Gratitude in Healthcare: an interdisciplinary inquiry

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an interdisciplinary inquiry

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Abstract

The expression and reception of gratitude is a significant dimension of interpersonal communication in care-giving relationships. Although there is a growing body of evidence that practising gratitude has health and wellbeing benefits for the giver and receiver, gratitude as a social emotion made in interaction has received comparatively little research attention. To address this gap, this thesis draws on a portfolio of qualitative methods to explore the ways in which gratitude is constituted in care provision in personal, professional, and public discourse. This research is informed by a discursive psychology approach in which gratitude is analysed, not as a morally virtuous character trait, but as a purposeful, performative social action that is mutually co-constructed in interaction.

I investigate gratitude through studies that approach it on a meta, meso, macro, and micro level. Key intellectual traditions that underpin research literature on gratitude in healthcare are explored through a metanarrative review. Six underlying metanarratives were identified: social capital; gifts; care ethics; benefits of gratitude; staff wellbeing; and gratitude as an indicator of quality of care. At the meso (institutional) level, a narrative analysis of an archive of letters between patients treated for tuberculosis and hospital almoners positions gratitude as participating in a Maussian gift-exchange ritual in which communal ties are created and consolidated. At the macro (societal) level, a discursive analysis of tweets of gratitude to the National Health Service at the outset of the Covid-19 pandemic shows that attitudes to gratitude were dynamic in response to events, with growing unease about deflecting attention from risk reduction for those working in the health and social care sectors. A follow-up analysis of the clap-for-carers movement implicates gratitude in embodied, symbolic, and imagined performances in debates about care justice. At the micro (interpersonal) level, an analysis of gratitude encounters broadcast in the BBC documentary series, *Hospital*, uses pragmatics and conversation analysis to argue that gratitude is an emotion made in talk, with the uptake of gratitude opportunities

influencing the course of conversational sequencing. The findings challenge the often-made distinction between task-oriented and relational conversation in healthcare.

Moral economics are paradigmatic in the philosophical conceptualisation of gratitude. My research shows that, although balance-sheet reciprocity characterised the institutional culture of the voluntary hospital, it is hardly ever a feature of interpersonal gratitude encounters. Instead, gratitude is accomplished as shared moments of humanity through negotiated encounters infused with affect. Gratitude should never be instrumentalised as compensating for unsafe, inadequately renumerated work. Neither should its potential to enhance healthcare encounters be underestimated. Attention to gratitude can participate in culture change by affirming modes of acting, emoting, relating, expressing, and connecting that intersect with care justice.

This thesis speaks to gratitude as a culturally salient indicator of what people express as worthy of appreciation. It calls for these expressions to be more closely attended to, not only as useful feedback that can inform change, but also because gratitude is a resource on which we can draw to enhance and enrich healthcare as a communal, collaborative, cooperative endeavour.

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One of the unanticipated joys of undertaking a PhD in middle age is being able to sound out ideas with one's children. Neal, the aerospace engineer, was ever prepared to ask the 'so what?' question on lockdown walks when many ideas in this thesis were walked/worked out. Zara, herself a doctoral scholar, has immeasurably enriched my experience of doing this PhD. Her enthusiasm for the project and practical help in critically reading drafts have been invaluable. My mum, Lise, has also been a willing, thoughtful reader and unfailingly encouraging of all that I attempt.

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Chapter 1 Introduction

This thesis contributes new knowledge on gratitude as relations of feeling to practice and emotion to performance within a selection of healthcare contexts. It addresses a gap in the literature on the expression and reception of gratitude in healthcare relationships.

'Thank you' is one of the most frequently spoken phrases in English (Shin & Nation, 2007). In spite of this, or perhaps because of it, thanking as an expression of gratitude resists easy definition or conceptualisation. My study of gratitude is undertaken in the spirit of *Sankofa* – a Ghanian word associated with the proverb *Se wo were fi na wo sankofa a yenkyi*, which translates as 'It is not wrong to go back for that which you have forgotten' (Henriques, 2022). The Akan people of Ghana use the symbol of a *Sankofa* bird turning its head to retrieve an egg (Figure 1.1) to symbolise the quest for knowledge based on looking to the past to bring what is good into the present, using patient investigation and critical enquiry (Berea College, 2022). The essence of *Sankofa* invites us to engage with that which is at risk of being left behind or taken for granted. Gratitude is a practice so quotidian that it risks being overlooked even though it is a fundamental facet of human sociality. The *Sankofa* bird also embodies an attitude of care, which is also a focus of this thesis.

Figure 1.1. Symbolic representation of the *Sankofa* bird from Ghanian culture. Source: Carter G. Woodson Centre

1.1 Motivation

The idea that gratitude in healthcare is worthy of study was sparked by engagements with students in the course of my professional role developing and delivering education in the medical and health humanities in the School of Medicine, Imperial College London. Over the years I have been alarmed by medical students' growing ambivalence towards the profession for which they invest years of training. The ideals and aspirations with which students embark on their medical education rarely survive even glancing contact with experience of work in the National Health Service (NHS).

Even before the Covid-19 pandemic, research showed that healthcare workers felt overworked, underpaid, and unable to provide a satisfactory level of patient care (Marangozov et al., 2017; Owen et al., 2019; The King's Fund, 2018). The impact of the pandemic on workforce burnout has contributed to the exodus of NHS workers (House of Commons Health and Social Care Select Committee 2022). A recurrent theme in research on the reasons that healthcare professionals leave the NHS is that they feel unappreciated, unrecognised, and undervalued. It is therefore unsurprising that so many medical students and all those training in healthcare services – people who are desperately needed – are reconsidering their life choices.

Whilst the challenges of working in higher education are not equivalent to those in healthcare, my personal experience is that students' gratitude makes a substantial contribution to job satisfaction. Perhaps idealistically, I embarked on this project hoping to explore the potential for unsolicited acts of gratitude to boost the morale of those working in healthcare.

The word 'hospital' shares its roots with 'hospitality', yet too many hospitals still feel like inhospitable, ungenerous spaces, ill-equipped to welcome their patients, visitors, or staff. Whilst there is attention to the relationship between the design of built environments in healthcare and improving staff and patient experiences (Halawa et al., 2020), the semiotics of communication in hospital spaces actively work against the concept of hospitals as places in which therapeutic interventions are delivered,

mostly very successfully. Instead, formal communication is dominated by the rhetoric of concern and complaint. Take, for example, the banner shown in Figure 1.2 (photographed in 2018). Although giving a compliment or praise is invited, the dominant expectation set by the text is of raising concerns to semi-smiley staff, pens poised, ready to transcribe patients' concerns. I do not wish for a moment to downplay the importance of raising concerns and complaints in healthcare, but I worry that the hospitals have become unfriendly spaces for displays of appreciation.

Figure 1.2. Typical banner greeting patients and staff at hospital entrances

As an example, I was once shown a refurbished 'day room' during a visit to a hospital in preparation for a talk I had been invited to give as part of the NHS's 70th birthday commemorations. The room was comfortably furnished but stark. 'Where are the thank you cards?' I asked. I was told that thank-you cards were no longer displayed because spaces with cards were difficult to clean, and they posed a fire risk. 'I think they get taken to the PALS [Patient Advice and Liaison Service] office,' said the ward manager. I walked down to the PALS office to ask. 'We used to keep them, but we don't anymore,' I was told.

Thank-you cards matter. In his cancer memoir, *Love for Now*, with its cover that resonates with the *Sankofa* bird (Figure 1.3), Anthony Wilson describes a scene that seems highly unlikely to be allowed now in most hospitals:

> On the way out I noticed that the handrail that runs both sides down the corridor from the waiting area to the radiation room is completely plastered with Thank You

> cards, stuck on with sellotape. Many depict flowers and sunsets: most are a bit yellowing. It struck me very hard that so many have obviously forged bonds here. (Wilson 2012, p. 226)

Figure 1.3. Anthony Wilson's cancer memoir Love for Now

Ahmed (2014) argues that emotions move through the circulation of objects. In so doing objects become 'sticky, or saturated with affect' (p. 12). Like the prising of thank-you cards off walls, boards and handrails, attitudes to gratitude have become unstuck.

The NHS, too, one feels has come unstuck. Is gratitude an emotion in which people take comfort when the fantasy of the NHS as 'being there for you when you need it' – already precarious prior to the pandemic – is threatened by utter, abject dissolution? Fantasy, as Berlant defines it, is the 'means by which people hoard idealizing theories and tableaux about how they and the world "add up to something"' (Berlant, 2011, p. 2). There is perhaps no greater scene of fantasy in British collective life than the NHS. In spite of the dire situation for millions of people on waiting lists for treatment and declining levels of satisfaction (Wellings, 2022), an IPSOS-Mori poll in April 2022 found that 62% of those polled said that the NHS was what makes them most proud to be British, an increase of 12% since July 2016 (Skinner et al., 2022). Support for the founding principles of the NHS remains strong (The King's Fund, 2023).

The dissonance between public sentiment about the NHS and experience of accessing care is not necessarily paradoxical: after all it is the *ideology*, rather than the reality, of the NHS that is the nexus of fantasy-sustaining optimism. I follow Berlant (2011) here in defining optimism as an affective, enduring inclination to return to the scene of a fantasy in the expectation that proximity to something (an event, a situation, a project, a person, an object) will enable a desirous transformation. The scenes of spectacular civic engagement with the NHS in the early parts of the Covid-19

pandemic are the epitome of gratitude as a fantasy-sustaining, optimistic, affective response to extreme precariousness.

Whilst pandemics are exceptional (at least hitherto in my generation), threats to health constitute everyday situations of personal precariousness to which the seeking out of healthcare is an optimistic reaction. I am interested in exploring how the discursive practices of gratitude help us (my students, healthcare professionals, patients, families, people, assemblages of people, me) to optimistically negotiate precarity.

The following section describes my reservations about situating my study within positive psychology – the discipline that intuitively seems most appropriate for studying gratitude. I explain why I have, instead, favoured an approach rooted in discursive psychology and affect theory as a means of explicating the ways in which acts of gratitude are made legible in a range of contexts associated with healthcare.

1.2 Disciplinary approaches to gratitude

In tackling a topic as broad as gratitude, even with the benefit of a focus on the context of healthcare, it is necessary to be selectively attentive. Theory functions to identify which entities to look out for and in what relationship those entities stand vis-à-vis one another (Warde, 2014). The academic study of gratitude intersects with multiple bodies of theory across a range of well-established disciplines. These most obviously include anthropology, theology, moral philosophy, psychology, affect theory, and sociology, but one could argue for gratitude's relevance to *any* scholarly endeavour that is interested in providing an account of human behaviour. Undoubtedly the discipline which has most successfully motivated for and capitalised on gratitude research has been positive psychology.

1.2.1 Positive psychology

Although scholars have been interested in virtue-based dispositions since ancient times, the establishment of positive psychology as a credible discipline is widely attributed to Martin Seligman's presidency of the American Psychological Association to which he was elected in 1996 (Cheavens & Feldman, 2022). Seligman chose to focus

on character strengths as instrumental in optimal human functioning, rather than psychology's usual preoccupation with dysfunction. Gratitude has been described as 'perhaps the quintessential positive psychology trait' (Wood et al. 2009, p. 43) and as a widely credited 'success story' of positive psychology (Gulliford et al. 2019, p. 1021). An assessment of the grateful character, so-called 'trait gratitude', has dominated empirical research on gratitude in recent years. A trait approach is based on Aristotelian virtue ethics – a philosophy based on ideal character traits as the basis for a moral life. This is ironic, perhaps, as Aristotle had little time for gratitude, maintaining that the noble natured do not take any pleasure in being grateful:

> [the benefactor] delights in the object of his action, whereas to the patient [person] there is nothing noble in the agent, but at most something advantageous, and this is less pleasant and lovable (Aristotle and Ross (trans.) 1999, p. 154).

Nevertheless, the case has been made that gratitude should indeed be considered Aristotelian because it is a good fit with his evaluative framework for moral virtues (Kristjánsson, 2015). By this measure, it is not enough to merely act in a grateful way to fulfil the requirements of gratitude, one must have the proper emotional disposition for an action to count as 'gratitude'. Thus, the expectation is authorised that people can be judged, not on transient episodes of expressive behaviours, but on their moral character.

Although character traits are thought of as 'stable' in cognitive psychology, the casting of gratitude as a 'transcendent character strength' (Peterson & Seligman, 2004) defines it as a capacity that can be intensified through moral education or cultivation. Gratitude, along with other virtues, becomes mobilised as a technology: a set of techniques that are operationalised in the service of self-efficacious character building. The traction this notion has received is evident both in the psychology literature and in the biopsychosocial model of 'wellbeing' that has fuelled a multi-million-pound wellbeing industry, mostly predicated on principles of self-help.

The exercising of gratitude is a prominent component of the wellbeing business. One needs only to look to the high-street for evidence. A selection of gratitude journals is available in every stationery store. There are thousands of gratitude-related products available online, including mini-motivational cards,

gratitude candles, 'gratitude jars', gratitude-themed colouring books, and fridge magnets. Commercial products are merely the tip of the iceberg though. 'Count your blessings' and gratitude journaling exercises are also often facilitated as part of ubiquitous wellbeing 'interventions' foisted on staff by companies. There is a thriving industry in wellbeing as a personal journey of learned optimism, with an array of guru guides from which to choose. Wellbeing apps tend to have 'gratitude prompts' that promise a happier life if you cultivate grateful habits. A Yale online course called 'The Science of Happiness' enrolled over 2.6 million students at the start of the Covid-19 pandemic (Yale, 2020). It includes a 'rewirement workbook' which prompts participants to carve out new habits, like 'intentional savouring' and keeping a daily gratitude journal. The course is free online, but students are also encouraged to share their data from the numerous psychometric assessments dotted through the curriculum to be used for research. This practice reflects a long-standing tradition in psychology research in the USA, including intervention studies on gratitude, in which students are signed up as research participants, often in exchange for partial course credit with little reflection on the coercive nature of this practice (Leentjens & Levenson, 2013) or the implications of recruitment biases for outputs.

The positive-thinking industry has come in for forceful critiques, famously in Barbara Ehrenreich's *Smile or Die* (Ehrenreich, 2010) and Will Davies's *The Happiness Industry: How the Government and Big Business Sold Us Well-Being* (Davies, 2015). Atkinson (2021) has written cogently about the toxic effects of subjective wellbeing, critiquing the hyper-individualised, 'supermarket model' of social resources that dominate current understandings of wellbeing.

Gratitude as a self-help intervention is given evidentiary credence by an extensive psychology literature suggesting that gratitude experiences have multiple benefits – for physical and mental health, subjective wellbeing, life satisfaction, and in promoting pro-social behaviours. For many people, gratitude techniques work as a way of managing anxiety and countering the pressures of daily life. But when wellness is harnessed to workplace productivity, 'corporate gaslighting' becomes a real concern. Gaslighting, in this context, is the manipulative passing off of structural shortcomings in the workplace as failures by individuals to be sufficiently mentally and emotionally resilient. The conceptualisation of the self as individuated, independent, and

intentional, with autonomy over mental health, is an inevitable consequence of positive psychology's emphasis on resources for character building. Rusk and Waters (2013) compiled a word cloud of terms that they used to identify documents to include in their quantitative evaluation of the size, reach, impact, and breadth of positive psychology as a discipline (Figure 1.4). The prominence of terms like 'self efficacy', 'autonomy', and 'self determination' evidences the emphasis of positive psychology on the interior self.

In the context of healthcare, one of the luminaries of the role of gratitude in positive psychology, Robert Emmons, the most prolific and influential scholar working on gratitude in the field of positive psychology, explicitly links trait gratitude to the performance of doctors. 'Grateful physicians are better physicians,' he says, and recommends gratitude journaling as an effective strategy for doctors to manage stress (Emmons, 2008, p. 84). Arnold-Forster (2020) has pointed out the dangers of resilience rhetoric in the context of surgery in the UK, arguing that merely telling people to be resilient is an unsatisfactory response to inadequate working conditions,

Figure 1.4. A word cloud showing the 233 key positive-psychology terms as identified by Rusk and Waters (2013). The font size is proportional to the square root of the number of times it occurred within the 18,401 documents the authors identified between 1992 and 2011 (Source: Rusk and Waters 2013)

mental illness, and emotional distress. Gratitude can just as easily be recruited as an accomplice for injustice as it can be a witness for the good in our lives.

As Joyes et al. (2021) have shown, the pandemic has raised awareness of the importance of social connectedness and interpersonal wellbeing as integral to recovery in hope-oriented, post-pandemic therapeutic settings. While proponents of positive psychology do recognise that gratitude is inherently relational, the methodological and conceptual orientation of the discipline to the interior self is a limitation when researching gratitude as a discursive practice displayed in interaction. Given that we do not have access to people's inner psychologies, an approach is needed that embraces discourse – verbal, textual, and gestural – as participating in the pragmatic and structural construction of emotion. The approach I consider to align with this objective most closely is discursive psychology.

1.2.2 Discursive psychology

Discursive psychology is a distinct branch of discourse analysis that looks at talk with respect to what it *does* rather than what it *reflects* (Veen et al., 2011). The discipline has been something of a niche methodology but it is rapidly gaining traction. Discursive psychology was pioneered by Derek Edwards, Margaret Wetherell, and Jonathan Potter in the 1980s as a challenge to conventional theorisations of psychology (S. Taylor, 2014). It shifts focus from the investigation of the individual as an autonomous agent with a coherent set of authentic characteristics, to practices constructed as the collective, cultural, and communal sense-making actions that constitute psychological life.

The central concern of discursive psychology, as described by Edwards (2005), is how psychological characteristics are handled as part of participants' practices, performed as social actions, and oriented-to in how they interact. This is not to discount the alignment of genuine emotions with what people say, but a discursive psychology approach does not assume that what is said, or written, is a transparent relay to underlying states of mind. The imputing of motives (anyway speculative in real life situations) by the researcher is abandoned in favour of investigating the speaker's 'display and management of subjectivity and attitude in talk' (Edwards, 2005, p. 19). As such, discursive psychology has a programme of 'respecifying psychological

topics' (reconsidering how they are understood) from 'veiled, individual cognitive constructs' to 'demonstrable, shared discursive practices' (Huma et al. 2020, p. 315). The discursive psychology approach gains support from recent experimental research in psychobiology that challenges notions of 'basic' natural emotions, arguing instead that emotions are 'made' and any category of emotion is filled with variety (Feldman Barrett, 2017).

Huma et al. (2020) outline a set of methodological procedures that set discursive psychology apart from other qualitative approaches in psychology.

- Discursive psychology takes an inductive approach to psychological topics by bracketing theoretical assumptions about the investigated phenomena, i.e. it is 'theoretically agnostic'.
- Discursive psychology considers language to be a medium for action with real-life consequences: discursive practices should not be treated as if they are glimpses into underlying cognitive structures.
- Discursive psychology treats talk or text as the product of formal procedures and rules that can be identified and described, and its task is to document the rules that organise psychological business in and through discourse.
- Discursive psychology eschews the experimental intervention approach, preferring texts and embodied talk that are naturally organised in everyday settings, and produced without researcher instigation.

What does it mean to take a discursive psychology approach to the analysis of gratitude? There is a long tradition of including the motives of benefactors and beneficiaries in socio-cognitive appraisals of gratitude (Tesser et al., 1968; A. M. Wood et al., 2008), but, as Gulliford et al. (2019) acknowledge, 'the line between genuine gratitude and ingratiating display is hard to draw and often difficult to call' (p. 1030). Discursive psychology is indifferent to the (unknowable) motivations of the speaker, although it remains interested in how people themselves speculate or posit motives in their interactions.

Considering gratitude as a socially performed emotion is emphatically not to undermine or demean its value as authentic feeling. This project is not a 'take down' of the individually felt emotion of gratitude, neither is it a reification. As Berlant (2004)

points out, scholarly critique and investigation of emotion do not seek to nullify the relations of affinity that are central to social life, but to try to explain the dynamics of its optimisms and exclusions. Conceptualising gratitude as an embodied and dynamic practice situates it in the ambit of affect theory.

1.2.3 *Affect theory*

Much of the scholarship of affect is influenced by the ideas of the French metaphysical philosopher Gilles Deleuze (1925–1995), who situated capabilities as 'becomings' or 'affects'. His notion of *puissance* as immanent power, that is power to act rather than power to dominate another, speaks to the ability to affect and be affected, to form assemblages that nonetheless respect the heterogeneous nature of their components (D. Smith et al., 2022). For Deleuze, subjectivity is figured as ongoing negotiation rather than a fixed entity, in which humans gain consciousness and agency through a constant give and take of perception, affect, and cognition (Conley, 2011).

The idea that subjectivities, and associated notions of identity, can be in flux makes sense in the context of the predicaments of those experiencing, or in proximity to, serious illness. The awareness that 'I am not feeling myself' is often a prompt for seeking medical help, which becomes exacerbated if the diagnosis is life changing. Patients and their loved ones are required to re-negotiate their agency, re-evaluate their capacities, and re-consider their identities when they become subjects of a healthcare system. People 'actively construct and revise the social self' (B. Brown et al., 2006, p. 199). This mobile subjectivity, in which feelings and emotions participate, provides further justification for considering gratitude as affect in line with the characterisation by Albuquerque and Pischetola (2022) as a force of mutual influence between subjects that affords affirmative modes of acting, relating, and existing.

In her book *Cruel Optimism*, Berlant (2011) describes how 'trauma' has become the primary genre of everyday life. People are forced to adapt to proliferating pressures in a scramble for modes of living on. She argues that

> conventions of reciprocity that ground how to live and imagine life are becoming undone in ways that force the gestures of ordinary improvision within daily life into a greater explicitness affectively and aesthetically (Berlant 2011, p. 7).

Although writing in the response to the failure of post-Second World War liberal-capitalist society to reliably provide opportunities for individuals to carve out the relations of reciprocity that help to constitute fantasies of the good life, Berlant's ideas are eminently applicable to the 'crisis ordinariness' that epitomises everyday existence in the NHS. The Covid-19 pandemic only exacerbated the sense of emergency that already pervaded, and continues to pervade, swathes of the health- and social-care sector in the UK.

Berlant's contributions to theorising affect are part of a trend of disenchantment with the dominance of analyses of social structures and a renewed interest in interpersonal relationships (Albuquerque and Pischetola 2022). This stance is a consequence of the possibilities for scholarship afforded by a shift of perspective from emotions as inherent to the self (intrinsic, universal, and instinctual) to emotions as contextualised ways of being that shift over time and in relationship with others (Kuby, 2014).

Historically, discourse studies and new lines of research on emotion and affect have been somewhat disconnected. Wetherell (2013) attributes the absence of productive dialogue between scholars of discourse and affect to formulations of human affect as 'extra-discursive events' in which the word is encountered first in a bodily way and secondarily discursively. This thesis is, in part, a response to Wetherell's call for a rapprochement between discourse studies and affect studies that situates both discourse and affect within emergent patterns of activity. The study of gratitude is ideally poised at the boundaries of discourse and affect. Expressions of thanks, whether written or verbal, always entail bodily adjustment, whether it is the movement of a pen on paper, the typing of a tweet, or the adjustment of posture and demeanour that accompanies spoken words of thanks.

Kuby (2014, p. 1293) poses the question, 'If explicit statements related to emotions are not voiced, how do we know and understand that people are performing emotions?' Happily, gratitude has an indicative practice with which it is normatively associated. That practice is the act of thanking. Gratitude and thanking are not synonymous: one can reflexively and unfeelingly express thanks, and one can express gratitude entirely through embodiment without the need for accompanying words. I am interested, however, in how discourse (spoken or written thanks) works together

with affect to mobilise gratitude as an intense, material encounter that can best be described as an 'affective-discursive assemblage'.

Discursive psychology and affect theory both resist simple categorisations as theory or methodology, enmeshed as they are in ontological and epistemological stances defined more clearly perhaps by their exclusions (what they don't or won't do) rather than their inclusions. The disciplinary alignments with discursive psychology and affect theory are ones I arrived at during the course of my research, rather than starting with these lenses in mind. The contingency wrought by Covid-19 caused me to have to delaminate my study from how I originally imagined it would develop. As a result, my research consists of an accretion of studies, dictated by the availability of corpora and their potential to be examined in the service of the broad aim of exploring gratitude in healthcare. To account for the unconventional structure of this thesis, the following section explains how and why pragmatic decisions were made about how to progress the research in the face of the obstacles and opportunities posed by Covid-19.

1.3 Formulating and reformulating the research programme

In 2017 I had been contemplating researching gratitude for some time but the idea felt too insubstantial to constitute a coherent study. A chance conversation with Victoria Hume, then the arts manager at the Royal Brompton Hospital, changed all that. Victoria and I were collaborating on designing and delivering workshops for students on the intersection of the arts with respiratory medicine. We were struck by how many of the artworks donated to or commissioned by the Hospital were motivated by experiences of care. I told Victoria about my tentative plans to study gratitude. She mentioned that a filing cabinet of thank-you letters had been discovered during the Hospital's refurbishment and been lodged on deposit in the Royal London Hospital Archive (now the Barts Health Archive). On visiting the archive, I found that the primary purpose of the letters was to solicit health reports from patients who had been treated for tuberculosis at the Brompton's sanatorium in Frimley, Surrey. But given the preponderance of gratitude in the letters, it is not surprising that they were thought of as thank-you letters. Certainly, they provided an exciting corpus of material for study.

With the help of my supervisors, I put together a research proposal in which an analysis of the archival correspondence could form the first phase of a study to investigate what we can learn from past and present practices of gratitude, using the Royal Brompton Hospital as a study site. The plan was to make ethnographic observations of gratitude encounters across a range of hospital wards, to record and map material displays of gratitude across the hospital, and to carry out interviews with staff and patients. Findings would be discussed at a series of workshops to which staff and patients would be invited, resulting in a co-produced series of recommendations for how gratitude could be better facilitated and recognised.

The first year and a half of my doctoral research was spent working on the metanarrative review (reported in Chapter 2) and archival correspondence (Chapter 3) in tandem with negotiating Health Research Authority (HRA) ethics approval to make observations on the wards of the Brompton Hospital. As others have found (B. Brown et al., 2006; Lee et al., 2022; Mapedzahama & Dune, 2017; Stevenson et al., 2015), the HRA is ill equipped to assess the nuances of ethnographic research. In spite of the wholehearted support of senior staff, the research manager, and the Lay Advisory Panel at the Royal Brompton Hospital, it proved to be a tortuous process to satisfy the information governance requirements of the HRA, and meet its fiercely precautious expectations around privacy, consent, and confidentiality in ways that would not undermine the tenets of ethnography.

After three rounds of review, HRA approval was finally granted for the study on 4 March 2020. Just two weeks later, the World Health Organisation declared Covid-19 to be a pandemic. The UK went into lockdown and a moratorium was imposed on all non-essential research.

Whilst the pandemic was a bitter blow to my original research plans, it also afforded an unparalleled opportunity to study the contours and contents of the conspicuous displays of gratitude to the NHS and healthcare workers that characterised the first lockdown. There followed a fruitful period of research that resulted in a study of tweets of gratitude expressed to the NHS (Chapter 4), and a follow-up analysis of the clap-for-carers phenomenon (Chapter 5).

Throughout these studies, I kept alive the hope of being able to undertake the ethnography for which I had obtained hard-won HRA approval. But by 2022 it became

apparent that it would not be feasible to undertake the observations and conversations originally envisaged within the timeframe of my PhD. Successive waves of Covid-19 meant that social distancing and mask wearing still understandably mandatory in hospitals, making it unlikely that it would be possible for me to capture the nuances of verbal interactions and facial expressions. In addition, the modifications I had been required to make to the project protocol to satisfy the HRA necessitated a level of burden on hospital staff that I was reluctant to impose. Clinicians were required to introduce the study to potential participants, and ward staff were expected to be available to record declines of consent. Staff assistance would also be necessary to ensure that explicit consent had been sought in advance from everyone conceivably likely to be present in the environment, any one of whom had the right of veto. I did not feel comfortable asking staff to take on these tasks when working conditions in hospital remained so difficult. Yet, forsaking the ethnography meant that there was a gap in my research on how gratitude is expressed and received in clinical encounters.

It has always struck me as incongruous that researchers have incredible difficulty gaining access to NHS sites for the purposes of research, yet there are dozens of documentaries and reality shows shot in surgeries and hospitals that allow viewers to witness exactly the interpersonal encounters that healthcare researchers are interested in studying. Broadcast footage does not provide the opportunities for immersive fieldwork afforded by ethnography, but it does allow for a level of close analysis that is unrealistic for manual data capture during *in situ* observations. The study of gratitude in the BBC documentary series *Hospital* is reported in Chapter 6.

Although the studies presented in this thesis cannot be claimed to cohere together in the way that the original research proposal envisaged, they are still highly complementary. The ideas within them are linked by a shared focus on the material manifestations of gratitude, alive to the contexts within which gratitude is made accountable. The Covid-19 pandemic brought into focus aspects of gratitude that allowed for a more ambitious and multifaceted study than I could ever have imagined.

1.4 Research questions

My aims in undertaking a doctoral programme of study were not only to make a substantive contribution to scholarship in gratitude studies in the context of healthcare, but also to engage reflexively with a range of methods, selected for their ability to address – not necessarily answer – the questions about which I was curious. My research questions have been dynamic: they evolved through the course of the study in response to changing circumstances, but also out of a commitment to experiment with interdisciplinary approaches to analysis, giving rise to unorthodox pairings of corpora with methods. In so doing, I align with Lather (2013) in advocating for qualitative research to 'imagine and accomplish an inquiry that might produce different knowledge and produce knowledge differently' (p.635).

I have also consciously sought to resist what is sometimes referred to as 'disciplinary decadence' – the phenomenon of overlooking of approaches to problems that do not neatly fit disciplinary boundaries in the belief that 'becoming right' merely is a matter of applying method correctly (Gordon, 2014, p. 86). Whilst I have approached this thesis with discursive psychology as a disciplinary umbrella, this is an orientating feature rather than a dependency. I have sought to think *with* disciplines rather than *in* them.

The starting question for my research is, 'How is gratitude expressed and received in healthcare?' The metanarrative review (Chapter 2) includes literature from a wide range of countries, but the other studies included in this thesis focus on the context of healthcare in the UK. 'Healthcare' is a broad term, deliberately not confined to the NHS because the corpus of documents analysed in Chapter 3 relate to the tuberculosis sanatorium at Frimley, Surrey, which pre-dates the establishment of the NHS in 1948. The emphasis in healthcare falls on 'care': my focus is on healthcare as a relationship, rather than the health psychology per se. This is in keeping with an understanding of health practices as aesthetic and temporal acts, and – crucially – as ways of being-in-relationship (Crawford et al., 2015). My study is lopsided in terms of analysing the expression and reception of gratitude: how and why people express thanks is much more amenable to investigation than how it has been received. This is mainly because motivations are usually made explicit in the act of thanking (people

say what they are grateful for, or the context makes this clear), whereas acknowledgements of thanks rarely articulate impact and, indeed, routinely and politely downplay it.

The dissertation that follows will address the following research questions:

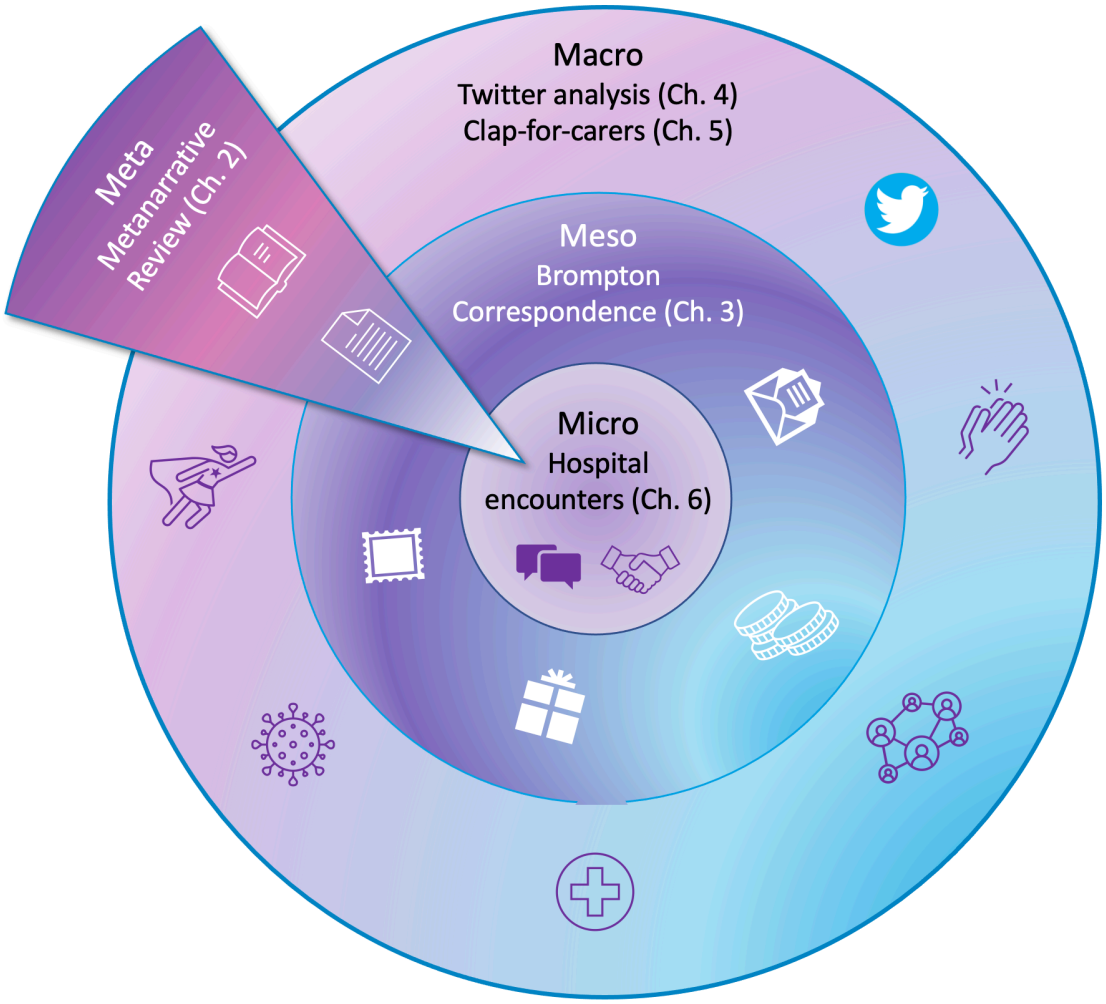
1. How is gratitude conceptualised, characterised, and analysed in the academic literature on healthcare?
2. What does the correspondence (1905–1963) between almoners at London's Brompton Hospital and patients treated for tuberculosis at the Hospital's sanatorium reveal about contemporaneous practices and attitudes to gratitude?
3. How was the NHS constructed in attention-attracting tweets that expressed and/or discussed gratitude to the NHS at the outset of the Covid-19 pandemic?
4. How does the rise and demise of the social movement known as 'clap for carers' intersect with debates on care justice and gratitude as performance?
5. What are the discursive and embodied elements of thanking encounters portrayed in the BBC documentary series *Hospital*?

1.5 Chapter overview

The chapters in this thesis are organised loosely by the reach of the unit of analysis from the level of societal interactions on social media to enactments of gratitude between individuals (Figure 1.5).

At the meta level of taking a broad, international overview, Chapter 2 presents a metanarrative review of the **literature on gratitude in healthcare**, with an emphasis on research exploring interpersonal experiences in the context of care provision. The review follows the RAMESES (Realist And MEta-narrative Evidence Synthesis: Evolving Standards) publication standard (G. Wong et al., 2013). The initial review, conducted in 2020, included literature up until 2019. Six metanarratives are identified and discussed. The literature search was repeated at the beginning of 2023 which resulted in 13 articles being added to the original set of 56 included articles.

Figure 1.5. Visual summary of the organisation of the thesis



Chapter 3 applies a meso-level lens to **gratitude in an archive of correspondence**. Expressions of gratitude are analysed in letters exchanged between patients treated for tuberculosis at the Brompton Hospital's sanatorium at Frimley and the almoners charged with tracking their health and their employment status. This longitudinal narrative case study implicates gratitude in the complex, moralising dynamics that pervaded the voluntary hospital system. It tracks attitudes to gratitude as a legacy of the paternalistic, communal regimen of the sanatorium, and implicates gratitude as participating in Maussian gift-exchange rituals.

Chapter 4 uses a macro-level lens to explore **expressions of gratitude to the NHS expressed on Twitter** during the first Covid-19 pandemic lockdown in the UK (22 March – 28 May 2020). A typology for tweets of gratitude was developed from a thematic analysis of the function (what the tweet was doing) and the plot (what the

tweet was about) of the sample of 834 tweets. The analysis shows that the NHS was thanked most frequently for working, effort, saving, and caring. The clap-for-carers campaign that encouraged people to applaud NHS workers and other key workers at 8 pm on Thursdays proved influential in encouraging people to tweet their gratitude, with tweets expressing words of appreciation peaking on Thursdays throughout the study period.

Chapter 5 provides a contextualising commentary on **the clap-for-carers phenomenon**. This chapter builds on the preceding study of tweets that highlighted the significance of the performative nature of gratitude displays. The clap-for-carers campaign is explored more fully, including its rise and demise as public performance, and its intersections with political rhetoric and care justice. This chapter draws on affect theory to examine perceptions of gratitude in the social domain in the context of claims to authenticity, and accusations of virtue signalling and hypocrisy.

Chapter 6 takes a micro-level look at the embodied **production and recognition of thanking expressions within the hospital environment**, as manifested in four series broadcast between 2019 and 2021 of the BBC documentary series *Hospital.* The study draws on pragmalinguistics and sociopragmatics to identify patterns across the thanking expressions identified in the corpus. Given that expressing thanks also functions as a civil means of conversation management (e.g. as a means of signalling the end of a turn at talk or closing a conversation), this study considers the strategies used by speakers to make their thanking be more likely to be hearable as gratitude. Using conversation analysis, I show how gratitude is accomplished interactionally, with particular emphasis on the post-operative briefing as a site where the timing of the take-up of proffered gratitude opportunities influences the degree of elaboration of news that surgeons undertake.

Chapter 7 is an **integrated discussion** of the implications of the studies included in this thesis. It provides an overall synthesis, analysis, and interpretation of the findings. Gratitude is theorised as a social, political, and ethical relation in healthcare. The implications of the governmentality of gratitude-as-conduct are discussed in the context of Foucault's model of biopower. Concepts from non-representation theory are used to position gratitude as a form of affective ethical enactment. The chapter critiques prevailing explanatory frameworks in sociology and

pragmatics for focusing on gratitude as a means of maximising self-interest. I advocate for a theoretical reorientation to gratitude as a dynamic, cooperative, relational social practice. The affordances of discursive psychology as a methodology for investigating gratitude as an emotion produced in interaction are discussed, and implications of the findings for the practice are suggested. Limitations of the thesis and their consequences are explained, and avenues for future research are proposed.

Chapter 8 forms the **conclusion** of the thesis. I return to the precepts outlined in this introduction, and reflect on learning gained from carrying out the doctoral research.

In sum, the chapters in this thesis navigate a variety of settings, methods, and disciplines, taking into account the embodied environments in which gratitude is enacted. The central claim of the thesis is that gratitude is a significant resource for action and reaction in the context of personal and institutional precarity in healthcare. I argue that gratitude is best understood as a social practice and an emotion made in interaction.

Chapter 2 Metanarrative review of the literature on gratitude in healthcare

The pioneering German sociologist Georg Simmel described gratitude as 'the moral memory of mankind' (Simmel, 1950, p. 388), lent credence by the plethora of perspectives from which gratitude has been approached in the history of ideas. These include psychology, philosophy, theology, sociology, anthropology, humanitarian studies, and positive organisational scholarship. Drawing on these intellectual traditions, a metanarrative review of current research on gratitude in the context of healthcare interactions is presented in this chapter. The review provides a portrait of gratitude research in healthcare, highlighting areas that have led to new insights and suggesting areas that would benefit from further development. The review was carried out in collaboration with Glenn Robert and Anne Marie Rafferty, and published as Day, Robert, and Rafferty (2020) (contributions are given in Section 2.2). Initially, articles up to and including November 2019 were considered. I revisited the review at the beginning of January 2023. A consideration of changes in the intervening two years, that takes into account potential impacts of the Covid-19 pandemic, are presented in Section 2.5.2. Sixty-nine articles are included in the review.

Although gratitude has been extensively written about in philosophy, theology, and in popular psychology, empirical research into gratitude is still in the nascent phase of development – partly because there is no consensus on whether gratitude is primarily a moral quality or whether its value resides in the acts of expression and reception of gratitude. Gratitude has multiple statuses as, amongst others, an emotion, a character trait, a psychological characteristic, a material gesture, and a politeness response. Accordingly, views diverge on how it should be constructed in theory or approached as a topic for investigation (Gulliford et al., 2013).

A lack of consensus has not been an obstacle to gratitude receiving a lot of research attention, particularly since the turn of the millennium. The surge in interest has been attributed to: renewed scrutiny of virtue ethics in moral philosophy

(Gulliford et al., 2013); the rise of positive psychology as an academic discipline (McConnell, 2016) and the concomitant positioning of gratitude as a compelling component of psychological and physical wellbeing (e.g. Yoshimura & Berzins, 2017); and the potential role for gratitude practices in addressing psychopathologies (e.g. Duprey et al. 2018).

2.1 Objectives and focus for review

The objective of this review – the first metanarrative review of gratitude in the context of care-giving relationships – is to identify theoretical frameworks that have shaped scholarship in the expression and reception of gratitude in order to draw out common threads and show areas of divergent thinking. The focus on a specific sector – healthcare – is predicated on the premise that gratitude is context dependent: values, policies and practices all shape the ways in which gratitude is expressed, received, welcomed, or withheld. Whilst gratitude can be expressed to inanimate objects (Boleyn-Fitzgerald, 2016), the 'standard view' is that gratitude describes an interpersonal relationship in which it is a response to a benefit provided by a benefactor (Shaw, 2013). This justifies attention to literature that explores gratitude in the context of interpersonal relationships and capacity building within healthcare.

2.2 Methods

2.2.1 The metanarrative approach

Given the plethora of types of review from which to choose, we considered that the primary research question ('How is gratitude expressed and received in healthcare?') calls for qualitative inquiry into concepts ('gratitude', 'healthcare') that are polysemic. An exhaustive search would be unachievable, as would a strength-of-evidence appraisal, ruling out systematic review. In our selection of method of review, we prioritised ability to deal with interdisciplinarity, relevance over comprehensiveness, the capacity to do justice to complexity, and the scope for engagement with discursive elements of research papers. Metanarrative review was a good fit for these requirements. The method allows for the mapping of the characteristics of the

literature afforded by a scoping review with the added capacity for a more interpretive approach. It also combines the advantages of narrative review to offer a synthesis and integrated analysis of the literature. The 'meta' descriptor allows for concept-level engagement with theoretical frameworks from a variety of disciplines engaged in research relevant to the research question.

Metanarrative literature review is a method for synthesising and conceptualising approaches to topics that have been studied by different groups of researchers (G. Wong et al., 2013). It is a semi-systematic approach that retains the interpretive engagement, inductive reasoning, and cross-interrogation of the narrative review for which Thorne (2019) has advocated. The metanarrative method, originally proposed and developed by Greenhalgh et al. (2004; 2005), has proved useful for making sense of topics that transcend disciplinary boundaries. The review followed the RAMESES (Realist And Metanarrative Evidence Syntheses: Evolving Standards) publication standard which outlines the phases that researchers should undertake in planning and executing a metanarrative review. Guiding principles are pragmatism, pluralism, historicity, contestation, reflexivity, and peer review (G. Wong et al., 2013).

2.2.2 *Scoping the literature*

The initial process of exploratory scoping of the literature involved thinking broadly about the topic of gratitude and how it manifested in research paradigms within the disciplines with which it is has been associated. From this overview, I familiarised myself with the way different authors conceptualised gratitude, and which empirical research and theoretical ideas were considered significant by multiple authors. This is analogous to a 'territory mapping' exercise (G. Wong et al., 2013). To assemble the boundaries of the review it was decided to focus on peer-reviewed scholarly journals, requiring included articles to have a discernible aim and findings and/or recommendations in which gratitude was elaborated in the context of healthcare. Secondly, gratitude needed to be addressed as a concept in the paper, either through an implicit or explicit definition, or situating it within a theoretical framework.

2.2.3 Search and selection process

Three search resources were chosen to reflect a range of scholarly sources: **1** Proquest includes 23 databases that cover social sciences, arts and humanities, and nursing; **2** PubMed covers journals and books in the life sciences and biomedicine; and **3** Academic Search Complete includes multi-disciplinary content. Initially the databases were searched from their inception to November 2019. The search period was extended to December 2022 when the review was updated in January 2023.

Search strategies were complicated by 'gratitude' frequently being used in the acknowledgement sections of articles (e.g. a full-text search of the database ProQuest for 'gratitude' reveals nearly 1.5 million documents). Restricting the search to article titles was an effective way of identifying articles that specifically dealt with gratitude as a point of focus for the article. The term 'healthcare' OR ('health' AND 'care') was added in the full-text search. A set of 191 articles was returned from this first run of the e-search strategy (June 2019).

Once duplicates had been merged, 160 articles were identified as potentially suitable for inclusion. I screened all of the articles, and Glenn Robert and Anne Marie Rafferty each screened a random sample of 25 papers, using the following criteria:

1. Does the article deal with gratitude as a concept?
2. Does the article deal with gratitude in a healthcare context?
3. Is the article from a source likely to yield substantive content (e.g. peer-reviewed journal rather than newsletter or magazine)?
4. Is there enough substantive content (gratitude is defined, theorised and/or discussed) to be worth analysing?

Forty-nine articles were agreed to meet these criteria and were initially included in the analysis. However, once data extraction began, it became evident that there was an anomaly in the use of the term 'healthcare' during the sifting phase. An approach that included healthcare as a setting rather than a practice, led to a predominance of articles in the field of health psychology in which many of the articles employed what might be termed 'drive-through gratitude': the inclusion of an instrument – generally the self-report questionnaire GQ-6 (McCullough et al., 2002) – amongst a battery of other surveys without adequate justification or conceptual consideration. It was

decided, therefore, to place more emphasis on the *care* part of 'healthcare' so that the relational aspects in which we had a particular interest were afforded sufficient profile. Clinical settings were not a prerequisite for inclusion, but all the included studies involved a therapeutic context (in practice or in professional development) in which gratitude was implicated in care relationships.

The revisiting of sifting criteria 2 and 4 with a critical eye (Glenn Robert and I examined all the papers and Anne Marie Rafferty considered a sample of 25), led to a more robust dataset that fulfilled the 'pluralism' criterion for a metanarrative review as identified by Greenhalgh et al. (2005). A further 24 articles were excluded, leaving 25 articles included from the first systematic search. A rerun of the search strategy in November 2019 to update the review led to a further seven articles being included. Promising-looking citations were followed-up which, once screened, led to the addition of 24 further articles. A total of 56 studies were included in the review published as Day, Robert, and Rafferty (2020). The re-running of the search in January 2023 to select for articles published November 2021–December 2022 identified an additional 32 articles of interest, of which 13 were included after screening. The process is summarised in Figure 2.1. All included articles are summarised in Table 2.1.

2.2.4 Data extraction

The following characteristics were recorded in a data extraction form: aim of the study; definition of gratitude (along with whether this was explicit or implicit); the theoretical underpinnings of the article; academic discipline; whether it was a commentary/editorial, qualitative, quantitative or mixed methods article; methods used (if any); study setting and participants; whether gratitude was expressed or received; the nature of any gratitude intervention; if quantitative, which instrument was used; the article's focus; findings and/or recommendations; and sources of funding (abridged in Table 2.1).

Figure 2.1. Overview of process for retrieval, screening, and selection of articles

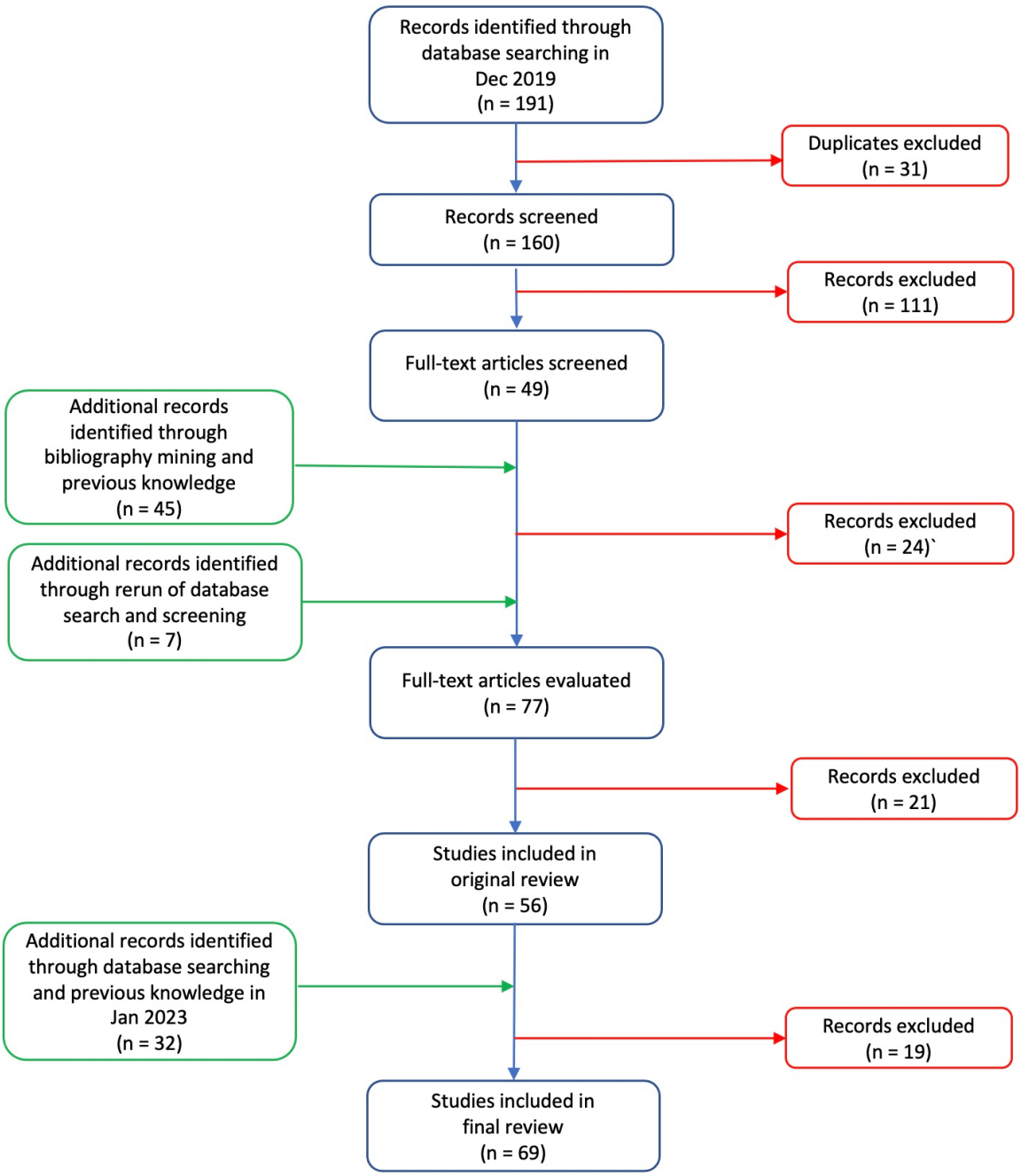


*Table 2.1. Articles included in the metanarrative review of gratitude in healthcare and their characteristics (*reference added in January 2023)*

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
*Adair, K. C., Rodriguez-Homs, L. G., Masoud, S., Mosca, P. J., & Sexton, J. B. (2020). Gratitude at Work: Prospective Cohort Study of a Web-Based, Single-Exposure Well-Being Intervention for Health Care Workers. *Journal of Medical Internet Research*, *22* (5), 1–14. https://doi.org/10.2196/15562	To examine the efficacy of a gratitude letter-writing intervention for improving healthcare workers' well being (*n*=1575 completing intervention and baseline, with 277 completing follow up one week later).	"Gratitude has one of the strongest associations with better mental health and well-being of any personality trait, even more than hope, optimism, or compassion" (p. 2).	Draws on previous linguistics research to predict associations between frequencies of words and depression.	Intervention study	A single-exposure intervention was found to improve healthcare workers' emotional exhaustion, subjective happiness and work-life balance scores using validated scales.	Benefits
Algoe, S. B., & Stanton, A. L. (2012). Gratitude When it is Needed Most: Social Functions of Gratitude in Women with Metastatic Breast Cancer. *Emotion, 12* (1), 163–168. https://doi.org/10.1037/a0024024	To examine the emotion of gratitude in women diagnosed with metastatic breast cancer, focusing on the social functions of gratitude through examination of situation appraisals of when gratitude might arise and downstream consequences of responding to benefits received.	Gratitude arises from an interpersonal context as an "other- praising emotion" (p. 164) reserved for special occasions in which an "interaction partner" is responsive to an individual and provides a benefit, which motivates a variety of prosocial behaviours (p. 163).	Refers to a social evolutionary account of gratitude (Algoe et al. 2008) to propose that gratitude functions to "find, remind and bind". The discussion refers to Fredrickson in discussion in context of gratitude having adaptive outcomes even in the context of profound stress.	Questionnaire / survey	Women who "transcend the ego" and express emotions easily were most likely to benefit from accumulated moments of gratitude over a three-month period. Reluctance to accept benefits was associated with less gratitude. Authors argue that this indicates that models that focus on exchange relations in gratitude are limited and gratitude has implications for high-quality communal relationships that are situational.	Social capital; Benefits
Althaus, B., Borasio, G. D., & Bernard, M. (2018). Gratitude at the End of Life: A Promising Lead for Palliative Care. *Journal of Palliative Medicine, 21* (11), 1566–1572. https://doi.org/10.1089/jpm.2018.0027	To evaluate the association between gratitude and quality of life, psychological distress, post-traumatic growth, and health status in palliative patients, and to develop an explanatory model. Also to identify which life domains patients considered sources of gratitude.	State gratitude is defined (p. 1566) as "a positive state that an individual consciously experiences when he receives a benefit; and the recognition that the source of this benefit was someone or something else, such as life or a more spiritual entity" (Emmons, 2008). As a dispositional trait, gratitude is often perceived as "a life orientation toward noticing and appreciating the positive in the world" (Wood et al., 2010).	Views positive psychology as a paradigm that complements clinical psychopathology to improve quality of life and prevent pathologies.	Questionnaire / survey; Cross-sectional study	Finds weak to moderative positive correlation between gratitude and overall quality of life. Gratitude did not correlate significantly with the relational dimension of QoL although patients mentioned (in open question) social relationships as a major source of gratitude. Possible explanation is that GQ-6 asks about quantity of people rather than quality of relationships. Findings are expressed conditionally: "gratitude may have a positive impact on QoL in palliative care patients, and may help reducing psychological distress at end of life" (p.1571).	Benefits

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Aparicio, M., Centeno, C., Carrasco, J. M., Barbosa, A., & Arantzamendi, M. (2017). What are Families Most Grateful for after Receiving Palliative Care? Content Analysis of Written Documents Received: A Chance to Improve the Quality of Care. *BMC Palliative Care*, *16* (1), 47. https://doi.org/10.1186/s12904-017-0229-5	To analyse what is valued most by family carers undergoing bereavement by means of a document analysis received by a palliative home service.	Written expressions of appreciation.	Study is placed in the context of quality of care in palliative services.	Content analysis	"Family carers show spontaneous gratitude for the professionalism and humanity found in palliative care. The relational component of care emerges as key to achieve a high quality care experience of palliative care homes service, and could be one indicator of quality of palliative care." (abstract, p. 1)	Quality of care indicator
Aparicio, M., Centeno, C., Juliá, G., & Arantzamendi, M. (2019, printed 2022). Gratitude from Patients and Relatives in Palliative Care - Characteristics and Impact: A National Survey. *BMJ Supportive & Palliative Care, 12(e4)*, e562–e569. https://doi.org/10.1136/bmjspcare-2019- 001858	To explore the influence of expressions of gratitude from patients and relatives on 186 palliative care professionals across Spain.	Acknowledge lack of agreement about the nature of the construct of gratitude, but say that in research it is treated as a stable trait or transient emotion. It is linked to wellbeing, happiness and satisfaction.	Links gratitude to Fredrickson's broaden and build theory.	Questionnaire / survey	Expressions of gratitude came most often from families (93). They evoked positive feelings in palliative care professionals: increased professional satisfaction, mood, and pride in their work and were a source of support in hard times. The authors conclude that gratitude was significant to those who working in palliative care, and may offer a protective role against and distress and increase in resilience.	Staff wellbeing
*Aparicio, M., Centeno, C., Robinson, C. A., & Arantzamendi, M. (2022). Palliative Professionals' Experiences of Receiving Gratitude: A Transformative and Protective Resource. *Qualitative Health Research, 32*(7), 1126–1138. https://doi.org/10.1177/10497323221097247	To explore the influence of expressions of gratitude from patients and relatives on 186 palliative care professionals across Spain.	"In the health context, gratitude has been conceptualised as an emotion, as a pleasant state, which occurs after people receive aid and is perceived as costly, valuable and altruistic" (p. e562)	Links to wellbeing and prosocial behaviour.	Questionnaire / survey	Respondents attribute multiple positive effects to expressions of gratitude, as a source of support in difficult situations, satisfaction, and professional and personal fulfilment. The authors suggest expressions of gratitude have a protective effect when facing situations of emotional distress.	Staff wellbeing

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Aparicio, M., Centeno, C., Robinson, C., & Arantzamendi, M. (2019). Gratitude between Patients and Their Families and Health Professionals: A Scoping Review. *Journal of Nursing Management*, *27* (2), 286–300. https://doi.org/10.1111/jonm.12670	To synthesise evidence regarding gratitude in healthcare relationships with a focus on expressions of gratitude from patients and families to health professionals.	"As a trait or disposition, gratitude reflects individuals generalised tendencies to notice and experience appreciation for the good in their daily lives (Emmons & McCullough, 2003). As an emotion, gratitude has been conceptualised as a pleasant state; a feeling of thankfulness that arises when one recognises something positive or helpful has happened as a result of someone else's actions (Emmons & McCullough, 2003; Roberts, 2004)" (pp. 1-2).	Study is framed by work in social psychology and placed in the context of indicators of quality of home care.	Literature review; Scoping review	Review demonstrates that spontaneous expressions of gratitude are a form of meaningful, valuable recognition, likely to enhance the wellbeing of those that receive it.	Staff wellbeing; Quality of care indicator
Aparicio, Maria, Centeno, C., & Arantzamendi, M. (2019). The Significance of Gratitude for Palliative Care Professionals: A Mixed Method Protocol. *BMC Palliative Care, 18* (28). https://doi.org/10.1186/s12904-019-0412-y	To devise a study protocol for understanding the significance of gratitude received by healthcare professionals from patients and relatives.	"Gratitude arises as a reaction to something which is appreciated or whose results are positive" (McCullough et al. 2001) (p. 1).	Paper sums up some of the recent research on gratitude and also examines coping strategies for reducing burnout in healthcare professionals.	Prospective study design	Paper anticipates a useful contribution to understanding the effects of gratitude on reducing burnout and emotional fatigue, and promotive resilience in palliative care health professionals.	Staff wellbeing
Beese, R. J., & Ringdahl, D. (2018). Enhancing Spiritually Based Care Through Gratitude Practices: A Health-Care Improvement Project. *Creative Nursing, 24* (1), 42–51.https://doi.org/10.1891/1078-4535.24.1.42	Aims to evaluate an intervention to increase provider awareness of spirituality in healthcare, increase the number of spiritually based interventions and gratitude practice interventions to clients.	Gratitude "involves being aware of and appreciating good things that happen and taking the time to express thanks (Lanham, Rye, Rimsky, & Weill, 2012, p. 343)" (p. 43).	Places study in the theoretical framework of a recovery model of mental illness that offers hope and healing through changing attitude, values, feelings, goals and skills.	Intervention study; Questionnaire / survey	Providing educational sessions on spirituality improves providers' attitudes, comfort levels and practice of providing spirituality-based care.	Benefits

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Berkland, B. E., Werneburg, B. L., Jenkins, S. M., Friend, J. L., Clark, M. M., Rosedahl, J. K., Limburg, P. J., Riley, B. A., Lecy, D.R., & Sood, A. (2017). A Worksite Wellness Intervention: Improving Happiness, Life Satisfaction, and Gratitude in Health Care Workers. *Mayo Clinic Proceedings. Innovations, Quality & Outcomes, 1* (3), 203–210. https://doi.org/10.1016/j.mayocpiqo.2017.09.002	To assess effect of a 12-week stress management and resilience training programme, that included gratitude, for healthcare workers.	Gratitude is considered to be part of a constellation of domains that contribute to happiness in the workplace.	Links to "organisational citizenship behaviour" in which "exceptional work performance by happy employees" extends to benefit coworkers and the organisation.	Intervention study; Questionnaire / survey	Significant improvements in gratitude were observed. Concludes that a course like the one described is a promising approach to improving happiness and wellbeing in healthcare workers.	Staff wellbeing
*Bradby, H., Humphris, R., & Padilla, B. (2020). Universalism, Diversity and Norms: Gratitude, Healthcare and Welfare Chauvinism. *Critical Public Health, 30* (2), 166–178.	To examine expressions of gratitude by women with migrant backgrounds in the face of inadequate or inappropriate healthcare, through interviews with eight women of non-European migrant backgrounds.	Expressions of gratitude may be attracted by episodes of everyday life where someone seeks and obtains a good service or support from another.	Foucault's biopower is used to conceptualise the logic of care in contemporary welfare regimes	Interview	Expressions of gratitude are described as situational (expressed by women who are still grateful despite poor service), generalised (expressed by women who had a bad experience but maintain gratitude by referencing general welfare problems), and positional (grateful despite bad services because of awareness of their own marginalised position). Authors conclude that the normative ideal of an anonymous care is widely understood and accepted, implicating welfare chauvinism (the belief that foreigners unsettle the welfare system by misusing public services to which they have not contributed).	Care ethics
Buetow, S. A., & Aroll, B. (2012). Doctor Gratitude: A Framework and Practical Suggestions. *Canadian Medical Association Journal, 184* (18), 2064. https://doi.org/10.1503/cmaj.120422	To advance some reasons why doctors should feel grateful. Asks "Could doctors' gratitude for their work inspire their performance and reclaim authentic meaning for medicine?" (p. 2064).	Gratitude is morally important for its own sake and can add joy and meaning to doctors' work. Gratitude is a form of social capital and is indicated through actions taken.	Framework is of moral duty and reflection.	None	Urges doctors to feel and show gratitude, e.g. through recording gratefulness in a diary, by taking actions with which patients can be reasonable expected to agree without specifically seeking consent (e.g. touching a distressed patient's hand), and showing gratitude for systems that help them uphold ideals like sanctity of life.	Social capital; Benefits

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Burke, R. J., Ng, E. S. W., & Fiksenbaum, L. (2009). Virtues, Work Satisfactions and Psychological Wellbeing among Nurses. *International Journal of Workplace Health Management*, *2* (3), 202–219. https://doi.org/10.1108/17538350910993403	To examine the relationship between virtues and work satisfaction and engagement, perceptions of hospital functioning and quality of nursing care, and psychological wellbeing of nursing staff. Measures optimism, gratitude and proactive behaviour.	"Gratitude involves feeling grateful for positive outcomes one has experienced; it is an emotional state and an attitude toward life. Gratitude has been found to be associated with life satisfaction and fewer physical health complaints (Emmons, 2003; Emmons and McCullough, 2003), positive emotions (Walker and Pitts, 1998), and happiness, pride and hope (Overwalle et al., 1995)" (p. 204).	Frames the study in terms of virtues in the workplace and a need to address human flourishing and positivity in organisations. The discussion invokes Fredrickson's broaden and build theory.	Questionnaire / survey	In this study there were no statistically significant correlations between the three virtues. Nurses scoring higher on gratitude indicated more favourable outcomes (job satisfaction, vigour, dedication and fewer absences owing to illness). Nurses scoring higher on gratitude indicated less exhaustion, less cynicism and greater efficacy, fewer psychosomatic symptoms and more life satisfaction. They also rated the health and safety climate more highly, received higher levels of hospital support, rated the quality of healthcare ore highly, and were more satisfied being a nurse. Demographics almost never were a significant factor in variance, and work situation characteristics were significant in about half the hierarchical regressions, and gratitude had significant and independent relationship in many of the analyses.	Staff wellbeing
*Caragol, J. A., Johnson, A. R, & Kwan, B. M. (2022). A Gratitude Intervention to Improve Clinician Stress and Professional Satisfaction: A Pilot and Feasibility Trial. *International Journal of Psychiatry in Medicine, 57* (2), 103–116. https://doi.org/10.1177/0091217420982112	Pilot study to estimate effects and assess feasibility of a brief gratitude intervention for primary care clinicians.	A skills-based practice showing promising effects on increasing measures of resilience.	Links gratitude to Fredrickson's broaden and build theory and Seligman's Three Good Things model	Intervention study; Questionnaire / survey	The change in gratitude increased slightly although was not statistically significant. The intervention had positive effects on several measures of resilience.	Staff wellbeing
Centeno, C., Arantzamendi, M., Rodríguez, B., & Tavares, M. (2010). Letters from Relatives: A Source of Information Providing Rich Insight into the Experience of the Family in Palliative Care. *Journal of Palliative Care, 26* (3), 167–175. https://doi.org/10.1177/082585971002600305	To qualitatively evaluate the contents of five years' worth of spontaneously written letters to two palliative care services, one in Portugal and the other in Spain.	Expressions of thanks.	The study refers to questions about the validity of patient satisfaction surveys and considers letters to be a rich source of feedback.	Thematic analysis	Letters can be an invaluable source of data to carry out qualitative research to explore the impact of palliative care services.	Quality of care indicator

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Cheng, S. T., Tsui, P. K., & Lam, J. H. M. (2015). Improving Mental Health in Health Care Practitioners: Randomized Controlled Trial of a Gratitude Intervention. *Journal of Consulting and Clinical Psychology, 83* (1), 177–186. https://doi.org/10.1037/a0037895	To investigate whether directing a healthcare professional's (HCP) attention to thankful events through gratitude diaries could reduce stress and depressive symptoms.	"Gratitude is based on the perception of personal benefits as undeserved or unexpected, and is expressed in terms of thankfulness or appreciation. Such benefits are often related to the actions of others, and so people who "count blessings" tend to find more positive qualities in those around them (Fredrickson, 2004)" (p. 179).	Frames the study in terms of gratitude as a form of self-help to reappraise stressful events positively, enhance emotional well- being and "reduce demand on personal coping resources".	Randomised Controlled Trial; Intervention study	Counting blessings is an effective approach to reduce stressful and depressive symptoms amongst HCPs which was maintained at 3-month follow-up after intervention.	Staff wellbeing; Benefits
Chun, S., & Lee, Y. (2013). "I Am Just Thankful": The Experience of Gratitude Following Traumatic Spinal Cord Injury. *Disability and Rehabilitation, 35* (1), 11–19. https://doi.org/10.3109/09638288.2012.687026	To explore the experience of gratitude in everyday life following traumatic spinal cord injury.	"Gratitude is defined as the emotional response deriving from the perception of a positive personal outcome, including recognition, acknowledgement and/or appreciation of the receipt of a benefit (Emmons, 2007)" (pp. 11–12).	Frames the study in terms of the trauma research that shows that gratitude is implicated in posttraumatic growth.	Thematic analysis; Interview	The 13 "positive" participants shared their personal experiences following five themes: gratitude for (1) everyday life, (2) family support, (3) new opportunities, (4) positive sense of self and (5) God. Authors conclude that these expressions of gratitude had an impact on positive adjustments to injury for all the participants.	Benefits
Converso, D., Loera, B., Viotti, S., & Martini, M. (2015). Do Positive Relations with Patients Play a Protective Role for Healthcare Employees? Effects of Patients' Gratitude and Support on Nurses' Burnout. *Frontiers in Psychology, 6*, Article 470, 1–11. https://doi.org/10.3389/fpsyg.2015.00470	To investigate whether support from patients and/or gratitude expressed by them have an effect on burnout. Also whether gratitude has an indirect effect on reducing negative effects of job demands or enhancing positive effects of job resources.	"Gratitude is considered to be a positive psychological characteristic. It is linked to a feeling of well-being (Toussaint and Friedman, 2008) and can create a positive spiral effect (McCullough et al., 2001), motivate pro-social behavior (Grant and Gino, 2010), and contribute toward cultivating social resources" (p. 2).	Study is framed in terms of occupational health psychology in which the quality of work life and the quality of care, and their consequences for patients' health, are linked.	Questionnaire / survey	Compared with oncology nurses, emergency nurses expressed higher levels of psychological burden, emotional exhaustion, depersonalisation, and in general, a lower sensibility to the positive relationship with patients, but present more intense protective effects of the interaction between job autonomy and support/gratitude. Oncology nurses showed a higher perception of gratitude expression and patient- initiated support and declared a higher personal accomplishment than emergency nurses.	Staff wellbeing

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
*Cuervo-Suarez, M. I., Molina-Gómez, K., Bolaños-López, J. E., Pereira, L. F., Devia, A. M., Nieto, N. D., Correa, I., Álvarez Saa, T., & García-Quintero, X. (2022). Cultivating Gratitude in Bereaved Families: Understanding the Impact of the Bereavement Workshop on the Families of Deceased Patients in the Pediatric Palliative Care Program. *Illness, Crisis & Loss*, 1–19. https://doi.org/10.1177/10541373221130877	To explore the impact of a bereavement workshop for 23 families of patients who died after receiving paediatric palliative care.	"Gratitude, is an emotion that has its origins in the Latin gratia, refers to kindness, generosity and the beauty of giving and receiving, and can be taken as a psychological state or a willingness to notice, appreciate and respond with emotions of gratitude to actions of benevolence" (p.14).	None given although positivism is referred to.	Intervention study	Forty-nine thank you cards were made by relatives emphasised gratitude for hope, compassion, humanisation, learning and listening generated by experiences of care and loss.	Benefits
Davies, M. (2015). Should I Accept Gifts from Patients? *British Medical Journal*, *350,* h617. https://doi.org/10.1136/bmj.h617	To discuss the ethical issues behind accepting gifts from patients.	Gratitude is one of the motivations for patients giving doctors gifts.	Commentary on ethical considerations of receiving gifts.	None	Article is circumspect about the receiving of gifts by doctors, although presents more than one point of view. Gives a range of advice.	Gifts
Day, G. (2019). Enhancing Relational Care through Expressions of Gratitude: Insights from a Historical Case Study of Almoner–Patient Correspondence. *Medical Humanities, 46*, 288–298. https://doi.org/10.1136/medhum-2019-011679	To consider insights for contemporary medical practice from an archival study of gratitude letters exchanged between almoners and former patients at the Royal Brompton Hospital.	Expressions of thanks and appreciation as a key element of relational care.	Study is put in the context of the history of profession building and the nature of patienthood, Maussian gift exchange, and thanking routines.	Case study	Gratitude that is sincerely expressed at the interpersonal level contributed to durable relationships, often spanning decades, between staff and former patients. Recommendations are made for communication strategies that could build on gratitude to improve relationships in contemporary healthcare.	Social capital; Quality of care indicator; Gifts
*Day, G., Robert, G., Leedham-Green, K., & Rafferty, A. M. (2021). An Outbreak of Appreciation: A Discursive Analysis of Tweets of Gratitude Expressed to the National Health Service at the Outset of the COVID-19 Pandemic. *Health Expectations, 25* (1), 149–162. https://doi.org/10.1111/hex.13359	To use discursive analysis to explore how the NHS was constructed in 834 attention-attracting tweets that expressed and/or discussed gratitude to the NHS.	Gratitude is a discursive practice that is strategised as a purposeful, performative action, and a cultural resource on which actors draw.	Fredrickson's broaden and build theory, discursive psychology	Thematic analysis	Thanking practices and attitudes to gratitude were dynamic and responsive to events. Clap-for-carers formed a nexus for thanking activities on social media. Ambivalence surrounding gratitude highlights the volatility of emotional, ritualised social performances and how susceptible these are to context. Gratitude has figured as a prominent, if contentious, social value, catalysing debates about social behaviours and prompting a reappraisal of the risks and rewards of healthcare and social care work.	Care ethics

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Diesen, P. S. (2016). "I Feel Lucky" – Gratitude Among Young Adults with Phenylketonuria (PKU). *Journal of Genetic Counseling*, *25* (5), 1002–1009. https://doi.org/http://dx.doi.org/10.1007/s10897-015-9931-8	To explore young and early-treated Norwegian adults' lived experiences of PKU.	"Gratitude is described as being linked to well-being as a positive coping strategy, mediating stress and enabling people to deal with the problem (Wood et al. 2010)" (p. 1003).	Process is "inspired by grounded theory". Holistic approach to understanding the illness experience.	Interview	Patients expressed gratitude for circumstances and to parents. Whilst grateful for the expertise available at the Hospital, some patients were resentful about constant blood monitoring. Authors suggest that gratitude can act as a coping strategy (although this is not investigated).	Quality of care indicator; Benefits
Duckworth, A. L., Steen, T. A., & Seligman, M. E. P. (2005). Positive Psychology in Clinical Practice. *Annual Review of Clinical Psychology, 1*, 629–651. https://doi.org/10.1146/annurev.clinpsy.1.102803.144154	To summarise advances in positive psychology in the context of clinical psychology (i.e. the prevention and treatment of psychopathology) by reviewing intervention studies.	Discusses Emmons and McCullough's 2003 paper so gratitude is not defined but it is referred to as an intervention.	Gives a detailed background to positive psychology and its conceptual organisation: the pleasant life, the engaged life and the meaningful life.	Theoretical or conceptual review	Makes recommendations for future research to use clinical populations, and to build on ideas from various disciplines and to rigorously test them empirically.	Benefits
Fournier, A., & Sheehan, C. (2015). Growing Gratitude in Undergraduate Nursing Students: Applying Findings from Social and Psychological Domains to Nursing Education. *Nurse Education Today, 35* (12), 1139–1141. https://doi.org/https://doi.org/10.1016/j.nedt.2015.08.010	To report on the introduction of gratitude-based assignments to a nursing program.	"Gratitude is one human response to the receiving of, or the perception of, somethingvaluable (Highfield, 2001). … Gratitude has been defined as a trait, an action, an emotion, and as a moral virtue that exhibits an inherent thankfulness (Gulliford et al., 2013; Emmons and McCullough, 2003). Gratitude has also been described as more than just a feeling. It is power to evoke focus, and motivation to act in kindness—for the society (Froh et al., 2010)" (p. 1139).	Links gratitude to the education of nurses according to models of patient- and person-centred care.	Case study	Integration, role modelling and support of gratitude behaviours was well received by students and further research is recommended.	Staff wellbeing
Gaal, P., & Mckee, M. (2005). Fee-For-Service or Donation? Hungarian Perspectives on Informal Payment for Health Care. *Social Science & Medicine*, *60,* 1445–1457. https://doi.org/10.1016/j.socscimed.2004.08.009	To review debates in Hungary around causes of and reasons for informal payments (known as gratitude payments) to doctors and healthcare workers.	Gratitude is an expression of thanks taking the form of a gift from recovering patients.	Informal payments are considered from a review of the theoretical literature, considering socio-cultural, legal-ethical and policy factors.	Literature review; Theoretical or conceptual review	Gratitude in the healthcare setting is not straightforward: research on patients' motivations (donation or fee) for making gratitude payments is inconclusive and contradictory making it difficult to make policy recommendations. Further research is advised.	Gifts

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Galvin, R. (2004). Challenging the Need for Gratitude: Comparisons between Paid and Unpaid Care for Disabled People. *Journal of Sociology*, *40* (2), 137–155. https://doi.org/10.1177/1440783304043453	To explore the role of gratitude in compounding feelings of loss in response to becoming disabled.	"The Oxford English Dictionary defines gratitude as 'a warm sense of appreciation of kindness received'" (p. 139).	Research is put in the context of disability theory.	Interview; Thematic analysis	Those who rely on the goodwill of others commonly experience shame and frustration whereas those who paid for formal care tended to feel more comfortable and in control of their lives. "Only when gratitude regains its position as a matter of etiquette, a comfortable expression of appreciation, rather than a source of soul-destroying obligation, can it be claimed that a state of true independence and autonomy has been reached for disabled people" (p. 152).	Social capital; Care ethics
Gardner, W., & Lidz, C. (2001). Gratitude and Coercion between Physicians and Patients. *Psychiatric Annals*, *31* (2), 125–129.	The paper examines the ethical literature on the sentiment of gratitude and considers whether physicians (psychiatrists) should expect patients to be grateful for coerced care.	Gratitude is a response to someone who has benefited you.	Refers to the work of philosophers Berger, Card, Fitzgerald and McConnell to address the question, "When do individuals have a duty to be grateful?'	Theoretical or conceptual review	Authors maintain that patients who are committed are never or rarely sincerely grateful for their treatment because their cognitive appreciation for benefits of treatment is paired with feelings of injury from the denial of autonomy.	Care ethics
*Gillespie, A., & Reader, T. W. (2021). Identifying and Encouraging High-Quality Healthcare: An Analysis of the Content and Aims of Patient Letters of Compliment. *BMJ Quality & Safety*, *30*, 484-492 https://doi.org/10.1136/bmjqs-2019-010077	To identify the practices being complimented and the aims of writing in 1267 compliment letters to frontline staff and senior management.	Gratitude is elicited by feelings of thankful-ness that emerge when people experience behaviours that are voluntary, beneficial to them and have a cost to the benefactor. Gratitude aims are identified as acknowledging, rewarding, and promoting.	None explicitly mentioned, although gratitude is linked to wellbeing, motivation, patient involvement in care, and prosocial relationships.	Thematic analysis	Letters are unsolicited reciprocations aimed at recognising and motivating staff and thus improving healthcare.	Quality of care indicator
Herbland, A., Goldberg, M., Garric, N., & Lesieur, O. (2017). Thank You Letters from Patients in an Intensive Care Unit: From the Expression of Gratitude to an Applied Ethic of Care. *Intensive and Critical Care Nursing*, *43*, 47–54. https://doi.org/10.1016/j.iccn.2017.05.007	The study aimed to analyse thank-you letters from intensive- care patients to identify messages intended for the intensive care team that could form the basis for future action.	Expression of thanks, in this case by unsolicited letter, from patients to intensive care unit (ICU) staff.	Study findings are put in the context of "an ethic of care" (Gilligan, 1982) which defined phases of caring and elements of care through reciprocal practice.	Thematic analysis	Qualitative analysis of the letters shows the main themes are caring attitudes (humanism, professionalism, family-centred care), appreciation for survival, and "unique testimony of the moral and physical strain of a distressing stay in ICU'. Letters provide encouragement and information for ICU staff.	Quality of care indicator; Care ethics

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Huang, C.-H., Wu, H.-H., Lee, Y.-C., & Li, L. (2019). What Role Does Patient Gratitude Play in the Relationship Between Relationship Quality and Patient Loyalty? *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, 56. https://doi.org/10.1177/0046958019868324	To use relationship marketing to investigate the role of patient gratitude, loyalty and relationship quality between patients and physicians in the medical service industry in Taiwan.	"Gratitude is a pleasant mood and is a positive experience of the recipient who recognises the benefit from the giver, which in turn represents his or her feedback (McCullough, Emmons & Tsang, 2002; Casellas-Grau, Font & Vives, 2014; Rashid, 2015)" (p. 2).	The study uses a relationship marketing paradigm, specifically commitment–trust theory.	Questionnaire / survey	Patient satisfaction, trust and commitment mediate patient loyalty via patient gratitude, which, for the authors, confirm that gratitude drives a successful doctor–patient relationship.	Quality of care indicator
Julesz, M. (2018). The Legal History of Gratitude Payments to Physicians in Hungary. *Journal on European History of Law, 9* (1), 149–157.	To review the legal history of gratitude payments to physicians in Hungary and other eastern European countries, and to discuss the ethics of this practice.	"While we can find the word 'gratitude' in numerous articles by Western European, North American and Japanese health researchers, we can also see that the word denotes some positive feeling on the part of the patient towards the treating physician. In the post-communist part of the world and also in a great many developing African countries, authors always mean corruption when they use the word 'gratitude'." (p. 157).	This paper takes a long view of payments to doctors in the history of medicine, starting with Ancient Egypt, mentioning Christianity, the Middle Ages, and the birth of scientific medicine.	None	Gratuity payments were legal in the 19th century when doctors were paid more than promised for a job well done, or received gifts such as art. Today, doctors are legally obliged to pay tax on gifts, although the difficulty authorities have in checking these, means that corruption is rife. During the Communist era, it was the social norm for patients to pay doctors for ostensibly free medical services. Although against the Code of Ethics, and those soliciting money in advance are prosecuted (with low penalties), gratuity payments are still customary. Author argues that all such payments are corruption.	Gifts
Jun, W. H., Yang, J., & Lee, E. J. (2018). The Mediating Effects of Social Support and a Grateful Disposition on the Relationship between Life Stress and Anger in Korean Nursing Students. Asi*an Nursing Research*, *12* (3), 197–202. https://doi.org/https://doi.org/10.1016/j.anr.2018.08.002	To examine the mediating effects of social support and a grateful disposition on the relationship between life stress and anger in Korean nursing students.	Gratitude is a disposition that is a protective factor for stress and anger.	Study draws on positive psychology and research in nursing education.	Questionnaire / survey	The results of the study showed that a grateful disposition and social support could reduce the impact of stress on anger by functioning as full mediators of the relationship between these variables.	Staff wellbeing; Benefits

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Kenworthy, N. J. (2014). Global Health: The Debts of Gratitude. *Women's Studies Quarterly, 42* (1/2), 71–87.	To elaborate some of the ways in which pernicious forms of debt (including gratitude) accompany global health efforts.	Gratitude is the debt engendered by the understanding and practice of global health as a gift, when actually health is the debt owed.	Draws on Derrida, Graeber and Mauss to characterise gratitude as complicit in gift relationships which can be destructive. Draws mainly on Fanon to frame perceptions of generosity to become what is owed.	Theoretical or conceptual review	The politics of charity, in which global health efforts are rarely conceived of as anything more than works of generosity and goodwill, cause deficits of power in which gratitude is a "cunning fiction" -- the phenomenon of a calculation.	Care ethics; Social capital
Kindt, S., Vansteenkiste, M., Cano, A., & Goubert, L. (2017). When is Your Partner Willing to Help You? The Role of Daily Goal Conflict and Perceived Gratitude. *Motivation and Emotion, 41* (6), 671–682. https://doi.org/http://dx.doi.org/10.1007/s11031-017-9635-5	This study examined whether (1) same- and prior day perceived gratitude (i.e., received appreciation for providing support) in partners and (2) same- and prior day goal conflicts in partners (i.e., amount of interference between helping one's partner in pain and other goals) predicted partners' helping motivation for individuals with chronic pain (ICP).	"Gratitude has been defined as "the recognition and appreciation of an altruistic gift" (Emmons and McCullough 2004, p. 9). It is the positive emotion felt when another person has intentionally given (or attempted to give) something of value (McCullough et al. 2001)" (p. 672).	Study is placed in the context of self- determination theory which holds that individuals' sustainable motivation, development and integrative functioning are facilitated when their autonomy, competence and relatedness are nurtured.	Intervention study; Questionnaire / survey	If partners perceived more gratitude from ICPs on a given day, they not only reported helping for stronger autonomous helping motives during the same day, but they even provided more autonomously motivated help the next day. On days that partners experience a lot of interference between helping the ICP and other life goals, they feel more pressured to provide help that day, which might also affect the quality of help that is provided.	Social capital
Kreitzer, M. J., Telke, S., Hanson, L., Leininger, B., & Evans, R. (2019). Outcomes of a Gratitude Practice in an Online Community of Caring. *Journal of Alternative and Complementary Medicine,* acm.2018.0460, 385–391. https://doi.org/10.1089/acm.2018.0460	To report on the findings of a brief gratitude intervention hosted in an online social network (CaringBridge) for people following difficult diagnoses.	"Living gratefully matters" and interventions can benefit those facing health-related adversity (p. 2).	No specific theoretical framework, but mentions studies that show links to healing, psychological adaptation and well-being.	Intervention study; Questionnaire / survey	Statistically significant changes were observed in self- reported stress and were greater for those with greater frequency of practice. Only small changes were observed for gratitude, social connectedness, and social assurance. Positive health outcomes of decreased stress and increased gratitude appeared to plateau at 4 days without statistically detectable changes beyond that time frame. Authors hypothesise that those that choose to participate are already grateful with a good degree of social support and connectedness.	Benefits

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Lanham, M. E., Rye, M. S., Rimsky, L. S., & Weill, S. R. (2012). How Gratitude Relates to Burnout and Job Satisfaction in Mental Health Professionals. *Journal of Mental Health Counseling, 34* (4), 341–354.	To examine how gratitude relates to burnout and job satisfaction in mental health professionals.	Gratitude "involves being aware of and appreciating good things that happen and taking the time to express thanks (Park, Peterson, & Seligman, 2004)" (p. 343).	Gratitude is construed as a positive psychology construct and a number of theoretical positions are mentioned: prosocial behaviours, corporate social responsibility, coping skills and Fredricksen's broaden and build theory.	Questionnaire / survey	Workplace-specific gratitude predicted burnout and job satisfaction after controlling for demographic/job contextual variables and another positive emotion (hope). Dispositional (trait) gratitude did not predict burnout and job satisfaction but did predict personal accomplishment. Authors say this highlights the importance of measuring dispositional and situational gratitude because they may impact different aspects of wellbeing. Findings recommend encouraging gratitude journaling and letter writing (although these did not form part of the study).	Staff wellbeing
Lau, B. H.-P. & Cheng, C. (2017). Gratitude and Coping among Familial Caregivers of Persons with Dementia. *Aging and Mental Health, 21* (4), 445–453. https://doi.org/10.1080/13607863.2015.1114588	To examine the role of gratitude on relieving emotional distress in the context of familial caregiving for persons with dementia.	Gratitude, as a key factor for subjective well-being, is a psychological resource for caregivers.	Frames study in terms of Algoe's find- remind-and-bind theory and Fredrickson's broaden-and-build theory.	Questionnaire / survey	Gratitude was found to be related to higher levels of psychological resources and emotion-focused coping both of which lowered psychological distress.	Benefits
*Lindauer, C., Speroni, K. G., Godinez, K., Lurz, T., Oakley, R., & Zakes, A. (2021). Effect of a Nurse-Led, Patient-Centered, Gratitude Intervention on Patient Hospitalization Experience. The Journal of Nursing Administration, *51* (4), 192–199. https://doi.org/10.1097/NNA.0000000000000997	To conduct a pilot study to evaluate patient perceptions of a nurse-led, patient-centred gratitude intervention, and whether nurses identified actionable items to improve patient's hospitalisation experience in two medical units in hospitals in the Mid-Atlantic region of the USA (*n*=91).	Gratitude is a feeling of thankfulness and appreciation and an effective form of self-care. Gratitude and caring interventions have been shown to have a positive effect on patient health and well-being.	None explicitly mentioned although Watson's theory of caring included in literature search terms.	Intervention study, Questionnaire / survey	Patients categorised the intervention (gratitude entry form) as helpful and improved their hospitalisation experience. Nurses were also able to identify patient experience–related actions that could be taken by staff to improve the patient experience.	Benefits, Quality of care indicator
Macauley, R. (2014). The Ethics of Cultivated Gratitude. *HEC (Healthcare Ethics Committee) Forum, 26* (4), 343–348. https://doi.org/10.1007/s10730-013-9233-1	To explore the ethics of "grateful patient fundraising programmes".	"Grateful" is a way of describing those patients that make donations to a healthcare organisation after inpatient treatment.	No specific theory of gratitude, but paper is framed in terms of ethics surrounding philanthropy and coercion.	None	Author calls for all amenities provided through GPF programme to be non-clinical (e.g. not promising access to better care). Transparency should be central to GPF, with which benefits are being provided to whom and why being essential to avoid compromising justice and autonomy. To do otherwise is to risk coercion.	Gifts

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
*Manara, D. F., Giannetta, N., & Villa, G. (2020). Violence Versus Gratitude: Courses of Recognition in Caring Situations. *Nursing Philosophy*, *21* (3). https://doi.org/10.1111/nup.12312	To advance a phenomenological argument that proposes that violence and gratitude to nurses can be explained by Ricoeur's courses of recognition.	"Gratitude is the fruit of recognition, relieves the generosity of the initial gift from the obligation to reciprocate and balances: it breaks up and reassembles the gift–counter–gift relationship because 'it puts the couple aside from giving-receiving and the other receiving-reciprocating' (Ricoeur, 2005)" (p. 6).	Paul Ricoeur's courses of recognition and Curci's (2013) concept of the gift of care.	Theoretical or conceptual review	The pandemic stopped a growing phenomenon of attacks on healthcare professionals in favour of a mutual recognition between nurses and patients, centred on a mutual gift in giving and receiving care. Crying begins with an ethical act which corresponds to a mutual gift whose logic is not of justice or reason but of mutuality and gratuitousness.	Care ethics
*Marconi, E., Chiesa, S., Dinapoli, L., Lepre, E., Tagliaferri, L., Balducci, M., Frascino, V., Casà, C., Chieffo, D. P. R., Gambacorta, M. A., & Valentini, V. (2021). A Radiotherapy Staff Experience of Gratitude during COVID-19 Pandemic. *Technical Innovations and Patient Support in Radiation Oncology*, 18, 32–34. https://doi.org/10.1016/j.tipsro.2021.04.002	To introduce a gratitude-focused 'inter-group contact tool' using Whatsapp during the pandemic for radiotherapy staff at a hospital in Rome, Italy.	Gratitude takes the form of messages that are perceived as helping workers find gratification and rediscover meaning in their work.	None explicitly mentioned, but wellbeing and psychosocial models of stress are mentioned.	Intervention study (unevaluated)	It is suggested that the intervention improved teamwork, particularly in circumstances of uncertainty and high stress.	Staff wellbeing

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Martini, M., & Converso, D. (2014). Gratitude, or the Positive Side of the Relationship with Patients. Development and First Validation of New Instruments: A Scale of Gratitude Perceived by Operators and a Scale of Support Offered by the Gratitude Expressed by Their Patients. *Psychology, 5*, 572–580. https://doi.org/10.4236/psych.2014.56067	To report the development and analysis of a scale to measure gratitude expressed by patients perceived by operators and of a scale to measure the perception of support this offers.	"Gratitude is usually considered, also according to common sense, as a psychological positive characteristic related to a feeling of well-being (Toussaint & Friedman, 2008) and it is seen as a strength typical of some individuals (Peterson & Seligman, 2004). It has been regarded at and analysed as a trait, a mood, a moral virtue, an emotion. Gratitude is, in other words, an "emphatic emotion" (Lazarus & Lazarus, 1994), that can be defined as a response to behaviors that other people perform to contribute to the wellbeing of someone and that may in turn activate analogous behaviors (McCullough, Kilpatrick, Emmons, & Larson, 2001; McCullough, Emmons, & Tsang, 2002)" (pp. 573–574).	Explicitly refers to the Job Demand- Resources (JD-R) model (Bakker, Demerouti & Schaufeli, 2003) which describes interactions between requests and resources at work.	Interview; Focus groups; Questionnaire / survey	The authors conclude that the instruments show good internal reliability and confirm divergent and convergent validity.	Benefits

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Martini, M., Loera, B., & Converso, D. (2016). Users' Gratitude as a Source of Support for Social-Health Operators: First Validation of the Perceived Gratitude Scale (PGrate). *Bollettino Di Psicologica Applicata, 274* (3), 23–33. https://doi.org/http://dx.doi.org/10.4236/psych.2014.56067	To propose an instrument (PGrate) to measure the perception that healthcare workers (social-health operators) have of the gratitude expressed by users, and with the significance that this expression has forthem.	"Gratitude is regarded as an emotion, an affective trait, a mood or a moral virtue and considered a positive psychological characteristic linked to a feeling of well-being (Toussaint & Friedman, 2008), a strength that some people have (Peterson & Seligman, 2004), related to life satisfaction, to better mental health and to improved interpersonal relationships (Emmons & McCullough, 2004; Morgan, Gulliford & Kristjánsson, 2014; Watkins, Uhder & Pichinevskiy, 2015)" (p. 24).In the gratitude scale, gratitude to professionals is defined as "being recognised, thanked and rewarded by users for actions performed to contribute to their well-being and, as a consequence, feeling relieved for efforts at work and more motivated on the job" (p. 25).	Study is placed in the context of positive psychology, specifically ones of work-related support and stress reduction related to wellbeing.	Questionnaire / survey	The PGrate scale (3 items related to gratitude expression and 5 on gratitude as source of support) is found to have good reliability. Recommends that measurement instruments should be distinct for structural support from a specific source (users) and functional (emotional and cognitive support). Many limitations are identified.	Benefits
Martins Pereira, S., & Hernández-Marrero, P. (2016). "In Memory of Those Who Left": How "Thank You" Letters Are Perceived and Used as a Team Empowerment Motivational Factor by a Home-Based Palliative Care Team in the Azorean Islands. *Journal of Palliative Medicine*, *19* (11), 1130–1131. https://doi.org/10.1089/jpm.2016.0255	To understand the emotions, meaning and use given to letters of thanks received by Azorean healthcare workers.	Thanks expressed in letters.	The study is put in context of the Expectancy Theory of Motivation in which symbolic and verbal forms of recognition are considered to be very effective in terms of "reward valence".	Questionnaire / survey	Thank-you letters promote a sense of reward, recognition and satisfaction. Letters might help to understand "micro-meso-macro" linkages in palliative care to facilitate culture change to enhance organisations' effectiveness.	Staff wellbeing; Quality of care indicator

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Moosath, H., & Jayaseelan, R. (2016). “Dear Diary…”: Exploring the Experience of Gratitude among Oncology Patients. *Indian Journal of Positive Psychology, 7* (2), 224–228.	To explore whether gratitude exercises (journaling) contributed to subjective wellbeing of oncology patients.	"Emmons and McCullough (2003) define gratitude as 'a cognitive-affective state that is typically associated with a perception that one has received a personal benefit that was not deserved or earned, but rather, due to the good intentions of another person'," p. 224.	Refers to a "pathological paradigm", which focuses on human functioning using a problem-oriented framework, in contrast to positive psychology (drawing largely on Seligman). "Build what's strong" rather than "fix what's wrong".	Interview; Thematic analysis; Intervention study	Benefits reported by participants included happiness, distraction, and time to reflect: "nurturing a sense of gratitude may be a powerful step that one can take towards a fulfilling life" (p. 227).	Benefits
Mpinganjira, M. (2019). Willingness to Reciprocate in Virtual Health Communities: The Role of Social Capital, Gratitude and Indebtedness. *Service Business, 13,* 269–287. https://doi.org/10.1007/s11628-018-0382-9	To examine the role of social capital, gratitude, and indebtedness in explaining levels of willingness to reciprocate in virtual health communities.	Feelings of thankfulness and appreciation of benefits enjoyed.	Resource exchange theory and affect theory. Proposes a conceptual model that posits that social capital wields emotions effect on users that influences willingness to reciprocate.	Questionnaire / survey	Willingness to reciprocate in online health communities is directly influenced by social capital, emotions of gratitude and indebtedness. Findings can be used by managers of virtual health communities to stimulate more knowledge sharing.	Social capital
Mullin, A. (2011). Gratitude and Caring Labor. *Ethics & Social Welfare, 5* (2), 110–122. https://doi.org/http://dx.doi.org/10.1080/17496535.2011.571061	To explore care ethics associated with gratitude in the context of adult recipients of personal care.	"What is gratitude? Interpersonal gratitude, or gratitude to a person, as opposed to being grateful that some particular thing has occurred, involves appreciative attitudes towards both a benefit and a benefactor (Walker 1988)" (p. 112).Criticises Fitzgerald's (1988) conceptualisation of gratitude as being appropriate even to those that harm us or indirectly or unintentionally benefit us. Argues that benefit must be given out of benevolence and that "respect" is a component often neglected.	Places gratitude in the context of a feminist ethics of care. Reject Aristotle's Nicomachean Ethics which links gratitude to dependency. Looks at relational autonomy in the context of ethics of care (Sherwin 2000). Draws on Dillon's conception of "care respect" (2009).	Theoretical or conceptual review	Gives an account of interpersonal gratitude and when it is merited. Contends that, in the context of caring labour, gratitude is a morally appropriate response to care provided in a manner that recognises and respects the humanity of the recipient.	Care ethics

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Niner, S., Kokanovic, R., & Cuthbert, D. (2013). Displaced Mothers: Birth and Resettlement, Gratitude and Complaint. *Medical Anthropology, 32* (6), 535–551. https://doi.org/10.1080/01459740.2013.769103	To examine the effects of displacement on the lives of Karen women from Burma-Myanmar who resettled in Australia, through the focus of perinatal health.	Gratitude is considered to be appreciation expressed, e.g. for "good heart" and "good intentions", also "gracious acceptance".	Theories of gratitude are not invoked directly. The study as a whole is in the context of social inclusion for migrants.	Case study; Interview	Overdetermined discourses of deservingness (and non-deservingness) and gratitude risk perpetuating inequalities and disadvantage for forced migrants and asylum seekers. Women's reactions were on a spectrum from overwhelming gratitude to preparedness to voice complaint, related strongly to their pre-settlement experiences.	Care ethics
*Nourpanah, S. (2021). The Construction of Gratitude in the Workplace: Temporary Foreign Workers Employed in Health Care. *International Migration, 59* (2), 57–71. https://doi.org/10.1111/imig.12769	To discuss the construction of gratitude in the political economy regime of temporary foreign work for nurses on temporary work permits in Canada.	Gratitude is described as a delicately articulated feeling which is produced, systematically and as a process, as a "structure of feeling" within a particular state policy framework.	Marx's writings on capitalist regimes of production structures. Mauss and Appadurai are also referred to.	Interview	Gratitude is an aware, strategic and layered structure of feeling, developed pragmatically and juxtaposed with issues of labour protection, citizenship requirements and family reunification. Gratitude is produced and manipulated in the workplace, making it burdensome. The author calls for employers to be removing from immigration processes to avoid migrant workers feeling beholden to employers.	Care ethics

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Nouvet, E. (2016). Extra-ordinary Aid and its Shadows: The Work of Gratitude in Nicaraguan Humanitarian Healthcare. *Critique of Anthropology, 36* (3), 244–263. https://doi.org/10.1177/0308275X16646835	To explore the power effects of gratitude (often thought of as a banal sentiment), asking what social and political relations, expectations, and provisions expression of gratitude materialise and normalise within the Nicaraguan context.	"Gratitude has been defined in philosophy as 'one of the most common ways that morality asks us to relate to others' (Fitzgerald, 1998: 120). (p. 249) ... Gratitude can mean many things depending on its intentions, what it is in response to, and how it positions objects and subjects of gratitude in the moral landscapes it helps to form. ... Crucial to an analysis of what gratitude does in the Nicaraguan context of humanitarian health care is an understanding of what Nicaraguans' expressions of gratitude in this context are delimiting as 'good' and worthy of recognition" (p. 252).	This study draws on critical humanitarian studies and queer/feminist affect theory (which is argued to be at the forefront of engaging with the social work of banal and taken-for-granted feelings).	Interview	Gratitude in the Nicaraguan context draws attention to the importance of small acts. It is isolated from global politicisation of foreign healthcare missions. It is linked to a critique of the Nicaraguan public healthcare system. The foreign medical mission volunteer is constructed as a person of exceptional virtue.	Care ethics
O'Brien, G. M., Donaghue, N., Walker, I., & Wood, C. A. (2014). Deservingness and Gratitude in the Context of Heart Transplantation. *Qualitative Health Research, 24* (12), 1635–1647. https://doi.org/10.1177/1049732314549018	To explore how the lived experiences of heart transplant patients are grounded in social discourses about organ donation, the gift of life and gratitude.	Gratitude is a way of showing a "correct moral stance" (in this case in response to receiving an organ) (p. 1636).	Contextualises the research in terms of Maussian gift-exchange theory. Adopts the "tyranny of the gift" idea proposed by Fox and Swazey (2002) (p. 1636). Prosocial and broaden-and-build conceptualisations are referred to.	Interview	There is not necessarily a direct trajectory from receipt of a gift (even a heart) to unmitigated gratitude. The source of gratitude might also lead to an array of other emotions (joy, hope, anxiety, shame, guilt and/or obligation).The focus in social discourse on organs as gifts emphasises a moral transaction but minimises complex moral relations between recipients and other candidates who have not received hearts. The expectation of making a return on the benefit received is not possible in the context of organ donation, but the "giving forward" by helping others was prominent in the discourses.	Social capital; Care ethics

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Ootes, S. T. C., Pols, A. J., Tonkens, E. H. & Willems, D. L. (2013). Opening the Gift: Social Inclusion, Professional Codes and Gift-Giving in Long-Term Mental Health care. *Culture, Medicine & Psychiatry, 37,* 131–147. https://doi.org/10.1007/s11013-012-9293-8	To study contradictions between the objective of social inclusion for mental health clients in which gifts may be implicated, and the professional norms of declining gifts.	Gratitude is one dimension of client–professional relationships that prompts gift-giving.	This paper draws on sociological theory of gift exchange (Mauss, Komter, Levi-Strauss, Bourdieu).	Ethnography; Interview; Thematic analysis	Four types of gifts were being given in long-term mental healthcare: a symptom gift (e.g. one that enacts a symptom such as insecurity), a compensation gift (given with the expectation of reciprocity of service or in compensation for a service - often take the form of money), a courtesy gift (restores social balance by thanking a professional for care, acknowledging this has a social dimension) and a personal gift (personalised gift in the context of a long-term relationship that can enhance social inclusion). Authors recommend reflexivity procedures to constantly evaluate ethical discussions around gift-giving.	Gifts
*Otobe, Y., Suzuki, M., Kimura, Y., Koyama, S., Kojima, I., Ichikawa, T., Terao, Y., & Yamada, M. (2021). Relationship between Expression of Gratitude by Home-Based Care Receivers and Caregiver Burden among Family Caregivers. *Archives of Gerontology & Geriatrics, 97*, Nov-Dec:104507. doi: 10.1016/j.archger.2021.104507	To investigate the relationship between the frequency of self-reported gratitude from care receivers prior to needing care and caregiver burden for 700 informal (familial) care givers in Japan. Whether the effect of gratitude from care receivers on caregiver burden varied with the caregiver's age was also investigated.	Gratitude is described as having traits that are characterised by habitual positive well-being, and high levels of expression of gratitude between partners is associated with greater satisfaction and commitment in the long-term.	None given.	Questionnaire / Survey	Frequency of gratitude from care receivers prior to them needing care was significantly higher in those with 'mild' caregiver burden scores than those in the 'severe' burden group. This association was only found in relationships between older people (spousal relationships) and not in middle-aged carers where the relationship was more likely to be parent–child.	Benefits
*Özdemir, T., Karadağ, G., & Kul, S. (2022). Relationship of Gratitude and Coping Styles with Depression in Caregivers of Children with Special Needs. *Journal of Religion and Health, 61* (1), 214–227. https://doi.org/https://doi.org/10.1007/s10943-021-01389-1	To investigate the relationship between gratitude and coping styles with depression in 330 caregivers in Turkey with children with special needs.	Gratitude is defined as a positive thought, a satisfaction and a feeling felt towards God.	Results of are put in the context of spirituality as a style of coping.	Questionnaire / Survey	Caregivers of children with special needs had high levels of gratitude and tended to use coping styles of turning to religion, planning, positive reinterpretation, and using instrumental social support. The authors call for healthcare professionals to evaluate the spiritual needs of caregivers to improve mental health.	Benefits

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Rådestad, I., Westerberg, A., Ekholm, A., Davidsson-Bremborg, A., & Erlandsson, K. (2011). Evaluation of Care after Stillbirth in Sweden Based on Mothers' Gratitude. *British Journal of Midwifery, 19* (10), 646–652.	To describe mothers' gratitude for actions tokens by HCPs in connection with stillbirth.	Gratitude is considered to be a response to the question, "Are you grateful today for anything that the health professionals did for you in connection with the birth of your child? Please write as much as you wish here in your own words."	None mentioned	Questionnaire / survey; Thematic analysis	Mothers who experienced a stillbirth after 1990 were grateful that their baby was treated as a live born child and the memories that the nursing staff helped them create. Those who had a stillbirth before 1990 did not feel grateful for not being allowed to hold their child and grateful for little else that HCPs had done following the stillbirth. Gratitude or lack of gratitude had nothing to do with memories but with the care received.	Quality of care indicator
Rao, N., & Kemper, K. J. (2017). Online Training in Specific Meditation Practices Improves Gratitude, Well-Being, Self-Compassion, and Confidence in Providing Compassionate Care Among Health Professionals. *Journal of Evidence-Based Complementary & Alternative Medicine, 22* (2), 237–241. https://doi.org/10.1177/2156587216642102	To determine the impact of brief, online training for health professions in three types of meditation, one of which was gratitude-focused.	Gratitude is part of a constellation of positive emotions that temporarily broadens thinking, creativity attention and cognitive functioning.	Places gratitude in the context of positive emotion and Fredrickson's broaden-and- build theory.	Intervention study; Questionnaire / survey	There were significant improvements in gratitude following the gratitude unit. The authors conclude that online training of this type appeals to diverse health professions and there is a need to evaluate of this training on clinician burnout, quality of care and patient outcomes.	Staff wellbeing
Riskin, A., Bamberger, P., Erez, A., Riskin-Guez, K., Riskin, Y., Sela, R., Foulk, T., Cooper, B., Ziv, A., Pessach-Gelblum, L., & Bamberger, E. (2019). Expressions of Gratitude and Medical Team Performance. *Pediatrics, 143* (4), e20182043. https://doi.org/10.1542/peds.2018-2043	To examine whether and how expressions of gratitude from individuals representing different roles (expert or mother) affect the performance (accurate diagnosis and treatment) of neonatal intensive care unit (NICU) teams in a simulation.	Gratitude is a "prototype of positive social interaction" (abstract, p. 1).	The study is put in context of affect-as- information theory and previous work by the authors that showed that rudeness has adverse consequences for individual and team diagnostic and treatment performance.	Intervention study	Members of medical teams may be more sensitive to parental gratitude than gratitude expressed by experts or authority figures. Maternal gratitude to NICU teams robustly boosted team performance outcomes. The authors recommend that medical communities find ways to expose their teams to grateful feedback in the interests of boosting the ability to provide high-quality care.	Benefits; Quality of care indicator

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Roche, S., Brockington, M., Fathima, S., Nandi, M., Silverberg,B., Rice, H. E., & Hall-Clifford, R. (2018). Freedom of Choice, Expressions of Gratitude: Patient Experiences of Short-Term Surgical Missions in Guatemala. *Social Science & Medicine*, 208, 117–125. https://doi.org/10.1016/j.socscimed.2018.05.021	To examine the experiences of patients in seeking surgery delivered by short-term medical missions and to explore the asymmetric relationships between aid recipients and donors.	Gratitude is a rhetorical trope regularly expressed by patients who receive aid.	Study is put in context of global health volunteerism, politics and health policy.	Interview	Gratitude was a nearly universal theme, usually taking the form of unprompted statements. The authors concluded that although volunteer medical teams may be motivated by kindness and compassion, they may contribute to complexities and inequalities in which "grateful postures" are expected.	Care ethics
Shaw, R. (2011). Thanking and Reciprocating Under the New Zealand Organ Donation System. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine,16* (3), 298–313. https://doi.org/10.1177/1363459311411167	To explore issues of reciprocity and intercorporeality that arise in response to organ donation, specifically in the context of anonymity protocols.	Gratitude is an expectation raised by the 'gift of life' rhetoric, imposing a sense of moral responsibility which is difficult to discharge.	The analysis draws on Maussian gift- exchange theory, and social norms of gift giving and reciprocity.	Interview; Thematic analysis	The language available to participants is key to what one is able to say. The difficulties that donors have in writing the thank you letter are discussed.	Social capital; Care ethics
Silva, D. S., & Viens, A. M. (2015). Infection Control Measures and Debts of Gratitude. *The American Journal of Bioethics, 15* (4), 55–57. https://doi.org/10.1080/15265161.2015.1009565	To discuss the basis for and ways in which one discharges "a debt of gratitude" to those healthcare workers returning from Ebola-infected regions in the context of infection-control measures.	"Gratitude can be understood as an attitude or feeling grateful toward persons for their actions or for something received" (p. 54).	Places gratitude in the context of moral philosophy, particularly in relation to gratitude as a debt.	None	Discusses whether reasons for gratitude should be treated additively, in which case losses associated with infection control should be minimised. But if what matters is showing gratitude to individuals who voluntarily contribute to risk minimisation, then reasons for gratitude should be treated non-additively. Reciprocally responding with gratitude for risks taken and losses incurred are important in legitimising infection control measures.	Social capital; Care ethics
Spence, S. A. (2005) . Patients Bearing Gifts: Are There Strings Attached? *British Medical Journal, 331,* 1527–1529.	To consider ethical and clinical questions when patients give doctors gifts.	Gratitude is one of the motives that underlie the giving of gifts to doctors.	Explains "the patient's mind" in relation to gifts using the language of psychoanalysis and neurobiology.	None	Doctors must exercise discretion over the acceptance of individual items and ask "Why now?'. Gifts given out of the blue should arise suspicion. Suggestions for patients' motives are made.	Gifts

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Starkey, A. R., Mohr, C. D., Cadiz, D. M., & Sinclair, R. R. (2019). Gratitude Reception and Physical Health: Examining the Mediating Role of Satisfaction with Patient Care in a Sample of Acute Care Nurses. *The Journal of Positive Psychology, 14* (6), 779–788. https://doi.org/10.1080/17439760.2019.1579353	To explore the effects of expressed gratitude by examining how receiving expressions of gratitude predicts nurses' physical wellbeing via work-related satisfaction.	"… gratitude is a positive affective experience that typically follows another's beneficial and caring gesture towards the self, particularly when the gesture is perceived to be costly or valuable, intentional and voluntary (McCullough, Kimeldorf & Cohen, 2008)" (p. 779).	Puts study in the context of Conservation of Resources theory (Hobfoll, 2001) and Fredrickson's 'broaden and build' theory.	Questionnaire / survey	Gratitude reception indirectly predicted better physical health (sleep quality, headaches, healthy eating intentions) via psychological well-being, specifically through satisfaction with quality of care.	Staff wellbeing
Stegen, A., & Wankier, J. (2018). Generating Gratitude in the Workplace to Improve Faculty Job Satisfaction. *Journal of Nursing Education, 57* (6), 375–378. https://doi.org/http://dx.doi.org/10.3928/01484834-20180522-10	To determine the effects of cultivating "an attitude to gratitude" on job satisfaction and collaboration amongst nursing faculty.	"Gratitude can be difficult to define. It is individual in nature and to some can be considered an emotion or attitude, yet to others a habit or a coping response. … According to Emmons and McCullough (2003) gratitude can be defined as a "general tendency to recognise and respond with grateful emotion to the roles of other people's benevolence in the positive experiences and outcomes that one obtains'," (p. 376).	Places gratitude in the context of studies on workplace gratitude. Mentions Fredrickson's broaden-and-build theory for positive emotions.	Intervention study	Response was overwhelmingly positive and gratitude practices resulted in more open communication, more appreciation for each other, and higher job satisfaction.	Staff wellbeing
Stepurko, T., Pavlova, M., Gryga, I., & Groot, W. (2013). Informal Payments for Health Care Services - Corruption or Gratitude? A Study on Public Attitudes, Perceptions and Opinions in Six Central and Eastern European Countries. *Communist and Post-Communist Studies, 46* (4), 419–431. https://doi.org/http://dx.doi.org/10.1016/j.postcomstud.2013.08.004	To compare public perceptions of informal patient patients in Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine.	Gratitude is considered in relation to informal payments and gifts (token and in-kind) which are traditional in many Eastern European countries but could be considered a form of corruption.	Study is placed in the context of political structures of state and measures to combat corruption.	Theoretical or conceptual review; Questionnaire / survey; Interview	Across the countries, informal cash payments are perceived negatively as corruption, whereas in-kind gifts are often seen as gratitude. Authors conclude that it is important to prohibit acceptance or request of any gift unless there is a system to distinguish the nature of it. Lack of good regulation and poor pay for medical staff also contribute to the persistence of informal payments.	Gifts

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Stomski, N. J., Morrison, P., Sealey, M., Skeffington, P., & O'Brien, G. (2019). The Association between Gratitude and Burden in Australian Mental Health Carers: A Cross-Sectional Study. *Scandinavian Journal of Caring Sciences, 33* (1), 215–221. https://doi.org/10.1111/scs.12623	To investigate the association between dispositional gratitude and carer burden in Australian mental health carers.	"Gratitude has been conceptualised as a wider life disposition towards identifying and appreciating positive aspects of the world, wherein individual gratitude traits contribute towards a higher order gratitude construct (Wood, Froh & Geraghty, 2010)" (p. 215).	No specific conceptual framework identified, although previous literature on dispositional gratitude and well-being are referred to.	Questionnaire / survey	Authors conclude that the promotion of dispositional gratitude may result in significant reductions in mental health burden, even though there was a direct, significant relationship between "simple appreciation" and carer burden which the authors say can be attributable to iatrogenic effects on gratitude induction. They recommend that worrying, urging and tension could be decreased through fostering a sense of "lack of deprivation" (taken to be congruent with "a focus on what the person has"), and supervision (guarding the cared-for person's medicine intake, sleep and dangerous behaviour) could be lowered by enhancing appreciation for others.	Benefits
Toledo-Pereyra, L. H. (2006). Gratitude. *Journal of Investigative Surgery, 19* (3), 137–140. https://doi.org/10.1080/08941930600745650	To emphasise the importance of gratitude in the professional lives of surgeons and all people.	"... gratitude 'is a feeling of thankfulness and appreciation at a benefit received. Feelings of gratitude can strengthen friendship and communion when accepted with an assumption of good faith' (Wikipedia)" (p. 138).	Draws on various authors' characterisations of gratitude. No specific theoretical framework.	None	Calls for the development of a program that will highlight the "eternal implications of gratitude" amongst surgical professionals.	Benefits
Wright, S. M., Wolfe, L., Stewart, R., Flynn, J. A., Paisner, R., Rum, S., Parson, G., & Carrese, J. (2013). Ethical Concerns Related to Grateful Patient Philanthropy: The Physician's Perspective. *Journal of General Internal Medicine, 28* (5), 645–651. https://doi.org/10.1007/s11606-012-2246-7	To identify ethical concerns associated with philanthropic gifts from grateful patients.	Gratitude is the term often used to characterise the motivation behind patient philanthropy.	Put in the context of the ethics of philanthropy.	Interview	Several domains of ethical issues were identified most prominent of which was possible effects on the doctor-patient relationship. Informants mostly suggested that there are no ethical issues with grateful patient philanthropy, leading the authors to suggest that they have the "illusion of unique invulnerability".	Gifts

Reference	Aim	Definition of gratitude	Theoretical underpinnings	Methods	Findings and/or recommendations	Assigned metanarrative
Zhang, S., Liu, Y.-H., Zhang, H., Meng, L., & Liu, P. (2016). Determinants of Undergraduate Nursing Students' Care Willingness Towards the Elderly in China: Attitudes, Gratitude and Knowledge. *Nurse Education Today, 43,* 28–33. https://doi.org/https://doi.org/10.1016/j.nedt.2016.04.021	The purpose of the study was to explore the relationships among knowledge about aging, care willingness, attitude towards the elderly and gratitude.	"Gratitude is regarded as a response to value (Highfield, 2001). It was first proposed as a positive feeling after someone offered his selfless love and help to others (Wood et al., 2008). After years of improving the concept of gratitude constantly, it was defined as a trait, a behavior, a feeling, and a moral virtue to express thankfulness (Gulliford et al., 2013)" (p. 29).	Study is put in the context of China's problems in encouraging gerontological nursing.	Questionnaire / survey	Attitudes towards older people, knowledge about aging and gratitude were all significantly correlated with care willingness. Gratitude "plays a mediating role" between knowledge and care willingness.	Quality of care indicator

2.2.5 Analysis and synthesis

All three research collaborators independently noted the characteristics that were descriptive of the research traditions, or fields of study, to which we felt the included articles belonged. These were either specific academic disciplines with associated methods (e.g. positive psychology or sociology), or context-driven scholarship (e.g. health education, policy). For articles that were vague about their paradigms and conceptual modelling of gratitude, an examination of implicit definitions and methodological framing helped to align the research within particular traditions.

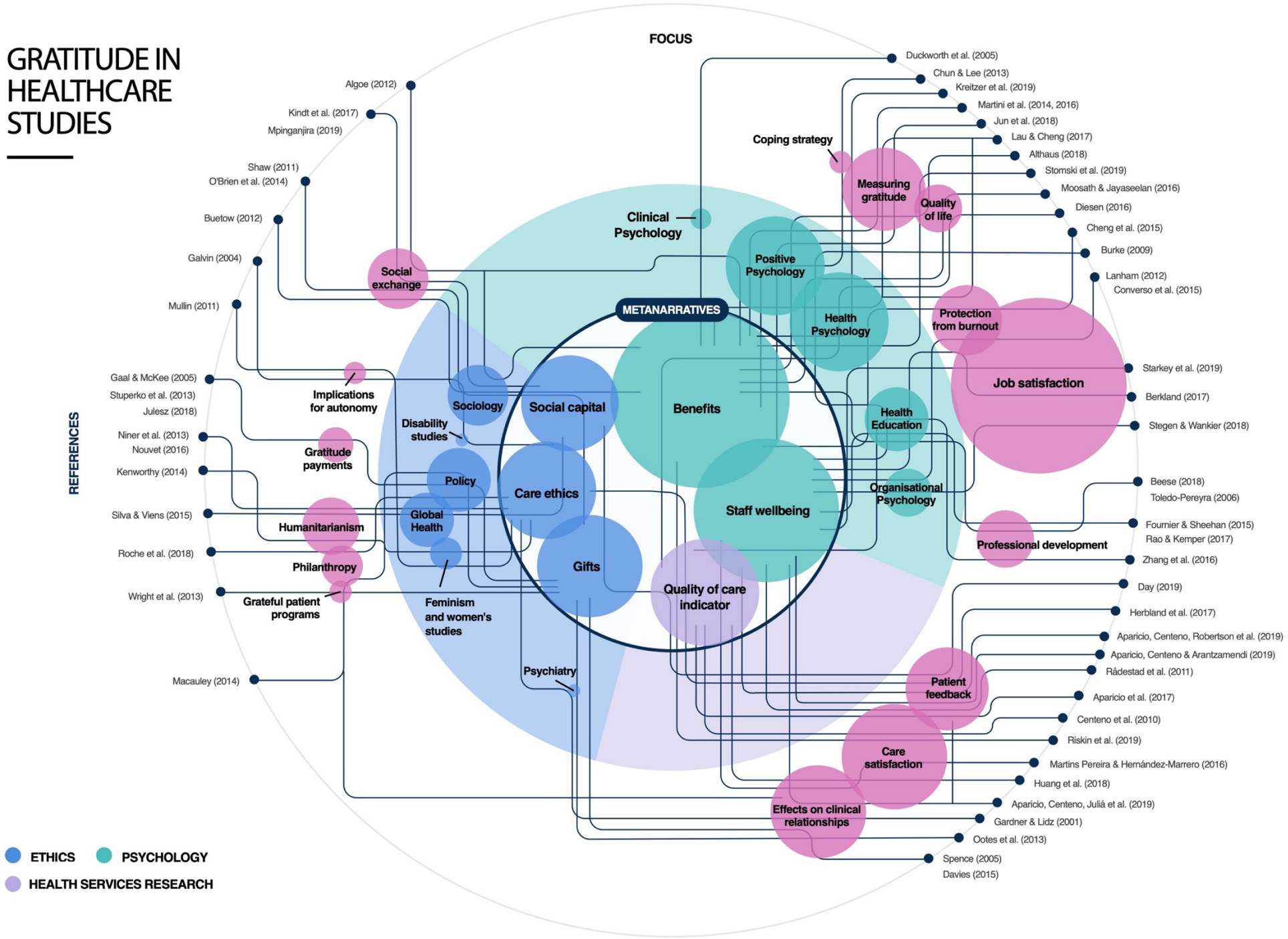
The metanarratives were arrived at through independent inductive coding initially, and then an iterative process of discussion and review amongst the three collaborators to refine the list of potential metanarratives to ones that we most confidently felt described the body of work under review. We took into account the theoretical underpinnings that the articles referred to, key authors or studies cited as informing the article's approach, and the ways in which findings were framed, paying careful attention to any imagery and metaphors used. Having assigned each article to at least one metanarrative, each article's focus and disciplinary orientations were mapped, acknowledging that the characteristics could not be exhaustive and allowing for some articles to fit more than one metanarrative.

2.3 Results

2.3.1 Article characteristics

Although no start date was imposed on the search criteria, all the included articles date from 2000 onwards with most published after 2013. Eleven of the included articles were editorials or commentaries, 24 presented qualitative research, 19 quantitative research, and 15 used mixed methods. Of the articles included, 31 gave an explicit definition of gratitude. These most often cited a definition by Emmons and McCullough (2003) or a variation of this in which gratitude is thought of as a generalised tendency to notice and experience appreciation for the good in daily lives or a response to a benefit received. Other characteristics are reported in Table 2.1. and mapped in Figure 2.2.

Figure 2.2. Visual representation of the initial review (studies up to November 2019)



2.4 Main findings

The metanarratives we identified are arranged below according to the chronology of their theoretical antecedents. This gives a sense of the evolution of distinct but related research traditions that have shaped each narrative.

2.4.1 Metanarrative 1. Gratitude as social capital

The term 'social capital' is thought to have first been used by Hanifan (1916) who defined it as assets that 'count for most in the daily lives of a people, namely goodwill, fellowship, mutual sympathy, and social intercourse among a group of individuals and families who make up a social unit' (p. 130). Since then, sociologists – including those working in healthcare (see Derose and Varda 2009 and Jaye et al. 2018) – have made much use of the metaphor of 'capital' to refer to intangible qualities, like gratitude, that can be thought of as being accrued or expended in particular circumstances.

Many of the studies included in this metanarrative reported that the accumulation of social capital through gratitude empowers and motivates recipients through strengthening social bonds, encouraging social connectedness, and predicting willingness to reciprocate. Gratitude as empowering is elaborated in particular in Algoe and Stanton (2012), Buetow and Aroll (2012), Day (2020), Kindt et al. (2017), and O'Brien et al. (2014). However, for those obligated to expend social capital through gratitude for care, autonomy is eroded. The pernicious effects of a grateful consciousness are discussed specifically in Galvin (2004) and Kenworthy (2014) – these two articles are also allocated to the 'care ethics' metanarrative in which the relationship between gratitude and power relations is elaborated more fully.

Two articles, Buetow and Aroll (2012) and Mpinganjira (2019) directly refer to social capital. Buetow and Aroll describe gratitude as a form of social capital that supports 'a contribution-based morality' (p. 2064), and that can add 'joy and meaning' to a doctor's work and strengthen social ties. In contrast, Mpinganjira constructs gratitude, not as a form of social capital per se, but as an emotion that mediates the relationship between social capital and willingness to reciprocate. Drawing on the disciplinary perspective of resource-exchange theory, she argues that managers of

virtual health communities can instrumentalise gratitude as a strategy to stimulate more knowledge sharing on their websites.

This body of research often describes a temporal dimension in which gratitude can be 'carried over' from one time point to another. Kindt et al. (2017), for example, use a framework of self-determination theory to contextualise their findings that the partners of chronic pain patients are more motivated to provide help after their partners are perceived as being grateful. Similarly, in a wide-ranging, nuanced analysis of the experiences of heart transplant patients, O'Brien et al. (2014) shows that 'giving back by giving forward' is a common phenomenon in which donor recipients often express their gratitude by participating in support groups and research, and through advocacy.

The language of reciprocity, using economic metaphors, features strongly across all the articles in this metanarrative. The philosopher Claudia Card likens the balance metaphor to 'moral bookkeeping' in formulations of gratitude common in moral ethics (Card, 1988, p. 116). She explores obligation as a means to understanding gratitude as part of the dynamics of interpersonal relationships, a concept which underpinned many of the articles included in this metanarrative. Card notes that the debtor paradigm of obligation is a paradox: one cannot repay a debt of gratitude without transforming it into a transaction in which gratitude instinctively has no place. Critiquing moral economics, she maintains that unpayable debts in this paradigm, where reciprocity is not practical or desirable – as is often the case in healthcare – make the sense of obligation problematically unresolvable. This position is supported by the research we reviewed that engaged with the metanarrative of social capital: whilst economics metaphors are prevalent in the discourse of gratitude, the way it plays out in practice in healthcare is much more psychologically and philosophically subtle than the metaphor of 'capital' suggests.

In this metanarrative, gratitude is construed as a moral incentive to reciprocity, or a persistent 'debt' when reciprocity is not possible. Although social capital is intangible, these studies show that it does have material consequences for the dynamics of human relationships and social behaviours. The metanarrative of gifts, discussed next, is also concerned with reciprocity, but here gifts are tangible: they are

the giving and receiving of material goods, physical tokens of appreciation, or – controversially – gifts of money.

2.4.2 Metanarrative 2. Gifts

Theory underpinning human behaviour in relation to gifts is dominated by Marcel Mauss's influential essay on gifts (Mauss 2000, f.p. as *Essai sur le don* in 1925). Mauss argued that gifts are never disinterested: the expectation of return is what consolidates social ties in gift-giving relationships. Gifts are not inevitably associated with gratitude, and gratitude does not demand a gift, but much gift-giving does go on in healthcare settings and this raises ethical issues (see Drew, Stoeckle, and Billings 1983 for discussion of gifts to doctors, and Morse 1991; 1989 for gifts to nurses). There is a large literature associated with gift giving, of which this review includes only those articles on gifts specifically linked to gratitude as a *prima facie* motivation in a healthcare context. The included articles have in common a focus on the ethical and policy implications of gifts of goods or money presented by patients, either to individual healthcare providers or to organisations.

Authors that deal with gifts recognise that gift-givers' motives may be benign if motivated purely by gratitude for care deemed worthy of extra recognition, but gifts become problematic when a gift is given in anticipation of privileged treatment. Spence (2005) and Ootes et al. (2013) draw on psychoanalytic frameworks to explore the mindsets of patients who give gifts. Spence (2005) explores the risks of doctors accepting gifts, urging special caution for gifts that arise 'out of the blue' before the doctor has done anything to 'deserve' them. Ootes et al. (2013) also urge practitioners to reflect carefully before accepting gifts. In their ethnographic study in a Dutch mental healthcare context, they identify types of gifts for professionals and discuss these in the context of social inclusion of clients and professional codes. They argue that attention should be paid to gift giving as potentially altruistic instead of invariably interpreting gifts in terms of reciprocity.

Some gift-giving practices are described as 'gratitude' but are, in reality, obligatory cultural norms. There are a number of articles that scrutinise Eastern European customs of giving 'gratitude payments' (Gaal & Mckee, 2005; Julesz, 2018; Stepurko et al., 2013). Gratuity payments were usually legal in the nineteenth century

when doctors were paid more than promised for a job well done, or received gifts such as produce, wine or art. During the Communist era it was the social norm for patients to pay doctors for ostensibly free medical services. Low pay for medical workers has contributed to the persistence of informal payments. In his study of the practice in Hungary, Julesz (2018) found that payments are still customary although they are contrary to the Code of Ethics, and those soliciting money in advance are prosecuted (although low penalties mean that this does not act as a deterrent). The author argues that all such payments are corruption, and says that, alarmingly:

> In the post communist part of the world and also in a great many developing African countries, authors always mean corruption when they use the word 'gratitude' (Julesz 2018, p. 157).

The ethics of 'cultivated' gratitude were also explored in Wright et al. (2013) and Macauley (2014). Hospitals often channel donations from grateful patients and their families into philanthropic programmes that seem, at first, to circumvent the compromising effects of individuals accepting gifts. But these authors show that these initiatives are not immune to exploitative tactics that can compromise trust in the doctor–patient relationship.

The discourse on gift giving in articles in this metanarrative often mentions 'questions': unfinalised practices that tend to raise questions to which there are no easy answers. Medical professionals are urged to ask themselves questions about the motivations of patients in giving gifts, necessitating a degree of interpretation that cannot be encoded in policies. Research aligned with this metanarrative explores tensions between gifts as benign gestures of gratitude that are culturally normative and gifts that are essentially supplementary fees or tips. Issues around the giving and receiving of gifts pose fundamental ethical questions about beneficence and autonomy to which authors of articles in this metanarrative have been acutely alert.

2.4.3 Metanarrative 3. Gratitude and care ethics

Articles in which acts of charity or generosity are conceptualised metaphorically as gifts fall outside the boundaries of the way we have circumscribed the 'gift' metanarrative. These articles engage less with the transaction of goods or money, and

more with the implications of gratitude as a response to a construal of 'care-as-gift'. An example is the study by Kenworthy (2014) which argues global health interventions in developing countries can be interpreted as a gift for which gratitude is the obligatory response. She explores how this engenders 'new debts, obligations, and forms of peonage for recipients' (Kenworthy, 2014, p. 83). Articles like this, that also explore balancing of power and voice, were assigned to our third metanarrative: gratitude and care ethics.

Care ethics as a field of ethical theory was founded by Carol Gilligan, whose research on relationships between identity and moral development led her to locate care as central to women's 'different voice' – a voice which binds relationship and responsibility, calling for responsiveness and careful listening to voices that were previously met with indifference (Gilligan, 1993). In the context of gratitude, an ethic of care pays meticulous attention to the voices and the circumstances of those expressing gratitude in order to understand its impulses and implications. These articles were generally characterised by a qualitative, anthropological approach based on in-depth case studies and underpinned by a well-elaborated theoretical framework that drew on Gilligan as well as subsequent work by feminist and disability theorists.

Addressing a feminist ethics of care most directly is Mullin (2011) who argues that gratitude is consistent with how relations of care are understood as morally valuable when they attend to the needs and also the capacities of care recipients. She contests the idea that those who are paid to care are not appropriate targets for gratitude, arguing that gratitude is important in generating mutual respect. In common with Algoe and Stanton (2012), she finds that gratitude is distinguished from indebtedness because motives of goodwill and caring are imputed to the benefactor rather than the expectation of equivalent payback. Acknowledging that both the recipients and the providers of caring labour are groups of people who need support, Mullin says it is important for both care recipients and providers to make sufficient time to demonstrate mutual goodwill and respect, and gratitude is integral to this relationship.

Galvin (2004), however, warns of the problematic nature of gratitude when it exacerbates a lack of autonomy for physically disabled people through ongoing reliance on informal care in which gratitude is the only currency available:

> For those who are able-bodied, gratitude may well comprise a comfortable and unproblematic response to kindness, but for disabled people it can signify an unbearable state of perpetual obligation (Galvin, 2004, p. 137).

She found that people who had access to paid personal assistance tended to feel a greater sense of control, comfort, and autonomy than those constrained by feelings of shame and frustration when having to be persistently grateful for the goodwill of others.

A similar wariness is expressed in the study by Niner, Kokanovic, and Cuthbert (2013) of the birthing experiences in Australia of displaced Karen women from Burma. The women they interviewed expressed gratitude for a variety of circumstances (safe haven, secure environment, care given, post-birth support) in spite of many having experienced suboptimal care and a lack of autonomy, exacerbated by a lack of interpreters. The authors attribute the women's 'gracious acceptance stance' (p. 544) to imperatives to normalise distress in the context of adverse past experiences and their self-reliant attitudes, as well as cultural aversions to complaining. Bradby, Humphris, and Padilla (2020), too, found that women from migrant backgrounds expressed gratitude for national healthcare services despite receiving poor or negligent care because, the authors argue, of 'welfare chauvinism' – the perceptions that migrants are less deserving or have fewer rights to access care. Nourpanah (2021) found that nurses from migrant backgrounds face similar expectations of gratitude. The author labels it a 'pernicious burden' (p. 61) that exacerbates social inequality in the capitalist political economy.

Consistent gratitude as a hallmark of entrenched disempowerment is similarly a theme considered by Nouvet (2016) who explores the power effects of gratitude in the context of American surgical missions to Nicaragua. Nicaraguans interviewed felt the patient-centred care they received from foreign missions stood in contrast to the dehumanising, discriminatory treatment they had experienced in the public healthcare system. Whilst noting the importance of the 'small drops of humanity' (tone of voice, vocabulary, smiles) for which many patients expressed gratitude, the author notes the ambiguity of the politics of gratitude in that it simultaneously enacts affirmations and denunciations of the status quo. Similarly, Roche et al. (2018) found

that explicit, unprompted gratitude was expressed by nearly all the aid recipients they interviewed in Guatemala. In common with Nouvet (2016), the authors hypothesise that foreign visiting medical teams may unwittingly contribute to inequalities by making ongoing access to benefits contingent on appropriate display of 'grateful postures' and that recipients of aid may be construed as failing to successfully navigate and pay within formal health structures.

All the articles that enact the metanarrative of a care ethic are attuned to the voices of the grateful, listening to but also interpreting narratives within a framework of politics and power relations. Ambiguity is a key concept here: gratitude is a sincere response to good intentions and care that is often delivered with humanity and warmth. But context is all important. When gratitude becomes obligatory it moves from being an act of responsive relations to a marker of disenfranchisement and may exacerbate health inequalities.

2.4.4 Metanarrative 4. Benefits of gratitude

Overwhelmingly, the empirical work identified in this review reported on the benefits of being grateful. Although published in a wide range of journals, this work is most often situated in the paradigm of positive psychology – a field of scholarship introduced by Seligman and Csikszentmihalyi (2000), and already referred to in Section 1.2.1. Proponents of positive psychology consciously seek to counter the dominant medical model of human functioning that focused on distress and pathology whilst neglecting factors that contribute to wellbeing, happiness, and life satisfaction. In studies allied with this metanarrative, gratitude has been investigated as a personality disposition, or trait, that is correlated with wellbeing, possibly with a causal relationship (A. M. Wood et al., 2010). Studies sought ways of measuring the beneficial effects of gratitude, elaborating associations with other measures of wellbeing and life satisfaction, and/or evaluating gratitude interventions like journaling or 'counting blessings' exercises.

Attention to the positive effects of gratitude dates from a collaboration between psychologists Robert Emmons and Michael McCullough in the late 1990s. McCullough et al. (2001) offered an influential functional theory of gratitude and reinforced it with empirical support. A landmark edited volume *The Psychology of Gratitude* followed in

2004 (Emmons et al., 2004). The 'breakthrough' article that heralded this a new paradigm in empirical gratitude research is McCullough, Emmons, and Tsang (2002). The authors describe a series of studies that validate a self-report 6-item, unifactorial questionnaire (GQ-6) for measuring trait gratitude, i.e. a grateful disposition or character.

Eight of the articles in our review used GQ-6 or a modified version of it. Other scales, notably the Gratitude, Resentment and Appreciation Test (GRAT) and the Appreciation Scale, are described and reviewed in Davidson and Wood (2016), and compared in N. A. Card (2019). Martini and Converso (2014) have developed a scale, PGrate, specifically to measure healthcare providers' perceptions of patients' expressions of gratitude. To date, the PGrate scale appears only to have been used by its authors (Converso et al., 2015; Martini et al., 2016; Martini & Converso, 2014). Özdemir, Karadağ, and Kul (2022) use the gratitude scale developed by Hlava, Elfers, and Offringa (2014), a 16-point scale which, they argue, uses a more expansive definition of gratitude than GQ-6 because it includes transcendent and spiritual connection subscales.

Articles included in this metanarrative often focus on gratitude benefits as a factor that could be used instrumentally to inform care interactions. Althaus, Borasio, and Bernard (2018) conclude that gratitude may have a positive impact on quality of life and reduce psychological distress in patients receiving palliative care in Switzerland. A thematic analysis of interviews with patients who had suffered a traumatic spinal cord injury found that they benefited from appraising adverse life experiences as positive through the lens of gratitude (Chun & Lee, 2013).

Studies have investigated gratitude interventions as possible therapies. Kreitzer et al. (2019) found that gratitude practice in an online therapeutic community led to reported improvements in stress levels, gratitude, and social support, although effects were relatively short-lived. Moosath and Jayaseelan (2016) analysed questionnaires and conducted interviews with eight patients receiving chemotherapy in an oncology ward of a Bangalore hospital, India, who took part in a gratitude journaling intervention. The study found that gratitude journaling boosted subjective wellbeing and also gave insights into patients' reflections on the nature of gratitude.

Benefits of gratitude were identified, not only for patients, but for familial and professional caregivers. Lau and Cheng (2017) carried out a survey of Chinese familial caregivers of people with dementia and found that gratitude was related to emotion-focused coping and psychological resources that reduced distress. Caregivers who recalled being frequently thanked by partners prior to the onset of a caregiving relationship experienced a lower burden in a study of 700 family caregivers in Japan (Otobe et al., 2021).

A study by Stomski et al. (2019) of associations between gratitude and carer burden in informal Australian mental health carers had more equivocal results: simple appreciation was associated with a higher care burden, but the trait of 'lack of sense of deprivation' (a focus on what a person has) and an appreciation of others reduced the burden leading the authors to recommend that gratitude interventions should specifically target these tendencies.

The metaphor usually associated with the 'benefits' metanarrative is 'building'. Positive psychology was described by Duckworth, Steen, and Seligman (2005) as a 'build what's strong' rather than a 'fix what's wrong' approach (p. 631), and this imagery is at the heart of one of the most influential models of gratitude, attributed to Barbara Fredrickson: 'broaden-and-build'. The model holds that 'positive emotions appear to *broaden* people's momentary thought-action repertoires and *build* their enduring personal resources' (Fredrickson 2004, p. 147, italics in original). This is in contrast with negative emotions that invoke a narrow thought-action repertoire for quick and decisive action in situations which may be life-threatening. Although the situations which bring forth positive emotions may be transient, Fredrickson argues that the personal resources that one builds are durable and can be drawn on to cope and survive.

Methodological limitations, which have also been discussed in gratitude scholarship more widely (see, for example, Gulliford, Morgan, and Kristjánsson 2013; Jans-Beken et al. 2018; Lambert, Graham, and Fincham 2009), were evident in the research we reviewed here. Empirical studies tended to report low to modest effect sizes, and gave limitations like small sample sizes, narrow sampling bands, high attrition rates in long-term studies, and difficulty in setting up meaningful control groups.

Articles in this metanarrative approached gratitude as having benefits for psychological wellbeing of patients and informal caregivers. Patients tended to have long-term or life-long conditions. Carers, too, that were research participants tended to be involved in familial or long-term caring relationships. It was notable that both populations were seen as being resilient but prone to psychological distress – hence their potential to benefit from broaden-and-build gratitude interventions. Studies that examined these benefits within a *professional* healthcare context had different emphases which warranted a separate metanarrative: gratitude and staff wellbeing.

2.4.5 Metanarrative 5. Gratitude and staff wellbeing

The mental and physical health of healthcare practitioners is a matter of global concern (see, for example, Galanis et al., 2021 and O'Connor, Neff, and Pitman, 2018). The metanarrative of gratitude and staff wellbeing is concerned with interventions, surveys and reviews that focus on gratitude expressed or received by healthcare students and professionals. Although mostly situated within positive psychology, research in occupational therapy, positive organisational scholarship and health education also informs these studies. They have in common a construction of the professional caregiver as vulnerable to stress and burnout against which gratitude awareness and practice might protect. The cultures of care in professional settings explored by studies in this metanarrative interrogate the role of gratitude in enhancing job satisfaction, reducing absences, improving retention, and/or boosting teamwork – factors that did not feature strongly in the studies involving informal caregivers that we assigned to the benefits metanarrative.

Interventions in healthcare education and professional development encourage participants to express gratitude as a means of enhancing their own wellbeing but also to augment their capacity for patient- and person-centred care (Fournier & Sheehan, 2015; Rao & Kemper, 2017). Our review includes one randomised controlled trial of a gratitude journaling intervention for healthcare practitioners across five hospitals in Hong Kong, which found that the practice effectively reduced perceived stress (–2.65 points; 95% CI [–4.00, –1.30]; d =–0.95) and depressive symptoms (–1.50 points; 95% CI [–2.98, –0.01]; d =–0.49) (Cheng et al., 2015). The most ambitious of the studies included in this review is by Stegen and Wankier (2018) who implemented multiple

gratitude interventions over the course of a year within the nursing faculty at Weber State University, Utah, USA. The authors found that post-intervention survey participants reported that job satisfaction increased, as did teamwork and collaboration. In a wide-ranging study of virtues, work satisfactions, and wellbeing amongst 79 nurses in a single hospital, Burke, Ng, and Fiksenbaum (2009) found that nurses scoring higher on gratitude showed more job satisfaction, vigour, dedication, and fewer absences.

In studies that look at the impact of patients' gratitude on staff, a scoping review by Aparicio et al. (2019) found that gratitude may have important personal and professional effects on healthcare professionals. A self-report study of oncology and emergency nurses at two Italian hospitals by Converso et al. (2015) and a national survey of palliative care professionals in Spain (Aparicio et al., 2022) suggest that perceptions of patients' gratitude could have a protective effect against burnout. Starkey et al. (2019) also found receiving expressions of gratitude predicted physical health benefits in a survey of 146 nurses in Oregon, USA, via satisfaction with patient care.

Imagery that is prevalent in this metanarrative is that of 'levels'. The analyses speak of raising, improving, promoting, or enhancing desirable qualities such as morale and compassion, and lowering, reducing or decreasing or factors perceived as problematic such as stress. One study spoke of examining the impact of various 'doses' of skills training (Rao & Kemper, 2017). In common with literature in the benefits metanarrative, Fredrickson's broaden-and-build theory was often invoked as an explanatory framework (Fredrickson, 2004).

2.4.6 Metanarrative 6. Gratitude as an indicator of quality of care

There is a rich tradition of studying the effects of emotions in social interactions to try to understand helping and cooperative behaviours, and the way the self is evaluated according to the feedback of other social actors (see, for example, Tangney, Stuewig, and Mashek 2007). Although not usually specifically referred to, a hypothesis underlying many of the studies included in this metanarrative is 'feelings-as-information'. This hypothesis, articulated by Norbert Schwarz, holds that affect has cognitive consequences that can influence judgement (Schwarz, 2012). The articles we

grouped in this metanarrative linked gratitude and quality of care. Perspectives were explored either from the patients' or relatives' points of view in which gratitude is expressed after an experience of the delivery of good care, or in which gratitude precedes and predicts the delivery of high-quality care.

Whilst the writing of gratitude letters is a common gratitude intervention thought to contribute to the wellbeing of the writer, the receiving of such letters by healthcare professionals or institutions is generally regarded as an indicator of quality of care. Several authors have conducted thematic analyses of unsolicited letters to care units to evaluate their usefulness as a form of feedback on care provided and as a source of narratives of the patients' or relatives' experience (Aparicio et al., 2017; Centeno et al., 2010; Gillespie & Reader, 2021; Herbland et al., 2017; Martins Pereira & Hernández-Marrero, 2016). This metanarrative is also linked, either explicitly or implicitly, to staff wellbeing in that there is a perception that access to such letters can boost self-esteem amongst staff, potentially reducing burnout and acting as a motivating factor for staff. Herbland et al. (2017) also link their study to an ethic of care, arguing that thank-you letters received by the intensive care unit at a French Hospital resonate with phases of care consistent with Gilligan's characterisation of care as a reciprocal practice (Gilligan, 1993).

In my own historical study that looked at correspondence between 1,506 former patients with tuberculosis and staff at the Brompton Hospital in London in the 20th century, reported in Chapter 3 and published as Day (2020), I found that gratitude was central to the ongoing relationships of care that saw many patients continuing to correspond with the hospital for decades after discharge. I argued that communication strategies that acknowledge and build on gratitude have useful lessons for enhancing relational care in today's healthcare settings.

Riskin et al. (2019) also make recommendations for how gratitude can improve care. Their intervention study in Israel found that teams hearing a mother expressing gratitude prior to a simulation exhibited significantly better diagnostic and treatment performance during a neonatal clinical intensive care unit training session. The authors call for better acknowledgement within healthcare of the positive impact of gratitude gestures.

Two studies, Rådestad et al. (2011) and Diesen (2016), solicited patient or service users' feedback through a questionnaire and interviews respectively. Rådestad et al. (2011) analysed answers to a question about gratitude to staff to argue that changes in care practices in Sweden around 1990, allowing parents increased contact with their stillborn child, were effective. Diesen (2016) found gratitude to be a theme in the reflections of young adults in Norway with phenylketonuria. The authors argue that gratitude could be a major coping strategy for patients, in which a focus on the positive is an active and informed choice.

An interesting pilot study in a hospital in the USA involved nurses inviting hospitalised patients to complete gratitude forms twice daily, the feedback from which was used to inform care-related actions (Lindauer et al., 2021). As well as patient care being enhanced, members of the interprofessional team were shown to benefit from patients' gratitude being communicated.

In articles included in this metanarrative, which were mostly published in journals with a professional healthcare readership, there was little semantic homogeneity about the ways in which gratitude was characterised or analysed. Some mentioned that it was an indicator of satisfaction, others of recognition or empowerment. However, the narratives were all concerned with 'care' and the role of gratitude as a qualitative factor in delivering good care.

2.5 Discussion

2.5.1 Summary of findings

It is evident that there are multiple, complex strands in the growing body of literature exploring gratitude in healthcare. The impact of the groundwork laid by Emmons and McCullough is considerable – 33 articles cited their work – but this has not led to conceptual homogeneity, and indeed it might be unrealistic to expect consensus given the array of disciplines that take an interest in gratitude.

Certain themes were prominent across metanarratives. The norm of reciprocity featured strongly in the 'social capital' and 'gifts' metanarratives. In 'social capital', reciprocity was mostly appreciated as a driver of prosocial behaviour, but was also

criticised for locking those beholden to others' goodwill into a cycle of perpetual, obligatory gratitude. The problems with obligatory reciprocity are also explored in the 'gifts' metanarrative where culturally accepted practices can become pernicious when they become exploitative and exacerbate health inequalities. These tensions were elaborated on in studies assigned to the 'care ethic' metanarrative, many of which explored gratitude in the context of global health and humanitarianism. The bringing together of this research illuminated a contradiction that sits unresolved in academic approaches to gratitude: the 'economy' metaphors that are theory constitutive contradict the communal, moral generosity at the heart of gratitude which flinches from the obligatory reciprocity that economic metaphors demand (the implications of which are discussed further in Section 7.2.1.3).

Gratitude as advantageous to care givers and recipients was a theme evident in most of the articles, particularly in the 'benefits', 'staff wellbeing' and 'quality of care indicator' metanarratives. Some authors were forthright about how gratitude could be instrumentalised, either in eliciting prosocial behaviour or in devising interventions judged likely to have beneficial psychological effects on participants. Research situated in the paradigm of positive psychology authorises a favourable conceptualisation of gratitude, but research aligned with other metanarratives suggests that researchers should remain attuned to alternative, less affirming interpretations of situations in which gratitude is the expected response. Indeed, it may be insensitive to insist that people should find reasons to be grateful in the face of adverse life events or unsatisfactory working environments.

2.5.2 *Effects of Covid-19 on gratitude research*

Many countries proscribed certain types of research during the pandemic (Sohrabi et al., 2021). Access to healthcare sites was, understandably, highly regulated, and non-essential research projects involving the recruitment of patients and healthcare workers in the NHS were halted as resources were refocused to tackle the pandemic. However, a great deal of research was published on wellbeing interventions, including gratitude, as capacities to cope with distress and trauma became more urgent and relevant for many people. Most of this research was focused on self-care rather than relational gratitude within healthcare contexts, although three articles included in the

updated review did focus specifically on the pandemic: Manara, Giannetta, and Villa (2020); Marconi et al. (2021); and our own study on tweets of gratitude to the NHS reported in Chapter 4 and published as Day et al. (2022).

The pandemic prompted a re-evaluation of a possible role for negative experiences as having an adaptive function in promoting wellbeing. In 2011 Wong called for a reassessment of positive psychology's relentless focus on positivity often by ignoring the reality and benefits of negative emotions and experiences (P. T. P. Wong, 2011). Wong's advocacy for 'Positive Psychology 2.0', or what is sometimes referred to as Existential Positive Psychology, had hitherto received little attention by others, but it has received support from studies conducted during the pandemic that support a re-evaluation of the adaptive effects of negative emotions (Eisenbeck et al., 2021; Wąsowicz et al., 2021). This has also led to the development of a new scale, the Existential Gratitude Scale, which takes into account the tendency to 'count blessings in both good times and times of suffering' (Jans-Beken & Wong, 2021, p. 73).

A noticeable trend in gratitude research is a focus on gratitude in the workplace, reflected in the updated review by the inclusion of Adair et al. (2020), Nourpanah (2021), and Bradby, Humphris, and Padilla (2020). Adair et al. (2020) report on a gratitude writing intervention for healthcare workers (see also the systematic review of gratitude interventions on workers' mental wellbeing by Komase et al. 2021). In contrast, the other two studies raise concerns about how expectations of gratitude are instrumental in exposing and exacerbating precariousness in those from migrant backgrounds who deliver healthcare (Nourpanah, 2021) and for those who receive it (Bradby et al., 2020).

It is likely that the pandemic will continue to fuel studies in social psychology for years to come, and many gratitude-focused studies are likely to be still in progress or under review.

2.6 Comparisons with existing literature

This metanarrative review complements and extends the scoping review by Maria Aparicio et al. (2019) of gratitude between patients and their families and health professionals. Their thematic analysis of 32 publications, identified through a search

using the terms 'gratitude' and 'health professionals', concluded that professionals' wellbeing is likely to be enhanced if they are the recipients of gratitude and called for more research. In contrast to this review, however, they do not identify any downsides to gratitude, framing it as an indicator of excellent care and a meaningful form of feedback.

The review of gratitude and health by Jans-Beken et al. (2019) focuses on experimental studies on the effects of gratitude on mental and physical health. Our findings, particularly from literature considered in the 'benefits' and 'staff wellbeing' metanarratives, align well with their conclusion that gratitude is beneficially, although modestly, linked to social, emotional, and psychological wellbeing. A meta-analytic review of associations between gratitude and prosociality by Ma, Tunney, and Ferguson (2017) found that gratitude plays a central role in reciprocal behaviours, which were echoed by the findings in the 'social capital' metanarrative.

The revisiting of the review in January 2023 allowed for a 'sense check' of the metanarratives proposed in the original review. The 12 new papers that were incorporated were unproblematically assignable to the pre-existing metanarratives suggesting that these are robust.

2.7 Limitations

Searching for the term 'gratitude' is likely to be fallible. Lambert, Graham, and Fincham (2009) found that a great many features are associated with gratitude, for example, appreciation, thankfulness, generosity, and graciousness. By restricting 'gratitude' to titles, we effectively focused the e-search but this may be at the expense of articles which approached the topic less directly. As with most literature reviews, there is a degree of subjectivity in applying sifting criteria and other researchers might make different choices. It is possible that relevant articles are published in journals not covered by the databases we searched, and a further limitation is a publication bias for articles in English. The metanarratives offered here did not directly 'emerge' from the literature but were created through discussion amongst the review team. The constructions of others may differ, as might their attributions of focus and disciplinary alignment. This interpretation is offered as part of an ongoing dialogue on the

relevance of social elements of communication in healthcare rather than a definitive account.

2.8 Conclusion and recommendations

The study of gratitude – its properties, implications, and effects – has been of long-standing and intense interest to a diverse range of researchers. Its general literature is vast and amorphous which can be daunting for those hoping to make a meaningful contribution to the field. This review offers a map to those hoping to find purchase in the progressive programmes in which gratitude research currently finds itself. A usual recommendation for reviews of this type is to call for more systematic, evidence-based studies. However, on the basis of this review, we call for more attention to what constitutes robust 'evidence': are we content with extrapolating from responses to questionnaires that take mere seconds to complete, or should we be putting greater store in qualitative research in which responses are less constrained and more considered? Given the contested conceptual basis for gratitude, it is recommended that future work should focus on understanding the way gratitude acquires meaning in real-world situations as a precursor to devising more sophisticated empirical enquiries.

The focus on healthcare is timely and relevant, as it becomes increasingly evident that civility in workplace culture has a definitive effect on retention, job satisfaction and patient safety (see, for example, Armstrong, 2018, and Rajamohan, Porock, and Chang, 2019). We found relatively little attention paid to gratitude as a component of civility in care settings (addressed indirectly in Mullin, 2011, and Riskin et al., 2019). This is discussed in Section 7.4.1 as an area that could be explored in further research.

The Covid-19 pandemic provided new opportunities for investigating gratitude. Collective expressions of appreciation for healthcare workers in many parts of the world were accompanied by increasingly politicised conversations in the mainstream and social media about what constitutes meaningful gratitude. Valuable insights could be gleaned about the how gratitude intersects with issues of esteem, community

cohesion, and the languages of valorisation that often accompany expressions of gratitude.

Sociologist Arthur Frank reminds us that the foremost task of responding to illness and disability is to increase the generosity with which we offer medical skill, and that to be generous we need to 'first feel grateful' (Frank, 2004, p. 142). Given its importance to the prosocial enterprise that is healthcare, the challenge posed by the traits and multiple states of gratitude should encourage rather than deter the assiduous researcher. This metanarrative review shows that research in gratitude in healthcare has significant potential for developing understandings of conceptual issues around the intrinsic nature of recognition and appreciation in care-giving relationships. On the evidence of this review, gratitude should be recognised as integral to the social relations that significantly influence what people think, feel, say, and do in relation to healthcare.

Chapter 3 Gratitude in a historical case study of almoner–patient correspondence

This chapter is an analysis of how gratitude was an enacted in an archive of letters written in the twentieth century between almoners at the Brompton Hospital and patients who received treatment for tuberculosis (TB) at Frimley Sanatorium. In the context of the structure of this thesis, it considers gratitude at a meso level in that it pays particular attention to institutional contexts in which gratitude was expressed and received. Three metanarratives identified in the review in Chapter 2 will be elaborated in this chapter: gifts, care ethics, and gratitude as a quality-of-care indicator. The study considers the context in which the Brompton letters came to be written and kept, and the knowledge exchange networks in which they participated. I show that the performance of gratitude was an intrinsic part of these exchanges, helping to create, consolidate, and extend ties that originated in the communal regimen of the Sanatorium. A version of this chapter was published as Day (2020).

This study of gratitude in archival correspondence is aligned with the disciplinary inclinations of the history of emotions in that it seeks to show how gratitude was enacted through social performance, the rituals of hospital working life, and adherence – and sometimes defiance – of social and cultural scripts. As Dixon (2023) has pointed out, 'the history of emotions is a history of both bodies and ideas' (p. 14). The TB sanatorium is an ideal site for exploring links between bodily discipline and moral feelings. The theme of bodily compliance and gratitude in the context of the management of infectious disease established in this chapter is also arises in relation to Covid (Chapter 4 and Chapter 5).

Why is a study of data from the voluntary hospital era relevant? There is often a sentimental view of the past as being a more 'polite' era, with expressions of gratitude being consistent with social norms rather than being motivated by feelings. My study of gratitude in the years in the run up to the establishment of the NHS pays attention to gratitude as more than an embodied habit and politeness routine, it examines how

it helps to drive medical research and establish a continuity of care. Although healthcare is much changed from the early twentieth century from which this study draws its material, the central notion of rapport being integral to effective healthcare interactions is as true now as it ever was. This study, therefore, contributes to scholarship in the history of emotions that renders legible how the emotion of gratitude is made social through its traces in written inscriptions. It also points to semantic features of the almoners' correspondence which are likely to have contributed to the success of the almoners in maintaining contact with former patients.

Historiographically, working with hospital-related material – contemporary and archival – poses challenges. Much correspondence in the present day from patients to healthcare providers takes place using email or webforms, access to which by researchers is complicated by data protection and information governance procedures. Correspondence conducted by physical letter, however, is available to researchers when letters have been preserved in hospital archives. What has been selected for collection, however, is highly esoteric and often depends on the policies of individual medical superintendents (Lindsay, 2016). Identifying material in which specific expressions, like thanking, might feature is difficult. Practices of curation organise and catalogue archival material with an understandably focus on medical features. This means that searches for 'thank you letters' or 'gratitude' in online catalogues are fruitless. The handwritten nature of many materials means that, even when letters have been photographed and made digitally available, handwriting cannot easily be read by optical character recognition, so the material is not digitally searchable. Technology is improving all the time, but when this study was conducted, it was only through manually sifting through archival material that its affordances for studying relationships between words, artefacts, and social practices became apparent.

As mentioned in Section 1.3, I was made aware of the potential for material relating to gratitude in the Brompton archives through a chance conversation with a colleague. To see if there was similar material in a comparative archive, I arranged in July 2016 to meet with archivists at the University College London Hospital Archives. They were able to show me correspondence relating to patronage (e.g. legacy payments and the naming of hospital wings after benefactors), but there was no

collection of patient and staff voices comparable to the Brompton correspondence. Given the richness of the Brompton material, I decided to focus on the almoner correspondence as offering a starting point for developing a critical argument about how gratitude has been expressed and responded to within the Brompton Hospital. My initial proposal included plans to follow up the archival study with a 'gratitude audit' in the Brompton Hospital, to attempt to capture, on three sampling days, as many expressions of gratitude as possible, including letters, cards, emails to PALS (Patient Advice and Liaison Service), and gifts given to individual staff members who were willing to disclose these. The archival study would then have served as part of a narrative history of gratitude at the Brompton which I envisaged my thesis being able to tell.

Although there is always a risk with single-site studies that findings will not be generalisable, there is also historiographic value in taking a long view of one institution whose practices around relationship-building with patients are well documented and amenable to critical analysis. The scepticism of the Ethics Board as to how examples would be accessed and retrieved, and then Covid, derailed plans for the follow-up audit. A study of gratitude in the archival Brompton correspondence nevertheless has much to contribute to our understandings of the intersection of information management and practices of care.

In common with a discursive analysis approach to describing social life through close attention to how language works in talk and text (O'Reilly et al., 2021), I integrate research into the role of the hospital almoner with an analysis of *what* was written in the letters that constitute the corpus for this study, *how* they were written (tone and style), and *why* they were written.

Potter (2012) posited that discursive research treats discourse as having four key characteristics. It is **1** action orientated, **2** situated, **3** both constructed and constructive, and **4** produced as psychological. I follow these tenets by:

1. situating the language in the letters I study as being action oriented: gratitude is enacted in the correspondence as an integral part of a performance of ongoing care.
2. conceptualising gratitude as situated institutionally, sequentially, and rhetorically.

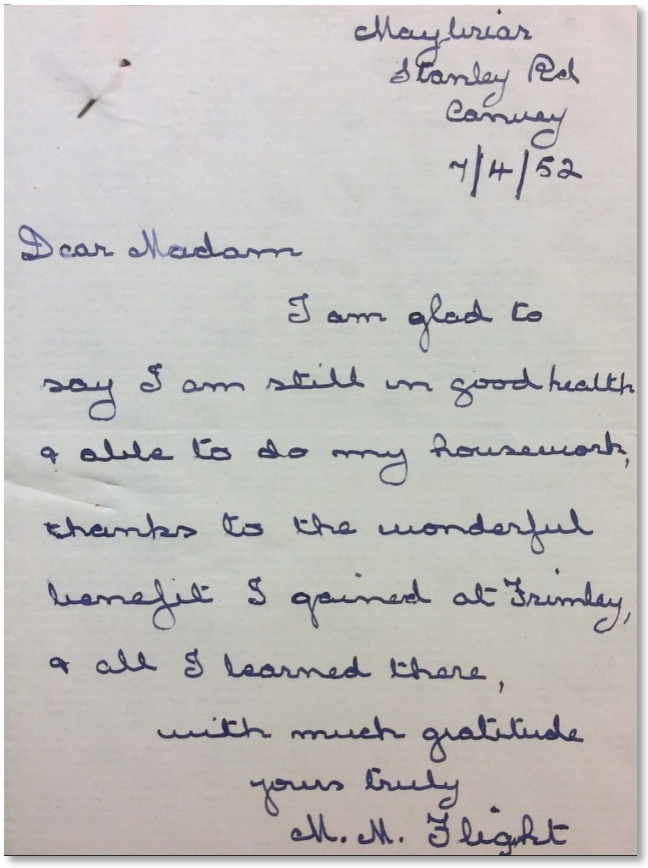
3. considering gratitude to be both constructed from resources (words, discursive frames of letter writing, normative practices) and constructive of socially organised discursive practices and histories of healthcare.
4. understanding gratitude as a psychological category and practice that features as a participant concern in the corpus under consideration.

In the era before the National Health Service (NHS), almoners were charged with assessing the eligibility of patients for charitable treatment but were also responsible for aftercare and advising patients on all aspects of welfare. The first part of the chapter is a longitudinal, narrative case study of the ways in which former patients expressed gratitude in their correspondence with the almoner, both through inscriptions, and material gestures. Patients sent money, gifts, and stamps – not only in gratitude for treatment received but also for the almoners' ongoing interest in their welfare. The second part considers rhetoric around gratitude both in the establishment of Brompton as a charitably funded voluntary hospital, and how the profession of almoner was never able to successfully distance itself from the impression that its primary concern was to handle money. The third part uses a textual analysis of examples of the almoners' replies to patients to investigate the discursive dynamics of reciprocal gratitude. The study highlights how personal, relational exchanges intermingled with the transactional, data-collecting exigencies of the communication. I use the lens of Marcel Mauss' influential 1923–24 essay *The Gift* (Mauss, 2000) to characterise the letters and their contents as constituting a gift-exchange ritual. The analysis throws light on the way the voluntary hospital system that predated the NHS projected gratitude as a moral and practical imperative.

3.1 Framing the study: 'with much gratitude'

On Monday 7 April 1952 Mrs Marian Margaret Flight, 69, sat down to write to the Frimley almoner, a hospital professional whose predecessor will have arranged for her admission to the Brompton Hospital and subsequent treatment for TB at the Frimley Sanatorium. Her letter (Figure 3.1) was an annual ritual for which she required no

Figure 3.1. Letter to the almoner from Marian Margaret Flight [RLHBH/AL/3/6]



Maylinias
Stanley Rd
Conway
7/4/52

Dear Madam

I am glad to
say I am still in good health
& able to do my housework,
thanks to the wonderful
benefit I gained at Frimley,
& all I learned there,
with much gratitude
yours truly
M. M. Flight

reminder. She had received treatment for TB in the 1900s, and yet here she is, four decades later, still corresponding with a hospital at which she had received treatment. She knew to supply the information that the almoner required: was she well and able to work? Mrs Flight supplies the sought-for information in the first two lines and the rest of the letter is devoted to expressing her gratitude for the benefit and learning gained from treatment at Frimley.

Mrs Flight is one of over 1500 former patients of the Frimley Sanatorium whose letters are held on deposit at the Barts Health Archive. Census records tell us that she worked as a shoemaker and married a post-office agent in 1907. When first diagnosed with TB, she is likely to have had an interview with Miss Maurice, the first Lady Almoner to be appointed at the Brompton Hospital, to determine her eligibility for charitable treatment. She would then have been recommended for rehabilitation at the newly opened, purpose-built Frimley Sanatorium, located in the Surrey countryside. Key factors in determining Mrs Flight's suitability for treatment would have been whether she was judged to 'possess considerable vitality', and, ideally, had realistic prospects of returning to work upon discharge as those that did not, 'would

almost certainly relapse quickly through inability to obtain adequate nourishment' (Habershon et al. 1914, p. 3).

Whilst at Frimley, Mrs Flight would have been required to conform to a scheme of graduated labour, a moral and physical system devised by the Sanatorium's first Medical Superintendent, Dr Marcus Paterson. Patients were given increasingly strenuous tasks starting at grade 1 ('walking from half a mile to eight miles daily') and progressing through to grade 6 ('using a pickaxe, trenching, mixing concrete, felling trees, &c. for six hours daily') (Horton-Smith Hartley et al. 1924, p. 12). Patients were also expected to clean the wards, polish the corridors and the brasswork, make their own beds, and generally help to run the Sanatorium. Enlisting patients to help improve the premises as part of their treatment was a win–win situation, saving the Sanatorium money and improving the environment for patients and staff. Many patients referred to 'good food' and 'happy times' at Frimley. Indeed, a bed was set aside for two months each summer from 1924 onwards for former patients to return as paying guests for a holiday (Bignall, 1979).

When discharged in 1910, Mrs Flight probably had little further contact with the Sanatorium until 1919 when she was contacted by the newly appointed Frimley Enquiry Clerk, Miss W. Simpkins, as part of a concerted effort to trace former patients so that the impact of different treatment regimens at Frimley could be studied. Miss Simpkins reported to the newly appointed almoner Miss Lily Constance Marx who brought order to a chaotic system of record keeping. Mrs Flight was asked to write to the almoner on an annual basis, which she did faithfully from 1919 to 1953.

Mrs Flight's letters form part of a unique collection of patient voices not usually heard in the history of medicine. Roy Porter noted in the 1980s that 'we remain so profoundly ignorant of how ordinary people in the past have actually regarded health and sickness, and managed their encounters with medical men' (Porter 1985, p. 76). Although work since has highlighted the historiographic possibilities offered by patient records in medical history (Gillis, 2006; Risse & Warner, 1992), patient records tend to offer little access to the freeform, patient-authored narrative that abounds in the Brompton correspondence. The 'ordinary' people treated at Frimley prove themselves to be extraordinary through their correspondence with the almoners. The letters are redolent with stories – stories of managing the adversities of war, of stigma

from neighbours and sometimes family members, and of health setbacks that accompanied TB in the era before antibiotic treatment.

3.2 Follow-up work at Frimley

Clinicians at the Brompton Hospital and the Sanatorium realised that long-term survival rates would provide the most convincing evidence of efficacy for treatments including graduated labour. A 1914 report laments the number of patients lost to follow up (about 30%):

> [I]t is much to be regretted that so many cases have been lost sight of. This is a difficulty met with in the statistics of all Sanatoria, and is almost inseparable from one like the Brompton Hospital Sanatorium, which draws its patients largely from the working and labouring classes, whose proneness to frequent change of residence is well-known. (Habershon et al., 1914, p. 5)

The Medical Research Committee (MRC) in 1917 awarded an annual grant of £150 for the Hospital to investigate the after-histories of patients treated at the Sanatorium (Medical Research Committee, 1917). When Dr R. C. Wingfield was appointed as Medical Superintendent of Frimley in 1919, he took on the task of compiling decennial reports on the after-histories of patients treated at the Sanatorium. He authorised the strenuous efforts that were made by the almoner, Miss Marx, and her clerk to trace the 1400 patients with whom contact had been lost. These included circulars of inquiry, advertisements in Sunday papers, letters to the Medical Officers of Health for each district, a search through the Death Records, and a personal canvass at every known address, 'no stone being left unturned in the endeavour to trace each individual' (Horton-Smith Hartley et al. 1924, p. 13). Over 1000 patients were traced through these methods, leaving only 10% of the 3400 patients treated between 1906 and 1918 as reluctantly having to be recorded as 'lost sight of'.

Determined to keep on top of follow-up, Miss Marx would meet, whenever possible, with patients before their discharge from Frimley to stress the importance of keeping in touch for the purposes of research. Enquiries were made every year by writing to, telephoning, or visiting every former patient, tracking follow-up appointments at the hospital or collecting intelligence through the dispensaries.

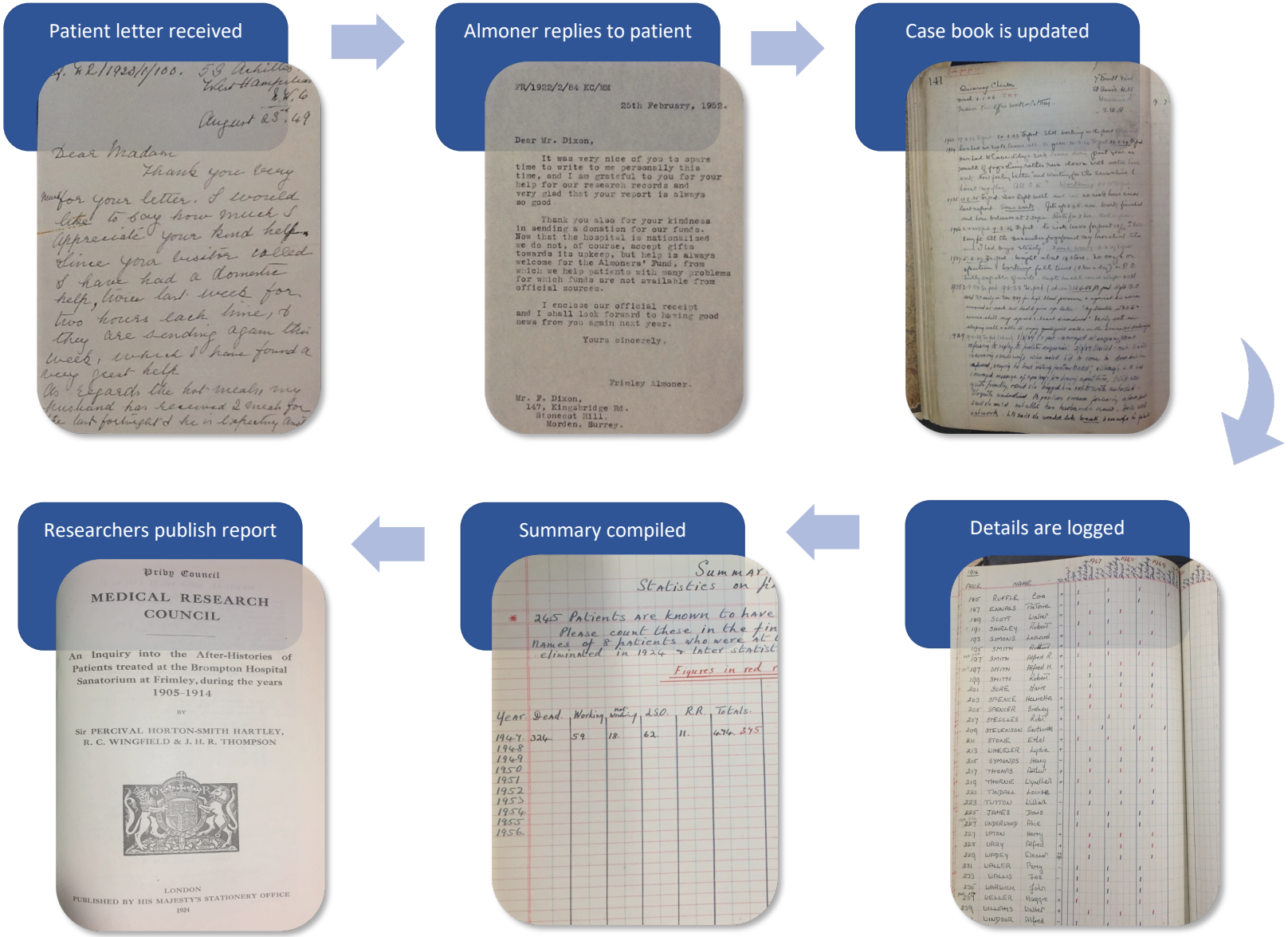
Detailed records were kept in a series of case books, organised by year of discharge. In spite of a remark from the authors of the MRC Report that 'with the patients drawn from the [labouring] classes treated at this sanatorium [...] letter-writing is no congenial task' (Horton-Smith Hartley et al. 1924, p. 12), many patients readily sent letters. Carbon copies were kept of outgoing correspondence and then matched with patients' replies. Statistics were compiled and summaries passed on to doctors at the Brompton Hospital who wrote the reports. A visual summary of the almoners' engagement with the process is shown in Figure 3.2.

Of over 6000 patients treated between 1905 and 1963 that were tracked for the purposes of Medical Research Council cohort studies, fewer than 6% were recorded as 'lost to follow-up' – testimony to the success of the almoners' strategies for maintaining long-term patient engagement. It was not until 1961 that '100% coverage' for following up former patients ceased to be the primary aspiration of Frimley almoners (Coltart, 9 Jul 1962).

3.3 Methods

The archive of almoners' correspondence with former Frimley patients spans 1920 to 1963. It is comprised of a mix of letters, forms, receipts, informal notes, and occasional photographs. The collection is far from complete. The case books refer to letters which are no longer in the files, and, although the correspondence is voluminous, there are clear gaps in the correspondence. Generally, carbon copies of typewritten letters from the almoners are interspersed with mostly handwritten patients' replies. Given the fragmentary nature of the archival holdings, a formal quantitative content analysis would not make for a robust analysis. Instead, certain themes that are apparent within the correspondence are summarised here, with selective use of illustrative extracts that are exemplary for these themes. This approach is endorsed by Riha (1995) who argues that detailed work on selected examples is perhaps more reliable than statistics at reconstructing every-day and, especially, medical life.

Figure 3.2. Summary of the processing of information in patients' letters



I worked my way twice through the letters from 1506 correspondents over several weeks in successive years noting specific expressions of gratitude. During the first round, the name of the correspondent was entered into a spreadsheet along with brief remarks on the nature of the letters in respect to gratitude. When the archivist kindly granted permission to photograph letters of particular interest, a visual database, numbering just over 2000 images, was compiled using the photo-editing software Picasa. The letters were then tagged with the name of the patient to whom they referred, the year in which they were written, and any additional keywords that referred to the ways in which gratitude was expressed, e.g. 'donation', 'stamps', and for what patients expressed gratitude, e.g. 'treatment', 'enquiries', 'advice'. In this way, an organic taxonomy of the various forms that gratitude took was built up and exemplar letters were identified, extracts from which are reported below.

Although my interest is in gratitude as inscribed in the letters, I have sought to resist an overly forensic analysis that would negate 'the surplus of life that floods the archive' (Farge, 2013, p. 31). The letters are solicited instalments of encounters with a medical system. As such, they speak to how people positioned themselves in relation to the instigations and expectations of the almoners. It is this context that has guided the selection of narratives to include, and the interpretive framework offered here.

3.3.1 Ethical considerations

There is a balance to be struck between maintaining confidentiality of information provided for medical purposes and acknowledging authorship of intellectual property. The archival correspondence comes under the category of unpublished literary materials with known authors. This means that rather than having the standard copyright term of 70 years after the death of the author, they remain in copyright until 31 December 2039 (Copyright, Designs and Patents Act 1988 Chapter 48). However, quoting excerpts from the letters comes under 'fair dealing' under copyright law. Although use of correspondents' names would normally be prohibited under Data Protection Act 2018, since the correspondents can be presumed to be deceased given the age of the correspondence, it was decided, in consultation with the archivist, that it would be good practice to use full names of correspondents and give the archival record numbers of the letters.

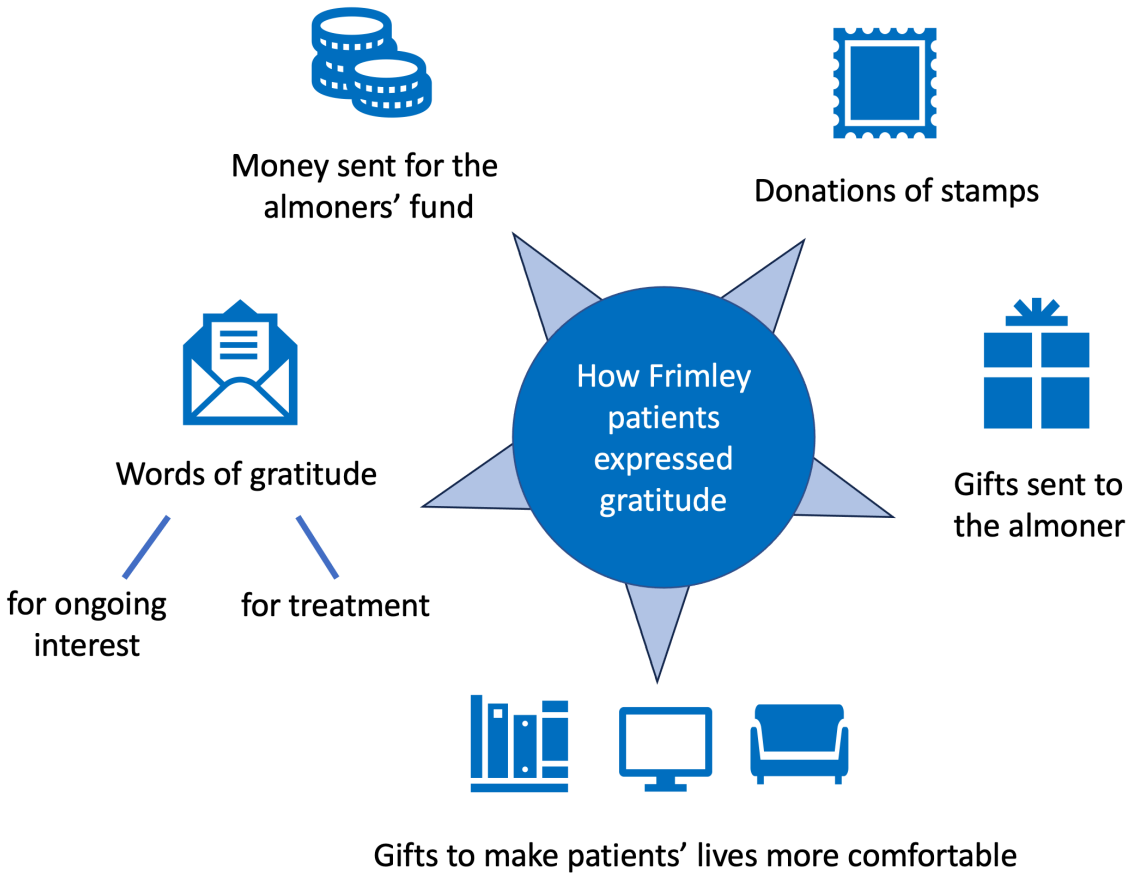
3.4 Findings

Gratitude from former patients took a variety of forms, summarised in Figure 3.3.

3.4.1 Gratitude for treatment

Many former Sanatorium patients expressed gratitude to the institution they

Figure 3.3. Ways in which former patients expressed gratitude in letters to the almoners at Frimley Sanatorium



considered instrumental in restoring their health at a time when TB was often still deadly. To give a few of many examples:

> I have enjoyed splendid health since taking your wonderfull [sic] treatment and must thank you always for it. I remain yours gratefully [...] [Mrs Lucy Froak, 10 Apr 1943, RLHBH/AL/3/8]

> Thank all at Brompton and Frimley for the kind help and treatment while I was there, and wish many others maybe so well. Thanking you all. [Beatrice Winkle, 2 Mar 1944, RLHBH/AL/3/8]

> I often think what Brompton Hospital done for me also staff and my Subscriber's letter. I must now thank one and all for restoring me to such fine health, going through last war and still A1 though crippled and wounded with stiff left leg since 1918 … I will now close and it gives me the greatest of pleasure to write these few lines on my health. Thanking once again Subscriber and Brompton Hospital for my health today. [F. C. Canty, 17 Mar 1942, RLHBH/AL/3/1]

Along with being grateful for treatment received, there is also a sense of pride throughout the correspondence through former patients emphasising that they are keeping up the 'lessons learned' at Frimley. When asked to give an account of the work they were doing, if any, many stressed that they were keeping up Frimley habits by exercising out of doors:

> I can do light duties and able to go [for] long walks when suitable weather … After the good time I spent at Frimley I feel I know how to live to keep in good health. [M. A. Fisher, 25 Oct 1943, RLHBH/AL/3/1]

> I think I have kept fit, because I was taught how to live at Frimley, and will always be very grateful for the care and attention I received there. [Minnie Slack, 27 Jul 1954, RLHBH/AL/3/16]

It is also noticeable throughout the correspondence that expressions of gratitude are often mentioned in close proximity to mentions of 'kindness'.

> I am very grateful for all the kindness shown me by Dr Wingfield and sisters and nurses in the Sanatorium. Would you please convey my gratitude to them all and accept some for yourself, dear Madam. / Believe me still / Yours Gratefully … [A. R. Barclay, 16 Nov 1961, RLHBH/AL/3/16]

The extension of gratitude for treatment to whichever almoner was currently in post, as shown in the extract above, is typical for patients who were pleased to still be remembered. Appreciation was often recorded in the case books as 'grateful letter from pt', sometimes with the phrases of gratitude transcribed. The almoner also

earned patients' gratitude by being quick to offer advice if patients did report health setbacks. She arranged for patients with respiratory problems to be seen at Brompton, and generally did her best to direct patients to sources of help regardless of nature of their ailments.

3.4.2 Donations of money, gifts, and stamps

One of the most conspicuous ways in which patients expressed gratitude was through sending donations by postal order or cheque along with their letters to the almoner. The almoner always acknowledged donations with gratitude and sent a receipt. An example is an exchange with Mrs Cramp, discharged from Frimley in 1910 but still sending annual reports of her health 30 years later. She typically sent 2s 6d (equivalent to about £5 today) with her letters, explaining, for example, it 'may help in a small way for something sadly needed, it is from my sister and myself' [Emily Florence Cramp, Apr 1940, RLHBH/AL/3/6]. The almoner replied on 16 Apr, 'It is very kind of you and your sister to send a donation … Your gift is much appreciated'. The last letter on file is from 1953 when the contribution sent has almost doubled to 5 s. The small amounts involved and the ways in which they are framed seem to support Gosling's contention that money carried meaning for the patient in that it marked their ability 'to do their bit' (Gosling 2018, p. 323). These are small but symbolically significant acts of philanthropy, aimed to benefit the almoner's work, rather than retrospective payments for treatment.

Some amounts donated by former patients of the Sanatorium were substantial. Mr Arthur de St Leiger, writing from Australia, gave a donation of £25 in 1928 (equivalent to about £1000 today). He asked the almoner for advice on what was needed, and the reply came back that the money could best be spent on comfortable chairs for the women's recreation room at Frimley. He asked for his generosity to be recorded: 'Could a small plate be placed on the back of one of the chairs indicating the purport of the gift, say, "from a one time male patient who had benefited by treatment here, with initials A.L."?' [Mr Arthur de St Leiger, 6 Dec 1928, RLHBH/AL/3/4].

Other gifts were also forthcoming. A grateful patient donated books to the Sanatorium library in 1951. A former patient gave a television to Frimley staff in 1956 and also offered the indefinite loan of one to any bedridden patient. A patient, writing

30 years after he was discharged in 1922, sent the almoner books of poetry along with a cheque 'for cigarettes – not for Ministry' [Samuel Gibson, 18 Feb 1955, RLHBH/AL/3/17]. The almoner replied [22 Feb 1955, RLHBH/AL/3/17]:

> Your donation is greatly appreciated and it has been placed in our fund from which we help patients in financial need – not in the Ministry funds! I am not quite sure about its use for cigarettes – they are not always permitted, but we have many patients with financial problems and it will be helpful for one of these.

Some gifts were sent expressly to the almoner. One of Frimley's earliest patients, Mr A. G. Barnes (discharged in 1910) was a steadfast correspondent from New Zealand. He sent a calendar for the almoners' office every year for 45 years until his death in 1955. His wife wrote:

> As he was so ill in the Brompton Hospital in 1910 we were very thankfull [sic] that he lived to the age of 78. I am continuing to send the calendars as he did as a mark of appreciation of the Hospital's care. [Mrs A E Barnes, 9 Nov 1955, RLHBH/AL/3/2]

Mr Lionel Baker sent a booklet with pictures of Australian scenery some 46 years after he was discharged, and the almoner replied with an aerial photograph of Frimley, likely to be the one shown in Figure 3.4: 'I hope that it serves to remind you of old times' [28 Jan 1953, RLHBH/AL/3/2].

When the almoner requested news of the health of former patients during the Second World War in 1943, it came with a plea:

> As the high rate of postage is likely to continue, I should be glad if you would kindly try and remember to send me your report next year by 1st February 1944, as this would be a help to us and save the hospital considerable expenditure. [Almoner to Miss Edith Maud Pacey, 24 Mar 1953, RLHBH/AL/3/2]

Figure 3.4. Postcard of aerial view of Frimley Sanatorium, date uncertain [RLHBH/P/1]

Miss Pacey was one of several patients who, with her health report, sent stamps to help the almoner with her work. The stamps were often accompanied by expressions of gratitude:

> I am enclosing 2/6 in stamps wishing I could help more, again thanking Brompton and Frimley for all past benefits. Yours gratefully, M. A. Fisher [25 Oct 1943, RLHBH/AL/3/1]

Donations were sometimes wryly seen as compensating for tardiness:

> I enclose a book of stamps to make up for people like myself who do not forward their returns until they are applied for, and so cost the hospital stamps. Please don't waste a stamp by acknowledging this. [Alfred Philip Moyes, 3 Jul. (1944?), RLHBH/AL/3/16]

> I am sorry I omitted to write to you earlier as requested. The matter was in fact borne in mind but I expect the necessity to 'dig for victory' obsessed my mind. For which omission I fine myself ten shillings enclosed as a contribution to Hospital Funds. [T. M. H. Moor, 17 May 1942, RLHBH/AL/3/8]

In 1947, the almoner sent some gifts of her own. There are some letters of thanks from patients for the 'Christmas gift': food parcels made up of donations from the Commonwealth as part of post-war relief efforts.

3.4.3 Gratitude for, and resistance to, ongoing enquiries

Along with thanks for treatment, correspondents most often expressed gratitude that they were still of interest to the Sanatorium.

> I can assure you how much I appreciate your annual letters and is indeed a pleasure to me to give you all the information I can about myself and I have had a wonderful year. [Mr C H Caswall, 13 May 1936, discharged in 1914, RLHBH/AL/3/10]

> I should like to say how much I appreciate your keeping in touch with me after so long [26 years since discharge]. [Miss Ida Loneragan, 31 May 1943, RLHBH/AL/3/13]

> I cherish grateful memories of the kind and wonderful treatment I received both at Brompton and Frimley, now 42 years ago. I thank you very much for your letter and it is nice to realise that you still have such kind interest in my welfare after so many years. Wishing you every success. / Believe me to remain ever yours gratefully / [sig.] / PS Will you please accept the enclosed £1 note as a small contribution to your gratitude box. [Ainger Nixon, Apr 1952 RLHBH/AL/3/30]

Cherry (1996) noted that almoners were 'often resented' (p. 215), and Doyle (2014) says the almoner was often portrayed as 'a heartless harridan' (p. 69), but in the Brompton correspondence there is a marked absence of rancour aimed at the almoners. Indeed, one correspondent who abhorred the treatment regime and considered Frimley to be 'a blot on the medical escutcheon' said, 'My most pleasant memory is of my interview with yourself' [Joseph Robertson, 8 Jan 1936, RLHBH/AL/3/31].

Whilst the almoner herself was hardly ever the focus of ire, not everyone was pleased to hear from her. There are a handful of letters that request the almoner to exercise discretion because of the stigma that being a patient with TB still engendered, including the fear of ostracisation and even blackmail:

> I am now married and my husband has a big dread of tuberculosis and any reference to my previous illness would cause serious domestic difficulties, in fact, he would

> leave me. […] also, lodgers in the house or other strangers might see the letters & serious consequences may result. I am not ungrateful, but I earnestly request that you do not send any more inquiries. [Kate Bunn, 11 Jan 1936, RLHBH/AL/3/8]
>
> I cannot help suggesting that the information sought for mainly statistical reasons should be obtained in person as correspondence is not always confidential and may cause serious trouble and inconvenience for when things are going okay we do not wish some people to know, whose tongues can put us to a disadvantage financially and socially. [F. Sildersleeves, n.d., RLHBH/AL/3/19]
>
> You must understand I am now married & should not like my wife to know of my stay at Frimley. There is nothing to be ashamed of I know, but it is just that feeling everybody should have in my position, so I hope you will not think too badly of me for not disclosing my address. […] Thanking you once again for the good you have done me in the past, also for your kind enquiries. [W. G. King, 31 Aug n.d., RLHBH/AL/3/3]

These letters reveal the complexities of patients needing to negotiate their commitments to the almoner, fuelled in part by a sense of obligation set up by gratitude, and the fear of the implications of revealing to others that they once had TB. For this reason, the almoner often obtained health reports from relatives or friends of patients, or trusted patients to write of their own volition rather than being sent a reminder. Patients' preferences for how correspondence should be handled were noted in the case books and underlined. It is perhaps the reliance on these case books, in which careful note was made of patients who asked for correspondence to be handled sensitively, that led Bryder to write, in her book on the social history of TB, that the Brompton almoner's 'extreme diligence was clearly unappreciated' (Bryder 1988, p. 220). The letters themselves, however, are full of appreciation, even when patients were circumspect about the nature and value of her enquiries.

3.5 Compliance and obligation

Thomson (2002) characterised the role of the almoner as poised between support and surveillance, which is consistent with Frimley patients being expected to comply with enquiries, often for the rest of their lives. It would be naïve to assume that the

gratitude so evident in the Brompton correspondence signifies an altruistic culture, unmotivated by any sense of obligation. In this section, I address the way the almoners constructed an expectation of compliance with enquiries. The entanglement of finance with administration and social work, as played out through the correspondence, is shown to be an ultimately fatal impediment to the profession of 'almoner'.

3.5.1 Surveillance

The imperative to cooperate with the collection of health reports was made clear to patients, usually on discharge:

> You will remember that when leaving the Frimley Sanatorium all patients are asked to keep in touch by sending a report once a year, to say how they are and if they are able to carry on their usual occupation. [Letter to G. Sims, 6 Feb 1935, RLHBH/AL/3/19]

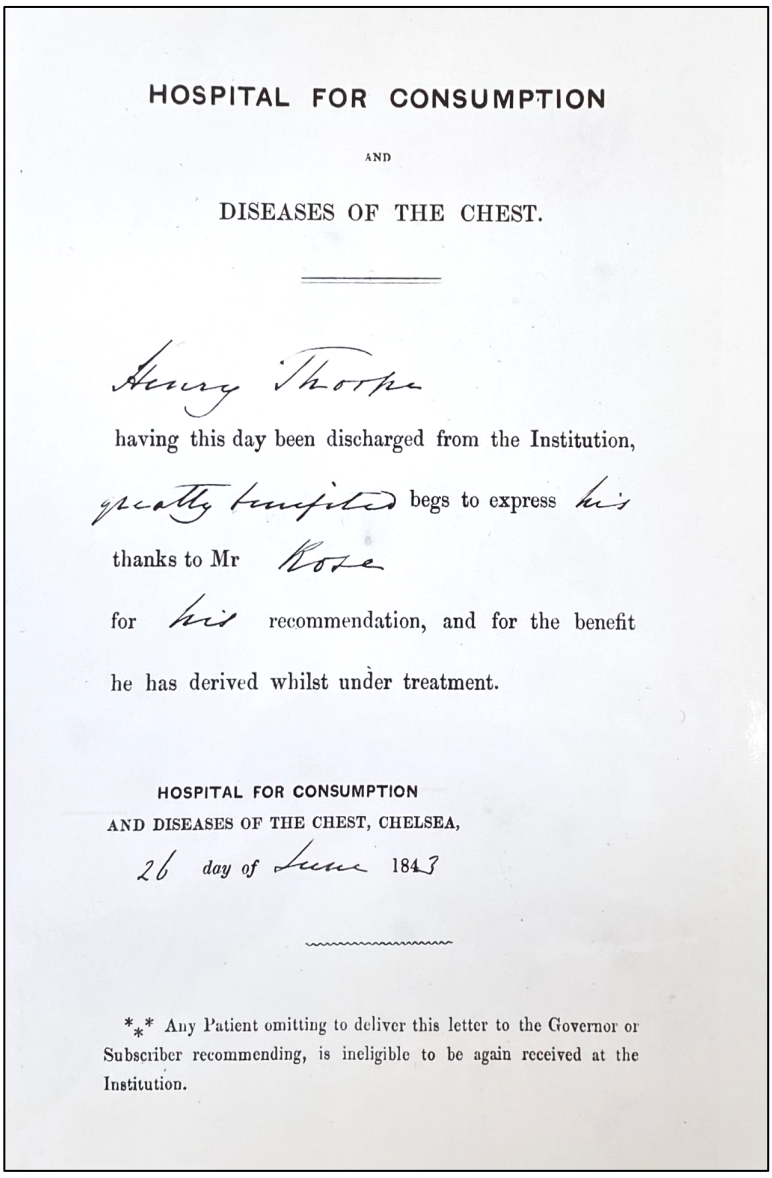
When patients did not respond to the almoner's enquiries, reminders were sympathetic but quite stern:

> I am disappointed to have had no reply from you to my letters in recent years, asking for news of your health, and do hope that your failure to answer does not mean that you are ill and unable to write. [...] As you know, these reports of yours are of great value to our doctors in their research work, helping them to decide on the most successful and lasting forms of treatment. Their findings are applied for the benefit of our many new patients, and the reports of patients who keep well, are naturally of especial interest. I do hope therefore, that you will continue to cooperate with us in this work by sending me annual news of your health. You can feel that by doing so, you are making a very real contribution to the relief of suffering. I enclose a form for completion, also a stamped addressed envelope for your reply, and I do hope to hear from you soon. [Letter to Mr Wilkinson, 23 Feb 1948, RLHBH/AL/3/3]

The moralising tone of this letter was consistent with the regime at Frimley which was explicitly moral as well as physical (Horton-Smith Hartley et al., 1924). Good sanatorium patients were, according to Margaret Coltart, the Head Almoner from 1942, expected to show 'self-discipline, and the particular brand of unselfishness needed in a community of ill people', using the opportunity 'to think and learn about

human nature in themselves and other people, as well as how to look after their health' (Coltart, Raine, and Harrison 1959, p. 53).

Gratitude as a moral imperative dated back to the Hospital's Standing Rules laid down in the 1842. One of the 132 rules stated, 'Patients leaving the Hospital relieved, are to return thanks to the Governors who recommended them; but, above all, it is hoped they will not omit to RETURN HUMBLE AND DEVOUT THANKS TO ALMIGHTY GOD, at their usual place of worship, for any relief or alleviations of suffering they may have received' (Bishop, Lucas, and Lucas 1991, p. 19). The return of thanks took the shape of a partially populated form to presented to the Subscriber or Governor who had recommended them on pain of being excluded from any future benefit from the Hospital (Figure 3.5). The so-called 'thank-you note' is dismayingly



HOSPITAL FOR CONSUMPTION

AND

DISEASES OF THE CHEST.

Henry Thorpe

having this day been discharged from the Institution,

greatly benefited begs to express his

thanks to Mr Rose

for his recommendation, and for the benefit

he has derived whilst under treatment.

HOSPITAL FOR CONSUMPTION

AND DISEASES OF THE CHEST, CHELSEA,

26 day of June 1843

*** Any Patient omitting to deliver this letter to the Governor or Subscriber recommending, is ineligible to be again received at the Institution.

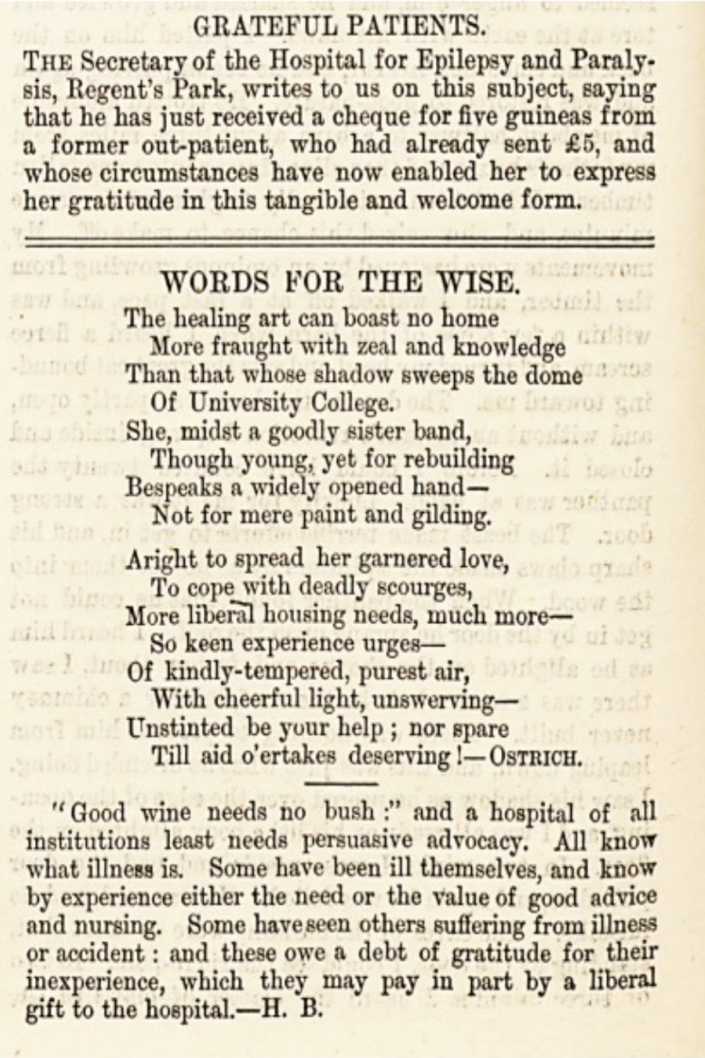
Figure 3.5. The obligatory 'thank-you letter' that patients were required to deliver to the sponsor who recommended them for treatment [RLHBH/P/1]

transactional, with no room for patients to elaborate on the thanks already entered into the pro-forma. Literacy amongst the working classes for whom the Hospital primarily catered might not have been high at the time, and one could imagine the form being filled out by a member of staff – which does not excuse the preclusion of the possibility for the patient to be permitted to express thanks in their own words. One can only hope that by delivering the form in person, patients would have an opportunity to perform their thanks in a way that signalled sincerity in a manner that the obligatory form actively works to counter.

There is evidence that these letters were sometimes augmented by personal testimony. To be sold to raise funds for Brompton Hospital, Mrs S. C. Hall (Anna Maria Hall) wrote a short novel called *The Forlorn Hope*. It is a sentimental story of the death of Mary, a young, beautiful orphan, dying of TB for want of 'a hospital for the relief and cure of consumptive patients' (Hall 2020, f.p. 1844?, p. 29). In an afterword, the author refers to the founders of public charities as 'benefactors to mankind, entitled to, and receiving, the gratitude of a whole people' (p. 28). She relates how she received patients treated at the Brompton:

> I have seen, not one or two, but several, pale faces return, after a sojourn in the Hospital, to thank me for "my [subscriber's] letter", with the hues of health upon their cheeks, and able to bless the Institution, without pausing to breathe between the breaks in every sentence. (Hall 2020, p. 30)

A lavishly illustrated report in the *Pictorial Times* of the Fancy Fair held on the occasion of the laying of the foundation stone of the new building for the Hospital for Consumption reports that 'an interesting little work, entitled "The Forlorn Hope" … met with considerable sale' (Anon., 1844, p. 372–373), suggesting that there was a public appetite for what Ginn (2019) has called a Victorian 'moralising mission' – voluntary effort directed at the urban poor based on an impetus for social reform (p. 3). Gratitude was positioned as an obligation and incentive in the rhetoric of philanthropy associated with the establishment and maintenance of public hospitals. Figure 3.6 shows a notice in *The Hospital* newspaper in which both those having experienced illness, and those who 'owe a debt of gratitude for their inexperience' are urged to pay 'a liberal gift to the hospital' (H.B. 1887, p. 150).



GRATEFUL PATIENTS.

THE Secretary of the Hospital for Epilepsy and Paralysis, Regent's Park, writes to us on this subject, saying that he has just received a cheque for five guineas from a former out-patient, who had already sent £5, and whose circumstances have now enabled her to express her gratitude in this tangible and welcome form.

WORDS FOR THE WISE.

The healing art can boast no home
More fraught with zeal and knowledge
Than that whose shadow sweeps the dome
Of University College.
She, midst a goodly sister band,
Though young, yet for rebuilding
Bespeaks a widely opened hand—
Not for mere paint and gilding.

Aright to spread her garnered love,
To cope with deadly scourges,
More liberal housing needs, much more—
So keen experience urges—
Of kindly-tempered, purest air,
With cheerful light, unswerving—
Unstinted be your help; nor spare
Till aid o'ertakes deserving!—OSTRICH.

"Good wine needs no bush:" and a hospital of all institutions least needs persuasive advocacy. All know what illness is. Some have been ill themselves, and know by experience either the need or the value of good advice and nursing. Some have seen others suffering from illness or accident: and these owe a debt of gratitude for their inexperience, which they may pay in part by a liberal gift to the hospital.—H. B.

Figure 3.6. A call for philanthropy in The Hospital

3.5.2 *Money matters and professional identity*

The frequency of donations sent with the health reports to the almoner might suggest that one of the motivations for corresponding with patients was for the purposes of fundraising. However, the almoner was careful never to imply that a monetary contribution was expected from patients. Mr G. E. Roper, in a letter received by the almoner on 10 Jan 1946, some 33 years after his discharge, says, 'Christmastime not auspicious for this sort of thing. Money tighter then. Enclosed please find ten shillings for Hospital with best thanks' [RLHBH/AL/3/9]. The almoner replies:

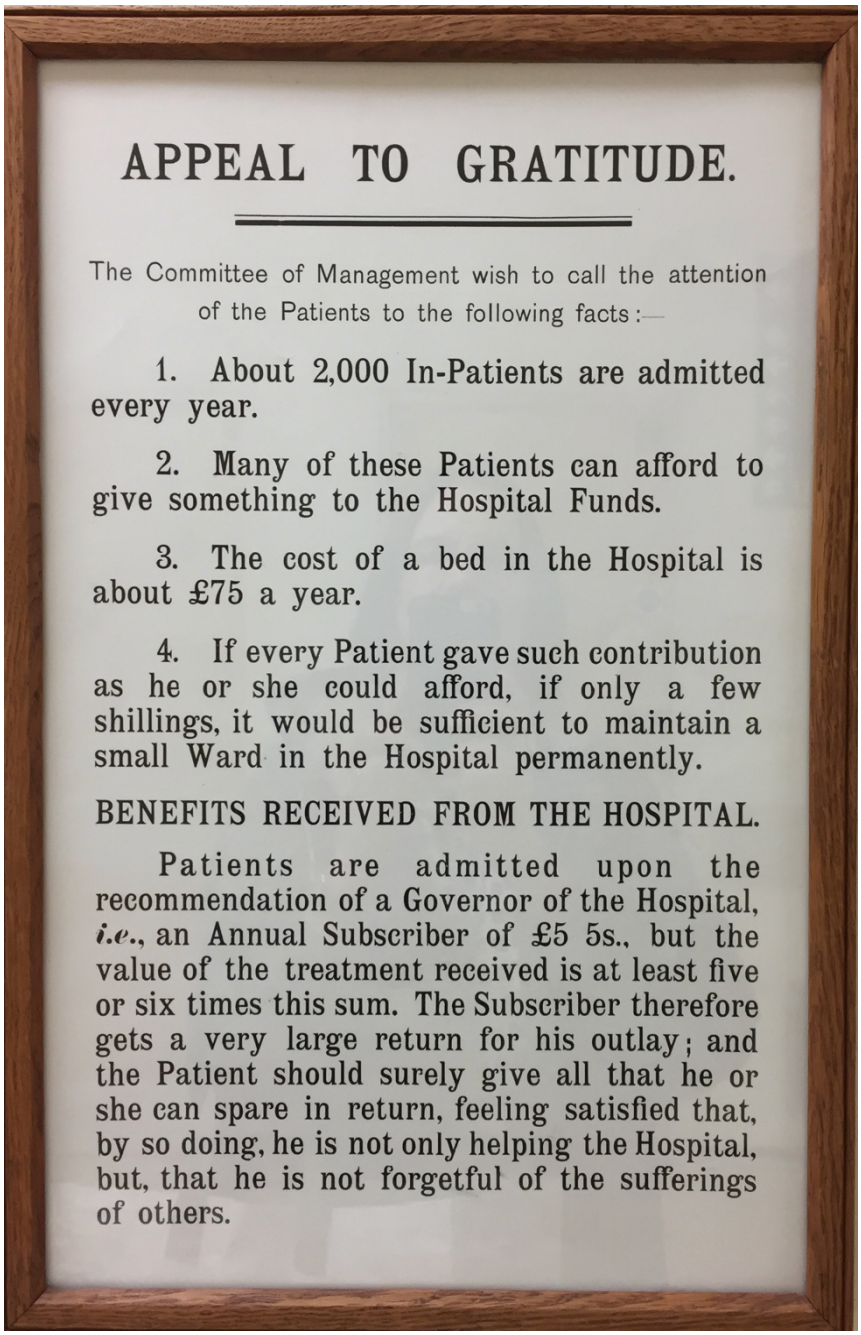
> I [...] would like you to know that when we write to you, it is not for the purpose of obtaining a donation, but purely in order to obtain your health report and I should be very sorry to think that you send money gifts you cannot easily spare. We are, of course, very grateful for financial help, but the majority of our ex-patients simply

> send us the information for which we ask and that is all we expect of them. [17 Jan 1946, RLHBH/AL/3/9]

It was not helpful that the title 'Almoner' derived from 'alms' – the giving of charity to the poor. It meant that the professional identity of the hospital almoner, since first established in the 1890s, was inextricably associated with finance. The insistence that no monetary contributions were expected is consistent with Gosling's argument that almoners actively tried to counter the widespread impression that their role was merely to handle money (Gosling, 2018). But Frimley patients had most likely internalised the message that generosity, no matter how token, was part of the legacy of their treatment under the voluntary hospital system. Most Sanatorium patients passed through the wards of the Hospital before being referred to Frimley. Figure 3.7 shows a poster from about 1934, until recently mounted on a corridor wall in the Royal Brompton Hospital as an item of nostalgia but also perhaps as a subtle exhortation to more recent patients. It indicates that a sense of financial obligation was almost certainly part of the culture in much the same way that conspicuous charity fundraising efforts are prominent in many of today's hospitals.

Acts of 1946 and 1947 establishing the NHS as free at the point of use caused confusion about whether donations could still be accepted by the Hospital since the state, as one patient put it, was 'soon to become the Fairy Godmother' [Mr Henry R. Woosman-Mills, 14 Jan 1946, RLHBH/AL/3/28]. The Brompton, however, was recognised in legislation as a 'teaching hospital' which meant that, apart from the ownership of the building equipment which was transferred to the state, the Hospital's Board of Governors would retain control over the day-to-day running of the Hospital, and there would be 'no interference with any future gifts to the Hospital, all of which would remain for the Board to spend at their discretion' (Bishop, Lucas, and Lucas 1991, p. 156). The ideological dissonance between the state's discouragement of fundraising and the philanthropic impulse of past patients is encapsulated in a letter from 1952:

> Now that you are under the government rule of the thumb, donations I take it don't interest you now. However I am enclosing p.o. [postal order] for 10/0 to be used as you think best. [Mr Frank Dixon, received 23 Feb 1952, RLHBH/AL/3/17]



APPEAL TO GRATITUDE.

The Committee of Management wish to call the attention of the Patients to the following facts:—

1. About 2,000 In-Patients are admitted every year.

2. Many of these Patients can afford to give something to the Hospital Funds.

3. The cost of a bed in the Hospital is about £75 a year.

4. If every Patient gave such contribution as he or she could afford, if only a few shillings, it would be sufficient to maintain a small Ward in the Hospital permanently.

BENEFITS RECEIVED FROM THE HOSPITAL.

Patients are admitted upon the recommendation of a Governor of the Hospital, *i.e.*, an Annual Subscriber of £5 5s., but the value of the treatment received is at least five or six times this sum. The Subscriber therefore gets a very large return for his outlay; and the Patient should surely give all that he or she can spare in return, feeling satisfied that, by so doing, he is not only helping the Hospital, but, that he is not forgetful of the sufferings of others.

Figure 3.7. Poster from the Royal Brompton Hospital, c. 1934

The almoner replies:

> I am grateful to you for your help with our research records … Thank you also for your kindness in sending a donation for our funds. Now that the hospital is nationalised we do not, of course, accept gifts towards its upkeep, but help is always welcome for the Almoners' Fund, from which we help patients with many problems for which funds are not available from official sources. [25 Feb 1952, RLHBH/AL/3/17]

The drop-off in contributions after 1948 was of concern to the almoner who recorded in her January 1953 report that voluntary contributions had more than halved

since the previous year. That contributions were considered to be a mix of gratitude and charity is evident:

> Although this shows a decrease, it is encouraging to find even this number of patients feeling impelled to send thank-offerings and good wishes for other patients in trouble to get help from the almoners' department. (Coltart, 12 Jan 1953, RLHBH A/12/8)

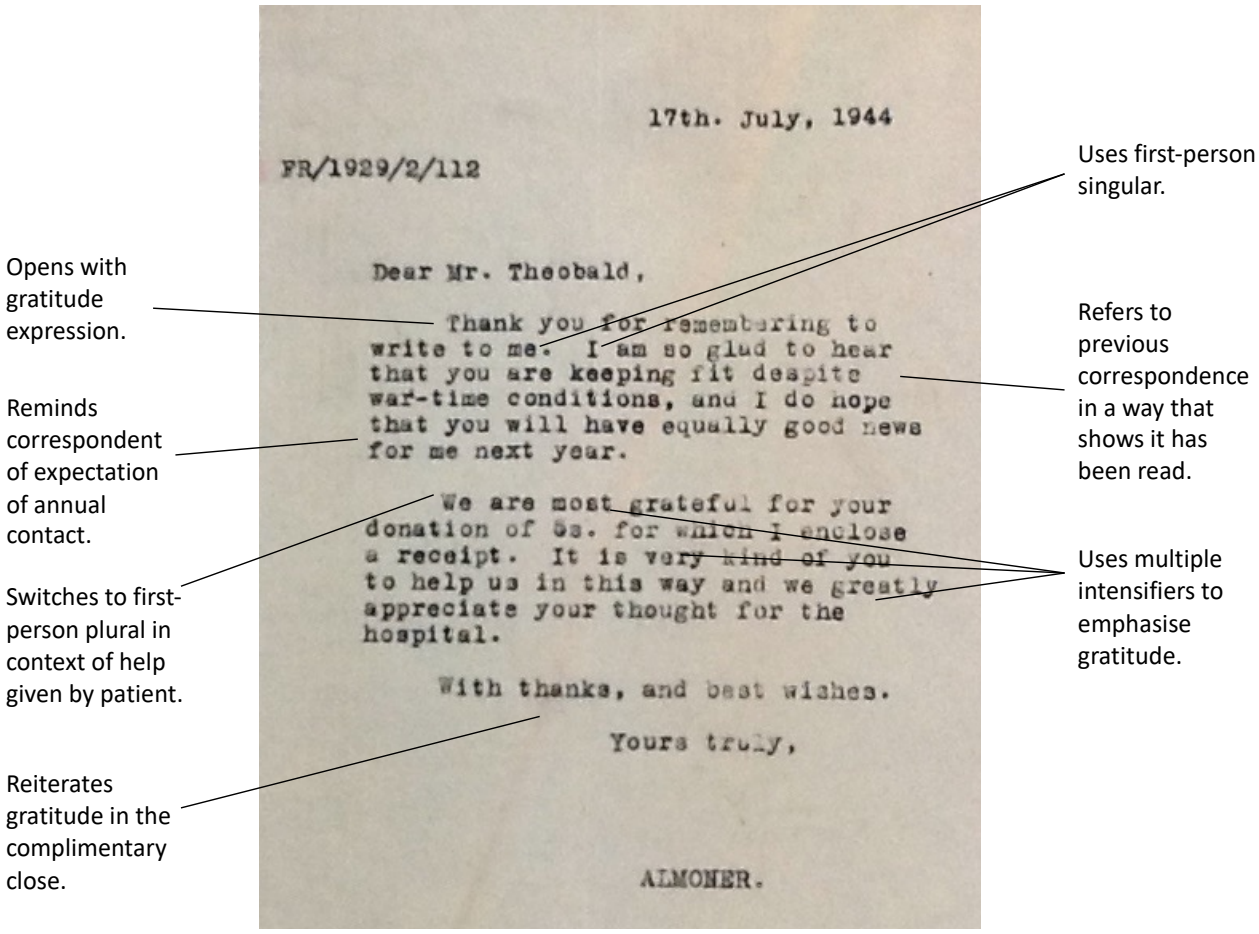
Gradually, the almoner's role had transitioned from one of giving alms (deeming patients eligible for charitably funded healthcare) to accepting alms from patients. This uncomfortable position – along with the acceptance of paying patients and the shift to local-council funded healthcare and eventually the NHS – led to the term 'almoner' becoming anachronistic. In 1949, Miss Coltart proposed that the almoner's department should be renamed the Social Service Department, because 'much public ignorance remains as to what is the primary function of almoners' work' (Coltart, 8 Mar 1949). The introduction of the NHS authorised the reorientation of the profession to legitimise the disentanglement of financial and social work (Gosling, 2018), although the two spheres were never entirely separable. The profession's national body, the Institute of Almoners, changed its name in 1964 to the Institute of Medical Social Workers (Gosling, 2017), and the job title of 'almoner' was phased out.

3.6 The almoners' voice

So far, the analysis has implicated the letters in complex entanglements of expectation, reciprocation, and obligation, where philanthropy was both conferred and received by the almoners and patients. Pelletier et al. (2018) argue that linguistic features, such as the giving and giving back of thanks, frame communicative rituals in which autonomy and hierarchy are at stake. A close reading of exemplars of the almoners' correspondence shows how semantic characteristics actively performed gratitude as a means of driving the ongoing gift relationship.

From the 1920s through to the late 1950s, the authorial voice in the almoners' correspondence is remarkably consistent. To read the letters is to imagine that they have been written by one person, familiar with each patient's history and life circumstances. Figure 3.8 shows the construction of a typical almoner's letter, showing

Figure 3.8. Example of a typical letter from the almoner to a former patient, BH/AL/3/25



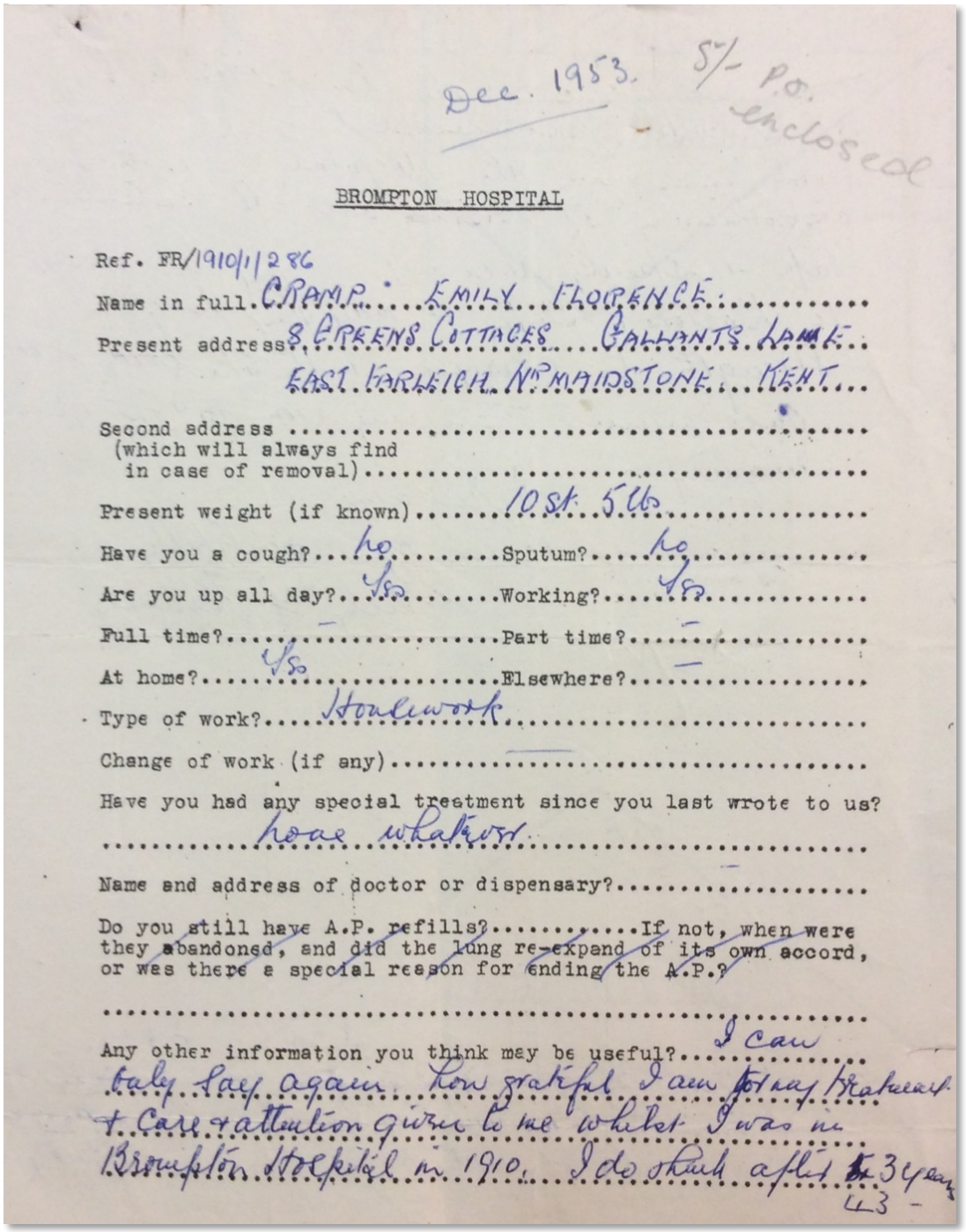
how integral gratitude was to the almoners' interactions with patients. The almoner makes frequent use of intensifying particles, often used at the expense of being concise (e.g. thank you very much, most grateful). Jautz (2015), in a study of thanking routines, finds that intensifiers, along with explicitly stating why one is grateful, 'lifts a mere token of appreciation to a situation-specific expression of one's personal gratitude' (p. 102). Intensifiers as a strategy for accomplishing gratitude are discussed further in Section 6.6.2. The almoners' use of first-person singular ('I', 'my', 'me') also helped to personalise what was essentially an institutional relationship.

The job title below the almoner's signature changes depending on the year of writing: Lady Almoner (up to 1942), Almoner (1942–48), Acting Almoner (1948–49), Frimley Almoner (1950–59), and 'Frimley Follow-up Department' or 'Follow-up Department "R"' (1959–63). This is the only clue, from a patient's perspective, to a changing cast of record keepers, and it belies the concerted effort by many hands to

maintain the work of follow-up alongside other duties. By the time Miss M. S. Coltart was senior almoner in the late 1940s, six other almoners were employed at the Brompton in various capacities along with a number of record clerks and typists.

One of the first signs of bureaucratic expediency came in 1939, when a form was sent with the almoner's letter for former patients to fill out their details (Figure 3.9). The form asked for details of name and address (including a second address – 'which

Figure 3.9. Example of a form sent out with enquiries from 1940 onwards, BH AL/3/6



Dec. 1953. 5/- P.O. enclosed

BROMPTON HOSPITAL

Ref. FR/1910/1/286

Name in full. CRAMP. EMILY FLORENCE.

Present address 8 GREENS COTTAGES GALLANTS LANE. EAST FARLEIGH NR MAIDSTONE KENT.

Second address .....
(which will always find in case of removal).....

Present weight (if known) 10 St. 5 lbs.

Have you a cough? No. Sputum? No.

Are you up all day? Yes. Working? Yes.

Full time? — Part time? —

At home? Yes. Elsewhere? —

Type of work? Housework

Change of work (if any) —

Have you had any special treatment since you last wrote to us?
None whatever.

Name and address of doctor or dispensary? —

Do you still have A.P. refills? .....If not, when were they abandoned, and did the lung re-expand of its own accord, or was there a special reason for ending the A.P.?

Any other information you think may be useful? I can only say again how grateful I am for my treatment & care & attention given to me whilst I was in Brompton Hospital in 1910. I do think after 43 years

43 -

will always find in case of removal'), weight, if having a cough and whether any sputum, details of whether working or not and in what capacity, any special treatment, other information, doctor's address, and insurer and insurance number if insured (for pre-NHS forms). The form was redesigned in 1940 to omit the request for insurance information and to place the request for any other information after the doctor's address, allowing extra space for more information that might be helpful.

The form accompanied rather than replaced the almoner's letter: the personal touch was still very much in evidence. Even so, the forms met with a mixed response. Most respondents seemed happy enough to complete the form, often adding chatty remarks in the space allowed for 'Any other information you think might be helpful'.

A few took exception. One of the first ex-patients to receive the form, having previously cheerfully responded to the almoner's enquiries, now wrote: 'I wish you to know I am an Englishman true born, & of good report, and refuse to acknowledge your right to enquire into my private affairs.' He still ended his letter with, 'With every good wish to the medical and nursing staff in their noble work' before signing off with, 'Believe me, / Yours grossly insulted / Charles Quirney' [28 Feb 1939, RLHBH/AL/3/2]. Mr F. Fergusson, writing in 1944, also took exception to the form, deeming it a 'waste of time and supplies' [20 Apr 1944]. The almoner writes back:

> I am very sorry if the fact you were sent a Frimley record form displeases you; but it is customary to send these forms to our ex-patients, and many of them prefer to fill in a form rather than write a personal note, or telephone or call at the hospital as you usually do. I will see to it that in future no form is sent with our usual enquiry.
> [22 Apr 1944, RLHBH/AL/3/5]

And she did.

A letter dated 17 July 1957 from the almoner's clerk, Kathleen Colgate, to the then Medical Superintendent of the Sanatorium reveals the administrative burden engendered by follow-up work (Colgate, 1957). Since the previous ten-year block of statistics compiled in 1946, some 3000 extra patients had been added to the records, many of whom changed addresses in the two-year interval between discharge and follow-up letters being sent out. The improvement in survival of new patients owing to chemotherapy meant that most patients were now available for 5-year follow-up, and

the technical information required was much more demanding than merely the determining of whether patients were alive and able to work. The Almoner's Report Book, kept by Miss Coltart catalogues ongoing problems with retaining clerical staff and a burgeoning workload. The decision was made to step-down follow-up work.

In 1958, letters from the almoner to earlier patients became a gentle 'thank-you and goodbye'. Mr James Smith, a Frimley patient in 1909 whose correspondence over nearly five decades is filled with gratitude, was informed:

> As modern methods of treatment have revolutionised the field of chest illnesses, we are no longer following up our earlier patients, but I shall always be pleased to hear from you and to see you if you come to London. [...] Many thanks for all the help that you have given by reporting for so many years for our research. [29 Jan 1958, RLHBH/AL/3/5]

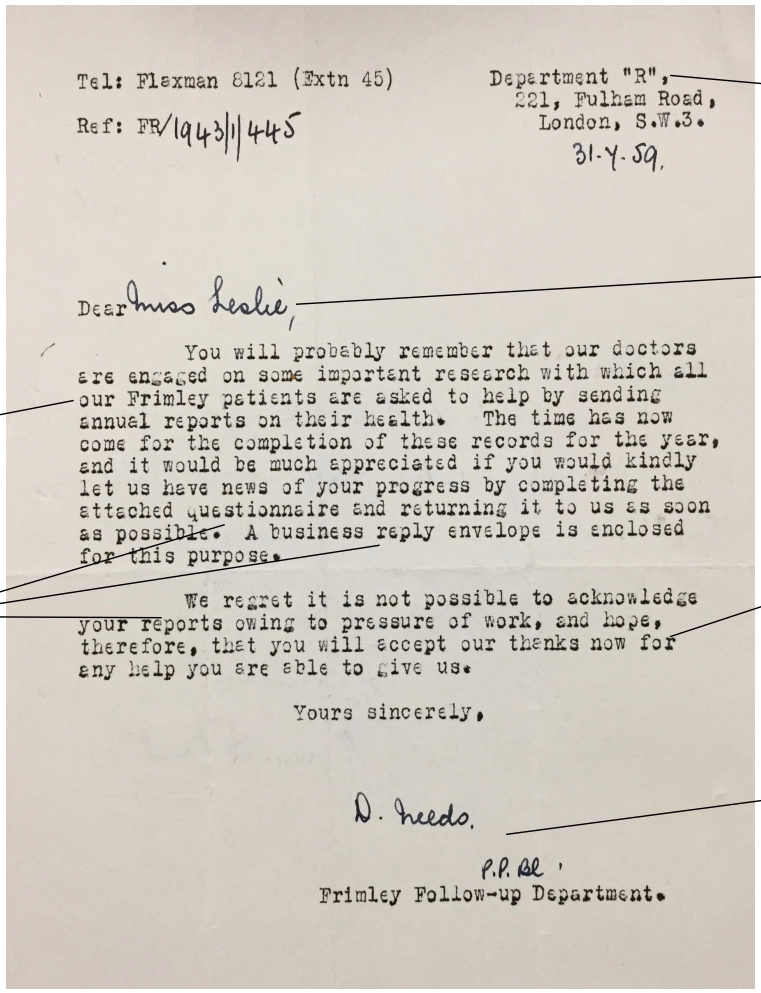
More recent patients were still asked for reports of their health in 1959, but the letters had now begun to take on a corporate register, form, and feel.

A key difference between the requests for reports from 1944 (Figure 3.8) compared with 1959 (Figure 3.10) is the semantic switch from pleasure (glad, fit, hope, good, grateful, kind, help, appreciate) to one of encumbrance ('time has come', completion, records, questionnaire, regret). Collecting data had come to outweigh its usefulness and follow-up was discontinued in 1960.

Nostalgia for the voluntary hospitals and scepticism about the NHS was hard to shake. Esther M. Woods, a retired nurse, treated at Frimley in 1925, writes bitterly in 1960:

> I suppose I am fortunate to be here, but it is hard going. There is no mercy in the National Health Service. It was the worst thing that the late Aneurin Bevan did to kill the Voluntary Hospitals as such. Up here in Lancashire things are very different from London and the South. The people are hard and very callous. [9 Nov 1960, RLHBH/AL/3/25]

Figure 3.10. Example of a typical letter from 'Frimley Follow-up Department' to a former patient [RLHBH/A/3/39]



Tel: Flaxman 8121 (Extn 45)

Ref: FR/1943/1/445

Department "R",
221, Fulham Road,
London, S.W.3.
31-Y-59.

Dear Miss Leslie,

You will probably remember that our doctors are engaged on some important research with which all our Frimley patients are asked to help by sending annual reports on their health. The time has now come for the completion of these records for the year, and it would be much appreciated if you would kindly let us have news of your progress by completing the attached questionnaire and returning it to us as soon as possible. A business reply envelope is enclosed for this purpose.

We regret it is not possible to acknowledge your reports owing to pressure of work, and hope, therefore, that you will accept our thanks now for any help you are able to give us.

Yours sincerely,

D. Needs.

P.P. RL

Frimley Follow-up Department.

Gratitude as a frequently evoked emotion associated with the NHS, as evidenced in Chapter 4, was still some way off for those who had benefited from the voluntary hospital system.

3.7 Discussion

Far from pursuing a narrow moral agenda or being a managerialist ploy to elicit greater productivity, gratitude – sincerely expressed at the interpersonal level – contributed to the durability of relationships in this case-study of correspondence between staff and patients. Although the correspondence was primarily intended to collect data for statistical purposes, the quantitative outputs in the form of reports of the after-histories of patients (Habershon et al., 1914; Horton-Smith Hartley et al.,

1924, 1935) have nothing to say to the rich, lived experiences that unfold through the pages of letters. It is through engagement with the hallmarks of gratitude in the correspondence that one gains an insight into the affirming, emotional heft of the work that offsets the administrative burden, of needing to keep track of thousands of patients.

Pelletier et al. (2018) demonstrated the value of using Marcel Mauss' concept of the gift in analysing exchanges in medicine that have ritualistic and performative aspects. Mauss elaborated the idea that gifts are not disinterested. They participate in economies of gift-exchange in communities, and the expectation of reciprocity consolidates social ties (Mauss, 2000). In the Brompton correspondence, patients' gifts took the form of material goods – donations, stamps, presents, etc. – but the most valued gift was the information that enabled the almoner to participate in other circles of gift exchange within the knowledge community of the hospital: the gifting of data to the doctors compiling research on the after-histories of patients with TB. This concept of knowledge exchange is in keeping with work by Konstantinou and Fincham (2011) which shows how gift relations of reciprocation and obligation enhance working capability.

Did the expression and reception of gratitude in the Brompton correspondence enhance the subjective wellbeing of the patients and staff? We cannot know for sure, but the material and linguistic markers of pleasure certainly point in this direction. Davis et al. (2016) carried out a meta-analysis of gratitude interventions which included letter writing, finding that they show promise for improving psychological wellbeing. A study found that writing letters of gratitude increased participants' happiness and life satisfaction, while decreasing depressive symptoms (Toepfer et al., 2012). A small, randomised control trial of an intervention that involved healthcare practitioners keeping gratitude diaries led to a reduction in perceived stress and depressive symptoms (Cheng et al., 2015). The writing and receiving of letters between the almoners and former patients in which gratitude was the dominant emotion might well have had a similarly positive effect. Indeed, Miss Marx in her report in 1921 had written that 'the very considerable time and labour expended [on follow-up] is more than compensated for by [patients'] gratitude' (Marx 1921, p. xvii).

3.8 Strengths and limitations

A strength of this study is that it draws on a longitudinal sample of letters in which, independently of each other, multiple patients repeatedly and robustly expressed gratitude. Having both sides of the correspondence, and a full account of the circumstances in which it was produced, is unusual in epistolary research. It enables the exploration of the dynamics of call-and-response, or 'turns', in the production and reaffirmation of institutionally proscribed relationships.

A limitation is that gratitude is undoubtedly over-represented in the correspondence, given that patients were alive when conducting the correspondence and therefore more likely to implicate Sanatorium treatment for their wellbeing. Also, only patients who had been at Frimley Sanatorium for more than 28 days were included in follow-up, meaning that voices are not included of those who discharged themselves, presumably dissatisfied with treatment at Frimley (although apparently this rarely happened according to Dr Wingfield's obituarist) (FHY [probably F. H. Young] 1946). Patients were required to submit completely to a strictly timetabled regime at the Sanatorium: there was no room for dissent. The Sanatorium's 'Black Book' catalogues reasons for patients' exclusion from the Sanatorium that include returning late from leave, drunkenness, fraternising with patients of the opposite sex, refusing to have dental treatment, and rudeness. Those patients who stuck with the regimen showed a willingness to comply with authority that may well have contributed to the high response rates to the almoners' enquiries.

3.9 Conclusion

This study explores the ways in which gratitude was enacted in an archive of letters between patients and almoners over a sustained period of time. I found that gratitude was performed through inscriptions, and material gifts of money and goods. My research independently confirms work by Gosling (2017; 2018) showing that almoners resisted being characterised as finance-first administrators rather than patient-focused social workers. However, there is more at stake in the Brompton case study than the gift relationship merely enabling the work of the almoners. The almoners' engagement with patients was reciprocally thankful, contributing to an ecology of gratitude that

supported medical research throughout the lifetime of Frimley follow-up enquiries. The correspondence took the form of an annual ritual that performed the continuation of care. It exemplifies what Mauss describes as 'the solicitude arising from reciprocity and co-operation' (Mauss 2000, p. 69). This performance of gratitude affords an insight into the affirming, emotional nature of the work that almoners offset against the administrative labour of needing to keep track of thousands of patients.

The exigency of gathering data from former sanatorium patients for research purposes had the happy side-effect of giving patients the chance to express gratitude and the almoners the chance to reciprocate. That the gratitude was unsolicited, rather than part of a formal service-oriented feedback process, made it come across as an unforced gift – not without the obligation to reciprocate, but also not purely instrumental.

The Brompton correspondence shows that, regardless of who was writing the letters, the semantic strategy of using the first-person singular ('I', 'me', and 'my') created continuity in a way that transcended politeness and made patients feel acknowledged and valued. The textual analysis of the almoners' letters argues that the replacement of the semantics of pleasure with those of encumbrance marked a shift from personalised conviviality to corporate cordiality to which former patients were far less responsive.

Gillespie and Reader (2020) analysed a national sample of compliment letters in the NHS, focusing on how patient-generated gratitude can improve healthcare quality and safety. They identified gratitude aims in the letters which they categorised as *acknowledging* (stating a feeling of gratitude), *rewarding* (requests to thank other and gifts), and *promoting* (commending behaviours as desirable and suggestions for improvement). The follow-up letters I studied differ from compliment letters in that gratitude could be said to be, in modern parlance, 'tagged' – it was not the ostensible primary purpose of the letters, but an availing of transactional correspondence to take up a gratitude opportunity. Whilst the letters are redolent with *acknowledging* and *rewarding*, patients rarely framed their feedback as suggestions for improvement, making it difficult to argue that the letters contributed to service improvement. But, of course, by cooperating with the almoners' request to supply information, the letters

enact patient involvement in improving healthcare. The motivation to keep supplying information meant, as the almoner made clear, that patients were contributing to valuable research work on forms of treatment and 'making a very real contribution to the relief of suffering' [Letter to Mr Wilkinson, 23 Feb 1948, RLHBH/A/3/3].

In summary, gratitude as a moral and financial imperative was a prominent feature of communication with, about, and by patients in the voluntary hospital system. Although gratitude participated in a deeply paternalistic attitude to patients (discussed further in Section 7.2.1), the almoner's correspondence was, with few exceptions, appreciated by former patients as evidence of continuity of care.

Chapter 4 An outbreak of gratitude: tweets expressing gratitude to the NHS in the Covid-19 pandemic

One of the findings of the metanarrative review presented in Chapter 2 was that there is a need for research on the ways in which gratitude acquires meaning in real-world situations. Yoshimura and Berzins (2017), too, have called for a focus on expressions of gratitude to extend and enrich the plethora of research on gratitude experiences. They identify a need to investigate the semantic features of gratitude expressions and the topics on which people focus when thanking others. Chapter 3 began this project by examining how gratitude acquired meaning in correspondence between hospital staff and former patients, tracing changes in semantic features of letters to patients over time. This chapter further addresses this research gap by exploring, at the macro (societal) level, the features of expressions of gratitude associated with the National Health Service (NHS) on Twitter at the outset of the Covid-19 pandemic, and how the volume and nature of these expressions changed over the course of the first lockdown in the UK (22 March–28 May 2020). The research was conducted in collaboration with Glenn Robert, Anne Marie Rafferty, and Kay Leedham-Green (contributions are given in Section 4.2.3), and a shorter version was published as Day et al. (2022).

4.1 Framing the study

4.1.1 Gratitude in a pandemic

Crises that pose a global threat, either in the past like bubonic plague and tuberculosis, or the present like global warming, have always proved inviting to researchers wanting to advance understandings of the effects on social relations of catastrophic events. In health disasters, in which social management of well bodies is crucial to the ability of health services to manage sick bodies, understandings of public attitudes are imperative. Emotional experiences have been implicated as having a

critical role in attitudinal and behavioural responses to crisis communication (Lu & Huang, 2018).

Whilst the early stages of the Covid-19 pandemic were characterised by what Jin et al. (2014) term 'crisis emotions', like fear and anxiety (Steinert, 2021), awareness of gratitude as a personal, social and health benefit grew in prominence during the pandemic. Consistent with past research which has shown that gratitude motivates prosocial behaviour (Ma et al., 2017), studies focusing on Covid-19 found that participants who were grateful or thankful were more willing to endorse measures that helped curtail the spread of the virus (Syropoulos & Markowitz, 2021; Tong & Oh, 2021). Practising gratitude was implicated as a predictor of wellbeing during lockdown (Dennis et al., 2022). Gratitude journaling was recommended in many of the online wellbeing courses that proliferated during lockdowns, including the 'Science of Happiness' online free course that attracted over 3 million enrolments during the pandemic (Yale, 2020). These interventions are consistent with the 'benefits of gratitude' metanarrative identified in the review reported in Section 2.4.4, and tend to be predicated on Fredrickson's 'broaden and build' model in which experiencing gratitude, along with other positively valenced emotions, broaden the repertoires of action that people are prepared to take (Fredrickson, 2004). Immediate effects sparked by positive emotion tend to be relatively short-lived, but the model predicts that these actions build durable resources that can be drawn on as coping strategies to survive and thrive.

4.1.2 Taking a discursive psychology approach

In addition to the analysis of tweets, this research is an investigation into the potential for social media data to be explored using an approach informed by discursive psychology. It adds to the relatively few studies that have used this approach to explore tweets (examples are Tekin & Drury, 2022, Hurst, 2017, and Rasmussen, 2015). Unlike the everyday conversational routines that usually comprise the data source for discursive psychology, exchanges on Twitter are asynchronous and constrained by the features for interaction afforded by the platform. Tweets do, however, perform the types of social and psychological actions that are paradigmatic to discursive

psychology, and the methodology has been proposed as having potential to play a very important part in understanding online interactions (Wiggins, 2017).

Hitherto, the dominant paradigm for investigating the relationship between language and emotions has been cognitive psychology. Cognitive approaches treat language as referring to or representing 'inner states': there is an assumption that there is a reality behind the talk that language allows us to access (Wiggins, 2017). For example, Kleinberg et al. (2020: online) assembled a 'ground truth data set' of emotional responses to the Covid-19 pandemic, arguing that the core aim of emotion detection is to 'make an inference about the author's emotional state'. Rather than investigating whether a tweet is written in a pessimistic tone, they are interested in whether the author of the tweet *actually felt* pessimistic. While this aim is admirable, it is predicated on the questionable assumption that constructed texts are direct relays to people's emotions. In an excoriating critique of a study by Mitchell et al. (2013) that used Twitter to map 'the geography of happiness', Jensen (2017) has cogently outlined the dangers of conflating online social life with offline emotional states, along with other limitations of this type of research, such as sampling bias and over-extending inferences. By focusing on what talk *does* rather than what it *reflects*, inferences about emotions that motivate displays of gratitude are avoided in favour of how emotions are made in talk or, in this case, tweets.

4.2 Methods

4.2.1 Selecting, characterising and compiling the dataset

During the initial phase of this research, various methods of 'harvesting' social media data were explored. An account was created with the social media listening service, Social-searcher (www.social-searcher.com), that delivered 100 search results on '(NHS AND thank) OR (NHS AND gratitude)' in an e-mail digest twice a day. It quickly became apparent, though, that posts that were widely shared tended to dominate the search results, resulting in multiple repeats of retweets, and limiting its usefulness in returning rich data. The search results did provide an early indication, though, that of

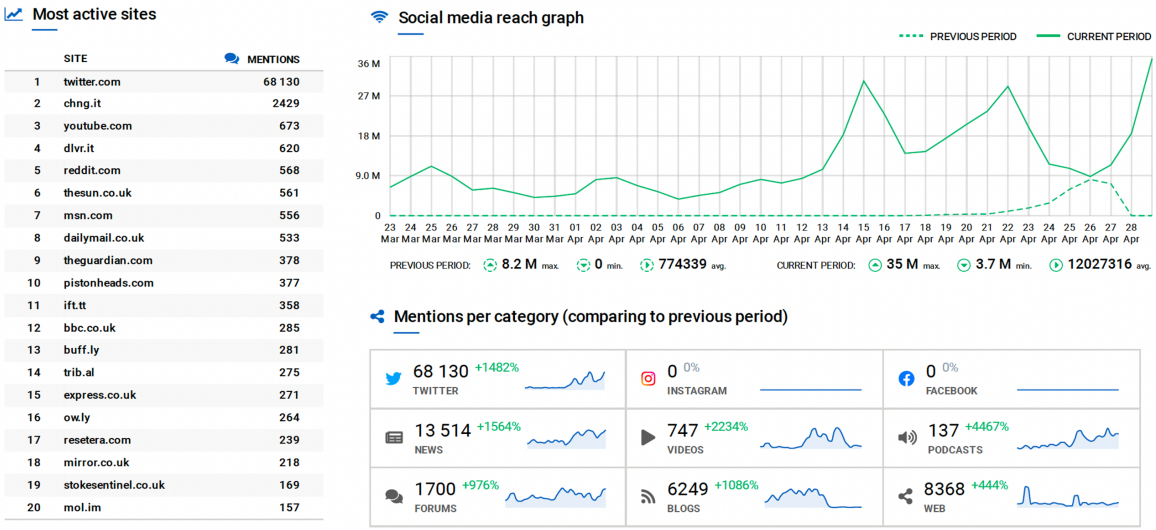
the range of platforms monitored by Social-searcher, Twitter dominated publicly available posts about gratitude and the NHS.

A 6-week paid subscription to Brand24 (www.brand24.com) was used to monitor traffic across websites. Brand24 aggregates data over a 24-hour period rather than providing a sample of posts. Although designed to track mentions of commercial companies for brand-reputation purposes, this service also returns data useful to academics interested in trends in particular topics on social media.

Monitoring from Brand24 showed that, at least in publicly accessible posts, Twitter was unequivocally the most active site for mentions of NHS and gratitude (Figure 4.1). Facebook and Instagram did not feature at all. Although it is likely that gratitude to the NHS did feature on these platforms, and also Whatsapp, privacy settings on these platforms tend to require participants to be friends or followers or to have been added to a group for posts to be visible and searchable. Based on these factors, it was therefore decided that a dataset from Twitter would be the most suitable route for harnessing the flavour of public conversations about gratitude and the NHS during the initial weeks of the pandemic.

Twitter is a dynamic platform, and its affordances and features are often updated. At the time of data collection, Twitter was a publicly available platform that offered free accounts to those who wish to tweet or to follow (or subscribe to) specific

Figure 4.1. Active mentions of NHS and (gratitude OR grateful OR thank OR thanks) compiled by Brand24 between 23 March and 30 April 2020



accounts, but no account was needed to access or search the site. Tweet entry was limited to 280 characters. Tweeters could add up to four photographs, a graphic, and short bursts of video. Twitter users could respond to a tweet by commenting on it, 'liking' it, quoting it, and/or retweeting it. The visibility of tweets depended on the privacy settings selected by the tweeter, Twitter's proprietary algorithms that personalise what appears on users' news feeds, and whether advertisers had paid for a tweet to be promoted.

A dictionary definition of gratitude is relatively uncontroversial: 'The quality or condition of being grateful; a warm sense of appreciation of kindness received, involving a feeling of goodwill towards the benefactor and a desire to do something in return' (OED, 2019). However, the nuanced meanings of gratitude, the appropriate application of the term, and the characterisation of its value, are highly contested (Carr, 2016). Gratitude has been found to be prototypically organised: features of gratitude do not belong to classically defined categories, the membership of which is specified by in/out criteria. Instead, gratitude is a concept made up of a 'fuzzy collection of features', some of which are considered more central than others (Lambert et al., 2009, p.1195).

The rationale for searching for tweets prioritised relevance to the phenomenon of interest (gratitude in relation to the NHS) rather than representativeness or comprehensiveness. We concentrated on the two features ranked as being most central to gratitude by UK participants in a prototype analysis (Morgan et al., 2014): 'thankful' and 'grateful'. We searched for linguistic variants of these using the search string 'NHS AND (gratitude OR grateful OR thank OR thanks OR #thank) lang:EN min_faves:300 until:[day after date of interest] since:[date of interest]'.

Twitter is opaque about when it starts to impose its own filters or limit numbers of search results – its guidelines say it filters for 'quality tweets and accounts' (Twitter, 2020). To reduce the chance of search results being capped, the volume of returns was limited by running the search separately for each day from 1 March to 23 June 2020. Search returns were manually sifted for relevance to the research question ('Does this tweet engage with issues of gratitude to the NHS?'). Tweets in which gratitude was not addressed to the NHS (e.g. 'Thank you everyone for staying home to protect our NHS') constituted about 30% of search results and were excluded.

The search was focused to capture a flavour of issues gaining traction on Twitter by filtering for 'likes' – an admittedly crude measure of salience (for a roundup of the complicated politics of 'liking' see Taylor, 2019), but an instrumentally useful one for harvesting higher impact tweets. We acknowledge the impetus to 'like' a tweet is not necessarily based on agreeing with its content – 'liking' may be indiscriminate or based on the status of the tweeter – but the amplification of certain messages became part of the online phenomenon itself. Regardless of the triggers for their amplification, Twitter users saw and engaged with the tweets in our dataset. A threshold of 300 'likes' allowed for a manageable number of tweets to be returned (range 8–55, median 22.4 after sifting for relevance every day in the first two weeks of the sampling period). The search was run at least one week after the date of interest to allow the number of 'likes' to accumulate. Details of each tweet were drawn into an Excel spreadsheet and imported into NVivo for coding.

Because the phenomenon of interest is the social expression of gratitude, we elected not to focus on the online identities of tweeters or the networks they inhabit. Offline and online identities are fluid, particularly during times of crisis: politicians become patients, scientists become celebrities, citizens become campaigners. Motivations for tweeting about gratitude may have included impression management and identity positioning. But rather than speculate on those identities and motives, we chose to characterise the content, function and form of popular tweets, exploring how these modulated over time and in response to events.

4.2.2 Constructing the coding frame

To construct the initial coding frame, a stratified sample of 100 tweets was selected from across the sampling period for inductively coding, leading to a list of characteristics useful for describing each tweet. This inductive approach is consistent with the 'emic' focus of discursive psychology (Wiggins, 2017) in which we worked with the categories we recognised in the corpus rather than imposing preconceived categories. Tweets were approached as 'micronarratives' consisting of characters, actions, objects, contexts, and instruments (Venditti et al., 2017). Informed by Haugh's study of im/politeness as social practice (Haugh, 2013), our coding focused on the action component or *function* of each tweet – what was it doing?; and the *plot* of the

tweet – what was it about? Once a draft codebook had been agreed, a second sample of tweets was assembled, coded independently, and discussed until consensus was reached. The codebook was further refined during results comparison, for example, we merged the codes of 'instructing/directing' and 'requesting/asking' because coders had difficulty distinguishing between the two. The resulting typology of gratitude which we used to code our dataset is shown, with examples, in Table 4.1.

4.2.3 Coding the data

For the full dataset of 834 tweets, we followed the principles and protocols for CQR-M (Consensual Qualitative Research – Modified) (Hill et al., 2005; Spangler et al., 2012). Coding was additive: each tweet was coded for at least one function and one plot but as many codes as were relevant were applied. I coded all the tweets, Glenn Robert coded 60%, and Kay Leedham-Green coded 40%, so that each tweet was coded independently by two coders before they were discussed, and coding agreed. Anne Marie Rafferty audited the coding. Kay Leedham-Green and I narratively coded for metaphors in tweets, and *in vivo* coding was used to capture explicit mentions of what the NHS was being thanked for, and references to groups or individuals to whom the thanks was being addressed.

4.2.4 Ethical considerations

Although Twitter is a public platform and this research does not include sensitive personal information, private people may have an expectation that their tweets are specific to the context of Twitter rather than being the subject of research. We drew on recommended frameworks for ethical use of social media in research (franzke et al., 2020; Williams et al., 2017). In line with guidance for good practice, examples of tweets reported verbatim in the analysis are from corporate accounts or public figures for whom there is a reasonable expectation of publicity (NESH, 2019), or I obtained explicit permission to quote the tweet. Examples for which it has not been possible to obtain permission have been paraphrased.

Table 4.1. Typology of tweets of gratitude by function and form

	Code	Description	Examples (paraphrased)	No. of tweets coded
Function (what the tweet does)	Commemorating	Words of gratitude in relation to deaths.	Our Filipino comrades who worked in the NHS and social care and unfortunately and very sadly died due to the pandemic. RIP [Folded hands emoji]. Thank you for all your service. [collage of photos] [Named individual] came out of retirement after a long NHS career to help fight the pandemic. He lost his life saving others. Rest easy hero. Thank you for your bravery [Broken heart emoji]	31
	Commenting, Critiquing or Criticising	Commentary, on the nature of gratitude or an issue associated with gratitude.	This campaign isn't just about saying thank you now in the midst of Covid-19. It's about recognising everyone who works around the clock to keep the NHS going even when there isn't a pandemic happening. Thank you NHS When this is all over, I really hope we find a suitable way to thank the doctors and nurses who have come out of retirement to fight the pandemic, and all the NHS workers who are extremely special	114
	Describing or Sharing News	An announcement or a statement of news, including links to news articles.	[Penguin emoji] [Blue heart emoji] NHS PENGUIN CHICKS NAMED! These penguin chicks have been named after NHS heroes and hospitals. Our staff will make sure they're fully cared for, just like the NHS care for us every day. A thank you to all of our NHS Heroes [video of penguin chicks being weighed] So proud to reveal this amazing piece artwork created by #Banksy as a thank you to all those who work with and for the	407

			NHS and [named] hospital. An inspirational backdrop to pause and reflect in these unprecedented times. [photograph of artwork]	
	Instructing or Requesting	Instructions, requests, pleas, directions or invitations.	Paramedics came and took my partner to hospital today. He's been unwell for a while and wasn't getting better. Thank you #NHS for continuing your work and helping to save lives. Can all the idiots that don't think this is real stop going outside now please? Footfall in the city centre is down 90%. Thank you to everyone who's staying at home. Please stay 2 m apart when you go out. Thank you to the NHS, social care & essential workers who are out saving lives. Respect them. #StayHomeSaveLives	144
	Reacting	This is a response to receiving or witnessing an act of gratitude.	Thank you to the Queen for speaking for us all tonight in your thanks to NHS and keyworkers, for giving us confidence in our national virtues and also hope in these dark times. I am in absolute hysterics over this, it is the strangest supportive gesture I've ever seen. Can you imagine any NHS worker seeing this and thinking 'thank you I feel supported'? [quotes tweet featuring video of ferry of London's Woolwich Ferry performing 'doughnuts' on the Thames]	154
	Recognising	Enactment of gratitude. Words or performance.	Thank you to @NHSuk and all the medical staff around the world [red heart emoji] Nearly three weeks in hospital, nearly died, but today [named person] came home [Folded hands emoji]. Thought this day would never come. Thank you to our incredible NHS #COVID19 #NHSThankYou	638

	Signalling Values	Drawing attention to personal or professional values.	Our country is going to be tested. But I know that, if we emulate the selflessness, compassion and commitment of our outstanding NHS staff, police, firefighters and emergency workers, there is nothing that we cannot overcome. Thank you [praying hands emoji] Ramadan Mubarak to everyone welcoming in the month of Ramadan. I want to pay tribute to all the Muslims working in our NHS, our care service and elsewhere on the front line of our fight against coronavirus. Thank you for keeping us safe. [video message]	29
	Benefit	Refers to a benefit offered in thanks, usually as a perk.	Well done [named branch of a supermarket]. Well organised entry, checking NHS identities, fairly well stocked of the essentials and beautiful flowers to thank me for working for our NHS. Thank you I've closed my holiday house but I have the absolute pleasure of giving the keys to a local NHS worker who doesn't want to risk taking the virus back to vulnerable family members. Thank you to our amazing NHS staff and key workers.	68
Plot (what the tweet is about)	Fundraising	Initiatives to raise money in gratitude.	PE teacher Joe Wicks has raised £200,000 for NHS Charities Together fund through his online classes, in gratitude to the medical staff following his hand surgery. We're thrilled to reveal our new away kit which is available to pre-order now. Like the home shirt, it conveys our thanks to the frontline heroes of the NHS and is part of our wider fundraising efforts for them.	38
	Performance	Creative action, e.g. videos, drawings,	[Rainbow emoji] Rainbows have become a symbol of hope and the NHS during the current pandemic, so we thought what better way to show our thanks to our amazing NHS and key	291

		banners, buildings lit in blue.	workers, than to re-brand our bus to a rainbow NHS bus? [photo of bus] Thank you NHS [Clapping hands emoji][Thumbs up emoji] We're showing our support to the incredible NHS workers who are working tirelessly to help those affected by the pandemic by decorating a number of our postboxes. The postboxes are painted in NHS blue and say 'Thank You NHS'. [photographs of postbox]	
	Political, social or economic	Comments on political, social or economic factors in relation to gratitude.	Thanks for the clapping but after a decade of voting for a party who always stripped the NHS and tried to sell it off, it is a bit of an empty gesture. Please vote in the future for a party who supports the NHS if you mean that clap seriously The prime minister's nurses Luis (from Portugal) and Jenny (from New Zealand) now have their measure of his gratitude: confirmed that, on top of the taxes they already pay, they will have to pay the NHS migrant tax	100
	Social culture	Substantive comments on behavioural or social compliance or solidarity.	[Loudspeaker emoji] #ClapForCarers is happening again tonight at 8pm. Let's join together to say a huge thank you to all NHS staff, carers and key workers [clapping hands emoji] #ClapForNHS #ClapForCarers #ThankYouNHS I beg you, do not release sky lanterns as way of saying thank you to NHS workers. They are dangerous to people, wildlife and for the environment as a whole. Clapping is perfect. I haven't met an NHS worker yet who wants this [quote of tweet advocating releasing lanterns in support of NHS]	64
	Specific act	Specifies an action that is gratitude-worthy.	I want to put this on the record: thank you to everyone at [named hospitals] and all in the @NHSuk for working during	82

			Easter break. The sacrifices you are making to protect us are incomprehensible. Congratulations to final year medical students who graduated early this week. They will help @NHSuk respond to the extraordinary challenges of the pandemic. We owe you and everyone in the #NHS a huge thank you and wish you well. #ThankYouNHS	
	Treatment or care experience	Personal experiences with connection to treatment or care.	Two months ago my aunt was admitted into hospital with coronavirus. Our family was told to prepare for the worst. Today she was applauded by NHS staff as she left the hospital. As a family, you will forever be in our gratitude and prayers #NHSheroes Giving birth to twins prematurely during this pandemic and staying on the ward for a week has made me so grateful for the littlest things. Forever in debt to the NHS for doing their best for my babies.	134
	Words of Appreciation (words themselves enact the gratitude)	Expressions of thanks.	To everyone working hard for our communities and vital services - the NHS heroes and others: THANK YOU The Prime Minister has thanked doctors and nurses for the 'exemplary' care he received. "I can't thank them enough. I owe them my life"	634

4.3 Findings

Most of the expressions of thanks to the NHS in the dataset were 'behabitives' in that they enacted the social behaviour of thanking by their very expression (Austin, 1965). These expressions were often implicated in a variety of other functions, of which the most prominent were sharing news, describing care experiences, giving instructions or making requests, and commenting, critiquing, and criticising. Gratitude was also harnessed to narratives of generosity, through offering or receiving benefits (such as donations of goods and discounts) and fundraising as a material form of gratitude. Figure 4.2 shows a thematic analysis of the free coding of text in tweets that were specific about what the NHS was being thanked for. Personal attributes for which people were thanked are aggregated under 'virtues': these were dominated by dedication, selflessness, kindness, and bravery, but commitment, courage, generosity, positivity, and compassion were also mentioned.

A frequency analysis over time (Figure 4.3) shows that the number of tweets expressing gratitude to the NHS ramped up in the days preceding lockdown. For the next five weeks, a cyclical pattern of peaks is evident, showing that the social movement campaign, clap-for-carers, on Thursday evenings served as a potent attractor for tweets of gratitude over this period. Although there was no one turning point at which gratitude to the NHS became less visible in our dataset, by the end of April criticisms of clap-for-carers were beginning to take effect (the reasons for which are explored in Chapter 5) and the event started to lose traction. This is consistent with the findings of McKay et al. (2021) who, in their analysis of tweets associated with the NHS and Covid during the first lockdown, found a decrease in engagement after the first month, which they attribute to lockdown fatigue and the effects on tweeting habits of the limiting experience of staying at home.

Figure 4.2. What the NHS was thanked for in tweets of gratitude (themes receiving >1 mention)

4.3.1 *The clap-for-carers effect*

Clap-for-carers, or more properly, Clap-for-Our-Carers, was a UK-wide campaign that encouraged people to take to their doorsteps, balconies and windows to give a round of applause to NHS workers and other keyworkers every Thursday night at 8 pm. Official figures do not exist for how many people took part in clap-for-carers, but it was put at 'millions' (BBC, 2020b) and a YouGov poll of 1664 adults in June 2020 found that 69% of respondents said they had taken part at least once (Abraham, 2020).

Figure 4.3. Number of tweets meeting inclusion criteria retrieved by Twitter search between 1 March and 21 June 2020

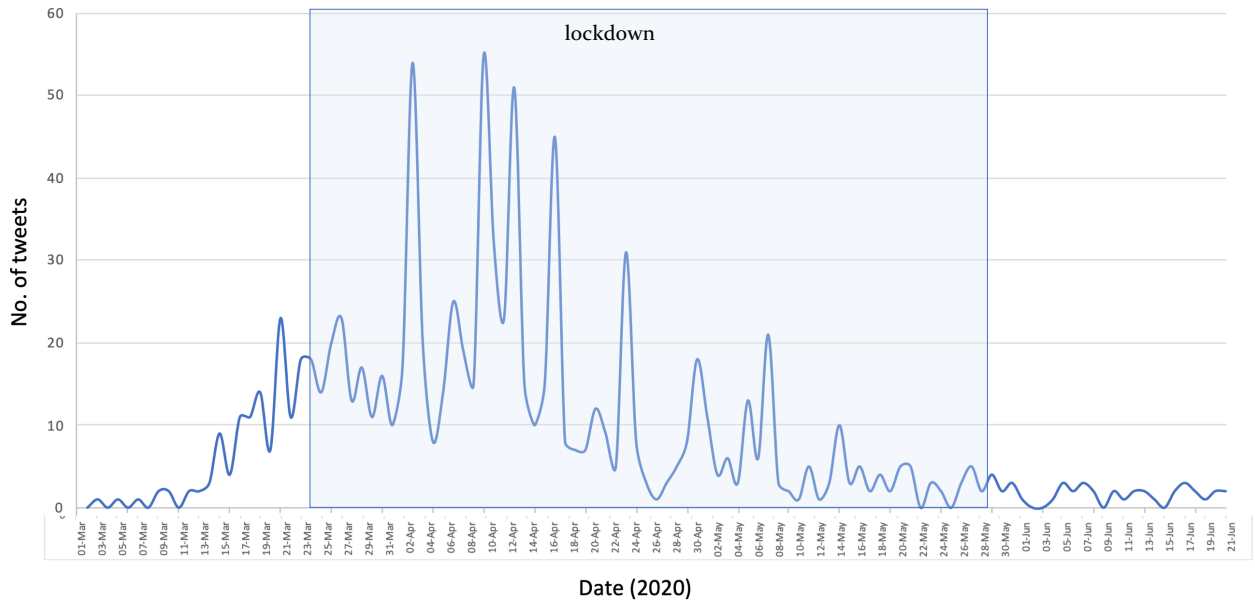


Figure 4.4 shows a streamgraph of our coding of tweets over time, annotated with events that featured in tweets on particular dates. Tweets associated with clap-for-carers tended to include performances, with videos of applause often shared in these tweets. Tweeters also used it as an opportunity for words of appreciation directed to the NHS and key workers – numbers of tweets coded for 'recognising' 'performance' and 'words of appreciation' peaked on Thursdays throughout the study period.

Participation in clap-for-carers featured in two of the three most 'liked' tweets in our corpus, both from 26 March 2020: one shared a video of the Duke and Duchess of Cambridge's children clapping, and the second was of the Prime Minister and Chancellor of the Exchequer clapping outside 10 Downing Street. But the tweet that gained the most traction (>300,000 likes, >40,000 retweets) was posted on 6 April and showed an 84-year-old man being wheeled out of intensive care to the applause of hospital staff having, against the odds, recovered from Covid. This role reversal in which healthcare workers – the original audience for the applause – reciprocated the clapping, often featured on social media posts. These tweets were either in the context of scenes outside hospitals in which healthcare workers participated in clap-for-carers, or they were shown lining the corridors to applaud when patients were discharged

from intensive care units. Occurrences of staff applauding patients were featured in the BBC documentary series *Hospital*, and an example is considered in Section 6.6.4.2.

Only the hospitalisation of the then Prime Minister Boris Johnson for treatment for Covid-19 and his discharge from hospital rivalled clap-for-carers as an inducement to tweet about gratitude to the NHS. In reaction, there was a concomitant increase in tweets that harnessed thanks to commentary about pay and conditions for healthcare workers, for example:

> It would be wonderful to see Boris Johnson turn his gratitude into influencing vastly improved conditions and wages for NHS staff and carers. (12 Apr, paraphrased)

This focus on the nature of work (and, by extension, 'doing' in phrases like 'all you are doing' which is included in the category 'effort' in Table 4.1), how it was characterised, and in what ways it was worthy of gratitude, featured strongly throughout our corpus.

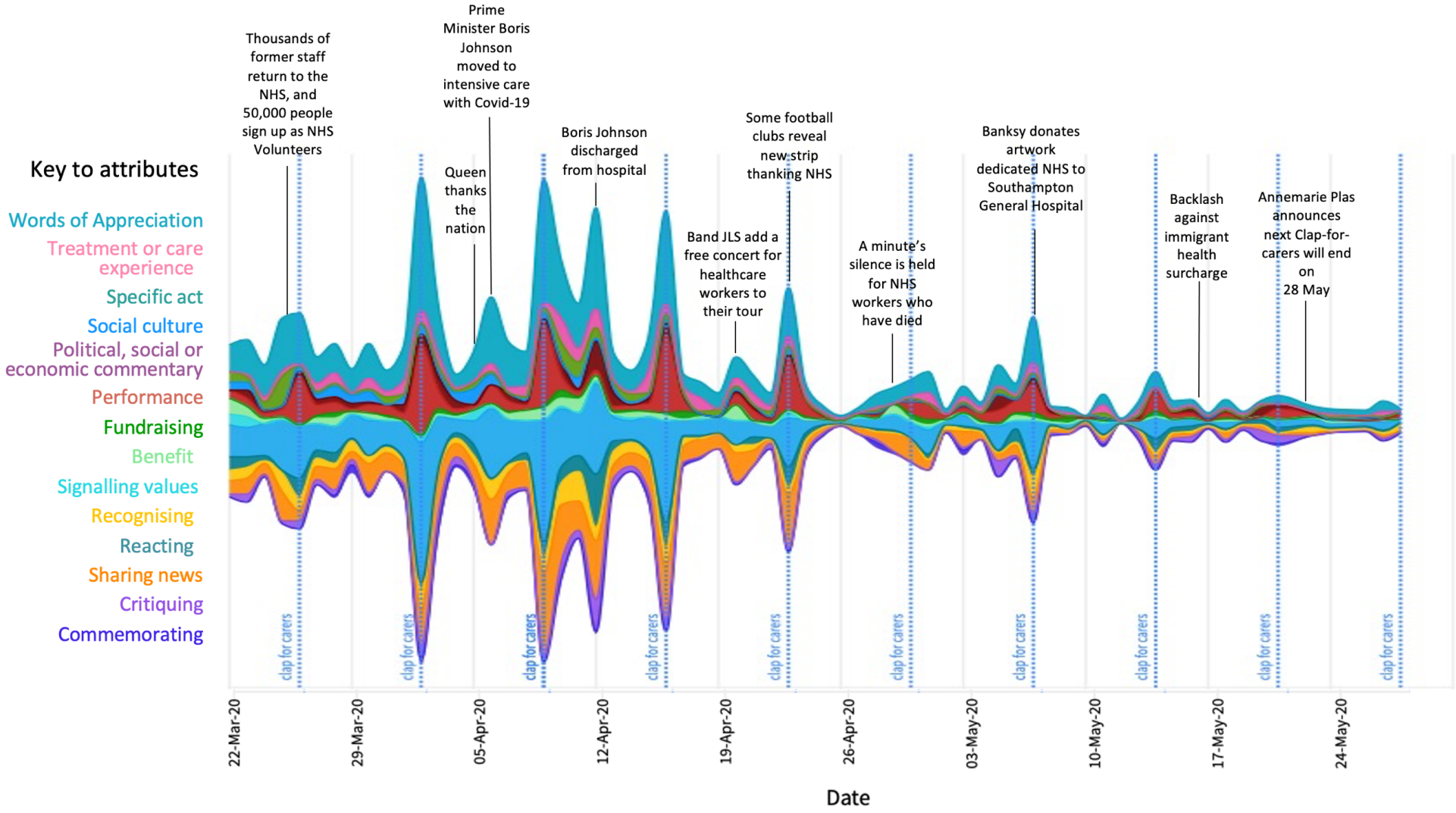
4.3.2 *The idealisation of work*

Over a quarter of tweets thanking the NHS implicated work in their appreciation. The most often used qualifier was 'hard', but references were often made to time: 'round the clock', '24/7', 'day and night'. The adverb 'tirelessly' was most often associated with 'working'. A typical example was:

> We want to thank every person who's working tirelessly to keep this country healthy. We're so lucky to have the NHS and want you to know how grateful we are for your selfless hard work during this terrible time. We're #StayingAtHome for you and the incredible work you're doing (3 Apr, @jlsofficial)

Other frequently used qualifiers to describe work included 'amazing', 'fantastic', 'great', 'incredible', and 'magnificent'.

Figure 4.4. The evolution of types of tweets of gratitude during the first UK lockdown, annotated with relevant events. The size of each individual stream shape is proportional to the occurrence of attributes of tweets



There is pronounced asymmetry – perhaps even an irony – between the characterisation of work in thankful expressions and the nature of the work being thanked for: someone can be praised for 'doing fantastic work' whilst the rationale for thanking is predicated on an acknowledgement that the work was not fantastic to do. Similarly, describing NHS staff as working 'tirelessly' is contradicted by the welter of narratives of strain which emphasised fatigue and exhaustion. In common with McKay et al. (2021) we were struck by the powerful disconnect between the symbolic and the tangible to emerge in tweets relating to the pandemic. They found that symbolism centred on the language and performance of valorisation was undercut by escalating hospitalisations and deaths. This disconnect is especially evident in our dataset in the ways in which 'saving' was referred to as a reason to thank the NHS.

4.3.3 *Saving the NHS and saved by the NHS: mutually constructed fragility*

Of the 482 instances that specified what the NHS was being thanked for, 37 referred to it as saving lives and 19 to the NHS 'keeping us safe'. Although some referred to specific treatment experiences in which 'saving life' was justified, most of these references were generalised:

> Thank you to everyone in the NHS for tackling coronavirus and risking their lives to keep us safe. (25 Mar, paraphrased)

The concept of the NHS keeping people safe, like 'working tirelessly', is difficult to square with the reality. In the early stages of the pandemic, the NHS was powerless to keep people safe. The construction of the NHS as keeping us safe contrasts with the – literal and positional – central injunction of the UK government's three-part slogan at the beginning of lockdown: 'Stay at home. Protect the NHS. Save lives.' This phrase, found to be very effective in mobilising public affect (Jackson et al., 2020), signals the vulnerability of the NHS and links the saving of lives to the public staying at home. However, the representation of the NHS in tweets of gratitude enact an assumption reversal in which the NHS is construed as protecting and saving.

4.3.4 Caring made visible

In her wide-ranging exploration of care published at the start of the pandemic, Bunting (2020) describes care as the 'invisible heart' and calls for greater acknowledgement in terms of recognition, funding, respect and value. The provision of care extends to a much wider context than that provided in the NHS to which our analysis specifically speaks. However, the prominence of care as an object for people's thanks suggests that care became more visible, and better appreciated, in pandemic discourse. The word 'care', unlike 'work', connotes a relationship, reinforced by the verbs with which it was often accompanied in tweeter's phrases: 'giving care' and 'taking care'. Gratitude for care tended to be more specific than those for 'work' or 'saving', with about half referring to treatment experiences of named patients. The prominence of narratives of care was also apparent in our analysis of those to whom gratitude was addressed. Carers were the third most-mentioned thanked category, after workers and staff. The word 'carers' in 'clap-for-our-carers' was probably chosen for reasons of alliteration, but, given the early-stage success of the campaign, it may have contributed to raising the profile of all carers. An outcome may be that the social reimagining of care work done by those exposed to risk and precarity, as called for by Rossiter & Godderis (2020), seemed more likely in a post-pandemic world, although in 2023 this has yet to materialise.

4.3.5 Meaningless or meaningful?

Sorace (2020) has argued that gratitude is the 'ideology of sovereignty in a crisis', too easily slipping from the recognition of individuals to an acceptance of the systems that reproduce their exploitation. When gratitude was suspected as being used as a substitute currency – supposed to compensate for low pay and unsafe working conditions, or to offset policies deemed exploitative – it was reacted to, unsurprisingly, with suspicion and resentment:

> I wasn't bowled over with gratitude with the clapping for the NHS. Great for morale but does not give us equipment or protective gear. Nice gesture but gestures don't translate to treatment. (27 Mar, paraphrased)

> The government is determined to depoliticise this crisis. Badges for carers it fails to protect, handprints for refugees it fails to fund, heartfelt thanks to the NHS staff it fails to equip. No. The UK's disaster is not an act of God, but of epic criminal mismanagement. (20 Apr, @jonlis with permission)

> ICU [Intensive Care Unit] nurses who saved the life of Boris Johnson now have their measure of his gratitude: confirmed that they will have to pay the NHS migrant tax on top of the taxes they already pay. (16 May, paraphrased)

An alternative construction of gratitude though, most prevalent in our dataset, is that expressions of thanks elicited reciprocal gratitude and brought moments of pleasure amidst the awfulness of the pandemic:

> Coming out of work tonight and there's a huge sign at the entrance of the hospital that members of the public have made saying 'thank you NHS workers'. It's little things like that that make you smile at the end of a 12 hour shift [Smiling face emoji] (23 Mar, paraphrased)

> On way home from work this evening called into a garage, the young man serving me noticed my lanyard and asked if I worked for the NHS. I said yes, there's a free tea or coffee there for you he said. Such a small act of kindness at the end of a long day spoke volumes. Thanks (24 Mar, @eamroulston with permission)

> My wife and I are #NHS consultant radiologists preparing for surge in #COVID19, with 3 small children. Close to tears from this unsolicited act of kindness from our wonderful neighbour Emma, who left this on our doorstep. Thank you! #ProtectOurNHS #StayHomeSaveLives #clapforNHS (17 Apr, @hudson_benjamin with permission)

In this instance, gratitude is not ineffectual. Neither was it unimportant for those proffering their gratitude, many of whom found it to be a 'feel good' moment of solidarity:

> #ClapForCarers was the moment we all needed. NHS workers are the best of us. Thank you everyone (26 Mar, paraphrased)

> Extraordinary support and togetherness across the country for our brave and brilliant NHS doctors, nurses and carers. Brings a tear to the eye. Wonderful. Thank you. (26 Mar, @GaryLinekar)

> I think one reason why people really go for the clapping - apart obviously from wishing to show gratitude to the NHS - is that it's our one chance now to do anything at all communal. And humans do actually need communality (9 Apr, @baddiel)

Emotions voiced by tweeters that were often allied to expressing gratitude, particularly in association with clap-for-carers were pride, love, and hope. In our dataset, about one in six tweets invoked solidarity and 'togetherness' as a value they appreciated.

4.3.6 Creative action online

The term 'bloom space' is used by Seigworth and Gregg (2010) to describe the capacities of affect to herald something next or new, even as it patterns itself on familiar choreographies of cultural action and social practice. What bloomed during lockdown were grand gestures such as football fields marked out with 'Thank you NHS', buildings lit up in blue, and a slew of dance crazes.

Amongst the more unusual creative acts that featured in our dataset was the release of a song called 'Thank You Baked Potato' by actor and comedian Matt Lucas to raise funds to provide meals for NHS workers. Also, rescued kittens, police horses and other animals were named in honour of the NHS, such as penguin chicks at Chester Zoo:

> These FIVE fluffy penguin chicks have been named after NHS Heroes and hospitals. Our zookeepers will make sure they're fully cared for, just like the NHS care for us every day… A little thank you to all of our NHS Heroes, from us [blue heart emoji] [video of penguin chicks being weighed] (5 May, @chesterzoo)

The most high-profile act of honorific naming was when Boris Johnson and his then-fiancée Carrie Symonds included 'Nicholas' amongst the middle names of their son in recognition of Dr Nick Price and Professor Nick Hart, who treated the prime minister when he was hospitalised for coronavirus.

In spite of the deadly seriousness of the pandemic, clap-for-carers created a performative opportunity for playfulness – sometimes to the bemusement of onlookers.

> I am in absolute hysterics over this, it is the strangest gesture I've ever seen. Imagine any NHS worker seeing this and thinking 'thank you I feel supported'. [quotes tweet featuring video of ferry of London's Woolwich Ferry performing 'doughnuts' on the Thames] (17 Apr, paraphrased)

The escalation of celebratory street-side performances, and the wave of fundraising efforts, had a polarising effect, with some revelling in the celebratory atmosphere and others being infuriated by it:

> Loved #Clapforcarers tonight. We had fireworks. Fireworks! Truly deserved. Thanks to each and every one of you @NHSuk (2 Apr, @alisonhammond)

> We're being played. Firstly, go out and clap hands to thank NHS, then bang pots 'n pans, then fireworks. Now they want our money. I quote Henning Wehn, German comedian: "We don't do charity in Germany. We pay taxes. Charity is a failure of Govts responsibilities". Don't be sheep. (23 Apr, @SueBon22, with permission)

In their study of national celebrations, Sullivan and Day (2019) argued that 'emotional enclaves' arise which question the credibility of celebrations by challenging their appropriateness, inclusiveness, or representativeness. As is borne out here, celebratory activities are always accompanied by the potential for calling out behaviours as discreditable and shameful. Social media tends to be dominated by the emotional climates of celebration, congratulation, and condemnation, with one construction readily morphing into another. This aspect of clap-for-carers is discussed in more detail in Section 5.5.

4.4 Discussion

This study set out to explore gratitude expressed in tweets to the NHS during the early part of the pandemic. We took a methodological approach that moves away from the dominant sociocognitive model for investigating gratitude to one that is more discursive. We followed the stance of those exploring other situated social actions,

such as apologies (Augoustinos et al., 2007), in treating variation and contradiction as prime analytic resources. Online incivility and harassment in communication is often associated with Twitter (see, for example, Maity et al., 2018; Tekin & Drury, 2022; Theocharis et al., 2020), but gracious communication receives barely any research attention. Whilst gratitude was linked to cogent criticism, sarcasm, self-aggrandisement, parody, 'virtue signalling', and hypocrisy in some tweets, the overwhelming majority of tweets in our dataset highlighted a different, more civil, side of Twitter: one in which gratitude was associated with recognition, appreciation, valorisation, congratulations, respect, compassion, generosity, humility, and enthusiasm.

A notable finding was that a nationwide, communal event – clap-for-carers – served as a nexus for thanking activities on social media, particularly in its first few weeks. Our analysis shows that meanings imputed to the acts of gratitude were highly mobile over our study period. Gratitude became the subject of competing and conflicting notions over what ought to be the focus of press and public attention, notions that were proxies for ideological battles over roles and responsibilities. In tweets about what constituted appropriate gratitude, displays of appreciation were characterised as being incommensurable with failures of responsibility. This applied both to tweets addressed to politicians ('if you were truly grateful to the NHS you would ensure that healthcare workers had PPE') and to the public ('it's very irresponsible to clap for the NHS on Thursday nights and then fail to follow the advice on social distancing').

The clap-for-carers case shows that the initial unity of purpose for the event lost coherence as it became ritualised and attracted criticism as being out of step with the exigencies of the pandemic. In the later stages of lockdown, gratitude was construed as misplaced and, in some cases, as offensive. It induced guilt in NHS workers who felt they were not able to do enough to merit the public adulation or felt pressured to act in ways that went beyond what could reasonably be expected (Cox, 2020). Greenberg et al. (2020) have drawn parallels with the NHS during the pandemic and the military to explicate the threat of 'moral injury' during the pandemic – a term describing psychological distress that results from challenges to one's moral code –

applicable to healthcare workers having faced impossible decisions about the allocation of scarce resources to equally needy patients.

The analysis of repeated instances of thanking in tweets in the specific context of the Covid pandemic in the UK revealed common repertoires of gratitude circulating in the public discourse surrounding the NHS. Many of the constructions of gratitude in our dataset could be described as 'wishful thinking' in that they cast the NHS as indefatigable and praised it for achieving the impossible during the early part of the pandemic: keeping us safe. Further work is warranted on whether thanking routines are intrinsically hyperbolic, perhaps as an intensification strategy, and/or if concepts circulating in public discourse (like 'tired' and 'save') have their cognates more readily incorporated into thanking expressions, irrespective of descriptive accuracy.

Discussions, in the press and on social media, of whether gratitude to healthcare professionals is appropriate echo long-running debates on whether gratitude can ever be due to institutions or those who are carrying out their professional duties within them. Simmons (1979) maintained that if the individuals occupying roles are merely doing their jobs, then no gratitude is due, and there may even be something illegitimate about applying the principle of gratitude to institutions. McConnell (1993) counters this, saying it is 'too quick to conclude that if an individual who helps provide you with a benefit is merely doing her job, then no gratitude is owed' (p. 194). McConnell's stance is borne out by the proliferation of social practices of gratitude evident in our dataset. The referencing of gratitude in the pandemic might appear to challenge the traditional conception – evident in both Simmons' and McConnell's constructions – that gratitude is a response to receiving a benefit. Many of those thanking the NHS were not expressing appreciation for a clear-cut benefit like treatment. Yet the analysis of what the NHS was thanked for reveals that benefits were no less real for being psychological projections: the NHS engendered expressions of feeling safe and protected.

4.5 Implications

This study supports the contention by Shaw (2013) that gratitude is implicated in assurances of 'mattering' that contribute to a moral community. Benefits that

stimulate gratitude convey the notion that others care about us and that we are worthy of their care. There is an evidential base for gratitude being linked to social, emotional, and psychological wellbeing (Jans-Beken et al., 2019). In the face of a concomitant mental health pandemic, the denigration of acts of gratitude, on social and in mainstream media, may discourage people who could potentially benefit from the wellbeing effects of practising gratitude. The potential for humiliation can be persuade people to act in ways that are incompatible with their own values-based inclinations (Svindseth & Crawford, 2019).

A House of Commons report highlighting the impact of workforce burnout identified lack of recognition as a significant contributor to feelings of 'abandonment' from sectors, like social care and pharmacy, that felt excluded from the public recognition being afforded the NHS in the early part of the pandemic (House of Commons Health and Social Care Committee, 2021). As we 'build back better', attention needs to be given to spaces and places that accommodate gratitude – not only in healthcare but in society in general. This is not to say that expressions of gratitude should be immune to criticism, but people's anticipation of accusations of inauthenticity and virtue signalling may discourage thanking activities that, if enacted, could make a real difference to motivation and morale.

The study also has implications for how the pandemic is remembered in popular culture and commemorated. Clapping has already become a shorthand for the disconnect between social appreciation and political intransigence. We need look only to the way in which sentiments like 'Blitz spirit' still influence people's strategies for coping in times of crisis (Jones, 2020) to realise that the way the pandemic is commemorated will influence how we respond to future crises. Given how contentious thanking the NHS became during the pandemic, the ways in which gratitude to healthcare workers is incorporated into commemorative acts and material culture should be the subject of extensive consultation to maximise its chances of striking the appropriate tone.

4.6 Strengths and limitations

An innovative aspect of this study is that we have developed a typology for thanking expressions that may be applicable to categorising gratitude in other contexts. This research benefited from a robust approach to data collection and analysis. Tweets were considered as a whole – including images and videos – which are not usually captured by data-scraping methods. The consensual approach to coding, whilst time consuming, allowed for a reflexive attitude to our data. We do not claim, however, that tweets constitute the 'naturally occurring talk' preferred by those using a discursive psychology methodology. Although they are 'natural' in that they are not intentionally solicited by a researcher, the search-and-retrieval methods necessary to assemble a dataset, and the opacity of Twitter's proprietary search algorithms, make data retrieval analogous to elicitation.

Acts of true creativity in thanking practices are likely to employ semantics that elude search strings even when those acts are highly culturally salient. An example is that the discourse surrounding Captain Tom's extraordinary fundraising activities for NHS Charities (BBC, 2020a) did not feature strongly in our dataset in spite of being a dominant narrative that featured an outpouring of gratitude during the first lockdown. Thanking exchanges took place mainly between Captain Tom and donors to his campaign with the NHS being invoked only occasionally in tweets that met our inclusion criteria. By focusing on 'micronarratives', some of the 'macronarratives' may be underrepresented, both because of our restricted search terms and by the purposive selection of attention-garnering tweets rather than relying on a random sample. As Venditti et al. (2017) have pointed out, social media use is driven by more than the spontaneous practices of users – it includes strategised activities, including 'liking', that are determined by the specific architecture of the platform. Insights into the pragmatics of user interactions are not available to researchers examining content, and care needs to be taken not to equate 'liked' tweets with public approval beyond the context of Twitter.

4.7 Conclusion

This study has presented a framework for analysing gratitude expressed on social media which was applied to attention-attracting tweets that engaged with gratitude to the NHS during the first lockdown of the Covid-19 pandemic in the UK. Thanking practices and attitudes to gratitude were dynamic and responsive to events. Gratitude was both *performed* and *critiqued* on Twitter, affording valuable insights into its discursive function and social value. The quantitative data indicated distinct patterns of activity, complementing the qualitative analysis that investigated the purpose and content of expressions of gratitude. The ambivalence surrounding gratitude revealed in this study does not render it unhelpful as a sociological construct. On the contrary, it highlights the volatility of emotion in ritualised social performances and how susceptible these are to context. The study shows that gratitude has figured as a prominent, if contentious, social value, catalysing debates about social behaviours and prompting a reappraisal by many of the risks and rewards of healthcare and social care work.

Chapter 5 Performing gratitude: a case study of the clap-for-carers movement

In the final chapter of *The House at Pooh Corner* by A. A. Milne, there is a vignette that is insightful about the nature of solicited gratitude. The characters gather at Pooh Corner to say goodbye to Christopher Robin. Eeyore reads a poem he has written:

> 'If anyone wants to clap,' said Eeyore, when he had read [his poem], 'now is the time to do it.' They all clapped. 'Thank you,' said Eeyore. 'Unexpected and gratifying, if a little lacking in smack.'

Having nudged his audience to applaud, Eeyore disingenuously calls the clapping 'unexpected' and then critiques it as 'lacking in smack'. The vignette's wittiness relies on the reader's recognition that Eeyore lacks the insight that asked-for gratitude is inevitably not as fulsome as unprompted expressions of appreciation. The vignette prefigures some of the ambivalence about public performances of gratitude to the National Health Service (NHS) in the early stages of the Covid-19 pandemic, most prominently the clap-for-carers movement, in which millions of people participated in a campaign to applaud healthcare workers from doorsteps, windows, porches, and pavements.

This chapter offers a case study of the clap-for-carers phenomenon. Using the lens of performance, and extending the macro, societal level analysis begun in Chapter 4, I draw on theories of affect and social practice to account for the emergence, flourishing, and demise of the event. I trace its trajectory in public discourse from its inception as 'thick' civic engagement to its construal as an opportunistic political tactic and – ultimately – a dangerous distraction that authorised unrealistic expectations of healthcare workers. Although clap-for-carers as a synchronised communal practice was relatively short-lived, I argue that it has a lasting legacy in the debates it spawns about the role of expressions of gratitude in collective life,

particularly in the contexts of affectual authenticity and care justice. A version of this chapter is forthcoming as Day (2023).

5.1 Setting the scene

The clap-for-carers initiative seemed at first to be an unambiguously positive counterpoint to the dawning reality of the disaster about to be wreaked by the pandemic. Yet, for all the apparent simplicity of its structure, clap-for-carers was a complex and polysemous phenomenon. Throughout its run in the British summer of 2020, and the failed attempt at its revival at the start of the third national lockdown in January 2021, participants morphed between roles of audience, performers, and critics. As I will elaborate, these ideologies were enacted through competing discourses that swirled around the weekly event – discourses that were suffused with references to embodied, symbolic, and imagined performances.

Performance and healthcare have a history of shared analogies. As well as a mutual preoccupation with 'gazes and stages' (discussed by Mermikides, 2020), dramaturgical metaphors are prevalent in medical discourse. Operations are 'performed' in a 'theatre', medical professionals are defined by 'roles', and protocols are often developed as 'scripts'. Schechner (2020) draws attention to the carefully crafted codes of dress and behaviour in medicine that make it, along with professions such as law, a specific category of performance. Thus, imagining the healthcare worker as laudable for 'performing care' in the perilous context of a pandemic was a readily available interpretation. This was all the more conceivable in the context of a pandemic in which expectations of roles deemed 'key', 'essential' and/or 'frontline', and concomitant risks, were a focus of acute attention.

Like the coronavirus, clap-for-carers was infectious. Its transmission was aided by the intensive involvement of mainstream and social media, and an organised campaign (#clapforourcarers – although the 'our' was often dropped, probably for reasons of better scansion). Amidst the disciplined commitment to strictures demanded by the government to control the spread of the virus, clap-for-carers allowed for a state-sanctioned interval of cathartic hubbub. The resulting street-side

performances were simultaneously earnest and playful, with some morphing into elaborate spectacles that found appreciable audiences on social media.

The act of clapping as an expression of communal appreciation takes its cue from theatre although its function is far from straightforward. Kershaw (2001) invokes a medical analogy when he suggests that applause might be an 'index to the health, or the disease, of a whole culture' (p. 134). He argues that the commercialisation of theatregoing has contributed to applause relinquishing its cultural power to judge the value of a performance. Instead, applause has become 'fatally tinged with a narcissistic self-regard' (Kershaw, 2001, p. 144) – an accusation that also came to be levelled at participants in clap-for-carers. The timing of applause is also significant. In the theatre applause is usually a coda to a performance. Appreciation is expressed once a benefit has been realised. When gratitude is enacted in anticipation of a benefit, it runs the risk of being perceived as manipulative. Could the timing of the clapping – at the start of the pandemic – lend credence to the claim by Juri that clap-for-carers was a form of social distancing, separating those who 'do' on our behalf from those who merely 'watch' (Juri, 2020: online)? Were we, Juri asks, applauding gladiators entering arenas to fight lions?

5.2 Dramatic structure

Overture. Clapping for healthcare workers began in Italy, as an extension of impromptu balcony concerts, video footage of which started appearing on social media on 12 March 2020. From 14 March, people in Italy, Spain, and Portugal took to their doorsteps and balconies – often timed to coincide with hospital workers changing shifts – in what the media often described as a 'standing ovation' for healthcare workers (see, for example, Booth et al., 2020; Slisco, 2020). Other countries around Europe followed, and by the end of March, synchronised applause was being reported from cities across North America, and some in Asia like Singapore and Mumbai.

Curtain Up. In the UK, the Clap for Our Carers campaign started with an Instagram post (Figure 5.1) by Dutch Londoner, Annemarie Plas, and the first national event took place on 26 March 2020. Plas received assistance from a professional communications

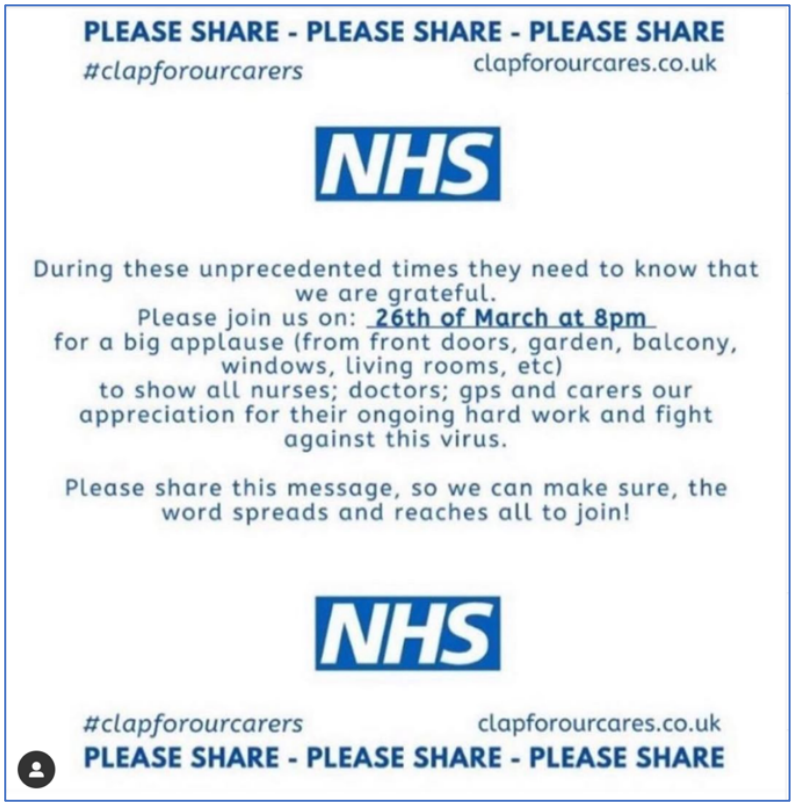


Figure 5.1. The original post from Annemarie Plas calling for applause

agency, Creative Clinic, to create a website and a visual identity for the campaign. Unlike some European countries where the applause took place every night until well into May when lockdown restrictions started easing, the UK's clap-for-carers was a weekly event held on Thursdays at 8 pm. In response to criticism that it was not just the NHS that deserved appreciation, the applause was extended to all keyworkers from 2 April (Plas, 2020), although it never shook off the impression that it was aimed primarily at healthcare workers.

Rising Action. The simplicity of clapping – no special equipment required – encouraged mass participation, with many augmenting their noise-making by banging pots and pans, cheering, whistling, and/or playing musical instruments. In some areas, the Thursday-night clapping morphed into impromptu concerts, perhaps causing the applause to be redirected to the performers rather than healthcare and key workers for whom it was originally intended.

Although applause is primarily an audible phenomenon, the affordances of social media transformed it into a very visual one. Photographs and videos of people, including high-profile public figures and celebrities, participating in the applause flooded social media every Thursday night. Tweets of gratitude to the NHS were

significantly augmented by the event (c.f. Figure 4.4). The clapping was part of wider action to express thanks to the NHS. Owing to the lockdown, some of these spectacles were able to have an audience only through being made visible on social media, for example thanks marked out on football pitches closed to fans, and drone-footage of messages mowed into farmers' fields.

The dramatic tension increased on 27 March 2020 when Prime Minister Boris Johnson and Health and Social Care Secretary Matt Hancock tested positive for Covid-19. The next day Amged El-Hawrani became the first frontline NHS hospital worker to die from the disease amidst growing criticism of the government for failing to provide personal protective equipment (PPE) and testing for healthcare staff.

Climax: Clap-for-carers reached its apogee around the second week of April. No official figures exist for how many people took part in clap for carers, but it was put at 'millions' by the BBC (BBC, 2020b) and a YouGov poll of 1664 adults in June found that 69% of respondents said they had taken part at least once (Abraham, 2020). The event was given impetus by the discharge from hospital of Boris Johnson on 12 April after treatment in intensive care. He issued an effusive statement expressing thanks to the NHS, and two nurses in particular, for saving his life. Later in April, a campaign to raise £1000 for the NHS Together Charities by 99-year-old Captain Tom Moore by walking 100 lengths of his garden gained momentum – it would eventually raise nearly £40 million. In an example of reproducing and repurposing creative action, a number of videos circulated on social media of healthcare staff applauding patients leaving hospital after recovering from Covid-19.

Conflict: A number of critical moments can be identified that started to erode the moral authority of the clap-for-carers initiative. Prominent from the start were accusations of hypocrisy aimed at Conservative government ministers who, when tweeting about taking part in clap-for-carers, were swiftly reminded of an incident in 2017 when Conservatives celebrated having voted against an amendment to end a public sector pay cap, widely paraphrased as voting against a pay rise for nurses (Figure 5.2). The clap-for-carers phenomenon also attracted criticism for attracting crowds outside hospitals in defiance of social distancing guidelines. Westminster

Figure 5.2. Tweet from Matt Hancock with an example of one of the many critics to include a clip of Conservatives voting against the lifting of a public-sector pay cap

Bridge, which affords a view of St Thomas' Hospital, was a particular focus for concern (Heren, 2020).

The release of a video, 'You clap for me now', on 14 April also proved divisive. It featured workers from black and global majorities reading lines from a poem by Darren Smith, highlighting discrimination faced by immigrants working in key services (D. Smith, 2020). The video divided opinion, with many embracing its anti-racist message but others expressing outrage at the politicisation of the clap-for-carers event and describing it as 'petty moralising' (Gray, 2020). Yet another factor which destabilised the event was a widely shared article in *The Guardian* by an anonymous NHS doctor who decried the clapping as a 'sentimental distraction from the issues' and referred to 'creeping clapping fascism' (Anon., 2020).

Curtain down. On 22 May, Annemarie Plas, the originator of the campaign in the UK, announced that the 'Clap for Our Carers' should end, saying that it had 'become politicised' and that she did not want it to be negative. A third of respondents to a

YouGov poll agreed that it had become politicised with 63% agreeing with the decision to end the formal campaign (Abraham, 2020). The final organised clap-for-carers took place on 28 May. There was an attempt to commemorate the NHS's 72nd anniversary on 5 July at 5 pm, but had limited success.

No second run. On 6 January 2021, just as the third national lockdown got underway, Annemarie Plas announced that #clapforourcarers was being relaunched as #clapforheroes. It was patterned on #clapforourcarers with clapping called for at 8 pm. The proposed event generated a negative backlash on social media. Plas issued a statement saying she and her family had been targeted by abuse and she was distancing herself from the applause and would no longer be promoting it. With the exception of a few corporate supporters, hardly anyone participated, and the event was not readvertised.

5.3 Gratitude as affect

Clap-for-carers is an example of socially sychronised affect. As a concept, affect is attributed to Spinoza whose argument in *Ethics* in 1677 took the form of a geometric proof written in Latin – a rhetorical tactic that, in spite of its formulation in logic, has led to much conceptual ambiguity (Robinson & Kutner, 2019). In the context of this case study, I take affect to be a dynamic capacity for embodied action, that acknowledges the role of emotion – in this case, gratitude – in motivating, participating in and resulting from social encounters. Affect is often described as an 'energy' that characterises structure of expression and connection, particularly with respect to rituals of public and private life (Papacharissi, 2015), or 'a force' that marks a body's belonging to a world of encounters (Seigworth & Gregg, 2010).

What is the value of taking the lens of affect theory to the clap-for-carers event? Orientations to affect aspire to explore, rather than explain, the mobilisation of people through connections and expressions oriented to other people via embodied thoughts and/or ideas. The emphasis on dynamism and networked flows, known as 'affective attunement' (Papacharissi, 2015), resonates with the clap-for-carers event that propelled people in lockdown to leave their sofas and engage in the rhythmic entrainment of applause for an audience imagined as healthcare and other key

workers, but also for themselves, their neighbours and – for many – a virtual audience online.

Applause is a particular form of cultural patterning for the expression of appreciation. It is one of the principal means by which people share in collective emotions or emote together (Sullivan & Day, 2019). Drawing on a theory of affect advanced by the American psychologist Silvan Tomkins, Gibbs (2010) argues that mimetic communication, of which applause is typical, forms the affective basis for social processes and social bonding, fostering a 'sense of belonging'. Clap-for-carers was both a response to and a reinforcement of the myth of social togetherness in the face of the prohibition of physical togetherness during the pandemic. Here I use 'myth' in the Barthesian sense as a culturally resonant, sense-generating narration of events rather than a falsehood (Barthes, 2000, f.p. 1957). Times of threat often fuel rhetoric around 'togetherness' which is harnessed to stoicism and resilience, and this was apparent in tweets referencing social cohesion in the context of clap-for-carers (for example Figure 5.3).

Figure 5.3. Tweet emphasising 'togetherness' in the context of clap for carers.

Jones (2020) has pointed out the parallels between responses to Covid-19 and the Blitz, arguing that the Blitz phrase, 'we are all in it together and we all need to come out of it together' was central to how people behaved in the first Covid lockdown. 'Blitz spirit' in Britain in the Second World War, as characterised by Kelsey (2013, p. 83), was a 'simple but powerful script' for ideological messaging. A survey of 1200 people on 21 April 2020 found that the belief that 'we are all in it together' was the most important factor driving self-reported lockdown compliance. Acting for the

common good was found to be centred on sentiment supporting the NHS (Jackson et al., 2020), suggesting that placing the slogan 'Protect the NHS' at the centre of the tricolon 'Stay at Home, Protect the NHS, Save Lives' was highly effective in mobilising public affect during the first national lockdown.

5.4 Gratitude and morale

Clap-for-carers arose out of an implicit but obvious anticipation of threats to the morale and wellbeing of healthcare workers posed by the pandemic. Morale in the NHS had been a matter for concern for decades before the pandemic. Constraints on funding and pay, increasing workloads, long waiting lists for procedures, and insufficient bed capacity all contributed to a sense of impending crisis. Surveys found the majority of nursing staff felt overworked and underpaid (Marangozov et al., 2017), and that a third of doctors were 'burned out' and suffering from secondary traumatic stress (McKinley et al., 2020). The King's Fund, an influential charity with a focus on driving improvement in healthcare, has consistently highlighted that a major contributing factor to the erosion of morale is that staff feel undervalued (Burkitt et al., 2018; Finlayson, 2002; King's Fund, 2014). Surveys of the public before the pandemic, however, consistently show a strong and appreciative relationship with the NHS (Burkitt et al., 2018). It is perhaps the contrasting discourses of demoralisation amongst healthcare workers against overwhelmingly appreciative attitudes to the NHS that gave impetus to public support for clap-for-carers in its initial stages.

The relationship between receiving gratitude and raising morale is poorly theorised in the psychology literature, although some studies have implicated gratitude in increasing job satisfaction and protecting against burnout (Aparicio, Centeno, Juliá, et al., 2019; J. Burke & O'Donovan, 2023; Converso et al., 2015; Starkey et al., 2019). However, we do not need theory to tell us that feeling appreciated is an integral part of morale, or to recognise that gratitude was deployed as a key morale-preserving strategy in government communications. Without exception, daily government press briefings during the first lockdown included expressions of thanks. This extract from Foreign Secretary Dominic Raab's statement on 9 April 2020

(10 Downing Street, 2020), whilst Boris Johnson was being treated in intensive care for coronavirus, demonstrates the prominence of gratitude in government communiques:

> … I want to say *a massive thank you* to everyone who has gone the extra mile during this very challenging period. *Thank you* to all of those who are looking after us in our time of need. The NHS workers on the front line who have treated the sick, saved lives and tended for those who, sadly, could not be saved. For the doctors and nurses who have died of coronavirus whilst caring for others, we will never forget their sacrifice, we will never forget their devotion to helping others. And I also want to say *a big thank you* to the carers, the charity workers, all those who are looking after, or even just keeping an eye on, those in their local neighbourhood. You are the lifeline to so many people in our communities. *Thank you* to the workers who keep the country running, the supermarket workers, the delivery drivers, the technicians, the cleaners, the public servants who just kept going, determined to keep providing the daily services we all rely on. I think you've certainly made us all think long and hard about who the 'key workers' are in our lives. *Thank you* to the volunteers who have stepped up across the country, whose big-hearted sense of responsibility defines British community spirit at its very best. And *a massive thank you* to every single person who has stayed home to stop this terrible virus from spreading, you have helped protect the NHS, and you have helped to save lives. [Emphasis added.]

Gratitude can be seen as fulfilling two main functions in this context. The first is the conferring of 'affective approval or encouragement' which the social philosopher Axel Honneth implicates in his account of recognition as central to social morality (Honneth, 1995, p. 95). Thanking phrases act symbolically here as insulation against criticism. Humility is signalled through repeated references to vulnerability by phrases like 'looking after' us. Blitz spirit is alluded to the phrase 'British community spirit' and the emphasis on 'keeping going', with a sense of solidarity implicit in the use of collective first-person ('we' and 'us').

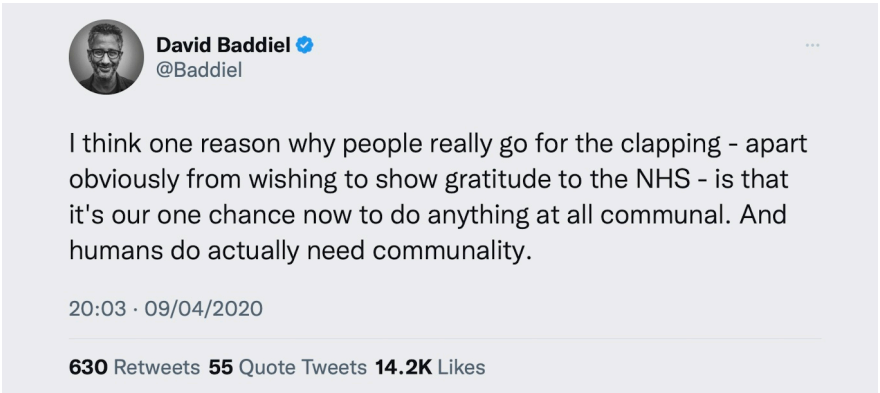
The second function of gratitude in this speech is to act as a political promissory note. Raab pledges to 'never forget' the sacrifices made by healthcare workers and to re-evaluate those in low-status, insecure employment on whom the nation found itself utterly dependent. Clap-for-carers was directly referenced in the press questions that followed the briefing. Raab said, 'I'll be taking part in the clap for carers this evening …

And I'm sure, there'll be the, you know, appropriate level of recognition at the right moment once we're through the worst of it,' implying that clap-for-carers was a placeholder for more substantial recognition to come. But, as Sorace (2020: online) has argued, gratitude is the 'ideology of sovereignty in a crisis', and it too easily slips from the recognition of individuals to an acceptance of the systems that reproduce their exploitation. The problems besetting the provision of PPE and the roll-out of testing to healthcare professionals meant that the 'sacrifices' lauded by Raab and others in government briefings came to be seen not as unfortunate or inevitable, but a result of incompetence. Matters were not helped by the Health Secretary, Matt Hancock, announcing a 'care' lapel badge to recognise those working in social care – a move that was widely derided as crass given the considerable problems faced by the care sector (Crace, 2020; H. Wood & Skeggs, 2020; V. Wood, 2020).

5.5 Thanking allowed?

The prominence of gratitude in politicians' statements and the popularity of clap-for-carers in April fuelled a debate about what constitutes 'appropriate gratitude' and whose gratitude could be afforded credibility. The 300-plus responses to a tweet from British comedian David Baddiel on the communality fostered by clap-for-carers (Figure 5.4), which was 'liked' over 14,000 times, is a telling case of sentiments circulating around 9 April. Of the replies displayed by Twitter, about 65% agreed with the sentiment, 7% were ambivalent, and 10% expressed scepticism or cynicism. About 8% invoked politics (referring to the failure of an initiative to 'clap for Boris' earlier in the week, or connecting voting behaviour with the state of the NHS). Remaining

Figure 5.4. Tweet by David Baddiel on the appeal of clap-for-carers and communalism



responses joked about the initiative (e.g. 'I simply can't advocate giving nurses the clap'), or were off-topic. A flavour of the tweets in favour, ambivalent, and against are given in Table 5.1.

Table 5.1. Types of responses that engaged with the content of this tweet from David Baddiel: 'I think one reason why people really go for the clapping – apart obviously from wishing to show gratitude to the NHS – is that it's our one chance now to do anything at all communal. And humans do actually need communality.'

Agreed with the sentiment	**Ambivalent**	**Expressed scepticism or cynicism**
It's really lovely to hear everyone get involved. People we've maybe never met before. All with common gratitude.	And yet I felt a sneaky admiration for my next door neighbours at 8pm who did not and have not clapped. One of them is a GP.	The sceptic in me says social media plays a big role. How many want to be seen being virtuous.
Totally. Think it should be a weekly thing long after corona virus.	At the risk of sounding cynical – giving us the illusion of community?	As someone with more than a passing knowledge of elderly and social care can I just say clapping does sh*t all except assuage the public's consciences & let the rancid politicians that crap on us every day off the hook. Keep your percussion, we need funding, staff, equipment.
And the NHS is the living embodiment of that sentiment.	Humans need communality??? Not sure about that.	Unfortunately for lots of people it's just a chance for 2 seconds of online fame with their little vids – I find it all a bit crap
I realise it's the highlight of my week now and look forward to 20.00 hrs Thursday.	I would like to point out that I clapped at your show because I was entertained. Communality I can take it or leave it	I must admit I didn't think about it like that. To me it's been an empty show of support by people who have repeatedly voted for the party that have denied NHS workers fair pay increases but props for making me think
Yep. Met neighbours I'd never laid eyes on before tonight as we emerged to clap – and we shouted across the street: 'How are you?' 'We're fine!'	Just wish people wouldn't let off fireworks because it frightens my dogs to death	Perhaps cynically you could also say it's a gesture which is lazy, non committal and requires very little effort on behalf of the 'clappeur'. But

Small talk, lovely chats. I closed the door and tears welled up. A sense of communality brought together by supporting our NHS		maximum reward is received (especially if you film it and share it to show how much you care).

As Baddiel's tweet and responses to it show, there was already a shifting emphasis in the primary audience for clap-for-carers. Expressing appreciation for the NHS was the impetus for the event, but in practice it became, for many, a way to connect with neighbours and affirm a sense of community in the face of crisis. But the focus on neighbours-as-audience played up to a long-standing trope of neighbourhood rivalry as a national characteristic. The stereotype, which plays on status aspiration, is a staple of comedy in British literature, particularly prominent in the novels of Jane Austen, and forms the basis of many a sitcom – most notably the 1990s BBC series 'Keeping Up Appearances'. It was not long before cartoonists and sketch-writers started mocking the event for its potential for one-upmanship. Comedian Will Hislop's parody of the event, for example, went viral on 9 May on Twitter. In the sketch, he mouths a conversation with his neighbour 'Karen' disparaging those who have not turned out to clap (O'Connnor, 2020).

Whereas previously, clap-for-carers could be seen as exemplary of Goffman's description of ceremony as a celebratory performance that highlights values of a society in 'an expressive rejuvenation and reaffirmation of the moral values of the community' (Goffman, 1969, p. 31), it began to be undone by associations with inauthenticity and accusations of 'virtue signalling'. The expression 'virtue signalling' refers to behaving in a way designed to garner approval rather than acting from a place of conviction. When the phrase first proliferated on Twitter in 2016, writer David Shariatmadari, ironically with hindsight, reached for an epidemiological metaphor to decry virtue-signalling as an expression that had proliferated like a virus and 'against which quarantine measures now urgently need to be taken' (Shariatmadari, 2016: online). He argued that it was a lazy put-down and had become indistinguishable from the thing it was meant to call out: 'smug posturing from a position of self-appointed authority'.

The shortcomings of the term notwithstanding, accusations of virtue signalling associated with clap-for-carers proliferated online. As a concept, virtue signalling is closely allied to 'slactivism', a low-effort, low-engagement signal of support for a cause without actually effecting change in a meaningful way (Lodewijckx, 2020). Drawing on Goffman's conception of 'ritual equilibrium', Persson (2019) argues that the equilibrium of social interaction is vulnerable to sabotage, including by using humour or reframing the interaction order. In the case of clap-for-carers, both apply: mocking the ritual and harnessing it to virtue signalling and slactivism reframed the event as a performance primarily for impression management rather than gratitude – as demonstrated by the more cynical replies to David Baddiel's tweet in Table 5.1.

Aspersions cast on authenticity are difficult to cast off – partly, perhaps, because Goffman's ideas are so pervasive about the inherently performative nature of social interaction, which he links to deception and illusion. As Diski has pointed out:

> [Goffman] presents a world where this is nowhere to run; a perpetual dinner party of status seeking, jockeying for position and saving face. Any idea of an authentic self becomes nonsense' (Diski, 2004, p. 10).

Of course, expressions of gratitude, whether enacted on the street as part of a social ritual or posted on social media, are not a guarantee of sincerity but neither are they insincere by default: the point is that we do not have access to each other's underlying psychologies. Although clap-for-carers is a gratitude-motivated event, we cannot assume that participating individuals are experiencing the emotion in-the-moment of participation, or when they tweet about it afterwards. What individuals say and do cannot be treated as a transparent window to their emotions and motivations. This does not prevent us investigating the 'display and management of subjectivity and attitude in talk' (Edwards 2005, p. 19), but it shifts the focus to practices – collective, cultural, and communal sense-making activities, rather than assuming individuals have coherent, distinct, and articulatable emotions amenable to evaluations of authenticity.

5.6 Clap-for-carers as shared affective practice or 'group-thank'

How did clap-for-carers come to be conceivable as a collective practice? On the face of it, it seemed unlikely to catch on. Not only had Brexit caused deep social divisions that made ideologically aligned collective action improbable, but Britain ranks very highly on the 'individualism' scale (Hofstede Insights, 2020) meaning that, unlike in 'collectivist' cultures, there is a highly developed focus on individual fulfilment and less emphasis on social interdependence. However, research into 'display rules' – cultural norms for emotional displays in social contexts – suggests that, somewhat counterintuitively, individualistic societies are more likely to exhibit higher expressivity of positive emotions to those outside their immediate circles than those in collectivist societies (Matsumoto et al., 2008). Display rules go some way to explaining why applauding healthcare and key workers seemed to be a more prominent responses to the early phase of the pandemic in Western European nations and in North America, although its conspicuousness may also be a function of the reach of reporting in the mainstream media and coverage on social media.

Durkheim coined an apt term to describe the emotionality of crowds: 'collective effervescence' (Durkheim, 2012). The phrase refers to the idea that people in assembled social groups experience an intensely affirmative experience that binds them to ideals valued by their social group, and are 'transformed through an emotional structuring of their sensory and sensual being' (Shilling & Mellor, 2016, p. 196), or what Sullivan and Day (2019) call 'phenomenological feel' (p. 206). Hopkins et al. (2016) found that an important source of positive experiences in crowds was people's ability to realise the values associated with their social identities. Although crowd studies have naturally focused on people in close physical proximity, clap-for-carers demonstrated that effervescence can still be generated when people are dispersed. Mackay (2021) has explored clap-for-carers as a form of 'sonic materiality' that qualifies as socially engaged artistic practice. Based on interviews with participants and his own recollections, he positions the sounding and listening that the event engendered as 'a prism through which to interpret its ambivalent pleasures and politics' (Mackay, 2021, p. 217).

Whilst clap-for-carers undoubtedly was fuelled by a celebratory atmosphere centred on the ethos and pathos of gratitude, there was always a potential for emotional dissonance between the group-based emotion in-the-moment and the contextual atmosphere of fear, anger, grief, and shame engendered by the pandemic. In their study of national celebrations, Sullivan and Day (2019, p. 212) showed that 'emotional enclaves' arise which challenge the credibility of a given celebration through questioning its inclusiveness, representativeness, or appropriateness. The potential for calling out behaviours as hubristic and shameful exists alongside the celebratory activity. This is borne out in the context of clap-for-carers by the criticism of politicians as hypocritical for taking part (H. Wood & Skeggs, 2020), and also the condemnation of people perceived to be excessively revelling in the event, such as those gathering in a carnavelesque-like atmosphere on Westminster Bridge to applaud and cheer in sight of St Thomas's Hospital, London. The embodied connotations of carnival, already actuated by the street-lining nature of performances associated with clap-for-carers, here reached their apotheosis.

A Bakhtinian reading of clap-for-carers may illuminate why participation was so compelling. The pandemic foisted on us the suspension of free and familiar contact among people, yet, as Bakhtin argued, 'The category of familiar contact is always so responsible for the special way mass actions are organised' (Bakhtin 1984, p. 123). Bakhtin juxtaposed carnivalisation with everyday life when he described carnival as bringing together 'all things that were once self-enclosed, disunified, distanced from one another' (Bakhtin 1984, p. 123). Under pandemic restrictions physical distancing is massively amplified. This detachment set up an affectual flow of nostalgia for the possibilities of physical proximity permitted under non-pandemic life. Clap-for-carers with its carnivalesque, ritual pageantry gave those participating in a social distanced manner the cathartic illusion of proximity. For those gathering en masse near hospitals, the near-proximity was perhaps experientially compelling enough for rule-breaking to occur in spite of the risks of virus transmission. Indeed Sullivan and Day (2019) have implicated rule breaking in the pleasure-full nature of carnivalesque connotations – connotations which were copious in clap-for-carers.

Allied to the concept of carnival is that of the parade – particularly in a military context. It is this connotation, with the allied semiotics of 'heroism', that caused

considerable disquiet amongst the event's critics. Cox (2020) has pointed out that although valuable work performed by healthcare workers during the pandemic is worthy of recognition and appreciation, a narrative of heroism does not provide a firm basis on which to build a response to a pandemic. The hero narrative is superficially fitting: the risks of continuing to work in a pandemic are appreciably greater than in usual times. But the hero narrative authorises the expectation of sacrifice and fails to acknowledge the limits of the duty to treat. Discomfort with the hero narrative as applied to healthcare workers perhaps explains the enthusiasm with which the public greeted Captain Tom's fundraising efforts. Here was a *bone fide* war hero willing – indeed delighted – to graciously accept deflected notions of heroism whilst acting as an honest broker for those eager to translate their gratitude to the NHS into charitable funding. It also heralded the entirely predictable backlash against the reshaping of #clapforourcarers as #clapforheroes in January 2021. The 'heroes' narrative had become – perhaps, in the context of the NHS, had always been – ideologically bankrupt.

5.7 Aesthetic creativity of gratitude performances

Clap-for-carers was part of a constellation of creative tableaux of gratitude that flourished during the first lockdown. These included projected images on buildings, chalked messages at the entrances to hospitals, a slew of songs expressing thanks, and front-garden snaking sculptures made up of community-sourced painted rocks. An important catalyst of performance-based creativity during the pandemic was TikTok, a social media app that, at the time, allowed video clips of up to 15 seconds in duration to be shared. Alongside various dance crazes that proliferated during lockdown, the app showcased thousands of gestures of gratitude to the NHS. The motif of the rainbow – that biblical symbol of hope in the aftermath of catastrophe – was often featured. Although rainbow pictures were originally proposed as something for children to spot in neighbourhood windows on lockdown walks, rainbow iconography quickly became prominently associated with gratitude to healthcare workers during the pandemic.

Rainbows supplied the optics, but there was also a powerful haptic symbolism in circulation that reinforced and was sustained by clap-for-carers: hands. With handshakes and hugs an infection risk, the only safe hands were those we kept to ourselves – whether clapping them together in appreciation, or rubbing our palms together as hand washing and sanitation took centre stage in public health messages. Artist Ian Berry formed an artists' collective of over 20 international artists who used clapping hands to inspire public works of art themed around gratitude that were displayed all over the world (Berry, 2021).

Clapping hands became a visual shorthand for appreciation during the early stages of the pandemic, but its iconography changed dramatically as lockdowns lifted. Suspicions that gratitude expressed to healthcare workers endorsed by politicians was a cynical tactic to deflect from inadequacies in the response to Covid are lent credence by promised recognition for healthcare workers failing to materialise through an audacious act of political amnesia. The framing of clapping as hypocritical was prominent in the unprecedented nurses strikes that took place in 2022 and 2023, when striking nurses carried placards saying, 'If you're happy to exploit nurses and you know it, clap your hands.'

5.8 Conclusion

The legacy of clap-for-carers is likely to be evaluated, in the fullness of time, on its effectiveness as a social movement. In their review of the literature in the context of implications for change in the NHS, Bate et al. (2004) point to the diagnostic characteristics of social movements. They are radical or unconventional, political, transformative, collective, and durable. People should join out of choice. Social movements come about spontaneously but require organisation to persist, and they are often characterised by conflicts with institutionalised system of power.

Change wrought by clap-for-carers is difficult to disentangle from the totalising, transformative effects of the pandemic on society. Nevertheless, the magnitude of participation in the event itself, the debates it sparked, and the social traces it left, on balance qualify it as transformative, collective, and durable. Can clap-for-carers be considered political? Although the originator of #clapforourcarers

campaign, Annemarie Plas, called for it to end after 10 weeks because it was 'becoming politicised' (SkyNews, 2020: online), in reality it was intensely political from the outset. 'When people come out en masse and cheer for the NHS, it is, by definition, a political act,' wrote Younge (2020: online) in the *Financial Times*, ' But, if we accept the event as intrinsically political, could it be said to have challenged institutional systems of power through conflict or resistance? Far from being subversive or unwelcome, clap-for-carers was characterised by consensual behaviour and, initially at least, being in tune with power structures. However, there were identifiable points of conflict and resistance associated with the event that challenged systems of power, particularly in relation to care justice (H. Wood & Skeggs, 2020).

At the very least, the event demonstrated a public appetite for challenging, as Chatzidakis and Segal (2020) put it, the limits of our imagination around care. Whilst it is easy to point to the hypocrisy of politicians who participated in clap-for-carers having equally enthusiastically cheered the blocking of the lifting of a public pay cap in 2017, all of us who participated in clap-for-carers are beholden not to be 'care-less' in the wake of the pandemic. To the roles of audience, performers, and critics, we need to add 'script editor' to ensure that past injustices around care are remedied in post-pandemic society.

Clap-for-carers was associated both with activism, through the 'You Clap for Me Now' film that spotlighted contradictory attitudes to workers from global majorities, and ineffectual slacktivism. Musicologist Jutta Toelle pointed out in an interview for *Frankfurter Allgemeine* that there is an inverse relationship between audience participation in a performance and the role of applause (Hruza, 2020: online). If we are all players, to paraphrase Shakespeare, applause becomes less important. It is perhaps because we were *not* all players – some were required to step it up while others were instructed to sit it out – that clap-for-carers became a guilty pleasure. Applauding healthcare workers afforded all the 'feels' of participation from the comparatively safe road-side vantage point of the spectator.

For all the criticism levelled at clap-for-carers, the intensity of emotions felt in-the-moment will be a lasting legacy of those summer evenings when we were still flushed with optimism that the pandemic might be a short, sharp scratch rather than the deadly, deep wound it transpired to be. Rachel Clarke reflects on the impact of the

applause in her description of the impact of clap-for-carers in her pandemic memoir (Clarke 2021, pp. 160–161).

> The idea of an impromptu ovation to express thanks to key workers has largely passed me by. But then, as I open the car door, applause begins to ripple and rise from my neighbours' doorsteps. … The entire village, it seems, is whooping and cheering, yelling "N – H – S!" and letting rip this most thunderous of thank yous to the nurses, the bus drivers, the cleaners, the porters, the shelf-stackers, the doctors, the delivery drivers, the checkout staff, the police officers, the paramedics, the teachers, the carers and all of the other key workers who are out there amid the virus, braving Covid for the sake of others, playing their part to keep their neighbours safe and well. And, honestly, I could fall to my knees at the sound. Its kindness and sweetness and community spirit overwhelm me with raw gratitude of my own. I stand on the asphalt, open-mouthed, tears streaming. All these people, this passion, this trenchant solidarity. It is the loveliest cacophony in the world.

Although clap-for-carers as an event has been furloughed indefinitely, this chapter in the Covid pandemic illustrates that attitudes to gratitude are constantly in flux. Of course appreciation must take a more sustained and material form than merely clapping. Proper remuneration and safe working conditions are an entitlement rather than a reward. But we cannot value care only by the yardsticks of capitalist economies. Gratitude is the emollient of the social exchange upon which all care and caring relies. It requires frequent and generous application to soothe and lubricate relationships of mutual dependency, support, and appreciation.

Chapter 6 Gratitude in the documentary series *Hospital*

Having argued, so far, that gratitude has a relational capacity in healthcare, the logical next step is to move to the micro level to examine the ways in which it is enacted as an interpersonal, discursive practice. In this chapter I will examine the embodied production and recognition of thanking expressions within the hospital environment, as represented in four series of the BBC documentary series *Hospital*, first broadcast between 2019 and 2021. I will use selected examples to argue that the context of healthcare produces and directs particular ways of talking in which thanking is implicated as an important component of politeness. I will also position gratitude as an emotion made and performed interaction. This chapter examines the ways in which thanking is enacted to accomplish interactional goals.

6.1 Framing the study: 'habit being so strong'

'Thank you' is one of the most commonly spoken phrases in English, yet it is also one of the most nuanced and complex. Because it expresses both an attitude and a social behaviour, 'thank you' was classed by J. L. Austin (1965) as a 'behabitive' – an expression that embodies an attitude by its utterance. An insight provided by Austin, a pioneer of 'ordinary language philosophy', is that a performative utterance does not have a truth value as such ('thank you' cannot be evaluated as true or false), establishing that performative utterances 'do' things rather than 'mean' things. Searle (1976) classified 'thank' as paradigmatic of an expressive verb, the illocutionary point of which is 'to express the psychological state specified in the sincerity condition about a state of affairs' (p. 12). However, several scholars have argued that, particularly in contemporary British English, thanking in social discourse has become divorced from the expression of gratitude as a psychological state and is routinised to the extent that any link with gratitude is residual (Aijmer, 2014; Jautz, 2015; Mosegaard Hansen, 2016). Like enacted interactions such as greeting and apologising, thanking can be a verbal routine that primarily helps to structure conversations in ways that make participants

feel at ease. But where does this leave the manifesting of gratitude as the purposeful display of emotion with the intention of conveying appreciation?

The writer Raymond Carver, who died of cancer aged just 50, captures the multivalenced nature of thanking perfectly in his poem, 'What the Doctor Said' (Figure 6.1). The poem takes the form of a recount, a salient reminder that conversations between doctors and patients have a narrative life beyond the encounter: the story of receiving a diagnosis will be relayed to others. The poem's single block of text, without punctuation, induces a feeling of breathlessness especially when read aloud. This mimics the symptoms of the lung cancer diagnosis being imparted. The poem presages breaking-bad-news advice that suggests patients have a limited ability to absorb information immediately following a terminal diagnosis (Lane, 2015; Meitar & Karnieli-Miller, 2022). The narrator's attempts at humour in the face of the doctor's implausible but lyrical enquiries about coping strategies are followed by the admission that the patient does not want the doctor to have to repeat the news or to have to fully digest it – showing a touching reciprocity of care. The patient is mindful of the doctor's distress.

The crux of the poem and its relevance to my study comes in the final line: 'I may have even thanked him habit being so strong'. Reflexive politeness in the face of being given 'something no one else on earth had ever given me' – a terminal diagnosis – and the sense of the narrator's astonishment at his possible action, memory having failed him at this point – 'I may even have thanked him' – prompts us to reflect on thanking as a ritual that kicks in at times of crisis. Whilst I agree with Leech (2014) that even highly ritualised utterances of thanks still 'convey an appreciative acknowledgement, however minor, that the conversation has been beneficial to each speaker' (p. 197), questions remain about how thanking as a practice participates in the construction of gratitude as an emotion made in interaction. Although thanking and gratitude are sometimes treated as synonymous, thanking – as the poem shows – does not necessarily entail gratitude, and gratitude can be enacted in ways that do not always entail explicitly voicing thanks.

Figure 6.1. 'What the Doctor Said' (Carver, 1996, *p. 307)*

What the Doctor Said

He said it doesn't look good
he said it looks bad in fact real bad
he said I counted thirty-two of them on one lung before
I quit counting them
I said I'm glad I wouldn't want to know
about any more being there than that
he said are you a religious man do you kneel down
in forest groves and let yourself ask for help
when you come to a waterfall
mist blowing against your face and arms
do you stop and ask for understanding at those moments
I said not yet but I intend to start today
he said I'm real sorry he said
I wish I had some other kind of news to give you
I said Amen and he said something else
I didn't catch and not knowing what else to do
and not wanting him to have to repeat it
and me to have to fully digest it
I just looked at him
for a minute and he looked back it was then
I jumped up and shook hands with this man who'd just given me
Something no one else on earth had ever given me
I may have even thanked him habit being so strong

To address the question of what makes thanking more likely to be hearable as gratitude, I draw on two different but complementary approaches: pragmatics and conversation analysis (CA). Both invoke the concept of 'strategies' in relation to how interlocutors accomplish goals in conversation. What do we mean when we use 'strategy' in the context of linguistics scholarship?

The word 'strategy' used in everyday language refers to a deliberate plan of action. In pragmatics and CA, however, 'strategy' is used to refer to the selection, often reflexive and intuitive, from an inventory of possible options with which to perform communicative actions. It is assumed that speakers use the formulation of words and embodied action that *they consider most appropriate* to the context, both for what they want to achieve with their utterance, and the relevant contextual factors such as the setting and who is being addressed.

Whilst there are situations in which we strategise communication in the sense that it is planned, deliberated, rehearsed, and edited – for example, formal speeches, high-stakes letters, academic papers – most conversational settings do not afford the time or opportunity to be highly considered in what is said. Speakers synchronise the pace of their talk with each other and pauses that are even microseconds longer than normal can signal trouble in conversation (M. Wilson & Wilson, 2005).

Conversationalists rely on ready-to-hand knowledge of language and context. Nevertheless, an inventory of choices is available to speakers and the selection of these is still intentional, hence the use of the term 'strategy' to refer to interactional moves. The evaluation of the success of strategies, and how these are codified within and across languages and cultures, is a cornerstone of politeness studies.

In this thesis, I use the convention in discourse scholarship of referring to 'strategy' to describe features of conversation that speakers use reflexively to make their thanking more likely to be hearable as gratitude. It should not be conflated with the common-sense understanding of strategy as something that is decided in advance and knowingly used to manipulate outcomes.

6.2 Pragmatics

Pragmatics is the study of person-to-person communication by means of language. Pragmatic meaning, as defined by Leech (2014), resides **1** in the communicative intention of the speaker, and **2** interpretation of this meaning by the addressee's recognition of the speaker's intention. Communicative intention is not retrievable from the sense of the utterance alone, it involves inference on the part of the hearer, and, by extension, the researcher. I follow Félix-Brasdefer (2015) in adopting a

pragmatic-discursive approach – a functional perspective that focuses on discourse as social action and interaction. The social action of gratitude is approached as co-constructed and negotiated through joint actions that conform with or resist sociocultural norms. Two specialties within pragmatics are particularly pertinent to the study of thanking in conversation: pragmalinguistics and sociopragmatics.

6.2.1 Pragmalinguistics

Pragmalinguistics is the study of linguistic features in relation to speakers' use of the structure and expressive resources of language. Foregrounded as a field within politeness studies by Leech (2014), pragmalinguistics considers the meaning of utterances independent of the social contexts in which they occur. It is well suited to the semantic analyses of what are referred to as 'conversation routines' – expressions that have a fixed grammatical structure and have a high degree of routinisation, such as 'thank you' (Coulmas, 1981) .

There are two influential works on thanking routines using pragmalinguistic approaches: Aijmer (2014) and Jautz (2015).

Aijmer analyses thanking expressions as formulaic speech acts in a chapter on thanking in her book *Conversation Routines in English* (Aijmer, 2014). She based her study on the London–Lund corpus – a collection of about 435,000 spoken words divided into text samples of approximately 5000 words – to evaluate the grammatical structure and frequencies of thanking expressions. Aijmer considers thanking to be a prototypical speech act and a routine that has a discourse-organising function. She explicitly does not deal with 'attitudinal routines' which express a speaker's attitudes or emotions. Therefore, when she uses the term 'gratitude' it is purely as a speech act. Although Aijmer does not evaluate thanking phrases as expressions of the emotion of gratitude, she does consider the 'emotionality' of expression to be one of the strategies available to speakers as intensifiers in the performance of thanking. Emotionality (or 'expressiveness') is marked mainly through prosodic devices (meter, rhythm, tempo, pitch, and volume). Other strategies specified by Aijmer include the use of intensifying adverbs ('thanks *very much*'), repetition ('Thanks. Thank you'), and combination ('Oh thank you. That's very kind').

In her book *Thanking Formulae in English*, Jautz (2015) analyses thanking expressions from corpora of spoken British and New Zealand English. The functions she identifies for thanking formulae are: discourse organisation; serving the phatic communication (which is communication that has a social rather than an informational purpose); responding to goods and services; responding to interpersonal support; and use in joking or ironic ways. Jautz identifies the operational elements in thanking events to be: naming a benefactor, using intensifying particles ('oh', 'ah'), and naming a reason for thanking (Jautz 2015, p. 83).

Although Aijmer and Jautz do not completely ignore context – Aijmer draws attention to telephone closings and Jautz examines radio texts – both approaches view thanking as a sort of 'subroutine' in conversation that is a feature of English language use rather than tied to a specific context. 'Framing' is used by both authors as a concept with which to research thanking (Aijmer, 2014; Jautz, 2015). Frames are considered to be easily retrievable or stereotypical pieces of knowledge, acquired though experience in social environments (Leech, 2014).

Frames are useful for identifying and analysing commonly used features that amplify the illocutionary force of thanking. However, it is clear that pragmalinguistics tell only a partial story about how thanking expressions are used in interaction. My study is interested in gratitude as situated within medical settings – a context in which roles are likely to circumscribe the range of permissible, culturally-sanctioned interactional behaviours. To bring in an awareness of how the medical setting enables and constrains the expression and reception of gratitude, the lens of sociopragmatics is useful.

6.2.2 Sociopragmatics

Sociopragmatics recognises that it is not merely the words spoken that make an expression meaningful, the circumstances of the utterance have an influence over the participation of language in reflecting and constructing social order. It is an approach often used, therefore, in politeness studies in which the appropriateness of communicative contributions in social interactions is an abiding concern. Sociopragmatics, as defined by Marmaridou (2011), 'relates pragmatic meaning to an

assessment of participants' social distance, the language community's social rules and appropriateness norms, discourse practices, and accepted behaviours' (p. 77).

Sociopragmatic politeness is a matter of judging politeness based on the words used, their meanings, and the contexts in which they are used (Leech, 2014). As Coulmas (1981) has observed, the object of thanking is not the only factor that influences the choice and intensity of a thanking expression. Interpersonal relationships between participants and context also have a role, and these are subject to cultural variation.

Sociopragmatics asks not only if the right words have been spoken, but have they been spoken at the right time in the right place to the right person? In Carver's poem (Figure 6.1), the narrator's assertion 'I may have even thanked him habit being so strong' is an admission of both pragmatic accomplishment and sociopragmatic failure: there is the recourse to habit that politeness requires as a closing ritual to a professional encounter, but also a recognition that thanking a doctor for catastrophic news might not be considered a contextually apt action.

6.3 Conversation analysis

At the same time that Austin (referred to in Section 6.1) was developing what came to be known as 'speech act theory' (Austin, 1965), sociologist Harvey Sacks was investigating how speakers perform actions with words in sequences of interaction in a series of lectures delivered between 1964 and 1972 (Sacks, 1995), laying the foundations of CA as the study of actions conducted through talk (P. Drew, 2018)

Although the term 'conversation' in 'conversation analysis' implies that it is focused on verbal accomplishments of actions, an important component of CA is that paralinguistic and embodied accompaniments of utterances are taken into account as resources on which people draw to form actions (Clayman & Heritage, 2014). In the words of Schegloff (2007) – who preferred the term 'talk-in-interaction' to 'conversation' which he said had 'the connotation of triviality' (p. xiii) – action formation consists of:

> [T]he resources of the language, the body, the environment of the interaction, and position *in* the interaction fashioned into conformations designed to be, and to be recognizable by recipients as, particular actions (Schegloff 2007, p. xiv).

In medical settings, valuable work has been done on examining sequential patterns in interaction whereby verbal and embodied communicative resources are used by participants to co-construct the accomplishment of actions such as history taking, formulation, treatment recommendations and uptake, and openings and closings of conversations (Barnes, 2019; Barnes et al., 2018; B. Brown et al., 2006; P. Drew et al., 2001; Eli et al., 2021; Heritage & Maynard, 2006). My study adds to this work in that it aspires to understand how gratitude is accomplished in clinical interactions.

If one were to take, slightly facetiously, a CA lens to Carver's poem (treating it as 'overheard' conversation), one might approach it as a bad-news delivery sequence. We would be interested in attitudes to language-in-action such as the forestalling of repetition ('not wanting him to have to repeat it / and me to have to fully digest it'); the face implications of the patients' responses; the turn design of the patient to supply what are considered to be congenial, 'preferred' second actions; the significance of the extended pause ('I just looked at him / for a minute and he looked back'), and the embodied thanks ('I jumped up and shook hands with this man').

6.4 Research questions

Whilst it is somewhat unconventional to combine pragmatics and conversational approaches in a single study, Drew (2018) has pointed out that the approaches can be complementary.

I will use **pragmalinguistics** to address the question:

- What intensification strategies help to make thanking more likely to be hearable as gratitude? (Section 6.6.2)

Sociopragmatics approaches will be used address the following questions:

- How does the context of the dataset as filmed and broadcast material mediate the analysis? (Section 6.5.1)
- Who expresses thanks to whom? (Section 6.6.1)

- Are there specific occasions that hospital context affords/demands in respect to thanking? (Sections 6.6.4.1 and 6.6.4.2)
- Has the pandemic had an influence on how thanking is expressed and received? (Section 6.6.3)
- How are thanking expressions responded to, and what does this tell us about how gratitude is orientated to in talk? (Section 6.6.5)

CA will be used to address the following questions:

- How might gratitude be approached as an emotion made in interaction? (Section 6.7)
- How is gratitude accomplished interactionally as a coordinated activity between participants? (Section 6.7.2)
- How does the timing of the taking up of the gratitude opportunity influence news delivery in the post-operative briefing? (Section 6.7.2)
- How is expressive touch implicated in the accomplishment of gratitude? (Section 6.7.5)

6.5 Methods

6.5.1 Data selection

An abundance of videorecorded healthcare interactions is available to researchers in the form of documentaries and reality shows set in surgeries, clinics, and hospitals. At the time of commencement of this study (June 2021), at least 12 documentary series following health professionals in their day-to-day work were available on the watch-on-demand platform of the BBC alone, with archive footage accessible to licence holders through the British Universities and Colleges Film and Video Council. A case could be made for any of these as providing data for analysis, given that they all feature healthcare interactions. In particular, the Channel 5 series *GPs: Behind Closed Doors* and Channel 4's *24 Hours in A&E* were watched and considered, but I selected the award-winning BBC documentary *Hospital* for the following reasons.

1. The series includes a range of participants and settings, rather than being situated in one particular department or practice, thus offering a broad range of types of encounters for analysis.
2. The preceding work using Twitter (Chapter 4) and Clap-for-Carers (Chapter 5) focused on gratitude during the pandemic. *Hospital* was the only documentary at the time to be filmed in hospital during the pandemic. I wanted the possibility of being able to compare filmed encounters of gratitude before and during the pandemic to investigate whether pandemic precautions changed how gratitude was enacted.
3. The mode of documentary making in Hospital combines expository and participatory styles (Nichols, 2017): there is a narrator, and occasionally an interviewer is heard posing questions to participants. Some participants also gave a to-camera commentary on their care experience. This allowed for an analysis of situations in which gratitude was enacted as well as it being talked about (stance alignment) by participants.
4. The series has impact. It attracts huge audiences (estimated to be over 2.2 million viewers per episode) and stories have real-world effects, for example there was a huge surge in people registering to be organ donors following the airing of an episode on transplants (BBC Media Centre, 2019). Healthcare professionals receive training around appropriate communication and demeanour, but lay viewers may have their expectations shaped by depictions of experiences shown in documentaries like *Hospital*. Research on the impact of journalistic television on audiences is limited and difficult to undertake (Rusch et al., 2021), but the *Hospital*'s large audience reach could conceivably play a part in role modelling civil behaviour at a time when increasing numbers of staff report being subject to abuse (House of Commons Health and Social Care Committee, 2021; Kirk, 2022).

6.5.2 Ethical considerations

When using data that one has not collected oneself, one has to trust that the footage was shot and edited in a reputable manner, and that participants consented to be featured in the programme. and *Hospital* is not an observational or fly-on-the-wall

documentary. A reassuring indicator is that participants were aware of the camera as participant in the interaction – a key consideration when vulnerable people are filmed. I wrote to the production company, Label1, in January 2022, in the hope of gaining more information about the process of recruiting participants, audience figures, and editorial policies, but no reply was forthcoming.

Although it is usual practice to anonymise interlocutors in research using discourse analysis, this can have a dehumanising effect. On balance, I decided that retaining names was the more ethical approach to reporting this research, especially as the participants' identities are already in the public domain. Naming conventions reflect how participants were referred to in the documentary as broadcast.

6.5.3 Assembling the dataset

The source material for the study consists of 28 episodes of *Hospital* comprising 27.5 hours of footage, divided equally between episodes filmed before the Covid-19 pandemic and those produced during the pandemic (Table 6.1). Episodes were accessed using 'Learning on Screen', an archive of programmes from free-to-air channels licensed through the Educational Recording Agency (Learning on Screen, 2022). The episodes were watched and re-watched, and a note made of sequences in which thanking and gratitude featured. Subtitles were searched for 'thank*' and 'grat*' as a check that any potentially includable encounters had not been missed.

A total of 440 gratitude encounters were identified (median 15.7 per episode, range 6–25, mode 13). I follow Goffman (1961) in considering an 'encounter' to be a 'focused gathering' or 'ecological huddle', ratified through expressive signs and a 'we rationale', i.e. a sense that *we* doing a thing together at the time (pp. 17–18). For data-gathering purposes, a gratitude encounter is defined as a sequence in which thanking is initiated, i.e. an interlocuter uses a thanking expression, either as an entire turn at talk (e.g. thank you, thanks, cheers) or as part of longer turn (e.g. I appreciate it, just want to thank you, I am truly grateful).

Table 6.1. Episodes of Hospital *included in the dataset*

Series	No. of episodes	First aired	Locations
Series 4	6	10 Jan – 14 Feb 2019 (pre-Covid)	Six NHS Hospital Trusts across Liverpool
Series 5	8	13 Feb – 2 Apr 2020 (pre-Covid)	Seven NHS Hospital Trusts across Liverpool
Covid specials	2	11 and 12 May 2020 (mid-Covid)	Royal Free Hospital Trust, London
Series 6	6	9 Nov – 14 Dec 2020 (mid-Covid)	Royal Free Hospital Trust, London
Series 7	6	11 May – 15 Jun 2021 (mid-Covid)	University Hospitals Coventry and Warwickshire NHS Trust

Responses, if any, to the thanking or repetition of thanks directed at the same recipient are considered to be part of the same encounter. The end of the encounter is taken to be where the programme cuts to a different scene, or the interlocutors move on to a different topic marking the end of the thanking sequence from the viewer's perspective.

For each encounter, dialogue was transcribed, with intonation marked and pauses indicated using Jefferson conventions (Jefferson, 1984) (Table 6.2). The process of transcription is the first step in analysis, necessitating viewing and reviewing of data, and absorption in the detail of the encounters. The following characteristics, where discernible, were noted for each encounter: setting (e.g. ward, operating theatre, corridor), situation (e.g. consultation, meeting, discharge), who was expressing thanks to whom?, thanking phrase used, reasons for thanking (implicit and explicit), any notable accompanying gestures (e.g. handshakes, hugs, thumbs up), and any responses to thanks.

This description of data, captured on a spreadsheet, allowed for the extracts to be grouped so that genres of thanking encounters could be identified and considered for closer analysis. Those encounters that had potential to address areas of particular interest – settings particular to healthcare in which gratitude is enacted,

encounters in which gratitude was notably intensified or muted, and pieces to camera in which gratitude featured in a floor-holding opportunity – were transcribed in greater detail. Audacity software was used to generate waveforms so that pauses could be accurately measured. Extralinguistic details were added. Data notes were made to summarise the contexts of extracts. The transcripts were then coded for features relevant to gratitude in terms of what was said/done, how it was said/done, and when it was said/done.

Table 6.2. Transcription symbols

Symbol	Name	Use
=	Equals sign	Latching of successive talk (signals the absence of a pause)
(1.3)	Time in parentheses	The length of a pause in seconds
(.)	Period in parentheses	Discernible short pause
[overlap]	Overlap	Marks the onset and end of overlapping talk
.	Period	Indicates falling intonation
?	Question mark	Indicates rising intonation
Hello	Underlining	Indicates emphasis by the speaker
HELLO	Capitals	Indicates speech at higher volume than surrounding talk
So::	Colons	Elongation of the preceding sound. Number of colons proportional to elongation
↑	Upward arrow	Precedes marked rise in pitch
↓	Downward arrow	Precedes marked lowering of pitch
°	Degree	Enclosed speech is markedly quieter
#	Hash	Enclosed speech is croaky
~	Tilda	Enclosed speech is wobbly
*	Asterisk	Enclosed speech is squeaky
£	Pound sign	Enclosed speech is delivered smilingly or laughingly

> <	Greater than and less than signs	Enclosed speech is faster than surrounding talk
< >	Less than and greater than signs	Enclosed speech is slower than surrounding talk
ok(hh)ay	h in parentheses	Laughter particles
((action))	double parentheses	Description of actions
.shih	period followed by shih	Wet sniff
.hhh	Period followed by h	In-breath, length proportion to number of h's
hhh	Sequence of h's	Out-breath, length proportional to number of h's
(doubt)	Word(s) in single parenthesis	Utterance is indistinct and transcription is in doubt

As a method, CA is glorious but laborious. I am grateful for assistance from Dr Deborah Chinn for checking my transcription technique and for useful discussion of excerpts. I participated in a number of data sessions that were invaluable in skills acquisition. The Conversation Analysis Data Sessions South (CADSS) series convened by Simon Stewart, and the Micro-Discourse Analysis (MDA) group hosted by the Centre for Language, Discourse and Communication at King's College London, were both welcoming and supportive environments for developing confidence and competence in CA.

6.5.4 Analytical considerations and limitations

There are analytical implications for using data from a television documentary. Editing decisions are likely to have been guided by the qualities of the footage and narrative potential rather than aspiring to representative sampling. Therefore, frequency analysis of the distribution of thanking encounters across participants, settings, or situations, are useful only for directing attention to patterns in the dataset and cannot be extrapolated uncritically to contexts beyond the corpus.

A further consideration regarding the 'naturalness' of interactions is that the presence of a camera crew inevitably leads to the observer's paradox in which people may alter their behaviour because they know they are being filmed, and – in the case

of television – potentially being broadcast to an audience of millions. Whilst the observer's paradox is often viewed as a limitation in discourse studies, it is also an opportunity for studying the manner in which participants perform healthcare interactions with the camera crew as co-present participants and the anticipation of an eventual televisual audience. Healthcare interactions are, in any case, often witnessed by co-participants and bystanders: all interactions need to be produced as accountable.

It may be suspected that grateful people are more likely to consent to participate in a documentary. In the case of *Hospital*, participants' stories begin before they have any cause to be grateful, and, indeed their participation does not guarantee preferential treatment, or treatment at all owing to circumstantial and/or clinical factors that the series elaborates. Nevertheless, participants' motivations are unknown and gratitude for previous interactions with the hospital and/or the NHS may be implicated in decisions to take part in the documentary.

It is not unprecedented for film to be used as sources of data for CA, although 'live' footage is often considered to be more credible as 'natural' than edited broadcasts in which participants may be directed, and footage is selected and edited (Chepinchikj & Thompson, 2016; Hutchby, 2004, 2020). Although the exact circumstances in which footage is procured and produced are opaque to the viewer, documentary is a medium that can be described and orientated to as interactional. For the interactional sequence to be plausible to the viewer, production teams must constitute it in a way that is consistent with the manner in which interactions are *typically* produced, organised and unfold in real time. Cuts tend to be introduced at natural conversation transitional points so that episodes of talk maintain their integrity.

As Mondada (2019) has pointed out, camera work in filming social interaction 'encounters problems very similar to those of the participants' by needing to anticipate and respond to emergent action (p. 98–99). The achievement of an authentic-seeming interaction in the broadcast footage is a form of proto-analysis: candidate examples of interactions have been selected and – if not preserved in their entirety – shot and edited to project the natural-seeming sequential unfolding of action. I approach the data reflexively and critically, as *filmed* healthcare interactions, produced and viewed

in ways that are consistent with the conventions and expectations of the documentary form.

That said, it is necessary to be mindful that encounters in the dataset are a function of what was filmed and included in the final edit rather than what occurred. What was broadcast is available for analysis, but it cannot be assumed that because gratitude was not shown as part of a particular encounter means that it did not take place. It is possible that thanking sequences of talk took place off-camera or were edited out. Although I did notice encounters in the series in which gratitude might be warranted or expected and it was not forthcoming, it seems insensitive to frame these encounters as examples of a lack of gratitude or active ingratitude, especially given that the participants of the documentary are recognisable individuals. Therefore, disconfirming or deviant cases – encounters in which gratitude was withheld – are excluded from the analysis, both as a consequence of the sampling method and for ethical resons. The implication of the decision to exempt disconfirming cases is that it weakens the ability to make claims about when gratitude might be normatively expected (not in any case a focus of my research).

6.6 Analysis

Whilst 'thanking' is often treated in the literature as synonymous with gratitude, I have elected to treat thanking as a subset of gratitude in this study. As will be demonstrated, gratitude is not limited to being enacted through explicit thanking behaviours. When I draw on pragmatics to discuss expressions and utterances, I have used the phrase 'thanking expressions'. I treat 'gratitude' as made in interaction.

6.6.1 Who thanked whom?

People in over 100 roles were shown on screen to be participating in thanking encounters. Categorisation is necessarily crude as roles can be interchangeable (e.g. surgeons tend also to be consultants, and nurses are also ward managers, expectant mothers can be, but are not necessarily, patients), and different hospitals

have different conventions of defining roles (e.g. nurses may be referred to as sisters, modern matrons and/or advanced nurse practitioners).

Patients were most commonly shown to express thanks (154 occurrences in the dataset), followed by parents of patients (69 occurrences). Consultants were the most frequent addressees of thanks (63 occurrences), and when consultants were acting in a surgical role, an additional 51 occurrences were noted. As well as receiving thanks, consultants and surgeons were also frequently shown to express thanks (45 and 42 encounters respectively). Although a vast array of functions of patient care is covered in the series, there is still an emphasis on dramatic events which tend to involve consultant surgeons. These types of encounters are over-represented in the dataset.

6.6.2 Thanking expressions and intensification strategies

A first step in characterising thanking expressions is to determine how often they occur in the dataset. Figure 6.2 is a diagrammatic representation of the thanking phrases used. It shows the variety of ways in which people embed their thanks in larger syntagmas (linguistic units that form part of a sequence).

'Thank you' was, by some way, the most common token (68.0%), followed by 'thanks' (19.6%). The frequencies are broadly similar to those found by Jautz (2015) in the British National Corpus (66.1% and 24.7% respectively).

To demonstrate how gratitude is intensified, a worked example is given in Extract 6.1 which is a transcript of part of the conversation between 81-year-old patient Joan and the surgeon, Joe Mills (JM), consultant interventionist cardiology at Liverpool Hospital. Joan has just had a Transcatheter Aortic Valve Implantation (TAVI) keyhole procedure to replace a failing heart valve.

The episode of *Hospital* (Series 4, Episode 6) which features Joan's story, highlights some of the incongruities in how access to procedures is determined by different health boards. Joan lives within the catchment area for Liverpool hospitals but lives in Wales. The funding criteria for people living in England and Wales are different, and a case had to be made to fund the operation to the Welsh funding panel. The panel first turned down the funding but an appeal succeeded. Seven pragmatic intensification strategies identifiable in Joan's talk are shown in Table 6.3.

Figure 6.2. Frequencies of thanking expressions across the dataset

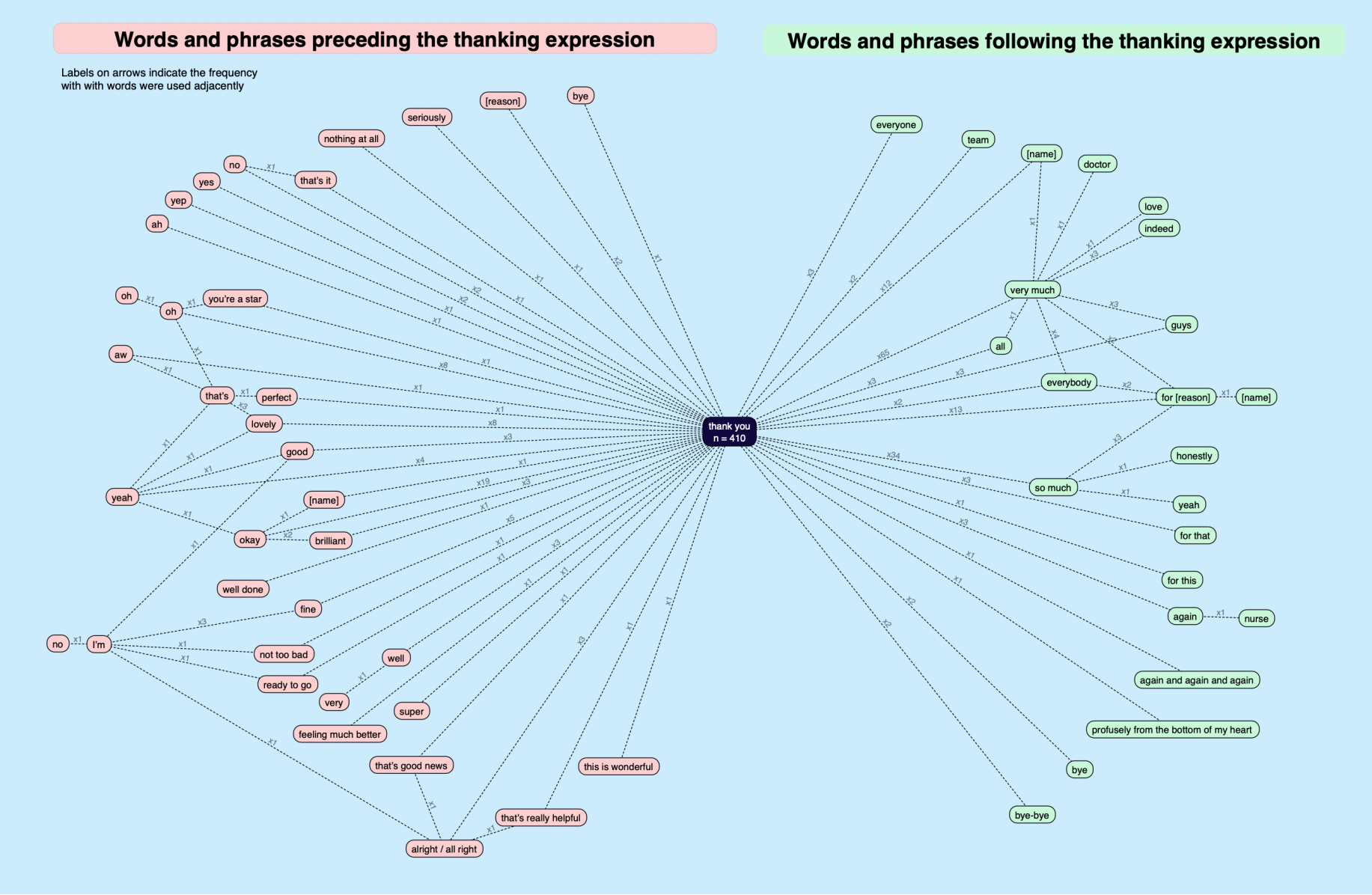
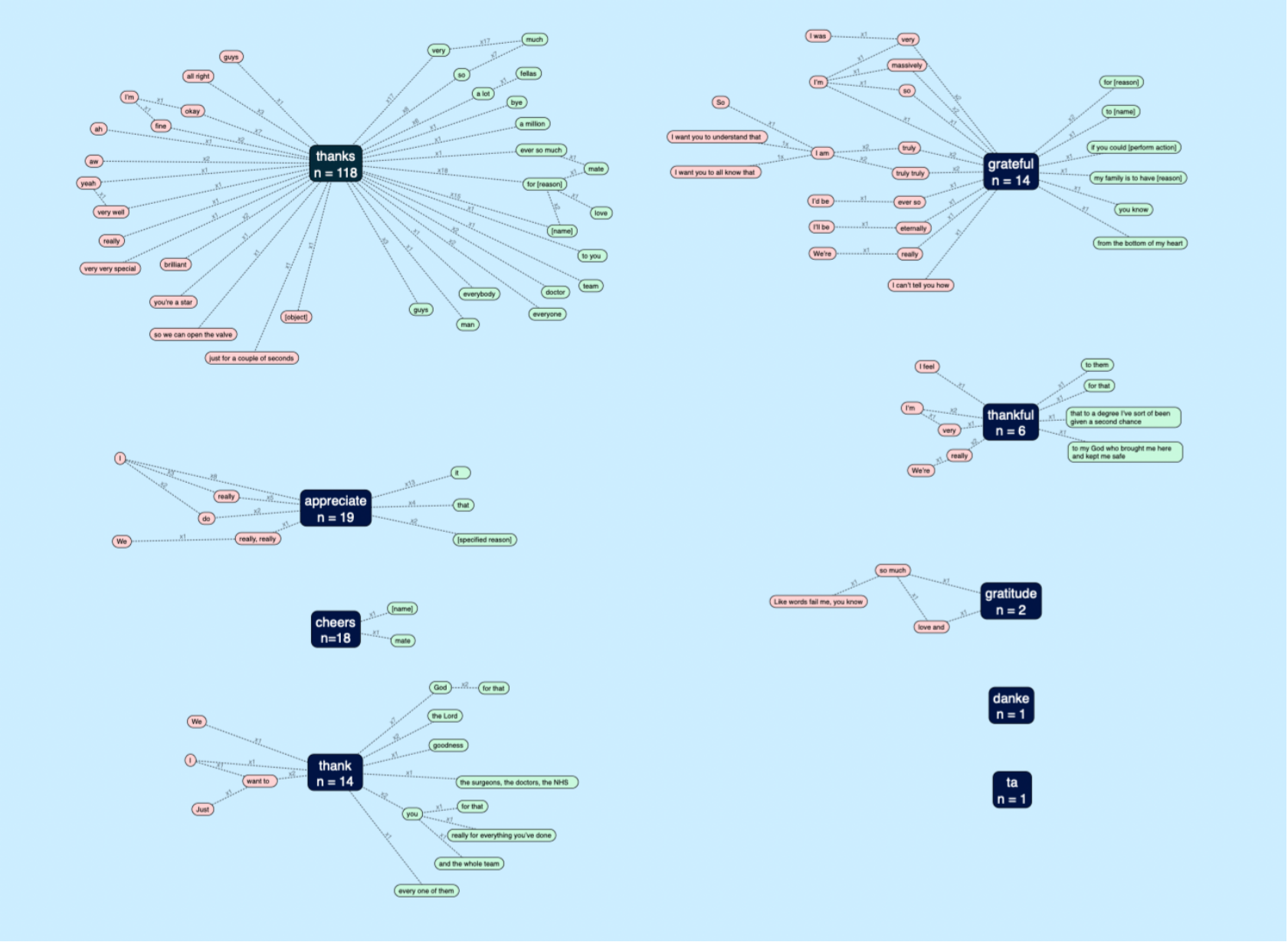


Figure 6.2 cont.



Extract 6.1. Joan thanks the surgeon after her TAVI operation

```
1  JM:     And how're you feeling
2          (0.2)
3  Joan:   Feeling much better thank you
4          (0.6)
5  JM:     Just looked at yer (.) ECG monitoring and it looks
6          absolutely fi:::ne? [I can see here yer blood pressure
7  Joan:                      [(Alright)
8  JM:     looks great so
9  Joan:   That's ↓great (.) th-thank you and: (0.7) and the
10         whole team:: (0.5) You've been brilliant all of you (.)
11         [I'm I'm: ~I'm
12 JM:     [°No that's been a pleasure°
13 Joan:   ~choked up you've been so good. ((She puts her hand to her
14         mouth)) #Figure 6.3
```

Figure 6.3

```
15         .hh waiting for so long for something to be done (0.5)
16         Uhhh (0.2) so (0.7) I'm very pleased for all you've done~
17         s-[really
18 JM:       [Well I am too (.) delighted=
19 Joan:   =Thank you
20 JM:     =And you've been very bra:ve waiting all this ti:me
21         (0.7)
22 Joan:   You keep thinking the odds are (.) going against
23         you the longer you wait? Don't you
24         (0.8) ((possible cut))
25 Joan:   Thank you for all the ↓ca:re
```

Table 6.3. Intensification strategies identifiable in Extract 6.1

Strategy	Linguistic marker	Position in Extract 6.1
Thanking somebody explicitly	'Thank you and the whole team'	Line 9–10
Giving a complimentary assessment	'You've been brilliant all of you' 'You've been so good' 'I've very pleased for all you've done'	Line 10 Line 13 Lines 16–17

Emotional assessment	'I'm […] choked up'	Lines 11, 13
Emotionality (wobbly voice, interrupted fluency, non-lexical elements)	'I'm I'm: ~I'm' 'Uhhh'	Line 11 Line 16
Repetition of thanks	'Th-thank you / Thank you / Thank you for all the ↓ca:re'	Lines 9, 19, 25
Identifying a thankable	'Thank you for all the ↓ca:re'	Line 25
Marked changes in pitch	'That's ↓great' 'Thank you for all the ↓ca:re'	Line 9 Line 25

The range of embodied options open to Joan to intensify her thanks, in common with many ill or recovering patients, are constrained by her having a limited range of movement because she is confined to bed. Some patients are unable to initiate expressive gestures like handshakes or embraces and rely on their utterance content and intonation to accomplish gratitude. Expressive touch is discussed further in Section 6.7.5.

6.6.3 Functions of thanking expressions

Devitt (2022) has pointed out that those using pragmatics should take care not to conflate the metaphysics of meaning (the study of what constitutes an utterance's meaning) and the epistemology of meaning (how the hearer interprets the meaning of an utterance). The study of filmed media introduces another layer to the speaker–hearer exchange: 'witnessing' as a viewer which is the position adopted by the analyst. Mindful of these distinctions, my classification of functions of thanking expressions in

have been compiled in an inductive fashion, taking the context of each expression into account as made available to me, as a viewer/analyst, with meaning directed by the editing choices of the programme makers but based on my interpretation of what thanking expressions are accomplishing in an encounter.

Table 6.4. Functions of thanking in each gratitude encounter

Function	Count pre-Covid	Count mid-Covid	Total
Polite closing of interaction such a consultation, phone call or meeting	48	96	144
Acknowledgement of service rendered or assistance given	38	39	77
Response to being given information	20	27	47
Response to reassurance	19	21	40
Acknowledgement of acquiescence, compliance, or cooperation	17	8	25
Response to thanking	15	14	29
Part of a response to a solicit such as 'Alright?', 'Okay?' or 'How are you?'	15	24	39
Component of leaving ritual on discharge	14	17	31
Response to an offer, a promise or expressed intention	13	20	33
Expression of gratitude to camera	10	3	13
Response to praise, congratulation, or compliment	7	14	21
Response to being given an object, objects, or documents	7	4	11
Response to welcome news	6	13	19
Response to permission	5	6	11
Response to good wishes	5	19	24
Thanking team at end of surgery	4	4	8
Unclear	4	9	13
Thanking God or Allah or thank goodness	2	8	10
Substitute for 'please' in a request	2	2	4
Response to teasing	2	1	3
Mollify or placate	2	0	2
Response to an apology	2	0	2

Response to sympathy	2	1	3
Preface to an excuse	1	0	1
Response to being given a gift	1	1	2
Polite opening of interaction such a consultation, phone call or meeting	1	3	4
Ameliorate a retort	1	0	1
Response to invitation	0	3	3
Total	263	357	620

As an example of how functions were assigned, the exchange with Joan in Extract 6.1 was included in the pre-Covid count for *Response to a solicit such as 'Alright?', 'Okay?', or 'How are you?'* (line 3) and *Acknowledgement of service rendered or assistance given* (lines 9–25).

The differences in thanking encounters in the pre-Covid vs mid-Covid footage are largely explained by what was filmed, e.g. many more staff meetings featured in the mid-Covid footage as the documentary covered how hospitals were adapting to the pandemic which accounts for the surge in 'polite closings' of encounters. Also, more thankable opportunities were generated by the atmosphere of heightened risk. People tended to 'check in' with colleagues through solicits ('how are you?') more frequently, and extended 'good wishes', such as 'all the best' and 'keep safe', for which thanks was a typical response.

6.6.4 Settings particular to healthcare in which gratitude is enacted

The spread of functions in Table 6.4 indicates that thanking expressions in *Hospital* serve the same functions as they do in society in general – helping to manage conversation, articulating gratitude, and being used ironically or jokingly (Jautz, 2015). In common with some other studies of interactions in institutional contexts (e.g. Mosegaard Hansen 2016; Aijmer 2014), thanking at the closing of phone calls in the dataset was highly conventionalised, regardless of whether the news received or imparted was welcome or not. There are three instances worth exploring in more

detail because they highlight features particular to filmed healthcare encounters: **1** thanking in the operating theatre, **2** thanking as part of discharge rituals, and **3** tellings of gratitude in pieces to camera. The situation of the post-operative briefing is a fourth example that will be explored in Section 6.7 using CA in a focused study of how gratitude is interpolated into news delivery following surgery.

6.6.4.1 Thanking in the operating theatre

The operating theatre is a complicated nexus of biomedical, hierarchical, social, and cultural interactions, in which cooperative communication is paramount. It is well established that discourse strategies in the operating theatre have significant effects on team performance (Clark & Kenski, 2017; Lingard et al., 2002; Riskin et al., 2015). The effects of politeness have not received nearly as much attention as the damaging effects of rude and disruptive behaviour. Katz et al. (2019) reports multiple areas that are negatively impacted by incivility, including vigilance, diagnosis, and patient management.

Being polite in talk, however, can come at the expense of being concise and direct. Brown and Levinson (2006) say that 'face' – the projection of one's social values in the presence of others – in the context of politeness, is routinely ignored in cases of urgent cooperation or in the interests of efficiency (p. 312). Liu, McKenzie, and Sutkin (2021) found that the use of some politeness strategies, such as implicature (when an instruction is implied rather than asserted), contribute to unhelpful ambiguity in the operating room. They recommend replacing polite instructions, such as 'the way I would do it is this way' with direct instruction, such as 'Do it this way' (p. 1945) so that politeness is not at the expense of speaking precisely.

Staff-to-staff thanking expressions in the operating theatre in the dataset are shown in Table 6.5. Overall, the operating theatre was depicted as a very civil environment in which politeness was maintained even in extremis. Thanking interactions were instrumental in showing deference. During surgery, 'thank you' mostly served as form of acknowledgement that an action had been satisfactorily accomplished or a request fulfilled. Regular thanking helped set a respectful tone without sacrificing precision.

Table 6.5. Thanking expressions in the operating theatre during and after surgery

Realisation	**Series (S), episode (E)**
Mid surgery	
'Okay let's have an inside knife please? Thank you'	S4, E2
'So we can open the valve thanks (Joe)'	S4, E6
'Can we have the table higher please? Thank you'	S5, E1
'Knife back to you' 'Thank you'	S5, E1
'Port out' 'Thank you [...] Good? Tha(:)nk ↑you' 'Thank you very much'	S5, E1
'Silence for me on the monitor will you guys in there? Thank you'	S5, E3
'They're happy for you to go. Thanks ever so much mate cheers'	S5, E3
'We're going to be outside. If you need us we will step in.' 'Thank you'	Covid Special, E1
'Come out with the clip. Thank you. Thank you very much.'	S6, E3
'Scissors and a pair of Debakeys to Prof as well' 'Yep' 'Thanks Susannah'	S6, E3
'Oka(:)y. Very tight ay. Forceps thanks.'	S7, E1
Post surgery	
'Thank you tea(:)m? Well done everyone?'	S4, E6
'Thank you very much everyone for everything that you've done. I'm sorry that we didn't have a better outcome (.) for this'	S5, E3
'Cheers Jack' 'Thanks Mattie'	S5, E7
'GUYS THANKS A MILLION'	S5, E7
'Okay thanks Cass. Thanks, everyone'	S5, E7
'Okay thank you everybody. Brilliant thanks Matt'	S5, E8

'That's exactly where we started off so we'll leave it there now. (.) Thank ↑you'	S5, E8
'Thank you very much. Bye.'	Covid Special, E1
'Thank you' 'Thank you everybody it's good to be back.'	S6, E1
'Thank you very much guys I'm sorry I need to ru(:)sh. Robotic hysterectomy BSO. Thank you team.'	S7, E2
'Thank you very much indeed'	S7, E2
'That was quick. Thank you Jason'	S7, E4
'You're good to go? Thank you so much?'	S7, E5

At the conclusion of surgery, thanking the team formed something of a ritual. Surgeons expressed thanks at the point of exiting the operating room, most often addressed to 'everyone' or the 'team', but also named individuals.

Thanks are not only expressed when operations go smoothly. One of the most poignant episodes (Series 5, Episode 3) shows Joe having high-risk surgery to repair a hole in his heart. The procedure is unsuccessful and he dies during the operation. In contrast to the frenetic atmosphere that preceded the realisation that the situation was irrecoverable, the communication slowed down and took on the qualities of a ritual. The transcript in Extract 6.2 begins after a discussion between the anaesthetist David Mayhew (DM) and the surgeon Suniel Aggarwal (SA) about whether a hole in Joe's right ventricle is repairable. They conclude that it is not. Theatre staff are visibly upset when the patient dies.

Extract 6.2. Thanking the team after an operation to repair a patient's hole in his heart is unsuccessful (Series 5, Episode 3)

```
1  DM:    At the moment you've got an uncontrolled bleed
2         (0.3)
3  SA:    =Yeah
4  DM:    =Which has no prospect of getting control
5         (0.3)
6  SA:    No ((underscoring music fades out))
7         (3.2)
8         Unfortunately we're going to have to .hh stop at that point
9         (11.0)
11        Thank you very much everyone for everything that you've
12        done (0.2) I'm sorry that we didn't have a better outcome
13        (.) for this
```

The 11 s pause at line 9 (which may have been edited down) preceding the expression of thanks emphasises the respectful silence in the theatre to acknowledge that the patient has died. The surgeon's thanking is coupled with an expression of regret about the outcome (lines 11–13).

Hartley et al. (2019) have criticised the discounting of a human response to deaths occurring in the operating theatre. If distress goes unnoticed and unacknowledged, it can make clinicians vulnerable to vicarious traumatisation. The stepping out of biomedical mode and into a relational, emotional frame – indexed by the surgeon's expressions of gratitude and regret – helps to validate a shared bereavement experience. Effort is constructed as the thankable ('thank you very much everyone for everything that you've done', lines 11–12). This example shows that thanking is not only an important part of acknowledging success, it also participates in high-intensity interactions when things have gone wrong and staff are distressed.

I turn now to a situation in which gratitude is reliably forthcoming: farewells between staff and patients when they are discharged from hospital.

6.6.4.2 Discharge rituals

Patients requiring treatment want nothing more than to gain admission to hospital, but once treated, they are desperate to go home. Being discharged from hospital often has ceremonial overtones, especially for patients who have spent long periods as inpatients and those that have had life-changing procedures. Some of the most intense thanking encounters in the dataset took place at moments of discharge. These encounters tend to be celebratory, providing a sense of closure for the patients and relatives involved. They also serve the purposes of the narrative arc of many of the episodes of *Hospital*, providing a denouement for the stories featured during each episode.

Thirty-one instances of thanking as part of discharge rituals featured in the dataset. Especially when patients are discharged from wards, it is the staff that are on duty that are thanked rather than those that have necessarily been most involved in a patient's care. However, the presence of the camera affords an opportunity for more expansive thanking than perhaps might otherwise have been the case. These filmed rituals are analogous to televisual thank-you cards.

I elaborate two examples that show features which offer insights into how thanking is conceptualised and responded to. A further example of thanking on discharge is given in Extract 6.5 of Section 6.6.4.3, where a father elaborates his gratitude after his daughter's much-delayed surgery.

In Chapter 5, the phenomenon of staff cheering and clapping as Covid patients were discharged was noted as a variation on the clap-for-carers phenomenon. Several examples of clapping for discharged patients featured in the dataset, one of whom was Nancy, a nurse at the hospital who contracted Covid and whose chances of survival were estimated to be 50%. In Extract 6.3 Nancy makes a speech (or 'makes testimony' as she describes it to nurses as she is packing her bags) to dozens of staff lining the corridor as she leaves hospital.

The camera cuts between shots of Nancy speaking and staff listening attentively. Her delivery is breathy, as might be expected from the respiratory effects of Covid for which she had to be intubated, and her words are subtitled.

Nancy's thanking is intensified by adverbial modification – I am *truly truly* grateful *from the bottom of my heart* (lines 7–8), and the repetition of 'truly truly grateful' (lines 7 and 12) with an addition two 'truly grateful's (lines 18 and 19). Nancy references two other emotions in her speech: anger (line 10) and pride (line 18). She also positions herself primarily as a professional rather than a patient, referencing how long she has worked for the NHS and using 'we' and 'us' to align herself with her colleagues.

A particular feature of Nancy's speech is that, in the 440 thanking encounters in the dataset, it is *the only one* that invoked 'indebtedness' ('We are indebted to a lot of you who've left their families so far away and you are here to help us'). The reference to indebtedness as part of a display of gratitude is an exception. It presents a further challenge to prevailing political-economic characterisations of gratitude that invoke the language of obligation and debt (discussed further in Sections 6.8 and 7.2.1.3).

Extract 6.3. Nancy makes a speech to colleagues when she is discharged from hospital (Covid Special, Episode 1)

Nancy: Aw:::::: ((Nancy walks down the corridor to 22.8 s of cheering, whistling and applause #Figure 6.4))

Figure 6.4

((Nancy addresses staff from the ward entrance))
Nancy: My colleagues (0.9) I want you to understa:nd
(0.5)
Voice: ((off camera)) Shhh [shhh
Nancy: [That I am truly (0.3) truly (0.2) grateful (0.9) from the bottom of my heart .hhhhh I've worked with the NHS since 1970 (0.5) I worked every day of my life .hhhhh never taken off sick .hh so you can imagine how (.) angry I am .hh that this stupid illness got me. .hhh I I want you to all kno::w .hh that I am truly .hh truly grateful. (0.5) ((possible cut)) We are indebted .hh to a lot of you .hh who've left their families .hhh so far away and you are here to help us .hhhh Please (0.6) just (0.4) hold on a little bit more:: .hhhh we shall overcome this .hhh and when we do:: .hhh the NHS hopefully .hhh will be the better for it. (.) #Figure 6.5

Figure 6.5

.hhh So I am truly grateful. .hhh I am proud to be a nurse. .hh Thank you. (0.3) ((clapping resumes)) I am truly grateful

Not all discharge rituals are as conspicuously celebratory as Nancy's send-off, but many displays of gratitude at discharge were emotionally charged. In Extract 6.4, a staff nurse (unnamed in the documentary) is the recipient of intensified thanking from Peter, who has also survived Covid against the odds, and his daughter, Lisa. This extract is of interest for several reasons: it is an example of impassioned thanking; the responses of the nurse who is the target of thanking are illuminating about the way gratitude is responded to; and there is a clear awareness of a wider audience (camera crew?, staff forming part of the television audience?) in the final line of the extract where Peter extends his thanks to 'everybody'.

Lisa initiates the thanking sequence with an intensified expression of thanks ('thank you so much', line 2). Peter than specifically thanks the nurse, signalling that she has been involved in his care ('very very special thanks to you', line 3). The nurse responds with an acknowledgement ('that's okay', line 4). Peter adds 'it was good' (line 5) without specifying what 'it' refers to – his care (in which case it feels like an understatement) or his experience in hospital (in which case it feels like overstatement given that he has had a very difficult experience). The nurse treats this as an extension of the gratitude and supplies a second acknowledgement, 'That's alright' (line 6).

Lisa now upgrades her thanks by using a more formal expression of gratitude which begins with the inadequacy of words to express thanks: 'I can't tell you how grateful my whole family is to have my dad back' (lines 9, 13 and 15). The nurse overlaps Lisa's thanks with an elongated 'Awwww' (line 12). This is a token (a linguistic unit) that works affiliatively to signal sympathy. The nurse responds to the emotional content of the thanking rather than to the words themselves, a strategy she renews with a second, initially inflected 'Awwww' (line 14) as Lisa extends her thanks to coming from her whole family for having her 'dad back'. The nurse responds with 'that's okay' (line 16), and then overlaps Lisa's upgrading of her thanks to say 'we're doing our job' (line 18). The use of 'we' suggests that the nurse knows that the thanks are directed at more than just her but that she is being addressed as proxy for the hospital staff in general.

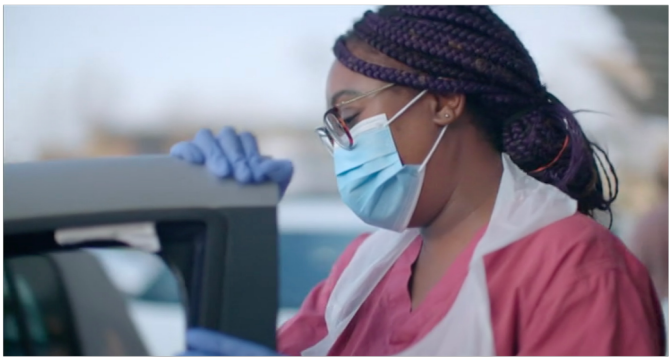
Extract 6.4. Covid-patient Peter and his daughter Lisa thank nurse as he leaves the hospital (Covid special, Episode 1)

Lisa: ((to the nurse as Lisa is putting Peter's luggage in the boot of the car)) Thank you so much::
Peter: Very very special thanks to you.
Nurse: =That's okay.
Peter: =It was good
Nurse: =That's all right.
Peter: I really appreciate it thanks
(0.7)
Lisa: I can't tell you how grateful
Peter: ((glancing at his daughter before getting into the car))
[~Uhhu~
Nurse: [Awwwwww
Lisa: my whole family is:: #Figure 6.6

Figure 6.6

Nurse: Awwww[www
Lisa: [to have my dad back.
Nurse: That's okay=
Lisa: =It's the most amazing (.) [brilliant amazing thing
Nurse: [We're doing our job
£Heh heh heh he£
Lisa: ((walking round to the driver's seat)) So much love and gratitude ((indistinct)) [thank you again ((she gets into the car))
Peter: [Thank you
Nurse: Kaaay #Figure 6.7((she closes Peter's car door))

Figure 6.7



(1.6) ((possible cut))
Peter: ((waving through car window)) Thanks very much everybody

On paper, a response of 'we're doing our job' sounds like a rejection of the thanks being proffered and risks coming across as impolite. However, in this context it is difficult to criticise the nurse for responding to thanks in this way. Emotional affiliation has already been expressed through the repeated use of 'Awwww'. The utterance 'we're doing our job' is not hearable as a dismissal of the thanks. This extract is exemplary of how responses to thanking expressions are key to the way gratitude is accomplished or resisted in interaction. Patterns of responding are considered in more detail in Section 6.6.5.

6.6.4.3 Tellings of gratitude in pieces to camera

Most thanking phrases in the dataset are in present tense: thanking was enacted in real time, rather than talked about as a past or future action. There are just three exceptions across the entire dataset: past tense –'I was […] very grateful', future tense – 'I'll be eternally grateful', and future continuous – 'I'd be ever so grateful'). Whilst constructions that use tokens other than 'grateful' are grammatically available ('I would appreciate it', 'I was thankful'), 'grateful' was the preferred construction when speakers used past or future tense. More salient, perhaps, is that two of these three examples occurred in pieces delivered to camera, a format of talk that elicited the labelling of gratitude and thankfulness as felt emotions ('I am/was/will be' formulations).

We have already seen how Nancy in Extract 6.3 used the occasion of staff gathering at her discharge to make use of the floor-holding opportunity to label her emotion as gratitude ('I am truly truly grateful'). Pieces to camera also afford floor-holding opportunities in which speakers can enact a 'telling' of gratitude that is pragmatically different to thanking as an illocutionary device displayed in conversation between a thanker and thankee. Although individuals who consent to participate in documentaries like *Hospital* cede epistemic rights to the production crew to decide who says what when, pieces to camera provide floor-holding opportunities for participants to narrativise their own experience.

Pieces to camera are a particular feature of the documentary style of *Hospital*. They provide opportunities for participants to provide a commentary on their thoughts, attitudes, and actions. Whilst these stretches of talk are not conversations

per se, they do still constitute interactions because the participant addresses the imagined viewing audience through the camera.

There were 13 examples of piece-to-camera gratitude encounters in the dataset (Table 6.6). Pieces to camera accounted for the majority of realisations of thanking expressions in which gratitude or thankfulness was an emotion explicitly oriented *to* by speakers through the labelling of their feelings as gratitude or thankfulness. 'I am grateful' and variants are voiced in excerpts in 1, 3, 8, 9, 10, 11 shown in Table 6.6 and 'I am thankful' and variants are spoken in 4, 6, 12 and 13. The two exceptions are Les (excerpt 7), who uses the piece to camera to enact his thanking ('I thank them'), and Blessing in excerpt 5 who conceptualises gratitude as a capacity ('so much gratitude').

Naming emotions has rhetorical functions: it 'construct[s] the world in ways that simultaneously evaluates it in some way' (Weatherall and Robles 2021, p. 17). By constructing care experiences as gratitude-worthy, the tellings of gratitude position the speakers as beneficiaries of 'thankables' – benefits for which thanks is a plausible response. Whilst thankables are often negotiated in interaction (as explored in Section 6.7.2), tellings are shown to educe references to thankables as identified in Table 6.6.

Table 6.6. Formulations of thanking expressions in pieces to camera

Excerpt identifier	Thanking formulation (tokens in bold)	Thankable	Speaker	Series and episode
1	I'm grateful that it's ((surgery)) happening	Opportunity for treatment	Ahmad, father of cardiac patient Aaima	S4, E4
2	I want to thank the surgeons the doctors the NHS. The effort they put in is just unbelievable. (1.6) I'm very thankful to them. (0.8) ((Cut to shots of thank you cards from patients.)) Because if you were living in a poor country, you know: they might not even have this treatment there. (3.8) ((Cut back to Ahmad)) All I can do is give them du'as, which is prayers, that's all I can do for them. ((Cut to shots of Ahmad carrying Aaima out of the ward)) For they saved my daughter's ↑li:fe	Effort Opportunity for treatment Saving life	Ahmad, father of cardiac patient Aaima	S4, E4
3	Knowing the fact that somebody's (1.0) had to die: so that I can (1.0) have an organ to live. That's hard and it must be very very hard on their family (.) and what they're going through at the moment. But I'm so(:) so grateful ((looking up then closing eyes)) (6.9) .hhh to both the donor ~and their family~ ((puts hand to mouth and uses fingers to wipe away tears))	Organ Saving life	Pamela, kidney recipient from a deceased donor	S4, E5
4	Blessing (to her son): Huh? Well the doctors the doctors have looked after Mommy(:). Haven't they? Queen (Blessing's mum): I am so happy, so thrilled. So we're really thankful really thankful.	Care	Queen, mother of lupus patient Blessing	S5, E1
5	I've been waiting for this day ((to go home)) for so long. And it's a week before Christmas. Like, words fail me tuh (.) you know (.) so much gratitude?	Timing of discharge	Blessing, lupus patient	S5, E1

6	Obviously? I-I was in like (.) a really critical situation? Um where I could've lost my life so erm (1.0) th-there has been really hard times but I'm thankful tha' I'm just back smiling again?	Saving life	Blessing, lupus patient	S5, E1
7	Okay they're run off their feet with the cuts. But they're doing a grand job. I thank every one of them. And I mean that. I really thank every one of them. For looking after the people(:) of Liverpool.	Looking after	Les, admitted with chest pains	S5, E2
8	So grateful uh you know I can't si(:)gn off that we're really grateful for what (.) potentially is there but (.) until I've got the keys in my hand ((referring to purpose-built house to allow Hari to be discharged)) (.) it won't be real.	Potential for care package	Michael, father of Hari who has a muscle wasting disease	S5, E5
9	I'm massively grateful for the fact that I've been able to have it. ((surgery))	Access to treatment	Jacob, pectoral surgical patient	S5, E7
10	To be offered this ((procedure to harvest stem cells)) is actually I was very surpri(:)sed (.) and very grateful.	Access to treatment	Suzanne, mother to cancer patient Edwards	S5, E8
11	There's hope now. (1.7) You know and I've got (0.2) an amazing surgeon (0.4) the top lady two top ladies amazing (0.3) and for her to give me the opportunity (1.7) ~I I'll be eternally grateful to Miss Shanbhag.~	Access to treatment	Natasha, cancer patient	S7, E2
12	At least he's in the right place so I'm thankful for that.	Access to treatment (implied)	Christine, spouse of heart attack patient	S7, E4
13	I feel thankful that to a degree I've sort of been given a second chance?	Saving life (implied)	Colin, Covid patient	S7, E6

The thankables of caring, saving, and effort are familiar from themes identified in the Twitter analysis in Chapter 4. A category distinctive to this dataset, though, is the opportunity to access or receive treatment, as indicated by Ahmed (excerpt 1 in Table 6.6, Jacob (excerpt 9), Suzanne (excerpt 10) and Natasha (excerpt 11). Michael too (excerpt 8) anticipates the thankable as a care package that will allow his son to be discharged from hospital. These all connect with a narrative that runs through *Hospital*: getting treated at all is something for which to be thankful.

To illustrate how the tellings of gratitude in *Hospital* participate in the construction of gratitude for access to care as a normative obligation, the piece to camera by Ahmad (Extract 6.5) is now considered in more detail as a public, morally calibrated response to Aaima's predicament, both as a seriously ill child and a victim of organisational stresses within Alder Hey Children's Hospital.

On the face of it, Ahmad has every reason to be angry, frustrated, and upset rather than grateful. His daughter Aaima, 5, has previously had surgery twice for a congenital heart defect. Her second admission lasted two months in hospital after she had a cardiac arrest during an operation. She now needs a Fontan operation to redirect a vein that will assist with the blood flow to her lungs. Aaima's parents and her baby brother are filmed accompanying Aaima to the hospital, only to have her surgery cancelled at short notice because there is no bed available for her post-operative care. Ahmad responds to the news that the surgery has been cancelled with 'No problem' and goes on to account for his equanimity by saying that Aaima was once an emergency case too and he is sure other children's operations were cancelled to look after her. The shortage of staff to care for critically ill patients carries on to the following day and Aaima's operation is cancelled again. When the surgery does finally go ahead, it is not without complications. A vein is punctured during the 11-hour operation necessitating a delicate repair.

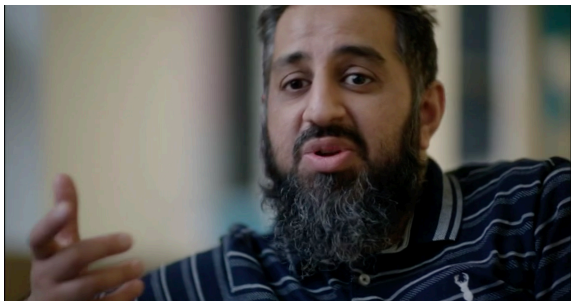
Extract 6.5. Ahmad's piece to camera

Ahmad: ((speaking to camera from a seat in a hospital corridor)) Her treatment's over now so:: (0.4) that's peace of mind for me now that you know (1.0) she can live her life now ((cut to shot of Ahmad carrying Aaima)) Aaima are you well? ((Voice-over to shots of Aaima in her father's arms as they are leaving the ward)) I want to thank the surgeons the doctors the NHS (.) the effort they put in is just unbelievable (1.6) ((Cut to Ahmad speaking to camera)) I'm very thankful to them. (0.8) ((Cut to shots of thank you cards from patients.)) #Figure 6.8

Figure 6.8

Because if you were living in a poor country, you know:, they might not even have this treatment there. (3.8) ((Cut back to Ahmad)) All I can do is give them du'as, which is prayers, #Figure 6.9 that's all I can do for them.

Figure 6.9



((Cut to shots of Ahmad carrying Aaima out of the ward))
Voice: ((out of shot)) Bye ((Aaima waves))
Ahmad: For they saved my daughter's ↑li:fe
Voice: ((out of shot)) By-eee

This piece to camera comes at the end of the episode, Ahmad formulates his thanks to surgeons, doctors, and the NHS (lines 6–7). He makes effort the thankable ('The effort they put in is just unbelievable', line 7), and reiterates his thanks in a labelling of emotion: 'I'm very thankful to them' (lines 8–9).

To emphasise that staff are thanks-worthy, the camera cuts to show a crowded shelf of thank-you cards and lingers on a few appreciative messages as Ahmad's voice-

over continues. Ahmad accounts for his gratitude in the frame of global health inequalities: 'if you were living in a poor country, you know:, they might not even have this treatment there' (lines 11–12). He then puts his thanks in a spiritual context, framing his prayers as 'all I can do' (line 13 and repeated in line 14). His speech concludes with 'For they saved my daughter's ↑li:fe' – with an expressive upward pitch.

In this, and other pieces to camera, gratitude is constructed as a moral moment – a publicly accountable, gracious response to situation *in spite of* a care experience that has been suboptimal. Aaima's procedure was cancelled on three occasions because of lack of staffing for an intensive care bed, then complicated by the puncturing of a vein. Ahmad's references to living in a country where the procedure is available as something to be grateful for, and also his evident spirituality in his references to offering prayers, put this gratitude for *this thing now* in dialogue with wider concerns of moral obligations to be thankful (others are not so fortunate, and prayers are a form of gift he has to offer).

6.6.5 Responses to thanking expressions

So far, the focus has been on thanking expressions in a variety of encounters that are afforded by the filming of healthcare interactions, including conversations, closing rituals, and pieces to camera. Eisenstein and Bodman (1993) observed that 'thanking is a speech act that is mutually developed' with the giver and the thanker collaborating to develop a mutually satisfactory, successful thanking episode (p. 74). Therefore, to gain an indication of whether gratitude has been successfully accomplished, one must not look only at thanking expressions, but examine how those being thanked respond to those expressing thanks. Using recipients' responses as evidence for how a practice has been understood is often referred to as the *next-turn proof procedure* (Sidnell, 2013).

'Thank you' (or 'thanks') as a phrase is potentially ambiguous in what it accomplishes as a turn in an interaction. When it functions as an expression of gratitude, it is likely to be seen by the thanker as an 'initiating turn' or first-pair part (FPP), which anticipates a responsive turn or second-pair part (SPP) to complete the sequence – some sort of acknowledgement that the thanks has been heard. As such, thanks and response to thanks form an *adjacency pair* (Schneider, 2005). However,

'thank you' is also a common closing turn, signalling the end of an interaction. As such, no response is expected. Examples in extracts analysed so far include Joan's final turn in Extract 6.1 and Peter's final turn in Extract 6.4. Both are thanking expressions for which no receipt is given, and none is expected.

Responses can be difficult to pinpoint in complex sequences of talk in which thanking is interweaved with compliments and talk is overlapping. An example is the encounter transcribed in Extract 6.4 in which the nurse's response to Lisa's thanking includes non-lexical utterances ('Awww'), and turns overlapping with Lisa's assessments rather than one of her thanking expressions.

Lisa: It's the most amazing (.) [brilliant amazing thing
Nurse: [We're doing our job

Sensu stricto, therefore, 'we're doing our job' is not a response to thanking in terms of next-turn proof procedure because it not part of an adjacency pair. It overlaps with a complimentary assessment rather than thanking. A frequency analysis of responses to thanks, therefore, has limitations in that it isolates adjacency pairs from their context in gratitude encounters, but it can still point to useful patterns in the data that give us clues to how participants enact thanking in interaction.

As with the analysis of the functions of gratitude, a numerical classification of responses gives a misplaced sense of precision. Nevertheless, it can give an indication of trends. Phrases used to respond to thanks are given in Table 6.7.

When thanking is implicated in conversation management, an explicit response to the thanking token is not required or expected. Examples are where small favours are done, information is given, or reassurance is offered: thanks might here be described as 'sealing' the exchange – terminating the sequence within an encounter in a convivial manner (Schneider, 2005). Although these expressions do not preclude a further turn that receipts the thanks, choosing not to add a further turn is entirely consistent with the context.

Across the 440 encounters analysed across the dataset, I coded 195 (57%) as 'not expecting' a response. These were mainly terminal turns, in which the thanking was

Table 6.7. Responses to patient- or relative-initiated thanks

Receipts of thanks	n
All right; that's all right; it's all right; you're all right	15
Okay; that's okay	14
Thank you; thanks; thanks very much	12
You're welcome; you're very welcome; welcome	12
No problem; no problem at all; no probs; it's no problem; not a problem	8
Yeah	5
No worries	4
That's been a pleasure; it's a pleasure; it's been a pleasure; that's my pleasure	4
Good; good stuff	3
Cheers	2
No that's fine; no thank you	2
Any time	1
Not at all	1
That's nice	1
Cool	1
Total	85

the final turn in the interaction, or it was pre-terminal and was followed by a farewell token. Farewell tokens were varied (bye, see you later, nice to see you) but prominent was 'take care'. This token occurred in a fifth of turns in the dataset following unreceipted thanks. It is not known whether the formulation 'take care' is especially prevalent in settings in which care takes place, or amongst care givers – I have found no mention of it in literature on conversational closings (Mosegaard Hansen, 2016; West, 2006; Woods et al., 2015; M. Wright, 2011).

An additional 54 of encounters (12%) were counted as a 'response not recorded' These where thanking turns when a response was hypothetically possible but a scene cut meant it was not shown, or the 'other side' of a phone call was not recorded.

6.6.5.1 Verbally receipting thanks

One of the clearest ways in which we can establish whether thanking has been accomplished is if the person to whom thanks is expressed acknowledges it in their conversational turn. In 85 instances, thanks directed at professionals by patients or relatives was responded to with an audible speech act that was unambiguous in its acknowledgement of thanking (Table 6.7).

One of the questions that can be addressed by a form-to-function analysis is whether patients/relatives repeat their thanks in an additional turn, if their first thanking turn is unreceipted. There are 133 encounters that show interactions between patients or relatives and health professionals. Figure 6.10 shows the proportion of thanking expressions that were receipted and unreceipted, and whether patients/relatives subsequently repeated their thanks in the encounter.

Thanking was repeated in 14 of the 44 encounters that did not educe a receipt. An example is given in Extract 6.6 in which a Covid patient, Anastacia, with a severe ankle break, is being offered a choice of beds in the newly opened Rainbow ward at Barnet Hospital by Sarah Stanley (SS), divisional director.

Extract 6.6. Example sequence in which thanking is unreceipted and repeated (Series 6, Episode 4)

1	**SS:**	You can pick which bed you want in that bay okay?
2	**Anastacia:**	Thank you.
3	**SS:**	Because you're going to be the first one
4	**Anastacia:**	Thank you.
5	**SS:**	How about tha:t?
6	**Anastacia:**	Thank you.

Figure 6.10. Thanking expressions that were receipted or not, and repeated or not (N=133)

A more counterintuitive finding is that is the high number of encounters (n=34) in which thanking was receipted, but it was still repeated. The adjacency pair of thanking and receipt suggests that gratitude is confirmed as having been accomplished if it is receipted and the conversation can progress to other topics or come to a close. Yet four in ten speakers chose to expand, reformulate, and repeat their thanks even when their thanks was acknowledged. We have already encountered two examples in extracts so far: in Extract 6.1 Joan's initial thanks (lines 9–10) was receipted by JM with 'No that's been a pleasure' yet she goes on to repeat her thanks in two more turns at talk. In Extract 6.4, too, Lisa's and Peter's thanks in lines 2 and 3 are receipted in line 4 with 'That's okay' but thanking is repeated in lines 21, 23, and 26. A receipt of thanking, therefore, does not routinely act to terminate the thanking sequence. The distribution of gratitude across several turns of talk implies that it is *significant orientation* in talk in spite of the perceived transactional nature of most communicative exchanges.

A common feature of the adjacency pair of gratitude expression and response in the dataset is that the receipt occurs in overlap with the thanking. The overlaps are responses to gratitude and do not cause the thanker to stop speaking, suggesting that

they are co-operative overlaps, as described by Tannen (1994), rather than a denial of the completion rights of the thanker.

6.6.5.2 Gestural receipts of thanks

Gestural receipts of thanking cannot be counted reliably in the dataset because the camera is usually focused on the speaker rather than the recipient of thanks (although we do usually hear their words). Nevertheless, nine embodied responses were observed. These consisted of nods (n=3), handshakes (n=3), hug (n=1), rubbing upper arm (n=1), and clapping and cheering (n=1) – this for Nancy as shown in Extract 6.3.

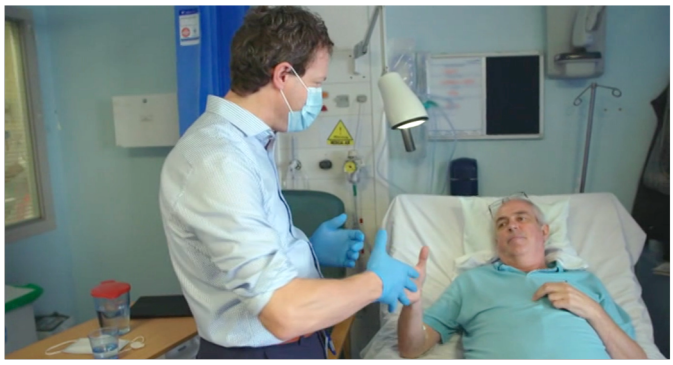
An example of an encounter in which thanking is receipted with a handshake is given in Extract 6.7. Gary, 58, has had complex surgery to treat cancer in his liver after having had surgery for bowel cancer two years ago. Prof. Joerg-Matthias Pollok, consultant liver and transplant surgeon at the Royal Free Hospital, has already had to cancel Gary's surgery after he'd been admitted because of a shortage of staff for an intensive care bed. Two weeks later the surgery does go ahead. Six days after surgery, Prof. Pollok, gloved and masked because it is mid-pandemic, examines him before he is discharged.

This encounter shows how gesture in the form of a solicited handshake participates in rapport confirmation between surgeon and patient. Gary's thanks is intensified by repetition, expressiveness in his voice, and the naming of the thankable ('everything you've done', lines 9–10). But at the heart of the encounter is the handshake which has ceremonial overtones: the polite request by the surgeon, 'May I?', and Gary's 'It'd be my honour'. JMP's double thumbs-up echoes the gesture with which the thanking sequence began. In Section 6.6.5 it was pointed out that 'take care' is a common farewell token in the dataset. Whilst usually proffered by professionals, here the patient uses it, suggesting the care relationship is reciprocal. This affective stance – the characterising of the relationship as one of mutual regard – is reinforced by Gary's comment to camera that it felt like 'saying goodbye to a friend' (lines 20–21), followed by a contemplative pause while Gary marshals his emotions before he refers to his life potentially being saved (lines 21–22).

Extract 6.7. Surgeon receipts Gary's thanking with a handshake (Series 6, Episode 6)

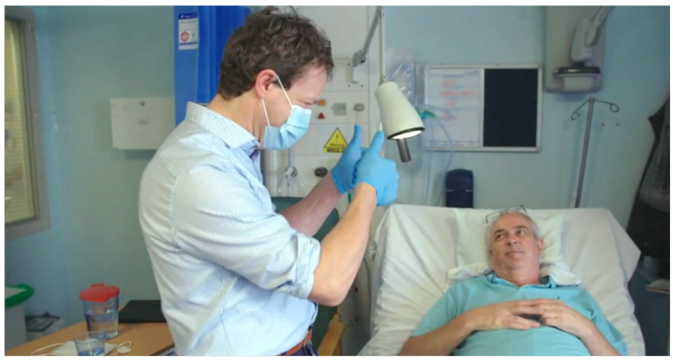
Narrator: Six days after major surgery (0.3) Gary is ready to leave hospital (.) and continue his recovery at home
JMP: If I may have a look at your (0.3) wound
Gary: [Of course you can=
JMP: [Before I send you home
((10.8s omitted from transcript where JMP examines the wound))
JMP: Good ((holds two thumbs up)) I'm very happy for you
Gary: Yeah thank you (0.3) ~Thank you for everything you've done.~
((possible cut))(1.0)
JMP: ((extends his gloved hand for a handshake)) May I?
((they shake hands)) (0.6) #Figure 6.11.

Figure 6.11.



Gary: ~It'd be my honour.~
(0.8)
JMP: ((holds two thumbs up #Figure 6.12)) All the best [bye bye
Gary: [~Take care~

Figure 6.12



JMP: Bye ((JMP leaves and is seen gelling his hands on way out))
Gary: ((to camera)) That does feel like saying goodbye to a ~friend~ (3.5) ~You know potentially that man has just saved my life~

6.6.5.3 Ambiguous responses to thanks

A small but noteworthy proportion of responses to thanking have not, to my knowledge, been considered in the pragmatics literature on thanking responses. These responses lexically echo some of the most common forms of thanking receipts – okay, alright, and yeah – yet they are made ambiguous by an upward inflection on the terminal syllable so that the response is poised between a receipt and a solicitation. In my dataset, these receipts took three forms: okay? (n=4), alright?/all right? (n=2) and yeah? (n=1). An example is given in Extract 6.8. This contrasts with the use of 'okay' and 'alright' by the nurse in Extract 6.4 (lines 4, 6, and 16) in which the inflection was neutral and not hearable as a question. In terms of next-turn proof procedure, patients and relatives treated upward inflected tokens either as an invitation to another turn to which they responded (e.g. Extract 6.8) or as requiring no response (or at least none was captured on camera).

Extract 6.8. Ambiguous response to thanking between cancer patient and surgeon (Series 4, Episode 3)

1	**Rebekah:**	>°Oh thank you°<
2	**Surgeon:**	Okay?
3	**Rebekah:**	.hhh ~Yeah.~ .shih

Ambiguous receipts tend to occur near the end of interactions. It simultaneously signals the speaker's ongoing engagement in the sequence – if patients or relatives have further questions they could ask them here – but also indicates that the encounter is moving to a close. If okay?/alright?/yeah? is treated as an initiating action rather than a receipt, the preferred response to is an affirmation, as seen in Extract 6.8 with Rebekah's 'Yeah'. Because the turn forms part of a gratitude sequence, the thanking that precedes it minimises the risk of a dispreferred, negative response. An ambiguous turn, therefore, has a 'hedging' effect: it neither agrees nor disagrees with the thanking turn. It also refocuses the conversation away from the recipient of thanks which might be a form of displaying humility.

6.7 Gratitude as an emotion made in interaction

From the analysis so far, we can see that pragmatics offers a system-level approach to thanking in verbal exchanges. I have used specific examples to generate an account of language use in the service of explaining linguistic and paralinguistic features of the complex business of expressing and receiving thanks. Whilst a great many thanking expressions do serve the purposes of communication management, we have seen how a range of intensification strategies helps to 'de-routinise' thanking expressions so the footing of encounters changes from routine to relational talk.

The settings of the operating theatre, the discharge ritual, and the piece-to-camera have already been considered as settings in which gratitude has a prominent role. My study now turns to show gratitude is accomplished interactionally within a particular genre of healthcare communication: the post-operative briefing. Using CA as a method for analysis here allows for a focus on the sequencing of interactions. The emphasis of the analysis moves from looking at patterns of thanking practices, to gratitude as an emotion displayed in interaction.

Why choose the post-operative briefing as the site of emotional display for analysis? There were a number of candidate genres of encounter in the dataset. Post-operative briefings were chosen largely for pragmatic reasons: they tend to be well-bounded encounters in which the participants have clearly identified roles; there were sufficient examples in the dataset (n = 19); and news delivery in clinical settings has already been established as being of interest to scholars using CA (Lane, 2015; Maynard et al., 2016; Maynard & Frankel, 2006).

6.7.1 The post-operative briefing

After a surgical procedure has been performed, surgeons meet with the patient and/or caregivers to relay news on the success or otherwise of the operation, give an account of what occurred, and to forecast future treatments and/or what can be expected during recovery. Whilst this task is often delegated to more junior staff for routine procedures, for high-risk cases – and perhaps prompted by the presence of a camera crew in my dataset – surgeons were shown to undertake the news delivery themselves.

In its most straightforward form, the post-operative briefing sequence has three parts: **1** news announcement, **2** gratitude expression, and **3** gratitude receipt. These stages are illustrated in Extract 6.9. Here, Charlie Evans, consultant colorectal surgeon at University Hospital Coventry, has used a surgical robotic system to operate on Joe, 71, who has bowel cancer. Immediately after the surgery he phones Joe's wife, Michelle, to update her on the operation.

Extract 6.9. Delivering post-surgical news (Series 7, Episode 6)

```
1  CE:          ((On speakerphone)) Hi Michelle it's Charlie Evans here
2               from the hospita::l? (0.2) .hhh I'm just
3  Michelle:    [Hello::
4  CE:          [ringing up hi hi I'm just ringing up about Joe:: (.)
5               We've just finished um the operation's gone really well
6               uh we just need to hope that he recovers well .hh and::
7               that we can get him up and about and going as soon as
8               possible.
9  Michelle:    Thank you profusely from the bottom of my heart that's
10              wonderful
11 CE:          That's [my-
12 Michelle:           [Thank you
13 CE:          My pleasure (.) and I'll be in touch .hh when we've seen
14              him and hopefully we we're on the mend and he's .hh on
15              his way out of the hospital. (.) Okay take care.
16 Michelle:    Super thank you. [Bye
17 CE:                           [Bye-bye. Bye-bye. ((He hangs up))
```

The news announcement comes in line 5 ('the operation's gone really well') with the gratitude expression in line 9 ('Thank you [...]'), and the receipt in line 13 ('My pleasure'), after which the interaction moves quickly to a close. Two components relevant to the construction of gratitude in interaction can be identified: the provision of the gratitude opportunity, and the laudable event proposal as part of an appreciation sequence.

6.7.1.1 The gratitude opportunity

DeSouza et al. (2021) have explored the concept of a 'gratitude opportunity space' – a standard time for expressing gratitude which is dynamically recalibrated by participants so that actions are co-ordinated and relationships are managed in social interaction. Although DeSouza et al.'s data involved the time of the passing of objects rather than turn design in conversation, the gratitude encounters in my data point to the tacit provision of gratitude opportunities during the news delivery sequence. In

Extract 6.9 Michelle takes up the gratitude opportunity as soon as the surgeon has finished the news announcement, and it is receipted in overlap with a second thanking token (line 9) from Michelle. The intensified thanking token ('profusely from the bottom of my heart') and the receipt ('my pleasure') indicates that gratitude has been accomplished and it terminates the news delivery sequence. The surgeon follows up with arrangement for future activities ('I'll be in touch [...]') – a pre-closing that (West, 2006) found was typical in doctor-initiated closings. Michelle reiterates her thanks (line 16) and the interaction comes to a close.

6.7.1.2 The appreciation sequence

In the context of post-diagnosis oncology interviews, Maynard et al. (2016) documented the frequent occurrence of an 'appreciation sequence'. Palliative care physicians are shown to induce appreciation through laudable event proposals in which they, tacitly or blatantly, encourage patients to assess news positively in terms of efficacy of care delivered thus far, even when possibility of a cure is not feasible. Some patients aligned with these laudable event proposals and displayed appreciation, opening the way for further treatment recommendations. However, others resisted the appreciation sequence indicating a misalignment in expectations of medical interventions between clinician and patient in a clinical context where acknowledgement of mortality must be balanced with mutual engagement in palliative care.

The base appreciation sequence proposed by Maynard et al. (2016) consists of the following elements:

A. Clinician: laudable event proposal
B. Patient: acknowledgement or agreement
C. Clinician: Solicit of appreciation
D. Patient: Display of appreciation
E. Clinician: Agreement or acknowledgement or approval

In my dataset, surgical outcomes were also often construed as laudable events. Extract 6.10 shows Smruta Shanbhag (SS), clinical lead for gynaecology at University Hospital Coventry, meeting with Wendy, 57, who has had a hysterectomy after precancerous cells were detected in her uterus. Wendy's surgery was delayed for 7 months by the pandemic.

Extract 6.10. Laudable event sequence after Wendy's surgery (Series 7, Episode 2)

A
1 **SS:** It's guh-↑gone (.) done ↑well (.) do you feel £relie::v(h)ed.£
2 **Wendy:** Yeah
3 **SS:** That it's £done£
B
4 **Wendy:** Yeah done and finished
5 **SS:** Yeah. (.) I didn't see anything I was concerned about Wendy
6 **Wendy:** [#Really#
7 **SS:** [the operation was straightforward as it could have gone
C
8 **SS:** I was [really really pleased with how it went?
9 **Wendy:** [#Yeah#
10 **SS:** ↑I'm hoping that this is it that we've cured you with the
11 hysterectomy because if it's early stage cancer (0.4) which is
12 what it's most likely to be because you've had the Mirena coil
13 (0.3)
14 **Wendy:** #Mm#
15 (1.2)
16 **SS:** This is it
17 **Wendy:** I keep missing these curve balls they keep throwing at me
18 like (.) covid and now this £huh huh£
C
19 **SS:** Yeah (.) if it's benign you're lucky enough never to £see
20 me again£
21 **Wendy:** Ha ha ha #

Figure 6.13

Figure 6.13

D
22 **SS:** Hm hm (.) Any questions for me?
23 **Wendy:** #No just want to thank you really for#=
E
24 **SS:** =No worries [no worries=
25 **Wendy:** [#Everything that you done.#
26 ((possible cut))
27 **SS:** Okay?
28 **Wendy:** #Alright#
29 **SS:** Bye bye Wendy
30 **Wendy:** #Thank you.# ((SS leaves the bay))

All the elements of the base appreciation sequence can be identified in this encounter. After the news announcement in line 1 ('It's guh-↑gone (.) done ↑well'), Miss Shanbhag overtly solicits Wendy's positive assessment of the laudable event (A): 'Do you feel £relie::v(h)ed.£' – with 'relieved' delivered in a 'smile voice'. Wendy's 'Yeah' (B) (line 2) is met with a continuation, 'That it's £done£' (line 3), with which Wendy again agrees. Miss Shanbhag then gives an elaboration of the news in line 7 and repeats her positive assessment (C) ('I was really really pleased with how it went?', line 8).

Maynard showed that bearers of good news often 'display their agency in generating the result they announce' (Maynard, 2003) and Miss Shanbhag shows this in line 10 with 'we've cured you'.

After mention of the Mirena coil (an intrauterine device thought to delay the spread of endometrial cancer), Miss Shanbhag pauses long enough in line 13 for Wendy to produce a minimal go-ahead (#Mm#, line 14), followed by a dramatic pause of 1.2 s, and an upshot: 'this is it' (line 16). There is a gratitude opportunity here that Wendy does not take up. Instead, she embarks on a troubles-telling about the 'curve balls they keep throwing at me' (line 17). Miss Shanbhag offers another tacit appreciation solicit opportunity (C) by making a joke at her own expense: 'if it's benign you're lucky enough never to £see me again£' (line 20). They laugh. Wendy does take up the gratitude opportunity (D) ('just want to thank you really', line 23) in response to Miss Shanbhag asking if she has any questions. A feature that is common in the collection of post-operative briefings sequences is that the thanking turn (line 23 and 25) is overlapped by the receipt (E) (line 24). The encounter then moves quickly to a close. Another feature typical of post-operative news delivery is that forecasts are constructed as subjective judgements to allow for the possibility of alternative outcomes. Miss Shanbhag's use of 'I'm hoping […] that we've cured you' (line 10) provides an optimistic but cautious forecast. This was also evident in Extract 6.9 when the surgeon says 'we just need to hope that he recovers well' (line 6).

Having established that surgical outcomes are often construed as laudable events through an appreciation sequence, I turn now to how gratitude is oriented to by participants in particular news delivery sequences in the dataset.

6.7.2 Good news, bad news, and the co-construction of the thankable

The post-operative briefing entails news delivery as a cluster of turns at talk in which displays of emotion can be understood as responsive to prior turns. Stevanovic and Peräkylä (2014) have shown that expectations regarding emotional expressions are implicated in relationship building and management. News delivery is primarily about sharing knowledge (what Stevanovic and Peräkylä refer to as orientating to the epistemic order), but displays of gratitude also require participants to orient to the emotional order. The following analyses show how gratitude is implicated in stance alignments with respect to news and to what is constituted as the thankable in the interaction.

6.7.2.1 Gratitude and the good news sequence

Extract 6.11 is an expanded version of the news delivery sequence during which gratitude is accomplished through verbal and embodied display of the participants, but also by the orientation of the narrative stance of the documentary to the surgeon as appreciation worthy.

Charlie, 3, has had surgery at Alder Hey Children's Hospital for a rare type of brain tumour called an ependymoma. This is the second attempt by consultant paediatric surgeon Conor Mallucci (CM) to remove the tumour after the first operation was halted because of the danger of brain damage. Charlie is scanned mid-operation to see whether any tumour has been missed. The radiologist spots a suspicious area and the operation proceeds to remove the final 4 mm of tumour. Mr Mallucci delivers the good news to Charlie's parents shortly after the completion of surgery.

After the greeting sequence, the news announcement ('really went well') is in line 5. The news is elaborated, with reference to the scans, in lines 12–23, including an account (lines 15–19) and a forecast (lines 21–23). Charlie's dad takes up the gratitude opportunity in line 25 ('don't know what to say mate'), which is in overlap with the surgeon's upward inflected 'yes?' in line 26, followed by a gratitude receipt in line 27.

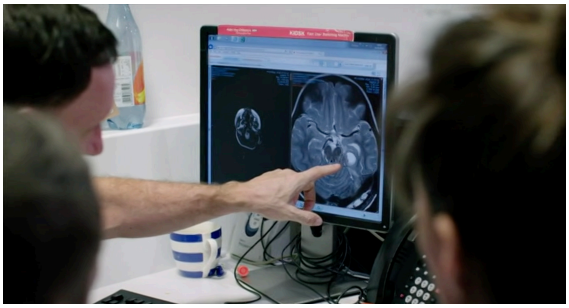
Extract 6.11. Charlie's brain surgery (Series 4, Episode 1)

CM: ((walking towards parents))Hi:: hi how are you (.) doing allright
Dad: How are you?
CM: £Good(hh)£ ((Charlie's dad hugs him, eyes shut #Figure 6.14))

Figure 6.14

Mum: How was it
CM: Good ↑brilliant ↑brilliant real:ly went well (1.3) ((Charlie's mum hugs him, eyes closed)) I'll show you the scans (.) Yeah? (0.6)
CM: It's fan[tastic yeah
Mum: [Now::?
((Cut to consulting room where CM is indicating to a scan on a computer screen))
CM: If you look care:fully (0.5) #Figure 6.15 there's this little thing much further down.

Figure 6.15



Dad: Wow
CM: That's below: the tent but it was (.) difficult to see. (0.3) It was hidden I can see why we missed it it was hidden under a load of scar tissue and a big blood vessel (.) so I managed to just sneak around that corner and there it was (.) and it came out?
(0.7) ((possible cut))
CM: I think he's got a complete remuh-resection and I don't and I've seen nothingk (0.7) either interop or on the scans that\ would make me think* he won't get back quickly to where he was
((*Cut to Mum nodding her head, her eyebrows raised))
Dad: £D-[don't know what to say£ mate
CM: [Yes? ((surgeon shakes dad's hand))

27 **CM:** Not at ↑all my my plea[sure ((surgeon shakes mum's hand))
28 **Mum:** ((She moves her hand from her cheek to shake surgeon's hand
29 then holds it over her mouth #Figure 6.16))

Figure 6.16

30 [Mir]acle(.hh)
31 ((She shakes her head and briefly puts her hand to her mouth.
32 Dad nods and mouths 'yeah'))
33 ((Cut to shot of parents leaving the room, hugging each other
34 with Charlie's mum audibly crying. They stop and look at each
35 other. Charlie's dad kisses her head))
36 **Dad:** It looks like he's got it all ((He holds her face in his hands))
37 Yeah:? (0.4) Yeah::?
38 ((Cut to parents visiting Charlie in the recovery ward.
39 43s omitted where parents greet Charlie and staff relay that he's
40 been asking for them.))
41 **Dad:** It's a miracle guys
42 **Member of staff:** ((standing next to Charlie's dad at his bedside))
43 Yeah yeah
44 **Dad:** ((stepping back and addressing staff within hearing))
45 How do you thank #Figure 6.17 someone fo-or saving your son's life
46 ((clip ends))

Figure 6.17

Mr Mallucci has, in previous sequences, already been characterised as an acclaim-worthy maverick for viewers by the voice-over narration ('the only neurosurgeon in the country prepared to attempt further surgery') and by the parents as a figure of reverence (Charlie's mum says, 'We do believe that Mr Mallucci can do anything'), which aligns with the description of the operation as a 'miracle', first by Mum (line 30) and then Dad (line 41). A verbalisation of gratitude is not made explicit in this sequence: Charlie's dad (line 25) says he doesn't know what to say. But this

inarticulation is receipted as gratitude. Mr Mallucci responds with 'not at all' and immediately upgrades his receipt to 'my my pleasure' while shaking the hands of Charlie's parents: a celebratory move. Charlie's dad's phrase 'don't know what to say' is consistent with the findings of Eisenstein & Bodman (1993) in which an admission of an inability to express one's thanks was deemed by their study participants to be an adequate expression of gratitude. By receipting it as such, Mr Mallucci is recognising the intent of the turn and signalling that gratitude has been accomplished. Charlie's dad will reinforce his framing of achieving thanks as a difficult by addressing a rhetorical question to staff at Charlie's bedside: 'How do you thank someone fo-or saving your son's life' (line 45), inflected as a statement rather than a question.

As seen in Extract 6.10, agency is emphasised in good-news delivery. Mr Mallucci adeptly manages to accrue credit (lines 17–18: 'I managed to just sneak [...]'). However, he mitigates against excessive hubris by referring to Charlie as having a resection rather than himself as performing it (line 21, 'I think he's got a complete remuh-resection') – a self-repair from 'removal' or, more likely, 'remission' (in which signs of cancer are reduced – inappropriate in this context because it is too soon to tell), to 'resection' (removal by surgery). As in Extract 6.9 and Extract 6.10, the forecast is hedged by emphasising that a good outcome is what the surgeon 'thinks' will happen.

6.7.2.2 Gratitude and the bad news sequence

Charlie's dad explicitly identifies the thankable (line 45) as the saving of his son's life: it is outcome-focused gratitude. But thanking is also implicated in news delivery where surgery has been unsuccessful. In Extract 6.12 the thankable is the effort made, in spite of the disappointing outcome. Sheila, 68, has waited for over a year for surgery to fix a hole in her heart. Prior to the encounter analysed here, the episode has shown her being prepared for surgery, only to have an anxious wait with her partner Ray to see if it can go ahead. An emergency during the preceding procedure means that her operation is eventually cancelled, and she must return six days later for the operation. During surgery, the team realise that Sheila's heart anatomy means they cannot repair the hole in the way they had planned, and the procedure is halted. Post-surgery Sheila

Extract 6.12. Gratitude in spite of Sheila's unsuccessful surgery (Series 5, Episode 3)

```
1  Ray:    Hello ((to SA who is entering the side room where Sheila is
2          recovering))
3  Sheila: ((croakily) Hello
4  SA:     Hello (1.5) ((to Sheila)) How are you doing (0.4)
5  Sheila: Fine thanks (0.4)
6  SA:     We found the hole is in such a location (0.7) it's not
7          actually suitable for (0.3) one of the devices we had thought
8          (0.4) been planning to put in?
9          (0.3)
10 Sheila: Ri:ght
11 SA:     But the extra pictures we've got today means that we'll have
12         to have another discussion in our meeting as tuh (0.2) what
13         else can be done for it?
14 Sheila: Oh thank you for what you've done any[way?
15 SA:                                          [Okay I'm sorry we
16         couldn't (0.2) do anything today
17 Sheila: Yeah
18 SA:     But we'll um see you soon hope[fully
19 Sheila:                               [Okay
20 Ray:    Okay
21 Sheila: Thanks very much
22 Ray:    Thanks very much
23 Sheila: =Thank you
24 SA:     ((shaking Ray's hand)) =Nice to see you (0.4) bye
25 Ray:    =Bye now
```

and Ray are given the bad news by surgeon Suneil Aggarwal (SA), consultant cardiologist at the Liverpool Heart and Chest Hospital.

This encounter shows the typical elements of post-operative news delivery with a greeting sequence (lines 1–5), following by announcement (lines 6–8), receipt of news from Sheila (line 10), arrangements for future activities (lines 11–13), take up of the gratitude opportunity by Sheila (line 14), receipt ('Okay') in overlap, followed immediately with regret framed as apology (line 15). There are reiterations of gratitude from Sheila and Ray (lines 21–23) preceding the closing (lines 24–25).

In common with Extracts 1 and 2, the surgeon's receipt in line 15 ('okay') is in overlap with the thanking expression, and gratitude marks the end of news delivery. There is no good-news outcome in this sequence but the gratitude opportunity is still taken up. Sheila identifies the thankable as process rather than outcome: 'what you done anyway' (line 14).

In the examples given so far, the nature of the thankable has not been contested. In Extract 6.13, however, the surgeons are resistant to the effusive gratitude from a patient's father. The misalignment is manifested through the putting up for negotiation of the thankable.

6.7.3 Resistance and insistence

In one of the most impactful storylines in the pre-Covid series, we follow the treatment of Yeshua, 2, for stage 4 para-aortic neuroblastoma. After a lengthy, high-risk operation, surgeons Matt Jones (MJ) and Jo Minford (JM) let anxious father Shaun know how it has gone.

The encounter opens with a good news announcement, receipted with embodied display of astonishment from Shaun. After some elaboration (lines 6–18) Shaun initiates thanking with an incomplete formulation of a 'want' ('I just want to give you a big hhhh'), with emotion interrupting fluency. Mr Jones frames his response as something he 'always' says, suggesting that it is his habitual response to insist that thanking is postponed until the patient has recovered. Shaun raises the volume of his rejoinder ('I KNOW THAT but'), only to have Mr Jones reiterate 'wait till he's better', with reinforcement from Ms Minford with 'always'. After an expanded account of the surgery in which the surgeons' agency (line 37) and luck (line 42) are implicated, Shaun hugs Ms Minford (line 48). He reiterates his thanks at low volume, shakes Mr Jones's hand and insists on a hug. Shaun's additional thanking token (line 58) is again overlapped with resistance from the surgeon ('Wait till he's better okay') which Shaun counters with 'It doesn't matter', but Mr Jones repeats, 'Wait till he's better.' Shaun possibly has more to say (line 62), but Mr Jones signals his intent to close the encounter with 'okay' and his move to the door. Shaun upgrades his thanking in words ('really salute you' and several more thank yous) and gestures (hand clasping and placing a hand on his heart to signal sincerity).

A pivotal turn here is where Shaun responds with 'it doesn't matter' (line 60) to the surgeon's repeated insistence that he should wait until Yeshua is better. Of course it does matter to Shaun that Yeshua gets better, but he is rejecting the notion that his gratitude is contingent on the clinical outcome of surgery. The misalignment is in what constitutes the thankable here – for Shaun it is the surgeons' willingness to attempt to excise the tumour (process) whereas for the surgeons it is the recovery of the patient (outcome). Because Shaun's has been told to defer his gratitude, rather

than having it effectually acknowledged, he continues to recycle his thanks, both verbally and in a variety of embodied displays.

Extract 6.13. Yeshua's cancer surgery (Series 5, Episode 8)

```
1   MJ:    The tumour is all ou:t.
2          (1.6) ((Shaun's eyes widen and he turns to look at JM who
3          looks serious but nods))
4   MJ:    So ((Sean turns to look at JM who nods))
5          (2.3)
6   MJ:    Sort of ninety-five per cent plus I mean I imagine there's
7           small: (0.2) little areas of cells and things [still
8   Shaun:                                                 [Yes
9   MJ:    behind that we can't see but everything we can see is out
10         (0.6)
11  Shaun: Any damage?
12         (0.5)
13  MJ:    No:.
14         (0.6)
15  MJ:    It's gone as well as it could have gone.
16         (1.2) ((Shaun shakes his head incredulously))
17  MJ:    So: uh both his kidneys look pink and his bowel's all pink
18         and happy so
19  Shaun: ((puts his hand to his mouth)) I just want to give you a big
20         [hhhh
21  MJ:    [It's alright(hh).
22         (0.6)
23  MJ:    Do you know what I always say you need to wait till he's
24         better=
25  Shaun: =I KNOW THAT #Figure 6.18 but ((lowers hand))
```

Figure 6.18

```
26  MJ:    Wait till he's [better
27         (0.8)
28  JM:    ((out of shot, indistinct))
29                        [Always
30  MJ:    Um::
31  Shaun: From the conversations we ~had~
32         (0.3)
33  MJ:    Yeah
34         (1.0)
35  Shaun: hhh I really thought you were going to open up (0.7) .hhh
36         and say .HHHHHHHHH it's too risky
37  MJ:    Well we're we we try pretty hard
38         (0.2)
39  MJ:    And: um:: I must admit for a while it really looked as if
```

```
40          that was the case? .hhh But we suddenly got somewhere so:
41          .hhh we started being able to identify things and so we just
42          sort of worked on from there so (0.2) he had a bit of luck
43          (0.3)
44  MJ:     [So
45  Shaun:  [I just want to jump on you
46          (0.6)
47  Shaun:  which way do we go first
48  JM:     Come 'ere ((Shaun and JM hug #Figure 6.19 and MJ stands up))
```

Figure 6.19

```
49          (1.7)
50  JM:     All right we'll look in on you: over the next few days
51          [make sure make sure it's alright
52  Shaun:  [°Thank you so much°
53  Shaun:  ((shakes hands with MJ)) Gimme a hug you're a big man
54          but ((they hug and Shaun pats MJ on the back))
55  JM:     Ha ha ha
56  Shaun:  God bless you ((They part))
57          (0.7)
58  Shaun:  Thank you so [much.
59  MJ:                  [Wait till he's wait till he's better okay
60  Shaun:  It doesn't matter
61  MJ:     Wait till he's better
62  Shaun:  I've:::
63          (0.5)
64  MJ:     Okay ((moving to the door))
65  Shaun:  Really salute you ((Shaun takes MJ's hand and places
66          his hand over it))
67  Shaun:  God bless (0.4) Thank you (.) Thank you so much (0.6)
68          ((Shaun places a hand over his heart #Figure 6.20)) Thank you
```

Figure 6.20

6.7.4 Delays in taking up the gratitude opportunity

Misalignments in conversations involving news delivery and gratitude are not only manifested in disagreements about what constitutes the thankable. Delayed taking up of available gratitude opportunities can indicate trouble.

There are many reasons that gratitude might be expressed but 'tempered' in a hospital setting. Waiting for treatment creates a state of impasse – a stretch of time fraught with uncertainty and hypervigilance – which is particularly disorienting for patients and their loved ones. If a major intervention is required, there is the added worry about whether it will be successful. The documentary *Hospital* often focuses on the topic of waiting. It looks at how operating lists are managed and explores the reasons for bottlenecks that prevent more patients being treated more quickly. It is not surprising that expression of gratitude might be equivocal in the face of a history of delays and cancellations. Extract 6.14 shows resistance to the taking up of early available gratitude opportunities by the mother of a patient. It also shows how prosody (the patterns of intonation in speech) signal trouble even when the thanking tokens (the words uttered) are intensified.

Nasreen, 23, has a range of difficulties since suffering a stroke as a child. She dislocated her hip a year prior to the operation and has been in agony. Much to the dismay of her mother, Aseema, her surgery has been postponed several times because of difficulties in securing an intensive therapy bed and having to compete with life-saving surgeries which take priority when theatre slots are at a premium during the pandemic. Prof. Richard King (RK) has successfully lobbied colleagues for her surgery to proceed.

The transcript begins where Prof. King briefs Aseema at Nasreen's bedside after the procedure. Aseema wears a face covering and Richard King wears a surgical mask and maintains social distancing, as mandated by pandemic regulations.

Extract 6.14. Delayed take up of gratitude opportunities after Nasreen's surgery (Series 7, Episode 1)

RK: ((entering the bay where Aseema sits by Nasreen's bedside))
.hhhh (4.1)
RK: AH (.) HelLO
(1.6)
RK: £HI::£
(0.8)
RK: ((to Nasreen who is in bed with a ventilation mask))
REMEMBER ME:? ((Nasreen does not respond))
(0.3)
RK: Just about probably
Aseema: $Hm mm mm mm$
RK: It was um (.) I'm glad it's done glad it's gone well
(0.4)
Aseema: Okay. #Figure 6.21

Figure 6.21

RK: Yeah so no problems really
(0.2)
Aseema: Okay.
RK: .hhh She's going to need (0.3) physiotherapy to try and=
Aseema: =Mmm=
RK: =.hhh stretch the leg ou::t
Aseema: Mm
RK: But as far as we can (.) tell from what we did it it it
looks good ((he nods)) #Figure 6.22
(0.2)

Figure 6.22

Aseema: Okay
(0.6)
Aseema: Thank you so much
RK: All ri[ght?
Aseema: [We really really appreciate it yeah
(0.3)
RK: I'm sorry it took so long to get to it
Aseema: NO no but we got there in the end.
RK: .hhh Yes hhhh[hhh

The prefiguring of the encounter with an audible sigh from the surgeon signals his trepidation. He begins with an attempt at jocularity which is met by Aseema with a closed-lipped laugh ('Hm mm mm mm') – a minimal response. Prof. King then embarks on a good news delivery sequence. He might possibly have been going to comment on the difficulty of the operation ('it was um'), but, in a repair, switches to a statement of positive emotion in relation to the accomplishment of the operation ('I'm glad it's done') which is immediately repaired to include reassurance ('I'm glad it's gone well'). The surgeon produces a clear thankable (the success of the procedure) here but the gratitude opportunities at lines 13 and 16 are not taken up. Prof. King then recycles the news in lines 22–23, producing a further gratitude opportunity which is not taken up. When it is finally taken up in line 27, it is produced only after a delay of 0.6 s.

Aseema's intonation in her news receipts is an indicator that the encounter is overshadowed by past trouble: her 'okays' (lines 14 and 17) are minimal receipts that are initially inflected, signalling understanding rather than relief, enthusiasm, or gratitude (see Beach (2020) for a discussion of the prosody of 'okays'). The surgeon responds to her first expression of thanks with 'Alright?' – an ambiguous response that is potentially hearable as a solicit or a receipt. Aseema upgrades the thanking ('we really really appreciate it yeah') but delivers this in an uninflected way that works in opposition to the intensification of the token: her thanks here is tempered. Prof. King responds with an apology for how long it has taken to 'get to it' (similarly to Extract 6.12 in which a 'sorry' formed part of the response to gratitude). Aseema rejects the apology ('NO no') followed immediately with 'but we got there in the end'. The use of 'we' and the verb mirroring (get/got) work to establish alignment, presaged by her thanking and his apology. Both parties confirm affiliation with 'Yes' tokens (his 'yes' is enfolded in a sigh), and the encounter moves to a close with 'All right. Bye' from Prof. King, and a repeating of 'thank you' as a close from Aseema.

This sequence shows how the surgeon's news delivery turns continue to construct the laudable event when there is resistance to taking up gratitude opportunities. When the opportunity is taken up, gratitude participates in action to re-establish alignment after acknowledgement of past trouble.

6.7.5 Expressive touch

Shaun's unabashed insistence on a hug in Extract 6.13 contrasts with two other examples in the dataset that show deference around hugging. In Extract 6.15 Rebekah seeks consent for a hug from her oncologist Sian Taylor (ST) after receiving good news. In Extract 6.16 Charlie's dad voices anxiety around the permissibility of hugging his son's oncologist Nicky Thorp (NT).

The hug in Extract 6.15 provides Rebekah with an additional thanking opportunity – one that is made more intimate because it is whispered in Prof. Taylor's ear. In contrast to Rebekah's tears, there is laughter in Extract 6.16 to mask the awkwardness in Charlie's dad's hug with Nicky Thorp. He does not complete his reservation about what is permissible ('I feel like I want to give you a big hug but it's probably not? …↑£probably not?£), leading to the oncologist not quite knowing how to respond to this non-invitation.

Participant roles in healthcare are known to circumscribe the range of permissible, culturally sanctioned interactional behaviours, particularly around non-procedural, expressive touch (Cocksedge et al., 2013; Kelly et al., 2018), with anxieties possibly heightened by awareness of the #metoo movement (Khubchandani et al., 2019). In pre-Covid footage hugging participated in rituals around comforting, celebrating and leave-taking, with 'thank yous' often whispered into the ears of the recipients during an embrace.

Extract 6.15. Rebekah meets with oncologist Sian Taylor (ST) for histopathology results after cancer surgery (Series 4, Episode 3)

ST: We knew that there was a cancer there. (0.5) Uh:: (0.5) and that's what it confirmed (.) .hh but the cancer was confirm-confined to the inner half of the womb? (0.3) Um::: it doesn't appear to have spread (.) beyond there (.) .hhh and so (.) you don't need any more treatment at the moment

Rebekah: >°Oh thank you°<

ST: Okay?

Rebekah: .hhh ~Yeah.~ .shih (0.5) I can give you (.) Can I give you a hug? .hh ((raises hands to nose and mouth))

ST: Course you can (.) come ere ((They stand up and hug #Figure 6.23, Rebekah sobs))

Figure 6.23 (Rebekah on left)

(1.0)

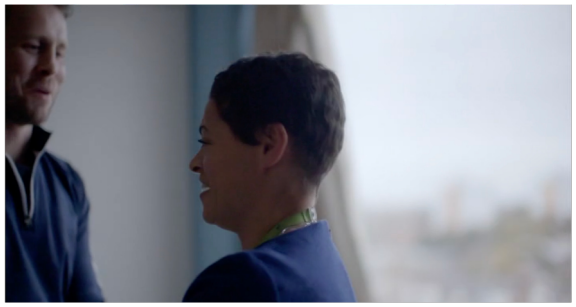
Rebekah: °Thank you. Thank you so much° .shih hh .hh ((they break away))

The absence of expressive touch was one of the most notable changes to thanking routines wrought by Covid. The handshake between Gary and Prof. Pollok shown in Extract 6.7 was the only example in the dataset of thanking being responded to with expressive touch during the pandemic. Hugging was important enough to be actively sought by interactants prior to Covid: it will be interesting to see whether the pandemic has long-term effects on expressive touch and whether this affects perceptions of interpersonal relationships in care.

Extract 6.16. Charlie's dad is unsure about offering oncologist Nicky Thorp a hug (Series 4, Episode 1)

1 **Dad:** I feel like I want to give you a big hug but it's probably not?
2 (hh)((NT laughs and steps towards him #Figure 6.24))

Figure 6.24



3 [↑£probably not?£
4 **NT:** [£Gah No worr-£
5 **Dad:** Gagh oh come on #Figure 6.25 (1.4) ((they hug))

Figure 6.25

6 Thank you.
7 (0.4) ((They break apart))
8 [Thank you so much.
9 **NT:** [£Okay he heh heh well it's a pleasure. It's been a pleasure.£

6.8 Discussion

This study has used an unconventional data source, a broadcast documentary, for studying the pragmatics and sequencing of gratitude encounters in healthcare interactions. The pragmalinguistic analysis showed that thanking expressions are accompanied by an extensive variety of supporting tokens (as shown in Figure 6.2), showing that thanking is less formulaic than some of the pragmatics literature (Aijmer, 2014; Jautz, 2015) might suggest. A range of intensification strategies are employed by thankers that help make their thanks more likely to be hearable as gratitude. Patients whose gestural repertoires are restricted by being in bed, or subject

to social distancing regulations, may rely on linguistic intensifiers to enact gratitude. Participants in the documentary also made use of the floor-holding opportunities afforded by pieces to camera to elaborate gratitude: these 'tellings' indexed gratitude referentially, whereas thanking enactments in interaction were displayed, with the evaluative stance determined by sequential position as a well as lexical and gestural components of talk.

What are the wider implications of this study for understanding gratitude in the healthcare environment? The findings challenge a characterisation of the functions of gratitude and responses to it that are prevalent – even paradigmatic – in the literature on thanking: moral economics. Philosophers such as Adam Smith, Thomas Hobbes and Immanuel Kant all invoked the language of obligation and debt in the way they conceptualised gratitude (Hobbes, 1926; Kant, 1886; A. Smith, 2004 f.p. 1759), as have more recent theorists (McConnell, 1993; Roberts, 2004). Of the 440 gratitude encounters examined, only one speaker, Nancy, referred to feeling indebted. When speaking more formally – notably in to-camera segments, or to groups of people – speakers tended to refer to gratitude as a state of being: 'I am grateful', 'I am thankful'. In conversation with others, thanks was *bestowed* ('thank you'), not as some inadequate recompense for a benefit, but more akin to an act of sharable humanity. Reciprocity may be a useful concept in social relationships, but it is far from normative in environments, like receiving surgery, in which reciprocating is neither practical nor desirable.

Schneider's work on responding to thanks has been foundational in pragmatics (Schneider, 2005). He compiled an inventory of possible responses to thanks, comparing uses in Ireland, England, and the USA. Other studies on responses to thanks include Bieswanger (2015); Gesuato (2016); Farenkia (2012); Rüegg (2014); Dinkin (2018); Jung (1994); and Barron (2022). Schneider (2005) introduced the term 'thanks minimiser' on the basis that the motivation for all responses to thanks is essentially the same, 'to minimize the thanker's indebtedness and, thus, to restore the imbalance between the participants' although there are different strategies for doing so' (p. 106).

The term 'minimise' appears to originate with Goffman who invokes it in his discussion of 'the remedial interchange' in which there is a 'victim' and an 'offender'

(Goffman, 1971). The 'victim' of some social offence that is being remediated might graciously make light of what has been foregone or suffered by saying something like 'That's all right' or 'Think nothing of it'. 'This move,' says Goffman, 'I shall call a "minimization"' (p. 143). Whist references to quantity are evident in intensification strategies (e.g. thank you *very/so much, profusely*), the transposition of minimisation to describing *all* responses to thanks has limitations. In the case of pragmatic analyses of responses to thanks, the expectation authorised by a quantitative framing, such as 'minimiser', is one of the balance sheet.

The metaphor of moral bookkeeping, critiqued by Card (1988) (and referred to in Section 2.4.1 of the metanarrative review), is theory-constitutive in the disciplinary approach of pragmatics to gratitude and its responses: it resonates, unchallenged, throughout the literature in spite of their being little evidence of indebtedness being invoked in the way gratitude is expressed or received. The only example of indebtedness in my dataset was when Nancy (Extract 6.3) referred to being indebted to colleagues who were far from home as part of an extended thanking sequence. There were no examples referring debt of imbalance drawn from any of the other 439 encounters.

In a three-pronged study of prototypical features of gratitude conducted by Morgan, Gulliford, and Kristjánsson (2014), it was found that UK lay participants did recognise that indebtedness is a negative aspect of gratitude, but it ranked low (48 of 63) on the 'centrality' ratings (i.e. where participants ranked what elements they thought should or should not constitute gratitude). This finding is consistent with an earlier prototype analysis of gratitude carried out by Lambert et al. (2009) in which 'indebtedness' and 'owing' came in the bottom five of the 52 features of gratitude that participants ranked as central. There is clearly a misalignment in the way gratitude is conceptually grounded by pragmatics theorists, and the way it is used in practice.

What are the implications of this misalignment? It filters through to the way categories of thanking responders are constructed in linguistic taxonomies. Schneider (2005) and also Farenkia (2012) include 'okay' (include 'alright', 'it's fine' and 'great') under the category of 'minimisers' – a far-from-intuitive categorisation. How is a response of 'great' consonant with a *minimising* function? Bieswanger (2015) critiques the term 'minimiser', arguing that not all strategies reduce the indebtedness of the

thanker. For example, a response like 'yeah' is a mere acknowledgement of the thanks. He still maintains that different strategy types reduce the imbalance between interactants, but it is a matter of degree. He suggests the replacement of the term 'thanks minimiser' with 'imbalance reducer after thanks (IRAT)' (p. 531), further entrenching rather than challenging the balance sheet metaphor.

It seems unfortunate that one connotation of gratitude, and a peripheral one at that, has come to conceptually dominate a field of enquiry in which much valuable empirical work has been done. Theoretical classifications should pay attention to tendencies displayed by language users. I propose a tentative alternative to the balance sheet in conceptualising thanking practices in Section 7.2.1.

A focus on how thanking is enacted in interactions added a layer to the analysis that shows that gratitude has a clear sequential organisation. The interactions extracted in this chapter, along with others in the collection, show that news delivery in the post-operative briefing is regularly structured in a way that presents patients and relatives with gratitude opportunities, the taking up of which influences the degree of elaboration that surgeons undertook. Even when surgery was unsuccessful, thanking for the attempt was forthcoming. The thankable was co-constructed either as outcome or process, often unproblematically, but misalignments did occur which resulted in awkward encounters. Expressions of gratitude marked the end of the news delivery, and also served as prompts for apologies or regrets if warranted by the context.

Overall, thanking encounters as shown in *Hospital* help to construct the depiction of hospitals as environments as sites of civility and politeness, even when under extreme pressure. This contrasts with polls that show alarming levels of abusive behaviour to healthcare staff, from patients and their families, as well as aggression from colleagues (Kirk, 2022). *Hospital* did cover some encounters with abusive, intoxicated patients (notably in Series 5, Episode 2), but the general tone is that challenges are faced with composure. The narrative presented by the documentary is the problems encountered and presented by staff, patients and relatives *never arise from people themselves*: they are victims of a dysfunctional system. Abusive patients have been let down by the lack of access to mental health services, bed shortages are due to shortages of properly trained staff, and lack of recruitment is because of

bureaucratic structures that disincentivise hospitals as appealing places to work. The civil behaviour displayed by participants in the documentary, of which thanking behaviours are prototypical, helps to construct an against-the-odds metanarrative which valorises everyone involved.

6.9 Conclusion

Goffman (1961) described encounters as providing the 'communication base for a circular flow of feeling among the participants as well as corrective compensations for deviant acts' (p. 18). Gratitude is shown in this analysis to be a particularly good example of a 'circular flow of feeling', demonstrating that it is an emotion made in talk, and often showing reciprocity of care.

This study builds on foundational work using conversation analysis to study news delivery in healthcare (Heritage & Maynard, 2006; Hudak & Maynard, 2011; Maynard et al., 2016). The findings support the contention by Ragan (2000) that no clear distinction can be drawn between so-called 'small talk' and task-related talk in healthcare interactions: discourse goals are both instrumental and relational.

The findings have consequences for cultures of care. First, it is encouraging that gratitude features so frequently in the hospital talk broadcast in the documentary *Hospital*. Whilst gratitude encounters undoubtedly serve the narrative arc of stories featured in the documentary and 'dramatic moments' are prioritised over more prosaic aspects of care, these encounters are a reminder that delivering healthcare is far from a thankless task. The sense that care was mutual – an awareness that professional care givers also need taking care of – was a subtext in many gratitude exchanges in our dataset. Participants, for example, formulated their wants around hugging as an act of generosity (I want to give you a hug) in preference to neediness (can you give me a hug?). Patients and relatives were cognisant of the constraints under which care was being delivered and their gratitude was often hearable as infused with compassion.

I began this chapter with a poem by Raymond Carver in which the narrator recounts being given bad news by his doctor. Another poem in his final collection also refers to an encounter with a doctor:

From *Proposal* (Carver 1997, p. 308):

> A few days back some things got clear
> about there not being all those years ahead we'd kept
> assuming. The doctor going on finally about 'the shell' I'd be
> leaving behind, doing his best to steer us away from the vale of tears and
> foreboding. 'But he loves his life,' I heard a voice say.
> Hers. And the young doctor, hardly skipping a beat, 'I know.
> I guess you have to go through those seven stages. But you end
> up in acceptance.'

Like Carver, many of the patients and their loved ones featured in *Hospital* had to face up to mortality, often much sooner than they had anticipated. To consent to medical treatment is intrinsically aspirational: it implicates involves hope, plans, and purposes, but — especially with serious conditions — it is also to risk disappointment, regret, failure, and loss. The anticipation of surgery is a period of intense anxiety, not only for patients and relatives but also by those professionals on whom hopes are pinned. Thanking is a readily available script for social interactions, but, as this analysis shows, accomplishing gratitude requires resourceful, strategised interaction that is not merely transactional but speaks to the mutual culture of care.

Chapter 7 Discussion

This chapter synthesises the results and discussion points from the individual studies that comprise the thesis. I suggest implications of the thesis for theory, method, and practice in healthcare. These implications can collectively be considered to articulate the strengths of the thesis. I then reflect on the limitations of the dissertation as a whole and indicate further avenues for research.

7.1 Overview of aims, study designs, and key results

This thesis started with the question 'How is gratitude expressed and received in healthcare?'. Each study began with a promising corpus of expressions of gratitude which was explored without fixed, preconceived notions about the method or mode of analysis. This emic approach allowed me to focus on the orientations and perspectives discernible in the data, prior to using an etic approach that brought those interpretations into the ambit of the wider academic literature. The emic-then-etic, inductive approach encourages responsiveness to realities within the data rather than imposing preconceived frameworks on the material.

Metanarrative review. The literature review reported in Chapter 2 uses the literature on gratitude in healthcare itself as data. The **aim** was to identify theoretical frameworks that shape scholarship in order to draw out common threads and show divergent areas of thinking. Whilst the **study design** is similar to other systematic review types, the metanarrative mode of analysis allows for a mapping of the field according to disciplinary orientations and conceptual repertoires. The **key findings** are that six metanarratives are effective in structuring the literature on gratitude in healthcare: social capital, gifts, care ethics, benefits, staff wellbeing, and quality-of-care indicator. A theme that was prominent across metanarratives was the norm of reciprocity – helpful in promoting prosocial behaviour but also potentially exacerbating inequalities. Research on psychological benefits of gratitude were well represented in research, but there were also papers focusing on less-affirming

interpretations of gratitude. The review showed that there was very little cross-disciplinary engagement between researchers working in psychology and health services research paradigms, and those coming from a care ethics perspective.

Brompton correspondence. The inquiry reported in Chapter 3 examines a twentieth century corpus of letters between patients who received sanatorium treatment for tuberculosis (TB) and almoners at the Brompton Hospital. The study **aim** was to consider the ways in which former patients expressed gratitude, and to use a textual analysis to demonstrate the discursive dynamics of reciprocal gratitude. **Key findings** included that follow-up letters and their replies participated in a Maussian gift-exchange ritual that positions gratitude as central to the personalisation of an institutional relationship. The tone and style of the almoners' responses to correspondents was instrumental in maintaining long-term patient engagement, the success of which was probably bolstered by a culture of compliance fostered by the sanatorium regimen. The roots of the voluntary hospital system in philanthropy, which frequently deployed the rhetoric of gratitude, contributed to an association with money that almoners sought to dispel. This chapter establishes two themes that are elaborated in later chapters: the participation of gratitude in moral effort in the realm of social idealism apparent during Covid (Chapter 4 and Chapter 5), and the rapport afforded by thanking practices between individuals explored in *Hospital* (Chapter 6).

Twitter analysis. The analysis of tweets of gratitude to the NHS (Chapter 4) made use of the opportunity afforded by the 'outbreak of gratitude' that accompanied measures to tackle the spread of Covid-19 in the UK. The **aim** was to characterise and analyse features of gratitude in attention-attracting tweets that expressed and/or discussed gratitude to the NHS. Changes in the nature and volume of these tweets were charted over the course of the first lockdown in the UK (22 March–28 May 2020). The **study design** used inductive thematic coding to assign functions and plots to each of the 834 tweets that made up the corpus. **Key findings** were that meanings attributed to gratitude were highly mobile and responsive to events, such as the hospitalisation of the Prime Minister and shortages of personal protective equipment. Common repertoires circulating in the tweets unrealistically cast the NHS as indefatigable and responsible for 'keeping us safe'. The weekly, communal event clap-

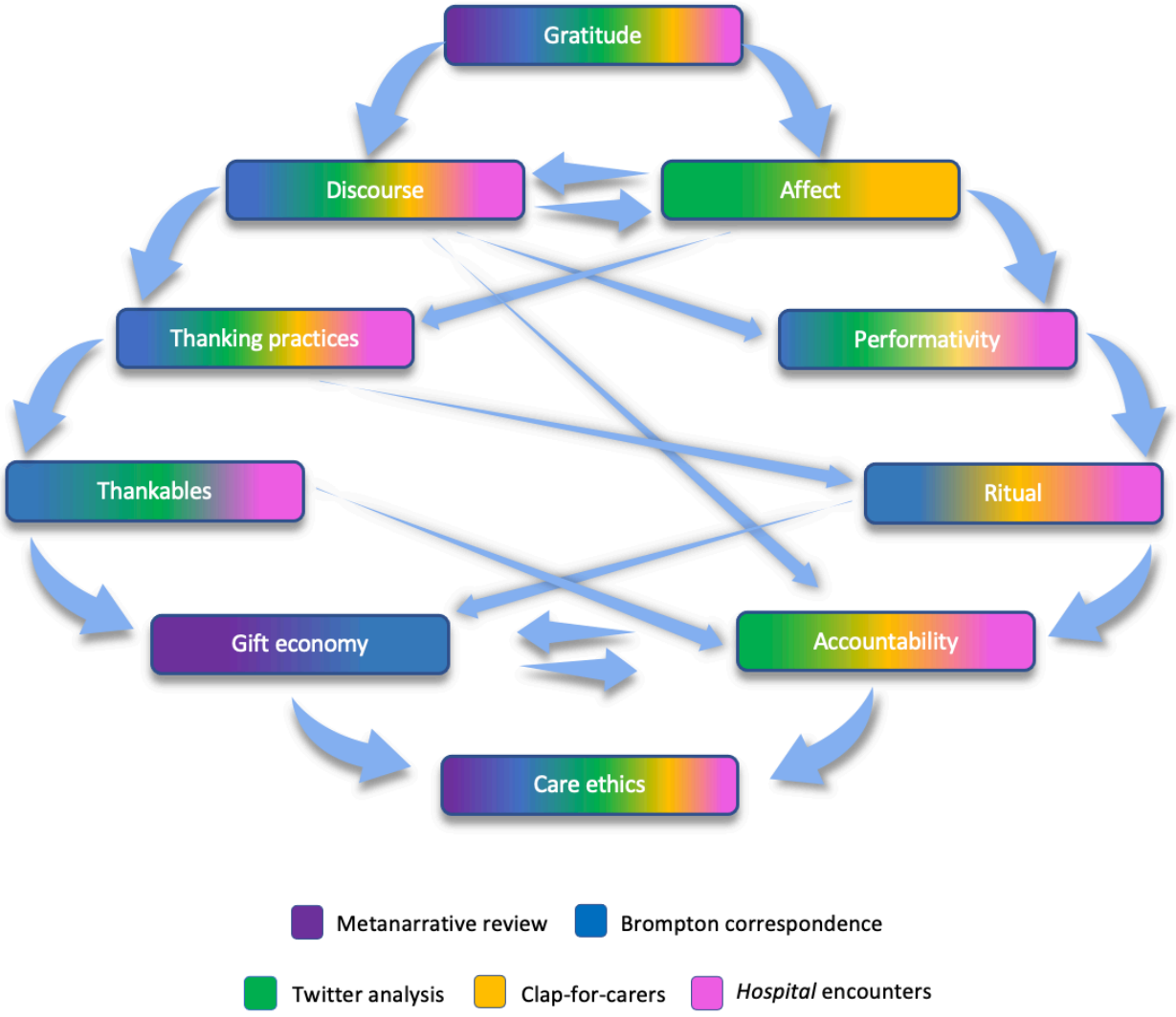
for-carers was shown to serve as a nexus for thanking activities which peaked on Thursday evenings throughout the study period.

Clap-for-carers. Prompted by findings from the Twitter analysis, the **aim** of the analysis in Chapter 5 was to explore the phenomenon of clap-for-carers using the lens of performance. The **study design** was a conceptual and theoretical inquiry that allowed for an essay-style critical analysis. **Key findings** included that clap-for-carers had a specific trajectory in public discourse that began as 'thick' civic engagement and ended with its construal as a dangerous distraction that authorised unrealistic expectations of healthcare workers. Although clap-for-carers was relatively short-lived, it has a lasting legacy in debates about gratitude in public life, particularly in the contexts of affectual authenticity and care justice.

Gratitude interactions in *Hospital*. The relational capacities of gratitude in twenty-first century healthcare settings is explored on a more granular level in the study reported in Chapter 6. The study **aim** was to examine the embodied production and recognition of thanking expressions within the hospital environment as represented in the BBC documentary series *Hospital.* The **study design** used a pragmatics-based approach to identify patterns in the data, and conversation analysis to investigate how gratitude is accomplished in interaction. **Key findings** were that gratitude features frequently in the hospital talk broadcast in *Hospital*, both as a politeness response and an intensified, purposeful performance of gratitude. The timings of the uptake of gratitude opportunities, and the construction of the thankable, influenced the degree of elaboration that surgeons undertook in post-operative briefings. Small talk and task-related talk are shown to be intertwined, achieving both relational and instrumental goals. Thanking behaviours exhibited by participants in the documentary help to construct an against-the-odds narrative that valorises individuals who are cast as victims of a dysfunctional system.

Figure 7.1 shows a visualisation of how key topics are configured across the studies that make up this thesis.

Figure 7.1. Map of topic flows through the thesis



7.2 Implications of findings

7.2.1 Implications for theory

The metanarrative review (Chapter 2) highlighted the plethora of disciplines, each with their own theoretical orientations, that are relevant to gratitude in healthcare. In my own studies, I have oriented to a number of bodies of theory – drawn mostly from social and cultural theory – to contextualise the findings. The Brompton correspondence study (Chapter 3) shows how the ritual of gratitude performed the continuation of care. It invokes Maussian gift economics to argue that the letters participated in rituals of knowledge exchange, and contributes new understandings of

the role of the profession of almoner in the voluntary hospital system. The tweet analysis (Chapter 4) and the clap-for-carers study (Chapter 5) elaborate the connection between affect theory and ideology, showing how gratitude is a socially ritualised social performance with implications for care justice. The *Hospital* analysis (Chapter 6) draws on politeness theory to characterise thanking expressions in the context of civil exchanges that have implications for patient safety. This study also contributes to scholarship on news delivery in healthcare, positing that the timing of take-up of gratitude opportunities influences the elaboration of news delivery in post-operative briefings.

How do these studies collectively contribute to theory? My purpose in this section is to put the studies included in this thesis in conversation with each other, in spite of their diffuse theoretical affinities, in order to articulate how they work together to advance theory. In so doing, I have attempted to resist merely pointing out what the studies have in common. Instead, I have sought to be more expansive in making connections – seeking to live up to Frank's definition of social science theory as the 'capacity to connect local research projects on specific issues' with a given historical period and 'the fate of those who lived then' (Frank, 2013, p. 19). Brown et al. (2014) described the interplay between coercion, emotional repertoires, interpersonal processes, and institutional fields as 'one of the key enigmas in the social study of compassion' (p. 385) – a perspective, I feel, that can be readily extended to include other social emotions, including gratitude.

A key question that is foregrounded by the way this thesis is structured, from macro to micro, is how gratitude scales up from an individual relation to one that translates to the social world of citizen subjects. Unless one is going to take a very narrow view of 'healthcare' as merely the clinical encounter, it is necessary to theorise gratitude as a component of healthcare as a social, political, and – crucially – an ethical relation. To this end, I focus on the implications of this thesis for gratitude in three areas of theory: **1** the governmentality of conduct as an aspect of biopower, **2** affective ethics of enactment, and **3** the shift from paternalism to patient-centred communication in clinical practice. This final implication serves as a prompt for challenging the dominance of the rhetoric of power imbalances in the theorisation of gratitude in pragmatics.

7.2.1.1 Gratitude and governmentality

Ideas about infectious diseases, particularly plague, as modelling forms of idealised disciplinary power are powerfully and influentially theorised by Foucault. The management of patients with TB in the late 1800s and early 1900s, and the lockdown restrictions placed on the UK population at the outset of the Covid pandemic, both entailed regimes of surveillance in the form of epidemiological monitoring of symptoms and forms of contact tracing. An aspect of theory that this thesis brings to the fore, though, is how regimes of governmentality of *conduct*, in the form of grateful postures, go hand-in-hand with biopolitics – regimes that differ in degree of visibility within the datasets across the studies I undertook.

Foucault describes conduct as a technique and practice in power and governmentality in his 1977–78 lecture series *Security, Territory, Population* (Foucault, 2007). He draws on an extended analogy based on the pastorate to elaborate conduct as the object of power. Pastoral power has the following features: **1** it is not exercised over a territory but over a 'flock in its movement from one place to another'; **2** it is beneficent – its raison d'être is doing good and its object is salvation; **3** it is the power of care – it provides sustenance and treats injuries; and **4** it is individualising power – sheep are counted in the morning and evening, and looked after individually for the good of the totality of the flock (Foucault, 2007, p. 126–128).

It does not take much imagination to see how exquisitely the pastorate, the object of which Foucault says is 'men's [sic] conduct' (p. 194), aligns with the regimen of the Frimley Sanatorium (Section 3.5). The governance of conduct applies both to the management of physical bodies in the sanatorium space, certainly through graduated labour, but also in the role of almoner-as-shepherd. Foucault creates a continuum of the shepherd with the pastor in the Christian West, and extends the analogy to medicine: the pastor is 'essentially a doctor who has to take responsibility for each soul and for the sickness of each soul' (Foucault, 2007, p. 175). Similar to the shepherd/pastor in Foucault's analogy, the almoner in the era of the voluntary hospital was assigned responsibility for tracking a patient population perceived by hospital administrators as itinerant: Brompton patients were drawn from 'the working and labouring classes, whose proneness to frequent change of residence is well-known'

(Habershon et al., 1914, p. 5). Almoners also took on pastorate duties by providing ongoing individualised care through the provision of aftercare advice, and formulating statistics as evidence of effective governmentality of disease.

Gratitude is relevant to pastoral power because it is one of the techniques – and a significant one at that – in which power is exercised through reference to conduct. In the Brompton Hospital, the coercive deployment of gratitude is blatant in the obligation to formally thank one's sponsor and one's God, on pain of being excluded from future treatment (c.f. Figure 3.5), the poster outlining patients' obligations to be grateful (c.f. Figure 3.7), and the expectation of patients' compliance with the almoners' requests to send annual updates on whether they were 'well and working'. The inescapable conclusion that one draws from archival evidence is that being treated for TB at the Brompton Hospital and the Frimley sanatorium entailed an element of moral obedience that was often constituted as salvational. Gratitude was salvational of one's soul given the emphasis on religious observance and the need to be mindful of the suffering of others. It was also salvational of the hospital, given that the voluntary hospital system relied on charitable donations to continue its work. It went on to be salvational of the research programmes on which clinicians relied to position the Brompton Hospital as having a credible evidence base for its treatment of patients with TB.

The harnessing of conduct in the form of gratitude to salvation is in keeping with Foucault's insight that power is occasionally repressive, but it is almost always productive. The inferences I draw from a study of archival evidence about the expectations of gratitude at Brompton and Frimley are that gratitude was intensely productive. The touting of gratitude as a reward for philanthropy was a rhetorically powerful in fundraising, for both the establishment and the ongoing functioning of Brompton Hospital and Frimley Sanatorium. Mutually expressed gratitude underpinned, I argued in Section 3.5, the success of the almoners in securing the cooperation of former patients, often for the duration of their lives. Gratitude also fuelled the gift relationships within the knowledge community of the Hospital, as discussed in Section 3.7.

What parallels can we draw between expressions of gratitude in the TB epidemic and the Covid-19 pandemic? One of Foucault's most insightful contributions

to critical theory was that power is exercised through normalising those technologies that claim legitimacy through the application of knowledge. As knowledge accrued about the Covid-19 virus and its effects, many technologies of control were required to be visibly conformed to in order to demonstrate adherence. These included lockdowns, social distancing, mask wearing, disease situation maps and dashboards, and mandatory reporting of testing. The relationship between power and gratitude in the Covid pandemic (Chapter 4 and Chapter 5) are less blatant than those that are evident from the archival research on the Brompton, but no less powerful for being more subtle.

The proprietary algorithms of social media companies are certainly one technique in which power is exercised invisibly. Clap-for-carers is an example of a gratitude-driven social media campaign that 'went viral', thanks in no small part to the power of the algorithms that propelled it to prominence. But social media also acts as a virtual panopticon. The panopticon, as theorised by Foucault (1995, f.p. 1975), based on Jeremy Bentham's characterisation of an ideal prison, is a powerful metaphor for explaining the idea that the awareness of possible audiences drives actions, leading to self-regulatory and performative behaviours. These behaviours, as discussed in Section 5.5, included calling out gratitude expressed on Twitter variously as deserved/unwarranted, ethical/unprincipled, virtuous/shameful, and heartfelt/inauthentic. There is a wider point to be made, though, in the ability of social media to make public people's feedback on healthcare services. Participants in the documentary series *Hospital* almost certainly modified their behaviour in the knowledge that they would be exposed to public scrutiny, but social media provides a constant underlying threat/promise of visibility. Gratitude mostly serves as an affirmative gaze, but this has no less potential for being 'disciplinary' than its corollary, the complaint, in that it inhibits certain behaviours and promotes others.

As my analysis of clap-for-carers showed (Section 5.5), gratitude has a complicated relationship with accountability. On one hand, it might be seen to encourage actions that meet with approval (as a 'quality of care indicator' as discussed in Section 2.4.6). On the other, displays of gratitude have been construed as detracting from accountability through providing elaborate displays of appreciation as a distraction from responsibilities of caring about those at whom gratitude is directed,

notably politicians participating in clap-for-carers whilst failing to put adequate safety measures in place to protect healthcare staff from Covid. Clap-for-carers, then, can be theorised as an aesthetic–ethical–political event. The epistemic regime around gratitude allowed for the constructing of legitimate and illegitimate actors based on contested claims to authenticity and what constitutes 'caring'. This bears out the contention by Wetherell et al. (2015) that 'discourses of emotions have a built in accounting flexibility suited to the play of power' (p. 63).

In the next section I expand on how my study findings show that biopower – political power that operates on bodies – worked through affect with consequences for ethical enactments of care justice.

7.2.1.2 Gratitude and the affective ethics of enactment

Anderson (2012) proposes that one of the characteristics of biopower is that it is 'based around forms of intervention that aim to optimise some form of valued life against some form of threat' in which *affective capacities* are targeted by forms of power (p. 3). This construction leads him to posit that Foucault showed how 'affect is rendered actionable at the intersection of relations of knowledge and relations of power and emergent from specific apparatuses' (p. 4). Anderson was writing before the Covid-19 pandemic, but his words seem particularly prophetic in the light of the 'actionability' of gratitude in the face of threat posed by the pandemic. Whilst an array of emotions are suitable candidates for histories of emotions in the Covid-19 pandemic – fear, anger, shame, frustration, boredom, pity, grief, to name but a few – the studies I have conducted (Chapter 4 and Chapter 5) show a coalescing of gratitude as affect around healthcare workers and, in the UK, specifically the NHS. The 'valued life' pitted against threat in Anderson's construction is epitomised by the place of the NHS in British public life given the threat to ways of living and dying posed by the Covid-19 pandemic.

A body of theory that is helpful in articulating the 'ethics of enactment' in relation to care is 'non-representational theory' (NRT), an inelegant moniker for a collection of progressive ideas that, according to Popke (2009), set geographical scholarship 'abuzz with passion, performance and affect, infused with a sense of playfulness and a spirit of optimism and experimentation' (p. 81).

NRT, like most scholarship engaging with affect, takes its inspiration from Spinoza and Deleuze. What does 'non-representational' entail? Anderson & Harrison (2010) draw on Ingold (2000) to provide a useful elaboration:

> [C]ertain embodied gestures and action sequences, certain turns of phrase and idiomatic expressions, certain organisations of objects in space, do not 'express' or 'stand-for' certain cultural meanings, values and models; they are not 'vehicles for symbolic elaboration' … Rather they are enactments; if there is elaboration it is conducted and composed by and in the on-going practical movements and actions, of which the symbolic is a part, but only a part. (Anderson & Harrison, 2010, p. 9)

Dewsbury et al. (2002) describes NRT, not as negating the representational as is claimed by some critics, but as taking representation seriously: 'not as a code to be broken or as an illusion to be dispelled rather representations are apprehended as performative in themselves; as doings' (p. 438). This conceptualisation is consistent with discursive psychology's emphasis on interactional approaches to emotion, and particularly its insistence that emotions are not merely representations of psychological states. Discursive psychology would also, I suspect, be sympathetic to a stance taken by NRT that the world is 'a continuous composition' with much of life still lived on 'that cusp and of the situational wisdoms it brings forth: of the body moving, of how to speak the right words at the right time, of how to arrange spaces so that they modify certainties, and so on' (Thrift, 2003, p. 2020–2021). This quote resonates because so much of my inquiry into gratitude, particularly Chapter 6, is animated by what constitutes speaking 'the right words at the right time'.

NRT has come in for criticism from one of discursive psychology's leading lights, Margaret Wetherell. She takes issue (Wetherell, 2013; Wetherell et al., 2015) with NRT's commitment to an ontology described by one of its main adherents, Derek McCormack, as seeing the world as 'emergent from a range of special processes whose power is not dependent on their crossing a threshold of contemplative cognition' (McCormack, 2003, p. 488). McCormack's insistence that affect precedes discourse is a position also held by the prominent affect theorist Brian Massumi (2002) and is one that Wetherell (2013), amongst others, has convincingly (to my mind) dismantled. Drawing on recent research in neurobiology and experimental psychology, Wetherell

argues that affect is 'always already occurring within an ongoing stream of meaning-making or semiosis' (Wetherell, 2013, p. 355).

The second tenant of NRT is an epistemological one: it challenges the prioritising of 'representations as the grounds of sense-making or the means by which to recover information from the world' (McCormack, 2003, p. 488). Whilst NRT argues for a reprioritisation rather than a disavowal of the role of discourse, the 'non-representational' in NRT gives the unfortunate impression that there is no room for considering discourse, as a form of representation, as integrated with affect. Certainly this is not a position that this thesis could endorse either in its approaches, methods, or findings – or indeed in its materiality, given that the nature of academia is to 'represent' scholarly activity.

It is outside the scope of this section to attempt to reconcile discursive psychology with NRT here, beyond suggesting that a rapprochement is not inconceivable. Whilst the paradigms seem incommensurate in some respects, the conclusions arrived at by studies using both NRT and discursive psychology are generally in agreement, as are the findings of this thesis, that 'the social' requires a relational – rather than a strictly cognitive – account that is sensitive to patterned forms of activity and meaning-making *in situ*. What I do want to do, however, is to argue that the NRT branch of scholarship has opened up a field of enquiry that usefully emphasises action, practice, and, especially, performance, within the realm of 'an ethics of enactment' (McCormack, 2005, p. 142), to which my study of gratitude speaks throughout, but particularly in the context of clap-for-carers (Chapter 5).

How might clap-for-carers be theorised as an 'ethics of enactment'? In Popke's conceptualisation, bodily performances 'enhance affective capacities and engender new forms of engagement and responsibility' (Popke, 2009, p. 82). For these performances to be brought into the realm of ethics, their goal is a 'corporeal response-ability' which frames an energetics of encounter 'in creative and caring ways which add to the potential for what may become' (Thrift, 2004, p. 127). As traced in Chapter 5, the formation of clap-for-carers as a social movement was born from an embodied, affective connection that was a manifestation of care. Clap-for-carers constituted an 'ethical promise', as it were, grounded in the taking notice of, appreciation for, and valuing of the vulnerabilities already present in the NHS but now

exacerbated through Covid. The pandemic lockdowns, although restrictive of the liberties to which Britons normally feel entitled, also heralded the potential for a new way of living and being – one in which the NHS would emerge from this crisis strengthened and invigorated, having finally been accorded the funding and validation for which its advocates had been clamouring for years. As such, clap-for-carers epitomised what McCormack called an 'ethics as sensibility or ethos' that 'demands an openness to the uncertain affective potentiality of the eventful encounter as that from which new ways of going on in the world might emerge' (McCormack, 2003, p. 249).

The intertwining of ethics and affect is a position elaborated by Anderson in the context of his consideration of 'hope': 'Being political *affectively* must … involve building a protest against the affectivities of suffering into a set of techniques that also aim to cultivate "good encounters" and anticipate "something better"' (Anderson, 2006, p. 749, italics in original). To participate in clap-for-carers for many felt, at the start, like a 'good encounter' and an ethical act. But to stop clapping for carers, too, felt like an ethical act when it became apparent that to do so was to feel like colluding in exploitation rather than the heralding of 'something better' for healthcare workers.

Clap-for-carers was a political, spectacular event in which gratitude was perceived first as an enabling, optimistic response to the precarity of the NHS and the pandemic. But gratitude came to be seen as a colluding in a denial of agency when it became obvious that it lacked the capacity to be transformative. How does this compare with the interpersonal performances of gratitude analysed in Chapter 6? The encounters in the *Hospital* analysis are also marked by ambiguity around agency. Just as gratitude can be characterised as an ontological event in that it 'marks a rupture with what exists and the creation of the new' (Hardt & Negri, 2009, p. 181), it also enacts rupture that marks a closing off or shutting down. It does this, my study shows, not only as a polite bringing to an end of a conversation, but as a forestalling of elaboration (Section 6.7.1). As such, this study has implications for understanding how gratitude serves as a pivot point for facilitating and/or discouraging agency in healthcare encounters. Allowing patients more autonomy is an important concept in patient-centred care (Goodyear-Smith & Buetow, 2001), and is often viewed as an evolution from more paternalistic models of practising medicine. I turn now to a

consideration of how invocations of power in the way gratitude is conceptualised in pragmatics theory are analogous to outdated, paternalistic models in healthcare.

7.2.1.3 Paternalism to patient-centred care

No consideration of gratitude and governmentality would be complete without a recognition of the power relations that infuse the clinical encounter. The Brompton Hospital and Frimley Sanatorium can be critiqued from a political economy perspective. As characterised by Lupton (2012), the political economy – grounded in a Marxist critique of capitalism – attributes the imbalance of power in medical relationships to status accorded medical professionals' knowledge and professional standing, their position in the class structure, and their ability to make authoritative judgements on health on the basis of ability to work. The paternalism which infused relationships at Frimley is evidenced by a contribution addressed to patients in the 1938 edition *Pine Tree Pie*, the Sanatorium magazine, from the Dr Wingfield, the medical superintendent:

> I am almost inclined to address you as "Dear Children," the inner meaning of which you, though not outsiders, would readily understand. (Wingfield, 1938, p. 4).

One does not have to be an insider to interpret this framing as profoundly paternalistic. Roter (2000) considers paternalism to have persisted as the prevalent model of medical communication throughout the twentieth century exacerbated, rather than ameliorated, by the rise of biomedicine with 'a resulting loss of focus on the patient as a person' (p. 6). A perceived corrective to the diminishment of patients' autonomy, liberty, and personhood by paternalism is patient-centred care, sometimes termed relationship-centred care. According to this model, the medical professional must share power with the patient in the relationship (Stewart et al., 2014).

How do power imbalances play out in interpersonal encounters? Although undoubtedly much of medical care is still deeply paternalistic and pervaded by multifarious power imbalances, the gratitude encounters analysed *Hospital* showed few of the hallmarks of the losses and gains of power in the 'transactional' model in which thanking practices are routinely constructed in theory. Even though the framing of the Brompton correspondence was overtly transactional in context –

because it required patients to give up information and the rhetoric of gratitude-as-duty was endemic in the voluntary hospital system – the expressions of thanks only very rarely invoked the language of debt. Similarly, across the 440 extracts analysed for Chapter 6, only one (Extract 6.3) invoked the gratitude as something owed. This finding is consistent with the prototype analyses of gratitude carried out by Lambert et al. (2009) and Morgan et al. (2014) in which 'indebtedness' and 'owing' came very low down the list of features that participants ranked as central to the concept of gratitude.

In Section 6.8 I used the analysis of gratitude to critique the implications for the way responses to thanks are conceptualised in theory, arguing that 'moral economics' is theory-constitutive in the pragmatics of thanking but metaphorically hollow as it does not align with what most people actually say. Responses to thanking are persistently characterised in pragmatics as a 'rebalancing of power' through 'minimising the debt' generated by the 'humbling of face' involved in expressing gratitude (Bieswanger, 2015; Jautz, 2015; Schneider, 2005). But people hardly ever invoke debt or reciprocity in the way they express or respond to gratitude in interaction. The semantics of gratitude do encompass a sense of extending or giving gratitude, not in the sense of it requiring reciprocity or even in the sense that it is itself a form of reciprocity, but with a sense of *generosity*.

Klein (1975) famously maintained that gratitude is closely bound up with generosity. She links gratitude to a sense of enrichment, but also emphasises how it can be undermined by a sense of envy. Framing gratitude as a generous action does not liberate it from the logic and nature of social reproduction and domination – indeed, Pelletier et al. (2019, p. 400) show how 'superiority is established through generosity' when a consultant returns the elaborate thanks of a junior doctor in their study of medical case presentations in an Accident and Emergency department in the UK. Generous conduct is a productive area of critical theory that is inevitably linked to Bourdieu. How does Bourdieu deal with gratitude? He addresses it most directly in the context of his discussion of the gift:

> … the giver knows that his generous act has every chance of being recognized as such … and of obtaining recognition (in the form of a counter-gift or gratitude) from the beneficiary (Bourdieu, 1997, p. 233)

Generous conduct becomes, not a choice, but 'the only thing to do'. Bourdieu recognises that there is something of a paradox to ascribe calculated intention to the gift, describing it as a 'theoretical monster': 'the self-destructive experience of a generous, gratuitous gift that contains the conscious aim of obtaining the counter-gift' (Bourdieu, 1997, p. 234).

Bourdieu maintains that every field of human endeavour is governed by competitive strategies and gift giving is perceived as such regardless of the motives of the giver. He recognises that his model is reductive – he refers to rewards and recognition as 'a *market*, if such an apparently reductive term is permitted' (Bourdieu, 1997, p. 233, italics in original). But Bourdieu continues to use economic metaphors with impunity. This is in spite of his assertion that 'it is not possible to reach an adequate understanding of the gift without leaving behind … the economism that knows no other economy than that of rational calculation and interest reduced to economic interest' (Bourdieu, 1997, p. 234) – an astonishing contradiction, given that the language of the economy is theory-constitutive for Bourdieu's model of habitus.

Graeber shares my puzzlement at Bourdieu's insistence on discounting the importance of actions that are not motivated by self-interest. He says it emerges from 'a flaw in the project of critical theory' (Graeber, 2005, pp. 29–30): by claiming that if power, dominance, and exploitation underlie every aspect of human life, we discount the importance of integrity and good intentions.

Alex Honneth, referred to in Section 5.4, is a theorist who has offered a reinterpretation of Bourdieu's concept of habitus that focuses less on Bourdieu's insistence on social actions as emotionally engaged forms of capital, and more (in Piroddi's 2021 paraphrasing) on the 'space of possibilities of action' generated by a social field: the norms and rules in which agents enact specific behavioural patterns because they are prone and inclined to do so. Honneth (1986, 1995) recasts habitus as creating possibilities for action depending on people's expectations of the consequences of adopting practical strategies. This conception allows for a

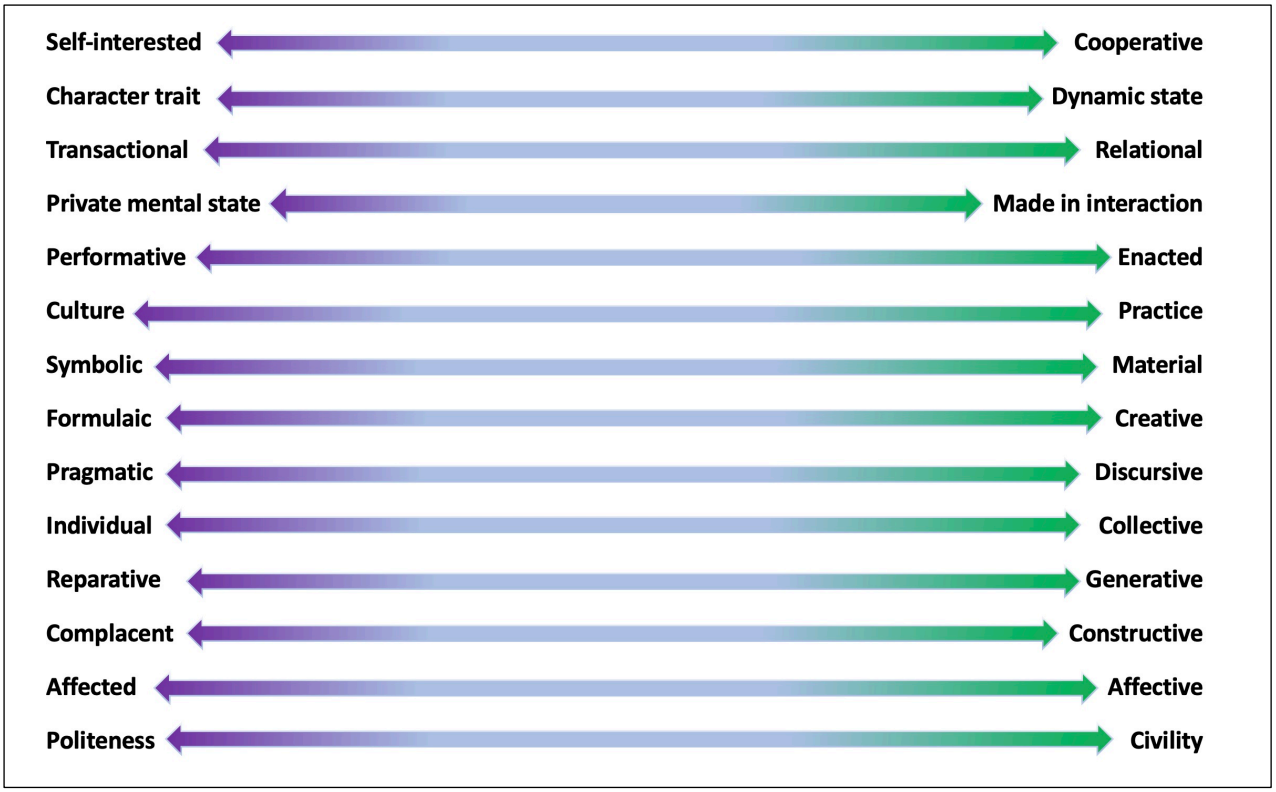
consideration of gratitude as an outcome of choices that favour a beneficial social life, rather than merely the inevitable consequence of mimetic socialisation. Habitus, then, in Honneth's reinterpretation, allows for strategic agency but also the accomplishment of relationships of recognition that, to be sure, are situated in contexts that are sites of power relations (like hospitals), but allow for displays of social emotion that, as the analyses in Chapter 3 and Chapter 6 attest, mostly satisfy interlocutors' expectations.

In the next section, I argue for a reconsideration of the heuristic of moral economics, which is infused by the language of power imbalances, in favour of a more relational model of gratitude.

7.2.1.4 Theoretical re-orientation

Many of the social theories that intersect with gratitude – Bourdieu (1977, 1997, 1998), Brown & Levinson (2006), Goffman (1956, 1961, 1967, 1969, 1971), and Mauss (2000) – are predicated on explanatory frameworks of maximising self-interest. Although acting in self-interest (through expectation of return, impression management, accrual of social capital, face management) is undoubtedly implicated in gratitude, it has, to my mind, a disproportionately prominent hold over theory. The findings in this thesis warrant advocating for more of a consideration of gratitude as a dynamic social practice. In Figure 7.2, I offer a map of different accounts of gratitude built from dominant descriptions, interpretations, and explanations on the left, and conceptualisations informed by this thesis on the right. To impose binary constructions, even when envisaged as a spectrum, is to risk reductionism, which is a position this thesis has sought to resist. I offer this schematic, not as a prescription, but as an invitation for those of us working in social theory to think more expansively about how theories of emotion, and gratitude in particular, can be animated by ways of thinking that are not in thrall to the maxim of self-interest.

Figure 7.2. Schematic of theoretical conceptualisations of gratitude, with affinities aligned to by this thesis on the right



7.2.2 Implications for methodology

The studies in this thesis are linked by a discursive psychology perspective, the first body of scholarship to focus specifically on gratitude as a situated emotional act that is produced in interaction. Methodologically, I situate discursive psychology in the broad sense of 'an umbrella term that captures within it a variety of approaches to the study of talk (verbal and non-verbal interactions) and text' (O'Reilly et al., 2021, p. 407). Whilst discursive psychology developed in the 1990s, its implications for understanding emotional stances have only recently come to constitute a distinctive research programme. Weatherall and Robles (2021) describe approaching emotions as ubiquitously constituted in social interaction as an 'emergent tradition' offering 'unique insights not found elsewhere in emotion literature' (pp. 1–2).

The attractions of discursive psychology as a methodology (a theoretical and analytical approach) for a study of gratitude in healthcare include **1** its insistence that emotions do not merely reside in the individual but are interactional phenomena, responsive to context, and **2** the permission it gives to approach emotion as a social

action rather than a character trait. Although discursive psychology most often takes conversation analysis as its exemplary method, in the studies reported in this thesis I follow Rotor (2006) in advocating for combining methods to maximise discovery and insight. I have chosen methods for their abilities to meaningfully address questions in the context in which they are raised. Methods reported in this thesis encompass metanarrative review, thematic analysis, conceptual analysis, discursive analysis, pragmatics, and conversation analysis.

I have sought to be innovative in my choice of data sources to enable the study of gratitude across a range of media. In so doing, I have furnished proof-of-concept that a discursive psychology approach can, and does, inform and enhance communicative acts that extend beyond the methodology's conventional emphasis on face-to-face communication. Written communication has always been revealing of discursive practices, even if the interval between the interlocutors' responses to each other lacks the immediacy of interaction that conversation demands. Discursive practices analysed in the tweets of gratitude to the NHS (Chapter 4) and the Brompton correspondence (Chapter 3) and are no less illustrative of discursive psychology's focus on 'life as it happens' (Wiggins, 2017, p. 20) than the encounters analysed using conversation analysis in the documentary series *Hospital* (Chapter 6) – the more conventional method for studying practices within the framework of discursive psychology.

Development of research methods tend to go hand in hand with available technologies for capturing rich data. Conversation analysis was made possible by the affordability of voice recorders in the 1960s, and discursive psychology rose in popularity in the 1990s when video cameras became widely available. Researchers in these traditions, though, have been slow to capitalise on social media as an important mode of communication in the twenty-first century. As the study of tweets of gratitude to the NHS (Chapter 4) demonstrates, though, there is plenty of potential for using social media to explore the features of discursive practice that Edwards and Potter (1993) identify as foundational for considering language as social action: action (situated social actions performed through talk), fact and interest (the construction of reports and descriptions as facts), and accountability (how speakers attend to agency,

intentionality, and causation both in reported events and in the act of reporting them).

Taking a discursive psychology approach to an archive of epistolatory correspondence is a novel development of the methodology (Chapter 3). Considering letters as 'turns' allows gratitude to be considered as action-oriented and constitutive of participants' concerns. I depart somewhat from discursive psychology's indifference to individuals' intentions and motivations (O'Reilly et al., 2021) by contextualising the letters within a wider rhetoric of gratitude that characterised philanthropy in the voluntary hospital system. The analyses of the register and linguistic features of the almoners' letters over time, in conjunction with engagement with their content, contribute an interdisciplinary perspective to the history of hospital medicine.

Conversation analysts tend to be sceptical of footage that is edited. My use of broadcast documentary footage as a credible source of data sets a precedent. In my study, editing decisions are considered to be a sort of proto-analysis in which production choices are made that constitute interactions as authentic to an audience. Using documentary footage allows for a measure of proxy access to a range of healthcare settings that circumvent the considerable barriers that researchers need to negotiate to gain access.

In each of the studies reported in this thesis, I have sought to establish the quality of my methods by:

- giving a rationale for the type of data used.
- being alert to the ethical implications of using extant datasets.
- ensuring sampling adequacy, based not only on sample size, but on reach and richness of information.
- engaging immersively with the data: every publication reported in the metanarrative review (and included in the thesis) has been read and thought about; every gratitude-containing letter in the Brompton correspondence logged, photographed, and considered; each tweet in the Twitter analysis scrutinised; every episode of *Hospital* watched repeatedly and each gratitude interaction transcribed.

- generating a clear audit trail that accounts for the ways in which the data was acquired, organised, and analysed.
- taking an iterative approach to research, revisiting analyses in light of new insights and information.
- conducting sense checks throughout the research through discussions with supervisors and collaborators, and being open to alternative approaches.
- submitting each study for publication, thus validating the research through rigorous peer review.

In summary, the studies documented in this thesis contribute to the development of the methodology of discursive psychology by examining the emotion of gratitude as action that acquires meaning in interaction. It uses novel data sources (tweets, letters, documentary footage) to demonstrate the value of a discursive-psychology approach to studying gratitude as social practice that is not confined to face-to-face talk. The use of a variety of methods has illuminated how different genres of gratitude are constructed in talk and in text, and how discursive formations hold people to account for gratitude as an attitude, a responsibility, an enactment of an ethical stance, a sentimental distraction, a hallmark of civility, and a recognition of benefits rendered.

7.2.3 Practical implications

When embarking on this doctoral research, I envisaged devising 'a guide to good gratitude' – an inventory of ways in which beneficiaries of good care could effectively communicate their gratitude, and recommendations for how healthcare organisations could maximise the potential that gratitude has for improving the morale of healthcare professionals. But gratitude intervenes in power relations in ways that open-ended, relational enactments can often slip into paternalism, patronage, and even exploitation. The potential for gratitude to be instrumentalised in ways that pressurise people to be grateful, or make some people feel appreciated at the expense of others who are equally worthy, has made me wary of being overly prescriptive about the ways gratitude should be handled in institutional contexts. We would not want to return to the patriarchal, pastoral regime of the voluntary hospitals (Section 3.5) in which gratitude was exacted in ways that might have made it difficult for patients'

gratitude to be imparted or received as sincere, given that it was mandatory. Similarly, the clap-for-carers case study (Chapter 5) shows that gratitude can all too easily become complicit in care injustices. However, there are some recommendations that arise from this thesis that do have practical implications.

7.2.3.1 Healthcare organisations and professionals should recognise that extending opportunities to express gratitude is a significant aspect of caring

Every study in this thesis has demonstrated that gratitude is a significant and meaningful response to situations of precarity: biological precarity in the face of ill health; psychological precarity when loved ones are suffering; and institutional precarity in the face of threats to the ability of the NHS to function in the face of 'crisis ordinariness' exacerbated by a pandemic. People like – arguably need – to say thank you, and they do avail themselves of opportunities to express gratitude. The analysis of tweets of gratitude showed that people eagerly took to social media to direct thanks to NHS (Chapter 4). The opportunity space for gratitude availed by clap-for-carers was taken up by millions of people at the outset of the pandemic (Chapter 5). Thousands of patients treated at Frimley Sanatorium took up the opportunity provided by follow-up correspondence with the almoner to express gratitude (Chapter 3). Patients and relatives of patients filmed for the documentary series *Hospital* (Chapter 6) took up gratitude-opportunity spaces in conversations with healthcare professionals, as well as pieces to camera, to express their thanks, drawing on a range of intensification strategies to accomplish gratitude. Even when thanking was unambiguously receipted, a quarter of thankers repeated their thanks (Section 6.6.5), suggesting that the impetus to express thanks was a significant orientation in those sequences of talk.

Continuity of care is recognised as an important aspect of receiving and delivering healthcare, with the balance of evidence showing that it leads to a better quality of experience for patients and staff, and improved health outcomes (Freeman & Hughes, 2010). Whilst there has been a focus in the NHS on improving continuity of care in general practice rather than in hospital-based care, the *Hospital* analysis (Chapter 6) showed that patients and relatives who had access to staff who had provided their care invested emotional effort in expressing gratitude. Do most patients undergoing routine surgery have the opportunity for a debrief with the surgeon, or

were these encounters over-represented in the documentary series because they serve the narrative arc of the programme? It is difficult to know. But on the basis of this study, it is recommended care providers recognise that having the chance to say 'thank you' is important to many patients, and providing opportunities to do so should be considered as part of initiatives to improve continuity of care.

7.2.3.2 Healthcare organisations and professionals should consider how 'thankables' can provide useful information about what people value about their healthcare experiences

One of the most telling moments across all my datasets is the sequence of talk in Extract 6.13 in which the surgeons try to insist that thanking should be deferred until the patient is better. 'It doesn't matter,' says the patient's grateful father – it is that surgeons have attempted such a difficult operation that is the thankable here. This is also evident from sequences in which operations were unsuccessful, yet thanking was still forthcoming, of which Extract 6.12 is indicative. Thanking for effort expended, rather than outcome, was a recurring refrain across the data. It is evident in the tweets of thanks to the NHS in which 'working' and 'effort' featured prominently (c.f. Figure 4.2). In the Brompton correspondence the thankables included the opportunity to have benefited from treatment, the 'lessons learned' at Frimley on how to live, and the almoners' ongoing interest in their welfare (Sections 3.4.1 and 3.4.2).

The datasets I considered are situated in particular contexts of infectious illnesses in which options for treatment were limited – Covid was a poorly understood infection, and the rationale for the Brompton letters was to investigate the success of treatments for TB at the Frimley sanatorium. But it is when outcomes are uncertain that 'care' really matters. Abraham Verghese, Professor of Medicine at Stanford University and an acclaimed memoirist and novelist, reminds us that, 'When there is nothing more medically you can do for patients, remember it is just the beginning of *everything* you can do for your patients' (Verghese, 2014: online). This sentiment is borne out by the extensive work on gratitude in palliative care, highlighted in the metanarrative review (Section 2.4.6) undertaken by a research group at the Institute for Culture and Society, Universidad de Navarra, Spain (Aparicio, Centeno &

Arantzamendi, 2019; Aparicio et al., 2017, 2022; Arantzamendi et al., 2023; Rodríguez et al., 2022). In palliative care, a cure is not possible, yet gratitude is abundant and meaningful to those giving it and to staff receiving it. The evidence of these studies, supported by this thesis, is that people prioritise 'caring' in their thanks, rather than 'curing'. By attending to the content of people's gratitude, healthcare providers can gain feedback on what people value about the care they have received.

7.2.3.3 The participation of gratitude in constructing idealised, optimistic fantasies about the NHS in British life must not be allowed to detract from accountable, practical, and political action

Within the languages of care to which discourses of gratitude speak throughout this thesis, the NHS is, irresistibly and perhaps inevitably, cast as a sick patient in need of saving. The somatisation of organisations is an enduring trope – we refer to organisations as 'bodies', with various associated corporeal metaphors: heads, arms, hearts, face, vision, etc. A persistent framing that circulates in media reports about the NHS – before, during and in the immediate aftermath of the worst of the pandemic – is that it is 'on its knees' and 'on the point of collapse'. The NHS becomes the patient undergoing a painful and slow death. The pertinent question to ask is whether the valorising discourse around the NHS, in which gratitude plays no small part, is an act of collective denial, complicit in denying the resources and funding that are needed for recovery and rehabilitation.

The analysis of tweets in Chapter 4 showed that what people thanked the NHS for was out of touch with reality: protecting us, saving us, working tirelessly were all prominent but idealistic thankables. More damaging was the labelling of healthcare workers as 'heroes' working on a 'frontline' – the military metaphor exacerbating the moral distress felt by many healthcare workers at being asked to risk their personal safety in the face of unrealistic expectations of what was personally and institutionally achievable (Cox, 2020).

As with all metaphors, effects on individuals vary: some healthcare workers felt empowered and appreciated by the discourses of valorisation on social media that the pandemic elicited, whilst others abhorred them. On the balance of evidence one can

conclude that collective action of mass gratitude at the start of the pandemic was more helpful to those taking part than it was for those at whom it was aimed.

Perhaps we needed those moments of collective solidarity that rehearsed the ideal-/idol-isation of the NHS in public life, because the alternative – that we could not be protected or saved, and that neither could the NHS – was simply too threatening to imagine. But the primacy of values that clap-for-carers and other sources of gratitude brought forth also exposed the complementary neglect of those values in practical, political action. Gratitude itself becomes precarious when it is perceived as being resorted to as diverting attention from acts that devalue those who are ostensibly being valued. Clapping in the context of appreciation for those taking preventable risks for the benefit of others is henceforth highly unlikely to lose its connotations with hypocrisy and care injustice. The lesson for the social practice of gratitude to the NHS is that gratitude requires accountability.

7.3 Thesis limitations

Whilst this thesis has addressed several timely issues on gratitude in healthcare in the UK, there is no doubt that it would have been enhanced by the ethnographic research at the Royal Brompton Hospital that was originally planned before Covid intervened. The *Hospital* analysis is, arguably, a reasonable substitute for overt observations on wards, but the opportunity to ask people about gratitude, given and received, would have allowed for stronger claims to be made about how gratitude acquires meaning *in situ*. The implications of this limitation are that the thesis is unable to examine local practices around gratitude. How are the material traces of gratitude handled, individually and institutionally? What environmental cues encourage or deter thanking? How does gratitude intersect with philanthropy? There are emotional geographies of gratitude that are untold in this thesis. Above all, I regret that the rich stories of largess and generosity that circulate as stories within the Brompton Hospital have not been able to be admitted as data for this thesis. Whilst contemplating undertaking doctoral research, I have had the opportunity to talk informally through my topic with many people working in healthcare. Everyone has had a story that illuminates a different aspect of the landscape of gratitude, the inclusion of which

through research interviews would have allowed for a more narratively rich, expansive analysis.

Conceptually there are problems with isolating one emotion – gratitude – from the constellation of emotions that rhetorically construct meaning in situations. Ascribing an emotion or naming a behaviour as displaying an emotion is itself a performative act (Weatherall & Robles, 2021). By focusing *a priori* on gratitude, there is an inevitable orientation to my understandings of gratitude rather than those assigned or invoked by participants in interaction. The implications of this are that I cannot claim to have carried out 'unmotivated looking', generally viewed as a marker of quality in discursive psychology (O'Reilly et al., 2021). Unmotivated looking is probably an unrealistic aspiration for any researcher: all forms of looking are motivated, implicitly or explicitly, and the ability to filter and select data is what makes a research project possible. Nevertheless, I do acknowledge that taking a telescope to healthcare discourse, scanning stretches of natural talk, rather than using a microscope to zoom in, was an option and would have me to situate my research more firmly within the paradigm of discursive psychology.

As it stands, much of my research relies on the assumption that thanking practices are how gratitude is performed in interaction. It influenced the search terms I applied to the metanarrative review (Section 2.2.3), the Twitter analysis (Chapter 4), and the selection of encounters to study in the analysis of encounters in *Hospital* (Chapter 6). Harnessing thanking practices to expressions of gratitude is a common-sense point of view which I consider to be defensible on the grounds of normative understandings of gratitude, but having greater critical awareness of that assumption at the outset might have allowed for a more sophisticated analysis of how people implicate gratitude in attributions of agency and responsibility in healthcare contexts. Instead of viewing expressing gratitude and thanking practices as synonymous, I now understand them as subtly different. Although they often work together as a joint accomplishment, thanking practices are temporal unfolding of intersubjective understandings, whereas expressions (tellings) of gratitude are stance alignments that are evaluative. The distinction has implications for how gratitude is made accountable, not only within the thanking encounter as investigated in the studies that constitute this thesis, but in the construction of *conduct* more generally as accountable. By this I

mean that gratitude is a display of stance towards the commitments, entitlements, obligations, and responsibilities of self and others for actions and interactions that constitute and account for conduct in relation to care. Gratitude as an evaluative stance, as distinct from thanking practice, is underexplored in this thesis.

7.4 Future directions

As indicated in the previous section on limitations, the work reported in this thesis could usefully be supplemented by ethnographic research and more of a focus on the role of gratitude in constructing accountable conduct. There is considerable scope for intervention studies and quality improvement projects that make gratitude more visible in healthcare spaces, in areas that are patient-facing but especially in areas that make appreciation more visible for staff. Other future avenues for research agenda are suggested below.

7.4.1 Improving organisational culture

Undoubtedly the biggest potential for impact lies in action-oriented research on the role of gratitude in improving organisational culture. Toxic culture in the NHS is a 'wicked problem' – complex, unpredictable, open ended, and intractable (Head & Alford, 2015). To produce meaningful long-term change, there needs to be serious attention to researching culture change in the NHS. As many musicians will attest, the judgement of fellow members of the orchestra has much more of a psychological impact on self-esteem than that of the audience. Gratitude from patients is unlikely to compensate for troubling relationships with colleagues.

The Civility Saves Lives campaign (*Civility Saves Lives*, 2023) aims to document the effects of rudeness and unsociable behaviour in clinical settings, providing evidence that incivility reduces the ability of staff to concentrate on tasks with a concomitant decrease in performance. The consequences can be fatal. The Ockendon review into failings in maternity services at Shrewsbury and Telford Hospital NHS Trust implicated a culture characterised by a persistent belittling of staff as directly contributing to avoidable deaths, and causing profound and permanent distress to staff and families (Ockenden, 2022). Concerns have been raised about patient safety

being compromised by a culture of bullying and intimidation at a number of Trusts, including calls for an urgent formal investigation into the culture at Birmingham NHS Trust (Dyer, 2022).

How do people who make it their profession to care for others end up acting in ways that are the very opposite of caring? Bullying, harassment, incivility, and disrespectful behaviour are never justifiable, but they are utterly predictable. When overwhelmed staff find themselves having to act beyond their competency and capability, forced to compete with each other for resources, the inevitable result is anger and frustration. For people to have the capacity to enact constructive emotions, like gratitude, they need to be able to feel confident that relationships with colleagues are as focused on care as those with patients, rather than destructive workplace politics. Years of under-resourcing and a lack of attention to staff recruitment and retention create a medical scene that is the very antithesis of care.

Future research in the role of desired emotions into workplace culture, however, needs to take into account that interventions that uncritically seek to increase gratitude could be an antecedent for hubris. In a heart-breaking case, 13-year-old Martha Mills died from sepsis after doctors in a well-funded, well-resourced unit at University College Hospital were complacent – in fact, downright condescending – about her family's concerns. Her mother was in no doubt that 'Martha died in part because of inflated egos' (Mills, 2022: online). Any research predicated on creating a more positive working environment in healthcare should be mindful that well-intentioned incentives to minimise conflict in professional relationships can easily tip into complacency.

7.4.2 Improved understandings of relational gratitude through considering a broad repertoire of healthcare settings

The examples of interpersonal communication in this thesis focus mostly on the hospital as a setting. Yet primary care – especially general practice – is likely to offer encounters that are qualitatively different to those in secondary and tertiary care. Community care, too, where continuity of care is more likely to be a feature of care

interactions, is likely to be a rich site for health communication researchers interested in emotion.

This thesis has focused on the NHS but research on gratitude in private practice usefully could illuminate differences in perceived thankables between patients entitled to care under the NHS, and those accessing care through direct payments or through health insurance.

7.4.3 *Exploring effects on gratitude of waiting for treatment*

The difference between waiting for treatment on the NHS and accessing care more quickly in private practice speaks to an area of interest which this thesis has not been able to address: how does having to wait for treatment mediate gratitude? The encounter analysed in Extract 6.14 in which Aseema delays taking up gratitude opportunities suggests that thanking may be tempered when suffering has been prolonged by waiting. But Joan in Extract 6.1 was one of the patients featured in *Hospital* whose gratitude was most effusive. although she'd been 'waiting for so long for something to be done' (line 15) – almost certainly because she was relieved at having survived long enough for a life-prolonging device to be fitted. Surviving long enough to benefit from an operation is a low bar for gratitude and shocking indictment of the psychological toll of waiting. Given that lengthy waiting times in the NHS are likely to persist for some time, research could inform what affectively intelligent care looks like for patients that are in a state of impasse. Here I draw on Berlant to understand impasse as:

> a stretch of time in which one moves around with a sense that the world is at once intensely present and enigmatic, such that the activity of living demands both a wandering absorptive awareness and a hypervigilance (Berlant, 2011, p. 4).

Patients waiting for treatment still require care, and the lived experience of impasse in healthcare is a productive research space for scholars of emotion.

7.4.4 Building on scholarship in relationship marketing

Those fundamentally opposed to the stealth privatisation of the NHS will instinctively recoil from any harnessing of the word 'market' to the NHS, but that is no reason to ignore sound research in the field of relationship marketing. This body of research offers novel perspectives on gratitude that complement those offered by scholarship in psychology, e.g. considering gratitude to be cyclical in relationships (Raggio et al., 2014); the association between gratitude and delight in building loyalty (Bock et al., 2016); the modelling of gratitude on individual, event, and organisation levels (Fehr et al., 2017); and how gratitude has emotional features that are distinct from satisfaction (Kim & Lee, 2013). None of these studies was in the context of healthcare, but there are fruitful possibilities for interdisciplinary work that remains mindful of the need to avoid conflating patients with customers.

In conclusion, investigating healthcare as a site of emotion repertoires – the use of communicable and mutually intelligible enactments to organise felt experience in role-appropriate ways (von Poser et al., 2019) – presents a challenging but an important research programme. This thesis has made some exploratory forays, but much work remains to be done.

Chapter 8 Conclusion

This thesis is an assemblage of gratitude as enacted in the context of healthcare. It respecifies gratitude as an emotion best understood, not as an individualised cognitive process, but as a shared discursive practice. Across the studies collected in this thesis, I have argued that gratitude is a significant resource for action and reaction in the context of personal and institutional precarity. But gratitude – forced by the times into affective explicitness as evidenced in the tweets, clapping, and filmed encounters studied in this thesis – also participates in the fantasy of the NHS as 'providing a comprehensive service, available to all' (Department of Health & Social Care, 2021: online).

It is deeply ironic that the NHS is intended to minimise conditions of precarity for those in need of care, yet, since the 1990s, it has itself been increasingly careering towards abject dissolution with a concomitant increase in the sense of precarity experienced by those who rely on it. Many healthcare workers regularly experience a state of overwhelm – the sensation of being engulfed by competing responsibilities that lead to a sense of mental and physical paralysis. It is these dire circumstances, in which imagined ways of caring are undone, that gestures of generosity – such as gratitude from patients and between colleagues – become a sustaining reason for carrying on. But the NHS cannot run on goodwill and gratitude. The bursts of microethical enactments that gratitude furnishes, in which people affirm a connection in spite of it all, are insufficient to counter the feelings of helplessness caused by overwhelm.

Gratitude cannot save the NHS, but that is not to say that it does not matter. The eloquent chronicler of precarity Lauren Berlant poses the relation of 'cruel optimism' as existing when something desirable to which you are attached is actually an obstacle to your flourishing (Berlant, 2011). This thesis demonstrates a reciprocal relation: obstacles to flourishing generate optimistic desires for attachment. Gratitude is one of the most powerful ways in which optimistic attachment is honoured.

In the spirit of reflexivity inspired by *Sankofa* (as described in Section 1.1), I acknowledge how my optimistic attachments have shaped the rationale and theoretical stance that I take in this thesis. Some of the attachments I have enjoyed during the course of my studies are depicted in Figure 8.1.

Figure 8.1. Collaged Sankofa bird (key on on page 272)

There is an important distinction to be drawn between contingency and precarity. Contingency is an awareness that uncertainty, ambiguity, and unpredictability are inherent properties of the human condition. By allowing for outcomes other than those predicted by past experience, education, and common-sense, we are alert to the possibility of the otherwise. Precarity, on the other hand, is

out of the control of the individual. It points to structural configurations that engender and sustain feelings of insecurity, because people are unable to rely on the infrastructures necessary to accomplish the outcomes that are required of them.

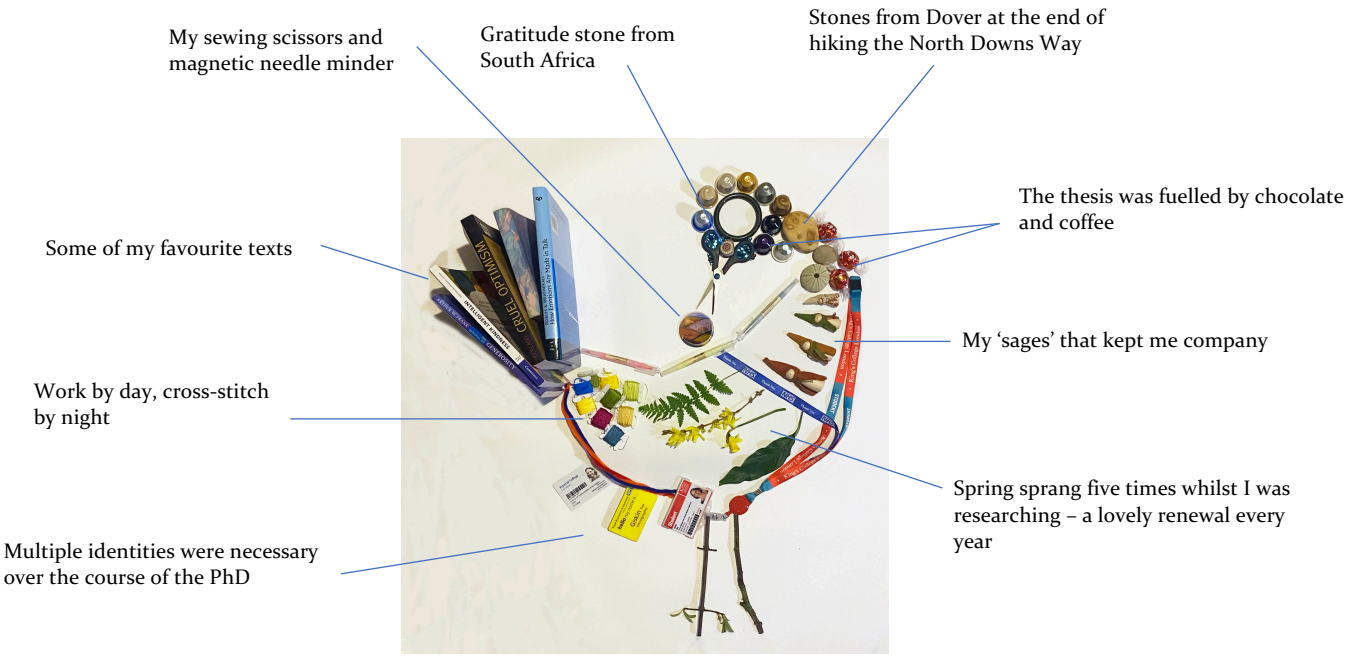
When I teach on the relationship between complexity and creativity, I often invoke the story of the argument between pre-Socratic philosophers Heraclitus and Parmenides to illustrate the paradox between change and stasis. Heraclitus argued that the fixity of objects is an illusion and objects are patterns of change, giving rise to the well-known aphorism, 'No man steps into the same river twice, for it is not the same river and he is not the same man.' Parmenides countered that objects are in stasis. They exist outside of time, and change is the illusion. Parmenides won the argument because if you argue that change is a constant, the immutable essence of things is change itself. As Graeber (2005) has pointed out, Parmenides' position was obviously absurd, yet, to make science – and indeed, education – possible, we have to imagine the world as constant.

The contradictions that this possibly apocryphal quarrel illuminate align with the incongruities that play out every day in the medical school in which I facilitate opportunities to learn. I witness daily how most medical students are simultaneously comfortable with fluidity around gender, sexuality, and ethnic identities, yet deeply disconcerted by notions of doctoring as a continual process of developing rather than emerging fully formed from a long and arduous process of education. Medical education, with its reification of 'objective' knowledge, tends to engender a dread of ambiguity. Through presenting students with opportunities to engage in analysis of materials associated with the humanities – poetry, art, film, creative writing – I aim to encourage a realisation that just because there is no one right answer, does not mean that no answers are right. The *process* of interpretation, and the co-construction of knowledge through exploring subjective lived experience – our own and that of others – admits a view of the world in which ongoing contingency is reconfigured as resource on which to draw for problem-solving, rather than a threat. In so doing, we make space for creativity – and make place for emotion – as a generative force.

A thesis and the empirical studies it reports, too, are in thrall to the Parmenidean project in which dynamic processes are treated as momentarily concrete. As Braidotti (2002) says, 'the mental habits of linearity and objectivity persist in their

hegemonic hold … thinking through flows and interconnections remains a challenge' (pp. 1–2). My Heraclitan sensibility means that I know that the representation of knowledge inscribed in this thesis is necessarily partial and imperfect. Yet, undertaking research is far more than the inscriptions it entails. It, too, is a process of 'becoming' – a coming to terms with my own nomadic subjectivity as I navigate roles of researcher, teacher, student, colleague, mother, wife, daughter, friend, white South African, immigrant, sometime patient – all of which make for more sense within the affective realm of knowledge, power, and desire, than the rationalist one. Braidotti (2002) offers a figuration of 'becoming' as about affinities and the capacity to sustain and general interconnectedness. My hope for the future is that healthcare environments will become more capable of generating affirmative forms of generosity for which gratitude would be evoked as an authentic, ethical response.

The opportunity to undertake this research has been made joyous by the affinities and interconnectedness I have experienced during the making of this thesis. It is an experience for which I feel boundless gratitude.



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