Pryce-Jones, 2013) made up of both positive and negative evaluations (Danna and Griffin, 1999). The GHQ12 (Goldberg et al. 1997) is composed of two factors: one scale measuring positive mental health and another capturing symptoms of poor mental health (Hu et al. 2007). Taken with Nagy's (2002) job satisfaction scale, these two measures permit inferences to be made about participant wellbeing. Additionally, the HSE Management Standards explore work related experiences and benchmark these against the UK general working population. .

4.1 RQ1: What is the wellbeing of PALS workers in healthcare?

Measuring Positive Mental Health

The GHQ12 (Goldberg et al. 1997) was used to measure the wellbeing of participating PALS staff. One hundred and thirty seven participants responded fully to these questions, hence n=137. Table 12 below reports the results of the positive scale comprised of 6 items.

Table 12 GHQ12 Positive Mental Health (Binary)

	n	Mean	Std D	SEM
Participants	137	0.24	0.68	0.58

When positively worded items are used 16.1% of PALS staff who completed this questionnaire report to feeling at least 1 positive state either more frequently than usual or the same (Figure 17).

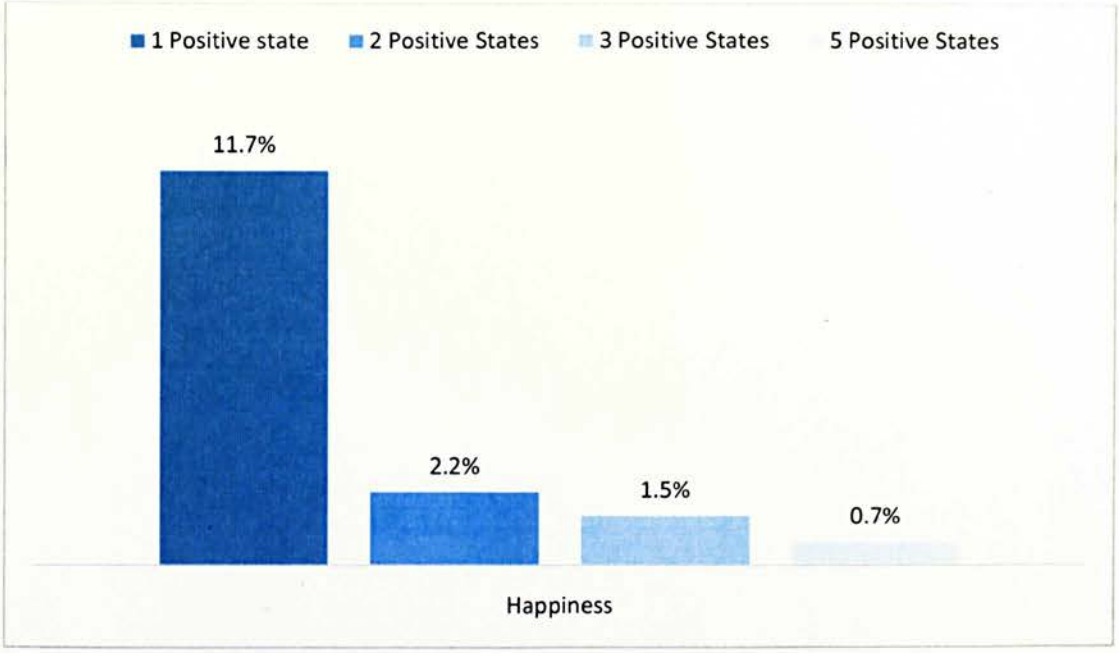

Figure 17 GHQ12 Happiness Trends

Item specific data indicates that 10% of the sample feels they are playing a useful part in things 'more so than usual' while almost half indicate no change. Also, 5% of the sample indicates that they are more able than usual to face up to their problems while 65% reports no change in their ability. Overall, these results propose that while responding PALS staff are not ecstatically happy, 1 in 6 do experience positive mental health, particularly when it comes to feeling useful and facing up to their problems.

Measuring Job Satisfaction

Next, job satisfaction analysis reveals that, in fact, respondents are largely satisfied with their job with scores representing a positive skew (Table 13).One additional participant responded to this question.

Table 13 Job Satisfaction Results

	n	Mean	Std D
Participants	138	4.48	1.5

Up to 75% of participating PALS staff indicate some level of job satisfaction while the greatest proportion of respondents, at 34.8%, chose the score of 5 as reflective of their job satisfaction level. Less than 3% confess to feeling extremely dissatisfied and double that, almost 6%, profess

to feeling extremely satisfied with their job. Overall, it appears that based on their answers, participants are largely satisfied with their job.

These two scales (happiness and job satisfaction) taken together, although not euphoric, do appear somewhat promising. Up to 1 in 6 participating PALS staff records favourable mental health and approximately 75% say they experience some level of job satisfaction.

Measuring Negative Mental Health

To calculate the negativefactor, the traditionally recommended binary scoring was used in the first instance (Goldberg et al. 1997); Table 14reports the results.

Table 14 GHQ12 Binary Results

	n	Mean	Std D	% ≥3	%≥4
Participants	137	5.19	4.15	56.2	48.2

When using the presence of three or more symptoms as the threshold, 56.2% of the sample are experiencing poor mental health. When this cut off point is increased to 4 or more symptoms then 48.2% indicate experiencing poor mental health. As an approximate, it appears that about half of the respondents report poor levels of mental health.

The greatest experience reported is constant strain. Twenty three percent of participants indicate feeling constantly under strain 'much more than usual' and 51% report 'rather more than usual'. Overall a staggering 74% indicate increased feelings of constant strain. When it comes to being unhappy and depressed, the sample seems divided; almost half appear to experience more frequent feelings of unhappiness and depression while again almost half either experience 'no more than usual' or 'not at all'. Nevertheless 13.8% confess to feeling unhappy and depressed 'much more than usual'.

In summary, from the calculations of positive and negative mental health, and satisfaction it can be said that PALS staff are reporting somewhat paradoxical wellbeing. While not a particularly large proportion are reporting favourable mental health at 16%, quite a high percentage, between 48% and 56% of the sample are indicating distressing mental health. Counter-intuitively, a disproportionate number of participants, at 75%, are indicating some level of satisfaction with their job with a score of 5 being the most often selected descriptor while 73% are reporting a high incidence of strain. In layperson terms, from the data, it appears that participating PALS staff are

simultaneously experiencing distressing mental health and job satisfaction with 1 in 6 reporting favourable mental health. The greatest experience of poor mental health is being reported as high strain with up to 73% of the sample indicating an increase in strain recently.

4.2 RQ2: How does this wellbeing compare to other relevant occupational goups?

To assess how the wellbeing of PALS workers compares to other customer service workers, significance tests were carried out using *t* tests and the data provided in the Stride, Wall and Catley (2007) benchmarking manual. This allows assessment of whether the mean between PALS staff from this sample and other occupational groups are statistically different.

Data from the previous RQ1 reveals that up to 56% participating PALS staff are experiencing distress. Reviewing Table 15, it can be seen that PALS staff from this sample score statistically worse on wellbeing than benchmarking sales and customer service groups (M=1.05, SD= 0.50] t=6.59 (df=136) p <.001** 95% CI [0.23, 0.42], private sector financial services call centre operatives (M=0.96, SD=0.46) t=8.40 (df=136) p <.001** 95% CI [0.32, 0.51] and mixed industry call centre workers (M=1.10, SD=0.51) t= 5.57 (df=136) p <.001** 95% CI [0.18, 0.37]. Finally the wellbeing of this sample was compared to that of city council workers as an example of other public service work and PALS still scored statistically lower (M=1.10, SD=0.54) t=5.57 (df=136) p <.001** 95% CI [0.18, 0.37]. Overall it appears that PALS staff experience statistically worse wellbeing than customer service workers.

Table 15 Wellbeing benchmark: t test results

Benchmark	Mean	Std D	t	df	Sig.	CI Lower	CI Upper 95%
Statistically worse wellbeing than:							
Sales/customer service	1.05	0.50	6.59	136	.000	0.23	0.42
Call centre (mixed)	1.10	0.51	5.57	136	.000	0.18	0.37
Call centre (finance)	0.96	0.46	8.40	136	.000	0.32	0.51
Administrators	0.97	0.47	8.20	136	.000	0.31	0.50
NHS administrators	0.95	0.45	8.61	136	.000	0.33	0.52
NHS managers	1.07	0.50	6.18	136	.000	0.21	0.40
Health and Social Care	1.01	1.01	7.39	136	.000	0.27	0.46
City council	1.10	0.54	5.57	136	.000	0.18	0.37
Local authority	1.20	0.56	3.55	136	.001	0.08	0.27
PALS staff from this study	**1.37**	**0.58**	-	-	-	-	-
No difference than:							
Civil service social workers	1.22	0.57	3.14	136	.002	0.25	0.58
Police	1.23	0.50	2.94	136	.004	0.24	0.48

Further investigations reveal that PALS staff report poorer wellbeing than administrators as well (M=0.97, SD=0.47), t=8.20 (df=136), p <.001** 95% CI [0.31, 0.50]. When this data was compared to the healthcare sector, PALS staff were found to report worse wellbeing NHS administrators (M=0.95, SD=0.45) t=8.61 (df=136) p <.001** 95% CI [0.33, 0.52] and even NHS managers (M=1.07, SD=0.50) t=6.18 (df=136) p <.001** 95% CI [0.21, 0.40]. When benchmarked against to the wider industry of Health and Social Care, PALS workers from this sample indicate more distress(M=1.01, SD= 1.01) t= 7.39 (df=136) p <.001** 95% CI [0.27, 0.46]. In fact, their wellbeing only begins to look comparable when assessed against social workers (M=1.22, SD=0.57) t=3.14 (df=136) p <.001 95% CI [0.25, 0.58] and the police (M=1.23, SD=0.50) t=2.94 (df=136) p <.001 95% CI [0.24, 0.48], with results showing no statistically significant difference between their wellbeings.

In summary, the data from this study's PALS participants was compared to benchmark occupational groups from the GHQ12 manual(Stride, Wall, & Catley, 2007). PALS staff from this

sample indicated lower wellbeing than customer service groups such as call centre workers, retail employees and public sector city council workers. They also fare worse than administrative workers and reported worse wellbeing than workers in the healthcare sector more broadly. It was only when PALS worker wellbeing was compared to two occupations with traditionally a high incidence of distress (Kinman and Jones, 2004) – social workers and police, that participants' scores reported better wellbeing. Overall, based on the data, it seems that participating PALS staff feel worse than customer service workers, administrators and even NHS managers; but that there is no statistically significant difference between the wellbeing of PALS staff and that of social workers and the police.

4.3 RQ3: *What work experiences are associated with this wellbeing?*

This third RQ investigates the psychosocial conditions at work that may be associated with the wellbeing of PALS staff. Using the HSE Management Standards, the dimensions of (1) demands, (2) control, (3) management support, (4) relationships at work, (5) role, and (6) change were measured and their impact on wellbeing scores was tested using regressions. As with the first RQ, wellbeing is looked at from three dimensions: happiness, job satisfaction, and distress. Hence, the aim of this RQ3 is to determine which psychosocial conditions contribute to participant (1) happiness, (2) job satisfaction and (3) distress scores. To do this, hierarchical multiple regressions were conducted with the HSE Management Standards dimensions and each wellbeing dimension. First, descriptive statistics for each Management Standards dimensions are provided inTable 16.

Table 16 HSE Management Standards Dimension Descriptives

Dimension	Mean	Std. Deviation
Demands	2.74	0.73
Control	3.68	0.74
Management Support	3.29	1.04
Peer Support	3.57	0.77
Relationships at work	3.58	0.78
5Role	3.89	0.74
Change	2.82	0.84

Bivariate explorations are shown inTable 17. All correlational are significant at $p<0.001$, except for the dimensions of role and demands which are significant at $p<0.05$.

Table 17 Correlations Table

	Demands	Control	Management support	Peer support	Relationships	Role	Change	JS	PMH	NMH
Demands	1									
Control	0.39**	1								
Management Support	0.45**	0.46**	1							
Peer	0.43**	0.42**	0.59**	1						
Relationships	0.49**	0.40**	0.61**	0.52**	1					
Role	0.20*	0.45**	0.55**	0.51**	0.37**	1				
Change	0.51**	0.55**	0.65**	0.45**	0.54**	0.50**	1			
Job satisfaction	0.39**	0.35**	0.54**	0.50**	0.37**	0.52**	0.43**	1		
PMH	0.53**	0.31**	0.44**	0.40**	0.45**	0.40**	0.48**	0.48**	1	
NMH	-0.56**	-0.35**	-0.45**	-0.42**	-0.50**	-0.50**	-0.52**	-0.50**	-0.94**	1

*$p<0.05$;**$p<0.001$

As can be seen, there is correlation amongst the variables which means that these constructs share a relationship. Next regressions were computed.

Table 18Positive Mental Health and Management Standards Multiple Regressions

	PSM	
	Step 1	Step 2
	β	β
Step 1		
Gender	0.12	-0.06
Step 2		
Demands		0.38**
Control		-0.08
Management support		0.02
Peer support		0.03
Relationships		0.12
Role		0.19*
Change		0.14
Summary Statistics		
R^2	0.01	0.41
Adjusted R	0.01	0.37
F value	1.77	11.2**

*$p<0.05$; **$p<0.001$*

As can be seen from Table 18, the HSE Management Standards dimensions model accounted for 41% of the variance in positive mental healthscores $R^2=0.41$, $F(7,117)=11.2$, $p<0.001$. It was found that both demands ($\beta=-0.38$, $p<0.001$) and role ($\beta=-0.10$, $p<0.05$) are significantly associated withthese scores. As some of the HSE Management Standards constructs have been reverse scored so that high scores indicate a positive condition, these results means that positive mental health scores also increase (i.e., good condition), demands and role scores increase (i.e., good condition).In other words, the more favourable the demands at work and the better the role, the better the mental health of PALS staff is likely to be.

Next, hierarchical regression scores were analysed between job satisfaction and the HSE Management Standards (
Table 19).

Table 19 Job satisfaction and HSE Management Standards Regressions

	Job Satisfaction	
	Step 1	Step 2
	β	β
Step 1		
Gender	0.19	2.59
Step 2		
Demands		0.19*
Control		-0.01
Management support		0.28*
Peer support		0.15
Relationships		-0.07
Role		0.26**
Change		0.00
Summary Statistics		
R^2	0.04	0.45
Adjusted R	0.03	0.41
F value	4.64	12.47

*$p<0.05$;**$p<0.001$

The data shows that 45% of the variance in job satisfaction scores $R^2=0.45$, $F(7,118)=12.47$, $p<0.05$ is related to the HSE Management Standards dimensions. Demands ($\beta=0.19$, $p<0.05$), management support ($\beta=0.28$, $p<0.05$) and role ($\beta=-0.26$, $p=0.001$) are significantly associated with participant job satisfaction scores. As job satisfaction scores increase (i.e., good condition), participants also score higher on demands, management support and role (i.e., good condition).

Finally, the relationship between the HSE Management Standards and distress scores was considered in Table 20.

Table 20Negative Mental HealthRegression Results

	NMH	
	Step 1	Step 2
	β	β
Step 1		
Gender	-0.08	-0.06
Step 2		
Demands		-0.43**
Control		0.06
Management support		0.06
Peer support		-0.02
Relationships		-0.16
Role		-0.29**
Change		-0.13
Summary Statistics		
R^2	0.01	0.50
Adjusted R	-0.00	0.46
F value	0.74	16.29

**p<0.05; **p<0.001*

As can be seen, the model was able to account for 50% of the variance in negative mental healthscores R^2=0.50, F(7,117)=16.29, p<0.001. It was found that both demands (β=-0.43, p<0.001) and role (β=-0.29, p<0.001) are significantly associated withdistress scores. In this case, the relationship has a negative association. As distressscores decrease (i.e., good condition meaning less distress), participants begin to report better demands and role conditions.

In summary, forty one percent of the variance in positive mental health scores, 45% of the variance in job satisfaction and 50% of the variance in negative mental health scores are described by the HSE Management Standards. In particular, responses on the demands and role dimensions are statistically significantly associated with both positive and poor wellbeing scores. For job satisfaction, the additional variable of management support also has a statistical impact on scores. In answering the third RQ, it could be said that up to half of participants' global happiness and distress scores have a relationship with psychosocial conditions at work;

particularly, demands and role, while job satisfaction is additionally influenced by management support.

4.4 RQ4: How do these experiences compare with the experiences of the general UK working population?

The responses from the Management Standards indicator tool were then compared to the HSE organisational benchmarking data taken from a survey of 136 companies (The Health and Safety Executive 2010); ranking and relevant action points are presented in Table 21.

Table 21 HSE Dimension Benchmarks

Dimension	Benchmark Ranking (percentile)	HSE Colour Code*
Control	Between 75th and 80th	Aqua
Management Support	Between 20th and 25th	Yellow
Change	Between 20th and 25th	Yellow
Relationships	Between 15st and 20th	Red
Peer Support	Between 10th and 15th	Red
Demands	Between 5th and 10th	Red
Role	Between 5th and 10th	Red

**Green=very good, maintain. Aqua=good, can improve. Yellow=clear need to improve. Red=urgent action required.*

From this data, it is visible that PALS staff in this study report no *green* dimension representative of their organisation's *very good* performance; the highest colour code attained is *aqua*. The dimensions of control fares the reported best with results indicating that scores range between the 75th and 80th percentile of the benchmarking data indicating *good* performance with some room for improvement. Both management support and change rank between the 20th and the 25th percentile when compared with the benchmarking data indicating a clear need for improvement, while demands, peer support, role, and relationships require urgent action. The worst reported psychosocial dimensions are demands and role ranking between a meagre 5th and

10th percentile – the same dimensions which were found to be significantly associated with wellbeing scores.

In this sample, while 63% indicate often or always being clear about work expectations, 27% still report being only sometimes clear while 11% indicate seldom experiencing clarity. When it comes duties and responsibilities, 4% are either seldom or never clear while 27%, as previously, are clear at times and unclear at others. There are appears to be somewhat more confusion about the organisation's aims with 13% report being seldom clear and 24% being sometimes clear. Although these percentages may not appear overtly poor, they are when benchmarked against other UK workers. For instance, above the 45th percentile, the general working population selects full scores this dimension. Hence these overinflated full scores mean that scores which would otherwise be considered high are now comparably low.

Sitting along the same percentile level, between 5th and 10th, is the demands dimension. Participants report often (19%) or always (12%) having to work to unrealistic time pressures, while often (46%) and always (30%) having to work intensively and often (46%) and always (18%) doing so fast. Thirty four percent admit that different groups at work demand things that are hard to combine sometimes, while 31% indicate this occurs often and 15% say this is always the case.

Peer support is benchmarked between the 10th and 15th percentile. Responses appear more positively skewed for this dimension, for example almost half the sample agrees that they receive help and support from colleagues while 15% strongly agree. Forty percent indicate that they receive respect they believe they deserve while 15% disagree and 24% remain neutral. However, the general working population fares better than this with scores of 4 and > 4 reported by those above the 40th percentile and even full scores by those above the 90th percentile.

Finally, when it comes to relationships at workhalf the sample reports poor conditions either often or always; for example 29% report that relationships are often strained at work, while 10% express this is the always the case. An immense 29% confess to always being subject to personal harassment and a similarly large proportion, 22%, indicates this occurs often. Thirty five percent state that there is often friction amongst colleagues whereas 12% confess this occurs always. These responses are indeed low when compared with general UK workers who report scores of 4 and > 4 starting from the 30th percentile and full scores from the 90th percentile.

In summary, when responses from participating PALS staff are benchmarked against the general UK working population (Health and Safety Executive, 2010), this sample appears to rank quite

highly on job control, sitting between the upper 75th and 80th percentile. In contrast, role and demands (the two variables found to be significant predictors of wellbeing scores) rank between the 5th and 10th percentile, while peer support and relationships rank between the 10th and 15th, and 15th and 20th respectively. These low scoring dimensions, according to the HSE's colour coding recommendations, require urgent action for improvement. Managerial support, an indicator of job satisfaction for PALS staff, ranks between the 20th and 25th percentile.

More detailed analyses reveal a high incidence of strained relationships at work, personal harassment in the form of unkind words or actions and friction amongst colleagues. Improvements could be made concerning respect, support and help from colleagues. Similarly, time pressures, working fast and intensively, and conflicting demands could be enhanced to improve participant wellbeing.

5. Discussion

The first thing that is noticeable about responding PALS is their demographic data. Most participants were mature women aged between 50 and 59 with a fair number of years of experience working with patient feedback (5 to 10 years). However, their earnings were comparatively low (e.g., between £21 176 and £34 189 per annum) with slightly above average banding. It is uncertain what this predicts for their perceived status. As already known from Xanthos (2008, p.e1) complaints managers need to have a "sufficient level in the organisation to carry clout" and that "status and age and experience" are important. In this sample, it appears that age and experience are of a satisfactory level; but status, as conveyed by banding and salary, is arguable.

Another point of interest here is that the most common banding reported in this sample is a stark contrast to the bandings reported in the PALS (2006) Professional Development Work Stream where the most frequently cited was band 3. This could be indicative of a positive change in the banding of PALS where this has been increased, or alternatively, the sample gathered in this study could be skewed towards higher bands and perhaps more senior PALS employees responded to the questionnaire than their junior colleagues. Finally, most participants indicate between 5 to 10 years' experience in this sort of post, suggesting that perhaps, working in PALS has been a career change for them. This raises the question of what would motivate an individual to seek a career change relatively late in life into the occupation of patient feedback when the financial compensation is (arguably) not particularly attractive. These demographic findings somewhat contrast with the call centre research precedence. For example in Belt (2002) call centres are found to be low skill and part-time 'female ghettos' while in this sample most participants are full time workers with quite some years of experience. The difference between their provided age and time spent working in their role suggests that participants may have changed careers into PALS relatively later in life.

The first RQ1 posed by this study asked about the wellbeing of PALS workers. This was measured by looking at positive mental health, negative mental health and job satisfaction scores. Using the threshold of four or more symptoms as indicative of poor mental health, 48% of the sample can be identified as reporting distressing mental health. Symptoms can include trouble concentrating and difficulties in making decisions. This is consistent with previous research where symptoms can include impaired decision making and high risk behaviours (Pabst, Schoofs, Pawlikowski, Brand,

&Wolf, 2013). These symptoms, although undesirable in themselves, can be a liability for an organisation that deals with life and death. A fair proportion of the PALS jobs involves problem solving complaints, negotiating resolutions and managing conflict between complainants and targets (Abbott et al. 2006; Xanthos, 2008); in this high stakes environment, there is little room for mistakes. It is concerning that 73% report feeling under constant strain and almost half the sample confess to feeling unhappy and depressed more often recently. These feelings can be further aggravated by the current NHS climate; with cost savings rife and the risk of job cuts, PALS who were implemented by the previous government, may fear for their position. This is particularly salient as 75% are nevertheless reporting some level of job satisfaction.

Although this is quite a promising discovery, satisfied workers are more likely to be productive (Appelbaum & Kamal, 2000) and perform a better quality work (Tietjen & Myers, 1998), it is also somewhat confounding how PALS staff can simultaneously experience such high global strain but relatively high domain specific satisfaction when it comes to their job.It could however be that the order of the measures in the questionnaire has exerted an influence on participant scores. As already mentioned, the job satisfaction scale was placed before the mental health and HSE measures. Perhaps if participants were asked about their satisfaction with their job after they had the opportunity to reflect on and recollect specific work experiences, their responses could have been lower. Alternatively, it may simply be that participants are pleased with their work, but experiencing poor mental health regarding other domains of their life, for example, personal relationships. Or it could be that PALS staff, who have poor wellbeing, are seeing their work conditions as worse than they actually are. In other words, directionality cannot be inferred from the data. Theoretical precedence suggests that work conditions are antecedents of wellbeing; hence the likelihood is that these come before their wellbeing experience.

One of the limitations of using a questionnaire is that the researcher is not present to ask probing questions. Here it would have been useful to ask participants to explain their experience of strain – what exactly is this 'strain' they are reporting? The GHQ12 does not elaborate on this state. Although from their answers, it is evident that participants think they are experiencing a lot of it, it is not quite clear what it is. For one individual, strain might mean a sore back; for another it might mean worrying. From the data, it is not clear whether this strain is psychological or physiological, nor what that experience feels like. Further research is needed to fully understand what this experience of 'strain' is and how it makes the individual feel.

A second limitation is that the GHQ12 does not capture physical health and thus either inadvertently makes the assumption that participants are physically healthy or simply ignores it.

The physical indicators in the questionnaire are arguably rather weak; one question asks about sleep and the other whether day to day activities are enjoyed. Neither of these are can be considered thorough evaluations of one's physical health.

The next RQ2 wanted to discover whether the wellbeing of PALS staff was lower than that of other customer service workers and indeed findings affirm this: PALS staff in this sample report statistically worse wellbeing than sales/customer service and call centre benchmark groups. PALS staff from this sample could be feeling worse than the benchmark group as it could be that people in general are feeling worse today than in the year when the benchmarking data was collected by Stride, Wall, and Catley (2007). However stress levels have *fallen* since 2007 (The Health and Safety Executive 2012b). It could be that PALS staff feel worse because the work that they do is harder, more strenuous and thus more taxing. When looking at the sorts of tasks that call centre workers do, for example contract cancellation, sending out technicians etc (e.g., Belt 2002; Sprigg, Smith and Jackson 2003; Zapf et al. 2011), it can be noted that these 'generic' activities are rather different from the complex investigative duties of PALS. This realisation along with the empirical evidence points towards key differences between PALS and customer service: the work is different and how the employees feel are different.

In fact, their wellbeing appears more comparable to social workers and the police force – two highly stressed professional groups (Kinman and Jones 2005). The evidence from this study indicates no apparent statistically significant difference between the mental health reported by PALS staff and that reported by social workers and the police. This positioning seems to fit appropriately with this study's proposition that PALS are in fact a more sophisticated and complex category of worker than general customer service. This is not to devalue customer service work, but simply to point out, that is not what the PALS job is about. Rather, there is something inherent within the role that makes it more comparable to human services more specifically (e.g., social work) rather than to people work more broadly (e.g., customer service, administration).

Although these findings are descriptive and they show that PALS workers from this study report feeling worse than customer service workers and more like social workers, it fails to evidence directionality. From the data, one cannot tell whether it is the job that makes them feel worse or whether individuals more prone to poor wellbeing are attracted to the PALS job. In the latter, PALS staff would still report lower wellbeing, but not necessarily due to the work. Equally, although the data shows on a descriptive level that their wellbeing is more comparable to social workers, it is not quite clear why; for example, whether the emotional labour of the role is the

culprit. Further research is necessary to understand what exactly PALS staff do that makes them feel like social workers feel.

The subsequent RQ3 explores known psychosocial workplace hazards. Consistent with previous research (e.g.,Guidi, Bagnara, and Fichera, 2012; Kerr, McHugh, and McCrory, 2009), all sixHSE Management Standards dimensions displayed significant relationships with wellbeing. Up to 50% of the variance in poor mental health scores was explained by psychosocial conditions, in particular the variables of demands and role. Twenty nine percent of PALS staff report that relationships at work are often strained while 35% would agree that there isoften friction amongst colleagues – 12% state this is always the case. This suggests that the social environment at work is volatile and disagreeable, placing further pressure on PALS staff who are already on the receiving end of negative emotions from complainants. It is suggestive that PALS staff encounter negativity both from external sources (e.g., patients) and internal ones (e.g., colleagues). Pragmatically, such a tumultuous social context is likely to slow down PALS investigations as resolutions involve communicating and negotiating with colleagues. These results confirm the qualitative findings from Abbott et al. (2005, p.133) who picked up on the difficulty of initiating a "bottom up culture change" in a "top down" organisation.

And yet, in spite of these interpretations, there is still half of their wellbeing left uncovered by the HSE Management Standards dimensions. In other words, the other half of the variation in their scores is not associated with these workplace hazards, but something different, not captured by the model. It could be that some participants were going through a particularly trying time at home and that this affected the other half of their poor mental health. Or it could be that the remaining influence on wellbeing scores is made up of many different components and perhaps the influence of demands and role at work are actually quite powerful.

It comes perhaps somewhat expectantly, as the NHS is presently re-structuring, that 13% of PALS staff seldom understand how their work fits into the organisation's overall aim while only 36% are often clear about this. Some participants, 11% of the sample, report being unclear about their expectations while only 36% admit to always knowing. This is congruent with preconceptions formed during the literature. Abbott et al. (2006), Xanthos (2008) and Mulcahy and Lloyd-Bostock (1994) do evidence that employees adopt different identities when dealing with complaints. Hence, for some PALS workers, knowing which identity to adopt can be perplexing, particularly during times of change. When comparing these change experiences with those of the UK general working population, PALS staff from this study come between the 20th and 25th percentile, suggestive that improvements can be made.

In addition to explaining 50% of the variance in poor mental health scores, demands and role also account for 41% of positive mental health scores. These are quite large proportions; recall that these are global measurements; hence demands and role at work have quite a weighty effect on overall wellbeing. In other words, these two work related variables have the power to influence almost half of how the individual feels in general. However, their push/pull ability is not equivalent. The same two variables explain different 'quantities' of positive and negative mental health. This is quite interesting as it suggests that psychosocial conditions have greater power to distress PALS staff than to make them happy. Basically, a little bit of bad can do worse damage than what a little bit of good can improve. It also leaves open as to what is associated with the remaining almost 60% of positive mental health scores. Perhaps non work issues exhert a greater power on positive wellbeing than on negative wellbeing. Perhaps this might be different depending on the individuals' disposition towards their job. It would useful for future research to explore individual differences, for example in how a person perceives their work – as just a job or a passionate endeavour. It could be that for individuals who are highly passionate about their work, their wellbeing is at greater risk of being influenced by work experiences than non-work experiences.

Overall PALS staff reporting better wellbeing were more likely to report less conflicting demands, the ability to work at a reasonable speed and less pressure to work long hours. When PALS staff were clearer about what expected of them at work, when they knew how to do their job effectively, when duties and responsibilities were clearly understood, then they were more likely to report positive wellbeing. This relationship was significant at both macro and micro-levels. For example, PALS staff with better wellbeing were more likely to understand how their role fit into the overall organisation's aim and were clearer about the objectives of their department more specifically. Hence, PALS employees who were clear about their role in relation to both the small picture (i.e., their job) and the big picture (i.e., the organisation) were more likely to report positive wellbeing more generally. This appears befitting as role conflict and ambiguity are known to lead to tension (Tubre and Collins, 2000). Hence, less conflict and ambiguity at work results in less tension overall.

In addition to demands and role, the facet specific measure of job satisfaction was also associated with management support. PALS staff who were more satisfied with their job were more likely to have line managers who encouraged them and gave supportive feedback. PALS staff who reported high satisfaction levels were more likely to feel as if they could speak to their line manager about problems and that he/she would help them out. These findings are consistent

with both the extended Job Characteristics model (Humphrey et al. 2007) which highlights the importance of feedback on wellbeing and the Demand-Control-Support model (Karasek and Theorell, 1990) which accents the role of social support.

Finally, the last RQ4 seeks to assess PALS worker experiences with that of other workers more broadly. When compared to the UK general working population, PALS staff in this sample score particularly poorly on relationships, peer support, demands and role. Using Kerr, McHugh, and McCrory's (2009) categorisation, thiscould mean that both job content (i.e., demands and role) and job context (i.e., relationships and peer support) conditions are much worse than that of most UK workers. In particular, demands and role at work, both of which account for a large proportion of overall wellbeing, are only ranked between the 5th and 10th percentile.

And yet, rather baffling, PALS staff report rather high job control. When compared to the general working population, the autonomy reported by participating PALS staff rank between the 75th and 80th percentile – a remarkable contrast to call centre workers. For example in Zapf, Isic, Bechtoldt, and Blau (2011) call centre workers report less job control than other service sector employees but better demands than benchmarking groups. PALS staff report the opposite, their job control is high but they score rather poorly on demands. In essence, PALS staff have more autonomy but greater demands to contend with. This dissimilarity in job control and demands between PALS workers and customer service workers further propagates this thesis' main argument that the PALS role is not general customer service. Rather, the psychosocial conditions reported in this study and the wellbeing of these employees is more comparable to the experiences of human service workers (e.g., van den Broek, 2003) and social workers (e.g., Stride, Wall and Catley, 2007).

About half of this sample, at 51%, report being harassed at work either often or always – this could be in the form of unkind words or even behaviours. From the questionnaire it is unclear whether this harassment is from patients or colleagues. It could be that PALS staff face irate patients who are abusive or defensive healthcare professionals who are the targets of these complaints. Still, it is disconcerting that such disrespectful behaviour is being tolerated. In fact, 17% of participating PALS staff do not believe that they receive the respect they deserve from their colleagues while 24% remain neutral. This does not bode well for a group of employees who are supposed to be initiating organisational change while, allegedly, having "direct access to the Chief Executive" (Department of Health (2002, p.32). In fact, these findings are more reflective of the experiences of administrators. For instance, administrators in Harkness et al. (2005, p.129) share that "people don't respect admin" and view it as a "subservient type of occupation".

To summarise, 48% of participating PALS staff are indicating poor mental health. Up to half of that is associated with demands and role at work, which rank rather dire when compared to the UK general working population. And yet, most startling, PALS staff are nevertheless reporting job satisfaction with 75% of participants indicating some level of satisfaction with their work. This is counter-intuitive. The data shows that PALS staff are reporting poor wellbeing, and that half of that is linked with a hazardous psychosocial work environment.The assumption would be thus that PALS staff are not satisfied with their job; however, the reverse appears to be the case, contrary to scholarly precedence.

Taking the data at the descriptive level and interpreting that indeed participant scores are reflective of their condition, it raises some interesting questions. Theoretically, wellbeing is understood as comprised of eudemonic and hedonistic aspects (e.g., Drakulic, 2013; Wright and Copranzano, 2004). For instance, in similar self-report measures individuals are more likely to choose comparable ratings for hedonistic and eudemonic questions, indicating that both aspects appear together (Berridge and Kringelbach 2011). For example, scores on happiness questionnaires (i.e., hedonistic) and life satisfaction scales (i.e., eudemonic) generally tend to converge, with 80% of participants selecting 'pretty to very happy' on the former and 80% between 6 and 7 on a 10 point scale on the latter (Diener et al. 2008). In this sample, however, it seems that a large percentage of PALS staff are reporting reasonable job satisfaction (i.e., high eudemonic wellbeing) at the same time as high global distressing mental health (i.e., low hedonistic wellbeing). This seems to suggest that although PALS staff can feel poor wellbeing, and that half of this distress can be accounted for by their work conditions, they can nevertheless still experience eudemonic satisfaction in their work. This appears to separate feelings of meaningfulness (i.e., eudemonic wellbeing) from daily struggles (e.g., hedonistic pleasure) such that the former can remain untainted by the latter.

6. Conclusions and Further Research

This study began as a quest to explore the wellbeing of PALS workers, to figure out how PALS staff were feeling and pin point some reasons why. While the data gathered has answered these research questions, it has also ended up raising additional ones. Two key findings catapult the need for further research.

On a theoretical front, it is befuddling how PALS staff can experience high eudemonic job satisfaction but low hedonistic happiness as these are the two composites of wellbeing. It has been suggested in this study that based on theoretical justification the lack of hedonistic pleasure could be a result of poor psychosocial conditions, in particular the demands of the job and the role itself. However it is unclear what intervenes in this experience so that, in spite of these psychosocial conditions, PALS staff can still experience eudemonic job satisfaction. This ability to simultaneously experience two conflicting states evokes the tragic clown metaphor of *vesti la giubba* with images of a half smiling and half crying Pierrot. It is also unclear what it feels like to experience these two conflicting states at the same time.

The survey design of this study simply reports answers and cannot probe further to discover the experience. For example while it can show that participants report a high incidence of strain, it cannot explain what this strain is or how it feels to experience it. Upon reflection, the lived experience of the person is not accessible, answers are simply percentages. Looking back on decisions made three years previously, it is easy to pick on limitations as one's knowledge has developed and grown over that time period. At the time of study one, a quantitative approach was deemed useful to determine whether in fact there was an issue with wellbeing at the occupational level for the PALS role. Now having seen the added value of qualitative research, there is a danger of evaluating the quantitative study from an Interpretivist perspective. Much like qualitative researchers argue that Positivist criteria such as generalisability ought not be applied to qualitative work, then using the same rule, one should not judge survey designs by pointing out its lack of depth. Indeed this first study is limited in what it can tell, but it does nevertheless contribute to the literature. For example, it develops on Bakker et al.'s (2003) work by evidencing that some complaints staff do actually report worse wellbeing than other customer service groups. This brings the discussion to the second key finding.

The second key finding is that PALS staff report worse wellbeing than other customer service workers. When their wellbeing is compared to social workers, the data does not show any statistically significant differences. In view of this, the initial argument proposed in the literature review, that PALS staff are misclassified as customer service, is revisited and reinforced; with the proposition that PALS may be a new category of staff – but what?

Some research questions, such as the ones posed by this study, are best answered by collecting large data and conducting numerical analysis. For example, without quantitative exploration, this study could not have benchmarked PALS employee work experiences to that of the UK general working population to compare work conditions. However, although the strengths of quantitative research can be appreciated, its limitations can also be acknowledged. For instance, its inability to capture the person behind the numbers, the lived experience of the participant. In addressing its four research questions, this study has paved the way for further intriguing explorations. But this time, a more open naturalistic approach was needed, one that could seek out rich descriptions and capture the lived experience of this group of workers to truly understand what it means to work in PALS. And so this raises a fifth research question:

RQ5: What is the lived experience of PALS worker wellbeing?

7. The Lived Experience of PALS Workers

While the first study investigated wellbeing in quite an operationalised manner, this second study undertakes a much broader, more inductive exploration. It does not restrict wellbeing to a theoretical framework, but opens up the opportunity to look at the lived experience of PALS worker wellbeing. This chapter sets out the methodological steps and decision making processes of this second study. First, the qualitative research approach will be introduced, followed by Interpretative Phenomenological Analysis (IPA) and how to judge the quality of qualitative research. Data collection, analysis and research ethics will conclude this chapter.

7.1 Introduction

Although it is easily identifiable that this second study is a qualitative piece of work, explaining what exactly 'qualitative' means is not an easy feat. Some authors take an overtly simplistic view of qualitative research and dichotomise it with quantitative research. For example, Strauss and Corbin (1998, p.11) state that qualitative means "not arrived at by statistical procedures or other means of quantification". Ergo, if a researcher is not counting, then it is qualitative. But qualitative is about much more than simply *not counting*. It is a naturalistic approach to exploring the world that is contextually embedded and sensitive to the meanings that people bring to their experiences (Denzin and Lincoln, 2000). What makes qualitative research distinct is its focus on in-depth understanding, naturalistic inquiry, and rich descriptive accounts that aim to provide a holistic understanding of the participant's social world (Ritchie and Lewis, 2009). However even amongst qualitative scholars, there are various debates about how qualitative research ought to be conducted (Hammersley, 2012). For example, some qualitative research can be more discursive and interested in exploring how experiences are socially and/or discursively constructed (e.g., Harkness et al. 2005). Others can be more Interpretivist, seeking to understand how people sense make their personal realities (e.g., Osborn and Smith 1998). As an over-arching explanation, Hammersely (2012) proposes that qualitative research is a data driven form of social inquiry that adopts a flexible and somewhat unstructured approach to the collection of (usually) non-numerical data while acknowledging the role of the researcher in the process.

One of the most important tenets of qualitative inquiry is reflexivity (Lewis and Zibarras, 2013). Reflexivity can be understood as the researcher's awareness of and engagement with the process of knowledge production, the context within which it occurs, and their own involvement in the research process (Alvesson and Skoldberg, 2009). So for example, in this thesis, the author's voice resonates quite loudly, decision making processes are transparently conveyed and reflections are made amidst the writing so that readers can judge for themselves. This level of active participation in the generation of understanding on the researcher's part is somewhat different from the more distant stance of quantitative studies.

This qualitative study is an extension of the quantitative investigation that started the original project; it is still part of its greater whole. The questions leading this study stem from the previous one; its findings will develop and add on to the knowledge from study one. Hence, it is not a distinct and separate piece of work, but both are linked. This pluralist way of working by mixing methods and approaches has increasingly become popular, and is an example of the current trend towards 'paradigm peace' (Frost, 2011). However this was not always the case. Traditionally, researchers had advocated a dualist perspective on research philosophy – either one's study resided with the Positivistic or the Interpretivist camp; and it was argued that the ontological and epistemological assumptions underpinning each approach were incompatible (Johnson and Onwuegbuzie 2004). Initially popularised by Kuhn (Donmoyer, 2008)the paradigm concept is defined by Guba (1990) as an assortment of assumptions that influence actions. In other words they are beliefs about the world; and comprise assumptions about the nature of reality (ontology) and the way in which this reality may be known (epistemology). In effect, the assumption a researcher makes about what constitutes reality impacts on how he/she then chooses to access this knowledge; for this reason paradigms were generally viewed as mutually exclusive due to irreconcilable differences.

Traditionally, social scientists have perceived of their research as equivalent to the natural sciences where it was possible to find 'true' and 'objective' knowledge that would mirror a set predefined external reality (Alvesson and Skoldberg, 2009). This paradigm, known as Positivism, is rooted within empiricism and is associated with a deductive approach whereby researchers test and validate theories by gathering empirical data. However, critiques from the Interpretivist movement argued that 'true' knowledge may not exist as all knowledge is a composite of experience and perception. In other words, knowledge is simply a product of interpretation and the perceiver cannot be 'objective' because he/she is involved in the sense making process that gives meaning to the experience. Hence, Interpretivists are making quite different ontological and epistemological claims about the nature of knowledge and how it may be researched.

More recently, researchers have begun to propose an eclectic and complimentary approach that is predominantly governed by the research questions themselves: *pragmatism*. Within this approach, data collection tools are selected based on their suitability to addressing the research questions and the schism between quantitative and qualitative is forgone for a more utilitarian middle ground (Morgan 2007). The premise of this argument rests on the acceptance of research tools as autonomous and thus transferrable between paradigms. Epistemological and ontological assumptions are not viewed as fixed to tools but rather seen as 'shared beliefs' instead of 'incompatible' (Zimmermann 2006). As such, researchers are free to adopt the most suitable tools for their research questions; they are not "imprisoned" by a paradigm (Gorard, 2003, p.9). Pragmatism paves a new dawn for researchers, one where misguided myths such as 'real' qualitative researchers "do not count" (Sandelowski 2001, p.230) or erroneous assumptions that Positivists "own" quantitative tools (Lamiell, 1995, p.160) are put to rest.

Now, first, the underlying assumptions of IPA will be narrated, followed by a discussion on how to judge the quality of qualitative research. Following this, the data collection process will be shared and analysis technique conveyed. This shorter chapter will then end, and thematic discussions will begin in the subsequent chapters.

7.2 IPA Approach

This second study adopts Interpretative Phenomenological Analysis (IPA) as its methodological approach.IPA is an experiential qualitative approach which seeks to examine in great depth participant experiences and how they make sense of their experiences (Smith, 2011). IPA as a qualitative research approach is fairly new; it was only articulated as a specific qualitative method in the 1990's although it has roots in phenomenological philosophy (Eatough and Smith, 2008). Phenomenology can be traced back to the 20th century works of Husserl and later Heidegger who critiqued the Cartesian notion of mind/body and subject/object dualism (Woodruff-Smith, 2013).Heidegger (as cited in Crotty, 1996) posited that human beings are being-in-the-world or *Dasein*, inevitably situated and framed by the world they live in. The meaning and understanding that individuals assign to events is grounded in the context within which they occur, for example, a particular society, culture, history and even language. By taking this stance, it is assumed that the social reality of participants is a product of their engagement with their social world and that experiences are composed of interpretations. Supporters argue that it is not possible to remove

experiences from the interpretations that give them meaning (Alvesson & Skoldberg, 2009). In essence, human beings do not exist in a vacuum nor is there a *tabula rasa*.

Applied to research methods, phenomenological researchers are interested with the way the world appears to the individual and the way people experience events; it is inherently experiential. However IPA is not the sole phenomenological method; it is a part of a family of phenomenological approaches which have transcendental and existential branches (Willig, 2008).In its descriptive form, it is inspired by Husserl's transcendental philosophy and aims to bracket preconceptions to arrive at the genuine essence of the phenomenon (Moustakas, 1994). The goal in this approach is to establish the underpinning 'structure' of the phenomenon being researched; basically, what components are essential to constitute said experience (Giorgi and Giorgi, 2003). In contrast, IPA is interpretative and draws both on Heidegger's existential phenomenology and Hermeneutic principles (Willig, 2008). It goes beyond the description of the phenomenon and also engages in interpretations of this experience. It is not concerned with the essence of the phenomenon, but rather, to explore the variations and diversity of human experience. In this way, IPA is quite idiographic, focusing on the particular case, the singular participant, as opposed to the universal.

Study one has illuminated the complexity of PALS worker experience and shown that participants are reporting a puzzling paradox of satisfaction and strain simultaneously. What is necessary now is to dig deeper into the participant's *lifeworld* to comprehend how they experience this wellbeing and how they make sense of this experience. An approach that goes beyond the descriptive level is needed to engage with the complexity of the data. Furthermore, although study one's findings are limited in explaining the wellbeing of PALS workers, they nevertheless do provide some insight. Hence it would not be feasible nor advisable to bracket this knowledge as required by descriptive phenomenology. IPA on the other hand provides a more suitable approach as it appreciates that research is a "dynamic process" where the researcher is actively involved and influential in data collection and analysis (Smith, 2012, p. 362). The role of the researcher is not assumed to be an objective data collector as in Positivism, but rather its hermeneutic axiology rests on the premise that the researcher is inevitably a part of the research process (Creswell, 2007).For example, it is not possible to research a pool water without changing it, as by the mere fact of touching that water, ripples are created by the researcher. Their own understanding and preconceptions inevitably influence the study. For this reason, reflexivity is imperative (Tomkins and Eatough, 2010). Unlike Positivist traditions where these subjective assumptions as perceived as biases that ought to be eliminated, in IPA they are accepted as necessary (Willig, 2008). Rather, what is important in this approach is to transparently and authentically convey one's pre-

conceptions through reflexivity. Reflexivity is based on the premise that empirical data is understood as a result of interpretation (Alvesson and Skoldberg, 2009). As such there is no 'true' data but simply understanding influenced by Hermeneutic engagement with the data. Loosely, reflexivity may be perceived as the more Interpretivist equivalent of 'reliability' and 'validity' – concepts that some authors such as Thomas (2011) argue are redundant in qualitative approaches.

IPA seeks to gain in-depth understanding of participants' lived experiences known as *lifeworld*(Lewis and Zibarras, 2013). As such, IPA researchers accept that they are not simply researching participant experiences but rather their *lifeworlds* because experience and perception are inseparable. As such, context is not perceived as 'external variables' to be controlled for, but rather as a critical part of the research process that gives meaning to participant accounts. The aim rather is to acquire understanding "through the eyes of those being studied" (Travers, 2001, p.8).This is known as the double hermeneutic; first the participant sense makes their experience, then the researcher interprets this interpreted phenomenon (Smith and Osborn, 2008). Hence the double loop. As Larkin et al. (2011, p. 321) eloquently explain, IPA is about "understanding the first person perspective from the third person position".

IPA is a prominent tool for psychologists (Langdridge, 2007) particularly health psychology (Reid, Flowers, and Larkin, 2005) as it encourages participants to provide detailed accounts of their experiences. It is a rich, deep and idiographic approach to qualitative research (Smith, 2011). IPA first analyses each account independently before considering all participants as data corpus to explore grand themes. In this way, each participant's own experience is given voice. For this reason, sample numbers are recommended to remain small (Langdridge, 2007). Doctoral theses are reflective of this orientation; for example Pimentel-Aguilar (2007) designed a similar mixed method design, with 124 questionnaire participants and six interviews, Williams (2007) opted for a pure qualitative study with 10 interviews while Lawson (2012) had only 5 participants. Six to eight is the recommended sample size for doctoral programmes (Pietkiewicz and Smith, 2012).

It was difficult to find many other mixed-method doctoral theses that used IPA. Pimental-Aguilar's (2007) work does not even touch upon the possible philosophical conflict of using a mixed-method design while Harrison (2010) mentions it at the very end, in her reflexivity chapter, which was not integrated into her thesis. Indeed Positivists and Interpretivists are making different claims about the world, and perhaps mixed method research is like trying to be a vegan and a meat eater at the same time. However Chamberlain (2011, p. 286) warns against methodolatry as the "slavish attachment" and "devotion" to method. He argues that researchers should not be so

preoccupied with 'method purity' that the participant's story suffers as a result. The simple pragmatic matter is that a questionnaire was the best tool to address the first set of research questions while an in-depth interpretative and phenomenological approach is the best approach with which to explore the next emergent question. To address this emergent research question, other qualitative techniques would not be appropriate. For example content analysis would not provide the depth required to explore inner experiences of participant *lifeworlds*. Content analysis would be better suited to discovering common and recurrent themes at a topical level, scratching the mere surface of the experience. Grounded theory would provide a more in-depth understanding but in its strict inductive approach it would not be appropriate either as study one has shed some light on PALS worker experiences. In this research, adopting a mixed method approach is a key strength as it provides both breadth and depth of exploration.

The Hermeneutic influence on IPA implies that participant descriptions can reveal their experiences (Willig, 2008). In essence, its epistemological grounding is largely realist.Herein lies possibly IPA's greatest limitation – its assumption that language does describe participant experiences. Social constructionist perspectives would argue that on the contrary language creates reality as opposed to merely stating and reflecting it. For example, if a participant shares that they are happy, IPA would seek to understand what that happiness feels like for the interviewee. In doing so, it assumes that participant accounts are interpretations of this phenomenon. Although it does not attempt to validate the 'truthfulness' of these experiences nor seek to 'prove' whether participant accounts are a 'true' reflection of an objective reality, it still assumes that language is a descriptive tool. The topic of quality in qualitative inquiry is broached below.

7.3 Quality in Qualitative Research

Although ontological and epistemological claims are set aside for the purpose of pragmatic work, this does not mean that the qualitative side of this research is without governance. For example, in positivistic discourses, readers would see reference to concepts such as reliability, validity and generalisability to assess the quality of their work (Bryman and Bell, 2007). These concepts may be coherent in the positivistic aim of predicting hence measurement of constructs ought to be consistent and accurate such that universal laws can be deducted from the data. However in qualitative inquiries the research aims are different, rather than broad universal laws, qualitative researchers seek in-depth contextual understanding. There are three broad ways of

conceptualising quality within this tradition. Some qualitative researchers, for example Mason (1996), remain quite close to the positivistic terms with some minor modifications. Others, such as Hammersely (1990) and Silverman (1993), export the meanings of these terms and redefine them within the qualitative tradition. And finally, some qualitative researchers, such as those presented in Table 22, propose new concepts as substitutes. Table 22 expands on these issues.

Table 22 Quality in Qualitative Research

Qualitative quality criteria	Recommendation for Hermeneutic Phenomenology
Credibility e.g., Agar (1986) Completeness e.g., Miles and Huberman, (1994) Consistency e.g., Hammersely (1990) Ecological validity e.g., Cicourel (1996) Trustworthiness and authenticity: - Credibility - Transferability - Dependability - Confirmability e.g., Lincoln and Guba (1985) Naturalistic generalisability e.g., Stake (1995) Saturation e.g., Glaser and Strauss (1967)	Reflexivity e.g., Willig (2008) Yardley (2000) model: - Sensitivity to context - Commitment/rigour - Transparency/coherence - Impact/acceptability

As the nature of qualitative inquiry is to acquire in-depth situated knowledge, both researcher pre-conceptions and participant context are important for generating meaning. This means that qualitative knowledge cannot be reliable or valid in the positivistic sense because the notions of objectivity and universal laws are refuted. However this does not mean that qualitative research is not rigorous or worthwhile, instead, the quality of such research ought to be judged by using criteria that *makes sense* in this tradition (Osborn and Smith 1998). For example, it does not make sense to argue that a vegetarian is a 'bad' vegetarian because he/she eats cheese. Not eating cheese is a practice associated with veganism and it does not make sense to use that criterion on another, different approach. Similarly, statistical generalisability is a positivistic practice and it does not make sense to criticise qualitative research by saying findings are not statistically generalisable as the researchers are working within a different paradigm. Instead, to judge the quality of IPA, Willig (2008) proposes that researchers engage with reflexivity. In other words that

researchers explicitly highlight the process of knowledge production, the context within which it occurs, and their own involvement in the research process (Alvesson and Skoldberg, 2009).

Unfortunately, there is not sufficient literature on the 'validity' of Phenomenological research (Langdridge, 2007). Recognising this shortfall, Langdridge (2007) recommends adopting Yardley's (2000) four qualitative criteria that may be used to ensure quality phenomenological research: sensitivity to context, commitment/rigour, transparency/coherence, and impact/acceptability. Each of these concepts is now discussed below.

It is recommended that phenomenological researchers ought to be sensitive to the theoretical and socio-cultural context of their study. First, theoretical sensitivity evidences the researcher's engagement with theory, previous findings and methodological philosophy. This has been shown in the literature review chapters, where theoretical foundations were explicitly presented and prominent research findings were discussed; and methodological chapters where justification for the approaches taken were made.

Second, socio-cultural sensitivity is important for quality phenomenological research. This is of course pertinent as participants are seen as being-in-the-world and research explores their *lifeworlds*. The socio-cultural setting influences how beings-in-the-world interpret their experiences and hence context is an integral part of the research. This is evidenced in this study by interviewing participants in their setting and considering their wider macrosystem; participants are neither physically not interpretatively isolated from their setting but situated in their context. Great care was taken in the literature review chapters to develop a conceptual map that was sensitive to the healthcare context, for example by considering the Department of Health and patient expectations. During data collection, care was taken to elicit lived experience examples from participants such that accounts were situated in their *lifeworlds* and not generic or abstract examples.

The third criterion is commitment/rigour and is concerned with the skill and competence of the researcher. This is evidenced by clearly conveying the time taken to research and informing the decisions made through the thesis. Additionally, guidance was provided throughout the research by Dr. Lewis, thesis supervisor.

Transparency/coherence refers to openly elucidating the decision making process of the research. This is evidenced by transparently illustrating how data was collected and analysed, by supporting claims using participant quotes, and throughout the thesis by engaging in reflexivity to show the

role of the researcher in proposing interpretations. A more irksome issue of consideration is the authorship style. In Interpretivist studies, it is possible to author one's work using the personal pronoun. This is in direct conflict with the traditional 'scientific' authorship of research studies. Although this research adopts a third person narrative, it is hoped that transparent reflexivity and ownership is conveyed loudly nevertheless.

The final criterion is impact/acceptability and refers to the utility of findings. It is questionable though that this final condition needs to be met for qualitative research to be considered 'good'. Furthermore, it is not evident how impact and acceptability can mean the same thing; certainly a piece of research can be accepted amongst scholars but have little impact value in practice. Langdridge (2007) is critical of the assumption that quality research needs to have an impact factor. While the socio-political context of research is such that funding bodies are pressuring researchers to consider the application of their work, it is not entirely convincing that it ought to be a necessary condition for quality research. Desirable yes, but essential, perhaps not. A more useful condition might be transferability. For instance, instead of considering statistical generalisability, discussions may need to centre on the transferability of findings (Gomm, Hammersley, and Foster, 2000). This may be done by providing rich descriptions to allow for naturalistic generalisability. In other words, while statistical generalisability is concerned with the discovery of context free laws, naturalistic generalisability seeks to propose whether knowledge acquired in one context may be relevant in another context (Stake, 1995). Hence such studies may provide rich understanding of particular cases and serve to illuminate issues that may be lessons learnt, and thereby be useful for policy makers (Simons, 2009). Having said that, it might limit highly esoteric work, which although useful on an abstract level, may have little transferability across settings.

In summary, by transparently conveying reflexivity and applying Yardley's (2000) quality criteria, this study ensures Phenomenological good practice. While it does not engage with the positivistic concepts of reliability, validity, and generalisability; it nevertheless produces authentic and valuable knowledge by abiding to qualitative good practice criteria. The process of collecting data is now shared below.

7.4 Data Collection

The primary aim of IPA researchers is to collect rich and detailed participant accounts of the phenomenon being explored (Smith 2012). Interviews tend to be the most popular method although focus groups (Tomkins and Eatough 2010) and observations (Reid et al. 2005) have also been used. In this study data was collected through semi-structured interviews. IPA interviews aim to 'give voice' to participant concerns (Larkins et al. 2006) and Smith (2012) recommends active listening, rapport building and trust between researcher and participant.

IPA interviews are not neutral data collection tools; the researcher 'works with' the participant in a collaborative manner to interpret the meanings that are used to make sense of the phenomenon (Reid et al. 2005). As recommended by Smith et al. (2009), an interview guide was prepared in advance to facilitate exploration. This is not meant to be prescriptive (Osborn and Smith, 1998). In most of these interviews, little use was made of the guide as participants were extremely eloquent and expressive.

Participants were recruited in two primary ways: by self-selection and through snowball sampling. Selection criteria were that candidates were working in healthcare and their primary job role was patient feedback. At the end of study one's questionnaire was an invitation to be interviewed. Some of the participants, Patrick, Adam, Lynne and Alicia[4], self-selected to participate by sending an email noting their interest. Of course, because the participants self-selected, it may imply that they had a story to tell. Participants had decision making autonomy on the whereabouts of the interview location. For example Adam wanted to be interviewed in his open plan office even though his colleagues were present. Adam was nonchalant and care free about sharing his story within earshot of his colleagues. Alicia on the other hand preferred to meet at a coffee shop. Admittedly it would have been ideal to interview each participant on their own in a quiet location (not least for the audio quality and subsequent transcription), however, perhaps that would have been artificial seeing as some of them worked in open plan, noisy and busy environments. It was almost poetic how the interaction between researcher and participant mirrored the interaction between participant and patient. In a way, speaking to them in their own turf, in their daily work environment was more appropriate, more true to the naturalistic ethos of qualitative science – and also aptly reflective of how patients may feel discussing confidential matters in the same environment. Table 23 depicts the physical locations of the interviews.

[4] All names used are pseudonyms

Table 23IPA Participants

Pseudonym	Interview location	Interview length
Patrick	Private office	1.30 to 2 hours
Lynne	Private office	1.30 to 2 hours
Laura	Private office	1.30 to 2 hours
Julie	Private office	1.30 to 2 hours
Alicia	Coffee shop	1.30 to 2 hours
Adam	Open plan	1.30 to 2 hours
Pauline	Open plan	1.30 to 2 hours
Helen	Open plan	1.30 to 2 hours
Sue	Open plan	1.30 to 2 hours
Total number of participants	9	

Although in an open plan office, Adam was interviewed independently as his colleagues did not wish to participate in the research. Pauline, Helen and Sue on the other hand (who shared an open plan office) were all keen to get involved. Although more than one person was interviewed at the same time, this was not a focus group. The aim of a focus group is to allow participants to discuss key topics in groups; the researcher is most often simply a facilitator(Bryman and Bell, 2007). Group interviews on the other hand may simply be a more efficient use of resources for collecting interview data – although they are not often used by social scientists (Frey and Fontana, 1991). In this group interview setting, the aim was not to explore discursive aspects of wellbeing or to instigate discussions amongst the participants themselves, but rather, to seize the welcome opportunity to interview a team who worked in an open plan office. At present, no studies could be found that have used IPA specifically in group interviews, but there are some utilising focus groups (e.g., Flowers, Duncan, and Knussen, 2003).

In group settings Smith (2004) recommends that researchers first look for group level patterns and then dig deeper into individual interpretations. Understandably, in group settings, some personalities may be more dominant than others. For this reason, Tomkins and Eatough (2010) caution against eclipsing the individual in favour of the group, warning that researchers doing so may create a 'false consensus' by pooling the data together. It can also be questioned whether participants would say the same things if they were on their own (Dunne and Quayle, 2001). For instance, less dominant group members might simply agree with the loudest speaker to prevent conflict. To counter these possible caveats of IPA in group settings, it is recommended that both

group dynamics and individual contributions are honoured by capturing the chronological development of a theme(Tomkins and Eatough, 2010). In this way, it be possible to tell who had the original idea and when/how consensus was developed. In practice, this may not always be possible as all interviewees may not engage with all topics equivalently, hence such mapping will never be perfect in the true sense of the word; although 'best' practice may not always be feasible, researchers nevertheless ought to aspire towards 'good' practice.

As recommended by Frost (2011) a research diary was kept. At times, this included diagrams, for example pictures of office space were drawn and art from walls was reproduced from memory. In other instances, own personal thoughts and feelings evoked during the interview and after the interview were recorded. Frost (2011) critiques the trend of including a separate section on reflexivity as at the end of a thesis, saying it makes of reflexivity as an 'afterthought' or an 'add on'. And indeed, she may be right; for this reason, reflexivity has been integrated in this thesis overall. At times it has been implicitly heard through the narrative; at others, such as the extracts below, it is more explicit. This explicitness is mirrored on IPA doctoral theses precedence (e.g., Featherstone, 2010; Osborn, 2002). The next few boxes (Box 1 – Box 9) are extracts from the research diary; they serve to introduce the participants to the reader and transparently convey the researcher's impressions much like Featherstone (2010) and Osborn (2002) did in their PhDs. Perhaps, as the researcher takes such an active interpretative role in IPA, it is important to convey one's personal preconceptions, almost as a catharsis, and then to focus on the participant accounts.

Box 1 Research Diary: Laura

Laura

Laura looked like a mother figure; she had a nurturing protectiveness about her, the kind of person who would embrace another and take them into her bosom and say it would all be OK. At the start of the interview, she said something that highlighted the age difference between interviewee and interviewer; and initially there was a fear that the interview would not be fruitful as Laura would not open up to someone much younger. Indeed she even described herself as a "mother figure" and at times referred to the "old days" but as the conversation progressed the spark of trust was ignited. Laura shared personal tales and touching stories; at the end, she even confessed that it was all rather "therapeutic". Perhaps it felt good to Laura not to be the nurturer this time, but rather, to allow herself to share her vulnerabilities with someone else.

Box 2Research Diary: Alicia

Alicia

Alicia is a soft spoken person, with a low voice, and a manner that begets wounds on her soul. She comes across as introspective and a bit unsure of herself, uncertain and doubting. Emotionally, she appears to be in a dark place and her eyes reflect pain. She sits crouched, making a small frame. There was some uncertainty on how to conduct the interview at first, not wanting to further pain an already hurting individual, but Alicia was very introspective and spoke of her very personal experiences in an eloquent and critical manner. This was undoubtedly the psychologically most strenuous interview, Alicia's pain was palpable. As a researcher, there was guilt with the knowledge that this was simply a research interview and that the sad reality was that things would not change much as a result.

Box 3Research Diary: Adam

Adam

Adam comes across as an open person, even in an open plan office; he was comfortable discussing sensitive personal experiences. He is funny, often making jokes, with a keen sense of satire and self deprecating irony. He is keen on self-development and is an avid reader. Adam appears in tune with his personal surroundings, choosing to surround himself with positive motivational sayings and morale boosting imagery. The thing that stood out straight away was the noise in the room but Adam seemed immune to it. The office space was inundated with a cacophony of sounds, telephones ringing, printers going off, and people talking – yet Adam seemed oblivious to it.

Box 4Research Diary: Lynne

Lynne

Lynne is a quickly intimate person who welcomes another as a confidante. Her manner of speech is reminiscent of sharing secrets and juicy titbits. She has a clinical background and professes that she applied to her PALS role so that she could go home at lunchtime and "walk my dog" (line 105). Once in the position, she explains she "just made it up, and developed it, and kept it" (line 120). Working her way from a "little band 2 down here and I managed to get up to a band 7" (line 134), she explains away "not bad for an old girl" (line 140). Indeed, Lynne is a strong woman, who as a single parent raised not one but two children to attend one of the most highly prestigious universities in the world.

Box 5Research Diary: Pauline

Pauline

Pauline used to work in a public sector organisation and moved to the NHS as a receptionist. She built up relationships with clients and then saw the PALS post, which made her think "Oh this would kinda see me to continue to have a more in-depth relationship with them". Pauline comes across as quite an assertive person, she explains that "no is not in my vocabulary; no probably means in a minute, later, not now; but not never" (line 273). Indeed Pauline fought for and got supervision for her and her peers due the emotionally intensive nature of the work that bordered on "clinical". At the same time, Pauline was really friendly, with lots of jokes and a loud boisterous laugh. She comes across as nurturing and protective, but also a no nonsense manner.

Box 6 Research Diary: Helen

Helen

Helen was a medical administrator and was specifically attracted by the PALS role because "you hear so many story, it was different, and I wanted to do something different, more challenging, more exciting because after a while that role it seemed to sort of, was gone flat" (line 203). Helen seems to have a happy go lucky attitude to life; she was quick to laugh and quick to brush things off.

Box 7Research Diary: Sue

Sue

Sue was an NHS administrative temporary worker; she did not specifically apply for the PALS role but was sent by the agency that contracted her. After working in a temporary position, Sue is now a permanent member of staff. The youngest interviewee in this study, Sue seems to enjoy the process based nature of her work; speaking of her colleagues' emotion work, she confesses that she could not do what they do. She likes to be on time and to meet deadlines, and looks forward to payday and the end of the week.

Box 8Research Diary: Julie

Julie

Julie was a lone worker, her office was hers alone and she was the only employee in her organisation dealing with PALS work. In spite of this, she would talk in the plural 'we', referring to herself and the organisation. Amongst all the interviewees, it seemed that Julie was the one who most empathised with hospital staff – perhaps due to her being the sole official in this line of work.

Box 9Research Diary: Patrick

Patrick

Patrick was reminiscent of a pirate. He was very eloquent and open, and in a frank manner conveyed his frustrations with the system. Out of all interviewees, Patrick was the most senior, perhaps for this reason; he was also the most disillusioned. This interview was also psychologically difficult as Patrick engaged in significant offloading; it seemed as if Patrick was in the midst of burnout and his cynicism, exhaustion and frustration needed an outlet which the research interview provided.

7.5 Data Analysis

Interview recordings were transcribed as soon as possible after meeting with the participants. Qualitative approaches appreciate that transcription can be part of the interpretation process(Poland, 2008); in a way analysis begins here. For this reason, to maintain the authenticity and integrity of participant accounts, it was important to recall as much as possible about the participant's tone and mannerisms as well as the researcher's own feelings during the interview. Interviews were transcribed verbatim and some notes were made where appropriate about participant intonation, office space and own personal emotions. To convey as authentically as possible the *lifeworlds* of participants, their ways of speaking, syntax and grammatical patterns were maintained. Some Ms Word short cuts were created for frequently used words to speed up transcription e.g., participant pseudonyms, org → organisation, bus → business etc. Commonly used transcription notations include:

- ... to represent participant pauses
- * * to represent participant actions and behaviours
- [ ] to represent researcher descriptions

The process of data analysis followed the recommended IPA guidelines (Smith, 2009). In IPA, analysis is "iterative, complex and creative" (Frost, 2011, p.56). Each transcript in its entirety was treated as *data corpus*, reduction or ordering was not done at this first stage. Being a 'hands on' and tactile person, the preference initially was to print out hard copies of the transcripts and engage with them physically by using colour highlighters, pens, and actually *touching* the data. Initial ideas were noted on one side of the transcript. Then transcripts were re-read again. Initial interpretations and patterns slowly emerged the more data immersed one became. As Smith was left handed, he recommended that the left side of the transcript be used for analytic

interpretations; however for this study, being right handed, the right side was used instead (Table 24).

Table 24 IPA Analysis Extract

Single mum Dog Flexible Work life balance?	Lynne: it fitted in my life at the time. Emm I was a single parent mum and it gave me a degree of flexibility I was determined to have a dog so I could come home at lunch time and walk my dog. I know that's so unprofessional, why did you choose this job? Well actually I had a dog.	Reasons for career change

Once this was completed, emergent themes were pooled together and viewed (Table 25):

Table 25Extract from list of initial themes

- Ownership
- Equipment
- Types of patients
- The system
- Helping people around the world
- Nice serial users
- Environment around office
- Physical reaction
- Transfer to home
- Reputation
- Taking sides
- Giving all day
- etc

An examination of emergent themes then led to clustering (Willig, 2008). Those that were conceptually similar were grouped together (Table 26):

Table 26 Example of initial theme clustering

Environment around office + Physical office →Embodiment
Ownership + nice serial users + helping people around the world → Job motivators

At this point, some themes were dropped while others were teased out further. The decision to drop themes was based on the research questions; for example, at times participants shared interesting albeit not relevant information about themselves. As much as possible, themes were kept as *in vivo* representations of participant words to authentically capture their inner worlds.

Each individual experience could be considered as an independent case study, for instance Eatough (2005) conducted a single person interview for her second study in her PhD. However in this case,the analytic process recommended by Smith (1996) was then repeated with all remaining transcripts as was done by Osborn (2002) in his PhD. Inevitably, as analysis was repeated it was at times difficult to separate accounts; and to ensure that each participant received their just attention, different transcripts were not analysed on the same day and a break was taken before moving onto the next interviewee. Once all transcripts were thus analysed, a flipchart paper was taken and all emergent themes were written down. From here, some super-ordinate themes logically clustered together, while others seemed independent. This was an in-depth and challenging phase; all themes seemed important and many could 'fit' with another grouping. At this stage, it was helpful to keep in mind the research questions as not to get 'lost' in the data. This was not a rigid or linear process either; many times new themes were birthed and old ones died. This iterative, and at times frustrating process, was repeated until all themes were accounted for, either incorporated in a super-ordinate theme or dropped.

The data was then transferred onto nVivo, a qualitative analysis software (please see Box 10 for an explanation of why nVivo was used in mid-analysis). The next stage recommended by Smith (1996) is to create summary tables which showcase themes and supporting participant quotes. This was done on nVivo by the use of 'node' lists (Figure 18).

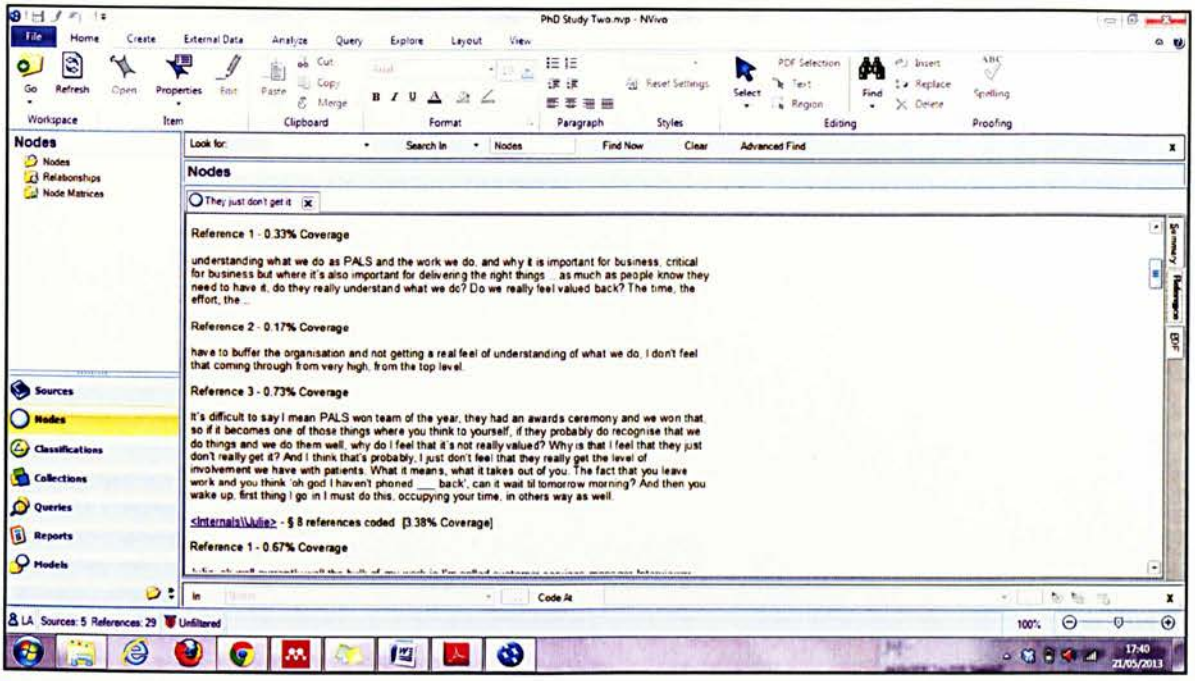

Figure 18 nVivo node list example

Generating the nVivo node lists is the equivalent of Smith's proposed summary tables with the only difference being the layout. Summary sheets have the output presented vertically, in a list format, while summary tables as the name suggests presents participant quotes in a table structure. The advantage of using nVivo was the ease with which one could change between themes and participants; for example double clicking on what nVivo calls a 'node' to see participant references or selecting the PDF function to see the full quote in context.

The final stage is to write up and present the data (Smith, 1996). Basically, this is about translating the themes into a coherent narrative account. There are two main approaches to writing up qualitative research (Burnard et al. 2008). The first, much like writing up a quantitative study, is to present separate findings and discussion chapter. The findings chapter would headline each theme and include supporting quotes, while the discussion chapter would link said findings to theory and previous research e.g., (Osborn, 2002). The second way integrates both findings and discussion into one longer chapter, presenting both themes and their relationship with theory, followed by a concluding chapter e.g., (Jenkins et al. 2010). This thesis uses a combination approach; while it merges findings and discussion into one large chapter, it does separate each super-ordinate theme into its own chapter. This structural decision was made to allow for in-depth discussion of each 'part' without losing sight of the 'whole'.

The next box provides an extract from the research diary, recounting the researcher's experience of data analysis (Box 10).

Box 10 Research Diary: Analysis

Analysis

There are two key points that need to be reflected on concerning data analysis. The first is about the location of the data analysis and how it moves from 'hands on' engagement to the use of software. The second is about the scope of the data and what was considered as data corpus. Each of these is now transparently shared.

A mistake was made in that, at the start, transcripts were analysed at home. This was a bad idea as the contents of transcripts were psychologically heavy and participants spoke of distressing events. For example, Patrick spoke about how he would rota his staff on what he called the 'dead baby' calls and used very vivid metaphors and at times violent imagery to convey his frustration e.g., 'baby with an axe through its head' (line 706). This information was really disturbing and confidential offloading was done with Dr. Lewis, dissertation supervisor without breaching participant anonymity. Soon, it became difficult to compartmentalise the negative emotions from the research away from home life, and often, analysis could be emotionally challenging. Tomkins and Eatough (2010, p.166) warn of the possibility that, at times, participants may say things that "just chimes with us and makes us feel that we know what he or she means". In this instance, it felt like being lost in this empathy.

Thereafter the decision was made to move data analysis to the town library as to keep the research separate from home life. In addition, nVivo was used as a tool to separate the self from the data – as participant accounts were now in softcopy and the laptop was physically separating the self from the data, there was some 'distance' between researcher and participant accounts. This helped in keeping a metaphorical separation between interviewee and interviewer emotions. It also assisted in generating higher level interpretations of participant accounts as opposed to simply experiencing empathy. Perhaps in a way, having done the process of data analysis both ways; once as a highly involved empath and once as an interpretative researcher, more authentic insight was gained into the experience of PALS worker wellbeing. At all times data was handled within good practice standards; it was never left unattended at the library and at no time anyone had the opportunity to see the work. Confidentiality was strictly maintained at all times including data transportation.

The second point that needs to be conveyed to the reader is that the data corpus was limited by the researcher and an *a priori* decision was made to restrict some parts that concerned grief. This

decision was made on ethical grounds. In a way, it seemed that while most of the interview was blanketed by the informed consent form, the particularly sensitive topic of grief was not. It may seem odd that these parts of the transcript were omitted from analysis when all participants clearly read and signed the informed consent form. But it can be questioned whether participants were aware of just how much they would disclose; that they would share such intimate information about the death and loss of their child, spouse, partner. This of course brings up a valuable lesson concerning informed consent and whether participants can in fact give it beforehand. Perhaps, in some cases, informed consent should also be confirmed at the end of the interview, once the participant is aware of the extent of their disclosure.

This study is not about grief. It would have been voyeuristic to 'use' those painful memories as data. This experience of grief is acknowledged as part of the participants' *lifeworlds*, for example on page 355 it is explicitly stated that grief has impacted on *having a wobbly*; but their recounted experience of grief and their memories are not quoted verbatim. At times, researchers have to use their discretion and break confidentiality to protect from harm (Wiles et al. 2008). Conversely, it could be that at other times researchers need to apply stricter confidentiality constraints. It is believed that using those memories as data, particularly when the research is a work related project, would have been a betrayal of participants' confidence. It is sufficient to say that grief has of course impacted on their wellbeing but it is not necessary to then conduct a post-mortem on these experiences and exhibit them at conferences for all to see. Indeed this decision conflicts with IPA's commitment to exploring *lifeworlds*, and perhaps it has not sufficiently dealt with the full impact of grief on the phenomenon of wellbeing; but if this study was repeated, the same decision would be made again. In this instance, being an ethical researcher takes precedence over methodological purity. Future research could of course explore the impact of grief on one's career choice, and this potentially would make for a very interesting study.

7.6 Research Ethics

An interview guide was prepared with open-ended questions. At the start were a few general questions aimed at setting the participant at ease e.g., *please can you tell me a little bit about your job? What made you apply for this position?* And then the interview moved onto more serious topics such as *how would you describe your wellbeing? How have you been feeling recently? Can you give an example of when you felt ____ [participants own word]?*As the overall topic of the interview is rather sensitive and from the results of the first study there was an

expectation that perhaps distressing experiences would be recounted, it was ensured that the interview ended on a positive note, by asking a question that would make the participant reminisce on a happy occasion. In truth, participants were all so eloquent and open, that often times the conversation simply flowed naturally and questions were answered without even being asked. Perhaps as their job involves communication, they are naturally interactive individuals with highly sophisticated interpersonal skills; also dealing with sensitive issues as part of their role, they did not shy away from sharing their distressing experiences. For them, this was perhaps 'normal' territory and they were desensitised.

Or perhaps the interview experience resurrected painful memories and triggered distress. Indeed some participants shared agonizing recollections from their past, the death of their child and the loss of a partner. Were particpants aware *a priori*, when signing the consent forms, that these memories would re-surface and be shared with the researcher? This seems highly unlikely and these moments were not used in the research as data; it would have seemed wrong to inspect these private emotions when this study's aim was not to investigate grief.

It could also be that the interviews elicited re-interpretation of participant circumstances. Perhaps before thinking about their work experiences in such depth, participants were quite satisfied with their jobs; but now, having dissected their successes and failures, are left feeling somewhat lower. Or it could be that having a researcher enter their difficult world and ask questions led to the spark of hope, that perhaps, she could do something to make things better. Truthfully, there is some remnant guilt in the knowledge that this research is primarly an academic enterprise. Of course, impact factor is important. There have been conferences and there will be publications, a business report and dissemination of data more publicly for instance through social media – but the truth is, policy is unlikely to alter dramatically as a result.

When diarising the interviews, participants were emailed the research summary (appendix 3) and encouraged to get in touch should they have any questions. On the day of the interview, prior to commencing, participants were verbally briefed and given a hard copy of the research summary along with a business card. Before recording took place, interviewees gave written consent to participate in the research, to be recorded, and for their data to be used anonymously in resulting publications. For a copy of the consent form template, please see appendix 5. The audio equipment was carried securely in a 'research bag' that also contained field notes and this was transported safely in the researcher's car and then kept in the researcher's office. The research bag was emptied after each interview to protect the anonymity of each participant. Upon arriving home, the audio was downloaded on a laptop and stored in a password protected folder. The key

for participant pseudonyms and subsequent transcripts were also stored in different password protected folders (i.e., audio, transcript and key were never in the same virtual location at the same time). As can be seen, reasonable adjustments were made and care was taken to ensure the protection of data at all times.

7.7 Summary

This chapter has narrated the methodological steps taken to exploring the lived experience of PALS worker wellbeing. It has shown how this second study has gone about answering the fifth research question that emerged from the initial investigation:

RQ5: What is the lived experience of PALS worker wellbeing?

In order to answer this much more descriptive and in-depth question, a qualitative approach was taken within the IPA tradition. In this way, it was possible to explore the *lifeworld* of PALS staff being interviewed and understand their perceptions of their wellbeing. While the first study generated broad knowledge by way of benchmarking and frequencies, this second study aims for deep knowledge to further knowledge on the phenomenon of PALS worker wellbeing. In this way, this project paints a more holistic picture, providing both wide and deep understanding.

Nine participants were interviewed using a semi-structured guide. By following Smith's (1996) guidelines of IPA analysis four super-ordinate themes emerged from the data that explain PALS worker wellbeing:

- *they just don't really get it*
- *changing a super tanker's direction*
- *breaking point and life in context*
- *this is a vocation and I wanna do it*

Each theme is now presented and discussed in its own separate chapter. Chapter eight will address what it is like being a PALS employee, chapter nine will describe being a change agent, chapter ten will recount participant breaking points and life in context, and chapter eleven will explain what it means having a vocation. Following this a general discussion chapter will integrate both the quantitative and qualitative studies into a concluding argument.

8. Being PALS: They just don't really get it

8.1 Introduction

This fifth chapter reports and critically discusses the first emergent theme:

Super-ordinate theme:

a) They just don't really get it

Sub-themes:

*a1) Quite a lot of *banging fist against heart**

a2) The NHS outside toilet

a3) Maybe they're right, I am useless

This *in vivo* theme label aptly captures the palpable misunderstanding of the PALS job role. Participants share that their job is really about **banging fist against the heart** while others erroneously equate it with generic complaints services in other industries. However the contents of the complaints and the manner in which they are conveyed are rather different and the PALS job role involves a great amount of emotion work. Participants believe that others see them as *the NHS outside toilet* while they see themselves as 'the spinal cord for the Trust'. These poignant metaphors vividly capture the gap between how PALS staff view themselves and how they believe others see them and explains how this discrepancy and misunderstanding affects their wellbeing lived experience.

8.2 Quite a lot of *banging fist against heart*

All participants interviewed conveyed an explicit sense that others simply did not 'get' what their job is about. As thought of in the literature review chapter, it seems to be a miscellany of tasks. Adam explains that they deal with "patients, the carers, parents, doctors" (line 33), that they "get a lot of you know emails from doctors and secretaries and mental health teams elsewhere in the country" (line 252). Lynne adds "corporate correspondence, we get a lot of mails from MPs, from emm say like newspaper sources, things like that. Major media requests for information" (line 144). Sue sums it up by saying "we get email complaints, phone complaints, by letter, in person,

yeah" (line 425). So it would seem that participants have to communicate with various audiences and receive work to do from different sources. A stream of it. Adam explicates that "our free phone number is on everything, on every leaflet, every poster, contact PALS" (line 419); so the job itself, "it is vague, but there are kind of boundaries around it, but vague ones, so you can be a little bit flexible, creative about things" (line 840).

There appears to be some administrative tasks such as acting as a "reserve switchboard" (Adam; line 34) and customer service tasks such as when "people do Google searches or they get our number from somewhere, so we get enquiries about services" (line 428). But it is their emotional function that takes up most of their time. Pauline explains that "between 9 and 5 we man the crisis information line, so anybody that's in a crisis, we deal with it" (line 242). At times, they function as a "reserve social worker or community psychiatric nurse" (Adam; line 465). Helen explains that "some cases that went onto, into a counselling session cause they were ringing back weekly and it goes on" (Helen; line 440). Pauline confesses:

> PAULINE: they don't take up a lot of my time, and they don't use me as a service per say, nine times out of 10, they're receiving services here anyway so I don't want too much to kinda be influencing what they're actually receiving, so it's just something just alongside what they're getting, so it's almost like a friend, so if I give them 15 minutes that to me is not too long to undo anything that probably they're getting professionally. But it gives them something that they keep ringing or just to talk about what they have done in like they in psychotherapy at the moment (line 423).

What Pauline describes above, weekly diarised sessions where she plays the role of a "friend" to patients who are perhaps in psychotherapy, simulates counselling. These are not *ad hoc* phone calls but pre-planned sessions. Pauline is appreciative that she is not a counsellor though; she ensures that she does not influence their formal treatment, but rather, she supports it, "just alongside what they're actually getting".

Julie hypothesises that perhaps:

> JULIE: I think maybe some people think it's like a complaints job in a you know for as I said in a mobile phone thing where they get 'oh dear really sorry we'll send you a new mobile phone' or something course it ain't like that and you know can't do it like that, it's totally different (line 803).

The main difference appears to be how much of themselves they invest in their role. Julie explains:

> JULIE: my boss is a very interesting lady, she's very process driven, very, very, and she loves the idea that people could pick the phone, I think she sort of thought, it was like contacting a company and saying my Hoover doesn't work anymore, saying my mobile phone has a problem. And she got this in her head really [...] Emm she's just very, she's brilliant at reading documents, all that, but it's not, quite a lot of **banging fist against heart** that really [...] this isn't just about process, this about actually engaging with people face to face. Talking to them, taking about their worries, their concerns, and things like that. You know it's very, you can't do it in a just a process. Anyway. (line 18)

Julie feels that her boss does not comprehend the level of emotional involvement inherent in the job. While her boss thinks the complaints function is process driven and equitable to Hoover services, Julie explains that it is actually about **banging fist against the heart*; talking to patients about "their worries, their concerns, and things like that". It seems that it is that very aspect, that humane emotional engagement that senior members are simply not seeing.

Alicia wonders:

> ALICIA: I just don't feel that they really get the level of involvement we have with patients. What it means, what it takes out of you. The fact that you leave work and you think 'oh god I haven't phoned ___ back', can it wait til tomorrow morning? And then you wake up, first thing I go in I must do this, occupying your time (line 102).

She recounts the level of involvement with patients, how much it takes its toll on her, and how work matters can occupy her mind even at home. She feels under-appreciated and under-valued, largely stemming from senior members not understanding just how much of herself she invests in her role.

For example, one of Adam's patients committed suicide. He shares that:

> ADAM: I could see from the outset you know that something could be done. Perhaps I'm wrong, perhaps, obviously could be wrong, perhaps he woulda done that anyway or I didn't do best I could and he wasn't sectionable, but I want to voice my opinion. Yeah but I mean. If it's obviously very negative outcome but you know that's the sort of thing we can change things and you know I definitely want to get my voice heard (line 830).

This example recounted by Adam is extremely different from the Hoover example or the mobile phone case. Here, a patient whom Adam was dealing with committed suicide. While Adam is

being rational about the situation and considering alternative explanations, he nevertheless entertains some self-blame and guilt, that perhaps, he could have done more. Although he says:

> ADAM: I did everything I could, you know I've got nothing to reproach myself, it's sad, but I did the best that I could. It does you know I said this is the reason that people kill themselves cause there isn't *that* (line 821).

Beneath his words, Adam feels the weight of this patient's suicide on his shoulders, conveyed through the force and passion in his tone.

For Patrick, the most senior interviewee, as a leader he also has the additional burden of managing the strain of his staff which in some cases can be horrific. For example, he discloses that:

> PATRICK: One of my staff was primarily dealing with safeguarding and this means that as a pan London organisation what she's dealing with all the time is dead babies. Yeah. And that takes it toll. So I had to take her off of it because it was just beginning to really get to her. Yeah. Really because that was big focal point of her work, was on serious case reviews which all involved dead children, who had been killed one way or the other, some from natural causes, some not by natural causes, baby P, classic example, and we see a lot of that. So there's that emotional trauma and just the notion of people shouting at you a lot (line 529).

As Patrick explains, it is not solely "the notion of people shouting at you a lot" but also the "emotional trauma" of the case. What Patrick appears to be implying is that for their job, both procedural aspects of communication (e.g., people conveying information by shouting) and distributive aspects (e.g., the traumatic subject of the case) are rife with difficulty and must be managed by the employee.

Pauline sums it up beautifully when she explains:

> PAULINE: the customers that we have are not the general customers that they wanna put under the same umbrella, cause to me a customer is somebody that is in a shop and is upset with a pair shoes or something, here, it's somebody that is upset with their mental health or the service or the care they're getting [...] it's different purchases. And to kinda label the whole thing as the same [...] Don't think they value what we actually do. Or they try to trivialise it in comparison to their own role. So they can't make it sound any more important than their jobs worth (line 891).

In both cases, there is an element of power, of diminishing the status of one occupation and perceiving it as somehow 'less'. As Julie and Pauline propose, there is a deep misunderstanding of the nature of their work. Participants simply do not see themselves as others see them nor as their job titles identify them. While others equate their job with or "trivialise" it as mass production generic customer service, the reality is by far different; it is about **banging fist on heart**.

In spite of this, Pauline, Helen and Sue are known as telephone advice workers:

> PAULINE: That you're only a telephone or you'll only dealing customer, *only*, that as well, in itself, that only [...] can take away the kind of value that we place on it. Regardless, and on the clients, their attitude is what seems to be reflected from the staff's attitude towards clients, so we're the only ones that are on the client's side. Cause staff are not reflecting that we're not just ONLY answering the telephone (line 891).

For Pauline, she takes offense at being seen as "only" a telephone adviser. It is interesting to note in this account, she begins to use the term "client" to refer to patients. In a way, while talking about the counselling function, Pauline has put on a counselling "mould" and sees herself as a counsellor who speaks with "clients". Her disapproval with being perceived as "ONLY answering the telephone" takes away the "value" she places on her work, the importance it holds for her. She is not pleased with her professional identity being compared to a receptionist for example as her function is not simply telephone queries but also "clinical".

Similarly Julie, whose job title is customer services manager, confesses that she is unhappy with this discourse: "I don't actually like it very much, and I've kind of fought against it" (line 12). This dissatisfaction stems from what she explained earlier as being **bangs hand against heart** as opposed to a process similar to, using her example, Hoover complaints. Adam even confesses that at times they act as a "reserve social worker or community psychiatric nurse" (line 413). Again, these two functions are more "clinical" and counselling like than how they are perceived as telephone advisors or customer service workers. This echoes the sentiments conveyed by social workers in the Van den Broek (2003); in her research social workers who operate from a call centre feel that this ethos undermines and diminishes the value of their professional identity.

Overall, PALS staff appear to be sharing a deep sense of being misunderstood. While their job involves quite a lot of **banging fist against heart**, the way they are perceived and their job titles ignore or disregard this crucial factor. It is interesting to note that for them, this **banging fist against heart** is important. It appears that they place value on this emotional component of their

job and express frustration that others do not appreciateor acknowledge it. This discrepancy between self-perceptions and the perception of others is developed further in the theme below.

8.3 The NHS outside toilet

In a poignant self-descriptive metaphor, Julie compares herself to the ugly and dirty imagery of an outside toilet:

> JULIE: I used to say to people it's like being the outside toilet, you just open the door and you go **makes throwing sound** throw things, close the door quickly, and that's dealt with, that's alright [...] **laugh* cause you can see this gungy sort of horrible thing you know oh quickly close the door and it's gone away then, I don't have to think about it, cause it's been dealt with (line 818).

This grotesque representation of herself and her job as seen through the eyes of others is encapsulated by foul visuals of a "gungy sort of horrible thing"; one can almost smell the fetid odour in Julie's description. Her choice of word "gungy" may perhaps be implying a never-ending stream of diarrhoea, in order words, complaints. It is apparent in her speech that she believes others see her role that way, this can be inferred from her speaking as if she were them looking at her: "oh quickly close the door and it's gone away then, I don't have to think about it, cause it's been dealt with". These are not Julie's thoughts, but rather Julie's impression of other people's thoughts concerning her.

What is additionally sad in this otherwise appalling metaphor, is how Julie feels separate from the rest of the organisation – she uses the comparison of an 'outside' toilet and not just any toilet, hence the sorts of things she has to deal with are so bad that they are thrown away in an 'outside' toilet, not deemed worthy enough of an 'internal' toilet lest they contaminate the rest of the organisation.

Indeed, Alicia explains:

> ALICIA: they [patients] go off and they claim merry hell all over the place, we try and contain them. So that you as a GP or you as a commissioning manager you don't have to worry about it, you in public health don't have to worry about it. And you don't (line 270).

As Alicia remarks somewhat bitterly, they as front line PALS staff "buffer" (line 73) the organisation and absorb the "merry hell" raised by patients; by them consuming the patient's

emotions, they contain them and prevent them from reaching the GPs and the managers – who, are most likely the targets of the complaints. Pauline captures this by describing their role as the "spinal cord for the Trust" (line 250):

> PAULINE: I thought that the Trust doesn't realise just how much we are absorbing and it was to kind of reflect to let them know yes we're taking all this but you're not ethically doing us any favours either. 'Cause I did, I kinda said one time, we're the spinal cord for the Trust (line 250).

Patrick adds:

> PATRICK: So anyone who is angry about whatever phones up and because we are a focal point for the organisation you know they get a lot of abuse and shouted at. And my own staff if, although they're trained to deal with it, if on a duty base if it's too difficult they'll put it through to a manager or they'll put it through to me, they'll put the call through to me, so I have to take my share of flack. Yeah (line 517).

Patrick shows that their "buffer" function is actually quite broad; he says that "anyone" can call about "whatever" as they are the "focal point". As a result, his staff get "a lot of abuse and shouted at". For him, as their leader, he gets the really tough cases that his staff forward to him so he too receives his "share of flack".

Pauline sums it up quite representatively as she explains that at times patient calls come through that are outside of their job spectrum; she says:

> PAULINE: Do I turn around and say oh no that's not my job. No there isn't. Well for me there isn't. You just say hold on, I'll find out for you, and I'll get back to you. Start finding out does anybody else know [...] and sometime we might have to say we don't know but we don't say that until we know we don't know (line 328).

In Pauline's explanation it seems that PALS staff perform an information provider duty for the NHS to patients consistent with findings in Bentley et al. (2006). In Pauline's example, she recounts how she would seek information even if she did not immediately have the answer.

Laura explains further that:

> LAURA: PALS should be the people that put the courtesy back into the health service and try and open doors. The one thing that we would hope

> we never say is I'm sorry that's not my department can't help you with that, that would be **shocked deep inhale** terrible for someone in PALS to say that **laugh** so there's always, always have to look for the opportunity to think there's something we can do to make things better (line 985).

She seems horrified at the notion that PALS staff could refuse to assist a patient because "that's not my department". The very idea shocks her and she judges that it would be a "terrible" thing for a PALS worker to say. She re-iterates that there is "always, always" the opportunity to help a patient. It is also interesting that Laura sees the PALS function as putting "the courtesy back into the health service". Unlike most other functions described in the previous sub-theme, this is the closest a participant has come to identifying themselves as 'customer service'. Yet again, even the identification with customer service comes from a helping motivation, as Laura says; PALS staff should "try and open doors".

Julie confesses:

> JULIE: a lot of the top teams would do anything, anything rather than speak to patients, my god you know people wouldn't dream of it, my chief executive, although she's got a nursing background, she wouldn't speak to a patient unless she really, really had to, and yet patients would sometimes expect to speak to them. I've had to safeguard chief executives in my time, many a time, you know I've had my old chief executive at the hospital standing in my doorway going *I'm not here* when I'm going 'oh yes well I'm sure you would like to speak to him and I will make sure that he knows that you called'. And you see, you protect them, you protect them an awful lot and I don't think that's recognised at all by organisations I don't think they got any idea. Cause its things they don't really want to hear (line 808).

Julie shares the extent to which she shields the senior leaders, she says she "had to safeguard", evoking images of armoured soldiers protecting the fort. As she recounts, how she has had to lie for the chief executive who was hiding from the patient's ire, but that she, the soldier had to "protect". She is sad when she says that this part of their role is not "recognised", in fact she does not believe "they got any idea" because "they don't really want to hear". In a way, it is implied that *others just don't really get it*, not through ignorance of not actually knowing how much PALS staff do, but rather, because they chose not to acknowledge it as admitting it would also mean accepting some hard truths about their own actions. It appears to be easier to simply open the outside toilet door, throw in the "gungy" stuff, and then quickly close it.

8.4 Maybe they're right, I am useless

Some of the encounters that get thrown away in this outside toilet include quite traumatic experiences:

> JULIE: you're dealing with a lot with people so people come in and say 'you killed my mother, you killed my mother', I've never seen your mother, but they put a photograph of somebody on the desk and say 'and this is the person, so I don't want you to forget who this person is' so very, very personal and because you're in a hospital and those things are happening it's very big, and that's, I hadn't had any training or anything (line 212).

And abuse from patients:

> JULIE: he was just saying you know how hopeless I was and what a disgrace (line 76).

When she hears such demeaning words, her wellbeing lived experience is affected:

> JULIE: I've just kept silent usually those things to be quiet but there's part of me that wants to go 'oh fuck off' you know and that, that's when I know you know really, it's funny actually it's not the shouters, it's the people who go, just telling me how awful I was [...] he phoned me up and he said 'what use are you? You're, you've missed the target, so you're absolutely useless, I have friends in high places' [...] And very personal, very personal stuff. I don't get lots I have to say but the ones that do I remember them all. And you know he kept saying 'tell me why you've missed the target' I said because you know it's taken longer with staff, 'well why?!' **nasty voice** and those are the ones that really get to me cause you think, please don't shout at me, you really don't need to shout at me, I understand that you're upset about this, but they're not, I understand the shouty upset people when they're scared, and anxious, I really understand that, and they're shouting because they you know themselves they're ill or their family is, but the people who are just obnoxious because they're probably obnoxious with everybody, cause they're part of me I can get really clipped and in fact this chap, the other day, said to me, you keep interrupting me **nasty voice** and I thought do I? [...] But it is quite funny, but that was horrible actually really horrible, cause also you feel professionalism is being you know I think hey I'm quite a good person really, I'm not you know I can be naughty but you know basically I'm ok, you don't

> need to, you don't need to be like this to me, you know I'm here to try and help not, and I know all I'm doing is just making it worse really and that's horrible. That's really horrible (line 577).

And although Julie puts up a brave face, it can get to her:

> JULIE: I just have to kind of take it on the chin there's nothing much I can do about it. I suppose the other side of me, really to be absolutely honest, I suppose I also think supposing they say to the powers that be, my bosses, etc, and I've got a load of them, you know she's useless, and they think mmm she probably is then, and then there's all of that, slight **ding ding ding** in the back of my head. She's not really good in this job either you know and I know it's silly cause you know I've been like that for years and I've had to kind of fight that, and most of the time it's fine and occasionally you think mmm maybe they're right, I am useless, and I shouldn't be doing it. But you know it's. Exactly because they're sort of be able to get to that chink in your armour really you know and that's weird, that's a really weird feeling. Don't let it, cause I say, I spend so much time saying to staff look you know this is not personal, don't take it personally, don't it, they're going for you because we represent something and they want something and you can't always give it to them, but you know practice what you preach, I don't always (line 619).

Julie shares how her self-efficacy can take a serious knock when patients are abusive. For her, it is not the loud ones that shout that "get" to her, but rather, the ones that creep inside her mind and call her "useless", making her question her own abilities. It is clear in Julie's account that she is highly empathetic, she even empathises with the "shouty" patients and excuses their behaviour by stating that they are "scared" and "anxious". What gets to her "chink in your armour" (again another soldier analogy) are the patients who attack her self-efficacy. While she recognises that she urges staff not to "take it personally", she confesses "I don't always [...] practice what you preach".

Similarly, Alicia also gets hurts by abusive patients:

> ALICIA: I think I've always had this problem of thinking that it's me, what have I done? Is it me? Is it to do with my experience? Is it to do with this? What did I say? (line 154).

In both accounts, the abuse from patients translates into self-doubt where both Julie and Alicia begin to question their abilities and self-efficacy. Here Alicia is almost self-flagellating, questioning her actions and behaviours, blaming herself for the abuse that she is receiving – in a way, this is a representative example of the thought processes of someone being abused, believing that it is their fault the abuse is occurring.

Laura describes it as 'tipping over':

> LAURA: there are times where one call that just kinda tips you over, you think you're coping quite well, and then one thing will happen and then you'll just think, that's it, get back out, I'm obviously no good at doing this, you know haven't helped anyone today, you know I'm very bad at this job (line 368).

And again, there is a sense of creeping self-doubt and lowering of self-confidence, thinking that she is "bad" at her work.

Adam explains that keeping his own temper in check when patients are "just haranguing us, at one point screaming at us, so you know not nice" (line 615), "it isn't easy, not easy" (line 586). He says:

> ADAM: you know I am genuinely trying to be helpful here and you're just, feels a bit deflating. But perhaps I'm too sensitive (line 728).

While Adam expresses how he feels when he receives abuse, he too wonders if it is his own fault for being "too sensitive".

Sometimes, it can be a matter of safety though. For example, Adam recounts:

> ADAM: previous day there was a guy turned up who was one of our patients who was over at ____'s for some kind of, was seeing the psychiatric or was in A and E, and he didn't have any money, and he wanted the bus fare home and I said I'm sorry, I'd made the mistake, I'm sorry you have to walk, you know you got here and you have to walk back, you know, he was, I discovered later, I didn't check beforehand, he was a forensic patient with issue of violence against people so that kind of thing it's you know it is, I mean it's probably the same for every PALS service in the general hospital, with us it's particular, it's a particular feature (line 52).

While Pauline, Helen and Sue confess:

> PAULINE: [...] the vexatious ones that we do get sometimes they just ring and just talk. For the sake of talking. And you give them their space. With me, I

just say yeah you got 5 minutes and at the end of the it, I said I've got to go in 5 minutes, I can't entertain too long a time.

HELEN: as soon as you find a solution, they move the goal post. Carry on and again.

PAULINE: as soon as you solve something they're, yeah what about this

HELEN: or that

PAULINE: oh we was unhappy with the package it came in or... [*mimics funny voice*]

SUE: everything and everything to complain about...

PAULINE: and the postman he didn't knock twice and...

Laugh

PAULINE: it can be a bit jarring, so for them, I still give them their time, but I will limit their time (line 650).

Patrick on the other hand makes light of it:

PATRICK: I've had people threaten to kill me. Not that I took it especially seriously in fact what's the guy gona do? Come half way across London I mean you know it's nonsensical really. But I was told you know and I understand why if threats of that ilk are made I must report them and blah blah blah and I just didn't bother at the time. But yeah I mean not just me but I'm probably more experienced, well I am more experienced, can probably manage it better but my staff suffer with it (line 523).

Although Patrick admits that he has received death threats, he does not take them "especially seriously". He seems to make light of them, and sees the formal process of reporting "threats of that ilk" as "blah blah blah"; however, what worries him is how his "staff suffer with it". He believes that his own experience has perhaps desensitised him from such threats, but is concerned that his less experienced staff have not yet developed a means to cope with it.

In contrast to the lived experiences described above, Pauline, Helen and Sue deal with similar situations in a different way. They describe it in a more empathetic manner:

PAULINE: Definitely. Cause once you tapped into that, then you can, that half of it, is they're angry because they're angry. And it's not personal to you, and once you've tapped into that bit, and you then can mediate with their emotion. As opposed to sometimes you get the screaming and shouting, and I just say, I can't talk to you if you're screaming and shouting, or sometime you

give them that space to scream and shout, and you know ok then what are your issues? And then kinda.

LILITH: and what's it like having to listen to someone doing the screaming and shouting?

PAULINE: it's just them screaming and shouting

SUE: yeah you just let them scream and shout, like the other day, when I was speaking to her, what did I say, I had to go to a meeting or something, I said, I asked her to call back, she was like, but she went on and on.

PAULINE: once you've realised that they just want to just...

HELEN: quite a lot of them come for a, they just wanna talk

SUE: yeah

HELEN: they just wanna hear another person's voice at the end of the phone, they're not complaining, complaining, they just wanna talk

PAULINE: and this is what the staff are not doing on the wards. Or in the community. They will come to them with their issue and it's all kinda brushed, so it's like a conveyer belt, and they just somebody to listen to them, and a lot of it is communication (line 501).

For Pauline when patients get abusive, "it's just them screaming and shouting". Sue concurs and explains that "you just let them". Helen discerns that at times patients "just wanna hear another person's voice at the end of the phone", that their call is not a genuinely complaint per se, but that "they just wanna talk". Pauline believes that once "you've tapped into that bit", you can then "mediate with their emotion".

Similar to Julie who believes that senior organisation members do not want to hear about what is thrown away inside the outside toilet, Pauline understands that patients want "just somebody to listen to them" because "this is what the staff are not doing on the wards". As a result, when staff members brush off these patients who go to them with their issues, the NHS "conveyer belt" just brings them to the PALS doorstep. This Patrick calls jokingly "the NHS pass the parcel" (line 136).

The difference between how Julie, Laura and Alicia respond to abusive patients and how Pauline, Helen and Sue see it is remarkably different. Of course, Julie, Laura and Alicia do appreciate that they ought not to take it personally and so forth; however, the impact of this abuse on their wellbeing is more profound and negative. For them, it translates into self-doubt and a decrease into self-reported self-efficacy. For Pauline, Helen and Sue, it appears to be channelled as empathy for the patient. In a way, it can either be turned inwards (e.g., self-doubt) or outwards (e.g.,

empathy). Perhaps the camaraderie in Pauline, Helen and Sue's closely knit office helped to mediate the effect of patient abuse on wellbeing?

To find out about what made their case special Pauline, Helen and Sue were asked to explain further about their experience of being the "voice of the system" (Adam, line 589). Initially, they make light of it:

> PAULINE: you put the phone down and you go ARGH and talk about shoes, talk about food
>
> **Laugh**
>
> HELEN: phone rings and we start again
>
> PAULINE: start again!
>
> **Laugh**
>
> HELEN: we start again
>
> PAULINE: so we don't get much time to sit in your despair (line 664).

But on further probing they confess having to put on a "mould":

> PAULINE: the conversations we have in between it. That is, has nothing to do with the work. And then we could be, duh duh duh **mimics chit chat voice**, and the phone rings, **makes like answering phone** good afternoon PALS how can I help you? **mimics professional calm voice** ... and then you put the phone down... yeah duh duh duh **back to chit chat voice**

Laugh

> LILITH: so is it like a face you have to put on? Or voice?
>
> PAULINE: it's a mould you get into. With me it's a voice first, then it goes into the mould.
>
> LILITH: and your face when you... good afternoon PALS
>
> **Laugh**
>
> PAULINE: yeah I do start off with the voice, and the face, and then get myself right, especially if I'm really not feeling it. I go **really chirpy voice** GOOD afternoon PALS how can I help you?! (line 676).

These experiences appear to be consistent with emotional labour theory; it appears that Pauline engages in acting by getting into a "mould" which for her starts off by mimicking a really happy and up-tempo voice. When Pauline acts out this voice, her face completely changes and it becomes a caricature of a chirpy and bubbly persona, with wide eyes and a Cheshire grin. It was rather comical, but also, a little frightening as that degree of happiness seemed unnatural.

8.5 Discussion

The pain and suffering experienced by PALS staff is palpably conveyed by participants. Almost all were eloquent and expressive; and perhaps the most striking thing about this theme was the imagery and metaphors used by participants to share their experiences. Metaphors in research are recognised as important tools with which to uncover participant ideas, their attitudes and values (Cameron et al. 2009). By looking at how participants construct analogies and make connections between their ideas, researchers can reveal how participants use language to explain abstract ideas and convey powerful feelings in an evocative frame (Cameron & Maslen, 2010). Metaphors are increasingly being perceived as a valuable interpretative resource in IPA and this can be inferred from the sorts of titles that authors chose for their publications e.g., 'the top of my head came off' in the title of an article about depression (Rhodes & Smith, 2010); 'I feel like a scrambled egg in my head' in a paper about anger (Eatough & Smith, 2006) to name just a few. By exploring how participants use metaphors, a better understanding of their emotions and conceptualisations can be developed.

In this theme, as participants tried to describe what their job was really about, Julie used the physical action of banging her fist against her heart. In a way, she could not vocalise the nature of her job, but had to use a physical descriptor to convey her meaning. She contrasts their work, which is about **banging fist against heart** with process driven complaints services in retail industries. This, this distinction, this difference, is what Alicia explains others "just don't really get". In a way, it is quite difficult to explicitly state what PALS is because it is so many things at once. It is also a somewhat 'gray' occupation, not quite customer service as others see them, but also not entirely a "reserve social worker" (Adam; line 413) all the time. This inability to clearly identify their job is most beautifully captured by Julie in her physical action – whatever PALS staff may do, it is about **banging fist against heart**.

The sorts of experiences they have in the workplace are quite far removed from the experiences of generic customer service workers. For instance, Adam's experience with suicide more closely resembles the work experiences of 999 operators who share the emotional impact of either hearing or imaging human tragedy at the end of their calls: "*imagine the effect of listening to a woman being beaten up in her home and dragged away from the phone, then consider how you would feel if you were exposed to this kind of thing every night*" (Bain and Taylor, 2000; p.15). Equally, Pauline's sentiments about having her role trivialised echo the emotions of home care

workers as opposed to customer service workers. Home care workers express how they feel disrespect at being perceived as aides similar to PALS who are equated with customer service:

> *"Nobody'll listen to you . . . you're just the aides. I get so tired of being thought of as incompetent and stupid and don't know anything. But I think it's always been that way. And I think it will continue to be that way. We're the ones that know the patients, and everything. But it's the power trip, the control trip . . . I could care less. I do what I do, you know?"* (Stacey 2005, p.839)

In describing how they are positioned between the organisation and patients, Alicia states that they "buffer" (line 73) the organisation, conjuring images of a country stuck between two opposing powers, trying to break peace or perhaps a biological buffering agent, maintain the pH of a solution against another acid. In either case, both comparisons convey an act of protection and prevention. Julie uses a similar battle analogy by stating that they "safeguard" senior staff members; in essence, it is PALS who are the face of the organisation while the senior leaders hide behind them. In a truly poignant metaphor, Julie says that being PALS is like being the "NHS outside toilet" that others use to throw away "gungy sort of horrible thing" (Julie; line 818). This comparison summons a rather putrid stench and ugly images; it epitomises the extent of how much PALS absorb in their job. It also separates PALS from the organisation, placing PALS outside of the inner circle that they safeguard and buffer against others. This is quite a sad world depicted by Julie; people have a fundamental need for connectedness, their attitude and relationship with the social world around them influences mental health (Rettie 1995). Here Julie is describing a world without connectedness, one where PALS is on the outside. While communication with others can create feelings of connectedness (Rettie 1995), in this case, people quickly shut the door of the toilet as soon as the rubbish is thrown away, further separating PALS from the organisation.

In a completely opposite comparison, Pauline describes the PALS job as the "spinal cord for the Trust" (line 248). Here, she sees their job as absolutely crucial to the Trust's functioning – it is the main pathway of communicating information between the brain and the nervous system, between the organisation and the patients. The feelings being drawn out with this metaphor are quite different; there is a clear sense of importance and value. The ideas being communicated here are positive and desirable. Unlike the toilet which is outside, the spinal cord is internal to the Trust.

It is interesting to note that in both instances, participants are choosing metaphors that suggest a live biological organism that is constantly evolving, implicitly intimating that the Trust is a living

organism being symbolically constructed through meaningful interactions. This perception of the Trust is quite a symbolic Interpretivism approach to organisation studies (Hatch., 2006). It adds a much needed fluidity to the traditionally static theories used to explain behaviour. For example, while both toilets and spinal cords are necessary for the functioning of a live organism, the former creates a reality where staff throw away their waste into the PALS toilet while the latter constructs a world where PALS are the lead pathway for communication. Perceptually speaking, these are two quite different organisations. And herein lies the problem – while PALS perceive their role as **banging fist against heart** and see themselves as the Trust's spinal cord, they think others regard them as the NHS outside toilet. This creates a rather gaping chasm between what PALS think they do and what they believe others think they do. This misunderstanding, the core of *they just don't really get it*, can be seen as the primary reason for them feeling under-valued and not appreciated. In other words, PALS perform quite humane and helping activities which are characterised by absorbing quite negative emotions; however, much to their dismay, the Trust does not seem to appreciate this pivotal function. On the one side, patients are offloading on PALS, and on the other, the Trust is disburdening itself.

So referring back to the extended Job Characteristics model by Humphrey, Nahrgang, and Morgeson(2007), it is known that *experienced meaningfulness* and *experienced responsibility* make up critical psychological states that mediate the relationship between work design characteristics and outcomes such as wellbeing. In other words, *experienced meaningfulness* and *experienced responsibility* explain how the external work design aspects take on internal psychological importance for the employee. However, in the case of PALS, as evidenced by this theme, the motivational characteristic of *task significance* is dependent on perceptions. In the one world, PALS staff believe they are viewed as an outside toilet, as something horrible and bad; hence the significance of their task takes on a different meaning than in the world where they are seen as the spinal cord of the Trust, something imperative and good. As pointed out by Grant (2008, p.109) task significance is a "subjective judgment" that is "socially constructed"; its meaning is created through social interactions with others where social cues are picked up and used to reframe employee perceptions. Inevitably the meaning that PALS staff draw from their work takes on a different hue in the world they see themselves as valued and appreciated compared to the world where others *just don't really get it*. It then becomes somewhat difficult to apply models such as the Job Characteristics model without considering individual perceptions as it is these that give meaning to the antecedents. As shown by this example, PALS staff can interpret their positioning in the organisation in two very contrasting ways; which will in turn affect the construction of *experienced meaningfulness* and *experienced responsibility*. As pointed out by

Heidegger, perception determines the meaning of items, this meaning in turn generates behaviours, which resumes the fluid loop of interpretation and construction once again.

Pauline explains that as PALS they "absorb" (line 250); invoking images of a sponge that is taking in; raising the question of what happens to what is being absorbed. This of course creates wellbeing outcomes. Much like the 'antecedents', they are also dependant on perception (as opposed to objective criteria in a static world). Even participant metaphors are reflective of this fluid and dynamic quality to wellbeing outcomes. For examples, the words that they use to describe the negative impact of this "gungy sort of horrible thing" (Julie; line 818) on their wellbeing are active words such as "deflating" (Adam; line 728) and "tips you over" (Laura; line 368). This can be contrasted to the more static variable of 'overload' in the third column of the table. The words used by the participants do not describe static and inert outcomes but rather mutable and fluid experiences. In the case of Adam, he explains it as deflating him, like a balloon that is losing its air; this is an active description of air being lost over time, and it is a sequence that is happening. Similarly, Laura equates it with tipping over whereby the descriptor is a movement.

8.6 Summary

This theme is unarguably sombre and psychologically heavy. The purpose of sharing these accounts with the reader is not to shock or upset; but rather to communicate the extent of misunderstanding about the PALS role and show the reader the lived experience of PALS worker wellbeing. This theme has shown that the PALS worker believes their job role is wrongfully grouped with other customer service roles. On the whole PALS staff feel that others *just don't really get* what their role is about, how much of their self is involved in the job and how their actions buffer the organisation. Similarly, they show displeasure at their job titles which fail to capture their high level of emotional involvement and investment. Participants can be known as 'telephone advice workers' or 'customer service managers' but they struggle against this identity that is forced upon them by the organisation. They take great pains to explain that their role is quite different from complaints services in other industries and that in their case their job is really about **banging fist against heart**. In a way, this physical action that cannot be vocalised represents the difficulty in identifying the PALS role as much of their work is unseen, interpersonal and implicit. This underlying theme of the physical, the embodied, resonates quite loudly in this study; and will be considered more fully in chapter ten.

Participants believe that others perceive them as the "NHS outside toilet" while they see their work as equitable to being "the spinal cord of the Trust". They explain that they "buffer" and "safeguard" the organisation and its members by picking up the "gungy sort of horrible thing" from the NHS "conveyer belt" while the system plays "pass the parcel". It appears that PALS staff are stuck in the cross fire between patients and organisation, receiving and "absorbing" the "emotional trauma" from both sides. PALS staff act "almost like a friend" to patients while still attempting to protect the organisation.

As a result, this can at times "get" to them. Sometimes, it can be "deflating" and the weight "tips you over" into doubting self-efficacy. These wellbeing experiences are recounted in quite embodied terms, reminding that humans experience the world through their senses and are not solely cognitive information processors. In some occasions, for example the highly amicable office where Pauline, Helen and Sue reside, increased empathy, contrary to theoretical precedence, can assist PALS staff in appreciating that it is not "personal". This could be suggestive that in some cases deep acting could actually be beneficial for wellbeing. The next chapter presents the experience of being a change agent in the NHS.

9. Being a Change Agent: Changing a Super Tanker's Direction

9.1 Introduction

While the previous theme evidenced how 'others just don't really get' the demands that are placed on PALS staff, this theme explores what it feels like to change a changing organisation. This theme captures the challenges of being the bearer of bad news in what is described to be a dysfunctional system and it explores PALS worker fears of the post-reform future. This is a complex and dynamic theme that is difficult to translate into a chronological narrative as challenges and obstacles are not easily separated nor their effects easily isolated. There is also something amiss in trying to make these sub-themes 'fit' into a linear order as imposing this structure fails to adequately represent their fluidity and interplay. The narrative of this theme tries to convey this dynamism but is restricted by its use of the written word as by narrating a chapter it inevitably imposes a certain chronological order and thematic separation to experiences. This chapter reports and engages in a critical discussion on the second theme of this study:

Super-ordinate theme:

b) Changing a super tanker's direction

Sub-theme:

b1) I'm not Paul Daniels, I can't pull it out of a hat

b2) Bringing back unpalatable messages

b3) It's not my NHS anymore

9.2 I'm not Paul Daniels, I can't pull it out of a hat

As part of their job remit, PALS workers are organisational change agents; they relay patient feedback back to senior decision makers and initiate changes (Department of Health, 2002). Adam compares this role to changing a super tanker's direction; he says:

> ADAM: it's like trying to change a super tanker's direction you know the NHS works and eventually get there but it takes time (line 275).

Lynne ponders:

> LYNNE: I don't know because it's so big I wonder if it would just get lost in the bigness of it. I don't know. I would... I don't know. I genuinely don't know how you can influence something that's so enormous and so bureaucratic (line 623).

Similarly, Pauline questions the longevity and sustainability of changes that are implemented:

> PAULINE: it's not aiming nowhere because these service improvements will be there year after year after year? And what was the improvements? After you've said this is what supposed to be a service improvement, where's the feedback to say this has been improvement?
>
> SUE: and it's continuing to be improved?
>
> PAULINE: and this what we've put in place because of that (line 628).

Pauline and Sue seem to be sceptical that sustainable changes are put in place following their recommendations.

When Laura is asked about how often they actually implement large scale changes, she replies:

> LAURA: emm not as often as we'd like. More often than not it's frustration, banging your head against a brick wall. But every once in a while, yes, when you think, oh you know we made that happen, that's quite good, so yeah (line 162).

The metaphor of a "wall" is used to represent the NHS. What Laura describes as "banging your head against a brick wall", Patrick compares to tunnelling through a prison wall:

> PATRICK: Many years of trying to change, chip away you know, I always think of you know the film the Shawshank Redemption, OK, well the analogy that I would use is I am the rock hammer. Yeah that it chips away, uses the rock hammer for 20 years to chip his way out. That's what it feels like. It's like chip, chip, chipping away all the time (line 286).

The metaphor of Stephen King's Shawshank Redemption where Andy Dufresne tunnels himself out of prison over a period of two decades is a poetic representation of how Patrick feels. He describes himself as the "rock hammer" "chipping away" at the NHS, until he can achieve change. For those who have read or seen Shawshank Redemption, the analogy epitomises sheer

determination. Andy's escape came at the expense of tunnelling through his cell's wall, quite literally, millimetre by millimetre, over the course of two decades. For Patrick, implementing change in the NHS is equivalent to Andy's arduous feat. Similar to Laura's "brick wall" (line 162), both are facing an impenetrable obstacle which they must overcome in order to do their job.

What is immediately hearkened in Patrick's choice of imagery are the sounds being evoked by "chip, chip, chipping away". Undoubtedly the participants in this study have been using very expressive metaphors (e.g., outside toilet, conveyer belt, etc) which up until this point have been visually striking. Here Patrick uses a sound to create an atmosphere and convey his feelings. The repetitiveness of his efforts to change the NHS can be 'heard' in the monotonous hammering of "chip, chip, chipping away". In both instances, participants see themselves as the tool with which to penetrate this seemingly impenetrable wall.

Patrick believes his job to be "impossible":

> PATRICK: these unachievable expectations. So it's just like being Paul Daniels with both hands tied behind your back by your own, your own colleagues. It's just impossible. It's next to managing the England football team it's the most impossible job [...] I can't you know I'm not Paul Daniels, I can't pull it out of a hat. And it's a meaningless target anyway, totally meaningless target (line 351).

He explains:

> PATRICK: if the ambulance service gets to the patient in 9 minutes and the patient survives that is a failure, if we get there in 8 minutes and the patient dies, that is a successful because the only thing that counts is the 8 minute target. Of course it's ridiculous but there you are (line 104).

And:

> PATRICK: we will have elderly people who are vulnerable to a fall who will press their community alarm pendant which goes through to a call centre and are not physically with the patient so they will make a 999 call and have nothing to tell us. As such that patient is categorised at a lower priority because we have no information about the symptoms. The truth of the matter is when then a crew turns up after an hour or 2 hours of whatever, and it's an 80 or an 89 year with a fractured neck of femur whose been lying in agony for 2 hours (line 116).

Patrick expresses a dire lack of motivation from these "meaningless targets" and uses sarcasm to vent his frustration. Patrick feels as if he is expected to perform magical feats such as Paul Daniels and jokes that he is not a magician who can pull out successes "out of a hat". Patrick, more so than the other participants, shares his frustration with the 'big' picture aspects of his job. Perhaps this is as a result of Patrick being the most senior interviewee. For him, these are the things that really get to him whereas for more junior participants, perhaps the operational side of their work is more pertinent. For instance, Alicia complains about the pragmatic aspects of initiating change. She states that PALS staff:

> ALICIA: ...weren't allowed to speak to commissioners because you know it was not within your grade or role, so therefore you sat on things until they were ready to answer your questions (line 40).

Laura in particular has little faith in senior organisational members. She explains:

> LAURA: these structures come up and they give them all these fancy names, and one reason why the health service has never been able to reform or restructure is because the very people that are held to be responsible for the restructuring are those that are trying to hang on to their very nicely paid jobs thank you very much. They're never gona, they're never gona streamline bureaucracy because they are all the people they put in charge of restructuring (line 688).

Alicia exhibits a similar disillusionment with the system; she divulges:

> ALICIA: I just look at this organisation and I just think to myself you don't function like you're supposed, you don't function like all the other PALS services work, if PALS query is about A, B, C, and D and it has an effect on patients you know those PALS report, PALS information will be used as part of patients safety or something, we don't, they just ignore all of the PALS data to a certain degree and I look at it and I think to myself that is a waste, it's such a waste. Because that data has, PALS is supposed to inform you about those gaps you have in services, it's supposed to tell you well look you know these things are happening, what do you need to do about it? (line 315).

In order to navigate this complex arena, Patrick states that he has become more Machiavellian. He explains:

> PATRICK: it's difficult because there's pressure to meet targets, there's pressure to achieve ____ etc and so it makes you more Machiavellian.

> Inevitably. It means that, there's also a side to this that is very much a bureaucratic exercise in many ways, so one becomes more adept at ticking boxes and putting a spin on you know I will and in our case I will big up the things that we have achieved because they are meaningful and I will tweak them to meet whatever descriptors I need to meet (line 231).

This confession raises a very interesting point. While Patrick is angry with the bureaucracy of the system and its tokenistic approach, in order to 'survive' in this environment, he also needs to become the very thing that frustrates him. In order words, while Patrick has shown deep disapproval at the system's lip service towards change, he nevertheless also engages in such "ticking boxes" strategies in order to get by. As Patrick sees it, the way the system operates "inevitably" "makes you more Machiavellian". Hence, a dysfunctional system creating a dysfunctional employee.

9.3 Bringing back unpalatable messages

Each "chip" represents the persistence of PALS staff in the face of adversity. Patrick sees himself as the bearer of "unpalatable messages":

> PATRICK: because [the Trust] don't want to know the answer, they don't want to risk the thought that perhaps the Trusts' targets and the manner in which the Trust works is the root cause of that whole issue. They don't want that. They don't want to know that. It's my job, in many ways, is about bringing back unpalatable messages. The Trust doesn't want to hear unpalatable messages (line 265).

To communicate these "unpalatable messages" PALS staff use a variety of strategies. First, they may boldly share the patient's plight at meetings and challenge organisational leaders. Or they may have to beg colleagues and "schmooze". Networking is crucial and, at times, PALS staff rely on their reputation to open doors.

Laura explains that PALS staff need to be firm during meetings:

> LAURA: Sometimes, sometimes, sometimes you have to be quite challenging in meetings, people are very proud, quite justifiably, some of the work they've done, and they perceive that they have made an

> improvement and you just have to be bold enough to say, can I just say,that from the patient's perspective that's not what's happening you know we may think that that's all working really well and that you've put all the necessarily changes in place but from the patients point of view it's made no difference whatsoever, they're still having difficulty getting through, understanding, whatever the problem may be. So it's sometimes you do have to be a bit challenging, hopefully we're not ever rude or you know but you do have to sometimes be a bit more driven to get the results that you want (line 200).

For Laura, it is about being "bold enough" to stand up for the patient during meetings; she explains that PALS staff have to be "a bit more driven to get the results".

In contrast, Adam shares how at times he has to revert to begging, for example to get colleagues to update their contact details on the database:

> ADAM: the switchboard use things like this email properties, right so it tells who you are **shows an example on his screen** it's got their number, where they are and all the rest of it, a lot of time doctors don't have it or it's out of date so it causes problems for us, it causes problems with switchboard you know [...]. So when people are asking you know want to know where people are what their job title is, where they work, what their number is, it takes an age to find out, you have to email them and wait a couple of days to get a response [...] it causes all kinds of problems, I've raised it and raised it again you know emailed loads of managers saying please, pretty please, pretty... this is a quote from one of my emails, 'please, pretty please, pretty please with sugar on top, please can you change your email properties and cascade it down', no response, but the IT guys are trying to sort it out now so that should change (line 229).

Adam discloses that such incidences "gets on my nerves" (line 229). He is frustrated that "things that could be done relatively easy" and would "make the whole organisation run better" (line 229) is still met with resistance even though he has "raised it and raised it again".

PALS staff can also engage in strategic networking. Lynne explains that reputation is crucial:

> LYNNE: because of the way in the NHS so much networking is done on reputation, you build a reputation, you have to, it's the only way you can become identifiable (line 248).

Laura says that:

> LAURA: you do learn to play the game, who you need to say what to, to get what you want. Very Machiavellian isn't it? (line 496).

She explains:

> LAURA: the first thing to understand and appreciate was that you needed to build relationships with some key personnel that you're gona need favours from in the future, so a lot of it in the early days was sort of getting your face known, a bit of schmoozing, cost me a fortune in chocolate biscuits to try and get into doors, because there is understandably a bit of reticence from the professionals thinking you know who's this person interfering, she's gona come and bang on the desk and demand patient rights and things, but slowly once they got to understand you a bit more and your role I think they can see that actually you can help them professionally as well as helping the patients so gradually there was more acceptable of the PALS role (line 44).

Lynne shares that a few years back, staff would say:

> LYNNE: you tell tales on people, somebody said to me years ago, I was DEVASTATED, we know what you do, you spy and you snoop (line 836).

This type of staff resistance can either make an already challenging job even more difficult or in some cases, it can work in the favour of the PALS employee:

> PAULINE: yeah internal affairs. Sometime it is in your favour, it works for you cause then they do it. And at other times they just shut down and be quite resistant (line 955).

Julie thinks the adversarial attitude may be as a result of the language that is used. She muses:

> JULIE: the word complaint is such an awful word for staff, they immediately think oh god that's it, I'm in trouble now, you know so [...]I feel I need to show them that I'm not on anyone's side, I'm trying to find a sort of win-win situation for both parties if possible (line 159).

In this way, Julie is doing her part in changing the blame culture of the NHS (Bann 2004). She is attempting to change the way complaints are perceived and show staff that learning from patient feedback can be a "win-win situation for both parties". Patrick on the other is sceptical. He sees little room for such "win-win situations" and believes that the learning agenda is simply lip service:

> PATRICK: The government makes lots of, the government and the NHS, make lots of noise about we must LEARN from people's experience and all

> this, it's tokenistic. The truth is they have no intention of meaningfully learning IF it doesn't fit with you know the Trust agenda or the government's agenda. I've been to many a conference and meeting where you have an acute Trust that crows about how it changed its signage because people found it hard to negotiate the hospital. Well that's great. You know I'm not saying there isn't the place for that but frankly it's trivial. Unless you can make some meaningful changes (line 172).

Laura shares:

> LAURA: you still, year on year, hear the same things coming up which makes you that bit more determined then to make the change because you then can see actually things haven't changed, you know whatever lip service they're giving it, however much they say things that are getting better, they're not, we can see that, it's evidenced by the similarity of the calls we're getting (line 170).

The philosophy behind the PALS work is lost behind "tokenistic" box ticking exercises. Laura explains how "year on year" the same complaints gets raised. Patrick is critical of hospitals paying lip service to the learning ethos by advertising "trivial" changes, but when it comes to "meaningful changes", Patrick does not think they are willing to learn unless it fits the organisation's or the government's personal "agenda".

Overall it appears that participants perceive their change agent function as "bringing back unpalatable messages" to senior members who do not "want to hear". There seems to be some despondency towards a systemthey view as "bureaucratic" and "tokenistic". In this complex political arena, PALS are nevertheless expected to perform their change role but they also share the difficulty and challenge of initiating "meaningful" change in a "tokenistic" culture. In addition to these present challenges, there is an additional force is placing pressure on PALS – the upcoming reform.

9.4 It's not my NHS anymore

Adam shares:

> ADAM: way we're going at the moment it's being privatised, that's what's happening, it's been privatised, there's more private patient enquiries, it's

> not a national health service, it's being disintegrated, literally disintegrated. You know so people are gona lose, cause of cuts and benefits, people are gona live in more misery and they won't, people just don't care about it any longer, and people like us are you know a little bit of their anger and frustration is going to be directed at us(line 776).

Adam's tone is genuinely upset about the effects of what he terms privatisation. He fears for the future of the NHS which he sees as "not a national health service" any longer. There is a sense of being broken; Adam describes the reform as having "literally disintegrated" the NHS. Adam also feels as if he and his PALS colleagues are going to be on the receiving end of the public brunt. He braces himself for the public transferring their "anger and frustration" on them – in a way, Adam is holding his breath for things to get worse.

Julie finds the new private sector ideology "quite stressful":

> JULIE: they're very nice. But it's changing the whole sort of ethos and it's not my NHS anymore and I've been working in the NHS since about 23, 24 years and it's quite, and I've been through all sorts of inceptions but suddenly this feeling like they keep talking about business and they're saying you know and I'm sure they are very caring, nice people who want to you know but they always say 'and this is good for business' adding it on you know so that's kind of weird for me, I'm finding that quite stressful now (line 62).

For her it is "weird" to think of the NHS as a "business", she says it is "changing the whole sort of ethos" and sadly "it's not my NHS anymore". Although she appreciates that privatisation is "the way of the world now" (line 58) she nevertheless says: "I don't like it at all" (line 57). Her fears largely stem from how it is changing the NHS ethos into what is for her a foreign business model. She illustrates:

> JULIE: we join the NHS cause that [the ethos], we believed in that [the ethos]. And now we're at this awful, I mean I'm involved in all these things like re-branding **shocked body language** cause there's all these, they're very sweet, I was thinking BRANDING? BRANDING? What?! I don't know why I keep getting involved in these, very nice young, they are very young. That's awfully ageist but they seem very young to me, about 12, and they're going, they're telling me how keen they are about, they're telling me about carers and you know they've just found out that carers have to look after people all day, yeah, and what we should be doing for carers, and I said, do you know

> one thing I think, we need to ask carers what they want not us telling them **mimics mocking surprised face** oh, oh yes, well you know and they get all excited cause I said and also it's not just about carers for older people there's you know parents looking after children with disabilities, and they got all excited then cause that looks good for the ____ brand. I know, I know I shouldn't be so cynical but I oooooh please no don't. But 'ooooh yeah we could do something on that, it's good for business' she said to me afterwards and I thought bloody hell don't tell me that please don't tell me that (line 472).

Julie talks about herself and her NHS colleagues as "we" while the new private sector organisation is referred to as "they". She also seems quite protective about the NHS and patronises the new "young" employees who are in her eyes "about 12", coming to her and thinking about how helping patients will affect marketing e.g., branding, good for business and such. For Julie, this conflicts with her ethos and why she joined the NHS, she is upset at this change and does not want to be a part of it: "bloody hell don't tell me that please don't tell me that". For Julie it is alien to think about branding and reputation:

> JULIE: the whole thing about our complaints process is it we investigate things, we do look at things very carefully [...] You know and it's not properly done unless it's done thoroughly [...] we should be doing that, we shouldn't be just going oh you know don't let them, worrying about reputation, that, we should worry about patient safety first, not reputation (line 496).

Julie seems to be drawing a distinction between private sector companies who are concerned with "reputation" and the NHS, as it used to be, worried about "patient safety". When probed further, she opened up her biggest fear:

> JULIE: I think they're trying to make it so people are, things are addressed immediately, which in some way or another, and I don't know, what's worrying is me is they might say, we'll compensate people I don't know this is just in my head, this is in my head, keep quiet, don't make a big about it, here's a 100 quid, go away, I don't know, but that's a kind of feeling that I've got and that would be awful and it's not right and staff would go mad about that as well. Cause you know it's got to be done properly otherwise you don't change anyway (line 504).

For Julie, the worst would be not investigating "properly" but rather compensating complainants for the incident. This, she argues, would prevent true change – which is a primary goal of her role.

In a way, Julie is stuck between role conflict and role ambiguity. She senses that the new ethos is "not my NHS anymore" and is unsure about what the new ethos will involve; this impacts on her wellbeing and Julie admits to be worried.

For Adam, the future is uncertain:

> ADAM: These are the sorts of things we hear from the grape wine, you know people are under stress, organisation cuts, we might be merging with another organisation, a bigger organisation, what's gona happen there, are people gona lose their jobs because of it or they're gona be downgraded in the future?
>
> LILITH: do you have any information with regards to the future?
>
> ADAM: emm no. We're kind of we just get fed drips and drops from above cause I mean you know the NHS highly hierarchical and it's you know although they have consultations decisions are made up there somewhere. We get informed about them. Although we were our kind of directorate had a meeting a couple of months back. And basically we have to reduce our budget by 20% you know that's the NHS so we have to come up with ideas either you know getting some revenue in and seeing things will be in you know things that we could cut or you know eventually probably it falls to staff the main key business in any organisation will have to be cut so I mean that's sort of in the background (line 475).

Adam describes how they are "fed drips and drops from above" and information is passed through the "grape wine" as opposed to formalised communication channels. As theorised in the HSE Management Standards (2012) change and how that change is communicated to staff members can impact wellbeing. As Adam describes it "that's sort of in the background" – similar to Julie who is "worrying" about it.

Alicia takes it particularly hard:

> ALICIA: what it does, well it makes you think... because they're gona need us there, just to deal with the patients and all of the uncertainty with the patients, nobody actually... I don't feel anybody is saying oh what about them, how do they feel where they are at and what it means for them? We just don't know. They don't know and they don't know because they haven't had to, not wanting to think about it because we're just doing what we're supposed to do, now we're in this position, have to think about it, and you're still not coming with anything concentrate in terms of what this means for

> our future, now for me, I would say, ok then fine, you're a critical business function, we'll slot you in so you don't have to go through this interview process, you don't have do this, you don't have to do that... because we need the experience we need people to be able to answer the phones and be able to sort of manage patients queries around the whole process, what's going on, blah blah blah blah blah, so you are uncertain about the future, you think about it, and then you just come in and then you just do the day job. So you're in this, kind of floating around, and not being proactive in terms of your own future. Cause you can just go like this, just flat line, until you know what's going on, at the moment you don't know what's going, you don't know... thinking of, do I now need to be looking outside this box, as much as I don't want to, I can't just sit here and keep managing this for you, and not be considering my future (line 291).

For Alicia the uncertainty translates into "floating around". She shares that no one is interested in how PALS staff feel, that there is not "anybody saying oh what about them". She wants to be acknowledged as a "critical business function" but without this she simply comes in and does "the day job". Previously Alicia had explained how much of herself she invests in her role, now, for her to be talking about simply the "day" job, evidences how she is disassociating herself from her work in order to cope with the uncertainty of the future. It is however not a successful coping strategy for Alicia as she admits that "you can just go like this, just flat line, until you know what's going on". Here Alicia is comparing herself to a dead individual who is in "flat line". In a way, Alicia has reached a stage where she has desensitised herself to this extent; and she appreciates that she "can't just sit here" and not "be considering my future". What is particularly challenging about these accounts is the uncertainty *of uncertainty*, the ambiguity of it all. As Alicia summarises:

> ALICIA: Because no one's actually said to you, your future is uncertain. You don't know (line 310).

Laura deals with it in a similar way by disassociating herself from her work:

> LAURA: I think a sense of perspective you know at the end of the day, this is a job, you're paid to be do so many hours, you're one person, you're one human being, and that outside of work, then that's where your real job starts, you know you still got your family and friends out there, and a home to run, and things like that, so getting a sense of perspective always kinda helps, I think really. And for me personally, you know as the work's gone up and up and up, I've just made it quite clear to my bosses, that I used to be quite good

> at doing my job, now I'm just piss poor at doing everyone else's, as the organisation's being run down you're asked to back fill everyone else's role, which you're not trained, you're not skilled for, you don't particularly have an aptitude for or even a liking for, so you know just making them know that and warned them all, I said you know there's so many balls in the air at the moment, that sooner or later I am going to drop one, and when I do, you know potentially it could be quite serious, I'm just telling you, that I'm gona drop a ball sooner or later, so when things do go wrong and when I have forgotten something or missed something or done something wrong, I just go to them and say 'see I told you so!' **laugh** for me, very much, sort of pass the blame up the line, so you know if I could just do my job, I could probably do it quite effectively, it's just then you're asked to do everything else, so I let them all know (line 394).

Laura rationalises it to herself; she gains a "sense of perspective" by telling herself that "this is a job" and that "outside of work, then that's where your real job starts". She prioritises her "family and friends out there, and a home to run, and things like that". However there is also the impression that her thought patterns are as a result of being over-worked and fed up with being asked to "back fill everyone else's role". This increase in work demands is definitely affecting her wellbeing and she recognises this; in fact, warning her bosses that "there's so many balls in the air at the moment" and that "sooner or later" she is "gona drop a ball". She also senses that "potentially it could be serious". Laura is concerned that she might "have forgotten something or missed something or done something wrong" – all possibilities in an employee that is being over-worked. These sorts of wellbeing outcomes are not only undesirable for their effects on the individual, but also, "potentially it could be serious" for the organisation, especially when that organisation deals with healthcare and when the employee's job impacts on patient safety. If PALS staff go about 'dropping balls' and 'missing' important patient complaints, then this could have quite serious repercussions for patient care. As estimated by the National Audit Office (2005)50% of occurring safety incidents could have been averted if providers had learnt lessons from previous error reports.

Pauline experiences a similar sense of being over-worked. She explains:

> PAULINE: we're a very, very small team... what we take over, and if one, even if one person is not here for illness or leave, we can just about handle it, but when we got people sick and thing we just totally crash (line 680).

Adam concurs:

> ADAM: you know if people do go off sick, it has a kind of cascading effect, stress on other people (line 684).

He does confess:

> ADAM: I say about burnout I mean I have I do get stressed and it's been noticeable in my sick record because we've got, recently we've had a we've all had to pull our socks up because part of the things that's happening is we might be merged (line 126).

Here, participants are clearly communicating that expectations and demands placed on them during the change transition is either exceeding or about to surpass their coping abilities. Adam gives a particular example where cutting costs affects his wellbeing:

> ADAM: we ran out of paper we have to go upstairs, it's like we got a Stalinist command economy with our stationary. Have to go upstairs, get the paper, so it's all sort of managed, cutting back on the paper budget, cutting back on this, that and you know I've managed to acquire these, someone gave these, we ran out of these [printer ink], I don't need to order them, so I you know savings for the NHS there. So you know all those little kind of sound trivial but they have a kind of a drip, drip effect (line 656).

Here Adam recounts how he has to "go upstairs" to get paper and equates such management with a "Stalinist economy", having to account for printer paper and such. Adam has even had to revert to acquiring printer inks so that he does not have to order them. While he appreciates that "those little kind of sound trivial", he understands that "they have a kind of drip, drip effect". Again, here is a use of a repetitive sound metaphor, like Patrick who said 'chip, chip, chipping away', representing the small but incremental increase of their strain. Overall:

> PATRICK: You know but it's tough and it wears you out. (line 286).

9.5 Discussion

In the previous theme, it was most striking that participants were using vivid imagery to convey the weight of their burden. In this theme, it is noticeable that participants are choosing to express their challenges by the use of sound. Metaphors need not only evoke visual comparisons; in this theme, participants are making use of loud or repetitive sounds to express meaning. In the field of musicology, authors make the argument that the changing sounds of music conjure a number of bodily metaphors for example heat, light and tension (Adlington 2013). In this manner,

participants in this study are also alluding to moving sounds to convey their experiences. For example when asked about sustainable changes, Patrick is critical of other Trusts that "crow" (line 172) about changing trivial matters such as signage. His disapproval is quite palpable in his choice of bird – not known for its pleasant voice – and communicates his annoyance on hearing such lip service to the change agenda. Interviewee musings coincide with the thoughts of participants from the Abbott et al. (2006) study. There too they questioned the realism behind the PALS change agent function:

> *"it's trying to be a bottom-up culture change, instead of a top-down one, which – I don't know how successful that will be with such a large organisation" (Abbott et al. 2005, p.133).*

In describing their experiences of changing the NHS, participants compare it to "banging your head against a brick wall" (Laura; line 162). The visual image of the action also calls forth 'banging' sounds, repetitive and unpleasant. Similarly, participants depict themselves as "chip, chip, chipping away" (Patrick; line 286), the repetitiveness more so evident in the re-using of the word 'chip'. Both are expressing a monotonous repetition – the continuous tiresomeness of their change role. This embodied experience also conveys the self-perception of being a tool, using oneself to wear down the NHS obstacles. In a way, their body is the tool (i.e., rock hammer) that they are using to break the barriers to change (i.e., brick wall).

At times, participants may have to circumvent obstacles such as bureaucracy by being Machiavellian or resorting to "ticking boxes". Such strategies are known in the literature as employee resistance and could be interpreted as tactics that 'get back' at the organisation (e.g., Bain and Taylor, 2000). For example, when faced with managerial hyper-vigilance towards meeting daily call targets, some call centre workers 'cheat' the system by logging voicemails as actual calls. Or they may take longer on sick leave as to qualify for sick pay which only kicks in after three days off (Mulholland, 2004). Retail customer service employees would disobey company policy by not formally logging complaints (Harris and Ogbonna, 2009) and so forth.

At the time of this research, the healthcare sector was bracing itself in wait for the fundamental changes to the NHS (Ham, 2012). It is quite difficult to briefly recap the key changes – bloggists have even compared this feat to summarising War and Peace; suffice to say the NHS is facing significant restructuring. Primary care Trusts are being abolished, GP consortia are to commission services, and HealthWatch is to strengthen patient voice. The aim of this research is not to instigate a debate about the pros and cons of the new healthcare bill or to take sides in this political battle; but it is necessary to mention that the climate at the present time is rife with

conflict about the private sector influence on the NHS. For example, in 2012, Virgin won a controversial £500 million contract to run healthcare services in Surrey (BBC News, 2013).

The present NHS reform with a penchant towards privatisation is leaving PALS staff feeling alienated from the NHS ethos. There may be a fear that the genuine NHS ideology of care is being replaced by private sector concerns perceived as reputation, branding, and business. Overall they report that their wellbeing is suffering, for example by juggling a number of balls in the air and feeling burnout which is noticeable in sick records.

If Mulcahy and Lloyd-Bostock's (1994) taxonomy is applied to participant account, it could be that PALS staff are worried about their role digressing from change agent to gatekeeper; a role where they would be expected to deflect the complaint at the source, without actually learning from the error. This could put them in a situation of role conflict as the private owners could be expecting a resolution that goes against, what participants perceive to be, the NHS ethos. This is however simply speculation as the events discussed have not yet taken place; what can be said though is that participants are showing signs of role ambiguity as the conflict is as yet unknown. Such experiences of role conflict and ambiguity are "worrying" (Julie); they are notable sources of employee stress (Stamper and Johlke, 2003) and can affect performance (Tubre and Collins, 2000).

The mundane daily resource shortages resulting from the NHS reform are described by the sounds of a dripping tap; it has a "drip, drip effect" (Adam; line 656). In all these sound elucidations, sheer repetitiveness and monotony is loudly conveyed. There is something quite penetrating about sound; in a way, hearing is quite a passive and unprotected sense, one cannot choose what to hear or what not to hear. Sensory bombardment has been documented as a form of torture (Waltz 2012), and in a way, PALS staff are expressing the phenomenon of being a change agent in the NHS context by using words that convey an auditory assault, mimicking the effect it has on their wellbeing.In exemplifying their current state, faced with an uncertain future, the words "flat line" (Alicia; line 291) are used to signify metaphorical death; being neither active nor engaged, but simply "floating", waiting to hear. This analogy also creates a very loud song, the piercing monotone beep of a flat line. Yet again this is an unpleasant sound, going one step further than repetition to an overpowering cacophony. Perhaps participants may revive once they *hear* about news regarding her future.

Participants also make use of a powerful sound, that of crashing, when having to deal with the additional workload that comes with a colleague who is off sick (e.g., "totally crash" Pauline; line 680). This brings about another quite potent and loud sound, like the 'banging' and 'flat lining'.

Similarly, it is also an embodied sound metaphor, reflecting the tension and force placed on their body – a body, which is referred to as tools.

In the previous theme, *they just don't really get it,* participants used embodied metaphors such as 'deflating' and 'tips you over'. These are active words. In a similar vein, the sound metaphors in this theme are fluid and moving; they imply action and are not inert. Conventional wellbeing theories such as the Demand-Control-Support model (Karasek, 1979) suggest certain linearity to experience; antecedents neatly leading to consequents. However, as expressed by participants in this study, their experiences are fluid and not static. For example the emotional demands they face (equivalent to the Positivistic notion of antecedents) are represented by active words such as "absorb" (Pauline; line 250) implying a continuous movement. Their change agent function is described by conjuring auditory repetitiousness such as "chip, chip, chipping away" (Patrick; line 286), implying a constant and loud action. Equally, the effect the work has (comparable to outcomes or consequents) is expressed by embodied metaphors for example "totally crash" (Pauline; line 680) and repetitive sounds for example "drip, drip effect" (Adam; line 656). These participant descriptors reflect fluid experiences that are process based and that re-invent themselves through action; this perspective critiques the notion of linearity in conventional literature. It could even be said that language, such as the written words in this thesis, are limited in their ability to explain these phenomena as they too are fixed once created. Perhaps a more appropriate representation of the wellbeing phenomena experienced by PALS staff in this study would be through a visual and auditory medium, for example, the following YouTube clips:

- http://www.youtube.com/watch?v=7rYdPIJG05g
- http://www.youtube.com/watch?v=SYkURMmojRo

The atmosphere created by both these clips, and the sounds therein, package PALS worker emotions and their experienced strain and continuous pressure in a rather embodied manner. The next theme will now discuss the experience of being an embodied being at work.

9.6 Summary

Participants admit that trying to change the NHS is like *changing a super tanker's direction*, a difficult and challenging feat. To initiate such organisational development, PALS workers have a purpose of bringing back unpalatable messages to senior members. Unfortunately, PALS staff think that the organisation "don't want to hear it". There is also reported discouragement by "meaningless targets" and a loss of faith in the ideology behind the NHS re-structuring; the

impression conveyed is that PALS staff need to battle the very system that employs them in order to perform their change agent function.

So far, it has been apparent that participants use poignant metaphors to communicate their experiences. Vivid visuals and striking sounds are used to express emotions, actions and perceptions. What is particularly noteworthy in their accounts is how many of their metaphors can be considered embodied metaphors. Embodied metaphors make use of senses and the arrangement of the body; they communicate employee perceptions through spatial and temporal manifestations (Heracleous and Jacobs 2008).

Finally, the theme of *changing a super tanker's direction* highlights the importance of the wider social environment – after all, organisations are not closed systems but decisions made outside them inevitably impact the macrosystem (Hatch, 2006). Humphrey et al. (2007) do include the variable of 'interaction outside the organisation' but this is more about the employee's interaction with people outside of their firm and is not quite what PALS staff are referring to when they discuss the system. In a way, PALS staff do anthropomorphise what they see as the system, which seems to be a broad cultural status quo. The next chapter will present the third emergent theme *breaking point and life in context* and it will show how bodily experiences and physical interaction with the world are key to wellbeing experiences.

10. Being Embodied: Breaking Point and Life in Context

10.1 Introduction

This theme actually contains three conditions (bodily experiences at work, burning out, and home-work interface) which were initially thought to be independent themes. But during the interpretation it became apparent that these sub-themes were interconnected. For example, participant experiences of burning out could not exclusively be attributed to work challenges – nor to home troubles. Rather, it was a combination and culmination of events that led to *having a wobbly*. As Pauline so eloquently sums up: "if you've got a cold at work you're gona have a cold at home aren't you. Cold don't change because in you're in a different environment" (line 727).

Similarly, it was not possible to describe this collapse of wellbeing without mentioning bodily sensations; embodied interactions with the outside world were very much a part of wellbeing experiences. This theme discusses the body in relation to space at work, burning out, and moving between work and home domains. It thus catapults the body into the forefront of wellbeing and will be returned to in chapter twelve where the implications of this finding will be considered. This chapter presents the third theme of this study:

Super-ordinate theme:

c) Breaking Point and Life in Context

Sub-themes:

c1) Body and space

c2) Having a wobbly

c3) Movement between spaces

10.2 Body and Space

This sub-theme introduces the broader theme of embodiment. It demonstrates that participants actively engage with their external environment and receive information from the outside world

via their senses. Office setting and surroundings appear to be important influencers of participant wellbeing; and this is experienced in largely embodied terms.

For example Adam actively engages with the space around him through his body. His desk is set up against the wall, sandwiched in between the printer for the whole floor and the door (Figure 19). This means that when colleagues from another department print a document, they enter the room from his right, *walk behind him*, and pick up their paper on his left. He explains:

> ADAM: I mean this sounds trivial but this is how I work, there's one printer for this floor, so they've got rid of most printers to save money, so it's here, so every so often people come in and reach around [...] you know got used to it now, get used to anything (line 650).

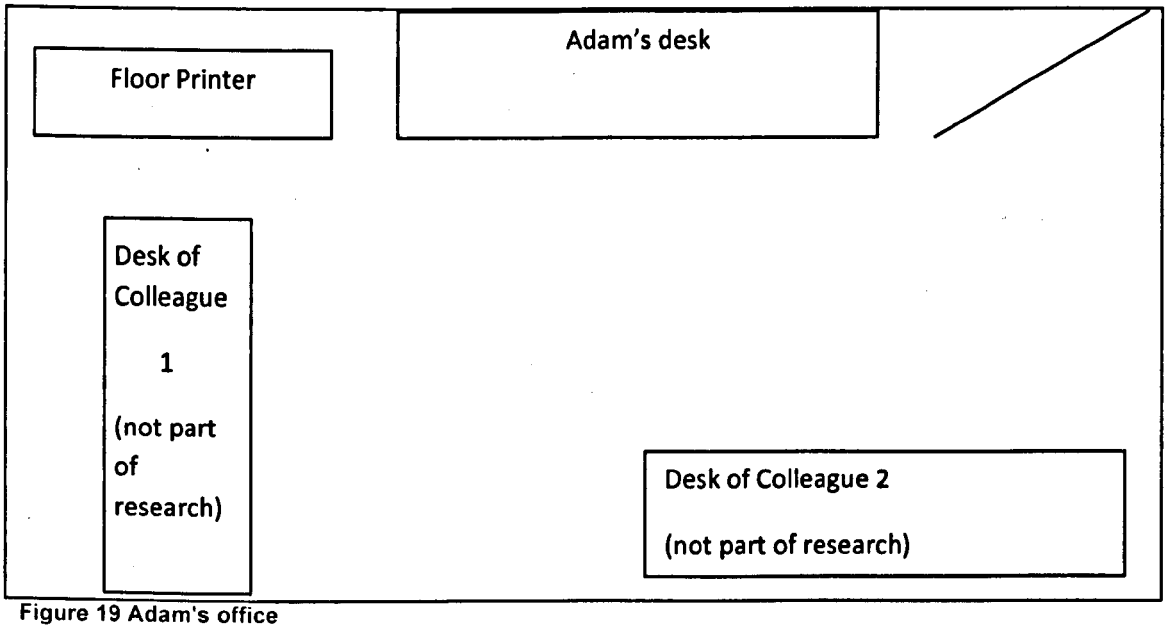

Figure 19 Adam's office

For Adam, facing his desk, "every so often" colleagues come in to fetch their printed documents and walk behind and "reach around". Adam while concentrating on his work, facing the wall, may sense someone opening the door and in the peripheral vision of his right eye see a shape entering the room – and then senses movement behind him – while the shape reaches around to his left and takes the document. Adam may not fully see but can sense the movement to his left and something being removed from his personal space, culminating in the door opening and closing again. Adam must engage in the heavy emotion work he does with patients in an environment where his personal space is "every so often" breached. In a way, Adam is surrounded, to his front is a wall, and to his sides and back is movement which he cannot control.

Adam says he is now "used to it" and explains it by can "get used to anything" (line 650). It may be that similar to cognitive dissonance, Adam has gotten used to these intrusions by turning off his body so that these experiences are no longer felt; perhaps some sort of physical dissonance.

Lynne is not "used to it" and she dislikes being in an open plan office and discussing difficult cases. Luckily for her, she had the support from her colleagues who argued her case. Laura stood by her and recounts how:

> LYNNE: we've had to sort of fight for Lynne quite hard to keep her in this [personal office] environment and that's because different people work different ways and some of the calls that we take are quite heavy, either quite personnel, quite emotional or quite angry and for some people and Lynne in particular, she found it quite inhibiting being in that open office environment (line 650).

Alicia, who is in a larger open plan office, also wishes for privacy:

> ALICIA: I don't like, I think that was part of my emm it doesn't help me in terms of my wellbeing... so when I'm on the phone... my colleague, she's got quite a loud, loudish kind of voice, and she doesn't care who's listening to the conversation you're having with the patient. But I've always worked in an environment where patient information and what you discuss is confidential, so if someone's called me and it's about their mental health or their HIV status or things like that, I don't really want anybody else to know, but I don't know if that comes from me being quite a private person as well, and respecting the information that they've given me (line 189).

Alicia describes the auditory assault of her colleague with the "loudish kind of voice" who "doesn't care who's listening"; this conflicts with Alicia's beliefs for whom "respecting the information" that patients give is important. She explains that it is difficult to have these sorts of conversations within ear shot of others as the contents are sensitive and confidential:

> ALICIA: we are in a wrong environment to be discussing that kind of information [...] I feel uncomfortable in that kind of environment, you know I'd rather be in an office somewhere where you can discuss quite openly with a patient their health concerns and know you're not gona be overheard, that information won't be taken and discussed somewhere else (line 196).

Alicia is uncomfortable; her embodied self is in the wrong physical environment to be discussing confidential matters. She fears being overheard by others and says that this impacts on her

wellbeing: "it doesn't help me in terms of my wellbeing". The effect this has on her is described as oppressive:

> ALICIA: yeah it affects, it does, make me feel more, more oppressed, I don't want people to hear me having a conversation, to me the conversation I'm having with someone is quite...yeah... (line 203).

Alicia is forced to discuss quite confidential information in an environment not conducive to privacy. In a way, Alicia is being made to act against her ethical standards of how patient information should be treated and how confidentiality should be maintained. The behaviours she must exhibits conflicts with her beliefs. She believes it is wrong, and yet, on a day to day basis, she must (in her mind) breach confidentiality. This "uncomfortable" "oppression" is affecting her wellbeing, and even her performance:

> ALICIA: it's an open plan environment that strips away your effectiveness, your efficiency, and it does for me, I know it does for me (line 407).

Alicia believes that her effectiveness and efficiency is removed; her office environment "strips away" her competencies and leaves her bare. Naked and without her ability to perform, Alicia feels "oppressed". Her cognitions, feelings and behaviours are developed because of the sensory interaction between her embodied self and the outside world. At times, this sensory bombardment can be overpowering, and coupled with personal life matters, can result in participants *having a wobbly.*

10.3 Having a Wobbly

Participants like Alicia, Adam, Lynne, Laura and Patrick share their private distress at *having a wobbly*. This eruption of strain and breaking point in their wellbeing cannot solely be attributed to the work challenges depicted in *they just don't really it* and *changing a super tanker's direction.* Rather, it is evident from participant accounts that non-work events, such as the death of a loved one or the breakup of a significant relationship, also contributed to *having a wobbly*. This sub-theme captures these painful experiences and recounts how it feels to go such a breaking point.

Adam only realised he was going through burn out when his body intervened. Adam recounts how:

> ADAM: one time I knew for sure I was going a bit... this was a few years ago now, and this is when I decided to try and be, realise I was getting a little bit burnt out, someone just hang up on me and I was trying to explain something

> and I just **does gesture of banging phone down** you know, broke the phone, so it was only a cheap thing replaceable, but thought might need to do something about that you know I have, I was open about to, you know well my colleagues obviously knew about it, and I about it to my boss, said you know this is happening (line 542).

For Adam, his realisation of "getting a bit burnt out" came when he "broke the phone". It happened when his rage was expressed physically, a manifestation that he "was going a bit...", and this made him think that he "might need to do something about that you know". It is hard to allocate a specific cause to Adam's breaking point, he explains how it was a culmination of:

> ADAM: so sometimes I'll think, oh what's the point in working here, do I actually help anybody, do I duh duh duh (line 524).

And:

> ADAM: I broke with my partner and my mother died in December, so that's kind of dementia, so I've got kinds of personal issues as well but I am, purely at work, I am sort of coming out the other way side kind of dark period of my life really (line 595).

For Adam, it seems that feeling insignificant and helpless at work mixed with "personal issues" led to his eventual outburst – a very much physical embodied outburst. Adam now feels as if he is "coming out the other side"; for Patrick on the other hand, he seems to be in the midst of drowning in burnout:

> PATRICK: it's just incredibly frustrating [...] I've been trying to lead change on some elements for 8 years and [...] and only now is it beginning to take fruition [...] so when I see it being implemented in a half cock way, I find that frustrating because hang on guys it was me who was telling you about this for 8 years, do you not think I am ideally placed to tell you how to go about? Yeah? So I find that frustrating. I find it incredibly frustrating that in 10 years I've had 10 line managers. And every single one of them including the chief exec for a period of time, so this permanent revolution of restructuring, and every single one of them knows how to do my job better than me [...] so why not do it then guys? You know? Why do you need me for? And I find that incredibly frustrating. People always think that they, everyone has a view about complaints management everybody has a view, and I don't tell my operational colleagues how to meet their targets or how to run an ambulance station, don't tell me how to organise a complaint. I know how to do it. So I find that wears me down. In fact, I need to leave, I'm so worn out with it.

> That's why I said at the beginning, that I feel after 10 years I need to be somewhere else (line 292).

For Patrick, the experiences he encounters at work translates into feeling "worn out" and he describes how various events "wears me down". His chosen figure of speech implies a sense of exhaustion, depletion and being thoroughly spent. Overall, this extract is representative of Patrick's emotions. He repeats the word 'frustration' as he tries to verbalise his feelings of being "worn out". The bitterness and cynicism in his communications flag burn out. He complains that:

> PATRICK: I've been really unwell recently and in my own mind there's no doubt that it's because part of the reason is because you know no one on their death bed said I wish I'd spend more time at work, right you know so I'm trying to slow down a bit cause I can't sustain that. (line 507).

Patrick appreciates that he can no longer "sustain" the way he has been going. He assigns "part" of the blame to work and jokes that "no one on their death bed said I wish I'd spend more time at work". He rationalises his health scare:

> PATRICK: I'm lucky cause I didn't die, yeah. But I think, I mean, mine was fairly traumatic because I was flewn into hospital and I wasn't, I didn't have a heart attack but I had all the signs of it, so that kind of, I won't go into it all, that taught me that [...] I need to take a bit more control over what I do and you know that kind of work life balance is a contributing factor and how I manage at work is another factor. They're not the only factors, and all the rest of the stuff, not saying that, but they are factors. So I have to think about them. So that's what I'm doing. Cause I kinda wanna live a bit longer really. You know don't wanna live for forever but I don't wanna die tomorrow kinda thing you know (line 729).

Patrick is worried that maintaining such high strain at work could result in death. He explains that he "wanna live a bit longer" and thinks that he can do so if he were "to take a bit more control over what I do [...] and that kind of work life balance". As Adam, he does not solely attribute his breaking to work; "they're not the only factors" he admits "but they are factors". He describes his poor wellbeing experience as:

> PATRICK: it makes me angry. I think it's almost a form of clinical depression really. I think makes me angry or short tempered. And my own coping strategy I've learnt not to say mean, simple things like that, otherwise I'm likely to rip someone's neck off (line 582).

Patrick has taught himself not to be "mean" otherwise he might "rip someone's neck off" – his experience largely manifests itself as anger and being short-tempered. He interprets it "almost a form of clinical depression really" which is somewhat odd as his symptoms do not reflect depression but rather rage.

Lynne explains that she had "a bit of a wobbly last year" (line 141). At work, it started by:

> LYNNE: There are things like people getting the wrong kidney taken out, the bad kidney is left behind, the good kidney is taken out and these are people's lives. Now I sat on that panel for 3 years and in ____ they have to report all the suicides, and the suicide levels are going up and up and in the end it just broke my heart, it physically broke my heart. And I got to the point where I thought I can't read this anymore, I cannot physically read this [...] it's tough, really tough, and I had to give up (line 326).

Lynne describes the culmination to her wobbly in quite physical terms; she explains how it "just broke my heart, it physically broke my heart" until she "cannot physically read this anymore". She conveys the depth of the toughness by referring to a heart break. Here Lynne's embodied self is experiencing a metaphorical heart break and her body fought against the information it was receiving by preventing her from reading further cases. When Lynne thinks of how these events affected her work, she recounts:

> LYNNE: I have people calling up the whole day going I can't get an appointment with my dentist and I'm thinking fine, fine, you can't get an appointment with your dentist, so?! Whereas that is not my attitude. But it did. So it does affect you. (line 518).

For Lynne, her wobbly translated into dissonance and a lack of empathy. This experience echoes Julie's:

> JULIE: I think I had a sort of a semi kind of breakdown, I kept working and everything but I think I was very badly affected by, and I thought I can't do this anymore cause, you know you have to show compassion and interest, and I was sitting, I remember thinking, there's a little old lady and she was crying, and all I could think was 'I wonder how long she's going to be crying for?' **laugh** I can sort of, you know is she going to take half an hour? An hour? And I thought, you can't do this, this isn't right, it's not fair, so I just went (line 128).

Similar to Lynne, Julie describes feeling distant from her patients and unable to empathise and connect with them. As part of the job, PALS staff need to show "compassion", however, going through a wobbly, it inhibits these emotions. From emotional labour theory, it is expected that such instances of surface acting would be strenuous for employees (Hochschild, 1979). In the front stage, PALS staff need to show compassion to the patient, but in the back stage, they are dealing with their own pain. This means that PALS staff need to invest energy in faking, which in the context of their job inherently involves a high level of empathy.

Laura describes it as an incremental process that leads to a "tip over":

> LAURA: you don't realise how tired you get, or what an accumulative effect all these calls have on you until you reach that point [...] emm, but it may be unfair to say it's the caller that has made you tip over, it might just be that you were going to reach that point anyway [...]
>
> LILITH: and how do you know you've reached that point?
>
> LAURA: usually I suppose by thinking that you're not good enough anymore for it. So you know when you start questioning your own ability and thinking this is I'm not right for this job I'm not doing well for people here so when you reach that point I think that's when I kind of sit back and go oh maybe, maybe time to book some annual leave or **laugh** something (line 373).

Similar to the emotions shared in the theme of *they just don't really get it*, Laura engages in self-doubt, thinking she is "not good enough anymore" and "questioning your own ability". She describes the bad moments as being deflated:

> LAURA: then it might just take one call [...] and it's all fallen down, all your best laid plans, all the energies that you've put into a resolution, suddenly got to start again, it's that repeating of the same problem that is emm is draining, so yes, go from feeling up here **raises hand by head level** to feeling completely flattened and drained and thinking actually that was all for nothing. And then once you're back down again, to feeling drained, it just takes one phone call, you have a shouty person across, oh you don't care, or I'm gona kill myself, and then that will really take you down there, and then before you know it, you've tipped right over. So yes, you can go from being really good to being really down just in the space of a couple of hours sometimes (576).

Laura explains the process as beginning with feeling "drained" and "flattened" and describes it as a motion of falling from high to a low place. From that space, "it just takes one phone call" and "before you know it", "you've tipped right over". For her, the experience is cumulative but can be quick. Similar to what other participants have shared, these detrimental wellbeing experiences affect her interactions with others:

> LAURA: the really down is everything is an effort, you do get a bit of poor me, very aware that sometimes then is the time that you could potentially turn on your colleagues because you look at them and think, well hang on a minute you haven't been doing as much as I have this week, or you know you've been going off early, or how come you've got time to sit there and read the paper atlunch time and so, could potentially become quite an unpleasant colleague I think because hopefully you don't say these things, but they're going through your mind you know or looking at the bosses at the managers around you and thinking you get paid twice as much as me do you work twice as many hours, are you twice as qualified as me, are you twice as committed, you know where is the worth? So you do get into that poor me thing. And I do, I would say that I do, do that (line 572).

Laura describes how the "really down" translates into a lot of effort, a "poor me thing" and anger aimed at her colleagues and managers. She sums it up as:

> LAURA: resentment that's what it brings in me I think. The down. Resentment (line 582).

In their explanations of the 'outcomes' of poor wellbeing, it seems that participants are often experiencing emotional consequents, for example resentment in Laura's case, a lack of empathy in Julie and anger in Patrick.

In Alicia's case, she experienced the wobbly in an actual physical way – she lost her voice:

> ALICIA: It was really bad to the point where I lost my voice. I lost my voice for 3 months.
>
> LILITH: you lost your voice? You mean metaphorically or physically?
>
> ALICIA: I wasn't well then I came, went away on leave, came back, picked up a cold, and then after that I developed laryngitis and the laryngitis then kind of didn't get better, I left work for about 3 weeks and during this time, just before I went off on leave [...] Yeah. So I lost my voice, and I lost my voice for 3 months. And I had to go to ... check my throat, make sure there wasn't anything cancerous, and then they said that it's probably down to stress and strain and all of those things, I couldn't feel my vowels, my words properly,

> that's probably to do with not dealing with the situation at work. Emm and having to make ... that I can either do something about it or do something else. I had a little bit of counselling around that as well (line 137).

Alicia, who was made to behave in ways that conflict with her identity, experienced physical symptoms as a result. In her account, Alicia expresses the belief that she lost her voice as a manifestation of her strain. She sums it up as "you go through these peaks and troughs and you say to yourself is it me? You know are people seeing the same things I see or not see?" (line 240) and describes it as "it's like a steam cooker" (line 516). Her steam cooker metaphor is reflective of Laura's cumulative description; of a process on the edge of eruption.

When things got really bad, Alicia could not physically go to work:

> ALICIA: There were times where I, I'd come out the house and I'd get to the bottom of the road and walk back home. I'd be in tears, I just couldn't go in (line 48).

This physical inability to do something can be resembled to Lynne's physical inability to read the safety incident documents. Eventually, it seems that participants are saying, there comes a time when the strain is so heavy, that the body shuts down and refuses to act.

What appears to be common in participant accounts of reaching that breaking point is its incremental nature. It seems that a culmination and accumulation of events lead to the eventual wobbly. It is a process, a build up, like a "steam cooker" filling up with hot air, gradually reaching that point of 'tip over'. On the other side, PALS workers are deflated and drained; finding it difficult to harbour empathy, turning on colleagues and being resentful of others, and in severe cases, physically shutting down.

10.4 Moving between Spaces

The first sub-theme discussed the importance of the body and space in participant wellbeing experiences and the second illustrated severe ill health. In this final sub-theme, how participants transition from one space in their life to another will be explicated; for example, the transition from work space to home space, and between different work spaces e.g., PALS and complaints. In

other words, it will detail between-domain transitions and within-domain movement. First the former will be discussed followed by the latter.

Participants describe how moving between different 'spaces' in their lives is an important wellbeing factor. For example, Pauline and Helen seem to engage in a separation 'ritual' as a way of ending work and entering non-work life. Pauline wipes her feet while Helen shuts the door; both of these physical actions serve to put work away:

> HELEN: when you're going home you leave everything in the office when you go through the door
> LILITH: how do you do that?
> PAULINE: wipe your foot, I wipe my feet
> LILITH: you wipe your feet? Physically?
> PAULINE: yeah
> LILITH: here?
> PAULINE: outside, on the door, just wipe my feet, but now I go through the back door
> HELEN: as I go through the door, I shut the door, that's it, home! I'm thinking oooh food what are we gona eat?
> **Laugh** (line 779).

For Pauline and Helen, it appears that their cognition of 'having finished work' is brought about by a physical action (i.e., wiping feet, shutting door). These 'rituals' allow for the transition between one location and to another.

Lynne also engages in a similar physical 'ritual'. Upon arriving home, she changes her clothes. In a way, her embodied self engages in a separation 'ritual':

> LYNNE: I do, change my clothes, I walk in the door, walk upstairs and change my clothes [...] totally. Never ever, ever, EVER do I do anything other than walk in the door, go upstairs and change my clothes (line 768).

This act of removing her 'contaminated' clothes and changing into different attire both physically and psychologically distances her home from her job. It aides her to leave behind all the horrors she encounters in her work life. In a way, it mediates her wellbeing by placing a separation between Lynne-at-work and Lynne-at-home.

Alicia separates home and work by taking her badge off and putting it in her bag:

> ALICIA: sometimes when I leave here, I walk home, find a way to walk, leave it behind, I can get on a bus and that's a good way of getting home, but one of the things a colleague who's working at ___ she said she was told by someone the way in which you disengage from work, I think she started to pull away her badge, so you tag your badge, stuff it in your bag. I do that [...] I think it's a way of doing it, definitely a way of doing it, in terms of saying that's the end of my day.
> LILITH: take your badge, put it in your bag.
> ALICIA: and that's it (line 495).

However these transitions are not always effective. For example, Laura confesses that after a particularly bad day at work, her patience is "used" up. She perceives her inner "niceness" as something tangible, that after being used up at work, runs out:

> LAURA: I think sometimes if you've had lots of patient interaction during the day or you've had to do lots of schmoozing at work, I do sometimes go home and I say to the family, you know I've only got so much niceness in me and I've used it all up today, and I think sometimes that's true isn't it, you can only be pleasant for so long, and then when you get home you think, now I'm fed up of being nice and diplomatic and obliging and everything, now I'm just going to kick back and do nothing. So you know or they'll say 'my goodness, you don't talk to your patients like that do you?' I say 'no I'm very nice to my patients but now all the niceness is gone, so you get the rough end of me' **laugh** so yes so sometimes work does take all the good bits of you and then the family just gets what's left (line 542).

As Laura explains, she has "only got so much niceness in me". If these resources are then depleted at work, she feels "fed up of being nice and diplomatic and obliging and everything", and what is left for her family is the "rough end of me" as "all the niceness is gone". Laura also perceives this part of her as quantifiable, she remembers that:

> LAURA: When my daughter was very little, she used to run down the garden path when my husband came home from work, and she used to go 'be careful dad, she's this close' **shows small distance between thumb and index** **laugh** cause I used to, you know could feel things getting really tense, I'm this close to breaking. And then they'd say, how close are you now mum? And I'd say oh I'm this close **a bit bigger distance** **laugh** (line 542).

Laura describes how she conveyed her inner wellbeing as a quantifiable symbol using the distance between her thumb and index finger to illustrate how close she was to "breaking".

For Helen, she explains the importance of keeping stringent boundaries between the work domain and the home domain. Her husband and her decided to erect a non-permeable boundary between these two parts and agreed that when they enter the home domain, they "come home to each other":

> HELEN: so the two of us... it was a thing between us, said right, when we come home, we come home. We come home to each other, we don't come home and bring work with us. And so we don't do it (line 799).

She describes the movement between these boundaries in quite physical terms:

> HELEN: we leave the work, until we get back, oh yeah back at work now [low voice] got my head on **Laugh** (line 790).

Helen perceives crossing the boundary between home and work as putting her "head on". This can be equated with Pauline's earlier reference to putting on a "mould" (line 682) when dealing with patients. For Helen, moving between domains is a physical embodied experience, she exchanges one identity for another by putting on a different "head".

The transition between different domains (e.g., work and home) is not the only boundary that can be affected; transitions within the same domain can also be straining (e.g., multiple roles at work). For example, some participants report that PALS and complaints have been merging in their organisations and as a result employees have to do both roles. Laura explains:

> LAURA: emm, just recently over the past couple of years they've tried to bring PALS and complaints more together for what they would like to call a customer care service. But I think we would still argue that those skills aren't necessarily transferrable and I've been covering the complaints manager now for about a month or so while she's been on extended leave and complaints is very much more process driven, it's very much more about dotting the I's, crossing the T's, whereas PALS is a bit more intuitive, it's a bit more relaxed and friendly (line 70).

She gauges that PALS is "more intuitive" while complaints is "process driven". She explains that the skills required to do one well may not necessarily be transferrable to the other. As she describes it, complaints is about "dotting the I's, crossing the T's" while PALS is "more relaxed and friendly". This could suggest that a person who possesses the former skills could actually

experience conflict when required to act in what is quite a contrary manner; being relaxed about matters is almost the opposite of crossing T's. She explains that crossing the boundaries between these two jobs where "skills aren't necessarily transferrable" can be challenging:

> LAURA: The one thing that I found quite difficult is that PALS you try and deal with things as quickly and as locally as possible and get a resolution, so at the end of the day, hopefully you haven't got too much hanging over you to take home, whereas with complaints you're very often you know one simple case can be stretched out over a matter of weeks, and that's the accumulation, taking things home and thinking we still need to do this, we haven't done that is quite hard I think (line 80).

It seems that Laura is saying that with the PALS part of her job, issues are managed quickly and "at the end of the day, hopefully you haven't got too much hanging over you to take home" while in the complaints part of her role cases "can be stretched out over a matter of weeks". This means that to do her complaints job, she engages in "taking things home" and "thinking we still need to do this, we haven't done that". What Laura seems to be describing is that complaints crosses its given boundaries and spills over into the home domain which she finds "quite hard". She describes this sensation as cases "hanging over you", almost a physical weight, 'hanging' atop her person, being taken from one domain into another where it is not welcome.

Similarly, Alicia shares that she dislikes moving from PALS to complaints. She explains that in her organisation, her and her colleague work on a morning and afternoon "rota basis" (line 87). She points out :

> ALICIA: so I just come off the PALS phone this morning, and then this afternoon I'll go back to complaints (line 87).

Alicia performs two different work roles in one working day – one in the morning as PALS, and one in the afternoon as complaints. For her, much like with Laura, this is a difficult transition:

> ALICIA: you have to switch yourself off because if there are things in your PALS that you haven't followed through, you literally have to ignore it, and concentrate on your complaints [...] it felt chaotic, it felt disengaged, it wasn't flowing very easily. And you know we just had to be very, very focused on you know if the PALS were ringing, let them ring. It's alien to us. You know what we've had to do now is we accept, we allow the phones to maybe ring for an hour, then we'll pick up the calls and make a call back. If it gives us a bit of time or space to catch up on the PALS stuff (line 92).

She shares that this transition was "chaotic". She was forced to let the PALS phone ring without answering it; for her, this was "alien" and she did not approve; the moving boundaries between PALS and complaints "wasn't flowing very easily". Eventually, she came up with a strategy to let the phone ring for an hour and then pick up the missed calls – using Heidegger's conceptualisation of "time or space" to explain how she creates a mini-PALS domain in the complaints region to call back patients.

Lynne in stark contrast builds a wall:

> LYNNE: Argh I don't do complaints. you see this? See this wall. This is me, hello, no, bye. I'll give you the name of somebody who does it. That's it, end of story, I couldn't do complaints if my life depended on it, I would go cry (line 80).

For Lynne, she has created a "wall" that separates her PALS job from the complaints job and she simply "couldn't do complaints if my life depended on it". It appears that Lynne has decided that for her wellbeing, there cannot be any permeability (Ashforth et al. 2000) between PALS and complaints domains. This wall is so thick, so impenetrable that Lynne sums it up as "that's it, end of story".

10.5 Discussion

This theme of embodiment is really important because often psychological and management theories can outlook that human beings are embodied beings, that people have physical selves as well as being cognitively capable. The body tends to be considered 'peripheral' in understanding cognition or behaviour (Wilson and Foglia, 2011). When considering wellbeing theories, cognitive and emotive factors seem to be preferred at the expense of the physical. Even when looking at work design theories, too often the body is either missed out or seen as something passive, to be protected from injury or falls (i.e., health and safety). However, the body is central to developing cognitions and emotions; it is not solely the brain which generates experiences, but the body as well (Wilson and Foglia, 2011). It senses the world, acts within it, and is the means through which information about the outside world enters our psychological world.

Looking back at wellbeing theories from chapter two, many of them entirely fail to mention the body and space. For example Lazarus and Folkman (1984) argue for a highly cognitive explanation whereby the employee appraises events and evaluates them against his or her coping resources.

Karasek's (1979) Demand-Control-Support model was mostly concerned with effect of control and social support on employee wellbeing, and the understanding of 'control' was about job control. In other words about decision latitude on the job itself, so for instance whether the employee could choose when to take breaks and so forth. Some models, such as French's (Edwards, Caplan, & Harrison, 1998) Person-Environment (PE) Fit model, make reference to the environment but use it to mean a different thing. In this model, it is referring to the match between the job and the organisation, and the employee's skills, abilities and values – not the sensory interaction described in this theme. Others such as Danna and Griffin's framework (1999) and the extended Job Characteristics model (Humphrey et al. 2007) do mention the importance of external space but use it in a restricted physical sense. For example, Danna and Griffin (1999) do include 'work setting' in the antecedents column and appreciate that physical experiences are also important; they note: "an individual's experiences at work, be they physical, emotional, mental, or social in nature, obviously affect the person while she or he is in the workplace" (p.358). However the authors were mostly making reference to health and safety concerns and ergonomics. Similarly Humphrey et al. (2007) include a 'work context' dimension in their model but on closer scrutiny it becomes apparent that the authors are interested in biological concerns such as physical demands, health hazards and ergonomics.

In this study, the body is simultaneously an actor and an 'experiencer'; it can externally manifest internal strain (Adam breaking the phone); it can live through and endure strain (Alicia losing her voice); or it can simply shut down and refuse to function (Lynne being physically unable to read). The body can also assist in moving between boundaries; it can engage in transition rituals taking the person from one domain to another. These transition rituals can be understood phenomenologically and psychologically. Heidegger (Shumate and Fulk 2004) explains that the notions of time and space are important 'organising mechanisms' that help individuals form appropriate identities. For instance time and space separate the person's day into perceived parts (e.g., home, work, pub); in each part different social behaviours may be exhibited. To segment different regions, individuals can create 'mental fences' that separate areas and contain them (Zerubavel, 1991). These boundaries can be physical, emotional and cognitive separations and help to order the environment (Ashforth et al. 2000).

Once in the appropriate region, the individual then takes on that particular identity and enacts the relevant role. On the psychological front, Boundary Theory posits that individuals manage multiple roles by negotiating the boundaries between different domains (Ashforth, Kroner, and Fugate, 2000). These boundaries can develop along a continuum and each segmentation has its own associated norms (Kreiner, Hollensbe, and Sheep, 2006). As the identities can be different

between domains (and thus have different behavioural expectations), employees can engage in transition rituals to move from one part to another (Ashforth, Kulik, and Tomiuk, 2008). This is meant to help and facilitate the transition and psychosocially prepare the individual to take on a different identity. At a macro-level, such rites of passage can take the form of say a graduation to mark the transition from university to work; or at a micro-level they may be simple activities such as wiping one's feet (Pauline) or taking off one's work badge (Alicia).

Finally, the last point to make about this theme is about the spill over effect from one domain to another (e.g., Laura having no "niceness" left). Although some individuals may be capable of keeping a strict separation between work and non-work (e.g., Helen), there is increasing evidence that stresses from one domain can impact on the other (Danna and Griffin, 1999). Broadly, there are two perspectives on this spill over effect. One is the 'negative spill over' view where distressing experiences from one domain can have a detrimental effect on the other; and the contrasting perspective is the 'positive spill over' where increasingly research is showing beneficial cross over (Grzywacz et al. 1991). In this study, there does not appear to be evidence of positive spill over. This is not to say that it does not occur, simply that the data does not reveal confirmatory findings. For some, compartmentalising roles is possible (Helen who segments away her work life from home); for others, this partitioning is less feasible (such as Laura who explains that her "niceness" is all used up at work).

10.6 Summary

For long, the Cartesian separation between mind and body had dominated science. A quick perusal through the literature review will show that wellbeing theories either ignore the body or discuss it as a passive entity – something that outcomes happen *to* e.g., tension, muscular spasms etc. It is seen as something that wellbeing happens to and the mind is considered the key information receiver and processor. But in the accounts of these PALS participants, it is quite evident that their body is not simply a passive puppet controlled by the mind, rather it is an active communicator with the external world, with the space around it.

Overall, this theme shows that mainstream wellbeing models may be limited in their ability to explain PALS worker experiences because they do not consider the person as an embodied being, capable of mind *and* body. However looking at wellbeing from a phenomenological perspective can help better understand the important role that the body plays in wellbeing experiences, not least being the means through which external information enters (e.g., sight, sound etc.) and

internal experiences leave (e.g., using the distance between one's thumb and index to represent closeness to breaking point). It is also important to point that office space has come up as an important consideration for PALS staff; with some participants changing offices as a result of their "wobbly" (e.g., Lynne, Adam) while others would like to as the environment is "oppressive" (e.g., Alicia). Hence where their body resides can have an impact on their wellbeing.

During analysis, there was thought around whether the notion of embodiment was best captured 'within' one super-ordinate theme or whether it was interwoven through all themes in this study. Finally it was recognised that both were the case. Embodiment and embodied metaphors are in the background of the previous themes discussed, but in this theme, they take the forefront. In the previous themes, embodiment underlies participants' recounted experiences; in this theme, it is about embodiment itself. For this reason, it was deemed necessary to discuss embodiment both as an underlying current of all themes and as a theme in its own right.

So far, in the three themes already discussed (1 – *they just don't really get it*, 2 – *changing a super tanker's direction,* and 3 – *breaking point and life in context*), the lived experience of PALS worker wellbeing appears disheartening. These three themes have most evocatively recollected the painful experiences that can be a part of the PALS job role. Participants have most eloquently communicated their lived experience of strain and shared their distress. It would seem reasonable then to ask if matters are indeed so dire, could the findings from the previous study be incorrect in the reported satisfaction levels? Indeed, up until this point in the participants' story, wellbeing accounts have illustrated their distress and satisfaction has been absent. And here is where their story takes the most unexpected and gratifying turn. Amidst all the suffering, the lack of appreciation, the 'banging one's head against the NHS wall', and losing one's voice, participants reveal *this is a vocation and I wanna do it.*

11. Having a Calling: This is a vocation and I wanna do it

11.1 Introduction

This theme was an inductive discovery. At the start of this research project, there was no expectation or preconception that PALS staff might be motivated by such a strong desire to help, to nurture, and to take care of others. In fact, the presumption was quite the opposite; that PALS staff would abhor their job, and broken and strained would seek opportunities to leave. However, as this theme shows, this is the furthest thing from accurate. Indeed while *they just don't really get it* and *breaking point* evidence the extent of their distress and *changing a super tanker's direction* admits their aversion to the system, *this is a vocation and I wanna do it* most beautifully captures their devotion to their role and their motivation to help in spite of the challenges described in the previous three themes. Being an inductive theme, the discussion section is noticeably longer than for other chapters. This is because specific literature on the concepts that have only now been unearthed need to be covered. Such a lengthy discussion section is quite typical of inductive research. This chapter thus presents the fourth and final theme of this study:

Super-ordinate Theme:

d) This is a vocation and I wanna do it

Sub-themes:

d1) Being helpful

d2) Making the world a better place

d3) A sense of humour

11.2 Being Helpful

This section begins by first showing participants' dedication for helping patients, then their regard for supporting staff members, and finally each other. In spite of their current uncertain situation with regards to the NHS reform (will they/won't they have a job), participants are

expressing motivation and commitment to their role. For example, Laura explains it as still having a "job" to do:

> LAURA: a sense of not feeling that you have to be influenced by the organisation, you know the fact that that's now running down, closing, that, doesn't reflect how I feel about my work. I still see there's a job out there to do (line 644).

It seems that Laura can separate the organisational side of things with the work that she does. In a way, it is distinguishing between the organisational politics (e.g., PCT closing down, departments merging etc.) and the actual job of PALS (e.g., helping patients). For Laura, the variables in the macrosystem do not deter her from performing her role, they do not "reflect how I feel about my work"; her motivation is maintained by the job itself.

For Alicia, what 'keeps her in it', is helping others. In spite of the strain and angst that she shared during the interview, she nevertheless experiences an urge to help others, to make a positive impact in the lives of patients. She shares that by the time they reach PALS they have been through a number of revolving doors, which Patrick calls "NHS pass the parcel" (line 136). Alicia elaborates:

> ALICIA: Why can't we just take 5, 10 minutes to find out what those issues and concerns are? And say we'll look this is what I'm gona do for you. I'm gona give you a number anyway, but I'm going to call this service, you called me, these are your issues, these are your concerns, and I'm gona ask them to ring you [...] why can't you make people feel good about the fact that they got you on the phone, and they've not been passed on again without someone listening to what they have to say. I think that's probably what keeps me in it (line 170).

She questions "why can't you make people feel good"? Implying that one of her motivators is being benevolent towards others and making a positive impact in their lives. Alicia's motivations echo Laura's:

> LAURA: I think really when you hear immediately in the voice of the patients some, they've actually got through to somebody who can influence their situation. By the time they get to us they often have left answer phone messages everywhere that haven't been returned, they've been told I'm sorry that's not my department over and over again, and when they actually reach someone who says listen I might not be the right person but I promise you I'll find someone who can help you and get them to call you back or I'll call you back. So I think instantly hearing that relief in them,

> thinking oh gosh thank goodness, somebody actually understands or is taking me seriously or something. That in itself is rewarding (line 141).

She summarises that:

> LAURA: I guess the biggest buzz if you can then feed or they feed patient feedback into the system and get some big service improvement out of it that probably is the biggest buzz really (line 158).

From her musings it is evident that her motivation comes from helping and supporting, and making things better for those who need it. She recognises that her "biggest buzz" comes from making service improvements i.e., changing the NHS for the better.

When Adam was asked to give an example of a particularly motivating experience, he recalls how he helped a patient in Moscow. This was not the first time he helped someone in a foreign land; Adam now notes these countries on a map:

> ADAM: that's the reason I brought the map of the world in, just to sort of you know lighten the place up and also gives me a sense of achievement as well [...] you know I have spoken to people in Finland and I've helped people out in Iran I've you know what's the weirdest place? I found a treatment centre for someone in Moscow they didn't know (line 209).

For Julie, identical to the other participants, helping is key:

> JULIE: I know sometimes I feel really pleased when I know that patients or families have said that's been so helpful, thank you. And sometimes they write back after a meeting or something to say that was really useful, that's great. That's a really good feeling you know that you know they've understood, they're pleased that you've changed you know you've told them what's happened and you know apologised you've said right we're gona do this from now on, that's a great feeling (line 536).

In fact, Laura may even offer home visits if that is the best way of diffusing the situation:

> LAURA: Very often if people have received a very poor service then actually a home visit can go a long way. If you've got a very angry person as well. Actually going and offering to meet them, either at their home or in the local cafe or wherever, that in itself is enough to defuse the situation so we try and make ourselves as accessible as possible (line 237).

While Lynne might offer to call after hours:

> LYNNE: if a mum comes on the phone I always make sure I can phone at a time that's convenient, that say sometimes I'll phone her later in the evening, maybe the kids have gone to bed, but I really work with them (line 596).

Adam sums it up beautiful when he says: "I think that's a lot of the time, we're just giving re-assurance to people or just you know listening ear" (line 445) while Sue describes it as 'therapeutic':

> HELEN: a lot of counselling
>
> PAULINE: definitely
>
> HELEN: comes with the job
>
> SUE: it's therapeutic speaking to you guys, when they ring, innit (line 492).

Pauline forms quite strong relationships with her patients:

> PAULINE: I call them my little boys, cause there's quite a few of them [...]
>
> HELEN: and he'll come through and ask
>
> PAULINE: they will ring and ask
>
> HELEN: I'll say 'oh your man's on the phone'.
>
> **Laugh** (line 545).

For Pauline:

> PAULINE: for me, that would be one that I can say, yeah well done, cause I've got that relationship with him (line 548).

For Helen, she explains that the change in her patients is rewarding:

> HELEN: yesterday she was sobbing and crying and this morning she was happy and laughing (line 120).

Similarly, participants may receive gifts from patients with whom they have strong bonds:

> ADAM: So for example the guy who actually did that picture [the Munch scream copy] he's one of our service users.
>
> LILITH: oh wow that's amazing.
>
> ADAM: yeah it is.
>
> LILITH: yeah it reminds me of, which one is the one with the scream...
>
> ADAM: Munch, that's what I said, I actually said that to the consultant, said you know it reminds me of the German expressionist you know (line 281).

For Patrick, openly sharing his anger and frustration, perhaps comes more easily. Although he does not explicitly state that his motivation is to help, this is implicitly evident when deconstructing his achievements:

> PATRICK: it was the best attempt in my working life time to actually change the culture of something that has always been a very adversarial approach. And I remain committed to the concept of learning as opposed to punitive measures (line 58).

He gets frustrated when he cannot initiate change:

> PATRICK: I don't really want to be here anymore cause I don't feel that, if you can't change an organisation to a level that you really want, then there's no point keep banging your head against the wall, and I think I've probably changed this organisation as far as I'm gona be able to. So I think I probably and I'm tired of putting up with that. I'm tired of that frustration (line 313).

But feels rewarded when he manages to make changes:

> PATRICK: I'm always pleased when we actually do get the organisation to change something. That legitimatises my existence basically I'm also pleased when I've been very fortunate in that the number of things that I've done throughout my professional life have been adopted nationally in one context or another. And I kinda like that cause you know it gives me something without being immodest it gives me something that I can say I did that or you know so that I find that very rewarding (line 743).

Although Patrick does not openly admit to his helping nature, from careful interpretation of his statements above it can be noted that helping, supporting the organisation to learn and therefore become better, and initiating changes are his motivators – they "legitimatise my existence".

As shown so far, participants express a keen motivation to help and to make things better. Some even form strong bonds with patients, receiving gifts or having special nicknames. This sort of pastoral care is not solely given to patients but also to staff members. For example, Lynne recounts how staff members turn to her for a shoulder to cry on. She remembers:

> LYNNE: Also just on a day to day basis, say something goes wrong, people are upset, say members of staff, it's not just patients, its members of staff as well. Cause you get patients who can be really arsy and unpleasant and people come in here and just say 'Can I come and have a cry?' 'yeah of course you can, shut the door, have a cup of tea'. So it's nice. (line 256).

She adds proudly:

> LYNNE: I've been helping one of the students here with her Masters, she just came in and she said 'I don't know where to begin', I said 'OK keep calm, let's work through it' (line 251).

And:

> LYNNE: I'm very supportive of GPs [...] one young GP last year who was almost in tears with this woman [...] I said to him 'right you are gona have to accept that I'm saying this with you in mind, you are not gona like what I'm gona say' so I prefix it, and you can feel this, sigh at the end of the phone 'I said you have really got to toughen up cause you in 6 months will be out of a job if you don't get a grip and recognise you cannot be all things to all people'. And he wrote me this amazing letter thanking me. I know (line 985).

Similarly, Julie reminisces on how rewarding it is to hear that staff value her help:

> JULIE: I like it when staff you know say it's really nice to have you there, it's great that we've got you there, that's just a nice feeling you know that you could be sort of helpful (line 543).

Julie also cares about making positive changes for staff; she says:

> JULIE: since I've been in this post, we've established far more about doing much more one to ones with people [...] staff seemed to like it, they feel more supported through that process because you know I go with them to the meetings obviously and they feel it's better than, and, because we've shown that where's stopping things from getting worse (line 104).

And:

> JULIE: I quite like I really like it when staff phone me and say 'Julie you've got to come and help us, this is awful' and I think 'aww, let's see what we can do' (line 151).

In her tone and use of the expression "aww", it is noticeable how Julie enjoys being needed by staff, being helpful and, importantly, being perceived to be helpful. And in return, she also empathises with staff members and appreciates the hard work that they do:

> JULIE: I remember, getting a complaint about a ward sister, about her ward, and she said, I just want to give up, and she was an excellent nurse, she was a really good nurse, she said I want to resign, can't believe it, can't believe, it's just so horrible, she was so hurt by it. And I do understand that. Really painful cause you think you're providing a really good service and you think staff have worked hard and then someone complaints and you think what?! What?! What now?! What else can I do?! (line 426).

As can be seen from the accounts presented above, participants share a common motivator: to help. This mostly involves helping patients, but it can also refer to helping staff members. And yet their helping nature does not stop there; they even help each other. For instance, Laura explains:

> LAURA: phoning Lynne up and saying Lynne I am so rubbish at this you know I've upset all these people today or this person's told me I'm useless, this person's told me I'm disruptive, or whatever it might be, and then she'll say a few words and you'll get it all into perspective, or vice versa, or what have you, or we'll go out for lunch or something like that (line 384).

Lynne concurs that "debriefing, offloading that's what Laura and I do between us, every now and then" (line 931). For Pauline, Helen and Sue, they share a palpable joyful camaraderie in their open plan office. Pauline explains that it is the conversations that occur in-between the work that eases the tension, she describes it as "our therapy" (line 891). Helen laughs and explains that they talk about:

> HELEN: food! And shoes.
>
> **Laugh**
>
> LILITH: shoes are always good.
>
> PAULINE: I think we've all got quite good relationship really and I think that helps. In the sense that I don't feel that we're supported outside
>
> SUE: we've got each other (line 292).

Through their amicable and fun interactions about food and shoes, the participants receive social support from "each other" even though they do not feel "supported from outside". Pauline stresses the importance of such "banter" (line 478) and Helen compares it to being a family unit,

she says "cause we're like a little family" (line 754). Pauline uses the analogy of a homely Italian family and she believes that their love of food creates this atmosphere:

> PAULINE: I think that's what kinda makes it feel like a family. We're kinda like Italian-y things, where there's just mum, and the way mum used to make it... (line 824).

The image of an Italian mum that Pauline invokes seems so exact as this is the very impression she gives off – an aura of being a motherly figure that nurtures but also does not take any nonsense.

It is intriguing that this open plan office is "like a little family" but that Alicia's is "oppressive". Adam and Lynne also moved offices and are happier in their new set up than previously, so what is it about Pauline, Helen and Sue that differentiates their room? It could be simply a combination of compatible individuals, the right ingredients in the right amounts. It could also be Pauline's nurturing that gives strength to her peers. For instance, Pauline fought hard, and received, clinical supervision for her and Helen and Sue. It appears that when the team was initially created, a nurse was supposed to join them, however this never occurred. As a result, Pauline, Helen and Sue ended up performing a significant amount of clinical tasks such as those explicated in the theme *they just don't really get it*. Pauline recognised this, and thanks to her assertive approach, took the matter to her seniors:

> PAULINE: well that was the reason why as well I insisted we had supervision, 'cause before we never had supervision. Clinical supervision. 'Cause we were dealing with quite a lot of clinical information, we never had that 'til only about a year?
>
> HELEN: a year ago yeah
>
> LILITH: you requested for that?
>
> PAULINE: mmm
>
> HELEN: there's nothing Pauline don't ask for, she doesn't get.
>
> **Laugh**
>
> HELEN: she does not accept the word NO.
>
> **Laugh**
>
> PAULINE: not in my vocabulary. 'No' probably means in a minute, later, not now. But not never. Yeah that's my challenge.
>
> LILITH: and what made you, I think it's great that you did, but what made you ask for that?
>
> PAULINE: because doing counselling I realised that we have to have supervision, with issues and cases that would kinda bring out, and we didn't have, we were just bouncing off each other here (line 248).

It is evident from this example that Pauline watches out for her peers, that she noticed the burden they carry, and did something about it. She pursued the matter until her request was granted and she and her colleagues received clinical supervision. The successful room ambiance could very well be as a result of the clinical supervision. Indeed, this is the only team interviewed to be receiving such formal support from the organisation. Having said that, it would not be just to downplay the importance of Pauline's role in this trio, for the clinical supervision would not have materialised without her persistence. In a way, Pauline was being a PALS worker to her peers.

Laura and Lynne also take on a 'caring' role, but in their case, it is towards more junior colleagues:

> LAURA: There's been an unspoken thing we've got a couple of people who are on slightly junior grades to ourselves within the team, and we've never been given instructions to line manage them or anything like that but just by the nature of the role they would come to us, either for help with a particular problem or for support in what we consider to be a line management type way, be personal issues or, so we tend to be the go to guys even though that's not necessarily the role.
>
> LILITH: so it's like mentoring?
>
> LAURA: absolutely. You know one of them say, ask me if they could come to me, for their supervision. And I said oh I don't think I was your supervision. She said well you did it last week. And I said oh I thought that was just a chat. But there you go. If they see that as supervision then that's, if that's what they need, that's fine. And I think probably because Lynne and I a bit older than them, probably a bit of a mother figure (line 107).

Similar to Pauline, Laura evokes the notion of a "mother figure". In both cases, it appears that participants are attempting to externalise feelings of nurturing by bringing up the imagery of a mother, a caretaker. From Laura's example, it is evident that those junior to her look up to her, and seek her support. In return, Laura is protective over them:

> LAURA: a quick example, last week, some of our colleagues were having an absolutely horrendous week, they were picking up all the dropped balls from all sorts of other services, covering everybody else's backsides, and our ultimate boss walked through, and just happened to say to her you know these girls have had a terrible week, they've been going over and above, and then she said, oh it hasn't gone unnoticed, and I said there's a difference between noticing something and acknowledging something, so

> she might have noticed that these girls have been their socks off and are being pressured to their very limit last week, but she hadn't acknowledged it or said to them at all, you know [...] you'd think, you'd think wouldn't you. And had to say to the director one day from saying something to a colleague, they'd just taken their first call where they'd had a suicide threat, I said don't be telling them what a bad day you've had. I wasn't, I was just gona say that I just come out of my fourth meeting of the day, and I didn't get home til midnight last night, and you think no but you also didn't say that you get paid four times as much as she does (line 741).

Just as Pauline relies on her assertiveness and persistence, Laura uses fierceness to protect her 'mentees'. She stands up for them in front of managers and even protects them from directors – much like she does with patients. As Pauline invokes the Italian nurturing mother who takes no nonsense, Laura resembles a lioness protecting her cubs. In these examples, participants are engaging in protective helping behaviour towards each other; they are being PALS workers to each other. Hence, participants help and advocate for patients, other staff members, and each other.

11.3 Making the world a better place

This sub-theme explores participants previous roles and their plans for the future should they be made redundant in, what was at the time of data collection, the upcoming NHS change. It shows that most participants seem to be coming from what can be construed as helping backgrounds, ranging from training to community work. It explores their future plans and discovers that participants believe their future ventures will still involve helping others.For them, it is about *making the world a better place.*

In fact Julie admits that she would be quite upset if she was no longer doing her job. She says:

> JULIE: I would probably that's you know if you said you can't do it anymore, I would be upset, they would be part of me thinking oh god, but mostly, most of me, would say, oh no, that's a shame (line 765).

When after her breakdown, Julie tried a different sort of role, it was simply not right for her. She remembers:

> JULIE: boy did I miss it, really, oh god yeah, in fact I used to get really annoyed because when they were patient issues coming up and people didn't, I would say 'oh I'll deal with it' (line 137).

In her anguish Alicia muses:

> ALICIA: I don't know why I put myself through that kind of mental torture, I don't know why I do it, if someone could explain to me why I do it. It would be helpful. But I don't know. What is it about me that feels that you know this isn't good for me, why are you doing it? Do you like the self-infliction of pain? Or do I feel that I need to prove myself? That I'm not worthy? Or I feel that this is a vocation and I wanna do it. I don't know. Why I enjoy what I'm doing, do I really enjoy what I'm doing? Or do I find it a challenge? What, I don't know what keeps me doing what I'm doing. I don't know Lilith, you tell me (line 434).

Alicia's pain and concern is evident in her reflections. She likens working in an under-appreciated environment to "mental torture", and as she chooses to remain through her own volition, she calls it as "self-infliction of pain"; painting a portrait of a self-harming employee. She wonders why she would put herself through this agony, whether this line of work is a vocation. She concludes that it might just be so:

> ALICIA: It's not valued, it's not given the prominence that it should be given because a lot of people will give a lot more and get nothing from it. So it seems like a vocation, so something it's like a vocation, I probably see that... (line 250).

Alicia's interpretation of her job seems to be quite accurate. For instance, when deconstructing participants' pasts, it becomes evident that their previous roles were also about making a positive difference in other people's lives. Hence what motivates them is helping others and what they used to do was about helping others. In addition, when probed about future plans, participants profess that it would still involve helping others. Hence they are motivated by helping, they used to help and will carry on to help. This link between past, present and future provides support for seeing the PALS role as a vocation.

Alicia for example has a "complaints background" (line 19), similar to Patrick. Although she was not working in the same organisation or doing exactly the same role, she was nevertheless engaged in the sort of work that helped to set right a wrong i.e., complaints resolution. When

probed about the sort of work that she might do if she were to leave, she recognises that it would still be an "emotional" job:

> ALICIA: I got a feeling it won't be anything less emotional, it is something emotional" (line 497).

She elaborates:

> ALICIA: Definitely around trying to get the best out of an individual, trying to see things move forward for an individual, growth within that individual, and change, where I'm gona get that, I don't know, I don't know where to start. I have an idea what I want to do, but it's getting there, getting out of this rut (line 490).

She sums it up by saying: "I'm passionate about people" (line 528).

In her reflections, Alicia recognises that she derives meaning from helping others and explains that her potential new role would still be "emotional" and seek to initiate "growth" within others. It is people that she loves working with, and it is helping them to grow and change that motivates her.

Lynne has a similar helping background, having worked with "the community for older people" (line 91) and having "loved it" (line 100), her career motivation comes from making "the world a better place":

> LYNNE: I always go home knowing that I've helped make the world go around. I've helped make the world a better place (line 534).

Even Patrick whothreatens to leave, when he lets his guard down, he admits:

> PATRICK: we're in a situation where the nature of the work itself can take its toll on you. Sometimes I think it's good, I mean you know occasionally I'll get something that brings me to tears, you know just the human nature of it. Which always reassures me that I haven't lost my humanity. You know that's quite good. I use that as a positive way (line 548).

For Laura, if she were made redundant, she would:

> LAURA: look for a job, hopefully in the same kind of fields, but not necessarily at the same grade or hours. So you know you can maybe work less or work at a lower seniority (line 657).

She daydreams:

> LAURA: you know at times I quite fancy working with the homeless, so something perhaps where advice, information, support, advocacy that kind of thing is still involved, but something a bit more different you know we know that those jobs aren't very well paid, and you kinda get tied into your mortgage and things, so, if I use my redundancy money for that (line 665).

Laura analyses that "advice, information, support, and advocacy", basically "that kind of thing" would still be the crux of her new role. This echoes Pauline's sentiments who used to be a "trainer" (line 201). She confesses that if she were made redundant, she would not be too displeased, but that:

> PAULINE: out of all the exciting things I want to do, still, all relates right back now to mental health (line 844).

One idea that Pauline has been toying with is setting up a counselling centre. She would even consider voluntarily working part-time in her current role and admits that:

> PAULINE: I've always said that I would do here voluntary, sort of like one day a week (line 865).

Adam also has a helping background, having previously worked in the "local community" (line 80). He summaries that:

> ADAM: it's always been public sector. And that's why I like it. (line 86).

When inquired about his future plans, he responds:

> ADAM: it's gona happen whatever there's no use worrying about it, everyone feels that. So you know it's gona happen, it's gona happen. c'est la vie. That's the phrase, you know I'm not gona, you I get made redundant, I get made redundant, hopefully I won't, but you know I'll look at it as a new opportunity. I'll use my transferrable **mocking voice** skills such as they are yeah so that sort of thing doesn't worry me. My worry is really about you know the operational side of things, the woman I'm doing a complaint for, the other woman who's not complaining about our service who's complaining about a maternity unit somewhere else in London that was brought in to deal with. Those kinds of things worry me (line 490).

For Adam, there is "no use" worrying about the future; his worry is about "the operational side of things", the actual people he helps, the complaints he attempts to resolve. It appears that

much like Laura and Alicia, he can separate the organisation (e.g., redundancy etc) from the PALS role (e.g., operational side of things).

But not all participants share the same motivators. Sue, the youngest participant to be interviewed, says she has an administrative background and looks forward to "payday" (line 576) while Helen, who shares a similar administrative background, admits:

> HELEN: I'd retire tomorrow! Got exciting things to do (line 841).

Helen and Sue's perspective can be contrasted with that of the others. In their case, their background is administrative; although this includes helping and supporting others, it is more clerical and organisational than the helping backgrounds described by the majority of participants. Helen and Sue also appear less invested in the intrinsic helping nature of their role. For Sue, the motivator is extrinsic (e.g.., pay) while for Helen it is external to the organisation (e.g., "leisurely activities" line 864).

11.4 A sense of humour

So far findings have been pointing at the PALS role being a vocation with participants' key motivation resulting from wanting to help, to make the world a better place. In their positive quest to change the world for the better, participants declare that a sense of humour is a necessity for survival.

For example, Lynne reveals that she has a "naughty" sense of humour:

> LYNNE: Oh emm you have to be able to, I would say, be fairly resilient. Emm you can't let stuff get to you. I have an amazing sense of humour, I am known for emm I'm very naughty, I'm very irreverent. But within the context of appropriateness by the way. Ok. Emm. I've done some very naughty things (line 353).

Lynne then goes on to describe how she "did this skit on what it's like to be a patient in the community when the health service kicks in your life" (line 818). She recounts how she:

> LYNNE: had 3 layers of clothes on. So my first layer was a district nurse, my next layer was an occupational therapist, oh no, first was a social services inside, then physio, then occupational therapist, then district nurse. And I had these props. So I huge bag of old medical medicine boxes. Bag of them. And I had a huge pile of information all in that bag. And I came in as these 4

> people and talked to nobody. Because why would you talk to a patient you know? So it was a play on the awfulness of the way in which communicate with people (line 820).

Basically, Lynne was doing a parody of the "awfulness" of the way these sorts of professionals communicate with patients (i.e., the sarcastic comment about 'why would you talk to a patient you know?'). Her first skit was of a nurse:

> LYNNE: So this nurse walks in with this huge bag of drugs, drops it on the table, and then hangs a piece of paper with a 'do ring us anytime, but not after 5, not on a Saturday, not a Sunday, not after 6 o'clock and anything happens at midnight, just hang on, hang on til 8 o'clock in the morning and somebody will get back to you, but they might not answer cause voicemail will be on' and that's the nurse (line 830).

As can be seen from her caricature comedy, the nurse makes it very difficult for the patient to contact her. Lynne being a PALS worker, is then on the receiving end of this hypothetical patient's complaint. Although it quite apparent that this show was done with good humour and for laughs, there is a resonating sense of truth in it – which is what makes satire funny. As expected, Lynne "had this room in stitches" (line 826). Lynne then rushes out and quickly takes off her first layer and comes back into the room for her second spoof:

> LYNNE: got the green on so everybody knows green is occupational therapist. And I had these huge names across me, all in just like stickies, and I put bosoms in to make my bosoms bigger. And I go in, everybody and stand there like this with these BAGS of equipment and I unload the bag. And I go 'and this is for the bathroom, and this is for the bedroom and this is for sliding out of bed and this is to put in the car, this is to put upon the toilet duh duh duh' and I walk out (line 843).

In this second farce, Lynne begins to use slapstick to elicit laughs by putting "bosoms in to make my bosoms bigger". As before, Lynne uses satire to represent a stereotypical occupational therapist's communication with the hypothetical patient. While in the first mockery, the nurse was placing obstacles for the patient should they need to get in touch, in the second, the occupational therapist is simply unloading a "BAG of equipment" and rushing through information without really explaining anything. Evidently, these sorts of communication patterns are going to leave the hypothetical patient probably more confused than when they began. And here is where PALS staff would enter and pick up the patient.

Lynne admits that her sense of humour is "very naughty. But I'm known for it" (line 812). She does skits as described above and she confides "I take off people" (line 813). In a similar vein, Adam reveals:

> ADAM: We have a lot of laughs, we sometimes have, there's a little element of dark humour, which creeps into our work (line 157).

This was quite evident during the research interview where Adam would often make sarcastic and witty comments. For example, when asked what he does upon arriving home, he joked:

> ADAM: when I get home, I crawl up to bed, and I assume the foetal position you know **laugh** no I don't know the usual sorts of things that people do, look at telly, I'm a kind of fanatical reader (line 751).

Or when asked whether the Munch painting reproduction was a patient gift, he responded:

> ADAM: yeah it was. I don't know when we got it. But it was a couple years of ago. He didn't send this as part of his complaint did he? This is how you make me feel **laugh* the scream! (line 315).

Such acerbic yet funny comments are representative of Adam's manner of speech – much like with Patrick's speech. In Patrick's manner of speaking, irony and sarcasm, perhaps more so, were plentiful and prominent. For example:

> PATRICK: ... you know the performance is looked at, why is so and so taking so long, why have you got so many complaints open, these kind of questions, I mean you know they're silly questions really, what do you expect me say, it's cause we're all lazy, we're all lazy and incompetent, that's why we got so much open you know (line 613).

Adam elaborates that "dark humour" can be cathartic, that in a way, it helps to ease the tension:

> ADAM: oh yeah sort of you know catharsis it sort of releases tensions and you know. I mean it is noticeable when we don't talk to each other than you know that we're all really involved in work really deeply involved so it is, little joke here, a little you know yeah, flippant remark here and there (line 162).

He sums it up by saying: "you know have to laugh 'cause you know you're trying to maintain your own sanity you know" (line 618).

Julie appears to agree and explains that in order to cope with the PALS job, one needs:

> JULIE: to have a bit of self-awareness and you know a good sense of humour, they have to have that, cause you'd die otherwise! (line 248).

Alicia agrees:

> ALICIA: You know you can't do this work if you don't have a little bit of fun, a little bit of banter, for complaints you've got to be able to see the funny side of things, you've got to be able lighten the mood (line 393).

As demonstrated in the participant accounts above, a sense of humour can be quite helpful when one's motivation is to make the world a better place. It can be cathartic and enables the safe release of strain that builds up as a result of such heavy and emotional work. Although this theme was not as frequently mentioned as the others nor as detailed in accounts, it is nevertheless an important theme. This is where IPA's strength is truly highlighted; in its ability to show the importance of having a sense of humour without it necessarily being repeatedly discussed. If this study employed another technique, for example, content analysis which requires themes to have a quantifiably high number, then this theme would have been lost and the analysis would be have less rich for it.

11.5 Discussion

Early scholars, for example proponents of Theory X, assumed that punishments and control were necessary to motivate employees to work as they were inherently lazy (Houlihan 2000). Emerging human relations perspectives, from which stemmed the positive psychology movement, critiqued this view and proposed that employees could actually enjoy work e.g., (Herzberg, 1966), (Maslow, 1954), (Mayo, 1949). This is evidenced in this theme by PALS employees explaining what they love about their job. They share what drives them, motivates them and rewards them about their work – in spite of the distress shown in *they just don't really get it, changing a super tanker's direction*, and *breaking point*, PALS staff nevertheless are *being helpful* and *making the world a better place*. This theme, eloquently captured by Alicia as *this is a vocation and I wanna do it*, can be explained by drawing on three different disciplines: psychology, public administration, and management. The psychological literature contributes by putting forward the constructs of *task significance, experienced meaningfulness* and *experienced responsibility*. The public administration field proposes *public service motivation* while management suggests *prosocial motivation*. Each concept is somewhat different from the other,

but they do all share commonalities and each contributes to furthering understanding of what is happening with PALS staff. Each of these is now discussed below.

First, beginning with the discipline of psychology, the experiences reported by PALS staff can be explained by the variable of *task significance* as proposed by Oldham, Hackman, and Pearce (1976) in the Jobs Characteristics model. As mentioned in the literature review chapter, task significance is one of five job characteristics considered to be a motivator through the mediation of three critical psychological states: experienced meaningfulness, experienced responsibility, and knowledge of results (Liden et al. 2000). Task significance is the extent to which an employee's work affects the wellbeing of others and Oldham, Hackman and Pearce (1976) argued that when individuals are aware that their job enhances the wellbeing of others, then their motivation to do the job increases. Hence, the more significant the job, the more motivated the employee. This seems to assume some level of mental health from the individual as presumably an employee with antisocial personality disorder would not be interested in improving the wellbeing of others.

The core hypothesis of the Jobs Characteristics model is that jobs high in (1) skill variety and/or task identity and/or task significance, (2) with high autonomy, and (3) feedback are more likely to lead to intrinsic motivation. Intrinsic motivation is about the wilful exertion of effort based on the pleasure of doing the work itself (Ryan and Deci 2000). It is not conditional on receiving extrinsic rewards such as pay. When Hackman and Oldham (1976) tested the empirical validity of their model, they found general support for the first part of their proposition and confirmed that skill variety, task identity and task significance predicted experienced meaningfulness. But the second and third parts proved to be more problematic: feedback dimension results were less strong than others and autonomy was not alone in determining experienced responsibility.

As part of a doctoral dissertation, Fried and Ferris (1987) conducted a meta-analysis and found conflicting evidence to Hackman and Oldham's (1976) supportive findings. In their meta-analysis, task significance and skill variety were associated with experienced meaningfulness but task identity was not. In addition, the authors found that experienced meaningfulness and experienced responsibility were more strongly associated with motivation than the five dimensions independently, but that there was no relationship with performance. It is difficult to tell which job dimension exerts the most influence and Law et al.(1998) characterise the motivational pull of all five dimensions as an aggregate model. In spite of conflicting evidence, task significance nevertheless comes up an important contributor to experienced meaningfulness. Hence employees derive value from doing work that they deem important.

Later Humphrey, Nahrgang, and Morgeson(2007) proposed an extension to the original Job Characteristics model and incorporated additional salient variables such as social conditions and ergonomics. In testing the extended Job Characteristics model, they found that experienced meaningfulness was the most influential mediator between work characteristics and outcomes. In fact, even autonomy and feedback exherted influence through experienced meaningfulness. In other words, the degree to which employees perceive their job as meaningful is the strongest mediator between motivational antecedents, such as task significance, and outcomes, such as satisfaction and organisational commitment.

Experienced meaningfulness has been found to be important in a variety roles; ranging from healthcare professionals such as doctors and nurses (Bajwa, et al., 2010) to customer service workers such as hotel employees (Lee-Ross 1995) and salespersons (Thakor and Joshi 2005).Experienced meaningfulness is associated with positive wellbeing outcomes and performance (Humphrey et al. 2007);for example, enriched work can strengthen the employee's sense of ownership (Vough et al. 2008). Conversely, low levels of experienced meaningfulness in one's work can lead to depersonalisation and a decrease in feelings of accomplishment (Maslach and Jackson 1981), alienation and disengagement (Aktouf, 1992).

In this thesis, the concepts of task significance and experienced meaningfulness resonate quite loudly. PALS employees are aware that the work they do is important and they value their work. By *being helpful*, they draw a sense of achievement. This help could be local (e.g., "they feel more supported through that process because you know I go with them to the meetings" Julie; line 104) but also extended internationally (e.g., "I've helped people out in Iran" Adam; line 209). They perceive their role as integral to the organisation (e.g., "we're the spinal cord for the Trust" Pauline; line 250) and believe that by fulfilling their role, they are *making the world a better place*.

While, certainly, there is evidence of task significance and experienced meaningfulness in thesethemes, the concept of *public service motivation* from the public administration field can also be applicable to PALS worker experiences, particularly as they work for the NHS. In fact, evidence from this field shows that public sector workers rank *task significance* higher than private sector workers (Lee-Ross 2002). The hypothesis from the public administration domain is the government workers have a greater level of what Perry (2000) terms *public service motivation*. He proposes that context (e.g., public versus private) makes a difference on critical psychological states such as experienced meaningfulness(Perry 2007). This seems to make

intuitive sense as public sector workers, by virtue of working for the government or its related offices, potentially have more opportunity to do work that impacts a larger number of people.

There are two broad perspectives on public service motivation. The first is proposed by Perry and Wise (1990) who think it to be motives specifically grounded in public institutions, and the second, defined by Rainey and Steinbauer (1999), views it as a drive to benefit society more broadly. In other words it is not necessarily tied to public sector organisations but to altruistic tendencies more generally (Vandenabeele 2008). Altruism is defined as behaving in accordance with the needs of others as opposed to one's own (Perry et al. 2010); in other words, having other-orientated values. PALS staff by *being helpful*, caring about patients and colleagues, and providing pastoral care to others in need can be seen as engaging in altruistic behaviours. Theoretically, four key dimensions are associated with public service motivation: being attracted to policy, being committed to public interests, being compassionate, and engaging in self-sacrifice (Perry, 2000). Research shows that being committed to public interests is a strong determiner of how much effort a public sector employee is likely to put in at work (Leisink and Steijn 2009). In other words, government employees who are more committed to public interests are more likely to put in effort at work. Linking this with the psychological literature, it could be that for these individuals task significance is greater.

Public sector workers with high levels of public service motivation show greater organisational commitment (Crewson 1997) and more tolerance for the bureaucratic characteristics of their organisations (Scott and Pandey 2005). While there is evidence in this thesis for the former finding (i.e., PALS staff want to remain in their jobs), the latter is not upheld – quite the opposite. Rather, the theme of *changing a super tanker's direction* aptly captures the frustrations vented by PALS staff about working in a bureaucratic organisation. That is to say, PALS staff in this study are not tolerant of these characteristics but it is hard to tell whether private sector workers would be less so.

Research further shows that employees with high public service motivation are more likely to be satisfied with their job (Naff and Crum, 1999) and value intrinsic rewards such as feelings of accomplishment (Houston 2000) over more extrinsic rewards such as bonus payments (Andersen et al. 2012). This could explain why most PALS staff, those coming from helping backgrounds, speak of *making the world a better place*, but only one participant, from an administrative background, mentions salary. Naff and Crum's (1999) finding could also explain the paradoxically high levels of PALS staff job satisfaction when compared with their reported distress and strain.

Overall, the data does show that PALS staff could have high levels of public service motivation. For instance, some may explicitly state that government work is what they like (e.g., "it's always been public sector. And that's why I like it" Adam; line 86) while others imply it (e.g., "I quite fancy working with the homeless" Laura; line 665). In stating that *making the world a better place* is rewarding, it makes sense that public sector work or even voluntary work would be sought out as a means of achieving this. The one difficulty with using the concept of public service motivation exclusively is that it is US centric (Camilleri 2007). While the US and the UK may be considered 'western', there are nevertheless influential differences between the way the two countries are managed. For example, UK public servants may have multiple competing loyalties and pressures over government welfare, while American federal workers have to contend with regard for politicians and patriotic civic duty (Vandenabeele et al. 2006). In this thesis, PALS staff do speak of the former in the theme *changing a super tanker's direction*, but there is little to no mention of politicians or even the Department of Health. And while they do discuss ideology, there is no sense of patriotic civic duty; rather they seem to uphold the 'NHS ethos'. This brings into question the transferability of Perry's (2000) proposed dimensions (i.e., being attracted to policy, being committed to public interests, being compassionate, and engaging in self-sacrifice) as they may mean different things in each country. For instance, while compassion in public servants is highly valued in America on a humanitarian level, in the UK the concept has received little attention; rather, the focus has been on providing public welfare as a collective (Vandenabeele et al. 2006).

Therein lies the trouble with the overall concept of public service motivation. While it is not necessary to have international transferability for it to have value, it does make it more troublesome when applying it cross-culturally as governments – and thus what motivates people to working there – can be very different. Hence, the concept is perhaps too culturally bound. For example, it would not make sense to use it in Germany as compassion is thought to conflict with the German civic values of objectivity and neutrality (Vandenabeele et al. 2006).

A more globally transferrable explanation is provided by Grant (2007) who revisits the construct of *prosocial motivation*. Unlike public service motivation where the aim is to do public or societal good, prosocial motivation is simply about doing good for others. The former is aimed on a large scale whereas the latter can simply be an individual. This individual, which Grant (2007) terms beneficiary, can be external to the organisation, for example a patient, or even internal, such as a colleague. In this thesis, there is ample evidence that PALS staff are not only interested in

supporting patients (e.g., "you know listening ear" Adam; line 445) but that they also engage in extensive pastoral care with staff (e.g., "I go with them to the meetings" Julie; line 104).

Grant (2012) defines prosocial motivation as exerting effort through one's own volition in order to benefit others. It is motivation fuelled by the need to do good to others and perform prosocial behaviours. This can be seen in PALS staff statements such as: "why can't you make people feel good?" (Alicia; line 170). Prosocial motivation is intrinsically driven and shares similarities with the concept of intrinsic motivation. Similarly, individuals who are prosocially motivated, do so in-and-for-itself and not for external gains. However prosocial motivation goes beyond intrinsic motivation. While the latter is about internal satisfactions, the former is addressed externally. In other words, intrinsically motivated employees work because it feels good to them while prosocially motivated employees work because it feels good to others. For example, when PALS staff recount rewarding scenarios, the other-centeredness of this satisfaction is apparent. For participants, it is about "hearing that relief" in patients' voices (Laura; line 141) or having "staff phone me and say 'Julie you've got to come and help us" (Julie; line 151). It is debatable whether any other-centred action can ever be truly altruistic for if making others feel good feels good to oneself then that act becomes egotistical. However, that is more of a philosophical controversy that is beyond the scope of this thesis. At the moment, suffice to say that prosocially motivated employees are energised into action to benefit others.

There is evidence to suggest that both prosocial motivation (Kasser, 2000) and intrinsic motivation lead to positive wellbeing (Ryan and Deci 2000). For example, in a cross-cultural sample of 592 individuals, those who engaged in prosocial actions because they were intrinsically driven to reported higher levels of self-actualisation, self-esteem and positive affect than those who did good because they felt duty-bound (Gebauer et al. 2008). Similarly, in a group of 251 volunteers, positive subjective wellbeing and satisfaction were only associated with individuals who volunteered because they wanted to help (e.g., intrinsic prosocial motivation) but not with those who felt obligated (Vecina and Fernando 2013). Hence, the positive impact of 'doing good' on wellbeing depends on intent; it is not sufficient to simply do good, but one needs to also want to do it to reap the wellbeing rewards. With PALS staff, it is apparent that *being helpful* is a crucial motivator for them, and in their accounts, they are clearly intrinsically compelled towards this sort of work, towards *making the world a better place*. Even with junior colleagues, although participants have "never been given instructions to manage them or anything like that", they nevertheless provide informal mentoring out of their own volition (Laura; line 107). Similarly, when asked to perform activities outside of their job spectrum, "do I

turn around and say oh no that's not my job? No." (Pauline; line 328), PALS staff go above and perform citizenship behaviours.

Grant (2008a) considers prosocial motivation to be a state; in other words a temporary psychological experience that is aroused to pursue the goal of protecting the welfare of others. However, it has also been seen as a trait, for example, prosocial personality, which makes it a long lasting individual difference associated with Agreeableness (Graziano et al. 2007). In the first view, prosocial motivation is something that can be nurtured and stretched whereas in the latter it is fixed and stable over time. It is difficult to tell from participant accounts which is more likely to be their case; but it is evident that their prosocial motivation is enduring in spite of strain and does not seem to be diminishing even when faced with an uncertain future (e.g., "I still see there's a job out there to do" Laura; line 644).

Prosocial motivation is also an eudemonic pull; it is compelled by meaning and purpose (Grant 2008) – a meaning and purpose that PALS workers exhibit by wanting to change the NHS for the better, by propagating a learning culture. When asked about their future plans, participants revealed an inclination to pursue other helping opportunities. Many professed that if they were made redundant or had to leave their current post, they would nevertheless continue to help others in their new job. "The biggest buzz" may come from making an actual change to the system (Laura; line 158) or from making "the world a better place" and helping it "go around" (Lynne; line 535). For some, changing the organisation "legitimatises my existence" (Patrick; line 743). It is quite clear that for these participants meaning is derived from task significance. It is thus disconcerting that participants feel that others *just don't really get* what their job is about as research shows that receiving task significance cues on the job increases helping behaviours (Grant 2008b).

In spite that others *just don't really get* what their job is about and despite that actually making meaningful structural changes is like *changing a super tanker's direction*, these participants are pursuing a calling to help, to make a positive difference in the world, for them, *this is a vocation and I wanna do it*. If this motivation to make the world a better place is understood alongside their prosocial motivation, and if their previous roles and future plans are taken into account, it could be interpreted that most participants are pursuing a sort of calling. In fact, Vough et al.(2008) propose that an employee's calling orientation can influence how they perceive meaning in their own and respond to enrichment initiatives.

In individuals who perceive their work as a calling, the primary motivator is not money or even career advancement, but rather, the inner fulfilment of the work itself (Wright and Cropanzano 2004). For employees following their calling, it is about intrinsic motivation. For them, work is not a means to an end, but rather, an end-in-itself. Employees who are pursuing their calling appear to find "personal meaning" and "purpose" in their work (Elangovan et al. 2010, p.428). For most participants, it would appear that this personal meaning and purpose is derived from prosocial behaviours. In contrast, some employees (e.g., Helen and Sue), who perhaps consider their work as 'just' a job, the material rewards become stronger motivators. Here, work is a means to an end e.g., paying rent, buying food etc. In these cases, fulfilment is achieved in non-work activities; for example Helen who daydreams about retirement so that she can pursue her "leisurely activities" (line 864).

Theoretically, the construct of a vocation is associated with possessing other-oriented values (Dik et al. 2009); such as PALS staff who evidence prosocial motivation. Both callings and vocations are seen as ongoing, rather than at a single point in time. This appears to explain why most participants expressed a continued interest in helping roles should they be made redundant. Taylor (2013) argues that some individuals with high levels of public service motivation can see government work as a calling. The assumption being that for these individuals meaning and purpose is reserved for public service.

So it may be that for participants who are motivated by *being helpful* and are rewarded by *making the world a better place*, engaging in prosocial behaviours moderates the negative effect of *they just don't really get it, changing a super tanker's direction,* and *breaking point*. This would explain how in spite of the high distress evidenced, participants nevertheless remain in their positions and report job satisfaction. It would thus appear that prosocial behaviours could have a beneficial effect on wellbeing and might moderate negative consequents of strain. There is psychological research to support this explanation; doing good is good for wellbeing. For instance, it has been found that engaging in altruistic behaviours (Schwartz et al. 2003) and helping others (Weinstein andRyan 2010) can have a positive effect on mental health. Equally, volunteering can lower levels of depression and anxiety (Musick and Wilson 2003) and increase wellbeing (Thoits and Hewitt 2001).

In addition to prosocial behaviours PALS staff, much like other vocational employees, make use of humour and humour-related activities. For instance PALS staff confess to doing satirical 'skits' of healthcare professionals and often use sarcastic humour during the interview. Increasingly, the importance of humour in dire work situations is being recognised. For example, Sullivan

(2013) notes that gallows humour is often used by social workers to relieve tension and maintain sanity in 'insane' circumstances (Sullivan, 2013). These outcomes are almost identical to those noted by participants in this sample – Adam evens uses the word 'sanity' in his explanation for why he uses dark humour.

Using humour permits positive emotions (e.g., laughing) to overcome negative emotions (e.g., distress). For example, Folkman and Moskowitz (2000) found that caregivers construct positive experiences as a means of catching 'momentary respite' from the ongoing challenges of their job. In order to bring about these happy emotions, sometimes caregivers had to find humour in grim situations. Humour can also deepen the camaraderie and social bonding amongst colleagues (Rowe and Regehr 2010). It creates a separation between the in-group, who are making the jokes, and the out-group, who are being joked about.

Humour can be a form of catharsis when faced with high distress – even if this means findings humour in death (Roth and Vivona 2010). For example, crime scene investigators regularly face gruesome deaths for prolonged periods of time at close proximity. In order to release the horrors that are accumulated over the course of their job, investigators may use dark humour e.g., when working on a multiple gun shoot suicide case, an investigator joked: "when at first you don't succeed, try, try again" (Roth and Vivona 2010, p.325).

Although the use of gallows humours can have beneficial effects on wellbeing by helping to cope with stress (Moran and Hughes 2006), there are some critics who question the ethics of its use. While jokes can provide stress relief, they can also be used to communicate prejudice (Dovidio & Gaertner, 1986). For example, some doctors expressed concern at using derogatory language in cynical comments about patients (Wear et al. 2009). One trainee explained that even though he had yet to work with a patient with borderline personality, he had already formed certain beliefs as a result of comments made by colleagues. Hence, gallows humour is be a double-edged sword that helps employees manage difficult situations but can also cover up more sinister intentions such as expressing discriminatory comments in a seemingly socially acceptable manner.

11.6 Summary

The previous three themes, *they just don't really get it, changing a super tanker's direction* and *breaking point and life in context* portray a rather bleak wellbeing landscape. But this is not the case. In this theme, participants' motivation, sense of accomplishment and happiness is evident.

They share how their key motivation stems from *being helpful* and they feel rewarded by *making the world a better place*. For them, meaning and purpose is derived from helping, from engaging in prosocial activities. These could even temper the ill effects of their strain and makes battling the challenges worth it.

Most participants come from helping backgrounds and insist that should they be made redundant in the reform, they would nevertheless continue in occupations that help others. For them, emotion work may be a calling. Even though they experience high strain as a result, they are not deterred; they believe *this is a vocation and I wanna do it*. Like other high strain jobs, for example social workers and caregivers, PALS staff confess to using humour as a means of releasing tension from the "steam cooker" (Alicia; line 516) that is their wellbeing lived experience.

In summation, this study has added a much needed depth, descriptive and interpretative understanding of the experiences that make up PALS worker wellbeing. It has taken the broad knowledge provided by the first investigation and asked participants to immerse themselves in their experiences, and to share them. The next chapter then takes both of these studies, quantitative and qualitative, and along with the literature reviewed, discusses findings to reveal the wellbeing of PALS workers in healthcare.

12. Discussion

This mixed-method doctoral research consists of two studies; one that builds on another. After completing the first quantitative investigation, four specific research questions were answered:

RQ1: What is the wellbeing of PALS workers in healthcare?

RQ2: How does this wellbeing compare to other relevant occupational goups?

RQ3: What work experiences are associated with this wellbeing?

RQ4: How do these experiences compare with the experiences of the general UK working population?

But in answering them, a new inductive question emerged, reflecting the complexity of the topic:

RQ5: What is the lived experience of PALS worker wellbeing?

To address this more open question, a qualitative phenomenological exploration was embarked upon. This joins together both studies with a pragmatic appreciation that different methods are better suited to addressing each study's goals. Although there are two studies and thus two parts; they nevertheless make up a more complete whole. So far, the desk research conducted in the literature review and the aforementioned two pieces of empirical work have been discussed separately; however in this chapter, they are viewed as a whole. This technique of seeking information from different sources and/or using different methods to achieve a common goal is widely known as triangulation. Triangulation can strengthen research (Meyrick 2006). In objectivist perspectives, triangulation is used to affirm the accuracy of findings, and in qualitative approaches, triangulation can be used more openly to assess what else is known about a given case (Cunliffe 2010). In this thesis, information from three sources: the literature review, the quantitative investigation and the qualitative exploration; are now taken together to gain a deeper, richer understanding about the wellbeing of PALS workers.

By analysing the work project as a whole, three key contributions are made by this research. First, this research advances knowledge by pointing out that the PALS job is not equivalent to general 'customer service' work. Instead, it is being put forward that PALS staff engage in more sophisticated work, a relational type of work that relies heavily on their expertise and knowledge, advanced interpersonal skills and involves much emotion management. This proposed re-classification contributes to an interdisciplinary area covering the disciplines of psychology and public administration and may be transferrable to other comparable occupations in the public sector.

Moreover, this research also makes an unforeseen inductive contribution: to the fields of emotional labour and to work design. In the former, this thesis expands understanding of emotion work from being seen as largely a negative experience to one that can possibly be motivating and rewarding for employees. In the latter, it proposes Grant's (2007) relational work design framework as an alternative to explaining human service occupations than the traditional task focussed ones discussed in the literature review. Finally, the methodological approach chosen for the second individual level study illustrates two key limitations of traditional wellbeing theories reviewed in chapter one: Wellbeing is complex and dilemmatic, and it is an experiential phenomenon experienced by embodied beings. Each of these three key contributions are now discussed below by triangulating evidence from the literature review, the quantitative investigation and the qualitative exploration.

12.1 Contribution to Public Administration and Policy

The first contribution made by this research is that a new type of 'customer service' worker has emerged. This reasoning is based on the discovery that PALS staff are not generic customer service workers; rather their role is more evolved and complex. It requires expertise knowledge, sophisticated interpersonal skills, patient referral skills, advanced problem solving abilities and significant emotion management. While reading for the literature review, the wellbeing of PALS workers was questioned and noted as a knowledge gap within the fields of psychology, marketing, organisation studies and healthcare management. Tentative evidence from the psychological literature in a quantitative study conducted by Bakker and Schaufeli (2008) indicated that employees tasked with complaints duties reported greater emotional exhaustion and sickness absence than their non-complaints counterparts. However, the researchers were not seeking to measure wellbeing nor were they particularly interested in complaints staff; rather, these findings are more *ad hoc* and collateral discoveries to their main aims. Hence, although these results do hint that PALS staff may fare worse in wellbeing than other customer service groups, the evidence is not sufficient to draw any convincing conclusions.

Results from the first study of this project provide the confirmatory evidence that was missing by affirming this: participating PALS workers do appear to experience statistically worse wellbeing than sales, customer service and mixed industry call centre benchmark groups. In other words, when it comes to mental health, PALS staff have lower wellbeing than other customer service workers. However when the wellbeing of participants from this sample was then compared to the

wellbeing of social workers and the police, two highly stressed occupations (Johnson et al. 2005), there was no statistically significant difference, implying that the wellbeing of PALS workers is more comparable to these job types than to general customer service. There are two limitations to this interpretation. First although statistical computations such as *t*-tests can state that there is no statistical difference between the two groups, this does not necessarily mean that they are the same. 'No difference' does not mean 'the same'. Secondly, as this was a quantitative investigation, the researcher was not present to probe further to understand why these results may be coming up.

When the data was explored further to extrapolate what may be associated with PALS worker wellbeing, it was discovered that up to half of the negative mental health symptoms experienced by PALS has a relationship with the psychosocial variables of 'demands' and 'role' at work. In particular, there is a rather high incidence of reported strain among 73% of participating PALS workers. The findings from this study provide quantitative confirmation of the qualitative discoveries made in the budding field of healthcare management. For instance, the literature review found that NHS complaints managers experience role conflict and role ambiguity (Xanthos, 2008). Abbott et al. (2005) further highlighted the difficulties inherent in attempting to change a bureaucratic organisation as large as the NHS. Comments from the PALS (2006) informal report press this further with employees saying they feel undervalued, demoralised and generally unhappy.

Although study one does reveal that the psychosocial conditions of 'demands' and 'role' are partly associated with PALS worker poor wellbeing, its broad approach means that it is limited in explaining what it is like to live through these experiences. For this reason, study two then advanced understanding of these conditions through in-depth qualitative inquiry. It reveals that others *just don't really get* what PALS workers do and how much of themselves they invest in their job. PALS staff explain that their work entails quite a lot of **banging fist against heart** but express frustration that this human and interactive aspect is either misunderstood or ignored by those around them. While in carefully reading through Department of Health (2002) documentation one is certainly made cognisant of the complexity inherent in the PALS role; the literature review found no evidence that this 'unquantifiable' humane aspect of the job is being recognised – echoing PALS worker complaints from this thesis. In addition, when comparing this notion of **banging fist against heart** to the sort of work that call centre operatives do, for example cancellation of contracts (e.g., Grebner et al. 2011) and sending out technicians to customers (e.g., Holdsworth and Cartwright, 2003), there is an apparent skills gap. Contrary to these types of tasks, PALS staff have to rely on their sophisticated interpersonal skills, advanced

problem solving abilities and expertise knowledge to deal with complex and highly volatile situations such as suicide threats, crisis help and counselling as noted by participating PALS staff.

In addition, generic call centre workers are largely represented by young to middle aged women, educated to GCSE level who have minimal aspirations for the industry or career progession (Sprigg, Smith and Jackson, 2005) and low job control (Zapf et al. 2011). Such demographics lead Belt (2002) to calling call centres 'female ghettos'. In fact, participating PALS staff rank very high on job control, sitting between the 75th and 80thpercentile of the UK general working population suggesting that they have a high level of autonomy at work. The most common questionnaire participant was actually between 50 to 59 years of age with 5 to 10 years experience with patient feedback suggestive of quite lengthy work experience. Interview participants came from helping backgrounds such as training, nursing, and complaints; bringing with them specialised expertise of working with people in a prosocial manner. Many participants even expressed a strong motivation to pursue helping roles in their future should they be made redundant in the current NHS change, evidencing commitment and career aspirations.

Hence (1) the sorts of tasks performed, (2) how PALS staff feel, and (3) the type of person in this post appears to be quite different from generic customer service work. Instead the experiences reported in this thesis are more comparable to the experiences of Childline social workers who are based in a call centre (van den Broek, 2003) and to NHS Direct nurses who "give their all" to calling patients (Weir and Waddington 2008, p.73). Similar to PALS staff, they address general enquiries but also perform complex assessments. Results from study one support this premise. Although participants score worse on wellbeing than customer service benchmark groups, there were no statistically significant differences between the mental health reported by PALS staff and the mental health reported by social workers and the police force. This is further congruent with study two's qualitative finding that PALS staff are dissatisfied with job titles such as 'customer service manager' or 'telephone advice worker' as they are misconstrue their job without appreciation for all the **banging fist against heart** that they do. In a way, PALS combines expertise requirements with the relational aspects of emotion work. For participating PALS workers, it appears that the greatest definer of their profession is this very aspect – the humane, interactive and helping function they perform. As said during this study "PALS is meant to be an ethos, it's not just a department" (Adam; line 213). It is this very point that is overlooked and misunderstood.

This experience of being miscategorised is quite similar to the experience of prison officers. Crawley (2004) conducted a five year ethnographic study in correctional facilities and found that

prison officers, similar to PALS staff, feel misunderstood. Much like PALS staff who believe they are wrongly labelled as customer service, prison officers express a similar frustration with being perceived as police. In fact, they do not see their job as close to police work at all; but rather more like nursing and psychiatric work (Crawley, 2004). This echoes PALS who believe that they act as a "reserve social worker or community psychiatric nurse" (Adam; line 413) and feel that they are doing "quite clinical a role" (Pauline; line 228). Based on her findings, Crawley (2004) concludes that prison officers are actually not police but a distinct group in the judicial system of workers. In a similar way, this thesis argues that PALS staff are not generic customer service workers; but rather the time has come to construct a new discourse with which to identify this group of staff – a combination of customer service and human service.

12.2 Transferability of Findings

Qualitative research has made important contributions to health, medicine and public health (Meyrick 2006). By adopting a mixed-method design, this research combines both breadth of knowledge and depth of understanding; it explores reflections of human beings in their daily environment. In particular, such pluralist approaches are beneficial for the development of policy as they provide answers to both 'what is happening' and 'how it is happening'; neither quantitative nor qualitative studies can do this separately (Chih Lin, 1998). However what has been critiqued in such similar case specific research is its generalisability to other population groups (Yin, 2009). But this stems largely from a misunderstanding of how the word generalisability is used; in case-specific research the aim is not statistical generalisability (Yin, 2012). As probability sampling has not been used – a requirement of such external validity (Thomas, 2011), this thesis does not claim statistical generalisability. Rather, in the qualitative tradition, it shows that knowledge from this particular case can be transferred to other situations where it may have meaning (Finlay, 2006). For this reason, qualitative research often provides 'thick descriptions' and rich 'portraits of the setting' so that the reader may assess the relevance of findings for his or her context. Unlike the Positivistic discourse of random sampling and probabilistic inferences, transferability is the word proposed by Lincoln and Guba (1985) to refer to the qualitative concept of generalisability (Lincoln & Guba, 1985).

Consider for instance the following example: a lecturer at a mid-range university discovers that classes are growing larger, more diverse; that assessment feedback is expected quicker but also needs to be detailed. Based on this interview, the reseracher realises that these conditions increase pressure on the lecturer. After a few interviews with other lecturers from different

universities, the researcher observes that similar trends are reflected in their accounts. Looking at this example, it cannot be said that every UK lecturer is experiencing the same pressures, nor to say that each university had equal probability of being selected; yet it does reflect some common occurences in higher education. By deconstructing the underlying teaching and learning policies governing changes, it could be said that potentially, school teachers (who are also facing similar policy and administrative changes) are under comparable conflicting pressures to enhance quality of feedback but to do so quicker. This example illustrates how transferrability can be applied.

Based on the triangulation conducted in this thesis, the defining characteristics of the PALS role appears to be three fold:

(1) PALS involves expertise knowledge and sophisticated problem solving skills
(2) PALS involves emotion work and advanced interpersonal skills
(3) PALS has a prosocial role with the purpose to help

PALS can be argued to be a prosocial and relational work. Additionally, PALS is about emotion work; it is interactive and relational as opposed to task focussed. Their experiences have more similarities with social workers (van den Broek, 2003) and prison officers (Crawley, 2004) than with general call centre workers (e.g., Zapf et al. 2011). Certainly their wellbeing scores indicate this, but regrettably, this relational emotive part of their role is overlooked. And finally, PALS is a prosocial job; it is aimed at helping and championing the public good; representative of public sector work e.g., (Perry et al. 2010).

The three characteristics listed above share similarities with some other public sector roles, for example 999 operators, local government ombudsmen, citizen advice workers etc. The first example is now developed to show how findings from this thesis can be transferred to these other occupational groups. Emergency medical dispatchers, more commonly known as 999 operators, work in the same political context as PALS staff as they are also NHS employees. Furthermore, their job is also likely to involve significant emotion work as they deal with emergency life or death situations with panicked callers. Similar to PALS staff, after engaging in 'basic activities' such as logging calls and taking in caller details, comes the highly complex problem solving of deciding how best to handle a volatile situation until help arrives. This can mean remaining on the line with a highly distressed caller during a crisis and attempting to defuse it as best as possible. At times, it could be that 999 operators hear violence (e.g., spousal abuse), fear (e.g., a break in) and perhaps even death. However, in viewing the NHS careers website dedicated to 999 operators, there are clues that the job, similar to PALS, is not valued as it ought to be. For example, in the entry requirements section, the website stipulates that there is no national academic standard; rather

what is requested is "good general education", "keyboard skills", "developed computer skills", "knowledge of map reading" and "some understanding of medical terminology" (NHS Careers, 2013). In brief, there is no mention of the emotion work that comes with dealing with life or death situations and highly distressed callers. Even the discourse used e.g., operator, call handler, dispatcher could be devaluing the position. Similarly, it fails to capture what is likely to attract an individual into this sort of 'dirty' work - prosocial values and helping others. However, at this point, these are merely hypotheses, and further research is required to explore the wellbeing and work design of 999 operators.

The most potent commonality shared by all these occupations is their context. The changes in healthcare discussed in the context chapter of this thesis are reflective of wider changes in the public sector more generally. For example the NHS instituted the patient and public involvement agenda to improve public power over services and enhance accountability (Bentley et al. 2005) and the public sector saw the introduction of new managerialism and the push for professionalism and democracy (Exworthy & Halford, 1998). Public sector employees are faced with similar obstacles that are somewhat different from private sector challenges. For example, public organisations such as the NHS and the police serve a very complex social function by providing a service that cannot be neatly encased by economic markets such as supply and demand (Wright, 2001). Public organisations are indeed very large *super tankers*. Funded by the public as a whole, they are faced with multiple, at times, conflicting forces which place great restrictions on employees e.g., *I'm not Paul Daniels, I cannot pull it out of a hat.*In fact, theorists have even argue that the public sector work context is better at preventing employees from doing wrong than from motivating them to do good (Behn, 1995)e.g., red tape. Evidence for this criticism can be found in this thesis, for example PALS staff report many constraints to doing their job (*changing their super tanker's direction*) but minimal motivational incentive from the system; rather quite the opposite (*NHS outside toilet)*

It has been suggested that public employees have a greater need for task significance as they choose to work at public organisations which address important social issues (Perry & Wise, 1990). This comes from the assumption that employees are more likely to choose work that is best aligned with their needs and values. Some research supports this supposition, for example individual characteristics such as personality and values do predict the type of sector an individual is more likely to choose (Wright and Grant 2010). While the research in this area is conflictingand more recent research shows that hierarchical levels (e.g., managerial level) are stronger determinants than sector (Buelensis and Van den Broeck 2007), there is some evidence to suggest that public sector employees value achievement (Posner and Schmidt, 1996) and status (Wittmer

1991) less than private sector workers. Rather, they place greater importance on helping others(Wittmer, 1991) and there is also evidence to suggest that pay for performance does not increase motivation in public sector organisations (Marsden and Richardson, 1994).

It is difficult to conclude where the types of roles should sit professionally. Unlike nurses, social workers and police who are required to complete specific training for their role, PALS staff, 999 operators, citizens advice workers etc do not have a standardised training programme. In a way, they appear to be sitting along a continuum that is not generic customer service, and although closer to professional services, is not quite there either. One possibility is to legitimise these type of public service as a profession and develop a standardised training curriculum to gatekeep entrants. After assessing the work at a national vocational level, universities and colleges could play a role in this change by developing a training qualification. However this would also bring with it a number of financial consequences and limit candidates' opportunities to entering the profession. Before such a far reaching and large scale recommendation could be made, a thorough job analysis and input from the government is necessary.

In the meantime it is suggested that such roles would be better categorised as an expertise service rather than general customer service. This, of course, has serious implications for recruitment and selection, training and development, remuneration and rewards. It brings into question the supportive measures provided by the organisation, which as evidenced by this thesis in themes such as *breaking point*and *maybe they're right, I am useless*, is not adequate for the sort of work that is done. Line managers need to be made aware of the significant emotion work that make up the job. For example, in this thesis participating PALS workers rank between the 20th and 25thpercentile in managerial support when compared to the UK general working population – a placement that needs urgent improvement. It is also likely that improving management support would increase PALS staff job satisfaction as 45% of the variance in job satisfaction scores is explained by demands, role and management support. Formal organisational structures such as stress management training needs to be provided to better support these employees. In addition, developing a mentorship scheme would be advisable; this could function on a voluntary basis thereby not incurring additional costs to an already stretched system.

In brief, this thesis calls for a paradigm shift. The time has to come to do away with the dichotomy of low skill versus high skill. Rather a new discourse is needed to identify a group of workers who, although do not currently require *specific* qualifications for their post, nevertheless perform complex activities that cannot simply be brushed underneath the customer service umbrella. These individuals are highly experienced, bringing with them a wealth of expertise. They commit

themselves to their role and give for the benefit of the public good. Although the nature of work, public sector organisations and public expectations have changed significantly since the initial surge of work design research, unfortunately academia has lagged behind. It is not longer adequate to use terms such as customer service to refer to these jobs or to equate them with low skill work. Rather the time has come to recognise the complexity of the role, how much employees invest, and the effect it has on them. This latter point is now developed below.

12.3 Contribution to Emotion Work

Over and above the deductive contribution detailed above, this thesis also makes an inductive contribution to theoretical knowledge on emotion work and work design. By putting together PALS staff job satisfaction scores and their motivations detailed in *this is a vocation and I wanna do it*, this thesis uncovers that PALS staff might actually like their emotion work. It is interesting to note that for them, this **banging fist against heart** is important. It appears that they place value on this emotional component of their job and express frustration that others do not appreciate it or acknowledge it. This seems counter to the emotional labour hypothesis which views emotion work as largely detrimental. This second key contribution is now developed below.

Hochschild's (1979) seminal work on flight attendants helped to explain the experiences of employees working in emotionally demanding roles. Her work on emotional labour was further developed by Ashford and Humphrey (1995) who focused on behaviour, and by Morris and Feldman (1996) who distinguished between varying dimensions, such as frequency and length of contact, which were likely to increase strain. As told in the literature review, emotional labour theory posits that customer contact requires employees to manage emotions. Sometimes employees genuinely experience empathy for customers; at other times, they need to fake this emotion and act it out. Research evidences that indeed such jobs are taxing on wellbeing and they place employees at risk of burnout (Zapf et al. 2002). Although this is a very simplified view, the general consensus from emotional labour authors is that emotion work can be stressful for employees and on the whole it is viewed as a negative experience.

At first glance, both study one and study two from this thesis provides further support for the mainstream emotional labour hypothesis. Between 48% and 56% of participating PALS staff indicate distress levels with 75% reporting high strain; up to 50% of the variance in these scores is associated with the work conditions of demands and role. Additionally, interviewees share their

strong feelings of frustration and emotional misunderstanding in the theme *they just don't really get it*; and confess that at times this can lower their self-efficacy and confidence in *maybe they're right, I am useless*. This is consistent with previous research where emotion work has been found to be stressful (e.g., Wegge, Dick, and Bernstorff, 2010).

As expected from the literature, PALS staff detail having to put on a 'mould' when acting with patients and explain how they may put on a voice when answering the phone. Much like front line service agents from the Ashforth, Kulik, and Tomiuk (2008) study, in the theme *breaking point and life in context*, PALS staff report engaging in separation rituals when moving from one space into another. For example, they may wipe their feet when leaving the office or change their clothes as soon as they come home. This 'ritual' puts an end to their work persona and permits their non-work identity to reign.

So far, findings from this research are supporting mainstream views. However, more careful analyses bring to light an insightful development to emotional labour theory: it uncovers the motivational pull of emotion work. This inductive contribution is now developed further.

The theme *this is a vocation and I wanna do it*shows how *being helpful* is motivating and how *making the world a better place* is rewarding. It is quite apparent from participant accounts that in spite of the emotional strain associated with their job, they nevertheless feel passionate about what they do. In fact, they value the emotional component of their role and are frustrated that this goes unnoticed. Some PALS workers form strong bonds with their patients, calling them by endearing nicknames (e.g., 'my little boys'); others receive gifts such as drawings as expressions of gratitude. Abbott et al. (2006) also report similar positive experiences, for example PALS staff being 'chuffed' at resolving complex cases and complainants asking them to provide moral support at meetings.

In the theme *they don't really get it* PALS staff explain how their work is not process or task based, but rather it is about **banging fist against heart**. Participants share woeful grievances about their perceived disregard and how this can make them feel as if *maybe they're right, I am useless*. This all fits with the emotional labour perspective. However, when looking at the theme *this is a vocation and I wanna do it*, the outcomes drift towards the positive. Study one shows that the dimensions of demands and role are a double edged sword; they can influence distress but also happiness and job satisfaction. They account for quite a fair proportion; 41% of positive mental health scores are associated with demands and role at work. The same two work characteristics account for 45% of the variation in job satisfaction. It is already known from **banging fist against*

*heart** that PALS work demands are characterised by relational emotion work. The themes *NHS outside toilet, bringing back unpalatable messages,* and *it's not my NHS anymore* have already revealed how conflicting their role in the organisation can be. *Maybe they're right, I am useless, I'm not Paul Daniels, I can't pull it out of a hat,* and *having wobbly* hauntingly capture the negative effects of these experiences on PALS employee wellbeing. And yet, the same group of people believe *this is a vocation and I wanna do it.*They explain how they are motivated by *being helpful* and feel rewarded by *making the world a better place.* They divulge that it is about having "that relationship" with patients (Pauline; line 548) and profess that their future endeavours will be no "less emotional" (Alicia; line 497).

The question is thus whether the demands and role 'antecedents' of the distressing and satisfying outcomes are the same. For instance, the close relational contact with patients that comes with **banging fist against heart** could be a double edged sword. Because of its relational aspect, it drains PALS and makes them suffer due to all the emotions they 'absorb' and 'buffer'. But this relational aspect could also be the very thing that enables empathy for patients by bringing them close together and fostering emotive bonds. For example, in caring sciences such as nursing, closeness and an intimate understanding of patients are believed to be required for empathy (Määttä 2006). Phenomenological perspectives, such as that proposed by Stein (1891-1942), consider empathy to be about recognising the lived experience of another, having a 'second-hand' experience of their emotion. First, by reading the other's expression and demeanour, the observer attempts to transpose themselves into the other's shoes. Then, the observer identifies with the other and experiences his or her state of mind in a 'shared moment' of understanding (Davis 1990). Finally this closeness ceases and the observer returns to their rightful frame of mind. Hence, there is a need to bond and form sort of intimacy with the other in other to empathise with them. This can be seen in Pauline, Helen and Sue's office, for example where Helen explains "quite a lot of them come for a, they just wanna talk" and "they just wanna hear another person's voice at the end of the phone"(line 501). Pauline concurs and adds "Cause once you tapped into that, then you can, that half of it, is they're angry because they're angry. And it's not personal to you, and once you've tapped into that bit, and you then can mediate with their emotion" (line 501).

When PALS talk about their work they philosophically question: "why can't you make people feel good" (Alicia; line 170) and are proud not to give patients just "another number" (Alicia; line 167). They profess that it is about "that relationship" (Pauline; line 548) and theydo not want to play "pass the parcel" (Patrick; line 136) as patients stream through the NHS "conveyer belt" (Pauline; line 501). They empathise with patients who "just wanna hear another person's voice at the end

of the phone, they're not complaining, complaining, they just wanna talk" (Helen; line 501) and value that "a lot of the time we're just giving reassurance to people" (Adam; line 445). They want patients to feel that "they've not been passed on again without someone listening to what they have to say" (Alicia; line 170) and PALS love "hearing that relief in them, thinking oh gosh thank goodness somebody actually understands" (Laura; line 141).

The question put forward is thus whether PALS can cultivate this calling to help, this commitment to pursuing the patient's cause, this empathy without engaging in **banging fist against heart**. For example, could these employees just as easily be rewarded by working inside a medical laboratory and *making the world a better place* by developing cures for diseases. Undeniably both possess task significance and it is not farfetched to assume that both professionals would experience meaningfulness in their work. However, they are not quite the same. PALS is a highly relational role while medical research is very much task and process focussed. The former is about working with people; it is an emotional role where they are a "listening ear" (Adam; line 445) and form "that relationship" with patients (Pauline; line 548). Hence, while both jobs could contain task significance, how employees gain meaning from this can be different – task significance is the 'content' of the antecedent while relational emotion work is the 'medium' through which it is acquired. In other words, the answer to what motivates PALS workers would be task significance and the answer to how they gain this would be relational emotion work.

It is hard to imagine that these participants would feel equally motivated in a non-relational job. Certainly their future aspirations hint at emotionally demanding endeavours, for example "working with the homeless" (Laura; line 665) and "trying to get the best out of an individual, trying to see things move forward for an individual, growth within that individual (Alicia; line 490). Some would even "do here voluntary, sort of like one day a week" (Pauline; line 865). There certainly a lingering resonance of melancholic idealism in their hopes; some anguish "what is it about me that feels that you know this isn't good for me, why are you doing it? Do you like the self-infliction of pain?" (Alicia; line 434) and others explain "occasionally I'll get something that brings me to tears, you know just the human nature of it. Which always reassures me that I haven't lost my humanity" (Patrick; line 548). For this group of workers, it goes *beyond* finding significance in the tasks that they perform; it about being "passionate about people" (Alicia; line 528). It is this very humane, relational and emotive component of their job that is being argued as the medium through which PALS employees experience meaningfulness in their work.

In a way, this **banging fist against heart**, this emotion work could be seen as a double edged sword; both negative in that it makes PALS employees suffer, but also positive as it allows them to

soak up what motivates them – significance and meaning. There is some tentative support of this deduction in the literature. For example, home care workers also report a similar love/hate relationship with emotion labour; one participant explains:

> *"First thing they taught me when I was in school was, don't get attached. But, it's a lot of malarkey; it doesn't work that way, not in real life [...] you get close to people"* (Stacey 2005, p.844).

As a result, the bond with a client could be like "being married" but then leaving them could be like "breaking up from your wife or something" (Stacey 2005, p.844). This implies that home care workers have both positive and negative experiences with emotion work (e.g., intimacy of close family bond versus pain of separating from loved one). Similarly, midwives, who engage in significant emotion labour by providing emotional support to women in pain, also manage to gain positive emotions from these encounters and share that most births are 'special' to them (Hunter 2001).

If this deduction is correct, then emotional labour theory is missing out on the positive aspect of emotion work. Certainly Hochschild (1979) was rather critical of what she believed to be the 'commercialisation' and 'commodification' of emotions. And while mass production customer services can perhaps be accused of 'selling smiles' as Hochschild put it, this is not necessarily the case with caring occupations. In fact, high emotional labour workers do not always report more emotional exhaustion than those who work in low emotional labour jobs (Brotheridge andGrandey 2002). Furthermore, human service workers report higher levels of achievement and lower levels of depersonalisation than other groups. The argument being that individuals who choose these sorts of professions are intrinsically motivated to care and thus find the emotional demands of their work meaningfulness, and thus motivating and rewarding. Combining this with recent research that has begun to document the influential mediatory power of doing meaningful work in human services (Freeney and Fellenz 2013), a holistic emotion work theory can be build; one that appreciates how meaning can be gained through emotionally demanding work.

By focussing on the negative outcomes of emotion labour, the psychological discipline has sadly ignored the positive power of caring. It is not being argued that emotion work is not stressful; rather it is being proposed that the time has come to develop emotional labour theory and to also make room for the 'good' rather than simply focussing on the 'bad'. This ideology is consistent with the wellbeing perspective of this thesis which includes both happiness and distress. The danger here is that although emotion work may be motivating for some workers, the evidence of its detrimental consequences on wellbeing still remains. It may be that PALS staff, and possibly other caring occupational groups, are motivated by emotion work, but this does not necessarily

mean that it is good for their wellbeing. For example, a person might like smoking but this does not make it good for him or her. As findings from study one show, their reported wellbeing is not favourable. There is some tentative evidence from Pauline, Helen, and Sue's high empathy office that they manage better. In the theme *maybe they're right, I am useless*, their experiences are the only ones that do not show much detrimental toll. But also, their interview was conducted in a group setting. It could be that these participants conveyed a sense of bravado and showed a positive side to their emotion strain. It could be that their camaraderie helped ease the strain. It is difficult to tell.

One way of minimising the detrimental outcomes for employees is looking at their work design. For this kind of work, the section below proposes a relational job design that is tailored to their particular motivational needs.

12.4 Designing Emotion Work: A Relational Perspective

If emotion work is a double edged sword, then it becomes more difficult for the Department of Health and the government to design such public sector expertise jobs without compromising wellbeing, but also, without removing what motivates employees. This is of particular importance now as the NHS is re-structuring. PALS staff have raised concerns about the impact of 'privatisation' on their work, which means less time for the relational aspect of the more and more focus on hard outcomes – a continuous trend in the public sector (Heinrich, 2002). This could potentially be detrimental for performance as it is removing employees from what they love about their work and imposes on them more process based tasks. These involve less emotional contact with their beneficiaries.

When looking at work design models for assistance on how to manage this change process, traditional models are somewhat limited as they are not tailored for the particulars of expertise public sector work. For example, the Demand-Control-Support model (Karasek, 1979), one the most influential models that was the basis of the HSE Management Standards, is rather unhelpful in this specific job context. To start with expertise public sector work is highly interactive emotion work. It is not primarily task focussed but rather relational. Traditionally, jobs were seen as a prescribed groupment of tasks (Ilgen and Hollenbeck. 1991). In other words, a list of predefined and fixed activities. This is quite different from relational jobs, such as PALS, that are built on interpersonal interactions.Furthermore, participating PALS workers already report high levels of

job control, between the 75th and 80th percentile of the UK general working population. Hence, this 'antidote' as proposed by the Demand-Control-Support model (Karasek, 1979) is somewhat redundant. Firstly, recent research has evidenced that in human service occupations, autonomy on its own is not enough to fuel engagement; rather they need to use this resource to pursue work that is meaningful for them (Freeney and Fellenz 2013). Secondly, there is no evidence in this research that PALS staff are asking for more autonomy. Rather, they are beseeching their organisations for more understanding and are yearning for appreciation. For them, it is about *being helpful* and *making the world a better place*; about being perceived as *the spinal cord for the Trust* as opposed to *the NHS outside toilet.*

These sentiments are somewhat captured by Oldham et al. (1976) in their construct of task significance; although it is still limited by its operationalisation of *task* focus. While the Job Characteristics model certainly offers a better 'fit' than Karasek's (1979) Demand-Control-Support model, a more in-depth explanation of how task significance motivates these expertise public sector workers is still needed. Humphrey et al.'s (2007) extended Job Characteristics model develops this relationship by showing that experiencing meaningfulness and responsibility can mediate the effect of task significance on wellbeing. For PALS staff, this thesis has shown these two variables to be highly important. But experienced meaningfulness and responsibility are not standard across occupations; some jobs (e.g., healthcare) have greater opportunities for meaningfulness and responsibility than others (e.g., magician). For this reason, Humphrey et al. (2007) call for further research that examines how differences in industry can impact on the relationship between work characteristics and outcomes. In addition, this extension of the Jobs Characteristics does not show *how* employees gain this meaning.

This thesis proposes that for some workers meaning is gained via emotion work, and therefore Grant's (2007) relational job design may provide a well suited solution. Grant (2007) focuses on prosocial occupations that are likely to attract employees who are motivated by helping others and he extends the view on task significance. In his framework, the more task focussed dimensions (e.g., task variety) are dropped in favour of expanding the interpersonal antecedents. This approach, which is aimed both at prosocial jobs and considers relational aspects of work, seems to be a rather appropriate fit for the expertise public sector worker (Figure 20).

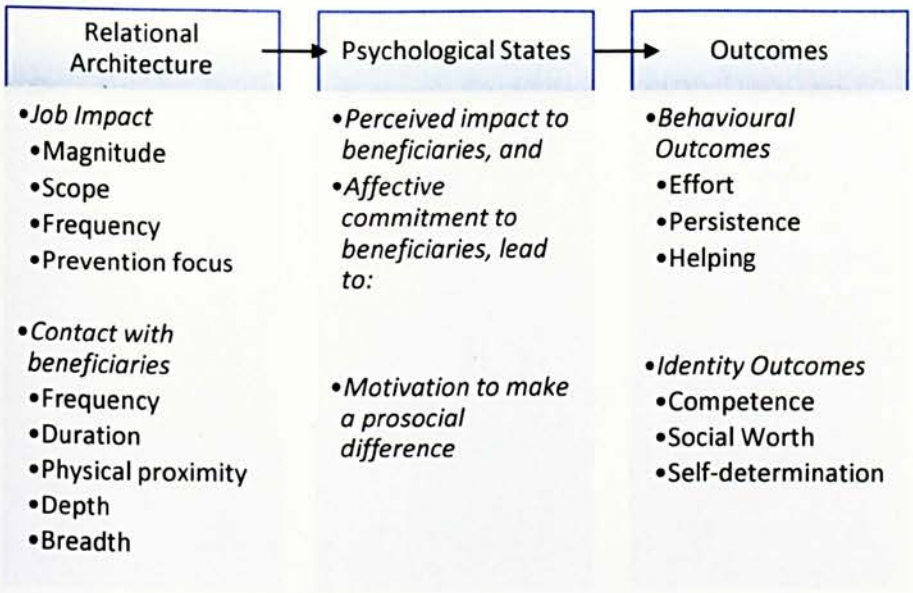

Figure 20 The Job Impact Framework *Adapted from Grant (2007)*

As can be noted from the first column, many of the dimensions closely resemble variables from the emotional labour literature as proposed by Morris and Feldman (1996). Grant (2007) proposes that the ways an employee connects and interacts with beneficiaries can influence his or her motivation to make a positive difference in that individual's life. Unlike the emotional labour literature, Grant (2007) interprets social interactions as *positive* motivational opportunities, consistent with the findings of this thesis. The hypothesis is that when employees experience frequent, prolonged, close, expressive and varied interactions with beneficiaries, their encounter is more likely to be meaningful for them. This contrasts with the emotional labour hypothesis which would consider such encounters are more likely to lead to stress. Instead, for individuals with high prosocial values, meaningful encounters are more likely to fuel their motivation to help. The more meaningful the impact, the more likely he/she is to feel motivated to make a positive change.

The two important psychological states that lead to prosocial motivation are perceived impact and affective commitment (Grant, 2007). Perceived impact concerns the employee's awareness of how their work affects their beneficiaries. Small and Loewenstein (2003) propose that it is this perceived social impact that further fuels prosocial motivation as it provides 'emotionally driven' evidence that the employees actions actually make a difference. This is important as experiments by Grant (2007; 2008a) show that when employees see the beneficial impact of their work, they are more likely to perform better. For instance, life guards who read stories about how other life guards rescued swimmers increased their hours of working and supervisor ratings; and fund

raisers collected more donations after reading stories on how the scholarships helped students. While these experiments are only the start (each experiment only measured 1 month of performance), they do provide insightful evidence on the power of task significance, perceived social impact, and prosocial motivation.

In the case of PALS workers, a number of bureaucratic obstacles are placed in their way, making it difficult for them to have a genuine impact. These challenges, such as bureaucratic red tape, box ticking, 'meaningless' targets and so forth, are captured in the theme of *changing a super tanker's direction*, limiting their ability to have a significant impact. Grant and Sumanth (2009) hypothesise that when employees can see that their beneficial actions are having little impact, then they are less likely to invest energy in making a prosocial difference as they do not see their effort resulting in satisfactory outcomes. The less likely they are to feel prosocially motivated, the less likely they are to feel motivated to come up with creative solutions to their challenges (Grant et al. 2011).

The relational job design hypothesis is good in that it appreciates the value of prosocial behaviours and focuses on the positive aspects of emotional labour but one of its problem areas is that it largely concentrates on performance – and not wellbeing. Hence, this relational job design may well increase performance, but do so at the expense of the employee's wellbeing, may lead to burnout. Grant (2007) does propose that positive outcomes are likely to come about for the employee, for example social worth and self-determination, but his experiments are primarily measuring performance. Hence while relational job design might add to work design literature tailored to emotion work, further research is needed to explore the impact on wellbeing.

12.5 Contribution to Wellbeing Theory

In the Introduction chapter of this thesis, section 1.2 provided a definition of wellbeing and positioned this study within the theoretical debates in the literature. It showed that this work identified itself as holistic and oriented itself in the middle of the psychopathological versus positive psychology spectrum. Now that the research has reached its end it is appropriate to return to this and engage in post hoc epistemological reflections. There are two issues of importance to note. First, linear models are limited in explaining the complexity of PALS employee wellbeing. Second, embodiment is largely absent in traditional explanations of wellbeing but resonates quite loudly in this research. Overall the methodological choices that were made while conducting this research have impacted on the kind of data collected (e.g., numerical or narrative) and also on the actual findings that emerged. Each of these reflections is developed below.

It seems that even though the literature review chapter stipulated that wellbeing is composite, the findings of study one – that participants were reporting both satisfaction and strain simultaneously – were nevertheless befuddling. In the 'neat' world of study one it was indeed puzzling to see such conflicting responses. The numerical answers provided little in the way of explanations and it was challenging to make sense of this paradoxical state that is both satisfied and strained at the same time. The linear wellbeing models analysed in the literature review chapters were limited in explaining how the same antecedents would lead to conflicting outcomes simultaneously.

In contrast, phenomenological perspectives argue against reducing the 'messy' and 'turbulent' process of making sense one's experience to mechanical and linear causal relationships (Eatough and Smith, 2008). Rather it is important to understand the individual's subjective experience of the phenomenon and the personal meanings that people assign to these experiences (Brockl and Wearden, 2006). IPA is interested in participants' subjective experience of the phenomenon being researched as opposed to the objective nature of this phenomenon (Willig, 2008). It appreciates that people can experience the same 'objective' conditions in a wide variety of different ways. This is because people attribute meaning to their experience, which then shapes their experience of the phenomenon. Hence, the external world does not necessarily determine the individual's perception of the phenomenon. Rather perception is influenced by the individual's own thoughts, beliefs, past experiences and wider context. By its lack of "totalness" (Smith, 2008; p.49) phenomenological findings can be complex, and by its subjective focus on meaning making, it can also be 'messy'. In adopting these assumptions, the findings of study one can be accepted more wholeheartedly. In the messy, non-linear, subjective world of phenomenology, it is possible that the same external world elicits different and conflicting experiences in participants. Indeed, it is not the outside world at all which is of importance but rather the personal and intimate insider view. Study one's limited ability in explaining the complexity of PALS worker wellbeing can be resembled to Osborn and Smith's (1998) limited ability of explaining back pain with linear medical models. Both of these highlight the complexity of human experience. IPA can access the person's lived experience and try to understand how that individual makes sense of their experience. For this reason Smith et al. (2002) suggest that an IPA approach is ideal in cases where the issue is complex and dilemmatic.

The findings from the IPA study re-affirm this study's initial critique of both stress and subjective wellbeing discourses. Wellbeing experiences in this study are neither perceived as strictly negative hazards nor positive happiness, but instead a rather complicated mixture of both *they just don't*

get it and *this is a vocation and I wanna do it*. The same 'antecedent' of **banging fist against heart** can be a source of frustration and pain, making them feel like *the NHS outside toilet* when those around PALS staff do not comprehend their devotion; but it can also be a rich and motivational experience of happiness because they are *being helpful* and *making the world a better place*. It does not have to be a case of either/or but rather can be both. And in the proposed holistic wellbeing discourse of this study, such conflicting experiences can co-exist and are not necessarily mutually exclusive. Furthermore, this possibility of having 'both' the good and the bad co-exist brings into question the marginalisation of negative emotions in the pursuit of happiness (O'Dwyer, 2013). This thesis critiques the avoidance of stress and proposes the acceptance of negative experiences as necessary and part of wellbeing. Removing these emotions from the repetoire of wellbeing would be denying the full spectrum of wellbeing experiences. Similarly, singlehandedly searching for positive and motivational experiences would be equally missing out.

The second epistemological impact of conducting an IPA study is the emergence of embodiment and how traditional theories do not sufficiently engage with this concept. Wellbeing theories fall short of adequately accounting for participant experiences and explaining how their bodies interact with the space around them to construct wellbeing interpretations (e.g., Alicia being "oppressed" in an open plan office). In a way, it is understandable why so many theories ignore the body; in fact, the body is quite easy to forget until something is wrong with it. For example it is not often that one realises how much effort it takes to walk unless sickness has tired the body. Generally when looking at models of wellbeing, the body makes a shallow appearance at the end, in the 'outcomes' column, where consequents happen to it. However, it is forgotten that the body plays an important role in the 'antecedents' column as well for this is the way that information from the outside world enters the human – through his or her senses. In the phenomenological perspective, human beings are embodied beings (Kupers, 2005). Merleau-Ponty (Eatough and Smith 2006), unlike Descartes, proposed that an individual's sense of self and their bodies were inextricably linked. He argued that the body could not be an object, distinct from the mind; but that the body was an existential entity, a sensory system, which communicates with the world.

The closest example of a physical employee is presented in Humphrey et al.'s(2007) extension to the Job Characteristics, but as already critiqued, this is more about ergonomics. While ergonomics can certainly be considered a part of embodiment, the latter is a much broader term, encompassing the former. It understands that human beings are also sensual beings, interacting with the world not only through rational cognitions but also through physical experiences such as touch, sight and hearing. In the phenomenological perspective, wellbeing is an experiential process (Kupers, 2005). The body is not only a dwelling place of wellbeing, subverted to the

'outcomes' column of a model; but it also plays an important role in allowing entrance to the 'antecedents' and framing mediation. As the theme of *breaking point and life in context* shows, PALS workers are embodied beings, engaging with the external world through their physical senses as well as their mind. The senses of touch and hearing are particularly important (e.g., office space and proximity to others, noise and sound); either liberating the employee or confining them. It is quite poetic that these senses are also used by participants to express themselves; in a way, it comes full circle – they experience the world through their embodied self and then make use of embodied metaphors to communicate their feelings. Vivid, poignant and resonating embodied metaphors are used by PALS staff to convey their experiences (e.g., spinal cord, outside toilet), highlighting the importance of the senses to wellbeing and work design, a dimension that is almost entirely neglected in the literature. Had a different methodological approach been chosen for study two, it could be that the rich quality of this theme would have been missed. Hence by adopting an IPA approach the experiential nature of wellbeing has been shown.

Recent developments in the alternative branches of cognitive science have begun to call for a more "embodied, active and situated" understanding of cognition (Larkin et al. 2011, p.318). The emphasis here is that thinking beings, such as humans, need to be considered first as acting beings, embodied beings that are situated in the world and that interact with it (Anderson 2003). Although such alternative approaches have been marginalised by mainstream perspectives, there is increasingly an appreciation of the need to move beyond the traditional "abraded, fleshless, ephemeral person" (Cromby 2002, p.e1.). It is not quite evident what is to replace this Cartesian mental being, but at least accounts such as this can help pave the way towards a new holistic understanding of mind and body wellbeing. Further phenomenological research is advisable to enhance wellbeing and work design knowledge by hypothesising a more embodied employee.

13. Conclusion

Introduction

The research questions that govern this thesis do not focus on a particular aspect of the PALS job or on a specific emotion. The aim of this study is to gain a holistic understanding. In a way, it wants to show the whole forest (e.g., wellbeing), instead of narrowing down on particular trees (e.g., happiness or stress). This topic was not chosen with premeditated intent; rather it emerged from the initial literature review. At the start, this thesis was about investigating the operations management of complaints in the NHS; it was while engaging with the literature that, as a psychologist, is became apparent that the wellbeing of employees tasked with taking in and addressing these complaints might be at risk. As the literature review advanced, wellbeing and work design models provided further justification for the preconceptions that were formed in the early stages. Such theories are abundant and it is simply not feasible to consider all of the literature published since the 1950's when interest in this topic waxed. Instead, it was necessary to rigorously draw a sample from prominent perspectives and to engage in a critical discussion about those included in the selection. As this research is about the NHS, the decision was made to focus on those theories covered by the European Agency for Safety and Health at Work as these, selected from Western international perspectives, denote EU good practice. It is a shame that non-Western views are not covered in this thesis and one could critique that wellbeing at work is very much a 'Western luxury' – however such debates are beyond the scope of this thesis.

Prominently accepted EU theories, that could be applicable to NHS workers, were then considered. Theories suggest that variables such as job control and social support can counter the negative effects of high demands at work (e.g., Demand-Control-Support model); psychological states such experienced meaningfulness and experienced responsibility can mediate the impact of work characteristics on wellbeing outcomes (e.g., extended Job Characteristics model). As with most research, some studies support while others refute these theories. As an Interpretivist, it is not believed that there is one objective truth; rather, it is quite possible that all these theories have something of value to say about human behaviour. However, the simplicity of these models is critiqued; people are believed to be far more complex than linear models allow and at times antecedents might not neatly lead to hypothesised consequents. The conceptual framework for this research was thus somewhat eclectic, taking some knowledge from work design models (e.g., the extended Job Characteristics model) and emotion work theories (e.g., emotional labour). It also engaged with diverse disciplines in developing this framework; literature was sourced from

psychological, marketing and healthcare management academic journals as well as government reports such as those commissioned by the Department of Health.

Initially, four research questions were raised, most of which necessitated numerical explorations and benchmarking:

RQ1: What is the wellbeing of PALS workers in healthcare?

RQ2: How does this wellbeing compare to other relevant occupational goups?

RQ3: What work experiences are associated with this wellbeing?

RQ4: How do these experiences compare with the experiences of the general UK working population?

PALS Worker Wellbeing: Methodology

For this study, it was unavoidable that a quantitative approach would be taken. For example, the first question, although asking a 'what' question, is really seeking a 'how much' answer, requiring a quantifiable methodology. The second and fourth questions need benchmarking comparisons, which again, require numerical data in other to make comparisons between the 'how much' of PALS and the 'how much' of other occupational groups. In fact it is only question three that could be answered in different ways, for instance open ended interviews. During the pilot phase, unstructured interviews were conducted to assess the face validity of the topic under investigation by seeking participant validation of preconceptions. It became apparent that the 'why' question had many different answers. Using an open ended approach such as interviews and then engaging in content analysis for example would be able to address this question, but it would be a tedious way of acquiring relatively simple information (e.g., a list of conditions). A better use of resources was assessing psychosocial conditions via a questionnaire; which also provided the additional advantage of benchmarking necessary for question four.

Hence, initially the research was envisioned as a survey design using an anonymous questionnaire comprised of three different measures which could access wellbeing and psychosocial conditions. A variety of measures were considered based on the study's aims and objectives. For example, job related wellbeing scales were dismissed as they were incongruent with the conceptual framework which considers wellbeing as global (i.e., including both work and non-work experiences). Eventually, based on academic justification (e.g., statistical validity of scales), theoretical compliance with this study's conceptual framework (e.g., face validity), and feedback from the pilot (e.g., time constraints) three measures were chosen: the GHQ12 (Goldberg et al. 1997), Nagy's (2002) job satisfaction scale, and the HSE Management Standards. If this study was to be reproduced, perhaps including an emotion work scale would be beneficial as a large proportion of

the PALS job involves managing emotions. Statistical inferences on this aspect of their job had to be made from the 'demands' variable in the HSE Management Standards which, unfortunately, mostly focuses on the quantity as opposed to the quality of demands. However, researchers also need to be pragmatic; the questionnaire is already lengthy and including an additional scale might decrease response rate. Using a job-specific wellbeing scale instead of the global measure used may have better focussed on the work stressors experienced by PALS staff; but it is uncertain whether changing this would have resulted in a 'better' study. After all, the theme *breaking point and life in context* shows that it is difficult to isolate the influence of work versus non-work; similarly, the wellbeing literature appreciates that a certain amount of spillover happens between domains. Particularly for jobs with a high emotive and relational content (as opposed to a task content), it may be artificial to impose a separation between emotions at work and non-work. Instead, a more feasible way of enhancing the research would be to conduct a longitudinal study and carefully assess the impact of psychosocial conditions on wellbeing scores.

Three complimentary sampling techniques were employed to access PALS staff. First, and most importantly, this research was championed by the National PALS Network who uploaded the questionnaire on their website and invited their PALS members to participate. This approach is believed to the ideal for this project as the study investigates PALS and this network is the national body for PALS; in other words, it could not get any better. Secondly, a list of NHS Trusts was compiled by manual purposive sampling and 'cold call' invitation emails were sent to PALS addressees similar to the process used by Ashforth, Kulik, and Tomiuk (2008) in their study. Through anecdotal evidence acquired during the unstructured interview phase, it was discovered that PALS staff have a high incidence of sickness absence and turnover; hence, this manual purpose sampling was done to compliment the National PALS Network emails which may not be up-to-date with the most recent individual in the post. Finally, snowball sampling was requested from participants to gain as much coverage as possible. One of the limitations of running these sampling approaches side by side was not being able to calculate a response rate. If the study were to be repeated each may be done separately so that cohort effects may be looked at.

The one difficulty encountered during sampling was the inconsistency of job titles across the NHS which were not uniform. Indeed, this tells an interesting tale about the discourses used to identify PALS staff (e.g., patient experience versus customer service versus communications), however, this discussion is beyond the scope of this study. Further social constructionist research is recommended to explore the intricacies of the terminology used to identify PALS staff and the impact this may have on their wellbeing – in this study, there is tentative evidence to suggest that labels such as 'customer service' and 'telephone advise worker' may have a negative effect.

Upon closing the questionnaire, basic good practice steps, such as cleaning data and so forth, were undertaken. Thereafter statistical computations on PASW were conducted, including correlations and regressions, as well as *t*-test benchmarking against other occupational groups taken from each measure's manual. There was a tension between taking results on a descriptive level, as indicative of participant 'truths', and on a reflective level, where alternative answers were sought.

Findings

Findings from this study were both intuitive (e.g., PALS staff exhibited high levels of strain) and also rather paradoxical (e.g., PALS staff reported job satisfaction). For example, while 73% of PALS staff report high strain and between 48% and 56% show evidence of poor mental health, 75% simultaneously reported some level of satisfaction with their job and 1 in 6 expressed positive mental health. Hence, the level of wellbeing of participating PALS staff shows high global distress but also job satisfaction (RQ1). On a descriptive level, these findings are indicative of low hedonistic wellbeing and comparatively reasonable eudemonic wellbeing, which conflicts with theoretical precedence as hedonistic and eudemonic wellbeing tend to come together. On a reflective level, it may be that the placement of the job satisfaction scaleexerted an undue influence on participant responses. Perhaps, had it been placed at the end, participants would have had the chance to think about their work and may have selected lower scores. Or, the opposite could have occurred and a back end placement could have positively distorted responses. Although a questionnaire is a quantitative tool, it appears that the narrative could nevertheless be important.

Next benchmarking against other customer service groups such as sales and mixed industry call centre workers showed that PALS staff in this sample actually experience statistically worse wellbeing (RQ2). However, there was no significant difference between the mental health reported by PALS staff and the mental health reported by social workers and police. Although these computations are able to say that there is no statistical difference, this is not the same as saying they are the same. The psychosocial conditions most associated with poor mental health are 'demands' and 'role' which affect 50% of scores and 41% of positive mental health scores (RQ3). For job satisfaction, 45% of its score variance is associated with the dimensions of demands, role and, additionally, management support. Compared to the UK general working population, these variables sit between the 5th and 10th percentile – a rather dire positioning (RQ4). However, if matters are indeed this poor, then it becomes difficult to explain the comparatively high job satisfaction scores.

The lived experience of PALS Worker wellbeing: Methodology

While interpreting the findings from this quantitative study, it was realised that PALS experiences are more complex than the tool was able to capture and a more in-depth exploration was necessary to understand PALS wellbeing lived experience. Hence a more open and phenomenological question emerged:

RQ5: What is the lived experience of PALS worker wellbeing?

It was astute to ask a phenomenological question at this point to capture the whole experience in its situated context, to uncover what these paradoxical experiences felt like for this particular group of people in their daily lives. For this reason, IPA is the best ideology to govern this second study. True, perhaps a less subjective approach, for example Thematic Analysis, could have explored the wellbeing of PALS workers in a qualitative way, but it would have been unable to uncover the deeper lived experience of these employees, to reveal inside out what it feels like to be a PALS worker and how these individuals assign meaning to their wellbeing experiences. Such Interpretivist lived experience research is important because wellbeing models may define and operationalise a variable, but they are limited in explaining what it feels like to experience that condition, how perceptions and social interactions interplay and give meaning to these variables. For instance, while experiencing meaningfulness is a known mediator between work characteristics and wellbeing, the model cannot tell how different groups may derive meaningfulness from their work – IPA can begin to shed some light on this. Hence, subjective Interpretivist work can add depth to the broad knowledge acquired from more objective approaches. By adopting a mature Pragmatic philosophical framework, two studies that employed different methods were incorporated into the thesis as a whole.

To dig deeper into the phenomenon that makes up PALS worker lived experience, questionnaire participants were invited to self-select for in-depth IPA interviews. Of course, this means that participants were already aware of the project and had the opportunity to think about their wellbeing and work design characteristics, thus perhaps initiating re-interpretations of their experiences. Also, as interviewees self-selected, it could be that the sample is more skewed towards a certain 'type' of person who is extroverted and eager to talk – possibly, also more disgruntled with 'something' to say. It would have been ideal to be able to compare participant interview answers with their questionnaire scores, however due to the anonymous nature of study one it was not possible to identify respondents. If this study were to be repeated, this would not be changed as confidentiality and anonymity are extremely important ethical tenets; hence this is simply a musing on an ideal research scenario.

True to IPA's idiographic approach which uses small sample numbers, nine participants were interviewed using a semi-structured guide; interviews lasted between 1.5 hours and 2 hours and consisted of in-depth explorations of quite personal and sensitive subject matter. The trust bestowed by participants is greatly appreciated and the depth of this study would not have been possible without them exploring, at times, quite painful memories. Indeed, if this study was repeated the chosen IPA tradition would not be changed as it was genuinely the most appropriate approach with which to explore the complex, dynamic and intricate lived experience of these individuals.

It is difficult to determine whether a stricter approach towards interview location would have yielded better results. Perhaps by interviewing participants in their everyday work place, this exploration remained true to qualitative research's naturalistic inclination. It did not isolate the worker from their context nor detach their reported accounts from the embodied experiences of their daily life (e.g., phones ringing, people interrupting etc.). It is true that perhaps speaking to participants in private might have led to different stories being shared than when they knew they were being overheard; certainly Helen and Sue might have been more forthcoming. It is possible that while they felt comfortable with sharing personal stories, they may have emulated their office norms about work experiences. For instance, perhaps they have a jovial culture in their office, and this is the impression they conveyed during their interview – although they may not all necessarily feel it.

From the one side, it seems 'poetic' that interviews were not entirely one to one. Participants share how the lack of confidentiality, anonymity, and privacy are key issues for their wellbeing; hence it seems appropriate that their stories are told in just such settings, reflecting their very experiences in parallel.

Recordings were transcribed and analysed according to IPA guidelines. If doing this step again, the transcription and analysis work would not be conducted from home; instead a strict separation would be kept between the participants' experiences and home life. In retrospect, perhaps having done data analysis from two perspectives – one as an empathetic listener and one as an analytical researcher – gives the study a richer, more hermeneutic interpretation true to the IPA tradition (Eatough & Smith, 2008). However for the benefit of one's own wellbeing, the advice would be to maintain a separation between the doctoral research and one's life... as Julie said "I don't want all *that* in my home" (line 776).

Eventually, both hand analysis and nVivo were used for data analysis. Each participant was given voice before common themes were sought to unravel the key experiences that make up PALS employee wellbeing. It is however acknowledged that group norms and office culture may have constructed a false sense of consensus amongst Pauline, Helen and Sue. Furthermore, the poignant and painful theme of grief was omitted from analysis to protect the trust that participants bestowed during the interview. This decision may be somewhat contrary to IPA's inductive ethos, however, it brings up quite important questions regarding informed consent and whether research participants are able to authorize *pre*-interview the use of their data when they, as yet, do not know what they are going to reveal. In a way, it may be seen as a sign of a 'good' interview that participants opened up and genuinely shared their personal stories; but how much of that is truly covered by informed consent when participants were unaware at the time of providing it that they would explore to such depth.

Findings

Overall, two things are very apparent – PALS is a really tough job, but participants nevertheless love what they do and value its importance. Participants complain that others *just don't really get* what the PALS role is about and they use a number of haunting sound and image metaphors to describe their work. For example, they fear being seen as the *NHS outside toilet* complete with 'gungy' and 'horrid' descriptors – a far removed interpretation from their self-perception as the *spinal cord for the Trust*. PALS staff explain that their job is really about **banging fist against heart** but that this key dimension is either misunderstood or ignored by others, leading to them feeling under-valued and unappreciated. Navigating this emotionally charged environment with minimal appreciation and validation can be difficult; at times, it can get to them and participants think *maybe they're right, I am useless.*

Battling patients, battling colleagues, PALS staff in their diverse and multi-identity role, buffer the organisation while performing their core function: that of acting as an NHS change agent. And that is a battle all on its own – one that is being compared to *changing a super tanker's direction*. As with the previous theme, evocative metaphors are used to communicate meaning. For example by alluding to Stephen King's Shawshank Redemption and describing their change agent activities as chipping away at the NHS, millimetre by millimetre staff conveying their continuous struggle for change through loud and repetitive sound metaphors e.g., banging. PALS staff explain that much of their work involves *bringing back unpalatable messages*, but when they face public sector obstacles such as bureaucracy and red tape along the way, participants complain *I'm not Paul Daniels, I can't pull it out of a hat.* Presently the NHS reform is underway and this makes

participants feel as if *it's not my NHS anymore*, indicating a loss of identification with the new ethos.

As expectant from theory, when demands and circumstances become too dire, employees may experience burnout. Many of the participants confess to experiencing a *breaking point* in their wellbeing, which they explain in embodied terms, for example using concepts of *body, space and time*. For most, the distress has led to *having a wobbly*; both experienced and expelled through the body. When recounting the spill over between their work and their non-work life, participants explain how it is about *moving between spaces*, for example, by engaging in ritualistic transitions to mark the end of one space and the entrance into another. This theme is quite insightful as in the literature, human beings are forgotten as embodied beings and instead the focus is on the cognitive or the behavioural aspects. However, there was an undeniable sense of the physical, ranging from sensory experiences such as the noise and the pictures in the room to the physical space such as office location. These embodied experiences influence wellbeing; and it is regretful that the physical side and the senses are often neglected in organisational theory in favour for cognitive aspects.

Within the NHS' high strain environment that is emotionally charged and socially complicated, PALS staff nevertheless experience a sense of calling, affirming *this is a vocation and I wanna do it*. For PALS staff, *being helpful* is highly motivating and in spite of all the challenges they face, *making the world a better place* is rewarding. To survive, PALS profess *a sense of a humour* is a must. This theme aptly explains the paradox of study one. Yes indeed, the work has many challenges, and overall PALS staff are reporting extremely high levels of global strain, raising the question of whether human services such as healthcare are suited to mass production customer service models. But in spite of this, in spite of *they just don't really get it, changing a super tanker's direction* and experiencing a *breaking point*, PALS staff have a vocational passion for their role. PALS staff understand the value and importance of their work, they are affectively committed to their beneficiaries which they safe guard by drawing strength from their prosocial motivation.

The meaning of this final theme in the overall thesis is quite important. It shows that understanding people's relationship with their work as a linear process whereby certain antecedents (e.g., emotional demands) neatly lead to certain emotive states (e.g., strain) is too simplistic. Instead it proposes that these relationships are dynamic and complex, and that how people interpret their experiences and the value they assign to their work impacts their wellbeing. For PALS staff traditional wellbeing and work design models are limited in explaining their experiences. PALS staff choose to do this sort of prosocial work because they want to help others.

Hence, for them, minimising 'hazardous' demands is not quite the right answer as eliminating the emotive component of their role would decrease the very thing that motivates them. Traditional wellbeing theories do not sit comfortably with this dilemmatic discovery. Neither stress nor subjective wellbeing discourses can account for the full spectrum of wellbeing experiences. By viewing wellbeing from a phenomenological perspective these conflicting findings can co-exist in the messiness and lack of "totalness" (Smith, 2008; p.48) of human experience.

More research on the positives of emotion work is needed. While the negative outcomes of emotional labour have been resolutely documented, the time has come to appreciate that some people might actually enjoy this and actively seek relational work. Much like the beginning of this thesis critiqued psychology's fervent fascination with dysfunction, the end of this thesis is urging for a more holistic and well rounded understanding of emotion work. This thesis alongside the work of researchers such as Grant (2007) and Määttä (2006) lays the groundwork for future scholars to pioneer the way.

Additional research on public sector jobs is necessary to better understand the complexities of the expertise worker. This thesis calls for the bridging of the disciplines of psychology, public administration and management to conduct detailed job analyses and work design evaluations. Further to this, the gap between research and practice needs to be breached so that these findings are then fed back to public institutions so that they may impact on policy development or revision.

It is thus being recommended that work design initiatives in these sorts of jobs might instead benefit from considering the relational job architecture of the position. It is encouraged that opportunities for prosocial motivation are increased, for example by showing workers the impact they have on beneficiaries and publishing positive change results widely. Organisations are urged to develop and provide stress management training tailored to these occupations and consider implementing a mentorship programme. Lastly, the recommendation is to increase the appreciation and value given to these *spinal cord* employees through top-down leadership by example. Admittedly, the public sector is a very large super tanker; it may yet take some time before employees can genuinely change the system, as Ghandi said:

"Whatever you do will be insignificant, but it is very important that you do it".

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15. Appendices

15.1 Appendix 1

Dear ____,

Hope you are well. I am a PhD researcher at Kingston University, supervised by Dr. Rachel Lewis. Our research is not commissioned by the Department of the Health or the NHS but is entirely based on personal interest and passion for the subject area.

My area of interest is front line professionals who work with patient feedback. In particular, I am interested in the occupational wellbeing of employees who work with patient feedback. Enclosed you will find an information sheet that will tell you a little bit more about my research.

If you or your colleagues in a similar job role are interested in my research, I am inviting you to participate in an anonymous questionnaire by clicking on the link below:

http://kingston.qualtrics.com/SE/?SID=SV_eE5yQbe88YGIYhm

If you have any questions about my research or if you would like any additional information, please feel free to contact me and I will help in any way I can. I am open to and welcome your suggestions and recommendations about how to proceed.

I look forward to hearing from you.

Warm regards,

Lilith Arevshatian

Department of Leadership, HR, and Organisation
Business School
Kingston University, KT2 7LB
07901 654 744
l.arevshatian@kingston.ac.uk

15.2 Appendix 2

KINGSTON UNIVERSITY

Lilith Arevshatian
Department of Leadership, HRM,
and Organisation
Business School
Kingston University
Kingston-upon-Thames, KT2 7LB
T: 07901 654 744
F: 020 8417 7026
e: l.arevshatian@kingston.ac.uk

www.kingston.ac.uk

Dear participant,

RE: Research on wellbeing, job demands, and coping of feedback professionals at work

I am a PhD researcher at Kingston University, supervised by Dr. Rachel Lewis who is a Chartered Occupational Psychologist and has extensive experience in the field of occupational health and wellbeing. Our research is not commissioned by the Department of the Health or the NHS but is entirely based on personal interest and passion for the subject area.

My area of interest is front line professionals who work with patient feedback. In particular, I am interested in the occupational wellbeing, job demands, and coping of employees who work with patient feedback. The aim of my research is to find out about wellbeing at work and to explore aspects of the job that may be challenging and rewarding. Finally, I would like to find out how employees who work with patient feedback cope with the nature of the job and what strategies work best. My research is not to tell you how you should work, but rather to provide a confidential medium through which you may share stories from your own experiences.

Benefits to Participation

This is very much a participant led piece of work and I hope that both professionals who participate and those who don't experience benefits as a result of my research. This is very important to me. I will provide an anonymised report based on the final results of this study and also give a presentation on these findings if you think this would be helpful.

Methodology

The study has three parts. First a national survey questionnaire will help us to determine current wellbeing levels at work. Then focus groups will allow employees who work with patient feedback to talk freely about your job and discuss particular aspects of your occupational wellbeing. Finally,

in-depth one to one interviews will give you the opportunity to detail how you may cope with your job role, basically what works and what doesn't in your experience.

What your contribution would involve

I was hoping that you or your colleagues in a similar job role would be interested in participating in my research. You do **not** have to participate in all parts, but may simply chose to respond to the questionnaire or collaborate in the focus groups or interviews. I also welcome any additional suggestions you may have about how you would like to contribute.

Confidentiality

All of this information is of course kept anonymous. The names and other identifiable information of those willing to participate in the study will not be divulged. I will provide an anonymised final report and feedback my findings so that you may use my research as a medium to share coping strategies from colleagues who have tried and succeeded or tried and can share lessons learnt. Of course, on a more personal level, the focus groups will also provide a very useful discussion forum so that you may network, share experiences, and forge professional relationships with colleagues.

If you have any questions about my research or if you would like any additional information, please feel free to contact me and I will help in any way I can. I am open to and welcome your suggestions and recommendations about how to proceed.

Yours sincerely

Lilith Arevshatian

PhD Researcher
Department of Leadership, HRM, and Organisation
Kingston University Business School
07901 654 744
l.arevshatian@kingston.ac.uk

SUPERVISOR: Dr. Rachel Lewis
http://business.kingston.ac.uk/staff/dr-rachel-lewis

15.3 Appendix 3

Wellbeing

1	QID33	1	DB	TB	
Selected					

Welcome. Thank you for your interest in our research. I am a PhD researcher exploring the wellbeing of front line professionals such as yourself who work with patient feedback in healthcare. The aim of my research is to find out about your occupational wellbeing in this questionnaire and then to discuss job demands and coping strategies that are particular to your role in focus groups and interviews. Your participation is entirely voluntary and all information you provide is strictly anonymous. You are invited to but do not need to participate in the entire study to complete this questionnaire.

The questionnaire will take about 15 minutes to complete and consists of different questions about your wellbeing, your work, and your feelings about your work.

1	QID35	1|2	MC	SAVR	TX

I would like to participate in this research:

- Yes
- No

YToxOntzOjg6IlF

1	QID50	1	DB	TB	
Selected					

Part 1: The first set of questions will ask you some general information.

1	QID1	1|2	MC	SAVR	TX

Gender

- Male
- Female

YToxOntzOjc6IlF

1	QID2	1|2|3|4|5|6	MC	SAVR	TX

Age

- 20-29

- 30-39
- 40-49
- 50-59
- 60 and above
- Other

YToxOntzOjc6IIF

1	QID3	1|2|3	TE	SL	

Job Title

1	QID9	1|2|3|4|5|6|7|8|9|1(	MC	DL	

Banding

YToxOntzOjc6IIF

1	QID31	1|2	TE	FORM	

How long have you worked with patient feedback?

Years

Months

1	QID7	1|2|3|4	MC	SAVR	TX

Hours worked per week:

- Less than 10 hours, please specify
- Between 10 hours and 20 hours
- Between 20 hours and 35 hours
- More than 35 hours, please specify

YToxOntzOjc6IIF

1	QID8	1|2|3|4	MC	SAVR	TX

Work type:

- Full-time
- Part-time
- Voluntary
- Other

YToxOntzOjc6IiF

1	QID52	1|2|3|4|5|6|7	MC	SAHR	TX

How satisfied are you with your job in general?

1 Extremely dissatisfied	2	3	4	5	6	7 Extremely satisfied
○	○	○	○	○	○	○

YToxOntzOjg6IiF

1	QID34	1	DB	TB	
Selected					

Part 2: The following questions will ask you about your wellbeing.

We should like to know if you have had any medical complaints and how your health has been in general over the last few weeks. Please answer ALL the questions simply by selecting the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those you had in the past. It is important that you try to answer ALL the questions. Thank you very much for your co-operation.

1	QID21	1|2|3|4	MC	SAVR	TX

Have you recently been able to concentrate on whatever you're doing?

- Better than usual
- Same as usual
- Less than usual
- Much less than usual

1	QID38	1|2|3|4	MC	SAVR	TX

Have you recently lost much sleep over worry?

- Not at all
- No more than usual
- Rather more than usual
- Much more than usual

Have you recently felt that you are playing a useful part in things?

- More so than usual
- Same as usual
- Less useful than usual
- Much less useful

Have you recently felt capable of making decisions about things?

- More so than usual
- Same as usual
- Less so than usual
- Much less than usual

YToxOntzOjg6IlF

Have you recently felt constantly under strain?

- Not at all
- No more than usual
- Rather more than usual
- Much more than usual

YToxOntzOjg6IlF

Have you recently felt you couldn't overcome your difficulties?

- Not at all
- No more than usual
- Rather more than usual
- Much more than usual

YToxOntzOjg6IlF

Have you recently been able to enjoy your day-to-day activities?

- More so than usual
- Same as usual
- Less so than usual
- Much less than usual

YToxOntzOjg6IlF

Have you recently been able to face up to your problems?

- More so than usual
- Same as usual
- Less so than usual
- Much less able

YToxOntzOjg6IlF

Have you recently been feeling unhappy and depressed?

- Not at all
- No more than usual
- Rather more than usual

- Much more than usual

YToxOntzOjg6IlF

Have you recently been losing confidence in yourself?

- Not at all
- No more than usual
- Rather more than usual
- Much more than usual

YToxOntzOjg6IlF

Have you recently been thinking of yourself as a worthless person?

- Not at all
- No more than usual
- Rather more than usual
- Much more than usual

YToxOntzOjg6IlF

Have you recently been feeling reasonably happy, all things considered?

- More so than usual
- About the same
- Less so than usual
- Much less than usual

1	QID49	1	DB	TB		Selected

Final part: Thank you for completing the questionnaire so far. The next set of questions consider your working conditions.

It is recognised that working conditions affect worker well-being. Your responses to the questions below will help us determine your working conditions now, and enable us to monitor future improvements. In order for us to compare the current situation with past or future situations, it is important that your responses reflect your work in the last six months.

1	QID24	1|2|3|4|5|6|7|8|9|1(	1|2|3|4|5	Matrix	Likert	SingleAnsw er

Please select the option that best describes your working conditions from 'never' to 'always'.

	Never	Seldom	Sometimes	Often	Always
I am clear what is expected of me at work	○	○	○	○	○
I can decide when to take a break	○	○	○	○	○
Different groups at work demand things from me that are hard to combine	○	○	○	○	○
I know how to get about getting my job done	○	○	○	○	○
I am subject to personal harassment in the form of unkind words or behaviour	○	○	○	○	○
I have unachievable deadlines	○	○	○	○	○

	Never	Seldom	Sometimes	Often	Always
If work gets difficult, my colleagues will help me	○	○	○	○	○
I am given supportive feedback on the work I do	○	○	○	○	○
I have to work very intensively	○	○	○	○	○
I have a say in my own work speed	○	○	○	○	○
I am clear what my duties and responsibilities are	○	○	○	○	○

Please select the option that best describes your working conditions from 'never' to 'always'.

	Never	Seldom	Sometimes	Often	Always
I have to neglect some tasks because I have too much to do	○	○	○	○	○
I am clear about the goals and objectives for my department	○	○	○	○	○
There is friction or anger between colleagues	○	○	○	○	○
I have a choice in deciding how I do my work	○	○	○	○	○
I am unable to take sufficient breaks	○		○	○	○

	Never	Seldom	Sometimes	Often	Always
I understand how my work fits into the overall aim of the organisation	○	○	○	○	○
I am pressured to work long hours	○	○	○	○	○
I have a choice in deciding what I do at work	○	○	○	○	○
I have to work very fast	○	○	○	○	○
I am subject to bullying at work		○	○	○	○
I have unrealistic time pressures	○	○	○	○	○
I can rely on my line manager to help me out with a work problem	○	○	○	○	○

1	QID26	1|2|3|4|5|6|7|8|9|1(	1|2|3|4|5	Matrix	Likert	SingleAnsw er

Please select the option that best describes your working conditions from 'strongly disagree' to 'strongly agree'.

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
I get help and support I need from colleagues	○	○	○	○	○
I have some say over the way I work	○	○	○	○	○
I have sufficient opportunities to	○	○	○	○	○

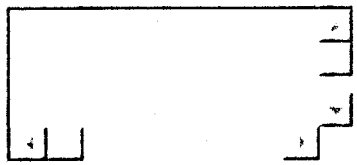
	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
question managers about change at work					
I receive the respect at work I deserve from my colleagues	○	○	○	○	○
Staff are always consulted about change at work	○	○	○	○	○
I can talk to my line manager about something that has upset or annoyed me about work	○	○	○	○	○
My working time can be flexible	○	○	○	○	○
My colleagues are willing to listen to my work-related problems	○	○	○	○	○
When changes are made at work, I am clear how they will work out in practice	○	○	○	○	○
I am supported through emotionally demanding work	○	○	○	○	○
Relationships at work are strained	○	○	○	○	○
My line manager encourages me at work	○	○	○	○	○

1	QID28		TE	ESTB	

You have reached the end of the questionnaire. Thank you for taking part.

If you would like to participate in the focus groups and/or interviews, or would like a copy of the final research report, please email me on l.arevshatian@kingston.ac.uk

If there are any comments you would like to share, please do so here:



Survey Powered By Qualtrics

15.4 Appendix 4

Outgoing email 25/11/2011:

Lilith Arevshatian
K0949744
Business School
Kingston University

Dear Ethical Review Committee,

RE: Application for Research Ethical Review (RE4)

I am a doctoral student at Kingston University, Business School, Department of Leadership, HRM, and Organisation and I am writing to you to apply for research ethical approval for the purpose of my PhD. My years of study are 2009 to 2013, with the period between 2009 and 2010 forming the ESRC accredited MSc in Business Management Research. My supervisor is Dr. Rachel Lewis, Senior Lecturer in Occupational/Business Psychology, and Course Director MSc Occupational and Business Psychology.

In support my application, please find enclosed:

1) Application form for ethical review (form RE4)
2) Supporting proposal
3) Organisation invitation letter
4) Participant information sheet
5) Participant informed consent form
6) Reference list
7) Survey questionnaire
8) Focus group schedule
9) Interview schedule

Should you require any further information please do not hesitate to contact me.
Thank you for considering my application. I look forward to hearing from you.

Warm regards,

Lilith Arevshatian

PhD Researcher
Department of Leadership, HRM, and Organisation
Kingston University Business School
07901 654 744
l.arevshatian@kingston.ac.uk

Email response received 06/12/2011:

Dear Lilith

Your research proposal has received approval from the Faculty Research Ethics Committee.

Best wishes

Valerie Thorne
Small Business Research Centre
Kingston University
Kingston Hill
Surrey KT2 7LB

0208 417 5247

15.5 Appendix 5

KINGSTON UNIVERSITY

1. Research Working Title

An Exploration of the Wellbeing of Feedback Professionals in the Healthcare Context

2. Statement of Consent

I agree to take part in the above university research project.

The purpose of the research has been explained to me and I have read the explanatory statement, which I keep for my records. I understand that agreeing to take part means that I am willing to be interviewed by the researcher.

I understand that my participant is entirely voluntary and that I can withdraw at any time without prejudice.

I understand that any information I provide is anonymous and that no information that could lead to the identification of any individual or organization will be disclosed in any reports on the project, or to any other party.

I agree that research data gathered for the study may be published provided that I cannot be identified as a participant.

Contact information has been provided should I wish to seek further information from the investigator at any time for purposes of clarification.

3. Agreement of Participant

Name of participant:_____

Signature of participant:_____

Date: _____