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FROM PAPERWORK TO PARENTING: EXPERIENCES OF PROFESSIONAL STAFF IN STUDENT SUPPORT

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ABSTRACT

Background

For academic staff, responding to student concerns is an important responsibility. Professional staff, or non-academic staff who do administrative work in medical schools, are often first to be approached by students, yet there is little research on how they manage student issues. Informed by the conceptual framework of emotional labour, we examined the experiences of professional staff, aiming to identify theoretical and practical insights for improving the provision of student support. We examined the scope of support provided, the impact of providing this support on staff and how these impacts can be managed.

Methods

Professional staff at two medical schools were invited to participate in semi-structured qualitative interviews. Interviews were transcribed and independently analysed for emergent themes. Data analysis continued with purposive sampling for maximum variation until thematic saturation was reached. Findings were returned to participants in writing and via oral presentations for member checking and refinement.

Findings

Twenty-two female staff from clinical, teaching and commercial backgrounds at nine urban and rural teaching sites were interviewed. Participants described providing support for diverse concerns, from routine requests to life-threatening emergencies. Four major themes emerged: firstly, all described roles consistent with *emotional labour*. Secondly, student support was regarded as *informal work*, and not well recognised or defined. Consequently, many drew upon their *personal orientation* to provide support. Finally, we identified both positive and negative *personal impacts*, including ongoing distress after critical events.

Discussion

Professional staff perform a range of student support work, leading to emotional, personal and work impacts. In turn, they need support, recognition and training in this essential but under-recognised role. Emotional labour offers a conceptual framework for understanding the gendered nature and impact of this work and how it may be managed. We suggest practical strategies for promoting positive and preventing negative effects on staff from supporting medical students.

BACKGROUND

Medical schools are obliged to provide academic and pastoral support to students. This obligation is supported by evidence on the extent of stress and distress in medical students (1), and the effect of stressors on student learning, progression (2) and professional behaviours, including unexplained absences, cheating and dishonesty (3). With adequate support, such lapses in professionalism do not inevitably lead to future problems, as many more students are identified with concerns than those who subsequently become impaired practitioners (4). Responding to student concerns is thus an educational and ethical responsibility, reflected by accreditation standards and codes around the world (5-8), and in expectations that institutions will manage the work of staff who provide support (9).

Professional staff (also referred to as administrative staff) in medical schools have varied and essential roles across the entire range of administration and management tasks which are required to deliver health professional programs at on-campus and clinical clerkship sites. Professional staff may have clinical, teaching or administrative experience and professional backgrounds, but they may also have no formal qualifications.

In this study, we focus only on frontline professional staff who interact directly with students. These staff are generally at entry or mid-range levels of appointment, and range from receptionists whose primary duties are to answer phone and in-person inquiries and assist with office duties, to more experienced student officers who provide administrative support for discrete program components, student cohorts, or teaching sites (5, 6). While professional staff roles are essential and complementary to academic roles, they have limited decision making authority about the program and student outcomes.

Nonetheless, professional staff are often the first to be approached when student concerns arise, and to learn about and initiate a school response to grave and catastrophic incidents,

particularly at clerkship sites. (10) This “triage” aspect of the role, which requires staff to identify the level of urgency and notify appropriate persons, shares similarities with the routine and gatekeeping responsibilities of receptionists in primary care services (11, 12).

Despite the centrality of such roles to student welfare, there appears to be little published evidence in the health, education or management literature about the student support work performed by professional staff.

Theoretical Framework

To generate new insights and assist in identifying practical responses, our study was informed by the concept of emotional labour (EL) (13). Coined by Arlie Hochschild to describe the customer service roles of female flight attendants, EL has since been expanded to include other occupations. EL is a type of *emotion work*, or management of one’s feelings for public display with the purpose of inducing a desired state of mind in others (13). When it is expected as part of employment, either informally as an organizational norm which governs behaviour, or formally, through directives about dealing with customers or clients, it is called emotional labour (13, 14).

Each occupation and organization has its own cultural norms or display rules for the appropriate expression of emotions, which are largely learnt through socialisation.

Hochschild likened the manipulation of verbal and non-verbal expressions in EL to acting: *surface acting*, when an actor adapts his or her expressions to give the appearance of feeling the desired emotion; and *deep acting*, when efforts are made to suppress or evoke emotions so that an appropriate expression is assumed (15).

The continual effort of acting may lead to emotional dissonance, particularly when institutional display rules are in conflict with the actors’ personal values or the values of their profession (16). This conflict is associated with high measures of stress, emotional exhaustion, burnout, increased absenteeism and turnover (17). These negative effects can be ameliorated by organizational responses such as managing work practices and training (14).

Previous research has confirmed the relevance of EL and its negative impacts in the caring professions, including nursing and social work (15, 18-20); in education, including school teachers (21-23) and university academics (24-26); and in service industries (27, 28). Early

research suggests that receptionists in medical practices perform emotion work (29), but no research was found which directly related to the roles of professional staff in medical schools. Informed by emotional labour concepts, we therefore examined the experiences of frontline professional staff who provide student support. Our aim was to identify theoretical and practical insights to better understand and improve the provision of student support by professional staff. Our research questions were:

- What is the scope of student support provided by professional staff?
- What are the impacts of student support work on professional staff?
- How can the impact on professional staff be managed?

METHODS

To explore the personal experiences of student support from the participants' perspectives, we conducted in-depth qualitative interviews with professional staff at two medical schools. We used EL concepts as theoretical tools for analysing how professional staff assign meaning to the student support work that they perform and to our interpretation of the results. To enhance rigour, we adhere to the Standards for Reporting Qualitative Research (SRQR) guidelines for qualitative research (30).

We took a constructivist approach (31); that is, we sought not to pre-suppose any findings for our research questions, and acknowledged the influence of our experiences as academic (WH, EF, RWK) and professional (RM) staff in medical schools on the study. We also drew upon our different disciplinary backgrounds (medicine, linguistics, sociology, education, medical administration), professional interests in counselling (WH, EF), and prior roles in student support (RWK, EF, WH) to bring multiple perspectives to the data analysis and interpretation. To avoid any perceived coercion to participate, none of the researchers had supervisory responsibilities with any of the participants.

Context

To enhance transferability, we conducted the study at different teaching sites in contrasting medical schools. Medical School A is a recently established, school leaver entry undergraduate medical program, with approximately 600 students across all cohorts. The

main campus is located in an outer metropolitan area, with 3 urban and 2 rural clinical school sites as well as remote clinical placements. Medical School B is a long established medical school, which at the time of the study offered a mixed school leaver and graduate entry program with 300 students in each year. The main campus is located in a metropolitan area with 5 urban and 3 rural clinical school sites. In addition to usual university on-campus student counselling, disability, health and welfare services at both medical schools, Medical School B has academic staff in part-time roles designated for student support, independent of teaching and assessment responsibilities. At both medical schools, there are professional staff employed to manage student requests for information, timetabling, enrolment, leave and other routine concerns related to medical program delivery. Our study focussed on these staff. It arose from a larger project which included interviews with academic staff, aimed at creating training resources for academic and professional staff in medical education (10).

Recruitment and Data Collection

As staffing, procedures, and practices differed between the teaching sites, we purposively sampled across all campuses and types of teaching sites, and for participants with varying employment backgrounds, levels of experience and responsibilities. Participants were invited by email using public staff directories. Written informed consent was obtained from all participants.

Open-ended semi-structured interview questions were developed, guided by a 2011 internal review of student support at Medical School A. Anticipating the potentially sensitive and personalised nature of staff experiences, we used a narrative approach (32), asking participants to choose and recount instances when they had provided support that they were comfortable to disclose (see Appendix S1 available online)

The interviews were independently conducted by WH, EF and RWK between 2011-2012, audio-recorded and transcribed verbatim. Participants were interviewed by either WH, EF or RWK, with interviews ranging from 19 to 77 minutes in duration. Transcripts were checked for accuracy and de-identified by the interviewer prior to data analysis. At interview, each participant was reminded of the voluntary nature of the research, and the interviewer's role as a researcher (33).

Approval for the study was granted by research ethics bodies of both medical schools [ID No. H8555 Western Sydney University, ID No. 1231385 University of Melbourne].

Data Analysis

Analysis of each de-identified transcript was performed separately by two researchers (WH, EF or RWK). Emergent themes were identified through systematic reading of each transcript to identify and name *a priori* ideas, or codes, as expressed by the participants (34), using qualitative data analysis software (QSR Nvivo v10, Doncaster, Victoria, Australia). These codes were then used to generate themes. Through iterative review and discussion, we developed agreed meanings and unique descriptors for each theme. Conceptually similar themes were then combined into major themes, or differentiated into separate themes and subthemes. Divergent participant views were sought by purposive sampling, compared with earlier analyses, and either new codes discovered or the data incorporated into existing themes and the descriptors revised. This process occurred concurrently so that sampling continued until thematic saturation was achieved (35).

To add depth and further explanatory insights to our analysis, all researchers (WH, RWK, RM, EF) reviewed the analysis in the light of key concepts in emotional labour. To enhance trustworthiness, several member checks were undertaken: written summaries of preliminary themes were returned to participants for their comment, and findings were presented at national conferences on health professional education and at workshops attended by participants. Audience feedback was used to refine the final themes and subthemes.

RESULTS

All invited staff agreed to participate with the exception of two who indicated that they did not deal directly with students. Participants were 22 professional staff employed in 9 teaching sites, comprising 2 main campuses, 2 inner metropolitan, 2 outer metropolitan and 3 rural clinical schools. All participants were female, reflecting the staffing profile of both schools. All had been previously employed in higher education, healthcare and commercial business sectors. Less than a quarter had teaching or clinical qualifications, and less than half had any prior experience with medical students, although the great majority (90%) had worked previously with university students (See **Table 1**).

Four themes and associated sub-themes emerged, regarding:

- the women's experiences in supporting students as *emotional labour*
- how support roles were perceived as *informal work*
- how *personal orientation* and prior experiences mediated these roles
- the *personal impact* of support work, and how it could be moderated.

These themes and their sub-themes are illustrated below. Themes and sub-themes are identified in italics.

STUDENT SUPPORT AS EMOTIONAL LABOUR

This first theme describes the scope of support work performed by professional staff, and whether it entailed emotion work, as dictated by organizational norms. The subthemes explored the nature of this work; staff were expected to *be accessible, customer focused, to act and manage their emotions*.

Being accessible

Participants confirmed that they were in frontline roles, always available to answer student queries, from mundane enquiries to dealing with serious disclosures about personal concerns. **Figure 1** outlines the range of reported concerns. Participants were accessible physically, by occupying a reception desk or open office, and socially, by having fewer hierarchical constraints. It was in the context of doing this routine work that pastoral concerns arose:

A lot of people, academic staff, are only part-timers and...because we are here Monday to Friday, we have to answer a lot of queries from students - distressed students (P22).

Being customer focused

Some participants used the term "customer service" to describe their approach to student support:

We had a big push at the end of last year about customer service, customer service, customer service and that's what it was going to be about.....that's been my background, so.... if you can go that extra bit you'd go that extra bit (P19).

These staff described their work as being aimed at keeping “customers” – students and academic staff – satisfied, by providing services that met customer expectations, such as organizing access to further supports and services if they felt these were required.

Acting and managing emotions

Many described a need to keep emotions in check when students came to unburden their anxieties, which were typically about relationships with peers and family, and study. They would listen sympathetically, displaying an understanding demeanour:

Yeah, letting them know that I am here, because I have been through things like that myself. So I’m open to them if they just need someone to yell at, [that] it’s not fair or whatever; I can deal with that (P21).

Surface acting to deflect intense student emotions was routine. But occasionally, there were unexpected turns during seemingly innocent exchanges which demanded much more effort to conceal their instinctive responses:

You’re having a general chat and then all of a sudden things start to come out.....and you just go like, “Oh my God, like this is just horrendous” (P_06).

In such crises, participants described making deep efforts to manage their own emotions, while acting to display an appearance of being calm and in control:

In a way I sort of had to be strong in front of everybody. [Professional Staff] sort of fell into a mess. So I pretty much had to say, right, we’ve got to do this, we’ve got to do that and I’m not going to ring [Academic] in this moment. He’s got patients.....So I sort of had to make all the decisions which was hard, because my head was just, you know, nearly about to explode (P1).

Although rare, these emergencies and extreme situations were vividly recalled, disturbing their equanimity and work for many weeks afterwards:

For some the exams went on and I just couldn’t concentrate on working. It was really hard. It was just like, this hasn’t happened, you know (P1).

In such circumstances, deep acting was again needed to manage the ongoing emotional disruption and continue their day to day work.

You've got to be strong and you've got to just go, 'Okay, well this is what we've got to do' (P6).

INFORMAL WORK AND REAL WORK

In this second theme, participants distinguished student support from their 'real work'. The subthemes relate to how this work was unrecognised and ill-defined, and thus *learnt on the job, not my real work*, leading to role *ambiguity and confusion*.

Learning on the job

An organizational ethos, or culture, about supporting students was inculcated in the participants through role models:

It started from Doctor [name] and Doctor [name], who were very much student orientated people. They really cared about the individual.....so I think I learnt, I had very good role models to learn from and we have continued to do that (P22).

Also learnt through observation were the behavioural norms or unwritten rules of the medical school when dealing with student concerns:

The whole business of privacy is very big in the medical world and I've internalised it....there's often a quick glance over the shoulder to see if anyone's listening and sometimes people jump into rooms and shut the door (P13).

Not my real work

Many felt a strong sense of responsibility, some calling it a "duty of care" towards students, but this was not supported by their formal job descriptions, nor by what they were initially hired to do:

So you sort of, I don't sort of do things that I'm not meant to, I don't think. But things that come up along the way, I'm not going to say, "Well, I won't touch that" (P20).

Participants believed student support work to be important, but the lack of formal accounting for it created tensions between what they called "real" work, and the work of student support:

And today is a pure example.... So my work - my Tuesday task list hasn't been touched, literally hasn't been touched. So you just go, "Oh well, tomorrow I'll have to do that, what was due yesterday" (P6).

While some accepted student support as a calling or an unavoidable duty, others experienced anxiety and role conflict when formal work was put aside to cater for impromptu student requests.

Ambiguity and confusion

Adding to this conflict, participants were unclear about the scope of support they were expected to provide:

From my perspective there doesn't seem to be procedures and policies around it (P10).

The mismatch between felt obligation, official approval and clear direction on what should and should not be done led to role confusion, even in experienced participants who were otherwise confident about their duties:

Because I was unsure if I was responsible or not, when...[Academic] said to me, "Look, we might go in there and he's hung himself from the stairs, that's what I'm worried about"..... I thought gosh, I don't know this [Student]; I felt dissatisfied that I didn't know [the Student] or know my role (P2).

PERSONAL ORIENTATION

In the absence of clear direction, this third theme relates to how the participants' approach was then greatly influenced by their personal orientation towards support work and prior experiences. The subthemes were *individual disposition*, the *nurturing mother*, and *setting boundaries*.

Individual disposition

Some described themselves as liking or having a temperament for engaging with students; they felt they were approachable, enjoyed the interaction, and were sincerely interested in the daily lives of students:

I think it's not discouraged that I fraternise....if I see a group of students out in the hall, rather than just go back to my office, which is I suppose my job, my *actual* job, I will go out and say hello and say, How are you going, what rotation are you doing, blah, blah, blah.... I'll do that, not because I've been told to do it (P4).

Several cited their own experiences with mental illness and how this sensitized them towards the signals and needs of young people in distress:

I'm fairly good at reading people, I think I just pick up.....So I sort of know some signs with stuff like that and depression, only because I went through that and I hid it quite well (P1).

The nurturing mother

Whether they were parents or not, some women strongly identified with the “mother hen” persona, with several referring to students as “chicks”. While this imagery was strongly influenced by personal disposition, it was reinforced by the way these particular women were portrayed in the school:

That's what [Academic] always calls me. He always goes, “Oh, this is your second mother. She's your mother hen; she'll look after you for anything. Just go to [name] and she'll fix it” (P11).

This imagery drew upon societal expectations of women to be caring and nurturing, and to be responsible for the welfare and outcomes of the young. They described how they would treat students as they would like others to treat their own children:

And I guess as a mum you want to keep the communication channels open, and that's what I've done with the students as well, that I haven't shut a door on them (P10).

Setting boundaries

However, not all saw the support role as being a nurturing form of parenting. These participants did not express warm emotions towards medical students, and related misgivings about adopting a forgiving approach, which fitted neither with their temperament, nor with their views on how medical students should develop and behave:

When I see [Professional Staff] with them, she's so mothering and I think, “I can't do that. I can't be like [her].” I just have to help them and send them off, and that's it. Off you go, you're not a baby.....maybe if they rely on us too much, it wouldn't help them go out in the real world. When they work in the hospital, it's rough (P14).

Not all were willing to perform emotion work, describing instances where they believed students should take responsibility for their own situation.

PERSONAL IMPACTS

The final theme, *personal impacts*, and subthemes refer to the significant *negative* – and *positive* – effects from dealing with student concerns that were described. Some of these impacts could be *managed* by the participants themselves, while others suggest organizational responses.

The negatives

In moving narratives, participants relived experiences of crisis events: the immediate shock, and the ongoing aftermath. Individuals responded differently to these experiences:

And you're just – you know, I went home and cried for three days after that...because I – well, I don't know if I'm equipped to deal with things like that (P6).

It didn't affect me personally, particularly..... and you feel dreadfully sad but it didn't affect me in the way that I would think (P2).

There were also cumulative effects from dealing with student concerns on a daily basis:

You can't just switch off like that – you take these things a bit personally yourself (P8).

Negative effects were heightened by frustration from a perceived lack of organizational responsiveness and lack of understanding of their work. Participants felt their advocacy was ineffectual even when dealing with straightforward concerns:

When you can't answer it and you need to take it to the next level and sometimes it doesn't get answered, that's when it gets frustrating and you feel like you're sort of stringing that student along and constantly saying, we'll get back to you (P19).

....and the positives

Nevertheless, participants also related positive effects such as satisfaction in having helped a student; sometimes just by providing information, or by using their networks to facilitate a resolution to the concern.

Occasionally, their support roles were publicly acknowledged and valued by academic staff. Longitudinal connections, where relationships with students had developed over time, and feeling that they had been part of the student's journey from being a naïve "first year" towards being a doctor, were immensely satisfying:

These little proud moments where you think, "That's one of my students", and then you have other moments where you think, "Oh, God, that's one of my students (P12).

That is, they felt part of the mission of the medical school, and of its collective efforts and investment in the medical profession, moulding the future doctors who would look after them and their families.

Managing the impacts

Participants suggested organizational responses to prevent, or ameliorate, negative impacts. Setting boundaries and enabling individuals to manage their work were particularly important for staff who were not oriented towards support work. It was important to select the right person for dealing with students; people who could understand the student perspective but not necessarily over-invest in student concerns:

Our previous coordinator used to joke whenever we were employing staff ... she'd usually put down: "Must Love Students". You don't have to *love* them love them, but you have to understand them and know what their anxieties and worries are (P20).

Rather than formal training courses, participants valued support from trusted peers and supervisors as situations arose, for collegial advice, unburdening and exchanging experiences. For those in isolated clinical sites, knowing that there was a more experienced staff member or academic who would hear them out was greatly reassuring:

Sometimes when everything is just becoming too much, what I've got to do is sit down with [Academic] for five minutes, she'll back me up (P17).

DISCUSSION

Our findings suggest that professional staff in medical schools play important but largely unacknowledged roles in student support. We identified significant emotional and other personal impacts from this work, with strong parallels to emotional labour. Participants performed emotion work that was part of societal and organizational culture, engaged in

surface and deep acting, and expressed emotional dissonance when the role conflicted with their personal orientation and perceived work roles. While many expressed a strong sense of personal responsibility towards student welfare, others were uncomfortable with prevailing organizational norms to be caring towards students, and had concerns with what they viewed as an overly benevolent approach. Nevertheless, even with contrasting histories, staff responsibilities, student cohorts and procedures, participants' narratives were consistent across both medical schools and all teaching sites. All told of episodes which had resulted in an emotional impact, and in some cases, significant distress.

Our participants were all women, yet none acknowledged how gender could have influenced how their support work was construed by themselves or others. Occupations requiring EL are highly feminised, such as nursing (19), teaching (22), service and administration (36).

Moreover, women are more likely to perform EL than men employed in the same role (25, 37), and may be judged more harshly when they do not (13). In keeping with this research, our findings suggest an unspoken but pervasively gendered culture in medical schools, with the division of labour reflecting how women are conditioned by societal expectations to be nurturers and carers. Participants felt responsible for student welfare, without being given formal instruction or direction to do so, drawing upon personal experiences and expectations to be "mother hens" to make sense of their roles.

However, EL research on the negative effects of customer service work does not completely explain the complexities of student support. Consistent with research on teachers (22) and first responder professions (38), there were positive aspects which were highly motivating for participants. These included a sense of satisfaction in having helped a student, and also feeling part of a higher purpose, to develop future doctors. This conferred a heightened sense of commitment which would not be expected in customer service roles where fleeting encounters with strangers predominate. Interactions with students are often short, but cumulatively over time they can evolve into individualized relationships. Longitudinal connections could protect staff from the negative effects of EL documented in customer service roles, such as burnout, absenteeism and turnover (39), but may also create unclear boundaries about where staff responsibility for students begins and ends.

Frontline professional staff roles could thus be re-conceptualized to be more than purely administrative as is often depicted in formal job descriptions for these staff. Participants

shared in the ups and downs of students' lives as they progressed in the program, dispensing nurture or sanction as appropriate. Professional staff roles may better fit with EL research from nursing (15) or teaching (25), reflecting the enhanced relationship between nurses and their patients, or teachers and their students. Our findings suggest a unique and important place for professional staff in medical schools.

Despite the sensitive nature of the topic, participants were keen to be involved and used the research as an opportunity to confidentially debrief and express their concerns. We were surprised at the openness with which the women related experiences that had affected them greatly, suggesting a need for debriefing and support. Others lacked confidence or were uncertain about their roles and used the interview to check whether they were taking the correct approach. There are few tangible outputs from the work of student support, but there appears to be a very real and sometimes ongoing impact on staff, suggesting that organizational responses are required.

Implications for organizational practice

Our findings suggest unmet needs for role clarification and management of work, which build on EL research from other fields to show how organizational responses could moderate the impact on staff and improve the effectiveness of student support.

Many participants had attended some training such as workshops on recognising mental health problems, but other strategies are needed to address the effects of constant accessibility, ambiguous roles and organizational procedures, and poor fit between personal orientation, workload and support roles. **Table 2** links themes and subthemes from our findings to practical responses that are supported by EL research from organizational and management science.

More positive experiences for staff and students may thus result when medical schools formally recognise the impact of support work, select staff who enjoy interacting with students, and assist them to feel involved in student development without crossing professional boundaries. While participants desired greater role clarity and structure, they realised that some flexibility was needed to cater for unpredictable situations and unexpected emotions. It appears important that academic and supervising staff promote informal

opportunities for just-in-time advice, debriefing and peer support (38). Such approaches create “communities of coping” for managing the impact of EL, and have been noted in social work, nursing, and other front line roles (40). They may also offer women respite from the constraints of expectations to care for students in academic environments where such work is not counted as real work. (41)

Limitations

Our findings are limited to participants from two medical schools. However, consistent findings across contrasting schools and sites, sampling to thematic saturation, multiple member checks in different fora over time, and comparability with previous EL research from different fields has enhanced the transferability and trustworthiness of the results.

We have identified gender as a strong implicit influence on the work of professional staff. Our study was not designed to investigate gender, so further work should more directly examine the relationship of gender to support work and student experiences.

For ethical reasons, we took care to separate our employment as academics (WH, RWK, EF) in medical schools from the research. While our positions facilitated our understanding of student support work and our entry to research sites, the standing of professional staff in medical schools, and in relation to us, cannot be ignored. For example, the repeated assertions that participants did not overstep their role are likely to have involved considerable face work (42) to ensure that they were not seen to be breaking unspoken rules about what professional staff can and cannot do. Conversely, the safe and confidential environment of a research study, providing an opportunity to give an open and honest account of practices which had troubled participants to researchers who were also women with student support experience, may have empowered them to speak up. The involvement of a researcher (RM) who is familiar with professional staff roles but unrelated to the research sites and student support has provided a more nuanced analysis and interpretation of our data.

CONCLUSIONS

Our study has revealed the experiences and confirmed the significant work of professional staff in student support. It has examined the impact of this work, and expanded the empirical

basis for the conceptual framework of emotional labour to a new occupational group whose work has not been well researched. Emotional labour has provided insights which build on research from other fields to inform practical responses for ameliorating the negative, and promoting the positive aspects of student support work. Medical student support involves many groups; our research has highlighted the work of one, albeit under-researched, group, and raises questions about the transferability of our findings to other professional and organizational cultures, the relevance of emotional labour to the work of academic staff, the influence of gender, and the effectiveness of the suggested strategies to manage the work of student support.

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AUTHORSHIP

Wendy Hu, Eleanor Flynn and Robyn Woodward-Kron were responsible for designing the study, data collection, data analysis, drafting, review, revision and final approval of the manuscript. Rebecca Mann was responsible for data analysis and interpretation, revision and final approval of the manuscript. All authors agree to be accountable for all aspects of the work and for ensuring that any questions relating to the accuracy and integrity of the work are appropriately investigated and identified.

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CONFLICTS of INTEREST

The authors have no competing interests to declare

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TABLE 1: PARTICIPANT CHARACTERISTICS

	<i>n</i> = 22
Female	22
Years in role (median)	1-17 (3.5)
Supervisor of professional staff	6
Qualifications	
• Administration	17
• Clinical	3
• Teaching	2
Prior employer	
• University & Vocational College	14
• Health Service	5
• Other, including Commercial	3
Prior experience with students	
• Medical students	9
• University students (non-health)	7

• Other health professional students	4
• No prior experience	2

TABLE 2: STRATEGIES TO MANAGE THE IMPACT OF EMOTIONAL LABOUR IN STUDENT SUPPORT

The following table links study findings with strategies which are supported by emotional labour research in other professions.

Theme: subtheme	Organizational strategies	Reference
Personal Orientation: Individual disposition Personal impacts: Managing the impacts	Recruitment and selection • Selection of staff with personal orientation towards emotion work and positive attitudes to students and their concerns	(17, 38)
Informal Work and Real Work: Learning on the job Ambiguity and confusion	Induction and orientation • Orientation to role and its alignment with the mission of the medical school • Role clarification of responsibilities in student support • Knowledge of and readily accessible current information about: (1) policies and procedures regarding: when to refer, assessment, progression, obligations to provide support, privacy and confidentiality, reporting and documentation (2) local support services and referral pathways (3) identification and initial response to common mental health presentations	(14)

Informal Work and Real Work: Not my real work Personal Impacts: The negatives Managing the impacts	Role design • Rotating duties with respite periods from being accessible to students • Formal recognition and inclusion of support work in workload agreements	(14, 43)
Informal Work and Real Work: Not my real work Personal Impacts: Managing the impacts	Supervision and teamwork • Team approach to student support, particularly in clinical teaching sites • Supportive and accessible supervisor who is aware of the impact of support work	(44)
Informal Work and Real Work: Not my real work Personal Orientation: Setting boundaries Personal Impacts: ...and the positives Managing the impacts	Ongoing support and professional development • Opportunities for informal exchange to build a community of practice and peer support • Skills training in student mental health and well-being, self-care and boundary setting • Policies and performance review that promote the positive aspects of emotion work	(17, 39, 40, 44)
Emotional labour: Acting and managing emotions Personal impacts: Managing the impacts	Emergency situations • A critical incident flowchart for in crisis situations, tailored to each teaching site • Opportunities for critical incident debriefings after distressing or disturbing encounters • Monitoring for early identification of ongoing trauma symptoms and need for assistance	(38, 41)

FIGURE 1: RANGE OF STUDENT CONCERNS DESCRIBED BY PARTICIPANTS



Scheduling, procedures, paperwork
Study: progress and assessments
Clerkships: learning issues, isolation
Relationships: peers, staff and family
Financial and employment pressures
Physical illness and impairments
Mental health and substance abuse
Acute life-threatening events, deaths



From Routine to Emergency