Health, policy and emotion

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CONTEXT AND PURPOSE

Not so very long ago, the idea of publishing a special issue on the topic of healthcare, policy and the emotions might have seemed odd, ridiculous even. Healthcare and policy would certainly have sat happily enough together. After all, healthcare has always had a political dimension. It has never been a simple dyad of patient and practitioner. From its very inception, healthcare has been embedded in a complex web of relationships with community, civic and state authority. Faced with devastating epidemic (as well as endemic) disease, ancient, medieval and early modern cities sought to harness medical knowledge to the benefit of the civic polity, while, as states grew in authority and ambition throughout the 18th century, medical practitioners recognised that health might be considered as a function of governance. Such associations were solidified as the 19th and 20th centuries witnessed the rise of mass societies and as states came to see the routine health of their citizens as a matter of strategic significance. Moreover, since the mid-20th century, we have seen the development of increasingly complex and bureaucratised systems of healthcare, some of them global in scope, which are deemed to require active *management*, leading to the development of entirely new forms of knowledge and expertise that serve as an adjunct to (not to say determinant of) the normative clinical dimensions of healthcare delivery.

But if healthcare and policy sit well enough together, what do the emotions have to do with either? Certainly, in the field of healthcare, emotions have not, until relatively recently, been given a great deal of consideration. Generally speaking, since the 'golden age of medicine' of the early 20th century, healthcare, at least within the conventions of Western biomedicine, has been conceived as the application of rational solutions to technical problems. Bodies are, according to what the sociologist Nicholas Jewson called the 'cosmology' of 'laboratory medicine', more or less the same, and, therefore, all effective healthcare requires is to develop the right technical fix (Schlich 2010), be that pharmaceutical, surgical or hygienic, and ensure that it is delivered to the greatest number of people as safely and efficiently (although not necessarily cheaply) as possible (Jewson 1976, 225–44). Within this cosmology, emotions were (and often still are) conceived as a contaminant of rational decision making, bad for practitioners, who might be 'swayed' by feeling to make poor clinical decisions, and bad for patients, who might make equally adverse choices about their treatment. Indeed, within the medical professional consciousness, emotions have generally been regarded as a synonym for irrationality, the preserve of 'cranks' like antivaxxers who fail to recognise the self-evident truth of empirical science, or the domain of complementary medicine, variously a suboptimal ancillary to 'real' medicine, an indulgent form of self-care or an outright con perpetrated by snake-oil salesmen.

Within the realm of policy, too, emotions have not traditionally been accorded a great deal of importance. Historically, policy has been predicated on the notion of the rational actor, an idealised individual who makes choices based solely on a Benthamite 'felicific calculus' (or 'algorithm') of pleasure and pain. In more recent years, however, things have changed. Policymakers, like economists, have come to recognise that people's decisions are shaped by a wide variety of factors other than rational analysis, including the emotional associations they attach to certain choices. 'What does this say about me?' or 'how do I feel about this?' are as important a consideration for many people as 'what does this do for me?'.

Likewise, in the sphere of healthcare, the role that emotions play in shaping decisions, experience and even clinical outcomes has, for the last 10–15 years, been given far greater consideration. Generally speaking, emotions are still conceived of as something to be obviated or, at best, managed. Much of the focus of those within clinical practice has been on negative emotional and psychological factors such as stress and burnout. These are seen as producing dysfunctional clinical staff, and their imagined solution is often rooted in quintessentially neoliberal concepts such as 'resilience', in which the primary responsibility for psychological and emotional well-being is devolved to the individual (Arnold-Forster 2020; Arnold-Forster, Moses, and Schotland 2022). Other clinicians have focused on similarly negative emotions like anger, and have sought to tackle the cultures of bullying that are widespread in certain specialties such as surgery (see the #HammerItOut campaign led by Simon Fleming).

Both bullying and stress are clearly important issues to address, and a couple of the contributions to this special issue deal directly with the negative emotions associated with clinical practice. However, this emphasis on intraprofessional emotional relations has occasionally come at the cost of a broader consideration of the *positive* role that emotions can play in healthcare and has sometimes occluded an understanding that the emotions of practitioners and patients are inextricably intertwined. Indeed, while practitioners often feel that values such as care and compassion are inherent to the very practice of healthcare and therefore do not require special consideration or training, it is abundantly clear that, for a complex variety of reasons, patients do not always feel *cared for*, no matter how good their treatment may be in a strictly clinical sense. Moreover, it is equally clear that such a felt 'lack of care' is not a subordinate consideration but can have a profoundly negative impact on clinical outcomes. Discussions about a lack of care are apt to produce defensive reactions in many clinical practitioners, evoking painful associations with such incidents as the Mid Staffordshire NHS Foundation Trust Inquiry in the UK (2010–2013). However, it is important to note that emotionally sensitive care does not mean putting the feelings of patients *before* those of practitioners. Rather, and as the excellent work of the Point of Care Foundation has demonstrated, it means adopting a more holistic and integrated understanding of what 'humanised healthcare' might involve.

This collection of essays comes out of a broad concern with the vital role that emotions have played and continue to play, in the practice and experience of healthcare. However, its origins lie in a very specific set of historical and policy interventions, initiated by the Surgery & Emotion project. This project was funded by a Wellcome Trust Investigator Award in the Medical Humanities and Social Sciences, led by Dr Michael Brown and based at the University of Roehampton in London, England, between 2016 and 2021. Alongside Brown, the other two editors of this special issue were project

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team members, as were James Kennaway, Lauren-Ryall Waite and, latterly, David Saunders. The project took a historical approach to the issue of emotion in surgery and sought, among other things, to question and nuance the dominant narrative of clinical detachment and the enduring stereotype of the surgical stoic, demonstrating the emotional richness and complexity of surgical culture across the period from 1800 to the present day. As part of this project, we ran an international conference on the topic of 'health, care and the emotions' in September 2019, taking pains to ensure that we had representation from a variety of different disciplines, as well as from as broad a spectrum of healthcare as possible. This special issue constitutes the ultimate fruits of that endeavour. It draws on scholarly interest in the emotions as a category of inquiry and the growing public and professional appetite to talk about emotional wellbeing in health and social care settings in order to explore the implications of emotional states for healthcare policy and practice.

DISCIPLINES AND APPROACHES

The contributions to this special issue were consciously drawn from a diverse array of disciplinary backgrounds, but they are bound together by the broader intellectual imperatives of the medical humanities. The medical humanities is now a thriving and mature discipline. It is, according to medical educator Martyn Evans, 'an integrated, interdisciplinary, philosophical approach to recording and interpreting human experiences of illness, disability, and medical intervention' (Evans 2002, 509). There has, however, been some debate over how 'medical humanities' should be understood. Key to most conceptualisations of the discipline is a sense of interdisciplinarity and interprofessional communication, dialogue and collaboration. It is an expansive discipline, one that draws together approaches such as the history of medicine, gender and the body, disability studies, literary analysis, art history and bioethics. It incorporates critical, scholarly accounts of healthcare and its history, the therapeutic arts movement and the involvement of the arts in developing healthy communities, and the application of the humanities to medical education.

Some of the most contentious issues around the definition of the medical humanities concern the word 'medical'. Concerns have been raised by academics and educators that this terminology narrowly, or exclusively, relates only to what doctors do, and there have been repeated anxieties around the lack of nurses and other healthcare professionals as either subjects of medical humanities research, or as agents of disciplinary development (Evans and Greaves 2002, 1). More recently, some have recommended the 'health humanities' as a more critical and inclusive discipline that attends to a more complex set of questions(Crawford *et al*. 2015) Crawford 2015. Rather than remaining limited to medical frameworks of understanding, it incorporates health professionals and therapists of all kinds to 'generate diverse and even radical means of creating healthier and more compassionate societies' (Crawford 2015).

Many of the definitions quoted in field-defining articles and position papers tend to focus on how the medical humanities might be best deployed in the training and education of budding doctors (and occasionally nurses) (Wald, McFarland, and Markovina 2019, 492–496). Emphasising the vital role the medical humanities could play in shaping healthcare professionals' intellectual and emotional skills, Craig M Klugman called it 'an interdisciplinary field concerned with understanding the human condition of health and illness in order to create knowledgeable and sensitive health care providers, patients, and family caregivers' (Klugman 2018, 474; Klugman 2017, 419–30). Again, highlighting the connection with medical education, Deborah Kirklin suggested that medical humanities draws on the 'creative and intellectual strengths of diverse disciplines including literature, art, creative writing, drama, film, music, philosophy, ethical decision making, anthropology, and history in pursuit of medical educational goals' (Kirklin 2003, 1050). This relationship or connection between the medical humanities and medical education is born out in the tendency for medical humanities researchers or teachers to be housed in medical schools rather than university humanities departments. While the humanities have a crucial role to play in the training and development of healthcare professionals, as this special issue demonstrates, their social utility is not—and must not—be confined to this position. The medical humanities cannot solely be explored in pursuit of healthcare professionals' interests.

Both quotations above reference the medical humanities' inherent interdisciplinarity. This special issue features contributions from history, art history, literature, social sciences, medical education and healthcare professionals' experience, and many of the articles blend multiple approaches to tackle integrated problems of healthcare, policy and the emotions. Moreover, in its close dialogue with health and social care practitioners, this special issue—as well as the Surgery & Emotion project— takes seriously Felicity Callard and Des Fitzgerald's claim that we can 'make more interesting interventions […] by collaborating *with* people in [the] sciences, rather than simply scrutinizing them', particularly in a moment in which medicine and the sciences seem ever more 'richly and capaciously' *social* in both their orientation and their practice (Callard and Fitzgerald 2015). Or, as William Viney *et al* argue, the medical humanities should occupy the role of the 'critical collaborator – one based on notions of entanglement, rather than servility or antagonism', because it allows it to develop the 'imaginative and creative heterodox qualities and practices', which have long been recognised as the medical humanities' 'core strengths' (Viney, Callard, and Woods 2015, 2).

Across these various disciplines, the emotions have emerged as a key area of research and scholarly interest (Ticineto Clough and Jean 2007). Since the 1980s, the 'affective turn' in the humanities and social sciences has prompted researchers to explore different forms of affects, feelings and/or emotions as they are experienced, expressed and theorised in and across historical periods and places (Leys 2011, 434–472). Scholars have investigated the forms of feelings that emerge in and shape people's encounters with humans and non-human animals, environments, cultures, ideas, technologies, and social or political events. The humanities and social sciences have interrogated how society, culture, politics and language variously structure different ways of articulating and understanding feelings.

In history, the senses, emotions and experience have attracted increasing attention over the past three decades (Dixon 2012, 338–44; Eustace 2012, 1486–1531; Plamper 2010, 237–65). Do feelings have a history? And how have they shaped historical processes? Historians rest on the assumption that emotions are shaped by social contexts. What someone can feel and how they can express those feelings are conditioned by the cultures and communities in which they live and with which they interact. Emotions, senses and experience are, therefore, historically contingent and subject to change (Boddice and Smith 2020). As is likely apparent, there is an expanding interest in applying the history of emotions to

histories of experiencing health and illness and the provision of medicine and care (Bound Alberti 2006). Historians have interrogated the emotional nature of the medical/nursing professional–patient relationship, and the extent to which gender, class or race might influence the diagnosis, treatment and prognosis of pathological emotional conditions (Bourke 2012, 430–52; Alberti 2009, 798–810). They have been attuned to the emotions of suffering patients, attended to the role feelings play in the construction of clinical stereotypes, and have addressed the emotional intensity of healthcare activism and the political deployment of public feeling (Brown 2017, 327–48; Brown 2017; Brown 2019, 19–41; Brown 2020, 239–59; Crane 2018, 52–74; Saunders 2019, 204–28; Boddice 2020).

Literature has followed a similar (although not necessarily the same) trajectory as history. Since the mid-1990s, affect theory has become a major paradigm in literary studies and served as a connection to other fields, such as social psychology, anthropology and political theory. Scholars such as Sianne Ngai and Sara Ahmed have explored the emotional contours of life and their colleagues have sought to organise 'affects' (subjective feelings) into discrete categories and typified their physiological, social, interpersonal and internalised manifestations (Ahmed 2004; Ngai 2007). Scholars have looked at the universals and particularities of affect, explored its embodiment, interrogated the political economies of emotion, and investigated the relationship between feelings, power and justice. Much like the history of emotions, affect theory has been repeatedly applied to the investigation of health, sickness, medicine and social care (Wasson 2018, 106–12).

Researchers in the humanities and social sciences who are interested in emotions in healthcare have tended to focus on the feelings of patients rather than doctors or nurses. They have explored states of ease and dis-ease; analysed narratives of pain, illness and suffering; investigated the emotions associated with patient activism and disempowerment; and have investigated processes of recovery and the anxieties of relative health. By contrast, historical studies that consider the emotions of healthcare practitioners are relatively scarce. Some scholars—including those represented in this special issue—have looked at the feelings of healthcare practitioners and the efforts on behalf of governments, administrators, managers, and policymakers to manage the emotional landscape of modern and contemporary healthcare. Exceptions include Sarah Chaney, who has looked at the development of 'compassion' as an emotional trait among British nurses (Chaney 2021), and Michael Brown and Agnes Arnold-Forster, who have explored the affective landscape of surgery in the 19th and 20th/21st centuries, respectively (Brown 2022; Arnold-Forster 2018; Arnold-Forster 2022). Social scientific investigations of practitioner feelings are perhaps more common. However, these tend to consist of ethnographic case studies of individual hospital departments or other health or social care institutions. They tend not to make big explanatory arguments or provide integrated accounts of historical, social or cultural change.

Researchers from across the humanities and social sciences have, therefore, taken emotions as a subject of inquiry. However, they have also increasingly explored the role of emotions in scholarly practice and investigated how scholars 'feel' about their research, particularly when that research touches on health, sickness, medicine and social care. Historians such as Chris Millard have looked at public expression of personal experience as a vital tool and site for self-development and scholarly research (Millard 2020). Similarly, Tracey Loughran (one of this special issue's authors), Dawn Mannay, Carolyn Steedman, Emily Robinson and Michael Roper have investigated the researcher's emotions, experiences and subjectivities (Robinson 2010; Loughran and Mannay 2018; Roper 2014; Steedman 2002).

These scholarly interests have parallels in healthcare practice and policy. As Michael Brown's research has shown, surgeons and physicians have been preoccupied by the emotional states of their patients since at least the late 18th century. However, new intellectual trends in the decades following the second World War brought patient feelings to the fore in debates about good clinical care and administration. As Victoria Bates has argued, references to 'humanising' healthcare were made in a range of mid-20th-century social and political contexts. These references were in part a reaction to the supposed loss of the 'human' aspects of medicine that accompanied the expansion of healthcare technologies and the professionalisation of medicine that took place in the first half of the century (Bates 2018, 5–19). While sometimes vague, this notion of humanising healthcare indicated a more 'person-centred' or 'patient-centred' movement, one that took the emotions and subjectivities of sufferers of illness seriously. The work of Michael Balint, for example, was part of this movement. He emphasised the importance of the use of emotion and personal understanding in the doctor's work and recognised the therapeutic potential of the doctor–patient relationship. Balint taught medical doctors to search for causes of anxiety and unhappiness in their patients and use this insight in their treatment of suffering (Hayward 2014).

Much like academic researchers in the humanities and social sciences, most healthcare professionals and policymakers were, until recently, predominantly preoccupied by the emotions of patients—or the affective dynamics of the doctor/nurse–patient relationship—rather than the feelings of practitioners. However, anxieties about the emotional health and 'well-being' of doctors, nurses and patients have gained increased public attention in Britain, North America and elsewhere. Professional organisations and health policymakers have placed new emphasis on issues such as stress, burnout and bullying. Research of this nature includes quantitative studies of recruitment, retention and pay; qualitative surveys of the clinical experience conducted by coprofessionals understandably seeking empirical evidence for their suffering; and laboratory-based investigations into the biomarkers of stress and fatigue (Luu et al. 2012, 1179–118; McDonald, Waring, and Harrison 2006, 1097–115; Rimmer 2014, 348–51).

There is a new consensus that health and social care are in the midst of a crisis of emotional ill-health and depleted well-being. Recent research has demonstrated elevated levels of depression and suicidal ideation among doctors and nurses; studies have revealed a high degree of burnout among clinicians and medical students in the UK, and new and persistent pressures have led to a supposed epidemic in serious psychological and emotional conditions. This epidemic has prompted a range of responses from those responsible for professional standards and training in Britain. It has also prompted this special issue, which explores how healthcare professionals conceive and conceived of their work in terms of emotions and interrogate the connections between certain emotional expectations and the realities of healthcare labour. Emotions are, we posit, key to understanding the modern and contemporary history of British health and social care. Attending to feelings helps us to access the meanings and values practitioners applied and apply to their work, and gives us insight into the relationship between policy change and experience (Arnold-Forster and Moulds, 2022).

Now, increased workloads, staff shortages and restricted resources have intensified the stresses and strains of healthcare life; and, at the same time, there has been a decline in informal support structures that are not being met by formal interventions designed to maintain professional emotional and mental health. At a time when governments, organisations and policymakers are intensely concerned with the nature and conditions of health and social care treatment and labour, and the changing politics of well-being at both work and home, this special issue intervenes in pressing conversations about contemporary healthcare policy, practice and professionalisation. It interrogates the potential relationship between the medical humanities and policy-making and explores the role humanities research can play in shaping policy discussions and frontline practice. These questions are particularly pertinent now, during the ongoing COVID-19 pandemic. There has, after all, been a groundswell of interest and new initiatives to support practitioner well-being, spurred on by the pandemic. How has the novel coronavirus exposed and exacerbated existing problems with health inequalities, patient experiences, health communication, and practitioner well-being?

Fundamentally, this special issue argues that humanities research can play a vital role in public and political debates about health and social care. Needless to say, the medical humanities have an inherent value in enabling us to better understand our historical and cultural relationships with health and illness. But they can also serve a more instrumental purpose, by functioning as a constructive critic within discussions of policy – one that inoculates discourse and decision making against nostalgia or crude simplicity, offering ways to adapt systems that have been successful in the past to a twenty-first century world and workforce, and grounding programmes and innovations in their historical and structural contexts. In this way, we hope what follows will also engage those beyond the immediate realm of the medical humanities and speak, as we have hoped to do through the Surgery & Emotion project, to those at the cutting edge of healthcare delivery.

CONTENT AND THEMES

The articles in this volume come from a variety of disciplinary perspectives and deal with a range of different historical and clinical contexts. They also speak to a common set of themes, however. Two of the most striking of these are the emotional labour of health and care work and the ways in which practitioners manage their emotions. In her opening article, Courtney E. Thompson considers the function of emotions in the nineteenth-century doctor-patient encounter. Looking at the archive of Andrew Bowles Holder, a physician in the Southern United States, Thompson suggests that literary thinking structured the physician's bedside manner, his coping strategies, and the performance of his professional identity. This case study of Holder, Thompson contends, offers an insight into how literature and the humanities provide tools for knowing the self and for navigating the emotional landscape of care.

The interrelationship between narrative and patient care is also examined in Joe Wood's article, which focuses on the approach to end-of-life care championed by Cicely Saunders (1918–2005). Looking at the conceptions of 'total pain' in her writing, Wood considers how attention to the emotions were central to Saunders' construction and performance of her identity, as with Holder in Thompson's analysis. Wood reveals the emotive force of anecdotes, soundbites and textual fragments in communicating patients' experiences of pain, asking what this approach to understanding narrative medicine might offer clinical education and the production of medical knowledge. The ways in which texts shape the emotional landscape of care informs the work of Leah Sidi, whose article traces representations of psychiatric patients in the tabloid press, before and after the 1990 NHS and Community Care Act. Sidi argues that, in the popular imagination, this legislation came to signal a shift from psychiatric care in the asylum to in the community.

The spaces and settings of care are also considered in Rosie Harrison's article, which elucidates the emotional labour of twenty-first-century paid care work. Drawing on her experiences of working in the care industry and ethnographic research in a domiciliary care company, Harrison scrutinises how carers negotiate different definitions of care - business, medical/professional, and familial. She argues that workers variously deploy or resist these conceptualisations in their embodied practices of care, not least to draw boundaries around their work and the emotional resources it entails. Like Thompson and Wood, Harrison sheds light on the construction of occupational identities, workers' interactions with patients, and coping strategies deployed by practitioners. Harrison's work is explicitly informed by her own experiences providing care and, across the issue, contributors are self-reflexive about the role of the researcher, considering their own affective engagement with their work, its emotional costs and rewards. Christine Slobogin interrogates her own feelings of working with an archival collection of Second World War photographs and illustrations of facial reconstruction. She asks how and why particular images and media elicit different emotional responses from the viewer. Unpacking the opportunities and limits of historical empathy with surgical images, Slobogin considers how these ideas can be applied to pedagogical approaches in surgical education and the medical humanities.

The ways in which humanities research can inform clinical education and practice is a key theme of Marie Allitt and Sally Frampton's article, which argues that today's medical students should be able to use the medical humanities to critique the structures and conditions which shape the profession they are due to enter, and ought to be armed with the skills to interrogate unhelpful, unhealthy, and exclusionary aspects of medical culture. Allitt and Frampton seek to expand ideas about emotions, affect, and cognitive states, beyond the focus on empathy. The role of historical empathy is also interrogated by Tracey Loughran, Kate Mahoney, and Daisy Payling. Their article critically reflects on their experiences of delivering public and professional engagement on the 'Body, Self, and Family' project, which sheds light on the 'everyday health' of women between the 1960s and 1990s. The authors share a series of case studies of their activities with medical students and the public, which sought to historicise understandings of gender, well-being, and embodiment and to develop historicised empathy. Sharing lessons learnt from their interactions with different audiences, the authors emphasise the importance of cultivating a dialogue across medicine and the humanities.

As Loughran, Mahoney and Payling attest, guiding audiences towards a sense of the 'messiness' and 'irresolvability' of history and of the emotions is both a challenge and a responsibility. The value of the humanities in this sphere is also uncovered in the work of Sydney McQueen, Melanie Hammond Mobilio and Carol-Anne Moulton. Like Thompson and Harrison, they focus their attention on the emotional experience of the healthcare worker. Their article calls for a holistic framework for understanding physician stress, one that foregrounds the subjective experience of 'the person behind the white coat'. This approach, they argue, is central to understanding how physicians lead, work in teams, make decisions and care for patients. This argument taps into the developing interest in the emotional

health and well-being of those who provide health and care, an area of concern which is increasingly prioritised in policy-making, as we have outlined.

It is this imperative which informs the closing commentary by trainee doctors Laura Archer and George Greenlees, who discuss their experiences of running Balint groups for undergraduate medical students, in particular what this revealed about feelings of guilt and shame. Archer and Greenlees argue for the importance of equipping aspiring doctors with the skills to express and manage these feelings. The authors explain that they were surprised to encounter these particular emotions in the groups. Throughout the issue, contributors attend to many of the surprising or unexpected feelings that underpin experiences of delivering, receiving and understanding health and care. As the special issue shows, appreciating the richness and messiness of this emotional landscape is central to the value that the health humanities offer to policy and practice.

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Correction: *Health, policy and emotion*

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