Leading change in health care: the challenge of anxiety

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Abstract

Purpose – The purpose of this paper is to identify the centrality of anxiety in health care, especially in the context of leading change. It identifies the importance of emotional labour for clinical professionals and the resultant development of defensive routines. The idea of containment is central to addressing anxiety.

Design/methodology/approach – The approach involves identification of anxiety as a key factor in leading change in health care, but one which is often ignored.

Findings – Anxiety is the elephant in the room vis-a-vis leading change in health care. To address the use of defensive routines, a range of activities can act as "containers" for anxiety and help with leading change.

Practical implications – To lead change in health care implies addressing the existence and importance of anxiety and the emotional labour which health-care professionals undertake.

Originality/value – The existence of anxiety and the profound impact it has on leading change in health care has typically been under-estimated or avoided. The paper aims to remedy this.

Keywords Change, Health care, Emotional labour, Anxiety, Containment

Paper type Conceptual paper

Introduction

This paper identifies anxiety as a key and ever-present feature of health-care organisations, which is exemplified by the emotional labour conducted by front-line employees. Anxiety is evident in individual behaviour and the defensive routines adopted to deal with it. However, anxiety has been something of an "elephant in the room", being largely avoided or denied. The growth of managerialism in health care has exacerbated such anxiety, aided and abetted by university business schools propagating generic approaches to managing. Individual and organisational approaches which acknowledge and engage with such anxiety are identified.

Anxiety

Anxiety is best described as distress or uneasiness caused by fear of danger or misfortune. This may be real or imagined, clear and present or vague and anticipated and threatening physically, emotionally or psychologically.

Anxiety has a "Goldilocks" relationship with personal and organisational change (Briere *et al.*, 2017). If a person experiences too little anxiety there is no motivation to change. If they experience too much there are likely to be destructive or self-limiting effects. They are likely to deny, deflect, distort, defend or be otherwise too fearful to change. They will be wary of trusting others and try to avoid any experimentation. Only when there is enough anxiety to motivate a search for new thoughts and behaviours, but not so much as to lead to fearful debilitation can anxiety enable change (Marshak, 2016) and provide the energy needed to risk being honest, direct, challenging and different.

Change makes most people anxious and their reactions to change are not solely rational or intellectual processes, but are also emotional, because people will have previously experienced both positive and negative personal reactions to change which they view

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through the template of their own emotional and psychological history. Such experiences will have been shaped and conditioned through family, work, professional, organisational and social groupings and been influenced by broader economic, social and political forces operating in employing organisations and across the wider society. As a result, people typically deploy a range of emotional and perceptual filters as a means of anxiety-reduction, including denial, avoidance and over-simplification (Edmonstone, 2019).

Anxiety is ever-present in all health-care organisations yet seems to be missing from most accounts of leading change in such organisations. The backdrop to anxiety relates to the VUCA (volatility, uncertainty, complexity and ambiguity) context within which all organisations now operate, to the extent that the current era has been termed the "age of anxiety" (Day, 2020), but more especially to the emotional labour which is an everyday reality for most health-care clinical professionals.

Emotional labour

Emotional labour is a psychological defence mechanism – the "suppression of private feelings in order to sustain a desirable work-related outward appearance that produces in others a sense of being cared for" (Mastracci *et al.*, 2012). In practice it involves:

- Depersonalisation and categorisation of patients.
- Cultivation of a dispassionate professional detachment and self-control – a "caring but distant" demeanour which suppresses and controls emotions (Bolton, 2001).
- Ritualistic task performance to detailed and standardised procedures, involving checking and rechecking of decisions and form-completion used as avoidance. Paperwork becomes a way to avoid blame and manage risk. It becomes the main criterion by which work is assessed and inspected, creating a cycle of behaviour which prioritises bureaucracy over people (Bunting, 2020).
- "Responsibility-shifting" - delegation upwards in the hierarchy to seniors to avoid personal responsibility.
- Suspicion of change – or alternatively an obsession with regular reorganisations. Ballatt and Campling (2011) suggest that rather than resistance to change, an uncritical acceptance of constant and inexorable organisational change in most health-care organisations has now taken its place. The almost evangelical approach to such change exemplified by politicians, health-care leaders and managers and by management consultancies can be seen as a defence mechanism itself, denying the complexity of providing health care to people who may suffer and die. It may also be the case that such reorganisations involving further organisational change simply overload the health-care system and create ever more dangerous levels of anxiety. Ham *et al.* (2015) suggest that the pace of change within the NHS has created a crowded policy context and has generated confusion among staff between different programmes and their impact.

Health-care clinical professionals routinely seek to control their personal feelings and any revealing emotional expression (Hochschild, 1983) because a premium is placed on being dispassionate and keeping their distance, so the exercising of detachment is prized. Over time, this mismatch between peoples' felt and expressed feelings leads to "emotional dissonance" (Zapf and Holz, 2006) and eventually to emotional strain. The protection against anxiety that care-giving induces by the suppression of these personal emotions over a sustained period, especially when individuals are exposed to frequent emotional trauma, leads to a reduced ability to withstand the emotional toll of care – which, in turn, leads to

either personal burn-out or to an unhealthy cynicism, detachment, depersonalisation and objectification of patients, no longer noticing or acting on the distress of others, sometimes called "compassion fatigue" (Grandey, 2000). Defensive styles of coping then become entrenched. This is marked by the growth of a kind of personal carapace inured to reality to cope and to survive. The development of Evidence-Based Medicine and Practice (EBM/EBP) can be seen as a means of transferring risks from the individual professional to evidence-based routines, which thereby would decrease anxiety for the individual, but with the concomitant risk that patients receive care which may not be optimal for them (Andersson and Liff, 2012).

Menzies-Lyth (1959) identified social defence mechanisms operating for individuals in health care as a means of distracting them from the existential anxieties associated with the uncertainties of sickness, pain and death and the enormity of the task of dealing with them. Examples of anxiety-induced individual behaviour include (Edmonstone, 2019):

- *A reluctance to join in*: An unwillingness to be creative in terms of personal behaviour and ideas and to ask the "What if [. . .]?" questions, resulting in highly "serious" behaviour.
- *A narrow self-view:* Low self-assessment of personal abilities and resources with a resulting "resource myopia" – an inability or unwillingness to recognise the valuable personal contributions that might be made.
- *Fear of losing face:* Worry about being perceived as having admitted to personal or professional incompetence or as having backed down.
- *Fear of recrimination*: An assumption that colleagues might misunderstand changed behaviour and get angry or resentful.
- *Fear of losing control*: Making matters worse than they might already seem to be.
- *Fear of failure:* In the eyes of colleagues in the employing and other organisations. Fearing the possibility of failure promotes difficulty in taking even calculated risks.
- *Fear of ambiguity*: An avoidance of those matters which lack clarity or where possible outcomes are unknown or unpredictable. A reluctance to try something out, to see whether it works or not and an over-emphasis on the known at the expense of the unknown.
- *Fear of disorder*: A dislike of complexity (often labelled as "confusion") and a preference for order, structure and balance, often expressed in terms of opposites, such as good versus bad or right versus wrong, with a corresponding failure to appreciate and integrate the best from such seemingly polarised viewpoints.
- *Fear of looking foolish*: Attracting negative comments from colleagues as having acted "out of character".
- *Fear of being vulnerable*: Of not really knowing what might happen as a result of trying an alternative approach.
- *Fear of letting someone else make a big mistake*: Feeling responsible for what another person or persons do.
- *Fear of influencing others:* A concern not to appear aggressive or "pushy" and hence a hesitation in identifying with emerging views.

This leads to the development of defensive routines or patterned avoidance behaviours (Argyris, 1985) – unconscious strategies for self-protection which inhibit the potential to learn – as exemplified by:

- *Spending time on inconclusive deliberations*: These are endless, unproductive and unsatisfactory meetings where decisions are regularly not reached or where the same issues permanently reoccur. It is the arena of the "definite maybe" and the "waver game" where a group cycles back and forth between two or more alternative decisions without ever coming to a final conclusion. When they almost get there, they immediately flip back to the opposite possibility and so the game begins again.
- *Surface-skimming*: It is not possible to fit the complexities and unpredictability of organisational life into an idealised and rational model as they are, by their very nature "messy" and the messiness of such situations can feel highly disturbing, especially by those who have a need to feel always in control and who, as a result, miss the opportunities for deeper learning about underlying concepts and assumptions. Attempts are usually made to minimise such discomfort by reducing complexity through ever-tighter organisational controls and an even greater focus on desired outcomes. This ignores opportunities for deeper learning that can create greater clarity about the possible choices available. It can also lead to misunderstandings, as there is insufficient space to inquire into underlying concepts and assumptions. Deeper reflection is avoided because it would mean exposing and then experiencing situations as being much more complex than originally envisaged, so increasing frustration and anxiety.
- *Believing that everything is urgent*: This relates to a "hurry sickness" characterised by a preference for non-reflexive urgent action which is a feature of much health-care culture (Friedman and Booth-Kewley, 1987). Time spent in meetings with tight agendas, where decisions are avoided tends to acerbate this.

These strategies will have been acquired over time and through personal experience because it will be believed that they maintain personal safety. They have been described as examples of "dynamic conservatism" – the tendency (consciously or unconsciously) to fight hard to remain the same (Schon, 1973).

Research has also highlighted the organisational impact – the psychological costs of such change on health-care employees:

- Regular reorganisations have been shown to have detrimental effects on staff health and psychological well-being, especially when those affected feel that they have limited control over events (Bamberger *et al.*, 2012; Oreg *et al.*, 2011; Vahtera *et al.*, 1997).
- Repeated or multiple experiences of organisational change appear to have detrimental consequences for employees' mental health (Flovik *et al.*, 2018).
- When such changes involve a reduction in the numbers of staff, those who remain experience "survivor syndrome" – a form of trauma involving guilt, anger, anxiety, fear and apprehension (Applebaum *et al.*, 1997; Wolfe, 2004).

More recently health care has been marked by the incidence of post-traumatic stress disorder (PTSD), severe depression and heightened anxiety demonstrated by many staff as a result of the Covid-19 pandemic (Greenberg *et al.*, 2021) and recently described as a form of "moral injury" (Slade, 2021; Alexander, 2021) – the distress that arises in response to actions or inactions that violate personal moral codes.

The impact of managerialism

Health care was previously marked by the notion of "domain theory" (Kouzes and Mico, 1979; Edmonstone, 1982). This proposed that health care was made up of three separate but loosely coupled domains. Each domain operated by different and contrasting principles,

success measures and work modes – and interactions between domains created conditions of disjunction and discordance. The domains were:

- *A policy domain*, or the level at which strategic-level governing policies were formulated and pursued by elected or appointed representatives and which highlighted the importance of corporate governance and probity. The structure was one of representation, the success criteria were those of equity and economy and the work mode was one of voting and/or bargaining.
- *A service domain* comprised the health-care professionals who considered themselves capable of some form of self-governance and so emphasised their autonomy and self-regulation – and who had the requisite clinical expertise to respond to the needs and demands of patients. The structure was collegial, the success criteria were quality of care and good practice and the work mode was patient-specific.
- *A management domain*, based on principles of hierarchical control and coordination and which attempted to mirror the ideology and approach of industrial and commercial management. The structure was bureaucracy, success was based on notions of efficiency and effectiveness and the work mode was one of planning and control.

Each domain was seen as being internally consistent but incongruent with each of the other domains. Interaction between these domains with separate and distinct identities produced an organisational form which was internally somewhat disjunctive and discordant, with a limited sense of overall coherence and connectedness. People in each domain collected only that information which was needed to purse their own purposes and to perform their own roles and selectively ignored or discounted information produced from other sources and thus frequently arrived at incompatible conclusions. "Problems" were only those things affecting one's own measures of success – so one domain's solution to that problem could well result in being a problem for another domain.

From this perspective a health-care organisation was a loose coalition, a diverse plurality of power-holders, drawing their power from a variety of different sources. Some degree of conflict was inherent and ineradicable – and might even, in some respects, be both positive and functional (Blackler and Kennedy, 2006).

From the 1980s onwards the policy domain was increasingly staffed by appointed people who, consciously or unconsciously, subscribed to a neoliberal managerial ideology (Davies, 2017). This policy domain then appointed the key managers and shaped the priorities of the management domain. Developments such as the introduction of clinical directorates in hospitals covering individual or grouped medical specialties sought to incorporate the service or professional domain, with doctors being encouraged to take on the role of Clinical Director with responsibilities for managing staff and budgets – a part-time managerial role – in addition to existing clinical commitments. Over time, a clear hierarchy was developed, whereby the service domain became beholden to the management domain, which in turn was appointed and directed by the policy domain, made up of Government appointees. These developments were part of what was termed the New Public Management (NPM) which, although advanced as a neutral theory of management and a means of securing increased efficiency in public services, had profoundly ideological underpinnings and was a programme for far-reaching cultural change (Cottam, 2018). NPM asserted that all organisations possessed more similarities than differences and that performance in all organisations could be optimised by the application of a set of common management theories, skills and techniques (Ward, 2011). They could (and therefore should) be managed

in the same way as any private sector organisation, despite the fact that, for most, they did not have the reconciling function of profit and that leadership in such organisations often had to be "selfless" (Brooke, 2016).

The role of university business schools

Business schools in higher education have consistently propagated a view that leadership and management is generic across all kinds of organisations. They seek to teach what Aristotle (2004) referred to as "episteme" or "know-why" – context-independent, impersonal tools and techniques based on the assumption that knowledge is universal, timeless and invariable. Such teaching is that of explicit knowledge (Polanyi, 1966) or what Revans (2011) called programmed knowledge. Business schools have often advanced a mechanistic formula for generic management knowledge and skills grounded in an "identikit" of how-things-ought-to-be competences and based on a preference for universality and standardisation (Shenhay, 1999).

(As a personal vignette, the author took on an honorary position with a health-care centre based in a university in 1987, where he taught on and became module director for a Human Resource module of a health-care MBA programme. The centre comprised around 20 people, involving health economists, IT experts, finance staff, political scientists, clinical professionals and health-care managers. In 2008 the centre was merged with other university departments under the heading of "public policy". By 2011 all that remained were two professors and an administrator and they were given an early retirement package. The author acted as academic supervisor for seven years for he "tail" of students completing their dissertations before the relationship terminated in 2019. Health-care staff wishing to pursue an MBA at the university are now only able to access a generic programme run from the business school).

Addressing anxiety

One way to deal with anxiety is to seek sanctuary in the views of "experts", who seem to provide anxiety-reducing answers and offer what seems like safety and security. This is often the realm of management consultants who appear to offer "magic bullets" to resolve challenges. Lawrence (2000) contrasts what he calls the "politics of salvation" with the "politics of "revelation". The former involves seeking to rescue people by giving them solutions and not letting them take the authority to make decisions for themselves. As such, it is conceived as a regressive approach – a move away from facing uncertainty and anxiety by creating an illusion of certainty. It is a false prospectus because ultimately there is no real alternative to people owning, focusing on and working on their own challenges, often with facilitative help, with all the messiness, confusion and uncertainty which that entails. The latter involves creating the conditions for people and systems to discover and transform situations for themselves.

Confronting anxiety may involve individuals relinquishing earlier roles, ideas and practices to create, find or discover new and more adaptable ideas, ways of thinking and acting and coping with the instability of changing conditions and the insecurity which change provokes. This is the process of "unlearning" where well-established patterns of thinking and behaviour are interrupted and breached and redundant mindsets are re-evaluated, re-positioned and embodied within a wider repertoire of possible responses. It is not about forgetting, but is concerned with advancing by slowing down, stepping back and letting go from prior understanding that may limit the future (Brook *et al.*, 2016; Chokr, 2009). It involves the cultivation of what the poet John Keats described as "negative capability", a state in which a person "is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after facts and reason" (Keats, 1899). Negative capability

involves reflecting on and re-ordering half-formed ideas in a state of potential and deferred judgement in which more complex transformations can occur (McAra-McWilliam, 2007).

Containment

Confrontation of anxiety requires the creation and use of what has been called a "container", a metaphor based on the alchemical notion that thoughts and feelings have to be held safely for any positive change to occur. It implies a safe psychological space and an enabling framework operating as a transitional arena for feelings and emotions, as well as rational calculations, to be expressed, to enable what may be unique to emerge, rather than slipping into well-meaning but premature understandings and solutions that avoid discomfort and effort (French, 2001).

Containment is the work of facing up to, understanding and managing emotions that are aroused by change, rather than simply engaging in defensive routines. It is a benign process of support and challenge. Support (or emotional warmth) helps people to feel confident and encourages them. Challenge opposes conventional ways of doing things and seeks alternatives. Support cannot simply be engineered but takes time to build. An appropriate degree of support is often needed before any real challenge can be acceptable. The latter is likely itself to generate anxiety, which can potentially have destructive or self-limiting effects, but can also provide the energy needed to risk being honest, direct, challenging and different.

Learning in this way involves vulnerability and risk-taking as people admit to the limits of their understanding or even to a lack of understanding. This can be facilitated by an atmosphere of trust, such that people may feel psychologically safe to both unlearn and learn (Coghlan and Rigg, 2012) and of empathy – "the ability to identify with what someone else is thinking or feeling and to respond to their thoughts and feelings with an appropriate emotion" (Baron-Cohen, 2012).

Addressing anxiety

If anxiety is a major feature of health-care organisations, how may it be successfully addressed? The first and most important factor is to recognise that this is indeed the case and to cease the pretence that such organisations are completely similar to others and that generic approaches are what are required. There are a range of activities which can help health-care employees operate successfully in an anxiety-suffuced environment. They include:

- Clinical supervision (Milne and Reiser, 2020)
- Action learning sets (Edmonstone, 2011)
- Schwartz rounds (Maben *et al.*, 2018)
- Buddy pairs (Fo and O'Donnell, 1974)
- Coaching (De Haan and Burger, 2014)
- Mentoring (Garvey *et al.*, 2009)
- Reverse mentoring (De Vita, 2019)

While these interventions can assist individual health-care workers, there is also an organisational impact. Bain (1998) extended the focus from clinical professionals to the wider "system domain fabric", which included organisational structures, roles, relationships and authority and accountability systems; policies and procedures and information systems; professional education and training and funding arrangements. The health-care workplace has been described as a "potentially explosive cauldron of, often unexpressed, emotional

dynamics" (Walton, 2021). These unconscious defence mechanisms permeate health-care organisations as "emotional toxins" (Hinshelwood and Skogstad, 2000) evidenced in structures, roles and work processes and so have a major, but largely unrecognised, impact on the way they operate.

Without a considered approach to harnessing such initiatives the danger is one of creating isolated pockets or "cultural islands" blocked by numerous barriers and boundaries to transmission and exchange. It requires means of avoiding *ad hoc* and short-term activities with limited reach and scope. Nicolini (2013) has described this as a "rhizomatic" approach – a rhizome being a bulb that extends roots in different directions – a variety of relationships and associations that extend in space and time to form a large, intricate and evolving texture of dependencies and references which enable relationships and dialogue to continue and develop beyond the level of the individual or group. The term "learning architecture" has been coined to describe this (Wilhelm, 2005; Pedler *et al.*, 2007) the way an organisation promotes and structures learning at both individual and organisational levels.

Conclusion

Anxiety is a feature of all health-care organisations, with an impact at individual and organisational levels and is marked by the emergence of a series of social defence mechanisms. A managerial world-view has predominated over a previous perception of health-care organisations as being comprised interlocking domains and this has been reinforced by university business schools increasingly offering generic management programmes only. To address anxiety in leading change requires the use of a range of interventions which act as containers for such feelings and these need to be integrated into overall learning architectures which extend into and permeate health-care organisations.

References

Alexander, M. (2021), "NHS staff are suffering from 'moral injury', a distress usually associated with war zones", Guardian, 12th April.

Andersson, T. and Liff, R. (2012), "Does patient-centred care mean risk aversion and risk ignoring? Unintended consequences of NPM reforms", *International Journal of Public Sector Management*, Vol. 25 No. 4, pp. 260-271.

Applebaum, S., Delage, C., Labib, N. and Gault, G. (1997), "The survivor syndrome: the aftermath of downsizing", *Career Development International*, Vol. 2 No. 6, pp. 278-286.

Argyris, C. (1985), *Strategy, Change and Defensive Routines*, Pitman Publishing, London.

Aristotle (2004), *The Nicomachean Ethics*, Penguin, London.

Bain, A. (1998), "Social defences against organisational learning", *Human Relations*, Vol. 51 No. 3, pp. 413-429.

Ballatt, J. and Campling, P. (2011), *Intelligent Kindness: Reforming the Culture of Healthcare*, RCPsch Publications, London.

Bamberger, S., Vinding, A., Larsen, A., Nielsen, P., Fonager, K. and Nielsen, R. (2012), "Impact of organisational change on mental health: a systematic review", *Occupational and Environmental Medicine*, Vol. 69 No. 8, pp. 592-598.

Baron-Cohen, S. (2012), *Zero Degrees of Empathy: A New Theory of Human Cruelty and Kindness*, Penguin Books, London.

Blackler, F. and Kennedy, A. (2006), "The design and evaluation of a leadership programme for experienced chief executives from the health sector", in Rigg, C. and Richards, S. (Eds), *Action Learning, Leadership and Organisational Development in Public Services*, Routledge, Abingdon.

Bolton, S. (2001), "Changing faces: Nurses as emotional jugglers", *Sociology of Health and Illness*, Vol. 23 No. 1, pp. 85-100.

Briere, F., Pascale, S., Dupere, V., Castellanos-Ryan, N., Allard, F., Yale-Souliere, G. and Janosz, M. (2017), "Depressive and anxious symptoms and the risk of secondary school non-completion", *British Journal of Psychiatry*, Vol. 211 No. 3, pp. 163-168.

Brook, C., Pedler, M., Abbott, C. and Burgoyne, J. (2016), "On stopping doing those things that are not getting us to where we want to be: unlearning and critical action learning", *Human Relations*, Vol. 69 No. 2, pp. 369-389.

Brooke, S. (2016), *The Selfless Leader: A Compass for Collective Leadership*, Palgrave, London.

Bunting, M. (2020), *Labour of Love: The Crisis of Care*, Granta Books, London.

Chokr, N. (2009), *Unlearning or How Not to Be Governed*, Societas Imprint Academic, Exeter.

Coghlan, D. and Rigg, C. (2012), "Action learning as praxis in learning and changing", *Research in Organisational Change and Development*, Vol. 8, pp. 59-89.

Cottam, H. (2018), *Radical Help: How We Can Remake the Relationships between Us and Revolutionise the Welfare State*, Virago Press, London.

Davies, W. (2017), *The Limits of Neoliberalism: Authority, Sovereignty and the Logic of Competition*, Sage, London.

Day, A. (2020), *Disruption, Change and Transformation in Organisations: A Human Relations Perspective*, Routledge, Abingdon.

De Haan, E. and Burger, Y. (2014), *Coaching with Colleagues: An Action Guide for One-To-One Learning*, Palgrave Macmillan, Basingstoke.

De Vita, E. (2019), "Reverse mentoring: what young women can teach the old guard", Financial Times, 7 March.

Edmonstone, J. (1982), "Human service organisations: implications for management and organisation development", *Management Education and Development*, Vol. 13 No. 3, pp. 163-173.Autumn.

Edmonstone, J. (2011), *Action Learning in Healthcare: A Practical Handbook*, Radcliffe Publishing, London.

Edmonstone, J. (2019), *Systems Leadership in Health and Social Care*, Routledge, Abingdon.

Flovik, L., Knardahl, S. and Christensen, J. (2018), "Organisational change and employee mental health: a prospective multilevel study of the association between organisational changes and clinically relevant mental distress", *Scandinavian Journal of Work and Environmental Health*, Vol. 45 No. 2, pp. 1-12.

Fo, W. and O'Donnell, C. (1974), "The buddy system: relationship and contingency conditions in a community intervention program for youth with non-professionals as change agents", *Journal of Consulting and Clinical Psychology*, Vol. 42 No. 2, pp. 163-169.

French, R. (2001), "Negative capability: managing the confusing uncertainties of change", *Journal of Organizational Change Management*, Vol. 14 No. 5, pp. 480-492.

Friedman, H. and Booth-Kewley, S. (1987), "Personality, type a behaviour and coronary heart disease: the role of emotional expression", *Journal of Personality and Social Psychology*, Vol. 53 No. 4, pp. 783-792.

Garvey, R., Stokes, P. and Megginson, D. (2009), *Coaching and Mentoring: Theory and Practice*, Sage, London.

Grandey, A. (2000), "Emotion regulation in the workplace: a new way to conceptualise emotional labour", *Journal of Occupational Health Psychology*, Vol. 5 No. 1, pp. 95-110.

Greenberg, N., Weston, D., Hall, C., Caulfield, T., Williamson, V. and Fong, K. (2021), "Mental health of staff working in intensive care during Covid-19", *Occupational Medicine (Oxford, England)*, Vol. 71 No. 2, pp. 62-67, doi: 10.1093/occmed/kqaa220.

Ham, C., Baird, B., Gregory, S. and Jabbal, J. (2015), *The NHS under the Coalition Government: Part 1: NHS Reform*, King's Fund, London.

Hinshelwood, R. and Skogstad, W. (Eds) (2000), *Observing Organisations: Anxiety, Defence and Culture in Health Care*, Routledge, London.

Hochschild, A. (1983), *The Managed Heart: Commercialisation of Human Feeling*, University of CA Press, Berkeley, CA.

Keats, J. (1899), *The Complete Poetical Works and Letters of John Keats*, Houghton Mifflin, Cambridge.

Kouzes, J. and Mico, P. (1979), "Domain theory: an introduction to organisational behaviour in human service organisations", *The Journal of Applied Behavioral Science*, Vol. 15 No. 4, pp. 449-469.

Lawrence, G. (2000), *Tongued with Fire: Groups in Experience*, Karnac Books, London.

McAra-McWilliam, I. (2007), *Impossible Things?: Negative Capability and the Creative Imagination, Paper Presented at Conference on Creativity or Conformity?: Building Cultures of Creativity in Higher Education*, University of Wales Institute, Cardiff.

Maben, J., Taylor, C., Dawson, J., Leamy, M., McCarthy, I., Reynolds, E., Ross, S., Shuldham, C., Bennett, L. and Foot, C. (2018), "A realist informed mixed methods evaluation of Schwartz center rounds® in England", *Health Services and Delivery Research*, Vol. 6 No. 37.

Marshak, R. (2016), "Anxiety and change in contemporary organisation development", *OD Practitioner*, Vol. 48 No. 1, pp. 11-19.

Mastracci, S., Guy, M. and Newman, M. (2012), *Emotional Labour and Crisis Response: Working on the Razor's Edge*, Routledge, Abingdon.

Menzies-Lyth, I. (1959), "The functioning of social systems as a defence against anxiety: a report on a study of the nursing service of a general hospital", in Menzies-Lyth, I. (Ed.), *Containing Anxiety in Institutions: Selected Essays: Volume 1*, Free Association Books, London, pp. 43-88.

Milne, D. and Reiser, R. (2020), *Supportive Clinical Supervision: Enhancing Well-Being and Reducing Burnout through Restorative Leadership*, *Pavilion Publishing and Media*, *Brighton*.

Nicolini, D. (2013), *Practice Theory, Work and Organisation*, Oxford University Press, Oxford.

Oreg, S., Vakola, M. and Armenakis, A. (2011), "Change recipients' reactions to organisational change: a 60-year review of quantitative studies", *The Journal of Applied Behavioral Science*, Vol. 47 No. 4, pp. 461-524.

Pedler, M., Warburton, D. and Wilkinson, D. (2007), *Improving Poor Environments: The Role of Learning Architectures in Developing and Spreading Good Practice*, Environment Agency, Bristol.

Polanyi, M. (1966), *The Tacit Dimension*, Routledge and Kegan Paul, London.

Revans, R. (2011), *The ABC of Action Learning*, Gower Publishing, Farnham.

Schon, D. (1973), *Beyond the Stable State: Public and Private Learning in a Changing Society*, Penguin, Harmondsworth.

Shenhay, Y. (1999), *Manufacturing Rationality: The Engineering Foundations of the Managerial Revolution*, Oxford University Press, Oxford.

Slade, S. (2021), "Moral injury and the Covid-19 pandemic: reframing what it is, who it affects and how care leaders can manage it", *BMJ Leader*, Vol. 4 No. 4, pp. 224-227.

Vahtera, J., Kivimaki, M. and Pentti, J. (1997), "Effects of organisational downsizing on health of employees", *The Lancet*, Vol. 350 No. 9085, pp. 913-930.

Walton, M. (2021), "Listening with care and understanding: getting to the core of presented issues", *IUP Journal of Soft Skills*, Vol. 15 No. 1, pp. 7-19.

Ward, S. (2011), "The machinations of managerialism: new public management and the diminishing power of professionals", *Journal of Cultural Economy*, Vol. 4 No. 2, pp. 205-215.

Wilhelm, W. (2005), *Learning Architectures: Building Individual and Organisational Learning*, GCA Press, NM.

Wolfe, H. (2004), *Survivor Syndrome: Key Considerations and Practical Steps*, Institute for Employment Studies, Brighton.

Zapf, D. and Holz, M. (2006), "On the positive and negative effects of emotion work in organisations", *European Journal of Work and Organizational Psychology*, Vol. 15 No. 1, pp. 1-28.

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