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Whiley, Lilith and Grandy, G. (2022) The ethics of service work in a neoliberal healthcare context: doing embodied and 'dirty' emotional labor. *Qualitative Research in Organizations and Management* 17 (1), pp. 136-157. ISSN 1746-5648.

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The ethics of service work in a neoliberal healthcare context: Doing embodied and 'dirty' emotional labor

Journal:	<i>Qualitative Research in Organizations and Management</i>
Manuscript ID	QROM-08-2020-2005.R3
Manuscript Type:	Original Article
Keywords:	Dirty work, Taint, Emotion work, Interpretative phenomenological analysis, Embodiment, Emotional labor

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The ethics of service work in a neoliberal healthcare context:

Doing embodied and 'dirty' emotional labor

Abstract

Purpose: We explore how service workers negotiate emotional laboring with 'dirty' emotions while trying to meet the demands of neoliberal healthcare. In doing so, we theorize emotional labor in the context of healthcare as a type of embodied and emotional 'dirty' work.

Methodology: We apply Interpretative Phenomenological Analysis (IPA) to our data collected from National Health Service (NHS) workers in the United Kingdom (UK).

Findings: Our data show that healthcare service workers absorb, contain, and quarantine emotional 'dirt', thereby protecting their organization at a cost to their own well-being. Workers also perform embodied practices to try and absolve themselves of their 'dirty' labor.

Originality: We extend research on emotional 'dirty' work and theorize that emotional labor can also be conceptualized as 'dirty' work. Further, we show that emotionally laboring with 'dirty' emotions is an embodied phenomenon, which involves workers absorbing and containing patients' emotional 'dirt' to protect the institution (at the expense of their well-being).

Keywords: dirty work, emotion work, emotional labor, embodiment, service work, healthcare, interpretative phenomenological analysis.

Introduction

Broadly speaking emotions are seen to be out of place in organizations and organization studies; they are marginalized and commodified, and construed in opposition to rationality (Hochschild, 1983; Leidner, 1999; Huws, 2019). At the same time, it is recognized that in certain contexts emotions are a ‘natural’, albeit uncomfortable, part of work (e.g., Fowler, Phillips, and Westaby, 2020). Healthcare is one such context where emotions are rife because illness, death, and (new) life envelop everyday practices. Neoliberalism in healthcare has instilled a culture of, so-called, efficiency, professionalism, and quality (Currie *et al.*, 2009; Sakellariou and Rotarou, 2017; Vincent-Jones *et al.*, 2009) that we contend is at odds with messy and unpredictable emotions. Healthcare workers are expected to manage the intense emotions of patients with care and in a professional manner – this emotional labor is expected but getting it right (or wrong) can come at a great cost to the well-being of workers (Mastracci and Mourtgos, 2021). Although some have written about the emotional labor of service workers in various contexts (Dyer *et al.*, 2008; Weir and Waddington, 2008; Mastracci, 2021), the ethics of organizations commodifying workers’ emotions (Johnson 2015; Barry *et al.*, 2018), and how we sensemake what work is valued and stigmatized (Amis, Mair, and Munir, 2020), there is still much to learn about the embodied lived experiences of emotionally laboring in neoliberal institutions. We therefore ask, what is it like for service workers, who gift their emotions and bodies for care, to work in the business of healthcare (in corporatized hospitals that produce and sell health), and what are the consequences of this labor?

Workplaces are sites of power relations (Hodson *et al.*, 2006), especially so when they are large hierarchical and bureaucratic institutions like hospitals (Pope, 2017) where medical labor is exploitable under neoliberalism (Ardila-Sierra and Abadia-Barreo, 2020). Modes of embodiment

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3 signify status (Bourdieu, 1990); one person is being servile to the other. It is through organizational
4 display rules that the embodied aspects of emotional laboring are corporately produced (du Gay,
5 1996) and via workers' embodied emotive performances their physical capital is valorized and
6 turned into economic capital by institutions (Witz *et al.*, 2003). Workers' emotions (and bodies)
7 are no longer personal or private, they have commercial value for the institution (Pillay, 2016).
8 Here we are interested in better understanding the ethics of this exchange, especially within the
9 complexity of healthcare. In this paper we theorize emotional labor in the context of healthcare as
10 a type of embodied and emotional 'dirty' work. Specifically, we look at the experiences of a group
11 of healthcare service workers in the National Health Service (NHS) in the UK, responsible for
12 managing patient concerns and complaints. In doing so, the research question guiding our work
13 is, how do healthcare service workers meet the demands of neoliberal complaints management and
14 negotiate their embodied, emotional, and 'dirty' performances?
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31 Our contribution is ~~four~~ three-fold. Firstly, we contribute to research on healthcare as a
32 neoliberal context (see for example, Currie *et al.*, 2009; Vincent-Jones *et al.*, 2009; Holton and
33 Grandy, 2016; Sakellariou and Rotarou, 2017; Ardila-Sierra and Abadia-Barreo, 2020). Secondly,
34 we extend research on emotional labor in healthcare with our focus on service (complaints)
35 workers (see for example, Zaluski and Makara-Studzińska, 2018). Thirdly, we extend work on
36 embodiment at work, embodiment in emotional labor, emotional labor and 'dirty' work, and
37 emotional 'dirty' work. We extend existing work on the commercial value of embodiment and
38 emotions (e.g., Witz *et al.*, 2003; Pillay, 2016) and emotional 'dirty' work by illuminating how
39 emotions and/or bodies are commodified in neoliberal contexts (Warhurst and Nickson, 2009;
40 Rivera and Tracy, 2014; Hoppania and Vaittinen, 2015; Mastracci and Mourtgos, 2021). Further,
41 we extend the research of Rivera (2015) and McMurray and Ward (2014) on emotional 'dirty'
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work to theorize and empirically illustrate how such emotional ‘dirty’ work is embodied – embodied in how workers absorb the ‘dirty’ emotions of patients and protect the institution from such ‘dirt’ (often at the expense of their own well-being), and also in how they absolve themselves from such emotional ‘dirt’ in an attempt to maintain well-being. Fourth, we approach ‘dirty’ work from an experiential perspective and apply Interpretative Phenomenological Analysis (IPA) to the lived experiences of ‘dirty’ workers. This is a meaningful methodological contribution because by doing so we can sensemake an embodied understanding of ‘dirty’ work.

Complaints service work in the context of neoliberalism in healthcare

Over the past quarter century, notions of neoliberalism have percolated into public sector management, transforming healthcare into a highly marketized institution. Ardila-Sierra and Abadía-Barreo (2020, p.1016) argue that these notions are “incompatible” with the purpose of care at the center of healthcare. Neoliberalism constructs a heavily commodified perception of healthcare and positions it as a consumable service (Sturgeon, 2014). Is it possible to achieve meaningful and genuine person-centred care under neoliberal imperatives? Blunden and Calder (2020) aptly argue that it is not. When corporatized management practices and rationalized myths such as LEAN Six Sigma are brought in to modernize services (Kitchener, 2002; O’Reilly and Reed, 2011; Hood and Dixon, 2016), managers are encouraged to perceive the organization’s reality as “grounded in economic notions of value and commodity” (Doolin, 2002, p.379). Under such a framing, hospitals over-emphasize professionalism and accountability, tight controls and individual responsibility, citizen involvement and market-driven logics, commercial advantage and cost savings (Currie et al., 2009; Sakellariou and Rotarou, 2017; Vincent-Jones et al., 2009).

In McCann, Granter, Hassard, and Hyde’s (2015) ethnographic study of four NHS organizations,

employees were wedged between business pressures, such as so-called ‘efficiencies’ of resources and overreliance on metrics, and the integrity of care inherent in caring for vulnerable people.

Indeed, neoliberalism realigns the institution’s ethos of *healthcare* with commercial enterprise and its enterprising behavior (du Gay, 1996), but these are at odds with the ethics of *care*.

One manifestation of neoliberalism in healthcare is the positioning of patients as customers (Sturgeon, 2014). Under this guise, patients (service users) have the right to raise concerns about the quality of the service (read care) that they are receiving. Following the commercial ethos, the narrative around managing patients’ concerns and complaints is often clouded in pseudo-legal terms (e.g., advocacy support, independent advice, service users instead of patients) (Department of Health, 2002; Statutory Instruments 2009). Flowcharts describe step-by-step processes; a “logical and rational” approach, “evidence based” investigations, “consistent” and timely, meeting “legal obligations” and “ensuring the good reputation of NHS” – and yet, also sympathetic and “appropriate to the seriousness” (NHS, 2017, p.6) Emphasis is placed on handling cases fairly and consistently, keeping detailed records ready for quality audits, and applying rules and regulations. Complaints are supposed to be “lessons learnt” and lead to institutional “implemented learning” (NHS, 2017); complaints systems are seen to be imperative to providing a quality service and service workers are envisioned to be “catalysts” for organizational change and improvement (Department of Health 2002, p.7) – all of which has, regrettably, led to a culture of suspicion ~~instead~~ amidst a rhetoric of patient empowerment (Sandall et al. 2009).

The culture of blame and fear is widely documented in the NHS (Stevenson *et al.*, 2019). Pope (2017, p.589) points out how the NHS is plagued with “avoidance, rejection and burial of bad news” where people “hear nothing, they see nothing and they say nothing”. There is a noted resistance to raising concerns and genuinely identifying problems; workers who try to blow the

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3 whistle are either ignored or punished, and there are constraints on managers speaking their minds
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5 (Pope 2017, 2019; Pope and Burnes, 2013). Critics argue that instead of being genuine change,
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7 many service workers are there to simply provide a “rubber stamp” for the institution’s agenda
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9 (Bentley *et al.*, 2005, p.62); they have limited power and are unable to address the real socio-
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11 political issues that cause complaints (Buchanan *et al.*, 2005). Indeed, there are many variations in
12
13 the discourses that are used by hospitals to identify these workers ranging from patient experience
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15 manager to telephone advice officer.
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19 Hospital demands for process-driven, rational, and logical investigations (espoused by
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21 neoliberalism) make it difficult for workers to act with authenticity in a true “ethos of helping”
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23 (Husso and Hirvonen, 2012, p.32). Yet, complaints management in healthcare must involve
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25 working with very powerful and challenging emotions – grief at a loved one’s death, anger at the
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27 doctors, blame towards the hospital. Service workers have to confront these emotions as “third
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29 party agents” of patients’ trauma, similar to how Samaritans confront society’s ‘dirty’ emotions
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31 (McMurray and Ward, 2014, p.1135). Hence, we propose service workers in healthcare perform,
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33 what Rivera (2018) would describe as emotionally ‘dirty’ work, work necessitated by working
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35 with and performing emotions, interacting with the emotions of patients and managing them, and
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37 dealing with the consequences of emotional arousal. Although compassion is often the
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39 organizationally mandated emotion (“you need to come across as like you can actually feel for
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41 them”; O’Donohoe and Turley, 2006, p.1437), neoliberalism constrains the labor; it must be done
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43 procedurally, with the correct emotional performance, and under conditions of hyper-surveillance
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45 (e.g., letters to patients are monitored and there is opposition to including an apology because staff
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47 are fearful of blame; Xanthos, 2008).
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3 Although plenty has been written on emotional labor in healthcare, Zaluski and Makara-
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5 Studzińska's (2018) literature review encompassing 2010 to 2017 shows that most research has
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7 focused on medical professionals such as doctors, nurses, healthcare assistants. We know less
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9 about non-medical professionals such as customer service workers and administrators, which is
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11 surprising given that they are front-line workers who are often the first to encounter patients,
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13 making them especially vulnerable to patients' raw emotions. Healthcare customer service workers
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15 are in a particularly susceptible role because their emotional labor involves being tasked with the
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17 objective (read emotionless) investigation of patient complaints while at the same time being
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19 employed by that very institution. We are interested in exploring how healthcare service workers
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21 meet the demands of neoliberal complaints management through their emotional labor and the
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23 implications of this for them; in doing so, we extend understandings of emotional labor in
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25 neoliberal institutions.

31 **Embodied emotional 'dirty' (service) work**

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34 We are especially interested in fusing emotional labor and emotional 'dirty' work through
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36 the lens of embodiment because it opens interesting avenues for researching the ethics of service
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38 work in a neoliberal healthcare context. Other research has also begun to connect how emotional
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40 labor and 'dirty' work can inform each other (e.g., Guerrier and Adib, 2003; Simpson *et al.*, 2011;
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42 Mavin and Grandy, 2013; Mastracci, 2021), but embodiment remains an underexplored
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44 consideration in the extant literature on 'dirty' work (see for exceptions, Dant and Bowles, 2003;
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46 Hughes *et al.*, 2017; Rivera and Tracy, 2014). Embodiment is, however, particularly pertinent to
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48 care work; there is a "recognition of shared embodiment" between care giver and care receiver
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50 (Husso and Hirvonen, 2012, p.32) because of the inherent (corporeal and otherwise) inter-
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52 connection necessary to perform care (Hamington, 2004). We are interested in exploring how
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3 healthcare service workers meet the demands of neoliberal complaints managements while
4 negotiating, what we propose to be, embodied, emotional, and ‘dirty’ performances.
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8 We take the view of Merleau-Ponty (1962, p. 82) in that the body is “the vehicle of being
9 in the world” and of Noland (2009) who defines embodiment as inhabiting a sensory body. All of
10 our experiences are rooted in embodied processes such as hearing, seeing, and smelling (Barsalou,
11 1999; Lakoff and Johnson, 1980); all work activities are inevitably experienced via embodied
12 visual, auditory, kinesthetic, olfactory, and gustatory processes (Gärtner, 2013). We contend that
13 embodiment is especially integral to understanding the experiences of emotional laborers because
14 of the inherent physicality of performing emotions (Goffman, 1967; Hochschild, 1983).
15 Specifically, emotions are not simply experienced within oneself; they are also corporeally acted
16 and displayed externally for others (e.g., patients, customers, *etcetera*). Although embodiment is
17 implied and inherent in emotional labor (Warhurst and Nickson, 2009), we are often presented
18 with a too cognitized and disembodied view of workers (Dale, 2001). Yet, cognitions and social
19 interactions are only one parts of experience; the other comes via bodily sensations such as hearing,
20 seeing, and smelling. Social stimuli do not only arouse cognitive responses but also animate bodily
21 sensations that influence emotional states (Barsalou *et al.*, 2003). Indeed, our sensory and
22 perceptual experiences drive our thoughts, feelings, and behaviors (Meier *et al.*, 2012). Our ability
23 to make sense of our experiences is also firmly rooted in these embodied processes (Barsalou,
24 1999; Lakoff and Johnson, 1980) – as well as socially constructed meanings. While we do indeed
25 interact with the world via discursive means (e.g., Cassell and Bishop, 2014), we also engage with
26 it in a material and felt way via our embodied selves.
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51 Hochschild (1983) argued that the body was the main tool of the trade in service work that
52 involved frequent and intense mediation with one’s own and customers’ emotions, necessitating
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3 many different facial and bodily displays (i.e., “body management and maintenance”) to hide away
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5 their own emotions (e.g., tiredness, boredom) and present professionalism (Adamson and
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7 Johansson, 2016, p.2204). Workers must, in many ways, embody their institution’s ideals and
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9 perform positive emotions for customers; they need to be polite and caring (Bolton and Boyd,
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11 2003) and do so under pressure and irrespective of customers’ behavior towards them (Payne,
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13 2009). For example, nurses in Bolton's (2001, p.97) research on emotion work explain how they
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15 have to deliver many different performances throughout the day, comparing it to being “like one
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17 of those one-woman stage shows” where “the management pull your strings”. Likewise, tour reps
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19 in Guerrier and Adib's (2003, p.1412) research on emotional labor explain how they are expected
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21 to be “lively jumping around joining in the games”, in essence “PR-ing the company”. In this way,
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23 emotional laborers have to be the “face and voice” of the organization (Ashforth *et al.*, 2008, p.6),
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25 but becoming “an emotional laborer is no easy, ephemeral accomplishment” (Witz *et al.*, 2003,
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27 p.37). There are continuous negotiations taking place between workers’ and customers’ bodies,
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29 especially in the context of giving care; experiences that are situated in the interpersonal space
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31 between the embodied engagement of actors (Adamson and Johansson, 2016) and within the wider
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33 environment (Smith, 1996). Indeed, Dyer *et al.* (2008) suggest that commoditized care requires
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35 both emotional laboring and body work; it “all has to seem to be perfect” (Ashforth *et al.*, 2008,
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37 p.24).
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45 Healthcare service workers have to listen and resolve often difficult situations and
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47 distressing subject matters (Healthcare Commission 2007). Complaints are highly emotive. And
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49 workers have to guide patients with often complex needs and concerns, who, by the time they have
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51 reached their department, are angry, bereaved, or even frightened. Workers also have to display
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53 especially nuanced performances because they are employees of the organization being
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3 complained about: “we have to represent our staff as well as the patient – we work for the hospital.
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5 It is very, very difficult. It causes us quite a lot of tension and stress” (Xanthos, 2008, p.11). While
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7 there is a requirement that service workers perform emotions, only certain emotions are
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9 permissible, specifically, the emotions that are displayed are supposed to serve the organization.
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11 For example, border patrol workers have to act tough despite feeling scared (Rivera, 2015),
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13 bereavement workers have to simultaneously perform sympathy while also being mindful that “the
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15 objectives are commercial” (O’Donohoe and Turley, 2006, p.1444), sex workers have to produce
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17 apparently authentic interactions with each client even though it is really a “business strategy”
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19 (Sanders, 2005, p.329). Emotional laborers have to perform “just the right amount of empathy”
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21 (O’Donohoe and Turley, 2006, p.1444), too much and customers are “going to start bawling” and
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23 “that’s not going to help the person” (p.1435), too little and they will complain that “it was like
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25 talking to a robot” (Weir and Waddington, 2008, p.74). Service workers are expected to be
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27 consistently “professional”, “in control”, and “in charge” (Rivera 2015, p.207), and there are
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29 repercussions for those who break these unwritten display rules, for example, workers who are cry
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31 at their desk incur a “major blackmark” (Harkness *et al.*, 2005, p.128). Hence, healthcare service
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33 workers are navigating a complex landscape of having to perform organizationally mandated
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35 emotions in the right way, juggling patients and peers’ expectations, all the while trying to manage
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37 their own, genuine, emotions.
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45 When these tightly controlled and intricate emotional displays are perceived as poorly
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47 performed or out of place, they become stigmatized – they become ‘dirty’. Indeed, the label ‘dirty’
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49 work has been used to describe tasks and employment that are morally (e.g., sinful or invasive),
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51 socially (e.g., servile), physically (e.g., in contact with waste or death), or emotionally (e.g.,
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53 managing the difficult and burdensome emotions of others) stigmatized (Ashforth and Kreiner,
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3 1999; McMurray and Ward, 2014; Rivera and Tracy, 2014). We theorize that herein lies the
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5 ‘dirtiness’ of some emotions. Indeed, not all emotions at work are ‘dirty’; some emotions are
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7 specifically contracted by the organization. We extend existing research to theorize that some
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9 emotions, and thus, emotional labor can be viewed as ‘dirty’ work and involve so-called ‘dirty’
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11 emotions because it places those performing the work in a vulnerable and stigmatized, position.
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13 Specifically, in situations where emotions must be expressed and mediated, the work (and worker)
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15 can become stigmatized because the performance of these (non-permissible) emotions at work are
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17 at risk to be viewed as objectionable, inappropriate, excessive, or vulnerable (Rivera, 2015). We
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19 contend that in this context of healthcare, ‘dirt’ can be conceptualized as symbolic, material, and
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21 relational.
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27 In her research on emotional ‘dirty’ work, Rivera (2015) argued that emotional labor is
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29 ‘dirty’ work because the display of emotions at work (or lack of display or inappropriate display)
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31 subjects the worker to harsh judgment and stigma, and is viewed as out of place in the prescribed
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33 work context. ‘Dirt’ is, in essence, matter out of place (Douglas, 1966). Something is said to be
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35 ‘dirty’ because it seen to be out of its contextually agreed position (Dick, 2005) – such as displays
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37 of emotions that do not fit the situation, which are excessive or that cause the person to subject
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39 themselves to ‘difficult’ feelings (Rivera, 2015). It is these out of place, so-called, ‘dirty’ emotional
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41 displays, that are stigmatized: in her work with border patrol officers, one commented, “these girls
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43 needed help, but one of the Minutemen guys laughed at me and called me a pussy because I wanted
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45 to make sure they were okay” (Rivera, 2015, p.211). Further, McMurray and Ward (2014) argue
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47 that workers who are responsible for handling difficult, negative or out of place emotions of others,
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49 “act as society’s agents in the containment of emotional dirt” (McMurray and Ward, 2014, p.1123).
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51 We extend the work of both Rivera (2015) and McMurray and Ward (2014) on emotional ‘dirty’
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work and argue that healthcare service workers act as the institution's agent to contain emotional 'dirt' and shield the organization. We fuse understandings of emotional labor and 'dirty' work through embodiment to explore how healthcare service workers meet the demands of neoliberal complaints management and negotiate their embodied, emotional, and 'dirty' performances.

Research Methods

This paper is part of the doctoral work of the first author that explored NHS service workers' well-being. The research was informed by ~~Interpretative Phenomenological Analysis~~ (IPA) principles (Smith and Osborn, 2014). Phenomenological research attempts to reveal how people perceive the world around them, and IPA is a specific tool within these approaches (Tomkins and Eatough, 2013). IPA distinguishes itself by its idiographic leanings and strong focus on understanding participants' lived experiences from their perspective, while also acknowledging that this is not ever truly possible as the researcher is also involved in the process of meaning making (Smith, 2011). In IPA, the researcher's role is not that of an objective data collector, who is able to bracket off preconceptions, nor a nuisance or a variable to be controlled. Instead, IPA is a double hermeneutic process of researchers interpreting participants' interpretations (Pitkiewicz and Smith, 2012). IPA is therefore both descriptive (e.g., this is what participants are sensemaking) and interpretative (e.g., this is what we as researchers believe it means). Indeed, IPA is concerned with illustrating participants' lived experiences while also recognizing researchers' role and involvement in the sensemaking of those accounts via reflexivity. In line with IPA best practice guidelines, we transparently narrate the "evidence trail that maintains a clear connection between data and interpretation" (Peat, Rodriguez, and Smith, 2019, p.8). Some of the ways in which we do this is by providing a data analysis extract (see table 1), weaving in reflexive accounts

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3 to illustrate how our thoughts and participants' accounts 'echo' against each other (Goldspink and
4 Engward, 2018), and transparently differentiating between participants' own words and our
5 interpretations thereof.
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12 INSERT TABLE 1 ABOUT HERE
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17 IPA is especially suited for examining "complex, ambiguous and emotionally laden"
18 phenomena (Smith and Osborn, 2014, p.41). For this reason, it is very popular in psychological
19 research (Pietkiewicz and Smith, 2012), and has also started to be claimed by organizational
20 scholars (e.g., Agarwal and Sandiford, 2021; Panda, 2019; McNamara et al., 2018). Further, IPA
21 lends itself to exploring *embodied* personal experience because the body is accepted as the primary
22 means of being in the world and experiencing it (Reid, Flowers, and Larkin, 2005). Tomkins and
23 Eatough's (2013, p.265) point out that phenomenological research can be valuable in theorizing
24 "about the embodied dimension of experience in general and the experience of work and
25 organization in particular". Given our interest in the 'dirty' emotional labor of actors who gift their
26 emotions and bodies for care, and our objective to reveal an embodied understanding of 'dirty'
27 emotion work in the neoliberal institution, this approach aligns well with both our research
28 question and theoretical grounding.
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44 *Data Collection*

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47 Similar to ethnographic studies, IPA favors a small purposively selected sample to
48 encourage researchers to engage in a multi-stage analysis of participants' rich accounts
49 (Pietkiewicz and Smith, 2012). The first author's doctoral research was exploratory in nature and
50 included visiting hospitals and having informal unstructured conversations *in situ* with service
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workers in their offices, as well as cold calling their helpline. The dialogue was free flowing and respondents led the conversations; each lasted about one hour with a total of nine healthcare service workers. The first author took written notes during those conversations. These initial conversations were supplemented by formal semi-structured interviews with an additional nine healthcare service workers that were audio recorded; interviews ranged from one and a half to two hours. All participants are referred to here with pseudonyms. The first author continued to take notes (see Table 2 for an overview of the participants interviewed via formal semi-structured format).

INSERT TABLE 2 ABOUT HERE

As is encouraged with IPA, interview questions were opened-ended and designed to invite participants to reflect on their cognitions, emotions, and actions (e.g., *what is like to work in this role? How did you feel when...? Can you describe what...? What were you thinking when...?*) (Reid, Flowers, and Larkin, 2005).

Data Analysis

IPA adopts an open and inductive approach (Pietkiewicz and Smith, 2012); we did not prepare categories *a priori* based on the extant literature, and allowed participants lived experiences to guide our classifications while to-ing and fro-ing between the data and our interpretations thereof. We applied the analytical procedure recommended by Pietkiewicz and Smith (2012), and via this iterative process, we developed and refined initial interpretations with the eventual aim to move from the descriptive to the more conceptual level of analysis (Tomkins and Eatough, 2014). We also considered “the significance of gestures, lacunae, hesitations, word

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3 choices, and figures of speech (tropes) such as metaphor, metonymy, and catachresis – the misuse
4 of terms” (Murray and Holmes 2014, p.23). The interpretative process was a two-stage, or a double
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6 hermeneutic, where “the participants are trying to make sense of their world; the researcher is
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8 trying to make sense of the participants trying to make sense of their world” (Smith and Osborn,
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10 2008, p.53) (see table 2).
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15 The initial stages of interpretation involved multiple readings and re-readings and note
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17 taking. Interesting and poignant statements were highlighted in the transcript, for example, how
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19 Adam likened being in the bus home after work to a “decompression chamber”. We jotted down
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21 our initial thoughts – that the bus ride home allowed Adam to distance himself from the weight of
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23 work, physically and psychologically too. Passages that intrigued us, pulled us back, and we
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25 discussed the insight that might be revealed about the participant’s lived experience (Smith, 2011);
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27 for example, how Pauline would start talking about something that she loved (i.e., food) right after
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29 speaking with a patient, and how she would put on a “mould” before answering the phone. Then,
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31 we transformed the exploratory notes into themes by grouping units of meaning together, and we
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33 finished by clustering common themes together. For example, we noted how participants would
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35 frequently perform physical actions to mark separations between themselves and their work (e.g.,
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37 wiping feet at the door, shutting the door as they left, putting down the phone etc.), which we
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39 interpreted as an embodied process of absolving oneself from the ‘dirt’ inherent in their work.
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45 Finally, we created a thematic table illustrating emergent concepts and participants’
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47 accounts. The entire process was iterative and involved going backwards and forwards; we
48
49 discussed amongst ourselves and went back to the data several times. Our themes and
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51 interpretations evolved as we discussed the emergent concepts; at times, we re-categorized, re-
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53 labelled, and re-interpreted to achieve agreement and articulate more authentically *our* interpreted
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3 meaning of participants' accounts. For example, what did it mean that Helen lowered her voice to
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5 recount how she got her "head on" for work? Did this bare-bear similarity to Pauline's "mould",
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7 or we were we simply seeing a link because of our knowledge of emotional labor? We took great
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9 care to be respectful of participants' trust in sharing their experiences, while highlighting the
10
11 contradictions, complexities, and nuances of their experiences. There is something somewhat a
12
13 little voyeuristic in asking people to unveil themselves in this way, and it was important to us not
14
15 to commodify participants' lived experiences further for the purposes of research. In writing the
16
17 first draft of the manuscript, the two authors considered what extracts to include, being careful not
18
19 to appeal to shock value (for example, we removed Julie's metaphor comparing her labor to a
20
21 toilet). We would also like to thank the anonymous reviewer who nudged us on this point and
22
23 encouraged us write ourselves into the analysis. It took several iterations to share and uncover our
24
25 involvement with theme-*making* and to present our interpretations for what they were instead of
26
27 snippets of truth. We also humbly acknowledge that laboring with this data was uncomfortable.
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29 Participants spoke of "dead babies" (Patrick) and did so with the ease of expert 'dirty' laborers;
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31 this was not the case for us as researchers. After the interviews, the first author felt the need to
32
33 debrief – almost to cleanse (see Starcher and Stolzenberg, 2020 on the secondary trauma of
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35 interviewers).

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38 Through the above described iterative and reflexive process, we interpret and hint at the
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40 ways in which healthcare service workers experienced, what we interpret as, embodied and 'dirty'
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42 emotional labor amidst the tensions of being in a neoliberal institution. In what follows we discuss
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44 three themes to empirically illustrate our conceptualization of healthcare service work as embodied
45
46 and 'dirty' emotional labor, namely: **(1) Containing patients' emotional 'dirt' and shielding the**

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3 **institution; (2) Using bodies to absorb and quarantine emotional ‘dirt’; and (3) Absolving**
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5 **oneself from emotional ‘dirt’ via embodied practices.**
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10 **Findings**

11 *Containing patients’ emotional ‘dirt’ and shielding the institution*

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14 We interpret that healthcare complaints can be understood as emotional ‘dirt’ (McMurray
15 and Ward, 2014) because they involve distressing, difficult, and sometimes gruesome matters that
16 most people would prefer not to think about, never mind work with daily. Moreover, in doing this
17 work, these workers act as the healthcare institution’s “agent in the containment of emotional dirt”
18 (McMurray and Ward, 2014, p.1123), shielding other parts of the organizations and the institution
19 as whole. We draw our interpretation from examples in participants’ accounts such as: Lynne
20 shared how surgeons wrongly removed a patient’s healthy kidney; Laura recounted how a midwife
21 had allowed a tongue-tied newborn who was unable to nurse to go home; and Patrick talked about
22 serious case reviews that involved infant deaths. We read ~~in~~ ~~and~~ interpret from ~~(and~~ in
23 ~~)~~ participants’ accounts, that ~~these~~ complaints of this nature go beyond being merely unpleasant.
24 For instance, Julie refers to them instead as a “gungy sort of horrible thing” that the institution
25 would prefer to “quickly close the door, and it’s gone away” (Julie).
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42 Complaints are supposed to form the basis of organizational learning and change, but
43 almost all participants reported that genuine change was difficult to accomplish and rare in the
44 current neoliberal institutional structure. Some, like Patrick, were rather sarcastic and complained
45 about how some hospitals “crow” about “trivial” changes. Others, like Alicia, lamented about the
46 “waste” of data that was supposed to inform gaps in service that the institutions simply “ignore”.
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54 Although; “the government and the NHS, makes lots of noise about we must learn from people’s
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3 experiences and all this, it's tokenistic. The truth is they have no intention of meaningfully learning
4 if it doesn't fit with the Trust's agenda or the government's agenda" (Patrick). It appears that the
5 projected role of being a change agent and investigator is simply "lip service" as expressed by
6 Laura: "things haven't changed you know, whatever lip service they're giving it, however much
7 they say things that are getting better, they're not, we can see that, it's evidenced by the similarities
8 of calls we're getting" (Laura).
9

10
11 Pauline shared how "nobody's not listening to them [patients] on the ward" and described
12 how patients were passed on from one service to another via the "NHS conveyor belt" until they
13 finally reached them. At times, participants formed strong bonds with patients, for example Pauline
14 had regular callers whom she fondly called "my little boys" – an endearing term that was further
15 boosted by the first author's interpretation of Pauline as motherly. Notes from the first author
16 describe Pauline as warm, caring, and protective. We can also see how participants opposed the
17 neoliberal imperatives that at times identified them as 'NHS police' and 'internal affairs'
18 (metaphors taken from unstructured conversations). They also resisted the emotion-less job titles
19 that resulted from the consumerization of healthcare. Julie whose job title was customer services
20 manager was not happy with this label and explained, "I don't actually like it very much and I've
21 kind of fought against it". Lynne explained that their role "isn't just about process, this about
22 actually engaging with people face to face. Talking to them, talking about their worries, their
23 concerns, and things like that. You know it's very, you can't do it in a just a process". Similarly,
24 Pauline took great pains to explain that "the customers that we have are not the general customers
25 that they wanna put under the same umbrella [...] it's different".
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51 Reflecting on these examples, we argue that by emotionally laboring with patients'
52 emotional 'dirt', participants effectively contained the 'dirtiness', in essence, protecting the
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3 institution. Alicia explained how the time that she spent with patients stopped them from “ringing
4 this service, ringing that service”. By containing the ‘dirt’, she protects the institution: “They
5 [patients] go off and they claim merry hell all over the place, we try and contain them. So that you
6 as a GP, or you as a commissioning manager, you don't have to worry about it, you in public health,
7 don't have to worry about it. And you don't” (Alicia). In this example, we can infer the possible
8 dangers of what might happen if participants fail at their quarantining efforts (e.g., patients
9 “ringing this service, ringing that service”, causing “merry hell all over the place”). These are
10 evidently undesirable consequences for managers and the institution, hence underscoring the
11 importance of participants’ quarantining labor. For example, Julie recounted how she would speak
12 to (and lie to) patients so that her chief executive did not have to labor with the ‘dirtiness’ of
13 patients emotions:

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28 A lot of the top teams would do anything, anything rather than speak to patients [...] I’ve
29 had to safeguard chief executives in my time, many a time, you know I’ve had my old chief
30 executive at the hospital standing in my doorway going, ‘I’m not here’ when I’m going ‘oh
31 yes well I’m sure you would like to speak to him and I will make sure that he knows that
32 you called’. And you see, you protect them, you protect them an awful lot and I don't think
33 that’s recognized at all by organizations, I don't think they got any idea. (Julie).

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42 From this example, we interpret just how critical a function Julie and her colleagues perform for
43 the neoliberal institution. We can also sense Julie’s frustration (echoed by other participants) at
44 feeling so little appreciation for their protective efforts. Julie sensemakes that perhaps they
45 (managers) know but choose to ignore because “it’s things they don’t really want to hear” – similar
46 to how Patrick explains their labor as carrying “unpalatable messages”.

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3 Reflecting on the similarities in participants' accounts, we observe how rather than
4 workers' emotional work performance being about *learning* from patient experience, it is a 'dirty'
5 performance that *safeguards* institutions via ~~by~~ emotionally laboring with patients' emotions. We
6 also note that participants believe that management is aware of this critical function that they
7 perform and freely uses it to their advantage. Although participants' role is officially presented as
8 that of an objective investigator (e.g., 'customer services manager'), a change agent that works in
9 pursuit of patient empowerment (e.g., 'NHS police'), we too interpret that the institution is simply
10 paying "lip service" (Laura) to these ethical ideals – "they have no intention of meaningfully
11 learning" (Patrick). In brief, the primary function of service workers' labor is "talking to [patients],
12 talking about their worries, their concerns, and things like that" (Lynne) so that the institution does
13 not "have to worry about it" (Alicia) and by doing so "it's [the dirt] gone away" (Julie).
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30 *Using bodies to absorb and quarantine emotional 'dirt'*

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32 We argue that containing emotional 'dirt' to shield the institution comes at a cost and is an
33 embodied experience for participants; participants absorb and quarantine patients' 'dirty' emotions
34 through their bodies. Adam explained that by the time patients reached him, they were usually
35 "quite angry, quite demanding [...] in distress" (Adam), needing to offload these emotions and
36 participants had to give them the "space to scream and shout" (Pauline). The 'space' that
37 participants gave patients could be metaphorical, by simply allowing them to vent their emotions
38 or it could be physical space as in the example shared by Julie below:
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49 You're dealing with a lot with people so people come in and say 'you killed my mother, you
50 killed my mother', I've never seen your mother, but they put a photograph of somebody on
51 the desk and say 'and this is the person, so I don't want you to forget who this person is' so
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3 very, very personal and because you're in a hospital and those things are happening, it's very
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5 big.

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8 When Julie described the physicality of her emotional laboring in the interview, the roleplay was
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10 uncomfortable to witness for the first author. Julie reenacted how the patient shouted at her, pointed
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12 a finger at her face, and banged a photograph on the table. It was a startling performance. We
13
14 imagine it was traumatic for Julie to live it based on her reliving it for the first author; indeed, she
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16 notes how these interactions can be "very, very personal" and "very big".
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20 There are several other examples of participants using bodies to engage with patients'
21
22 emotions. For instance, Laura would offer her body in its entirety for a home visit:

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24 If you've got a very angry person as well, actually going and offering to meet them, either
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26 at their home or in the local cafe or wherever, that in itself is enough to diffuse the situation.

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28 So, we try and make ourselves as accessible as possible and then whichever way people
29
30 want to contact you (Laura).
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34 Sometimes, it would only be parts of their bodies. For example, Alicia recounted how she would
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36 sit with patients for hours at a time, holding their hand: "It's people that do that intricate work with
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38 those patients... sit with them, hold their hand, take them through the process, you know it could
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40 be for hours, we spend hours and hours with them". The first author's notes indicate that Alicia's
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42 tone was one of frustration; she wanted to communicate the weight of these bodily performances
43
44 and the toll that they took. On the other hand, the first author recalls Adam's tone as endearing
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46 when he spoke of his lonely elderly patient; we interpret that Adam drew positive meaning from
47
48 this encounter. Adam would lend his ears and use his vocal senses to joke with an elderly patient
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50 who would call because he was lonely: "I just chat with him, you know tell a few jokes, he's quite
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52 elderly [...] you know, have a, have kind of a break with him".
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3 In these examples, and others, we interpret that even though participants are not performing
4 obvious bodywork (e.g., dancing, sweeping, brushing etc.), they are nevertheless *using* their bodies
5 in their labouring. We also propose that different senses are involved - their voices and ears when
6 listening to callers, their eyes and hands by reading emails and typing out responses, and their
7 bodies in entirety by offering home visits and holding patients' hands (almost merging their
8 corporeality together). When Laura talks about being "as accessible as possible", she enacts it
9 literally in a physical sense – she lends out her body to patients (and the institution), and by using
10 their bodies in this way to engage with patients' emotional 'dirt', participants effectively
11 quarantine it to "stop these patients ringing this service, ringing that service" (Alicia).
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24 Participants sensemade how they used their bodies in their day-to-day interactions with
25 patients. At times, their bodies were able to mitigate the burdensome effects of emotional laboring
26 with 'dirty' emotions. For example, Helen described how she puts her "head on" when she comes
27 to work in the mornings. She starts the process early, while she is physically getting ready for
28 work: "I've really got to think positive. Getting washed, getting dressed, going to work".
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35 At other times, their bodies could no longer manage the burdensome effects of emotional
36 laboring with 'dirty' emotions. For example, Alicia lost her voice, quite literally:
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40 There were times where I, I'd come out the house and I'd get to the bottom of the road and
41 walk back home. I'd be in tears, I just couldn't go in (Alicia).
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44 I developed laryngitis and the laryngitis then kind of didn't get better, I left work for about
45 three weeks and during this time [...] I lost my voice, and I lost my voice for three months.
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47 And I had to go to check my throat, make sure there wasn't anything cancerous [...] I
48 couldn't feel my vowels, my words properly (Alicia).
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3 Alicia sensemade that her lost voice was “down to stress and strain and all of those things”
4 and “not dealing with the situation at work” (which appears to be corroborated by her doctors).
5
6 Alicia’s body – her means of dealing with ‘dirt’ and alleviating the burdensome effects of
7
8 emotional laboring with ‘dirty’ emotions – shut down; she was physically incapable of getting to
9
10 work. Similarly, Lynne recounted how the emotional ‘dirt’ reached a level where it “just broke
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12 [her] heart” and she could not “physically” read reports anymore:
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17 Each month you have this list from say the acute Trust, of things that have gone really tits
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19 up big time. So, you have death of babies in delivery circumstances that just should not have
20
21 happened, that I just could not cope with it in the end. [...] Now I sat on that panel for 3
22
23 years and in [hospital name anonymized] they have to report all the suicides, and the suicide
24
25 levels are going up and up, and in the end, it just broke my heart, it physically broke my
26
27 heart. And I got to the point where I thought I can’t read this anymore, I cannot physically
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29 read this [...] it’s tough, really tough, and I had to give up (Lynne).
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33 Similar to Alicia, Lynne sensemade that she experienced a ‘physical’ heartbreak. The
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35 emotional laboring with the ‘dirt’ became so dire that it “physically broke [her] heart” and her
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37 visual senses shut down – she was unable to physically read the report. When the emotional ‘dirt’
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39 got too much to labor with, she sensemade that her body rejected it corporeally.
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42 Indeed, participants experienced significant strain because of their embodied emotional
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44 ‘dirty’ service work. Often, participants would internalize the strain; Patrick would get so angry
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46 that he was “likely to rip someone’s neck off”, Laura would feel “poor me” and become resentful
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48 of others, and Adam would question, “what’s the point of working here, do I actually help
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50 anybody?”. Julie described a “semi-breakdown” and Lynne a “wobbly”, while Adam broke the
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52 telephone after a particularly challenging patient call. Although Adam sensemade that “it was only
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3 a cheap thing, replaceable”, it made him realize that he was “going a bit...” and that he might
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5 “need to do something about that”.
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8 We interpret that bodies are the mediums through which participants experience emotional
9
10 ‘dirt’. Sometimes, they are able to minimize the effects by using the bodies kinesthetically and
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12 putting their “head on” (Helen) and going “into a mould” (Pauline) or relying on their vocal senses
13
14 by mimicking a hyper-chirpy voice “especially when [they’re] not feeling it” (Pauline), but at other
15
16 times, the emotional laboring with ‘dirt’ becomes too burdensome and these embodied practices
17
18 fail. Participants then experienced the dire outcomes corporeally as well. For instance, Alicia’s
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20 body refused to go work and she “just couldn’t go in”. Her vocal senses (that helped Pauline so
21
22 much) shut down and she “lost her voice” for three months. Lynne experienced physical heartbreak
23
24 and was unable to use her visual senses to read the ‘dirty’ reports. Although the institution gains
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26 by using ‘dirty’ service workers’ bodies as shields from patients’ emotional dirt, the workers
27
28 themselves experience significant strain because of their protective activities.
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36 *Absolving oneself from emotional ‘dirt’ via embodied practices*

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39 Participants also sensemade how certain physical actions would mark the end of their
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41 working day and the start of their non-work life in a very clear way. We theorize that
42
43 compartmentalizing the emotional ‘dirt’ at work in this way ‘wiped’ them clean and allowed them
44
45 to enter their non-work life without contaminating it – in this way we interpret that it was an
46
47 embodied attempt to absolve themselves of the emotional ‘dirt’. For example, Pauline described
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49 how she physically wipes her feet at the door as she leaves the office:
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53 Wipe your foot, I wipe my feet.

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55 Here?
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3 Outside, on the door, just wipe my feet (Pauline).
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5 Lynne recounted that she always changes her clothes as soon as she arrives home: “I just
6 know that my home is my home and my work is my work [I] change my clothes, I walk in the
7 door, walk upstairs and change my clothes [...] totally. Never ever, ever, ever do I do anything
8 other than walk in the door, go upstairs and change my clothes”. Helen similarly used the metaphor
9 of a door to explain how crossing its threshold cleansed the dirt away:
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16 If it’s on your chest, you gotta air it, get it off your chest.
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19 When you’re going home you leave everything in the office, when you go through the door
20 [...] as I go through the door, I shut the door, that’s it, home! I’m thinking oohh food ...
21
22 what are we gonna eat? **laughs** [...] we leave the work, until we get back, oh yeah back at
23
24 work now, **lowers voice** got my head on.
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28 Participants sensemake their transition from work to home; it appears that they interpret it
29 as a physical process that liberated them, and we note clues in statements such as the need to “air
30 it” (Helen) and “decompression chamber” (Adam). We therefore suggest that bodily transitional
31 experiences absolve them of the emotional ‘dirt’ they ingest at work. For instance, Helen talked
32 about how going “through the door” and shutting that door cleansed her of this (‘dirt’) while
33 Pauline used her feet and – literally and metaphorically – wiped the ‘dirt’ away “outside, on the
34 door” as she left the office. Lynne changed her clothes as soon as walked “in the door”. All of
35 these embodied actions helped to absolve the heavy burden of patients’ emotional ‘dirt’ so that
36 participants could go home unencumbered (and clean). The door, which has a solid material
37 presence in the world, also possesses a symbolic purpose; it confined the ‘dirt’ to the office space
38 and prevented it from transferring to the home space. In summary, we theorize that participants
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3 give their bodies to meet the demands of neoliberal complaints management and as part of their
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5 emotional laboring with patients' and the institution's emotional 'dirt'.
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10 **Discussion**

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14 Emotions that serve organizations' competitive advantage are commodified yet some
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16 emotions are seen to be 'dirty' (objectionable, inappropriate, excessive, or vulnerable; River 2015)
17
18 and are stigmatized. It is especially so in neoliberal institutions because the objectives of efficiency
19
20 and, so-called, professionalism (Hood and Dixon, 2016; Kitchener, 2002; Sturgeon, 2014) are, we
21
22 argue, at odds with the reality of emotional bodies at work. We therefore set out to understand how
23
24 these embodied workers labor with 'dirty' emotions while trying to meet neoliberal imperatives,
25
26 specifically, we asked how do healthcare service workers negotiate the demands of neoliberal
27
28 complaints management with performing embodied 'dirty' emotional labor? What we
29
30 conceptualize and empirically illustrate as embodied and 'dirty' emotional labor extends our
31
32 understanding of embodiment at work, embodiment in emotional labor, emotional labor and 'dirty'
33
34 work, and emotional 'dirty' work. We conceptualize that emotional 'dirty' work is embodied, and
35
36 is a combination of 'dirty' work and emotional labor (Sanders, 2010; Mastracci, 2021). We extend
37
38 the work of Rivera (2015) and McMurray and Ward (2014) on emotional 'dirty' work and theorize
39
40 that emotional labor can be conceptualized as 'dirty' work and involve 'dirty' emotions, and that
41
42 such emotional 'dirty' laboring is embodied. Empirically, we illustrate that service workers'
43
44 embodied engagement with patients' emotional 'dirt' protects the institution – by using their
45
46 bodies to absorb and contain emotional 'dirt', service workers (via their bodies) shield the
47
48 institution. Indeed, Patterson (2001, p.206) notes, "When it comes to encounters with disgust,
49
50 suffering, and other negative emotions, we pay and oblige administrators to 'take care of it'."
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3 Shielding the organization from ‘dirty’ emotions and ensuring (neoliberal) efficiency and
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5 professionalism in this embodied way does come at a cost to service workers; it leaves those
6
7 performing the work vulnerable and their well-being threatened. Service workers, therefore,
8
9 develop embodied strategies to absolve themselves from the drain of negotiating with such intense
10
11 and frequent emotional encounters, but when these actions fail to buffer, the cost is also embodied.
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15 Key in participants’ accounts are the bodily movements and actions that allow them to
16
17 labor with patients’ emotional ‘dirt’ and manage the strain thereof. Although the narrative around
18
19 healthcare service work is embedded in discourses of organizational change and learning (e.g.,
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21 Department of Health 2002; NHS 2017), participants pointed out that they ended up playing “pass
22
23 the parcel” (Patrick) with the “NHS conveyer belt” (Pauline). Indeed, Korczynski (2003) notes
24
25 that, under neoliberalism, workers’ purpose is to prevent customers from knowing that they are
26
27 riding an assembly line. By and large, healthcare service workers mediate with patients’ emotions
28
29 and are powerless to instigate genuine change – a rhetoric that they report is mostly “lip service”
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31 (Laura) and “tokenistic” (Patrick), which echoes with Abbott *et al.* (2006) who point out that UK
32
33 healthcare is about *projecting* patient involvement and with Buchanan *et al.* (2005) who note that
34
35 the NHS wants to *appear* as being a modern patient-centered organization. Indeed, trying to
36
37 emotionally labor in an institution that has reformulated the nature of healthcare in instrumental
38
39 terms linked with business, that favors corporate models of hypervigilant management, that
40
41 transforms patients into customers, and that de-skills authentic care under the narrative of
42
43 professionalism can be ‘dirty’ in-and-for-itself. There are also practical ramifications to these
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45 themes, for instance, the ever-increasing gap between institutional neoliberal values,
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47 organizational economic agendas, and the authentic experiences of frontline workers.
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3 Notwithstanding, organizations then fail to learn from (what could be) a rich data source of
4
5 valuable information – patient complaints. As Julie said, “it’s things they don't really want to hear”.
6

7
8 Instead, healthcare service workers gift their emotions and their bodies to furthering the
9
10 institution’s corporatized agenda. Its underlying neoliberal policies and philosophies thus reduce
11
12 emotional and embodied care to a commodity. Consequently, service workers are feeling the brunt
13
14 of these expectations. Although we do not explicitly look at aesthetic of labor, we can see some
15
16 similarities between our theorizing and Warhurst and Nickson's (2009) work that extends emotion
17
18 work and embodiment to include the commodification of workers’ embodied dispositions (and
19
20 how they must project a certain ‘look’ or ‘brand’). In a similar way, we argue that the healthcare
21
22 service workers’ emotions and bodies are valorized and commodified by organizations
23
24 (Hochschild, 1983; Witz *et al.*, 2003; Pillay, 2016). The body as their tool is especially evident in
25
26 the inherent physicality of their emotional laboring (e.g., giving patients the space to scream and
27
28 shout, offering home visits, going with them to appointments, even merging bodies with patients
29
30 by holding hands, etc.) – as Husso and Hirvonen (2012) note, there is a sharing of embodiment in
31
32 *doing* care. The idea of workers being readily available for institutional consumption is rooted in
33
34 modern Human Resource Management (HRM) views where people are perceived as resources
35
36 (Dale, 2012). The aim is to recruit able and motivated people and give them the opportunity to
37
38 contribute to the organization’s goals; workers (and their emotions and bodies) are viewed as a
39
40 ‘means’ to achieving this goal, but public servants “are not the means to organizational ends”
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42 (Mastracci and Mourtgos, 2021, p.1).
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49 It is difficult to determine just where corporately mandated emotional and bodily
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51 engagement ends and genuine gifting begins. Hochschild (1983) was quite clear in her criticism
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53 of institutional commodification. Organizations do encourage workers to naturalize their
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3 emotional laboring, which leads to its economic and professional devaluation whereby emotion
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5 work is delegated to those in the lower echelons (Johnson, 2015). Yet, others (e.g., Bolton and
6
7 Boyd 2003) have proposed that workers can perform genuine gifting of emotions – and by
8
9 extension, bodies. Certainly, participants in our study also found their work greatly rewarding and
10
11 many professed that they would continue to work in a caring capacity in the future. There is
12
13 evidence that workers who perform ‘dirty’ work can find profound meaning in their work (e.g.,
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15 Grandy *et al.*, 2015; Mavin and Grandy, 2011; Tracy and Scott, 2006). Nonetheless, we point out
16
17 that emotional laborers can also become “prisoners of love” (Dyer *et al.*, 2008, p.2032), continuing
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19 to perform care beyond institutional mandates (which, we note, bears much similarity to the
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21 strategic HRM concept of organizational citizenship behavior (OCB) defined as the voluntary
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23 contributions given by workers that go above and beyond their job description; Podsakoff *et al.*,
24
25 2016). Even within the HRM discipline, critics have pointed out that this strategic use
26
27 (consumption) of workers (and their emotions and bodies) for organizational imperatives often
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29 comes at the expense of workers’ well-being (e.g., Guest, 2017; Kowalski and Loretto, 2017) and,
30
31 indeed, our empirical research shows that these emotional and bodily ‘dirty’ performances
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33 (whether they be explicitly mandated, implicitly solicited, or philanthropically given) come at a
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35 cost to workers.
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42 We note, for example, how Julie experienced a semi-breakdown, Lynne had a “wobbly”,
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44 Adam slammed the phone so hard that he broke it. Although they might perform embodied
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46 practices, such as adopting a chirpy voice and putting on a smile, to separate their ‘inner’ (cleaner?)
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48 selves from the ‘dirt’, we can see that using their bodies in this way can also have a profound
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50 impact. Using one’s body vocally and through movement to perform a façade that is not genuinely
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52 felt (e.g., Pauline recognizes that she “start[s] off with the voice, and the face”) can lead to harmful
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3 outcomes for workers, which are also performed corporeally (for example, Alicia losing her voice
4 and Lynne's heart breaking). It is important to explore such metaphors because abstract concepts
5 and Lynne's heart breaking). It is important to explore such metaphors because abstract concepts
6 (e.g., heart break) are used to describe physical experiences (i.e., being unable to read the
7 documents). We interpret the use of this metaphor to signify that the emotional 'dirt' was so
8 profound (read so 'dirty') that Lynne was unable to use her optical senses to read the documents.
9
10 Indeed, metaphors can facilitate the identification of embodied processes and matter in otherwise
11 abstract discourse (Meier *et al.*, 2012) and we would encourage future researchers to explore how
12 metaphors might be used by those who emotionally labor with 'dirt' to sensemake their
13 experiences.
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24 Participants' accounts show that workers who labor with 'dirty' emotions also perform
25 embodied practices to absolve themselves. We note how participants put a distance between, what
26 we conceptualize as, their emotional 'dirty' work and their clean home via movements such as
27 wiping their feet. These physical rituals are performed to cleanse them and help participants not to
28 contaminate their homes with the strain of their jobs; "the door" puts a distance between them and
29 the 'dirt'. Our findings resonate with burgeoning embodiment research that show physical actions
30 can treat our emotional state of mind, for example, washing one's hands with soap can alleviate
31 guilt (Zhong and Liljenquist, 2006). Indeed, the research by Sanders (2005) has shown how sex
32 workers (as a type of 'dirty' work) use condoms to physically and psychologically create a distance
33 between paid work and personal lives. What our research reveals is that material effects and
34 absolving practices apply even for those workers who engage in the unseen and abstract notion of
35 society's emotional 'dirt'. That these experiences are embodied offers us a more nuanced
36 understanding of the complexities of doing emotional 'dirty' work and the embodied emotional
37 labor inherent in 'dirty' work. We also add to the work of others who have shown how emotional
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laborers might cope (e.g., Korczynski, 2003; Grandy, 2008; Blithe and Wolfe, 2017; Mastracci and Mourtgos, 2021) by revealing embodied practices.

We also believe there is more to be unpacked in our research in relation to gender. Although our work is not overtly informed by feminist theory, it is difficult to talk about embodiment and emotions without mentioning gender. Butler (1999) notes that our emotions and bodies have been associated with the feminine and contrasted with the (apparently) masculine reason and the mind – remnants from Cartesian mind/body dualism that has influenced much of today’s theorizing; she argues that it is this very association that has marginalized the former and allowed the latter to dominate. Certainly, the trend is noticeable in neoliberal discourses that promote seemingly masculine values (Osgood, 2010), with professional structures organized in such a way as to privilege the masculine (Adamson and Johansson, 2016). Spaces where emotions are performed, where caring and nurturing take place, are perceived as too feminine and therefore ‘un’-professional (Osgood, 2010). Indeed, caring is socially marginalized work (Cox, 2010), especially that which involves the body (Dyer *et al.*, 2008), and under capitalist market relations, is devalued work (Boyer *et al.*, 2013). Although Lawson (2007) argues – and we agree - that caring should be society’s work, McMurray and Ward’s (2014, p.1123) research with the Samaritans shows that we would prefer to outsource the ‘dirty’ work of dealing with society’s “grubby” emotions to others to “take care of it” (Patterson, 2001, p.206).

Our research also opens up other interesting avenues for further exploration. First, it is important to explore the nuances of performing emotional ‘dirty’ work, particularly in neoliberal contexts because capitalist market values and HRM regulations can create oppressive conditions for workers, for example via “dysfunctional dependence” on metrics and “incompatible” targets (McCann et al., 2015, p.786). Further, studying the embodiment of workers who work with

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3 stigmatizing emotions is important to unravelling how discriminatory experiences are sensemade
4 and experienced, and the impact thereof, and serve as a springboard for activist research. These
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8 topics would lend themselves well to ethnographic explorations, as well as other critical qualitative
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11 tools (e.g., analyses of discourse) because qualitative methodologies are especially pertinent for
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14 stigma research (Stutterheim and Ratcliffe, 2021). We support the application of IPA to these
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17 complex phenomena with the objective to sensemake an embodied experiential understanding, and
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20 also encourage the application of Critical Femininities (Hoskin and Blair, 2021) to emotional
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23 ‘dirty’ work given how this lens can unearth the taken-for-granted gendered assumptions of
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26 emotion work. IPA was especially fitting for our theorizing on ‘dirty’ emotion work because its
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29 epistemological and ontological position was aptly rooted in phenomenological philosophy
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32 (Eatough and Smith, 2008), which complemented our conceptual developments on the
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35 embodiment of ‘dirty’ work. Furthermore, IPA privileges participants’ agency (Smith, 2011) and
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38 thus is an emancipatory position that sits well with the dignified and respectful way that many
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41 scholars – including us, approach ‘dirty’ work (e.g., Bolton, 2003; Grandy *et al.*, 2015; Rivera,
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43
44 2014).

40 Conclusion

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42 Our theorizing in this paper adds to the extant literature (~~e.g., Amis, Mair, and Munir,~~
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44 ~~2020) on ‘dirty’ work that and~~ explores how neoliberal imperatives can sully emotional labor and
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46 stigmatize emotions at work and those who labor with them. ~~what work is valued (and who does~~
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48 ~~it) and what work is considered ‘dirty’ (and who therefore is stigmatized along with it) and~~
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50 ~~consider through mechanisms such as these how organizational life shapes society.~~ More
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53 precisely, we extend research on emotional ‘dirty’ work (McMurray and Ward, 2014; Rivera,
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55
56 2015) and theorize that emotional labor can also be conceptualized as ‘dirty’ work. Further, we

show that emotionally laboring with ‘dirty’ emotions is an embodied phenomenon. Specifically, we interpret that healthcare service workers absorb and contain patients’ emotional ‘dirt’ and by doing so protect the institution in a neoliberal context. Workers engage in embodied practices to absolve themselves of their ‘dirty’ labor, but shielding the organization comes at the expense of their well-being.

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Table 1. Data Analysis Excerpt: Absolving Oneself from Emotional ‘Dirt’ via Embodied Practices

Initial stage of interpretative process		Emergent themes	Clustering of themes
<p>Lynne: Never ever, ever, EVER do I do anything other than <u>walk in the door, go upstairs and change my clothes.</u></p> <p>Adam: when I go home, first of all, I get the <u>bus</u> home, cause I can't drive and that <u>helps</u> 'cause it's like a <u>decompression chamber</u>, you know you just <u>look out the window, read your book, you know forget</u> about things by the time you got home. That's the theory anyway. But when I get home, I crawl up to bed, and I assume the fetal position you know [laugh] no (line 748).</p>	<p><i>Activities to distract / distance from weight of work</i></p> <p><i>Also, gallows humor</i></p>	<p>Physical transition, walking through door, going up the stairs, changing clothes.</p> <p>Powerful metaphor. Process of separation, distancing.</p>	<p>Absolving oneself from emotional ‘dirt’ via embodied practices: Physical actions that mark the separation of the self from emotional ‘dirt’ (e.g., wiping feet at the door, shutting the door behind you as you leave, putting down the phone).</p>
<p>Helen: move on [...] soon as <i>the next call comes through</i> we forget about the first one.</p> <p>Helen: <i>phone rings</i> and we start again.</p> <p>Helen: When you're going home, you leave everything in the office, when you <i>go through the door</i> [...] as <i>I go through the door, I shut the door</i>, that's it, home! I'm thinking ooh <i>food...</i> what are we gonna eat? *laugh* [...] we leave the work, until we get back, oh yeah back at work now, *lowers voice* <i>got my head on</i></p>	<p><i>Ringling sound</i></p> <p><i>Shutting it out</i></p>	<p>Repetition, cycle, movement.</p> <p>Transition from one place to another, going ‘through’ something; shutting out.</p>	
<p>Alicia: sometimes when I leave here, I <i>walk home</i>, find a way to walk, <i>leave it behind</i>, I can <i>get on a bus and that's a good way of getting home...</i></p>	<p><i>Another bus.</i></p> <p><i>Walking away ; shedding the emotions</i></p>	<p>Process of separation again.</p> <p>Doing certain (physical activities) to assist process; shedding the weight of emotions.</p>	
<p>Pauline: yeah you <i>put the phone down</i> and you start talking, imagine, that was... start talking about <i>food</i>.</p> <p>Pauline: you <i>put the phone down</i> and you go ARGH and talk about shoes, talk about <i>food</i>.</p> <p>Pauline: it's a <i>mould you get into</i>. With me, it's a <i>voice first</i>, then it <i>goes into the mould</i>.</p> <p>Pauline: <i>wipe your foot, I wipe my feet [...] outside on the door, I just wipe my feet</i>.</p>	<p><i>Shedding dirt symbolically; distancing; distracting conversation</i></p>	<p>Transformation, change, acting, laboring. Process of distancing again. Putting down the phone, wiping feet, closing doors... all physical activities.</p>	

Table 2. Description of participants interviewed via formal semi-structured format

Pseudonym	Job Title	Employment Status
Patrick	Head of _____	Full-time
Lynne	_____ Manager	Part-time
Laura	_____ Manager	Full-time
Julie	_____ Manager	Full-time
Alicia	_____ Officer	Full-time
Adam	Senior Advisor	Full-time
Pauline	_____ Lead	Part-time
Helen	_____ Lead	Part-time
Sue	_____ Assistant	Full-time

26 August 2021

Dr. Christopher Hartt

Associate Editor

Qualitative Research in Organizations and Management

Re: Revised Manuscript ID QROM-08-2020-2005.R1 "The ethics of service work in a neoliberal healthcare context: Doing embodied and 'dirty' emotional labor"

Dear Dr. Hartt,

We are delighted that you have conditionally accepted our manuscript for publication in *Qualitative Research in Organization and Management*. We have addressed the remaining final comments from reviewers and have made the necessary changes in track changes and detailed in the table that follows.

We thank you and the reviewers for the constructive help in developing the manuscript.

Sincerely,

Authors

Reviewer 1 comments	
<p>Thanks for the revisions and additions to this paper – the examples and your thoughts add richness, and will no doubt encourage subsequent researchers to engage with material fully.</p> <p>Below are a few notes for your attention. Again, congratulations on an interesting piece of work.</p>	<p>Thank you very much. We are indebted to your feedback in recrafting the narrative of the methodology.</p>
<p>Page 3, Para 2: You could add to your contributions the use of IPA for this type of inquiry.</p>	<p>Thank you for this suggestion. We have now included IPA as a fourth contribution.</p>
<p>Page 16, line 49: Correct "bare" to "bear"</p>	<p>Thank you for picking this up. Corrected.</p>
<p>Page 18 lines 22-29 – read carefully; I think there are a couple extra (or missing) minor words here, just needs a copy edit.</p>	<p>Edits made.</p>
<p>Conclusion, p. 33: I think your reference to Amis et al. is a stretch here, as they are focused on the production of inequality within organizations; I think you have better, more targeted references to point to, in terms of stating that you are "adding to the extant literature..." (I originally mentioned their paper to you simply as one example of a broader discussion underway, but in the specific way you have referenced it I am</p>	<p>Thank you for picking this up. We have now removed the reference to Amis et al. in the conclusion and have also edited the rest of the sentence.</p>

<p>not sure it makes sense.) I also note that the first sentence of your conclusion is the same wording I wrote in my first review to you, and encourage that you double-check this is indeed your own interpretation and intention for the findings of this paper.</p>	
<p>Reviewer 2 comments</p>	
<p>Thank you for the opportunity to read this excellent manuscript. I must say that I was not one of the original reviewers. I read the manuscript as well as the authors' response to the reviewers' comments.</p> <p>I believe that the authors have done an excellent job addressing the reviewers' comments and that the manuscript reads really well.</p> <p>At this point, my recommendation is accept.</p>	<p>Thank you very much. We are delighted that you are pleased with the revised manuscript.</p>
<p>My only recommendation would be for the authors to look at the three following references, which they may find useful (two on the NHS and one on the UK museum sector, all of which highlight the impact of neoliberalism on the UK public sector):</p> <p>McCann, L., Granter, E., Hassard, J., & Hyde, P. (2015). "You can't do both—something will give": limitations of the targets culture in managing UK health care workforces. <i>Human resource management</i>, 54(5), 773-791.</p> <p>Aroles, J., Hassard, J., & Hyde, P. (2021). 'Culture for Sale': The Effects of Corporate Colonization on the UK Museum Sector. <i>Organization Studies</i>, 0170840621989001.</p> <p>Hyde, P., Granter, E., Hassard, J., & McCann, L. (2016). <i>Deconstructing the welfare state: managing healthcare in the age of reform</i>. Routledge.</p>	<p>Thank you for these recommendations. These readings were very interesting; in particular, the ethnographic piece by McCann, Granter, Hassard, and Hyde (2015) was so relevant that we decided to include it in our revised manuscript.</p>