

**The Lived Experience of being a Woman Doctor in Aotearoa/New Zealand
(Aotearoa/NZ): An Interpretive Phenomenological Analysis**

Jackie Hilton

A dissertation submitted to AUT University in partial fulfilment of the requirements for
the degree of Master of Psychotherapy

2022

Faculty of Health and Environmental Sciences

Department of Clinical Sciences

Discipline Psychotherapy

Supervisor: Paula Collens

Abstract

The objective of this study was to explore the lived experiences of three women doctors who had worked in medicine in Aotearoa/NZ for more than 20 years with a focus on the emotional aspect of their experiences. Data was collected via semi-structured interviews which were audio-recorded and transcribed. The resulting narratives were analysed using interpretive phenomenological analysis (IPA). From an emotional perspective Hochschild's concept of emotional labour was applied to the findings. This allowed emotions to be viewed through a sociocultural lens. The findings fell into three distinctive superordinate themes representing the societal, professional, and organisational dimensions of the women's experiences. These superordinate themes were titled 'Responsibilities of the medical role', 'Emotional management' and 'A pawn in a system' respectively. The research captured stories which as well as being personal were embedded within a particular time in history. From a personal viewpoint the participants described a variety of emotions connected with medical work, while societal, professional, and organisational expectations influenced how these were managed. As far as I am aware, this is the first study that explores the lived experiences of women doctors of an older demographic and provides new insights for doctors, psychotherapists, and their employers.

Table of Contents

Abstract	2
Table of Contents	3
List of Tables	4
Attestation of Authorship	5
Acknowledgements	6
Introduction	7
Literature Review	9
Women Doctors	9
Qualitative Papers investigating the Emotional Experiences of Doctors	9
Emotional Labour	11
Methodological Design and Approach	13
Epistemological Underpinnings of Interpretative Phenomenological Analysis (IPA).	13
Method	15
Participants	15
Recruitment.....	15
Ethical Considerations.....	15
Data Collection.....	16
Data Analysis	17
Reporting Findings	18
Researchers Reflexivity.....	18
Research Findings	19
Responsibilities of the Medical Role	20
The Weight of Caring	20
The Emotional and Relational Costs of Role Seepage.....	23
Emotional Management	25
Managing Intense Emotional States	26
Sharing or Going It Alone.....	28
Making a Difference: The Emotional Rewards	31
A Pawn in a System	34
Feeling Unrecognised.....	34
Value of Collaboration	36
Discussion	40
Limitations, Implications, and Future Directions.....	43
Conclusion	46
References	47
Appendix A: Participant Recruitment Advert	54
Appendix B: Participant Information Sheet	55

Appendix C: Question Guide for Semi-Structured Interviews	58
Appendix D: Consent Form.....	59
Appendix E: Ethics Approval.....	60
Appendix F: Approval of Amendments to the Ethics Application.....	61
Appendix G: Emerging Themes for First Case	62
Appendix H: Emerging Themes for all Cases	63
Appendix I: Patterns of Clusters of Themes	64

List of Tables

Table 1: Superordinate Themes and Sub-themes.....	19
---	----

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed _____ Date 1 Sept. 2022

Acknowledgements

Firstly, I would like to acknowledge the three doctors who so kindly gave up their precious time and agreed to participate in this study. Thank you for sharing your stories. I really appreciated your humility, honesty, and generosity especially at a time when work pressures were particularly intense.

Secondly, I would like to thank my supervisor Paula Collens who has been a wealth of knowledge regarding qualitative research and has guided me through this process, keeping me close to the data.

Also, thanks to Charles Grinter for his help with the ethics approval (Number 21/209 approved on 12th July 2021)

Finally, I would like to thank my husband, Paul for being part of my world. I can relate to Alice's story when I say that you provide something indescribably precious in terms of trust and a sense of shared understanding. Having you by my side seems to communicate something even without words, protecting me from feelings of isolation and a sense of holding emotions alone.

Introduction

This dissertation presents a qualitative study exploring the lived experiences of senior women doctors in Aotearoa/NZ. The desire to undertake such a study was motivated by my personal journey of a long career in medicine which culminated in psychotherapy training. As a young GP in England, I attended Balint groups which provided support to help doctors cope with the emotional aspects of their jobs, however with significant time pressures at that stage of my career, I prioritised learning medical facts rather than reflecting on emotional responses. It was not until I had psychotherapy that I started to really understand my own relational patterns and ways of managing emotions. I began to appreciate how unconscious relational and interactional dynamics had played out in my clinical work. A couple of particularly cathartic moments where challenging clinical experiences were reflected on with increased understanding inspired me to contemplate the emotional dimension of medical work and how emotions are managed over a long career. My question “The lived experience of being a woman doctor in Aotearoa/NZ” was formulated to explore this topic.

Spanning more than 30 years, my working life has undergone many modifications. During this period, the composition of the medical workforce has diversified significantly. In Aotearoa/NZ while women represented 32% of the practicing workforce in 2000, their numbers have steadily increased with a prediction that by 2025 women will outnumber men (Medical Council of New Zealand /Te Kaunihera Rata o Aotearoa, 2021). The number of women working as senior medical officers (SMOs) was small until relatively recently with women making up 9% of SMOs in 1990 although this had risen to 30% by 2012 (Else, 2018). The latest figures for 2021 reveal increasing numbers of women working as SMOs (37.3%) although in some specialties such as surgery, women are still underrepresented (Medical Council of New Zealand /Te Kaunihera Rata o Aotearoa, 2021). These trends are consistent with some other countries (NHS Digital, 2019). In addition, other changes such as the social standing of doctors, patient expectations as well as challenges regarding resourcing of healthcare have occurred. In these demanding working environments, the mental health of medical professionals has become more visible and the literature on burnout has exploded particularly during the last 10 years. These studies have found high rates of burnout in doctors regardless of gender, age, specialty and work setting although being female, young, working long hours, low job satisfaction and work/home conflict appear to increase the risk (Amofo et al., 2015; Imo, 2017; Marshall et al., 2020; Reynolds et al., 2021). Previous research seemed mainly to collect data using cross-sectional questionnaires allowing large numbers to be surveyed however only providing limited insight into the lives of those participating. I could find only a few qualitative papers exploring the lived experiences of

doctors particularly with respect to their emotional selves (Hubik et al., 2021; Nettleton et al., 2008; Stiefel et al., 2019). An explanation for this could be that within the medical profession, reason continues to be prioritized over emotion and the development of a manner of detached concern remains idealized in medical communities (Mcnaughton, 2013). This has perpetuated the pervasive belief that doctors are objective, rational and emotionally detached beings while other health professionals carry the bulk of the emotional work (James, 1989). As a result of the relative invisibility of emotions in the medical literature, a large range of doctors' experiences remains missing from any discussion of their working lives. This study therefore aims to explore this neglected area of research.

I have decided to examine the lived experience of SMOs as this group of professional women will have lived through significant changes within the social and medical landscape of Aotearoa/NZ. SMOs are doctors who have completed specialist medical training. The training can take 12-15 years to complete and involves obtaining appropriate qualifications and experience (SMO Commission, 2009). This qualification allows them to work independently without oversight provided they participate in an approved recertification program to assist them in maintaining their competence (Medical Council of New Zealand /Te Kaunihera Rata o Aotearoa).

The results of this study will be useful for psychotherapists working with women doctors as well as the medical profession generally. Doctors have historically not been good at asking for help and seeking therapy however highlighting the unique emotional events they are likely to experience will encourage discussion and debate regarding these issues (Garelick, 2012; Tomlinson, 2014). For psychotherapists working with women doctors, this study will provide insight into some of the dilemmas, contextual pressures and demands faced by those who navigate the medical world. The findings may also be of benefit to medical organizations by providing an appreciation of how workplace environments affect their doctor's mental health as well as illustrating strategies to protect this in the future.

Literature Review

The beginning of the journey to explore the lived experiences of women doctors will start with a look at the published literature on this topic. Research that will be reviewed in this chapter will initially focus on women doctors. The search will then be expanded to include qualitative research examining doctors' experiences regardless of gender. Similar to all healthcare professions, doctors work in the context of emotionally charged environments. I will therefore explore the concept of 'emotional labour' and what has been written about this in relation to healthcare workers.

Women Doctors

In response to the changes in composition of the medical workforce to include women, there was a proliferation of published research on women doctors' challenges and achievements after 1970 (Anderson, 1993). Particularly during the last 15-20 years articles focusing on job satisfaction, work-life balance and burnout have appeared in the literature. Most of these articles collected data using questionnaires and sampled large numbers, finding women were more likely to report symptoms of burnout than their male counterparts particularly if they considered they had little control over their work-life (Frank et al., 1999; McMurray et al., 2000). A few qualitative studies were identified. These continued with the theme of understanding potential gender inequalities, including why women continue to be underrepresented in leadership roles and overrepresented in the burnout statistics (Chambers, 2019, 2021; Chambers & Frampton, 2016; Marshall et al., 2020; Schueller-Weidekamm & Kautzky-Willer, 2012). After a survey investigating burnout amongst SMOs in Aotearoa/NZ found very high rates of self-reported symptoms amongst women ages 30-40 years, Chambers followed up with a qualitative study of 14 women in this age group (Chambers, 2019). Several themes emerged from this research including difficulties in work-life balance, an expectation of the prioritizing of medical work and the persistent presence of gender stereotypes within the medical system. Another study collected data from women doctors in their 20s and 30s who worked in various specialties in London (Allen, 2005). Again, the emphasis was on work-life balance and the results suggested that time management as well as juggling work and family was stressful for the women who participated. A further search found no similar papers exploring the lives of an older demographic.

Qualitative Papers investigating the Emotional Experiences of Doctors

Exploring the literature for detailed analysis of doctors' lived experiences regardless of gender, produced few studies. Despite societies fascination for books and TV series depicting doctors' lives, there appears to be little written in the academic sphere

regarding their working experiences. However interestingly most of the relevant papers were published relatively recently perhaps indicating a recognition that doctors are no different from other humans and are feeling as well as thinking beings. In 2008 Nettleton interviewed 32 men and 20 women from various medical specialties working for the NHS in England. She asked the question “How do you feel doctor” and collected data on the emotional aspects of routine medical work. Along with a myriad of emotions experienced, her results highlighted the presence of ambivalence as doctors attempted to balance their needs with those of their patients, between empathy and rationality, frustrations and achievements as well as work and home life (Nettleton et al., 2008). Significantly, she found some older doctors expressed nostalgia for a changing medical system as well as a general resistance amongst both men and women participants to the idea of overt sexism. This latter finding was replicated in a recent PhD which found that although most women doctors suggested they had been subject to sexist comments, these were so socially embedded as to be dismissed by the women receiving them (Vedi, 2021). Eighteen Japanese doctors (12 men and 6 women) were interviewed for a study in 2019. Thematic analysis of the transcribed data revealed a lonely physician with a tough job, torn between the ideal of patient-centered care and clinical reality, unsupported by peers, institutions and society (Stiefel et al., 2019). Exploring the emotional aspects of working in a palliative care service in Melbourne, Hubik interviewed 20 doctors. A multitude of emotions were expressed by the participants in response to patient, family, and staff distress as well as organizational issues. Strong emotional reactions were found to have an impact on the clinical care provided and the doctors’ personal lives (Hubik et al., 2021). A qualitative study of 22 medical oncologists’ experiences of their profession and work sustainability collected data through interviews. The findings revealed performance pressure, the need for mentoring, the emotional labour of caring for patients with cancer and the impact of a rapidly increasing workload (Broom et al., 2016).

All these studies highlighted the tension between medicine as an expert system which is objective, trustworthy and effective and the emotionally charged situations inherent in medical work. As the clinician responsible for profound matters of life, death and suffering, doctors tread a fine balance between their emotional and rational selves. In addition to being technically skillful, there is increasing appreciation of the importance of empathy in the doctor/patient relationship (Larson & Yao, 2005). Empathy is the ability to attend to both others’ feelings as well as one’s own and is considered important for good patient outcomes however involves emotional labour (Kerasidou & Horn, 2016). To support doctors in this endeavor, some have suggested that a change of culture is required within medicine including a focus on compassion and time for Balint or similar support groups (Fowler et al., 2019; Sternlieb, 2018; Youngson, 2012).

Emotional Labour

Emotional labour will be used in this study as a lens through which to view my findings as well as to ground the research within the medical literature. Viewing emotions in sociocultural terms, Hochschild explored how people manage their emotions within the workplace (Hochschild, 1983). Her theory described how emotional labouring involves two processes; surface and deep-acting (Hochschild, 1979). Both involve a degree of self-deception and are used to manage the tension between real and required feelings. With surface-acting the individual is aware that she is expressing feelings that are socially expected and actively suppresses the real emotion, while with deep-acting the individual has worked to create the desired emotional response which appears to come naturally. A persistent disconnect between inner feelings and outer expression Hochschild considered was likely to cause psychological harm. Regarding gender, Hochschild theorised that because of having less power and authority in society, women used feelings as a resource. Affirming and satisfying the needs of others through emotional labour could provide secondary gains which were misunderstood as a natural part of a woman's being (Hochschild, 1983). The original model as well as recent modifications, recognises that not all the effects of emotional labouring are negative. If emotional work results in positive responses from others, then the effort can be experienced as extremely rewarding (Sakiyama, 2009; Wharton & Erickson, 1993).

Although Hochschild's original studies were designed to understand the commercial use of emotion within the work environment, the concept has been applied to any situation where individuals must manage their emotional responses to create a desired response in another individual. In emotionally charged environments such as the medical system, the use of emotional labour although essential for good patient outcomes is often unrecognised and unappreciated. The recognition of burnout amongst healthcare professionals has resulted in research investigating the association between emotional labour and burnout (Bondarenko et al., 2017; Kim, 2020; Lee et al., 2010). A review of 20 papers investigating emotional labour in mental health nurses found three emergent themes which included 'emotional labor and caring' 'emotional exhaustion' and 'self-protection' (Edward et al., 2017). Having support in the workplace was identified as necessary to prevent the cumulative effects of emotional labour as were self-protective mechanisms such as having a clear sense of professional identity.

Despite a significant increase in the number of papers investigating emotional labour in health professionals, doctors are underrepresented in these studies as illustrated in two recent literature reviews (Riley & Weiss, 2016; Załuski & Makara-Studzińska, 2018). My search found that most of the papers where doctors were recruited employed self-reported questionnaires using validated tools and sampled large numbers (Lin & Chang, 2015; Liu et al., 2018; Psilopanagioti et al., 2012). These studies found that managing

emotions through surface-acting had a negative impact on job satisfaction while the effect of deep-acting was more complex.

In summary this literature review illustrates the relative lack of research exploring the lived experiences of doctors. The medical profession has historically been dominated by men although this is rapidly changing. Within healthcare settings the use of emotional labour has recently been highlighted as a previously invisible aspect of working lives although mainly amongst nursing professionals. My research aims to make visible some aspects of women doctors' lived experience at a time when both gender stereotypes as well as medical culture are being questioned.

Methodological Design and Approach

This study aims to describe, understand, and interpret the meanings made by a group of women doctors about the emotional aspect of their working lives. Considering the multi-layered, dynamic nature of this undertaking, a critical realist ontology has been chosen with interpretive phenomenological analysis (IPA) as the methodological approach and analytic method. IPA was chosen in preference to thematic analysis due to its allegiance to phenomenology and its widespread use in researching psychological phenomena.

Critical realism assumes there is a single reality but we cannot know for sure (Grant & Giddins, 2002). Any knowledge about reality is historically, socially, and culturally embedded. In my study women make meaning of their lives within a relational, socio-historical, and cultural context and there is no perfect way of determining the truth.

In order to understand some of the key ideas and epistemological underpinnings of IPA, I will firstly describe the theoretical origins of this methodology before explaining the method.

Epistemological Underpinnings of Interpretative Phenomenological Analysis (IPA)

Phenomenology is a philosophy initially conceptualised by Edward Husserl in the early 1900s. The original theory was concerned with the study of the structure of consciousness and the content of conscious experiences or phenomenon. From the perspective of qualitative inquiry, phenomenology has been used to create the conditions for the study of topics which are subjective in nature such as judgements, perceptions, and emotions (van Manen, 2017). The structure provides a tool to understand and describe “the thing in itself” recognising that what is perceived of other individuals lived experiences requires reflective attentiveness, unburdened by preconceptions and intellectualising. This involves the notion of “bracketing” or being aware and setting aside foreknowledge and prior assumptions which could otherwise unduly influence understanding (Pietkiewicz & Smith, 2014).

Expanding on these ideas Heidegger incorporated hermeneutics, believing that consciousness is not separate from the world but part of it. Supported by other existential philosophers such as Sartre and Merleau-Ponty, the idea of deliberate naivete and seeing things as they truly are, was considered impossible. They believed that human experience is embedded within a particular historical, social, and cultural context and cannot be understood separate to this. Hermeneutics, which were initially applied to the interpretation of religious texts, has more recently been used to appreciate that both verbal and non-verbal communication requires interpretation within the context of time and place in the world.

Combining both phenomenology and hermeneutics, IPA demands that a balancing act be maintained by the researcher. From a phenomenological perspective the researcher is required to give voice and stay close to the participants world while the interpretive aspect recognises that complete understanding is impossible and involves constant reflection. This involves a double hermeneutic where the researcher attempts to make sense of the participants who are making sense of their lived experiences (Smith, 2004). Any access to the experience is both partial and complex and is constructed by both the participant and the researcher (Larkin et al., 2006). The analytic process is dynamic and involves the hermeneutic circle on many levels. Starting with the relationship of the researcher and the participant during initial data collection, the subsequent data analysis involves repeatedly moving from the whole to the parts and back again (Smith, 2007). IPA is strongly idiographic. This requires that each case is examined in detail before moving onto the next (Smith, 2004). The Interpretation of the uniqueness of the individual occurs before considering the group as a whole through a cross-case analysis. By following this format all voices are heard and both the differences and similarities across the cases can be explored without compromising the depth of the analysis (Smith & Eatough, 2011).

Another feature of IPA is the application of inductive techniques which facilitate the emergence of new data (Pietkiewicz & Smith, 2014; Smith, 2004). The question being studied is kept purposefully open and broad. There is no hypothesis to prove or disprove and the flexibility of the process allows unpredicted research findings to emerge without constraints.

Questions suitable for IPA include those concerned with experiences of considerable importance in the participants lives. They can either tap into urgent, specific dilemmas or “hot cognition” or involve longer term reflection across a lifetime as with “cold cognition” questions (Smith & Eatough, 2011). In the case of my study, I wanted to explore my participants emotional experiences over a long medical career, which fits the later criteria of an appropriate question for IPA.

In summary, IPA is equipped with all the tools necessary to conduct a rich descriptive study open to emerging surprising data (Alase, 2017). Drawing on phenomenology, hermeneutics and idiopathic theory IPA explores the stories of study participants assuming that a truth is generated from human interactions where the researcher is actively listening and attempting to hear the narrative from the participants' perspective. However, although the findings will contribute to the existing psychological research, the interpretive nature of this process recognises that absolute truth is impossible and all knowledge is emersed in a particular time and place.

Method

Participants

Participants for this research were three women doctors who were presently medically registered and working as SMOs and had worked in Aotearoa/NZ for at least 20 years. The inclusion criteria included all medical specialties and workplaces within easy reach of Auckland including private medical facilities and district health boards (DHBs). This geographical criterion was initially applied so that face-to-face interviews could occur although a Covid-19 lockdown meant that not all interviews were in-person.

Recruitment

I invited SMOs who I had previously not known; a relative challenge considering the small size of the medical community in Auckland. Any personal relationship between a researcher and participant is likely to reduce the validity of the information collected. A previous study had recruited participants through an advert on the “Women in Medicine” Facebook page (Chambers, 2019). I was not a part of this group and felt it was an appropriate way to recruit women for my study. An advert (Appendix A) was placed on this Facebook page and invited women to participate in the research. This purposeful sampling strategy is widely used in qualitative research for identifying appropriate participants. Due to time restraints and the nature of qualitative research, the sample size needed to be small (Creswell, 2013; Smith et al., 2009). It is valid in IPA research to use small numbers and the AUT psychotherapy department approved a sample size of three participants for this project.

Each eligible participant was emailed an information sheet (Appendix B), question guide (Appendix C) and consent form (Appendix D). The information sheet emphasised the voluntary nature of participation and the right to withdraw at any stage up to transcription of the interview data. In addition, the aim, and method of the research was clearly documented to enable the participants to provide informed consent. Creswell highlights the importance of participants being aware of what is expected of them particularly if the research involves the gathering of sensitive personal information (Creswell, 2012). The question guide included questions regarding the emotional aspects of their clinical work, working environment, and personal relationships outside work. Recognising that not all doctors are comfortable talking about the emotional aspects of their lives, I wanted to indicate the focus of my questioning so they could feel prepared.

Ethical Considerations

An application for ethics approval from AUTECH was completed and approval was granted on 12th July 2021 (21/209) prior to starting recruitment. A copy of the approval letter is

included (Appendix E). Research should serve the interests of the participants as well as the scientific community and the dignity and integrity of the participants must be protected at all times. Before the start of the interview informed consent was obtained and the limits of confidentiality discussed. The management of personal information including the audio-recording and transcripts was highlighted so participants were fully aware of how this would be safeguarded. Each participant was given a pseudonym and any identifying personal details were excluded from the write up. Ample opportunity was provided for questions to be answered before the collection of any research data. In the middle of the data collection period the onset of a Covid-19 lockdown prevented any in-person meetings and I applied for an amendment of the ethics approval to include the option for online interviewing. This was granted on 5th October 2021 (Appendix F).

Data Collection

IPA views participants as cognitive, linguistic, affective, and physical beings who are sense making creatures. The method assumes a connection between what people say, their thinking and their emotional state (Smith & Eatough, 2011). Consequently, a semi-structured face-to-face interview was considered the ideal way to collect my research data. Reflecting on the sensitive nature of my research question, I reasoned that meeting in person was preferable to online. Eventually due to conditions out of my control, two of the three participants were interviewed face-to face while one was conducted online. The in-person interviews took place on AUT premises in private, sound-proofed rooms providing a safe space for both parties.

All interviews were of 70-80 minutes duration and were audio-recorded. Despite having no experience with qualitative research interviewing, my time as a doctor and trainee psychotherapist provided ample opportunity for developing skills in communication and effective rapport building. Kvale discusses how a qualitative research interviewer should be clear, gentle, and sensitive to not just what is said but how it is said and what is excluded (Kvale & Brinkmann, 2009). As well as being knowledgeable about the topic, he describes how the interviewer needs to hold the space in terms of practical structuring of the time as well as emotional containing. Although the question guide provided an indication of what needed to be covered, the interview was participant lead, and I maintained an open stance. With each interview, I found that my process changed slightly. Although I had included some general questions at the beginning to build rapport, with subsequent interviews these were given less focus so other information relevant to the research could be given more attention (Smith & Osborn, 2003). In common with a psychotherapeutic session, I tried to listen on different levels as well as use reflection and clarifying techniques. However, from an ethical perspective I recognised that the focus of a research interview is different to that of a therapeutic

interview, and I needed to hold a delicate balance between the desire to obtain knowledge to answer the research question and caring for the participant (Kvale & Brinkmann, 2009). At the end of each interview, I asked for feedback regarding the process and gave a \$20 gift voucher as a koha for participating in my research.

Data Analysis

Smith describes six analytic steps of IPA (Smith et al., 2009).

These include

1. Reading and re-reading the transcript
2. Initial noting
3. Developing emergent themes
4. Searching for connection across emergent themes
5. Moving onto the next case
6. Identifying patterns across cases

The recorded interviews were transcribed with the aid of voice recognition software. I read the text many times and created a document with three columns. In this way I was able to engage in an interpretive relationship with the transcript (Smith & Eatough, 2011). The middle column contained the whole transcript, and I highlighted significant passages illustrating aspects of the research question with a yellow pen while using the right-hand column to comment on the narrative. Smith suggests commenting on the data in three different ways. A descriptive comment involves describing what is said, a linguistic comment involves how it is said, while a conceptual comment is a more interpretive form of analysis (Smith et al., 2009). The left-hand column was available to develop emergent themes. These themes summarised the essence of the relevant phrase, being grounded in the data however also involving enough abstraction to be conceptual. The emergent themes were copied onto paper, printed, and cut into individual themes which were analysed to find connections across themes (See Appendix G). Once the first case analysis was completed, I moved onto the next case. During this process I regularly sought guidance from my supervisor who highlighted any blind spots and assumptions I had made in the interpretation of the data. In this way the validity of the analysis was enhanced (Yardley, 2008). This allowed me to reassess some of my previous coding and stay closer to what my participants were actually saying (Smith et al., 2009).

At the completion of the three cases, all the emergent themes were listed on sheets of paper with the themes from each participant identified by a different colour spot. The individual themes were then cut and connections between the themes were identified by placing them all on a board (See Appendix H). These connections required multiple revisions however I started to notice clusters of themes (See Appendix I). Patterns of meaning was searched for by continually revisiting the original transcripts to ensure that

the themes stayed close to the data. In this way some of the themes were modified and others were discarded. After rejecting several attempts, I finally was able to construct a table of superordinate themes which appeared to reflect the essence of the data. Under the superordinate themes a list of sub-themes were identified which demonstrated different aspects of the superordinate theme (Table 1).

Reporting Findings

In the final write-up verbatim extracts were taken from the transcripts to support the sub-themes. These were interpreted within the context of the wider text. Care was taken to exclude any identifying information and participants were given pseudonyms. The symbol [...] was used to indicate deleted speech which did not change the meaning of the extract and italics were used if clarification of the context of the text was required. Any significant emotions associated with the words was included in brackets.

Researchers Reflexivity

For this research I wanted to get close to the participants personal world and to stand in their shoes however recognised that this would not be completely possible (Pietkiewicz & Smith, 2014; Smith, 2004). Any analysis of the information collected would be considered from my perspective and in this way, I would be active in the process, not only using my previous experiences to make sense of the participants making sense of their world but being immersed and changed by the process at the same time. Although I would attempt to “bracket” my history, beliefs, and biases, I am aware that any interpretation of the data will be influenced by my background which I will make explicit (Creswell, 2013). I trained as a medical doctor and have worked in the Aotearoa/NZ medical system for more than 20 years. Having this background positioned me as an insider researcher which affords both advantages and disadvantages in terms of undertaking this research (Blythe et al., 2013). My previous experience provided an insight into the potential rewards as well as the challenges encountered by my participants and during the interviews it became obvious that this perceived connection helped foster rapport with a sense of shared understanding. However, although providing an invisible bond to encourage trust during the interview, I quickly became aware that my experiences were also very different, requiring me to constantly reflect on potential blind spots in my subsequent analysis of the data. Presumptions and lack of objectivity are recognised disadvantages of an insider stance and regular feedback with my supervisor was implemented to ensure the credibility of the findings (Blythe et al., 2013).

Research Findings

The next three sections will present the research findings. Three participants were interviewed. Rose was in her mid 40s and was married with children. During her medical career she had worked for various DHBs in Aotearoa/NZ and was presently working for a DHB. Alice was in her early 50s, married with children. Although she had worked in a variety of DHBs in the past she was presently working in private practice. Daphne was in her late 50s and was also married with children. She had worked both for DHBs and in private practice although when she was interviewed, she was only working for a DHB. They were asked to talk about the emotional aspects of their clinical work, work environments and the emotional effect of their career on personal relationships. The transcribed data provided a snapshot of the women's meaning making of their working lives. From the epistemological perspective underpinning this research it is assumed that meaning making has been influenced by context, including familial historical backgrounds, the unique personality of the women, and their experiences within the medical contexts in which they each worked. Analysing the transcribed data using IPA, I identified three superordinate themes including 'Responsibilities of the medical role', 'Emotional management', and 'A pawn in a system' with associated sub-themes as presented in Table 1

Table 1
Superordinate Themes and Sub-themes

Responsibilities of the medical role	<ul style="list-style-type: none">• The Weight of Caring• The Emotional and Relational Costs of Role Seepage
Emotional management	<ul style="list-style-type: none">• Managing Intense Emotional States• Sharing or Going It Alone• Making a difference: The Emotional Rewards
A pawn in a system	<ul style="list-style-type: none">• Feeling Unrecognised• Value of Collaboration

Responsibilities of the Medical Role

All three women talked of feelings of responsibility which developed in conjunction with their roles as medical professionals. This responsibility was reflected in the descriptions of their early clinical experiences as well as situations they had to cope with throughout their careers. A pattern identified in the data involving the responsibility the women carried for their patients' and co-workers' was explored under the sub-theme 'the weight of caring'. Other experiences of responsibility were expressed when they described finding themselves relationally being drawn into the medical expert role whilst off duty. These experiences were connected under the second sub-theme 'the emotional and relational costs of role seepage'.

The Weight of Caring

All participants expressed how as junior doctors the sudden realisation that they were expected to manage life and death situations felt daunting although each woman's experience of this phase appeared dependent upon the level of support received. Later in their careers having gained significant clinical expertise, they became pragmatic regarding carrying complex ethical and clinical responsibilities however remained feeling ultimately responsible for co-workers and patient outcomes.

Rose expressed strong memories of challenging emotional experiences as a junior doctor. There was shock in finding herself responsible for others' lives while feeling uncertain and unprepared for such an expectation. She found herself in the position of making ethical decisions regarding how to medically manage death and dying with little support. This left her feeling anxious and at times she experienced physiological symptoms of panic. It was assumed that she would manage these dilemmas which she did although she remembers these times as awful. As illustrated in the following extract the weight of these experiences was exacerbated by the sense of feeling lost and on her own.

Rose: ...and feeling quite lost. I think I was probably just an average house-surgeon but not feeling very prepared for suddenly in the middle of the night people looking to me to know what to do when someone is dying [...] and the sense at the time was that I just don't know what I am doing and so responsible

In this extract Rose indicates a sense of overwhelm in her words "not feeling very prepared" which was exacerbated by being called upon at night. In the darkness and quietness of night, her words paint a picture of isolation while carrying the weight of expectation and responsibility. She talks of "I just don't know what I am doing and so responsible" implying a crisis in her belief that she could follow through and hold the

gravity of responsibility placed upon her. An empathic interpretation of her experience indicates she may have felt lost and unsettled by the enormity of responsibility in a context that felt unsupportive.

Although particularly challenging at the beginning of their careers, responsibility remained a prominent feature throughout these women's work-lives. As an SMO Rose remembered a situation where she was looking after a patient when she felt fearful for her safety as well as her co-worker's and yet still felt responsible as explored in the passage below.

Rose: he is advancing towards us, and he looks like he is going to hit my colleague and so I am willing him to leave [...] anyway, I managed to leave without being assaulted but really quite frightened and then...but feeling... I think that what was really awful about that I remained feeling really responsible [...] I just want someone to sit down and look after me but I'm feeling really responsible for the situation

In this extract Rose gives an account of a highly emotionally charged and frightening situation with a patient. Her description of "managing to leave without being assaulted" gives a clear sense of danger and precariousness in this work situation. The sense of fear is palpable in the text, as she talks of feeling "really quite frightened" and wanting someone to look after her. It is clear in this extract that the situation she found herself in was experienced as extremely distressing, and that she felt unsafe and longing for some form of protection, care, and reassurance. It is also evident from the extract that intense feelings of fear had to be navigated alone as Rose makes clear that she is the one feeling responsible for her colleague and patient. It seems that the role-related responsibilities involved in some instances during her career have involved volatile and unpredictable situations which were experienced as emotionally challenging within the context of still being the one who is responsible.

Responsibility for co-workers' wellbeing was also identified in Alice's narrative. She expressed how this had been accentuated during the Covid-19 pandemic with her role as a senior in private practice creating an extra level of responsibility with regards to keeping her patients safe particularly as many were not eligible for Covid-19 vaccination. This was stressful as she was required to make difficult decisions in a rapidly evolving environment to ensure she provided an adequate service to her patients in addition to keeping everyone safe.

Alice: I'm one of the principal people in the practice so I'm responsible for the safety of the other employees and so that's um.... you know that's been... it's

been a big learning curve...it's been interesting actually but... but it is quite a lot... it's tiring [...] I'm worried about the safety of um.... of the family ...um personal safety as well as you know where is medicine's going to go?

From this extract Alice initially suggests that the responsibility for her employees had resulted in a big learning curve which has “been interesting” however overall, the experience has been “tiring” and she is “worried” about the safety of people she cares for. Managing anxiety while presenting an optimistic perspective requires significant emotional labour. Fear for personal and others’ safety was articulated in two of the narratives and appeared more significant as the situations they described were unusual and unpredictable. Alice explained during the interview that the Covid-19 pandemic had been the most stressful time she could remember in her entire career, and I wonder if what I am hearing in the passage above is the enormity of her sense of responsibility for keeping everyone safe. She repeatedly mentions the word ‘safety’ in terms of worrying about her employees, her family, and her personal health. A sense of fear and overwhelm is present in her question at the end of her sentence with “where is medicine going to go?” which seems to encompass the uncertainty as well as the far-reaching dimension of her concerns during this particular time in her career.

The weight of caring was illustrated from a different perspective in Daphne’s account with an emphasis on the commitment she makes to her patients which comes before everything else. Her specialty requires that her patients completely trust her, and she takes that trust very seriously. Her words express the intensity of her feelings, and she finds it exasperating that other people don’t understand.

Daphne: I cannot do that.... I just cannot leave that person you know, and I cannot leave....and I try and explain to people too if there is a fire, I cannot leave that person either I have to stay...of all the people ...you know.... I have to stay with that person.... I cannot.... I made them a promise... that I would look after them.... (exasperated)... you know....and it's really hard.... people have got to give me control of them.....I have about 10 minutes to make a rapportto get a rapport with a person... some of them...the first time I meet them is 10 minutes before..... I have to get them to trust me enough to do some terrible things to them and look after them and so I don't you know.... I would stay with them until the end.... you know..... yeah, because that's what I promised

The depth of feeling is highlighted in the above extract as Daphne talks about her “promise” to her patients. This word implies a pledge of duty which feels absolute with her final declaration of “I would stay with them until the end” emphasising her

commitment. The weight of responsibility she feels seems to be reflected in the urgency of her language when she repeatedly uses the phrases “I cannot leave”, “I have to stay” and “I made a promise”. She talks of how hard it is to be in a position of control where people have to quickly trust and rely on her. A sense of aloneness is apparent in the text as she repeatedly uses the word “I” as well as the phrase “I try and explain to people” perhaps indicating a perception she is alone in her commitment as others don’t understand. The weight of her caring appears to be on her shoulders alone.

The Emotional and Relational Costs of Role Seepage

All participants recounted situations where their role permeated other parts of their life as if the job was not confined to the professional context but one that leaked into interactional life across the participants’ life worlds. In this way they described finding themselves in positions of responsibility when they weren’t working. While this was sometimes accepted as a duty which came with the job, at other times it was experienced as a heavy burden which stifled enjoyment. There was the feeling that medicine was a vocation rather than a job and as such doctors were ‘on call’ at all times.

In the interviews one area that emerged was the sense of responsibility to society. An extract from Alice is indicative of the way the women described being pulled into a medical interpretation role with non-medical friends and how this could strain these relationships.

Alice: ...so that's kind of frustrating sometimes trying to explain to people about... non-medical people about why this is that this is happening and so I think also you do take a lot of medical interpretation role with your friends who are non-medical...I take quite a bit of that which can be a bit tiring [...] and I you know ...you have you have to step back and withdraw from...from those relationships a bit because otherwise you'd go mad and I'm you know although I will say what I think I'm not one to argue on Facebook for instance

As this passage unfolds there is a shift from engagement to withdrawal. Initially she talks of doing a lot of medical interpretation as if this is something that is expected of her while at the end, she is making the decision to step back particularly from commenting on social platforms. There is a sense of exasperation in her narrative and the strength of her phrase “otherwise you’d go mad” suggests that considerable emotional effort is expended to control her frustration resulting in her feeling compelled to “step back and withdraw” rather than disclose her real feelings. From an emotional labour perspective, I wonder if she finds herself balancing a sense of social responsibility with maintaining her friendships, a position which requires at times both suppression of her true feelings

as well as significant reflective practice in order to understand different perspectives. Rose's narrative highlighted another aspect of role seepage as illustrated in the following two abstracts taken from different places in the interview. For Rose, there was a longing for lightness in her social interactions rather than feeling she should behave responsibly consistent with her medical role. She described how there was always the potential to be pulled into the medical expert role even when having a relaxing "cup of tea" with her non-medical friends. This affected her ability to enjoy these otherwise fun and superficial interactions.

Rose: I mean...I end up having this experience where they (*non-medical friends*) are really emotionally disclosing to me.....in a way that I really don't want...and I'm never quite sure if they want... but I think...I suspect it leaves them feeling really vulnerable....or I worry that it leaves them feeling quite vulnerable or maybe they feel quite good...so they drop their kid off and come in for a cup of tea and an hour later I know all the stuff that I didn't really want to know....and then I disclosed less and less of myself because it feels like we have moved into this other relationship....

Rose: or people say things to you and...I don't...I never know if they are seeking...asking as a medical expert or not....and that real so again I we are going to come back to responsibility again that sense of responsibility

Her words "I really don't want" and "I'm never sure they really want" suggests some confusion about what is happening during these conversations however Rose worries that she inadvertently becomes the powerful one when her friends disclose their vulnerabilities. In this way, she is positioned as the carer and becomes unable to reveal her true self. It appears that this role confusion (expert or friend) requires her to carefully manage her emotions, so she responds appropriately to the stories she is hearing. An empathic interpretation of her narrative suggests that instead of the light-hearted get together she craves, the interaction moves into "this other relationship" and she is back in the responsible role.

Daphne's account provided a different perspective regarding the responsibility of the medical role seeping into her wider life when she described how her work experiences inform her of the potential awful consequences of some behaviours which possibly encourages a serious, risk averse view on life.

Daphne: I'm more likely to see the possible bad outcomes of an idea so instead.....like people tend to be enthusiastic....and I'm thinking shit I've just

looked after this guy and like the kids go I might get a motorbike and I go no....you know....(laugh)...shit cos no just no....(exasperation) so sometimes I think I stifle things because I always see the bad outcomes..... always see the bad.... I seem to take things a bit seriously too often

In this extract Daphne evocatively expresses a state of being constrained by her own medical experience and knowledge. Using honest language, she describes the tension between managing her family's enjoyment and enthusiasm while holding an awareness of potential "shit" outcomes. There is a sense of loss of ignorant bliss and playfulness when she talks of "stifling things" as well as "taking things seriously". The heaviness of her repeated phrase "I always see the bad" gives the impression of carrying an intense emotional load due to the insight gained during her medical career into 'what could go wrong' which colours everything.

This section explores the superordinate theme, 'Responsibilities of the medical role', which was explored through two sub-themes, the first encapsulating the responsibility of the medical role and the second describing how this role seeps into the women's non-working life. All the women expressed holding a strong sense of responsibility for their patients, colleagues, and families. Being responsible for human life is a recognised and expected aspect of being a doctor, and all women learnt ways of managing this facet of their jobs however all expressed a considerable emotional toll during unpredictable events such as when they were worried about their personal safety or the safety of others. The feeling of being constantly 'in role' afforded little opportunity for feeling light and playful and this was exacerbated for some since the start of the Covid-19 pandemic. From an emotional labour perspective, being the responsible one can involve modifying true feelings in order to create an impression of competence which is required by others. This can be emotionally exhausting particularly if it is difficult to get away from the role. In this context the women talked of various ways of having breaks from feeling responsible whether this was at home with the children, taking regular holidays or considering leaving medicine altogether.

Emotional Management

The different ways the women managed their emotions was explored under the superordinate theme 'Emotional management'. The first sub-theme under this superordinate theme, 'managing intense emotional states' encapsulates the three women's experiences of dealing with highly charged emotional situations over their working lives. A multitude of emotions were expressed by the women including fear, anxiety, inadequacy, regret, overwhelm, anger, frustration, sadness, loneliness, joy, and

excitement. The different ways the participants managed these states is captured in this sub-theme. Some memories evoked strong responses during the interview illustrating the persisting impact of these events. The second sub-theme 'sharing or going it alone' explores the different ways the women shared their emotional experiences and with whom as well as their use of self-reliance strategies. All participants discussed these in terms of coping with emotional aspects of their jobs and how this changed over time. The final sub-theme I identified in the data was that of 'making a difference: the emotional rewards'. In the participants' narratives the various ways in which they derived positive meanings from their experiences was captured in this sub-theme.

Managing Intense Emotional States

Although all the participants described intense emotional states as a junior doctor, Rose in particular remembered the first three months as especially emotionally challenging. In this extract she recalls an event which was representative of her early medical experiences.

Rose: I remember lots of awful things happening in that first year as a doctor, you know being called to the ED to a resus.....somebody has collapsed and have got no pulse and the new... we were doing CPR and they come back to life and it's amazing and then they crash again, and we can't rescue them and then your pager goes off so you go off to the next thing... and there is no... there was no debriefing

As the passage unfolds her words vividly emulate the emotional highs and lows of experiencing the precarious place between life and death as she describes feelings of euphoria quickly followed by despondency as a resuscitation attempt fails. The emotional language at the start of the passage, settles into the matter-of-fact phrase "your pager goes off, so you go off to the next thing" as she moves on with the practicalities of the work. Her use of the words "they" and "somebody" might suggest that this was not an isolated event. The impression is that there is an inevitability to the intense emotional arousal cycles she describes with an assumption that these will be coped with despite no opportunities for debriefing or support. Until I really analysed this extract, I found myself skimming over Rose's words. There was nothing surprising about her narrative and I realised that this had also been my experience of medicine. Reflecting on this taken for granted aspect of being a doctor, I wonder whether what Rose described was informed by implicit feeling rules encouraging coping through the discounting or minimizing of emotions.

The influence of the medical hierarchy in terms of feeling rules regarding the

management of intense emotional states seems to be articulated in the following account where Daphne expresses how she suppressed feelings of uncertainty in order to follow orders from her superiors.

Daphne: ... at the time I just did what I was told because that's what you did [...] you are desperate to do the right thing [...] to get those um references...you are desperate.... so, you do what you are told and don't think to say.... actually, is this appropriate [...] I had no fucking (laughed) idea whether she had died or not...but she looked dead to me (laugh) [...] oh my God..... you know but I didn't want to make this situation any worse for the family

What is striking in this passage is the highly evocative language used by Daphne to describe her desire to do the “right thing” and yet a questioning of whether what she is being told to do is appropriate. Her account places her holding multiple perspectives within the context of a highly emotional event of someone dying. She repeatedly uses the word “desperate” painting a picture of anguish as she balances her determination to be seen in a good light by her superiors while wanting to protect the patient’s family from her feelings of uncertainty. The use of the word “you” possibly implies a perception that this was what was expected, and that all doctors would have experienced similar dilemmas. An empathic interpretation of her experience indicates a power dynamic learnt early in her career which influenced her management of emotional states by suppressing uncertainty and doing what was expected. This is reflected in her expression “to get those references...” in recognition that references could either make or destroy careers while her laugh appears to make light of the emotional distress she felt. Her emotionally loaded phrase, “I had no fucking idea” seems to stress the impossibility of the situation she found herself managing with no help or support. From her narrative Daphne’s main concern was the experience of the family of the dead patient. She managed to minimise her own anxiety by concentrating on the family’s well-being. This requires significant emotional labour in term of surface-acting as she suppressed her own feelings in order to create the desired feelings in others (Hochschild, 1983).

Spanning many years of work life, all participants expressed how their management of intense emotional states had changed over the years. Within the field of medical practice there has been a move away from an emotional stance of detached concern to one of clinical empathy which encourages doctors to be more emotionally connected and to acknowledge the emotional state of their patients without experiencing the state themselves. This shift is reflected in Alice’s account as she describes how she feels doctors should respond when feeling sad about patients.

Alice: ...you have to remember that you are the doctor [...] not that you have to be unemotional, but you have to [...] they feel they can rely on you.....so you.... so, you can't be dissolving in tears or anything like that even if you feel really sad..... you can't be doing that because because they.... it's their time to dissolve in tears not yours...(laugh) [...] it's fine to show emotion [...] I think it's probably good to show a little bit but not to the extent that they feel that they have to...that they are comforting you I mean it is your job to be strong for them, I think

In this measured extract Alice eloquently describes her understanding of contemporary medical feeling rules with her repeated words “you have to” indicating the importance of conforming to these. The use of “you” rather than “I” perhaps suggests an attempt to normalise and generalise her description to doctors generally. There is a sense of control in her expression “its fine to show emotion...”, “I think it’s probably good to show a bit” implying that emotions are ok to show if carefully managed and titrated. Although some emotion can be expressed, her words suggest she attempts to navigate intense emotional experiences through balancing what can be shared with the patient and what must be contained to the self in order to perform and convey that she is reliable and strong. From an emotional labour perspective, her true feelings are reflected upon and only those perceived as helpful for her patient are expressed. If what is expressed conforms with how she has learned through her own reflective practice to genuinely feel then this involves deep-acting however if she is expressing emotions she doesn't feel, the use of surface-acting is required (Hochschild, 1983). Both these practices involve emotional labour although a persistent disconnect between inner feelings and outer expression is more likely to result in emotional exhaustion and burnout.

Sharing or Going It Alone

In the interviews the participants talked of two fundamental ways that they managed their emotions in their professional lives; one was through the sense of sharing with others while the other involved coping privately through self-containment and dealing with intense emotional states on their own.

In this extract, which seemed to be echoed in the other interviews, Rose describes how during the course of her career her coping strategies have changed. In the following account she describes how her tendency to manage emotional experiences through talking has changed with her priority now being to compartmentalise and not consider medicine outside work hours.

Rose: I think I probably talked about my work a lot more early on.... now I don't tend to talk about my work very much at all and I think talking about it used to be

a coping strategy and not talking about it is now a coping strategy.... trying to move away from being a doctor when I'm not at work...: though certainly if we are like really worried about a patient or a patient has died... that sort of things, it's quite nice those sorts of things would share (*with her husband who is a doctor*)

This passage appears to portray a developmental pathway in terms of managing emotionally intense events. Rose describes how a tendency to seek support through talking with others has declined over the years. One interpretation of her account is that as her career progressed, she increased her capacity to navigate complex emotional dilemmas by expanding her repertoire of coping strategies. Her use of compartmentalising as expressed in her words “trying to move away from being a doctor when I'm not at work” was repeatedly conveyed in Rose's transcript and this desire had impacted her wish to share her emotional experiences with her husband who is also a doctor. Sharing their experiences particularly in terms of frustrations regarding their working conditions sometimes felt retraumatising and had resulted in them mainly limiting their discussions to celebrate clinical wins. However, in the passage she moves from ‘I’ to ‘we’ perhaps implying a reciprocal aspect to their sharing with her finally admitting how “nice those sorts of things to share” when considering particularly moving emotional events. From an emotional labour perspective, this extract seems to suggest Rose chooses different coping strategies depending on the emotional intensity of her experiences. For highly charged and distressing situations the opportunity to share is “nice” however for those less impacting other coping strategies such as cognitive restructuring, self-monitoring and reflection could be used limiting the impinging effect of talking about work at home.

The importance of being married to a doctor who understands the emotional dimension of medicine was articulated in another participant's narrative. In this extract Alice talks of a “shared knowledge” where experiences are often not talked about, but an underlying knowing of the stresses involved in medicine is emotionally supportive.

Alice: ... things that people who are who are not doctors can't understand.....um particularly in your emotional life, I guess they can't, you know they can't understand it and equally somebody who is another doctor can just understand those kind of thing that you're going through or talk about things. It's not that we talk about work all the time (laugh) or anything but there is an underlying understanding that we have a, you know a shared knowledge about things..... I think that's actually very positive an um yeh I couldn't imagine not being married to a doctor to be honest

Alice's description of being unable to imagine not being married to a doctor implies something pivotal regarding the emotional support such a relationship provides. She seems to convey that the strange emotional world of doctors is only understandable if you are a doctor yourself. Clarifying that despite this "it's not that we talk about work all the time" followed by a laugh perhaps suggests that talking about work all the time would not be desirable. However, a softening in her defences at the end of the passage as she talks candidly of 'that's actually very positive' appears to imply a deep appreciation for being married to someone who she can rely on to understand. Within the sanctum of the medical world, it seems that having a trusted person to share work challenges has been very positive for Alice. Although she uses the opportunity to share selectively, the nature of being part of a shared world of understanding provides something indescribably precious in terms of safety and trust and seems to communicate something even without words, protecting her from feelings of isolation and a sense of holding emotions alone. Continuing with the developmental process of learning how to manage emotions during their career, Daphne's transcript highlighted how early experiences of sharing influenced her later sharing strategies. The following transcript illustrates the complexity of underlying motivations and learnings from early emotional sharing experiences which shaped subsequent sharing habits.

Daphne: ...but what upset me was her wanting to kill herself by setting fire to herself and coming in and still wanting to die.... that's all she said.... I want to die.....I want to die [...] yeh ...it wasn't terrible.... I felt I needed to talk about it, but x (*a family relative*) was going if you can't deal with these things, you shouldn't be...you know it's like completely missing the point... that it's actually not that I'm not dealing with it.... it's that this is my way of dealing with it.... is to chat about it... with someone so I learnt early on not to talk to just anybody about anything....so that's probably a good lesson

Daphne vividly remembered a very upsetting experience with a suicidal patient who she, without talking about specifics, wanted to talk to someone about. Her account takes us through a multitude of feelings with the presence of anguish at the beginning as she repeats her patient's words "I want to die". However, she seems to minimise the emotional impact this had on her by explaining that "it wasn't terrible" giving the impression that she was not particularly affected by the situation although felt a need to share the experience. The dismissiveness of her relative's response sounds so hurtful when she recalled her saying "if you can't deal with these things, you shouldn't be..." omitting to finish her sentence with "a doctor". At the end of the passage a sense of exasperation is palpable as she says its "not that I'm not dealing with it.... it's that this is

my way of dealing with it...” to emphasise how let down she felt to be so completely misunderstood. This feels more poignant as earlier in the interview Daphne had described how talking about her emotions had not been encouraged within her family dynamic. At the end of the passage, she concludes this was “probably a good lesson” suggesting that within the context of her whole career it has worked well for her to share selectively and only with people she trusts. However, there is also an element of resignation in her narrative which is vocalised more explicitly in the following accounts and reflects how her experiences have taught her to “go it alone”. These seem to indicate an element of ambivalence regarding the sharing strategies she has had to develop.

Daphne: there is no one to talk to [...] all these experiences add up to the fact that you learn to deal with it...to go it alone.... even my husband I don't always tell him.....what's really going on inside

An empathic reading of this passage suggests that Daphne does not experience her close relationships as places of shared understanding regarding managing intense emotional dilemmas at work. Instead, she has developed resources within herself and a capacity for self -containment which she has relied on during her career. In her phrase “there is no one to talk to” she uses the present tense to imply that this is still the situation and that it is something she has got used to. Many experiences have provided learning opportunities for her to dig deep into her own self-regulatory abilities and “learn to deal with it” and “to go it alone”. However, the following extract illustrates how at particularly stressful times she will seek relational support through sharing with a few trusted colleagues.

Daphne: I have a couple of colleagues that I really trust, and I tell them things that I wouldn't tell other people ...um and I talk to them and except and.... their feedback is really helpful and their.... they are very supportive....so I will do that

In this extract her words “I really trust” appear significant which is unsurprising in light of her experience of sharing with her relative. She implies these supportive relationships are professional rather than intimate, as reflected in her use of the word “feedback” which suggests a certain formality to the sharing.

Making a Difference: The Emotional Rewards

As well as being difficult and challenging, emotional responses were communicated in terms of amazing experiences by the three women. Alice's narrative clearly expressed satisfaction with medicine including her career progression and choice of speciality. Rose

was more ambivalent about being a doctor however feelings of achievement and making a difference to peoples' lives elicited moments of joy which made everything worthwhile as illustrated in her account below.

Rose:and I saw her a month later and she is nearly all better [...] that's why I do this.... that makes it worth it....and you know it's made.... she has made such a difference [...] and so it felt like some small interventions had had these big ripples for her and her family....and you know it felt like a real win

As this passage unfolds there is a feeling of surprise and wonder that small interventions can have such big impacts and how amazing this is when it happens. The feelings of achievement and joy are clear in Rose's words "that's why I do this...that makes it worth it". Her pleasure at experiencing how in some cases small interventions can have big effects is highlighted in her use of the word "ripple" which elegantly demonstrates the occasional far-reaching ramifications some of her treatments can have on others' lives. Although not a daily experience, it seems this feeling of making a difference has a wonderfully uplifting effect. This occasional "win" feels like a real success which helps her triumph over the negative impacts of highly stressful medical work.

Also echoed in another participant's account is the affirming professional effects of making a difference to others' lives. This is reflected in the following passage where Daphne describes an experience where she saved a child's life despite seemingly insurmountable challenges.

Daphne:and I thought oh my God and I felt for the first time in my life.....I felt like...I had made a difference.... that was because of me ...and no one else...you know and so that is about the only time I feel like it was.....you know in my whole career I feel that I made that difference

In this extract the words "oh my God" certainly emphasises potency but may also indicate an element of spirituality or the influence of a greater being, when Daphne talks about a time when she saved a boy's life. There is a palpable sense of wonder and awe in her account as she describes "that was because of me....and no one else". The passage conveys the emotional power of having the skills to save a life which is unique to medicine and not experienced in many professions. The event described by Daphne emphasises how her work providing critical services in life and death situations can be extremely rewarding when lives are saved. This account feels especially powerful as the journey prior to this positive outcome was described as particularly fraught and traumatic. Having overcome immense challenges in order to save a child's life, Daphne describes

a sense of elation which was enduring and continued long after the event had ended. The possibility of doing something truly great for other human beings seemed to sustain her throughout her work-life.

The academic challenges of a medical career were also vocalised as rewarding by one of the participants. Facing up to and pushing through strong emotions of anxiety and fear while being at the forefront of medical progress seemed to provide a sense of professional satisfaction for Daphne as illustrated in the following extract.

Daphne: ...it's pushed me (my career) it's been good.... you know.... and I like that....um.... about x.... the fact...and we're often at the forefront of making changes in safety and stuff like that... so the actual job I love you know despite the anxiety and despite everything else

Here the word “actual” seems significant. I interpret this as indicating that Daphne is describing the job of helping people which she “loves” rather than other issues of her working life such as the demands of the system she works within. Despite undertaking significant emotional labour in terms of managing her anxiety in critical situations she implies that making a difference to people's lives overwhelmingly outweighs the stresses she has to endure.

The medical profession is unique in that doctors sometimes have to manage intense emotional states particularly when dealing with critical life and death situations for which they carry ultimate responsibility. Some important patterns of meaning were identified in the participants stories including the different ways they navigated these states. Experiencing and managing intense emotions was found to be particularly challenging at the beginning of these women's working lives and they developed coping strategies by following various professional and family feeling rules which depended upon their early experiences. As they progressed along their career pathway their capacity to manage their emotional states seemed to increase using a combination of improved self-reliance and development of reflective skills as well as the ability to use a variety of sharing strategies as illustrated in the sub-theme, ‘sharing, or going it alone’. The option to share particularly distressing experiences within trusted understanding relationships was valued however choices were made regarding when they did so. At times when the management of intense emotional situations resulted in amazing outcomes such as saving a child's life or improving a family's wellbeing the participants described profound feelings of achievement which were highly inspiring and rewarding in terms of personal and professional identity.

A Pawn in a System

The different feelings associated with the women's work environment were explored under the superordinate theme 'A pawn in a system'. The women had worked for a variety of DHBs in Aotearoa/NZ during their careers and at the time of the interview only one was working solely in private practice. A prominent pattern identified in two of the participants interviews was 'feeling unrecognised' by the medical organisation they worked for. The second sub-theme identified in the data in relation to the women's working environment was the 'value of collaboration' with all accounts reflecting the importance of working with supportive colleagues.

Feeling Unrecognised

There were a few occasions during the interviews when a participant became visibly upset or used language which was particularly emotive, and these moments seemed to represent an experience of significance. These moments illustrated how recollecting previous experiences could trigger high levels of distress in the present. There were a couple of times while recalling a work situation involving a sense of feeling unrecognised when the women appeared emotionally affected.

Rose was obviously upset when she recounted an experience which resulted in her resigning from her dream job many years previously. From her story it felt that an overarching belief in her work had enabled her to manage the emotional impacts of a high workload until the pressure became too great.

Rose: I'm just holding together what I am doing (sigh) and then I was directed to do this other work and then I resigned.... gosh I feel a bit teary when I think about it.... cos I'd worked so hard for that team and for that organisation... (crying) [...] I felt such a little package of resource.... that you could move me from here to here...we will just keep using you up...even though you are saying you are all empty (*getting a tissue*)

In this passage, Rose eloquently describes a lack of autonomy as she was "directed to do this other work". Remembering the situation triggered a flood of feelings including sadness and resentment, as tears welled in her eyes revealing the still raw effects of this experience even after many years. Her words "a little package of resource" painted a picture of an object without feelings being moved around and used up for the benefit of the organisation. She continued with the depersonalising language throughout the extract including "moving me from here to here" and "using you up". An empathic interpretation of the experience indicates persisting sadness at the feeling that her hard work had not been recognised and instead she had been pushed to the limits of her

capacity without any concern for her wellbeing. In this state of emotional overwhelm and depletion with the continual sense of being unrecognised, Rose made the decision to leave the role. This might suggest that this organisational context was 'unbearable' for this participant, such that it could indeed no longer be managed or tolerated.

Rose: That this organisation doesn't care about me... is how it felt...

This last sentence encapsulates the essence of Rose's experience. In this small concise quote, she communicates a deep sense of being unsupported and uncared for as well as a lack of recognition for her own values and effort.

A conflict between personal and organisational values creating a sense of feeling unrecognised was identified in another participants narrative. In her interview Daphne talked of changes in her workplace in terms of reduced autonomy and different behaviour expectations. She described how she felt she was seen as a "dinosaur" in the work environment as her priority was patient safety rather than conforming to contemporary organisational rules. Feelings of anger and frustration were expressed in Daphne's narrative as she recounted how adjustments in the management of her service had placed her as well as her patients in clinically unsafe positions. Her words imply that after many years of clinical experience, her opinion is not recognised, and she feels silenced and unimportant.

Daphne: I started this.... medicine as a vocation....and it's a job now for me.....umso these days there is increasing frustration at the lack of control and ability to do what's best for like ...any patient under your care.... there'sanger about the decisions that are made by others with less or no clinical experience and that puts us in clinically unsafe or stressful positions and that's ongoing and constant...[..]. there is despair that with all my training and now 35 years of experience that I am not listened to.... you know [...] Jeess...why did I live through all this for.... why did I put so much into this place for to now be basically ignored?

In this extract Daphne's use of the word 'vocation' is significant in the context of her career in that it implies a sense that medicine was a calling for her, requiring an element of sacrifice for the greater good. Medicine as a vocation was articulated in her transcript as pivotal to her meaning-making of her career experiences and had enabled her to put her work before her family and her own needs. As the passage unfolds her evocative language gradually increases to a crescendo moving from "frustration" to "anger" and finally to "despair". The intensity of these feelings appears to be laden with sadness as

she describes the final phase of a career which has been dedicated to developing her skills and caring for her patients. Her words “lack of control”, and “decisions made by others” express a feeling of powerlessness. I can imagine this was particularly distressing considering that the changes left her in a situation where she was concerned for her patients’ safety, an aspect of medicine that she had prioritized above all. The last sentence seems to suggest both regret and despair as she wonders why she put so much of herself into her job only to be ignored. An empathic reading of his passage suggests that after a medical career spanning many years and involving many sacrifices, she now feels unrecognised. The sacrifices were undertaken willingly while working in an environment she trusted however recent changes in service priorities had left her feeling unrecognised and insignificant. This lack of recognition feels particularly painful when reflected on in terms of medicine as a vocation where the rewards for sacrifice are not monetary but feeling valued and appreciated by others.

Value of Collaboration

The value of collaboration as a positive way to survive the work environment was identified in all the participants’ transcripts. The care and support which was missing from the organisation was provided by the participants co-workers as described in one of the interviews.

Rose: I think it's the real buffering role of working with a bunch of women I really like.... I like my patients.... but more than that I really like my colleagues..... and we are of a similar age, and we have similar aged children and I think there are aspects to us that are similar in how we experience the work and I think that is really helpful. We don't talk a lot about the emotional load of this work that I think knowing that we both share in it...I find really helpful

Rose appreciated working with like-minded women. Her use of the word “buffering” seems to imply protection from some external onslaught. The importance of shared understanding is also highlighted here with the women being described as “similar” in terms of age, family circumstance and work experiences. This similarity seemed to create a sense of support through implicit knowing and understanding which was identified as very helpful. Although not talked about, feeling that they were all in the same boat and experiencing the same emotional load fostered strong mutually supportive bonds which she found very helpful.

Rose: ...and I feel really loyal to my team.....I don't feel that loyal to my big organisation.... I don't think they... oh that would be true for any of the DHBs....

I think I feel like a small pawn to them.... but I feel that I matter in my team....
that they would genuinely look out for me...I think that helps

This passage returns to the feeling of disempowerment when Rose talks of feeling “like a small pawn” to the DHB, however the buffering effects of a loyal mutually caring team seems to protect her and the overall feeling from the extract is one of positivity. Her use of the word “genuine” in terms of her team looking out for her, appears to imply a sense that DHBs may try to appear to care but this feels insincere. It seems that for Rose feeling part of a team which is emotionally understanding and supportive can significantly enhance her feelings of wellbeing and job satisfaction. The caring team buffers the effect of feeling like “a small pawn”.

Alice also emphasised the bonding experiences of working collaboratively with co-workers. She described how going through emotionally intense experiences with supportive medical staff particularly early in her career had created lifelong relationships.

Alice:by yourself at night with the nursing staff and getting to know those people and working together you know when...with the funny things that happen in medicine and also the terrible things [...] they are there with you the first time you have to tell someone that their relative has died...you know all those kind of things [...] I guess it's a bonding experience (laugh) you know that's one rewarding experience working closely with those people who I'm friends with to this day (laugh)

From her language I sense the deep connections she developed while sharing a multitude of emotions with nursing staff as a junior doctor. Her description of being “by yourself at night” and the “funny” and “terrible” things that happened presents potentially scary and traumatic work events as highly rewarding memories of her early working life. The contrasting images of being alone at night and working closely with people makes the bonding experience even more poignant and reading her words I can imagine the relief at receiving such support particularly when she was expected to respond in her newly qualified role to emotionally challenging situations such as looking after grieving relatives. In these stressful working conditions, it seems that developing strong collaborative relationships increased her capacity to manage the emotional highs and lows with long-lasting positive effects.

Working in private practice was described by one participant as presenting different challenges to working in a DHB. Alice expressed how choosing her co-workers carefully reduced work-place conflicts and encouraged a supportive work environment.

Alice: I'm very fortunate that I have a very good practice manager and so her and I talk a lot about everything that goes on in the practice and support each other in that way

This small quote succinctly communicates Alice's appreciation for having "a very good practice manager" who she is able to "talk a lot about everything". The word "everything" could imply that their discussions included both the emotional and practical aspects of managing a private practice. I interpret her use of the words "support each other" to imply reciprocity, which is one of the sustaining factors of these important professional relationships. It seems that the ability to talk opening and honestly in a mutually supportive manner has been emotionally beneficial for Alice.

A different aspect of collaboration was articulated in Daphne's narrative. From an organisational perspective, historically doctors have represented a cohesive group who help each other out professionally. This sometimes involves coming into work on their days off. With changes in organisational priorities, this element of 'good will' can be lost creating feelings of ambivalence regarding collaborative practises which is illustrated in the following account.

Daphne: ... yep....so these days I'm totally disengaged.... you know.... I go to work, and I do my absolute level best for every patient under my care.....but that is all I do.... I will come to help colleagues on my days off if I have to.... you know.... but I don't rush to put my hand up.... but if they are running into strife, I will put my hand up

In this extract Daphne appears to be battling with herself regarding how much she is willing to help and support her colleagues. As she talks there is a shifting sense of her own experience. At first, she communicates one that is focused on patient care only reflected in her words "but that is all I do". However, this sense of boundary is quickly revised as she considers her colleagues needing her help on her days off which she identifies as something she would still do. This willingness though seems full of contradiction as she repeatedly revises the limits of her collaboration in the context of feeling "totally disengaged" with the organisation she works for. My interpretation of this passage is that Daphne is vocalising an underlying loyalty towards colleagues which appears part of Daphne's professional identity. From my perspective I recognise the sense of 'all being in this together' which helps doctors do their absolute level best for their patients and their colleagues even when the organisation employing them isn't felt to be particularly supportive.

In this section I presented findings from my research which revealed the sense of the participants being 'A pawn in a system'. The title of this superordinate theme was taken from one of the transcripts and was felt to symbolise a feeling of being a small object in a large medical system. A sense of 'feeling unrecognised' emerged as a pattern in the data and this revealed the ways in which two participants reflected on some significant work-related experiences which had a negative impact on their job satisfaction and wellbeing. The other sub-theme 'value of collaboration' explored how the participants experienced relationships within medical organisations in Aotearoa/NZ. In some of the interviews supportive professional relationships were found to provide protective effects on both job satisfaction and wellbeing although for one participant changes in organisational stresses and priorities had introduced an element of ambivalence regarding how much collaboration was possible.

Discussion

The aim of this research was to explore how women doctors made sense of a long medical career in Aotearoa/NZ. The participants' stories illustrated the emotions they experienced as well as how societal, professional, and organisational feeling rules influenced their management. Three superordinate themes were identified including 'Responsibilities of the medical role', 'Emotional management', and 'A pawn in a system'. I will discuss how these findings dovetail with the existing literature and how they add to the body of knowledge regarding women doctors' working lives.

Medicine is a highly responsible job involving complex decision-making regarding the health and wellbeing of unwell people. In order to satisfy the professionalism of the role, doctors are required to shape their emotional responses in accordance with societal feeling rules regarding how a responsible doctor should behave. Applying Hochschild's theory of emotional labour, this involves presenting a controlled, calm demeanour so patients and society can trust their ability to provide the best possible care, a process requiring both surface and deep-acting (Hochschild, 1979, 1983; Mann, 2004). Considering the superordinate theme 'Responsibilities of the medical role', the transition from student to junior doctor was remembered as a particularly challenging time for the participants. This is well-documented in the medical literature with a recent study identifying feelings of fear, anxiety and uncertainty amongst junior doctors regarding their decision-making capacities (Kellett et al., 2015). Similar to my findings Kellett found that uncertainty was exacerbated while alone at night and if the juniors felt unsupported. The participants identified the transition to SMO as demanding a capacity to carry ultimate responsibility for non-clinical as well as clinical matters. In these positions of responsibility, a threat to personal safety was identified as especially emotionally exhausting, evoking feelings of anxiety which had to be managed in order to perform in the responsible manner expected of the role. This finding is consistent with Edward's review where threats to personal safety were predictive of burnout (Edward et al., 2017). In addition, this study highlighted how unprecedented events such as the Covid-19 pandemic can blur the boundaries of doctors' responsibilities as the participants described balancing personal, family, and patient health perspectives in a rapidly evolving pandemic environment. The emotional toll carried by doctors during this time has been well documented with questions now being asked as to who is responsible for doctors' wellbeing (Bartholomew et al., 2022; Karacic et al., 2021). From an emotional labour perspective, I wonder whether the unpredictability of these situations demanded strategies requiring the expression of feelings that were socially expected while actively suppressing the underlying real emotion. This management of emotions through surface-acting combined with limited opportunities for recharging and reflection could contribute

to emotional exhaustion (Hochschild, 1983).

Interestingly in contrast to some studies, the women in this research did not focus on difficulties with balancing work and family obligations and seemed to present an attitude of satisfaction at having strategies in place regarding this aspect of their lives. This finding is supported by a recent study of senior women physicians where the interaction between work and home responsibilities was significantly reduced later in the women's careers (Templeton et al., 2020). My interpretation is that having older, more independent children reduced the impacts of divided loyalties and emotional juggling which were identified in other studies involving younger women doctors (Allen, 2005; Chambers, 2019). In this study the influence of the participants' career on their personal life focused more on managing the expectations of non-medical acquaintances as well as how sometimes their medical knowledge affected their capacity to experience the light-hearted side of life. Constructions of medicine as a vocation rather than a job implies a set of obligations which are ill-defined, and I could find no papers in the empirical literature exploring the emotional demands associated with feeling 'in role' while not working. One interpretation of this finding is that societal assumptions regarding women as the caring gender places them in positions where they are expected to respond empathetically to work-related issues outside of work (Guy & Newman, 2004; Hochschild, 1983; James, 1992). Previous studies have found that women doctors outperform men regarding communication skills and empathy although the reason for this has been difficult to ascertain with some suggesting these differences are socially constructed (Cuddy et al., 2011; Roter & Hall, 2015; Roter et al., 2002; Underman & Hirshfield, 2016). Whatever the explanation, societal pressures for women to engage in hidden emotional labour can affect their quality of life.

During medical training, the expected culture of emotional management is learnt through professional socialisation and internalisation of professional core values (Timmermans & Oh, 2010). This provides a set of feeling rules regarding how doctors are expected to manage their emotions. These rules are cultivated by the implicit adoption of the attitudes, and behaviours of seniors represented by the medical hierarchy (Crowe et al., 2017). In this study, the management of a wide range of intense emotional states was captured in the data reflecting how to participants learnt to deal with a multitude of emotions in an environment which seemed to encourage emotionally suppressive coping strategies. However, the findings also provided evidence of a change in feeling rules with discussions regarding the usefulness of emotions in clinical care. The findings from this research regarding the use of emotional suppressive techniques as well as the influence of the medical hierarchy in moulding doctors to learn to perform aligns with recent research (Crowe et al., 2017; Doulougeri et al., 2016; Lundin et al., 2018). In a study investigating how medical students coped with negative emotions associated with clinical

work, suppressive techniques were found to be heavily relied upon (Doulougeri et al., 2016). Another qualitative study found the diaries of junior doctors full of words such as worry, scared, horrible, and daunting with responses to these emotions including, “I just got on with it” and “I pulled myself together”(Lundin et al., 2018). These studies reveal that despite some appreciation of emotions in clinical practice, the medical hierarchy continues to be intolerant of certain feelings such as anxiety, and the persistent perception within the profession that admitting to uncertainty could lead to questions of competence (Crowe et al., 2017). From an emotional labour perspective emotional suppression is conceptualised as a form of surface-acting where real feelings are suppressed in order to produce the desired response in another individual. This form of emotional management is considered maladaptive and has been associated with burnout and emotional exhaustion (Hochschild, 1983; Lin & Chang, 2015; Psilopanagioti et al., 2012). The finding in this study regarding participants framing emotions as useful for showing their patients genuine care and understanding is encouraged in contemporary medical practice (Underman & Hirshfield, 2016). Instead of advocating detached concern, medical training now advocates for doctors to understand their patients’ emotional state however to distinguish between their feelings and their patients’. The modification of emotional management methods over the participants’ lifetime illustrates how learning continued throughout their careers possibly involving significant emotional labour.

In order to cope with emotional events associated with their career, the women developed a variety of techniques which changed over their work-life. All participants’ narratives expressed different perspectives around sharing their experiences with others. Sharing strategies seemed to be influenced by family feeling rules and whether previous sharing encounters had been helpful or not. As the women progressed along their career pathway their need to share reduced and was influenced by a desire to not think about medicine outside work hours. Consistent with other studies, the women were found to restrict their sharing to a few trusted people who were familiar with the particular stressors they were under (de Vries-Erich et al., 2016; Hubik et al., 2021). A preference for sharing emotional experiences within one’s own professional community was found in a study of medical students in the Netherlands. They chose to talk to fellow students rather than formal mentor groups, describing how they needed someone who “gets it” (de Vries-Erich et al., 2016). This result was replicated amongst palliative care doctors who felt non-medical people either wouldn’t “get it” or would be burdened (Hubik et al., 2021).

The pleasure derived from genuinely feeling that you have made a difference is well recognised as affirming of professional expertise and the altruistic motivations for practicing medicine (Vedi, 2021). The participants described how positive feelings of

achievement protected them from the negative impacts of work stresses. Sakiyama hypothesised that people are happy to undertake emotional labour if they experience positive responses in return (Sakiyama, 2009). In addition the uplifting feelings associated with doing something for the benefit of humankind was identified in Nettleton's qualitative study (Nettleton et al., 2008). These findings emphasise the importance of preserving moments of joy in order to mitigate symptoms of burnout.

Although doctors' emotional displays are shaped according to professional feeling rules, the organisation they are employed by also has an impact on what they feel and how they manage these emotions (Hochschild, 1983). DHBs are large organisations increasingly coping with resource constraints and budget controls. Their emphasis on financial efficiency can be in conflict with doctors' professional values and identity. Vedi found a focus on efficiency was experienced as dehumanising with doctors feeling reduced to 'cogs in a machine' (Vedi, 2021). In this study the finding of 'feeling unrecognised' illustrated how some emotions have a detrimental effect on job satisfaction. This finding has been identified in previous studies where pressure from hospital management and high workloads produced feelings of inadequacy and of not being appreciated (Hubik et al., 2021; SMO Commission, 2009; Stiefel et al., 2019). From an emotional labour perspective Psilopanagioti found that feeling unappreciated exacerbated the negative effects of managing emotions through surface-acting while Wharton described how the effects of emotional labouring were impacted by perceived levels of autonomy and appreciation (Psilopanagioti et al., 2012; Wharton & Erickson, 1993). From an organisational perspective, the findings in this study reinforce the importance of recognising their medical workforce for the highly challenging work they undertake and considering ways to support them in this endeavour.

This study found that collaboration was one of the ways that the participants managed their workplace experiences. However, the findings also reveal that changes in organisational practises can undermine these cohesive professional ties impacting collaborative processes. Collective coping strategies have been identified as ways to foster workplace wellbeing in other studies (Korczynski, 2003; Vedi, 2021). In addition considering the impacts of emotional labour on wellbeing, Edward's review found that collaborative practices were protective (Edward et al., 2017).

Limitations, Implications, and Future Directions

The process of undertaking this research has been enlightening as well as challenging. I particularly enjoyed conducting the interviews especially as all participants were very different in terms of career experiences and emotional responses. This added an element of fascination as I resonated with different aspects of each woman's story however also made the recognition of patterns across all cases difficult. The coding and

identification of themes in the data were new processes for me, and I appreciated the feedback from my supervisor who verified my findings at each stage of the research. Through this feedback, further reflection and modification was possible and I have deeply engaged with my topic in order to provide a competent analysis of the data which respects the participants transcripts. This has enhanced the validity of my results (Yardley, 2008). However, I am mindful that as with all qualitative research, my positionality as a researcher and my biographical relationship with the subject would have influenced the analysis. My insider researcher stance was reflected by my gender as well as my work experiences, both aspects of which could shape the findings (Court & Abbas, 2022). I recognise as an insider researcher, the course of the interviews, what was and wasn't talked about as well as what I heard will be coloured by my history. There is also the risk when conducting semi-structured interviews that the participants will adapt their responses to express what they think is expected of them rather than their real feelings (Brinkmann, 2013). Complicating the process further was the requirement to conduct one of the interviews online thus generating a different interactive space for data collection which could potentially have affected the overall findings. In addition, within the bicultural context of Aotearoa/NZ, the participants were all Pakeha which limits the transferability of the findings.

Findings from this study have implications for doctors, their employers, and psychotherapists. The finding that the participants' experienced seepage of their role into their personal life in terms of feeling responsible for others requires further study. Considering this finding in terms of gender expectations where women are assumed to be the empathetic gender while men are seen as the more practical gender would be interesting to explore.

The presence of a wide range of emotions in clinical practice which was revealed through the findings of this study suggests that doctors should expect to feel a multitude of emotions, some of which, even for the most robust, will be difficult to manage. Emotional coping strategies were found to change over the participants' work-life highlighting how emotional management involves constant learning and psychological adaptability. In addition, the appreciation for the use of empathy in medical practice to improve clinical outcomes as found in this study is encouraging however involves emotion labour. This study therefore emphasises the importance of the availability of supportive structures within medical systems to provide adequate care for doctors' mental health (Kerasidou & Horn, 2016; Larson & Yao, 2005; Vinson & Underman, 2020).

From an organisational perspective this study provides evidence that any focus on cost effectiveness should include doctors' wellbeing. At a time when there is significant pressure on the availability of doctors, protecting the sustainability of the medical workforce by appreciating their skills and the challenging environment they work in could

prevent burnout and loss of skilled senior staff through resignations.

I hope that by increasing the visibility of emotions in medicine, this study will help to reduce the stigma associated with seeking support. A variety of supportive structures should be available to doctors throughout their working lives including individual therapy such as psychotherapy, and counselling, as well as informal and formal groups such as Balint groups. Balint groups were initially conceptualised by Michael Balint, a psychoanalyst and doctor, who created support groups in England in 1940s to help GPs understand unconscious dynamics within the doctor-patient relationship in order to improve the therapeutic alliance (Johnson et al., 2014; Mahoney et al., 2013). These various support structures could be introduced at medical school and then be provided by medical workplaces throughout doctors' careers. In this way the emotional aspect of clinical work would be normalised with individuals having the option to choose whichever form of support they required including none if adequate personal support was available. At the end of the interviews, all participants reflected that the opportunity to talk about their experiences had been enjoyable with one expressing a desire to commence psychotherapy.

For psychotherapists, I am hopeful that by making visible and talking about the emotional dimension of medical work, more doctors will consider psychotherapy as a way to better understand their relational and psychological patterns. By foregrounding the unique emotional demands and struggles within this career context, as well as some of the strategies employed to cope with these, this study provides information which could be useful to psychotherapists with women doctor clients.

Finally, I have hypothesised that feeling rules are influenced by socially constructed stereotypes. From this perspective it was interesting that none of the participants in this study disclosed feelings of gender discrimination during their careers. Consequently, it would be interesting to repeat this research with both a larger sample of this demographic as well as a group of younger women who have lived through a time when implicit gender expectations have become more explicit. Also, in future extending this research to include men as well as ethnically diverse doctors would add to the evolving understanding regarding the use of emotional labour in medicine.

Conclusion

This research is the first study to my knowledge in Aotearoa/NZ to collect qualitative data on the lived experiences of women SMOs who have worked in the medical system for more than 20 years with a focus on the emotional dimension. The study illuminates the significant emotional labour undertaken by the participants. Some of the findings are supported by previous research however there are some novel findings which seem to reflect the particular time and context in which the women's careers developed. After many years of working, the women were found to have developed strategies for managing the ultimate responsibility associated with being SMOs as well as the intense emotional states inherent in their clinical work. However, the findings also highlight that if their working environment was perceived as unsupportive and dehumanising, job satisfaction and wellbeing was affected potentially resulting in resignation.

References

- Alase, A. (2017). The interpretative phenomenological analysis (IPA): A Guide to a good qualitative research approach. *International Journal of Education & Literacy Studies*, 5(2), 9-19. <https://doi.org/10.7575/aiac.ijels.v.5n.2p.9>
- Allen, I. (2005). Women doctors and their careers: What now? *BMJ* 331, 569–572. <https://www.bmj.com>
- Amoafo, E., Hanbali, N., Patel, A., & Singh, P. (2015). What are the significant factors associated with burnout in doctors? *Occupational Medicine*, 65, 117–121. <https://doi.org/10.1093/occmed/kqu144>
- Anderson, K. (1993). *New Zealand Medical Women's Association 1921 – 2003*. <https://nzhistory.govt.nz>
- Bartholomew, A., Sanatkar, S., Counson, I., & Harvey, S. B. (2022). Junior doctors' mental health and coronavirus disease safety concerns. *Australian and New Zealand Journal of Public Health*, 46, 307-313. <https://doi.org/10.1111/1753-6405.13213>
- Blythe, S., Wilkes, L., Jackson, D., & Halcomb, E. (2013). The challenges of being an insider in storytelling research. *Nurse Researcher*, 21(1), 8-13. <https://ojs.ovid.com>
- Bondarenko, Y., du Preez, E., & Shepherd, D. (2017). Emotional labour in mental health field workers *New Zealand Journal of Psychology*, 46(1), 4-13. <https://www-psychology-org-nz>
- Brinkmann, S. (2013). *Qualitative Interviewing: Understanding qualitative research*. Oxford University Press, Incorporated. <https://ebookcentral.proquest.com>
- Broom, A., Wong, W. K. T., Kirby, E., Sibbritt, D., Karikios, D., Harrup, R., & Lwin, Z. (2016). A qualitative study of medical oncologists' experiences of their profession and workforce sustainability. *PLoS ONE*, 11(11), 1-15. <https://journals-plos-org>
- Chambers, C. (2019). 'Making up for being female' Work-life balance, medical time and gender norms for women in the New Zealand senior medical workforce. *Health Dialogue*(16), 1-70. <https://www.asms.org.nz>
- Chambers, C. (2021). "My employer is exhausting" Burnout in the senior medical workforce five years on. *Health Dialogue*, 17, 1-35. <https://www.asms.org.nz>
- Chambers, C., & Frampton, C. (2016). "Tired, worn-out and uncertain": Burnout in the New Zealand public hospital senior medical workforce *Health Dialogue*, 12. <https://www.asms.org.nz>

- Court, D., & Abbas, R. K. (2022). *Insider-outsider research in qualitative inquiry : New perspectives on method and meaning*. Taylor & Francis Group.
<https://ebookcentral.proquest.com>
- Creswell, J. W. (2012). *Educational research: planning, Conducting and evaluating quantitative and qualitative research* (4th ed.). Pearson.
- Creswell, J. W. (2013). *Qualitative inquiry and research design choosing among five approaches* (3rd ed.). Sage Publications.
- Crowe, S., Clarke, N., & Brugha, R. (2017). 'You do not cross them': Hierarchy and emotion in doctors' narratives of power relations in specialist training. *Social Science & Medicine*, 186, 70-77.
<https://doi.org/10.1016/j.socscimed.2017.05.048>
- Cuddy, M. M., Swygert, K. A., Swanson, D. B., & Jobe, A. C. (2011). A multilevel analysis of examinee gender, standardized patient gender, and United States medical licensing examination step 2 clinical skills communication and interpersonal skills scores. *Academic Medicine*, 86(10), S17-20. <https://ocean.ovid-com>
- de Vries-Erich, J. M., Dornan, T., Boerboom, T. B. B., Jaarsma, A. D. C., & Helmich, E. (2016). Dealing with emotions: Medical undergraduates' preferences in sharing their experiences. *Medical Education* 50, 817–828.
<https://doi.org/10.1111/medu.13004>
- Doulougeri, K., Panagopoulou, E., & Montgomery, A. (2016). (How) do medical students regulate their emotions? *BMC Medical Education*, 16(312), 1-10.
<https://doi.org/10.1186/s12909-016-0832-9>
- Edward, K., Hercelinskyj, G., & Giandinoto, J. (2017). Emotional labour in mental health nursing: An integrative systematic review. *International Journal of Mental Health Nursing*, 26, 215–225. <https://doi.org/10.1111/inm.12330>
- Else, A. (2018). *New Zealand Medical Women's Association 1921 – 2003 (updated)*.
<https://nzhistory.govt.nz>
- Fowler, J. B., Khan, Y. R., Fischberg, G. M., & Mahato, D. (2019). A cultural shift away from cognitive behavioral empathy. *Cureus*, 11(11), e6175.
<https://assets.cureus.com>
- Frank, E., McMurray, J. E., & Linzer, M. (1999). Career satisfaction of US women physicians: Results from the women physicians' health study. *Archives of Internal Medicine*, 159(13), 1417-1426.
<https://doi.org/10.1001/archinte.159.13.1417>
- Garelick, A. I. (2012). Doctors' health: Stigma and the professional discomfort in seeking help. *The Psychiatrist* 36, 81-84.
<https://doi.org/10.1192/pb.bp.111.037903>

- Grant, B. M., & Giddins, L. S. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary Nurse*, 13(1), 10-28. <https://doi.org/10.5172/conu.13.1.10>
- Guy, M. E., & Newman, M. A. (2004). Women's jobs, men's jobs: Sex segregation and emotional labor. *Public Administration Review*, 64(3), 289-298. <https://web-p-ebscohost-com>
- Hochschild, A. (1979). Emotion work, feeling rules, and social structure. *The American Journal of Sociology*, 85(3), 551-575. <https://www-jstor-org>
- Hochschild, A. (1983). *The managed heart*. University of California Press.
- Hubik, D. J., O'Callaghan, C., & Dwyer, J. (2021). Strong emotional reactions for doctors working in palliative care: Causes, management and impact. A qualitative study. *Psycho-Oncology*, 30, 1582–1589. <https://doi.org/10.1002/pon.5731>
- Imo, U. O. (2017). Burnout and psychiatric morbidity among doctors in the UK: A systematic literature review of prevalence and associated factors. *BJPsych Bulletin*, 41(4), 197–204. <https://www-ncbi-nlm-nih-gov>
- James, N. (1989). Emotional labour: Skill and work in the social regulation of feelings. *Sociological Review*, 37 (1), 15-42. <https://web.b.ebscohost-com>.
- James, N. (1992). Care = organisation + physical labour + emotional labour. *Sociology of Health & Illness*, 14(4), 488-509. <https://web.b.ebscohost-com>
- Johnson, A. H., Brock, C. D., & Zacarias, A. (2014). The legacy of Michael Balint. *International Journal of Psychiatry in Medicine*, 47(3), 175-192. <https://journals-sagepub-com>
- Karacic, J., Bursztajn, H. J., & Arvanitakis, M. (2021). Who cares what the doctor feels: The responsibility of health politics for burnout in the pandemic. *Healthcare*, 9(1550), 1-5. <https://www.mdpi.com/journal/healthcare>
- Kellett, J., Papageorgiou, A., Cavenagh, P., Salter, C., Miles, S., & Leinster, S. J. (2015). The preparedness of newly qualified doctors –Views of Foundation doctors and supervisors. *Medical Teacher*, 37(10), 949-954. <https://doi.org/10.3109/0142159X.2014.970619>
- Kerasidou, A., & Horn, R. (2016). Making space for empathy: Supporting doctors in the emotional labour of clinical care. *BMC Medical Ethics*, 17(8). <https://doi.org/10.1186/s12910-016-0091-7>
- Kim, J. (2020). Emotional labor strategies, stress, and burnout among hospital nurses: A path analysis. *Journal of Nursing Scholarship*, 52(1), 105–112. <https://doi.org/10.1111/jnu.12532>

- Korczynski, M. (2003). Communities of coping: Collective emotional labour in service work. *Organization*, 10(1), 55-79. <https://journals-sagepub-com>
- Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing* (2nd ed.). Sage.
- Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3(2), 102-120. <https://doi.org/10.1191/1478088706qp062oa>
- Larson, E. B., & Yao, X. (2005). Clinical empathy as emotional labor in the patient-physician relationship. *JAMA*, 293(9), 1100-1106. <https://doi.org/10.1001/jama.293.9.1100>
- Lee, R. T., Lovell, B. L., & Brotheridge, C. M. (2010). Tenderness and steadiness: Relating job and interpersonal demands and resources with burnout and physical symptoms of stress in Canadian physicians. *Journal of Applied Social Psychology*, 49(9), 2319–2342. <https://doi.org/10.1111/j.1559-1816.2010.00658.x>
- Lin, Y.-W., & Chang, W.-P. (2015). Physician emotional labour and job performance: The mediating effects of emotional exhaustion. *Journal of Health Management*, 17(4), 446–457. <https://doi.org/10.1177/0972063415606281>
- Liu, L., Xu, P., Zhou, K., Xue, J., & Wu, H. (2018). Mediating role of emotional labor in the association between emotional intelligence and fatigue among Chinese doctors: A cross-sectional study. *BMC Public Health*, 18(881), 1-2. <https://bmcpublichealth-biomedcentral-com>
- Lundin, R. M., Bashir, K., Bullock, A., Kostov, C. E., Mattick, K. L., Rees, C. E., & Monrouxe, L. V. (2018). “I’d been like freaking out the whole night”: Exploring emotion regulation based on junior doctors’ narratives. *Advances in Health Sciences Education*, 23, 7-28. <https://doi.org/10.1007/s10459-017-9769-y>
- Mahoney, D., Brock, C., Diaz, V., Freedy, J., Thiedke, C., Johnson, A., & Mallin, K. (2013). Balint Groups: The nuts and bolts of making better doctors. *International Journal of Psychiatry in Medicine*, 45(4), 401-411. <https://journals-sagepub-com>
- Mann, S. (2004). ‘People-work’: Emotion management, stress and coping. *British Journal of Guidance & Counselling*, 32(2), 205-221. <https://www-tandfonline-com>
- Marshall, A. L., Dyrbye, L. N., Shanafelt, T. D., Sinsky, C. A., Satele, D., Trockel, M., Tutty, M., & West, C. P. (2020). Disparities in burnout and satisfaction with work–life integration in U.S. physicians by gender and practice setting. *Academic Medicine*, 95(9). <https://doi.org/10.1097/ACM.0000000000003521>

- McMurray, J. E., Linzer, M., Konrad, T. R., Douglas, J., Shugerman, R., & Nelson, K. (2000). *The work lives of women physicians: Results from the physician work life study* (Vol. 15) <https://link-springer-com>
- Mcnaughton, N. (2013). Discourse(s) of emotion within medical education: The ever-present absence. *Medical Education*, 47, 71-79. <https://doi.org/10.1111/j.1365-2923.2012.04329.x>
- Medical Council of New Zealand /Te Kaunihera Rata o Aotearoa. *Glossary: Types of registration*. Retrieved 9th May 2022 from <https://www.mcnz.org.nz>
- Medical Council of New Zealand /Te Kaunihera Rata o Aotearoa. (2021). The New Zealand Medical Workforce. Retrieved Aug 2022, from <https://www.mcnz.org.nz/about-us/publications/workforce-survey>
- Nettleton, S., Burrows, R., & Watt, I. (2008). How do you feel doctor? An analysis of emotional aspects of routine professional medical work. *Social Theory & Health*, 6, 18–36. <https://doi.org/10.1057/palgrave.sth.8700112>
- NHS Digital. (2019). *International women's day analysis: The role of women in the NHS in England*. Retrieved 20th March from <https://digital.nhs.uk/>
- Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Czasopismo Psychologiczne - Psychological Journal*, 20(1), 7-14. <https://doi.org/10.14691/CPPJ.20.1.7>
- Psilopanagioti, A., Anagnostopoulos, F., Mourtou, E., & Niakas, D. (2012). Emotional intelligence, emotional labor, and job satisfaction among physicians in Greece. *BMC Health Services Research*, 12(463), 1-12. <https://bmchealthservres-biomedcentral-com>
- Reynolds, M., McCombie, A., Jeffery, M., Mulder, R., & Frizelle, F. (2021). Impact of burnout on empathy. *New Zealand Medical Journal*, 134(1530). <https://journal.nzma.org.nz>
- Riley, R., & Weiss, M. C. (2016). A qualitative thematic review: Emotional labour in healthcare settings. *Journal of Advanced Nursing* 72(1), 6–17. <https://doi.org/10.1111/jan.12738>
- Roter, D. L., & Hall, J. A. (2015). Women doctors don't get the credit they deserve. *Journal of General Internal Medicine*, 30(3), 273–274. <https://doi.org/10.1007/s11606-014-3081-9>
- Roter, D. L., Hall, J. A., & Aoki, Y. (2002). Physician gender effects in medical communication. A meta-analytic review. *JAMA*, 288(6), 756-764. <https://doi.org/10.1001/jama.288.6.756>

- Sakiyama, H. (2009). When emotional labour becomes 'good': The use of emotional intelligence. *Internal Journal of Work Organisation and Emotion*, 3(2), 174-185. <https://www.inderscienceonline-com>
- Schueller-Weidekamm, C., & Kautzky-Willer, A. (2012). Challenges of work-life balance for women physicians/mothers working in leadership positions. *Gender Medicine*, 9(4), 244-250. <https://doi.org/10.1016/j.genm.2012.04.002>
- Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1(1), 39-54. <https://doi.org/10.1191/1478088704qp004oa>
- Smith, J. A. (2007). Hermeneutics, human sciences and health: Linking theory and practice. *International Journal of Qualitative Studies on Health and Well-being*, 2(1), 3-11. <https://doi.org/10.1080/17482620601016120>
- Smith, J. A., & Eatough, V. (2011). Interpretative phenomenological analysis. In E. Lyons & A. Coyle (Eds.), *Analysing qualitative data in psychology* (pp. 35-50). SAGE Publications, Ltd <https://doi.org/10.4135/9781446207536>
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis : Theory, method and research*. Sage.
- Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology : A practical guide to research methods* (pp. 53-80). Sage Publications.
- SMO Commission. (2009). Senior doctors in New Zealand securing the future *Ministry of Health*. <http://www.moh.govt.nz>
- Sternlieb, J. L. (2018, Jan). Demystifying Balint culture and its impact: An autoethnographic analysis. *International Journal of Psychiatry in Medicine*, 53(1-2), 39-46. <https://doi.org/10.1177/0091217417745290>
- Stiefel, F., Stiefel, F., Terui, T., Machino, T., Ishitani, K., & Bourquin, C. (2019). Spotlight on Japanese physicians: An exploration of their professional experiences elicited by means of narrative facilitators. *Work*, 63, 269-282. <https://doi.org/10.3233/WOR-192928>
- Templeton, K., Nilsen, K. M., & Walling, A. (2020). Issues faced by senior women physicians: A national survey. *Journal of Women's Health*, 29(7), 980-988. <https://doi.org/10.1089/jwh.2019.7910>
- Timmermans, S., & Oh, H. (2010). The continued social transformation of the medical profession. *Journal of Health and Social Behavior*, 51(S), 94-106. <https://doi.org/10.1177/0022146510383500>

- Tomlinson, J. (2014). Lessons from “the other side”. *British Medical Journal*, 348. <https://www.jstor.org>
- Underman, K., & Hirshfield, L. E. (2016). Detached concern?: Emotional socialization in twenty-first century medical education. *Social Science and Medicine*, 160, 94-101. <https://doi.org/10.1016/j.socscimed.2016.05.027>
- van Manen, M. (2017). Phenomenology in its original sense. *Qualitative Health Research*, 27(6), 810–825. <https://doi.org/10.1177/1049732317699381>
- Vedi, P. (2021). *Emotional labour in medicine*. University of Nottingham]. . <http://eprints.nottingham.ac.uk>
- Vinson, A. H., & Underman, K. (2020). Clinical empathy as emotional labor in medical work. *Social Science & Medicine*, 251. <https://doi.org/10.1016/j.socscimed.2020.112904>
- Wharton, A. S., & Erickson, R. J. (1993). Managing emotions on the job and at home: Understanding the consequences of multiple emotional roles. *Academy of Management Review*, 18(3), 457-486. <https://www.jstor-org>
- Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods*. Sage.
- Youngson, R. (2012). *Time to care*. Rebelheart Publishers.
- Załuski, M., & Makara-Studzińska, M. (2018). Emotional labour in medical professions. Review of literature from the period 2010–2017. *Psychiatria i Psychologia Kliniczna*, 18(2), 194 – 199. <https://doi.org/10.15557/PiPK.2018.0023>

Appendix A: Participant Recruitment Advert



MASTERS RESEARCHER SEEKING:

WOMEN WHO ARE WILLING TO SHARE THEIR EMOTIONAL EXPERIENCES OF WORKING AS A DOCTOR IN NEW ZEALAND/AOTEAROA

Kia ora, my name is Jackie, and I am interested in talking to women SMOs who have worked in medicine in NZ/ Aotearoa for 20 or more years and who presently live in or near Auckland.

I have worked in medicine, initially as a GP and more recently as an SMO in sexual health and this research is part of a dissertation to complete my Masters in Psychotherapy qualification.

I am particularly keen to hear how women have experienced and made meaning of the emotional aspects of a long career in medicine.

Participation will involve a semi-structured interview of about one hour duration at a location of your choice. The interview will be audio-taped and then transcribed however no identifying details will be collected.

If you are interested in participating in this research, please contact Jackie on 0210424384 or email cqc3992@aut.ac.nz

Many thanks Jackie

Appendix B: Participant Information Sheet

Date Information Sheet Produced: 18/06/2021

Project Title: The lived experience of being a woman doctor in New Zealand/Aotearoa: a phenomenological study.

An Invitation

Kia ora, my name is Dr Jackie Hilton, and you are invited to participate in a research study being done as part of a PG qualification: Masters in psychotherapy. Please take your time to think about whether you wish to take part in it. Your participation is entirely voluntary, and should you decide after reading this information sheet and question guide that you do not wish to take part, please inform me and no further contact will occur. If you do decide to continue with the recruitment process, you are free to withdraw at any stage.

What is the purpose of this research?

The objective of the study is to explore the emotional experience of women doctors who have worked in NZ/Aotearoa for 20 years or more. The concept of “emotional labour” will be used to understand the emotional dimension of being a women doctor in the NZ/Aotearoa context. Women make up an increasing proportion of the medical workforce however little is known about their emotional experience and how changes in societal expectations have affected these experiences. The study will enable the stories of the women to be heard and provide an insight into both the challenges as well as the coping strategies employed. This information will be useful for psychotherapists working with women doctors as well as the medical profession where it could potentially inform strategies to improve wellbeing. The findings of this research may be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

You have responded to an advert placed on the “Women in Medicine” Facebook website inviting women who are interested in talking about the emotional aspects of being a doctor. As you fulfil the inclusion criteria of being a women senior medical officer who has worked in NZ/Aotearoa for 20 years or more and who presently lives in or near Auckland you have been invited to participate in this research.

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced removal of your data may not be possible. If you are happy to take part in the research, you will be required to sign a consent form (attached to this email) before the interview takes place. The signed consent form can be emailed, or it can be signed just before the start of the interview. If the interview is conducted online the consent form will need to be signed, scanned, or photographed, and emailed to me before the start of the interview.

What will happen in this research?

The study will involve a face-to-face or online interview with me lasting approximately an hour. The interview will be semi-structured, and I will ask a range of questions related to the focus of the study while providing space for you to respond freely and openly. An interview guide is provided with this email to give you an idea about the focus of the interview.

The interview will be conducted at a location convenient for you. Private interview rooms are available at the various AUT campuses (North, South and City) if one of these locations works for you. I am also happy to come to your workplace. Any location will be private and secure to protect confidentiality and safety. If it is not possible to conduct the interview face-to-face, there is the option to conduct it online. The zoom platform will be used, and all efforts will be made to protect the privacy of the interview including using a password and a waiting room.

The face-to-face interview will be recorded using an Olympus digital voice recorder. If conducted on zoom, the interview will be recorded using the recording option online. This recording will be deleted from the platform immediately after the interview and a copy will be stored in a password protected file on my computer. These recordings will then be transcribed using voice recognition software. The transcripts will be analysed to identify themes. Once the research is completed you are welcome to have a copy of the findings which will be emailed to you on completion of the write-up.

What are the discomforts and risks?

It is important that you only talk about material which you feel comfortable discussing however you may find yourself remembering events which are upsetting. As the research is focusing on the emotional aspects of your experience you may feel emotional during the interview.

How will these discomforts and risks be alleviated?

I have worked as a doctor for more than 30 years, initially as a GP and more recently as a SMO in sexual health. I have also recently completed the clinical component of the psychotherapy training. My training has enabled me to develop good communication skills including an ability to monitor verbal and non-verbal clues of distress. I will provide a safe space for this conversation. If you feel overwhelmed at any stage, you can pause or stop the interview. After the interview should you want to talk more about any distressing memories triggered by the interview, AUT Student Counselling and Mental Health is able to offer three free sessions of confidential counselling support. These sessions are available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9998.
- let the receptionist know that you are a research participant and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on <https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health>

What are the benefits?

The study will add to the body of knowledge regarding the everyday lives of doctors in order to better understand and support the emotional work provided by women working in medicine. By telling your story the interview process could potentially be supportive and helpful although the interview is not a 'therapeutic interview'. This research will contribute to my completion of the Masters in psychotherapy qualification and will benefit the medical and psychotherapy community by helping to improve the working conditions and health of women doctors.

How will my privacy be protected?

All your contact details will be assigned a pseudonym and kept on my computer which is password protected. The audio recordings will be downloaded to a file on my computer and the audio recording will be deleted from the Olympus digital voice recorder. This computer file will also be password protected. All identifiable information will be altered or removed from the interview transcriptions. Electronic data collected during the study will be stored on a USB device that will be securely stored in my supervisor's (Dr Paula Collens) AUT office for six years. At the end of this time period the digital data will be permanently deleted. All other material such as consent forms will be stored in my primary supervisor's AUT office and will be destroyed by a confidential document destruction company after six years.

What are the costs of participating in this research?

The recruitment process will involve an approximately 10-minute phone conversation when the research process will be explained to you. The interview will then take about 1 hour however it may be longer if you feel there is more that needs to be discussed relevant to the research. There may be some travel time to get to the interview location however I am happy to come to a location convenient for you. You will be given a \$20 gift voucher as a thank you for participating in this research.

What opportunity do I have to consider this invitation?

Once you have shown an interest in the study and have received an information sheet, consent form and question guide, you will have up to two weeks to consider whether you would like to participate. If I have not heard from you after two weeks, a follow up email will be sent to establish if you are still interested and if you do not respond no further contact will occur.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Paula Collens, paula.collens@aut.ac.nz, P 09 921 9999 ext 5780.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTC, ethics@aut.ac.nz, (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference.

If you have any further questions about the study, please do not hesitate to contact me. Participation should be beneficial to you as well as the wider medical and psychotherapy community. Many thanks for taking time to read this information sheet and for considering taking part in this study.

You are able to contact the research team as follows:

Researcher Contact Details: Dr Jackie Hilton, email cqc3992@aut.ac.nz, contact mobile number 0210424384

Project Supervisor Contact Details: Dr Paula Collens email Paula.collens@aut.ac.nz Phone 09 921 9999 ext 5780

Approved by the Auckland University of Technology Ethics Committee on 12th July 2021, AUTC Reference number 21/209.

Appendix C: Question Guide for Semi-Structured Interviews

What were your motivations for becoming a doctor? What were your expectations of a career in medicine?

How was emotion managed in your family for example where you encouraged to show/discuss your feelings, were there specific feelings that were allowed and others which were not allowed? Have you any particular examples where you remember having to change your feelings to fit in with what was expected or where you changed the situation to fit your feelings?

Can you talk about the emotional aspects of your clinical work? Can you give me an example of an experience that was particularly rewarding emotionally? Can you tell me what kind of feelings came up for you in that experience? Can you give me an example of an experience that was particularly challenging emotionally? Can you tell me what kind of feelings came up for you in that experience? How did you cope with these situations? Have these coping strategies changed with time?

Can you talk about the emotional aspects of working as an SMO in a hospital environment? Are there any examples when you remember managing your feelings in order to fit in with the DHBs expectations?

Can you talk about the emotional aspects of your personal relationships? How has your career affected your relationships with your family and friends?

Appendix D: Consent Form

Project title: The lived experience of being a woman doctor in New Zealand /Aotearoa: a phenomenological study.

Project Supervisor: *Dr Paula Collens*

Researcher: *Dr Jackie Hilton*

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that the interviews will be taped with a tape-recorder and transcribed.
- ☐ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ☐ I understand that in taking part in this study that I can withdraw my data up to the point of transcription of the audio-recording.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a summary of the research findings (please tick one): Yes ☐ No ☐

Participant's signature:

Participant's name:

Date:

Approved by the Auckland University of Technology Ethics Committee on 12th July 2021.

AUTEC Reference number: 21/209

Note: The Participant and supervisor should retain a copy of this form. The consent form must be signed and viewed by Jackie prior to commencement of the interview even if the interview is conducted online.

Appendix E: Ethics Approval

12 July 2021

Paula Collens
Faculty of Health and Environmental Sciences

Dear Paula

Re Ethics Application: **21/209 The lived experience of being a woman doctor in New Zealand/Aotearoa: a phenomenological study**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTC).

Your ethics application has been approved for three years until 12 July 2024.

Non-Standard Conditions of Approval

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by AUTC before commencing your study.

1. Replacement of the AUT Security Office with emergency services in the Researcher Safety Protocol escalation plan.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the [Auckland University of Technology Code of Conduct for Research](#) and as approved by AUTC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.

AUTC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through <http://www.aut.ac.nz/research/researchethics>

(This is a computer-generated letter for which no signature is required)

The AUTC Secretariat

Auckland University of Technology Ethics Committee Cc: cqc3992@aut.ac.nz

Appendix F: Approval of Amendments to the Ethics Application

Paula Collens
Faculty of Health and Environmental Sciences
Dear Paula

Re: Ethics Application: **21/209 The lived experience of being a woman doctor in New Zealand/Aotearoa: a phenomenological study**

Thank you for your request for approval of amendments to your ethics application.

The amendment to the data collection protocol (interviews on line) has been approved.

Standard Conditions of Approval.

1. The research is to be undertaken in accordance with the [Auckland University of Technology Code of Conduct for Research](#) and as approved by AUTC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.
8. AUTC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, and locality obligations or requirements for those jurisdictions.

Please quote the application number and title on all future correspondence related to this project.

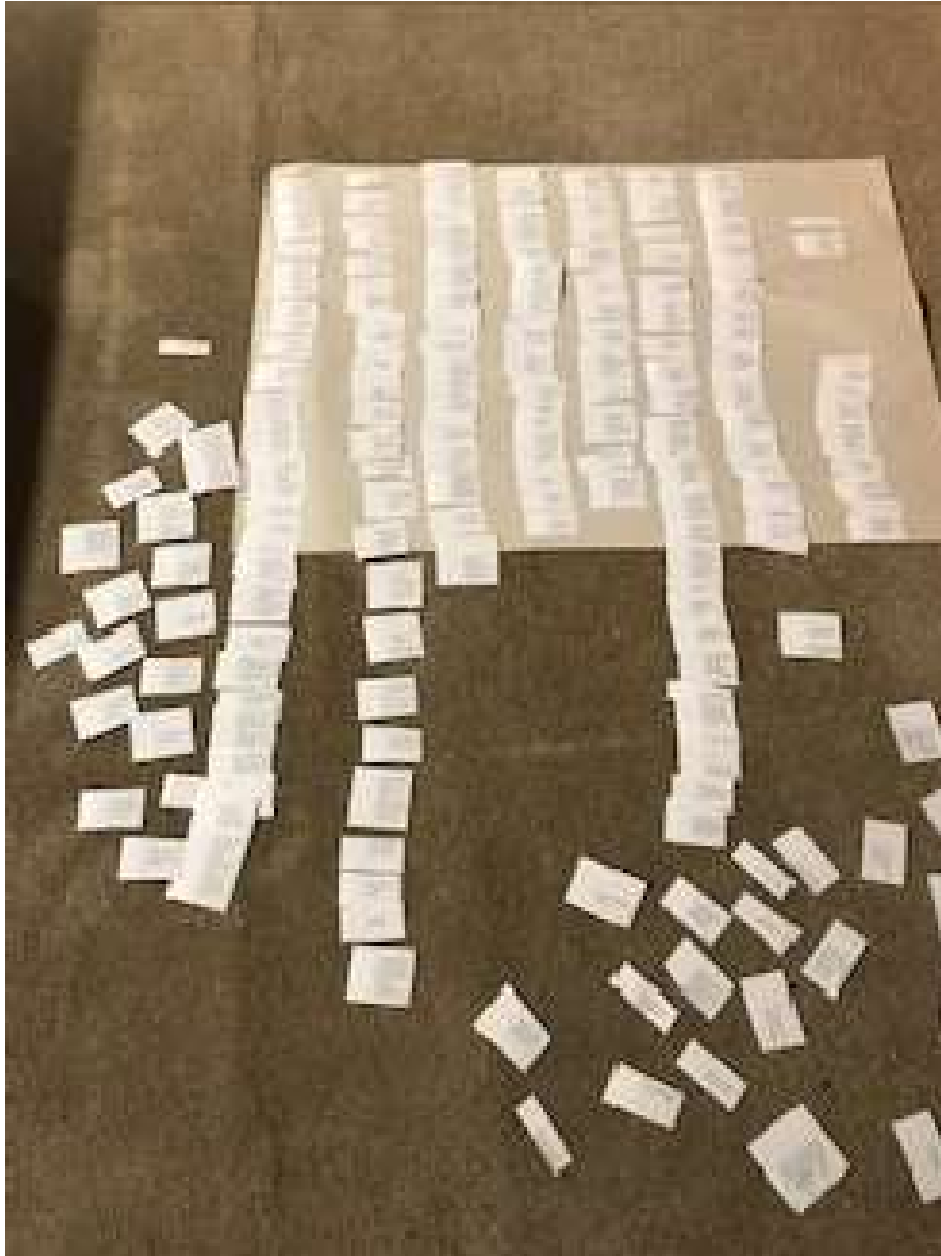
For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through <http://www.aut.ac.nz/research/researchethics>

(This is a computer-generated letter for which no signature is required)

The AUTC Secretariat
Auckland University of Technology Ethics Committee

Cc: cqc3992@aut.ac.nz

Appendix G: Emerging Themes for First Case



Appendix H: Emerging Themes for all Cases



Appendix I: Patterns of Clusters of Themes

