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Feeling Under Stress "Like on a Production Line" as Thinking Is Not Your Job: Some Insights on Intention to Leave in Healthcare Services Work*

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Abstract

Work-related stress, burnout, and job dissatisfaction are constantly growing phenomena in the Italian healthcare context, as well as in international healthcare systems, potentially leading to a significant loss in terms of human and financial capital. This article aims to shed light on the factors that fuel disaffection and alienation among frontline healthcare professionals in the Italian public healthcare system. The question is addressed through a qualitative case study of a specific group of frontline healthcare professionals who have been poorly explored in the literature to date – physiotherapists – within a territorial hospital in Northern Italy. Semi-structured interviews with all the physiotherapists working in the organizational case study were collected. Our detailed thematic analysis of the interviews revealed five main dimensions of quality of work life that can produce situations of disaffection and alienation: the emotional, organizational, relational, work-life balance, and symbolic dimensions. We argue that the mechanisms underlying the sense of alienation which may prompt physiotherapists to contemplate a change in company or profession are drawn from distinctive features of work in (healthcare) frontline services. The analysis sheds light on the fatigue of emotional overload; the marginal position of physiotherapists in the service triangle in the healthcare context, which is physician-centred; the intensification of work rhythms linked to Taylorization processes of the healthcare system; and interestingly, the lack

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of reward mechanisms – both material ones, in terms of flexible hours, conciliation policies, and training opportunities, and mainly in terms of symbolic and social recognition for intellectual labour of healthcare professionals, i.e. physiotherapists.

Keywords: frontline service work, healthcare professionals, alienation, intention to leave, meaningful work, quality of work life.

1. Introduction

This article focuses on the experiences of a group of healthcare professionals working in a hospital setting, which can be considered an example of "extreme" service work (Garavan et al., 2024). Such work is known to be physically, cognitively, and emotionally highly demanding (e.g., Vogus et al., 2020) and is performed in organizational contexts undergoing a transition to increasingly complex enterprises. Healthcare professionals appear unable to perform any open-ended interactions with their patients as they wish mainly due to external forces entangling economic, political, social, and cultural processes grounded in neoliberalism, bureaucratization, and technocratization (Krol & Lavoie, 2014; Reinders, 2008). The objective of this study is to examine the factors that contribute to a decline on quality of work life and particularly to strengthening of a sense of alienation, which may ultimately result in employees considering leaving the organization or changing professions. This latter issue represents a significant and pressing concern that requires empirical research to provide clarity and insight.

Healthcare systems are facing significant challenges in recruiting and retaining healthcare professionals due to the increasingly frequent occurrence of work-related stress and burnout (Myaskovetsky & Shmueli, 2023). The literature demonstrates a strong correlation between burnout and intention to leave, suggesting that the higher sense of burnout experienced by a professional, the greater the likelihood of resignation or leaving the profession (Cantu et al., 2022). This trend not only affects the individual worker but the entire organization, with a negative impact on healthcare quality, leading to a significant loss in terms of human and financial capital (Byoung-Kwon et al., 2016).

While most studies focus on physicians and nurses, physiotherapists, as helping professionals from marginal positions, are also among the groups most exposed to work-related stress, which often culminates in burnout syndrome (Bruschini et al., 2019). The Covid-19 pandemic only exacerbated this trend,

because the psychological impact of dealing with the unknown has led to an extraordinary level of stress for healthcare professionals (Grailey et al., 2021). During pandemic situations, healthcare workers are at higher risk of experiencing anxiety, depression, or other forms of psychopathology, including post-traumatic stress disorder (McGlinchey et al., 2021).

Given the key relevance of the topic, this study explores the factors that fuel disaffection and alienation among a group of frontline healthcare professionals in the Italian public healthcare system, namely the physiotherapists. The article aims to make a twofold contribution: firstly, to provide an account of the current working conditions in a relatively under-researched sub-sector of frontline service work, namely rehabilitation work; and secondly, to bring empirical evidence to the emerging debate on meaningful work, alienation and intention to leave, particularly in health service work. Straddling the two debates, this analysis shows how concepts from labour sociology on service work, in particular emotional labour, the service triangle, work rhythm intensification and Taylorisation processes, can be used to gain insights into the phenomenon of alienation and intention to leave among healthcare workers.

In the following, after describing the theoretical framework (Section 2), we present our empirical research by describing the research context, the data, and the type of analysis we conducted (Section 3). We then summarize the results of the analysis (Section 4), before we fully discuss them in Section 5.

2. Meaningfulness and alienation in frontline service work: the case of healthcare professionals

Scholars in sociology of work and organizations have been increasingly researching the service economy, paying special attention to frontline service workers (e.g., Lopez, 2010; Fullin, 2021). Growing managerialization, increasing privatisation of public services, greater focus on improving productivity and efficiency, segmentation of work organization, work intensification and Taylorization processes have markedly changed working conditions causing worrying levels of stress, unbalanced power relations in favour of the client/patient, sense of alienation and hard work identity across diverse frontline service subsectors.

The existing literature indicates that the level of alienation among frontline service workers is likely to be significant, particularly when interactions with customers or patients are brief due to standardisation and Taylorisation processes. This is because the approach becomes instrumental and the worker is in a position of subordination to the customer or patient, who is, to some

extent, regarded as a "sovereign" (Korczynski, 2009). This concept is exemplified by the notion of the 'service triangle', which posits a three-way power relationship between managers, workers and customers/patients (Leidner, 1993, 1996). A further form of alienation in service work is the incorporation of emotions into the work process itself (Hochschild, 1983; Taylor & Bain, 1999). Hochschild (1983) introduced the concept of emotional labour, which can be defined as the effort of aligning one's emotional displays with the organisational display rules. The interactions between customers/patients and frontline service workers have an ambivalent impact on the workers' lived experience and job satisfaction. On the one hand, interactions with clients are a significant source of stress for frontline service workers. However, on the other hand, these interactions can be perceived as meaningful by workers (Bolton, 2005; Bolton & Boyd, 2003; Coletto & Fullin, 2018). In other words, healthcare professionals may identify opportunities for professional autonomy outside of managerial control within the context of human relations with patients. Such "unmanaged spaces" have the potential to mitigate work alienation and contribute to the meaningfulness of work for healthcare service workers.

It is well documented that service work, particularly in healthcare, is physically, cognitively and emotionally demanding (e.g. Vogus et al., 2020). This makes it an extreme form of work (Garavan et al., 2024). Those employed in the healthcare sector are confronted with a number of particular challenges inherent to their work. These include high workloads and limited resources, exposure to traumatic adverse incidents, and the need to regulate their own convictions and emotions, as well as the emotions of others. Such working conditions are likely to have a deleterious effect on the mental and physical health of the workforce (Bodenheimer & Sinsky, 2014). Healthcare workers report the highest levels of work-related stress, burnout and job dissatisfaction of any professional group (Vogus et al., 2020). These poor conditions of quality of work life (Adamson & Roper, 2019; Gosetti, 2022) may precipitate elevated turnover rates, intention to leave, and shortage of healthcare professionals, phenomena that appear to be exacerbated by the global pandemic (Roth et al., 2024). This invites further investigation into the organizational factors that render work alienating and those that imbue it with meaning (Carreri, 2024) for healthcare professionals. The manner in which patient care is conceptualised and administered is undergoing a paradigm shift as a consequence of evolving political, economic and cultural discourses (Krol & Lavoie, 2014; McMillan & Perron, 2020). This shift is also exerting an influence on healthcare professionals' ways of being (Alvesson & Willmott, 2002) with the consequences of moral distress over the inability to take 'good' care of patients and resistance efforts to provide morally authentic care (McMillan & Perron,

2021; McMurray et al., 2011). Meanings are indeed fundamental to the building of work identity (Laaser, 2022; Schwartz, 1982).

With specific regard to rehabilitation healthcare professionals' the existing research highlights the role played by organizational and relational factors in defining what makes work satisfying and meaningful. A 2021 study on a sample of Italian rehabilitation healthcare professionals documents that individuals at high risk of burnout show significantly lower scores in areas of quality of work life related to job control, managerial and peer support, and role recognition, indicating the influence of both organizational and relational factors (Carpi et al., 2021). Further Italian research from 2020 shows that self-reported stress about rehabilitation healthcare professionals is mainly attributed to organizational issues such as high workloads, sustained pace, staff shortages, increased turnover rates, and reduced rest times. Conversely, stress decreases when conditions are provided to cultivate positive relationships within the team aimed at achieving a common goal as well as good relationships with users (Foà et al., 2020). In this regard, numerous studies demonstrate a positive association between a good therapeutic relationship and patient satisfaction, i.e., between adequate care relationships and the achievement of better clinical outcomes and greater adherence to therapeutic treatment (Bruschini et al., 2019). Significant factors that negatively influence physiotherapists' quality of work life, causing stress, also include lack of recognition and rewards at work, as well as lack of support from coordinator or colleagues (Wojtowicz & Kowalska, 2023). Autonomy is a very relevant aspect for physiotherapists and is closely related to job satisfaction. In particular, employees are satisfied when their work involves autonomy, variety and task significance (Latzke et al., 2021). Moreover, a reasonable balance between work and private life has a positive impact on employees' quality of work life. Indeed, professionals who have a satisfying private life, investing in free time, family, friendships, hobbies, and sports, are individuals who work more intensely and value their work more (Foà et al., 2020).

3. Materials and Methods

3.1 The research design

The research focus – exploring the factors that fuel disaffection and alienation among frontline healthcare workers – is addressed through a qualitative approach, deemed ideal for an in-depth understanding of the phenomenon. Specifically, we conducted a qualitative case study (Yin, 1984) to delve deeper into the organizational and relational factors that influence the

quality of work life in hospital unit, as reported in literature. The case study approach allows immersion in a multifaceted context as a potential exemplar of the phenomenon under investigation (Sena, 2024; Siggelkow, 2007). It allowed us to explore the working conditions of a group of healthcare professionals in a territorial hospital context, with the potential to lead to novel ideas and theoretical insights into a pressing research question relatively under-researched so far. The second author had unique access to this context, which lent particular insight to the study. Moreover, as the case study requires processes of triangulation, in our research we pursued it through continuous discussion during data analysis among us, and the comparison of interview data and autoethnographic notes by the second author. This type of observation, when the case study concerns an organisation, allows for the investigation of all activities carried out within the same organisation that are part of the 'everyday', that is to say, activities that are repeated without being made explicit (Mabry, 2008). To achieve this, it is essential to comprehend the distinctive characteristics of the context in which the organisation operates. As recommended in the literature, it is also necessary to define the boundaries of the case, which enables the delineation of the phenomenon to be studied ('Bounded system') (Creswell, 2009; Merriam, 2009). Indeed, for a case to be considered, it must be sufficiently circumscribed in space and time to determine the appropriate methodological path for detailed and in-depth data collection (Creswell, 2013). This is precisely what was done in the present study.

In Italy, the main planning tool for health care is the National Health Plan (PSN). Issued by the government and covering a three-year period, the PSN identifies priority areas of intervention and the essential levels of health care (LEA) that must be guaranteed to citizens. The PSN also defines the share of funding to be allocated to the regions, which have their own entrepreneurial autonomy in the management of capital, through the establishment of the Regional Health Plan (PSR), also for a period of three years. Each region, with its own health authorities, organises health services in accordance with the LEAs, but also in response to the specific needs of the reference population. The regional health services are guaranteed by the activity of highly specialised hospital centres (HUB), which manage complex cases with a higher intensity of care, and territorial hospital centres (SPOKE), which take care of basic hospital functions or the continuation of care after the high intensity phase. Each region can have more than one HUB and more than one SPOKE centre, each of which is made up of different operating units depending on the medical speciality.

The research context of the present study is the Physical and Rehabilitation Unit of a territorial hospital in Northern Italy, where physical therapy services are mainly provided on an outpatient basis to adult and paediatric patients with musculoskeletal and neurological conditions, both acute and chronic. In

addition, physiatry and rehabilitation consultations are also provided directly to acute wards or at home. The Unit implements a multidisciplinary approach by a team comprising four physiatrists, one coordinating physiotherapist, fourteen physiotherapists, one speech therapist, one occupational therapist, two healthcare assistants, and one secretary. We called this hospital unit "Physio Unit".

A patient's care is undertaken following a referral from a physical medicine and rehabilitation physician, who decides on the most appropriate type of treatment (physiotherapy, speech therapy or occupational therapy). Upon assuming care of a patient, physiotherapist is granted a certain degree of autonomy in his practice, collaborating with the physician and other healthcare providers as required. In fact, each professional operates on the basis of specific competencies, which are different from other roles in terms of both the content of the work and its organization. Given the specificity of each profession, it was decided to interview only physiotherapists.

3.2 Data collection and data analysis

Thirteen semi-structured interviews with all the physiotherapists working in the organizational case study were collected, except for the second author who, as an employee of the same Unit, facilitated the access to the empirical field and the building of trust with the interviewees for a full understanding of their experiences in the research context (Cardano, 2011).

Aware of a labour market that is becoming hybrid between employed and self-employed work for rehabilitation professionals (De Vita & Corasaniti, 2023), it is worth noting that all participants have permanent contracts with an exclusivity clause. Nine work full-time (36 hours/week), two work part-time at 80% (30 hours/week) and two work part-time at 70% (25 hours/week).

All participants work a five-day week, Monday to Friday, from 8:00 a.m. to 3.42 p.m. for full-time employees, and from 8:00 a.m. to 1:00 p.m. or 8:00 a.m. to 2.00 p.m. for part-time employees. If the daily shift exceeds six hours, employees are entitled to a break of at least 30 minutes.

Salaries and working hours are determined by the National Collective Labour Agreement (CCNL) for the Health Sector 2019-2021, which provides for a gross monthly salary of €2,013, equivalent to a gross annual salary of €22,959.96.

The CCNL also provides for a certain number of days of paid leave for medical visits and examinations, illness, accidents at work, personal and family reasons, as well as parental leave and leave for women victims of violence.

The sample was predominantly female (10/13). Given that gender can influence perceptions of factors that fuel work-related stress and burnout (Pustulka-Piwnik et al., 2014; Rodriguez-Nogueria et al., 2022), a larger sample would be needed to draw conclusions about gender-specific working conditions. Other limitations of the study include the sample size and the choice to conduct the study in a single context. Looking ahead, a first area for improvement involves the selection of a larger sample and different contexts, such as a larger hospital or private structure, in order to explore the working conditions offered by different settings. Collecting data in different contexts would allow for a broader exploration of physiotherapists quality of work life in the Italian health care system and promote a richer and more comprehensive sociological debate. Since working conditions include numerous aspects, another perspective for future research could be to explore age differences, or focus on the coordinator's point of view, providing insights from a different angle.

A singular role in this study is the second author's who, as a physiotherapist in the research field, may have both strengthened and limited the study. Trust relationship with interviewees and second author's knowledge of the context undoubtedly facilitated access to the empirical field and encouraged professionals to participate at the study. However, the added value of the second author is that she shares the same profession as the interviewees. In this sense, as a physiotherapist working in the empirical field, the second author is also the first interpreter of the data, acting as a mediator in understanding the data collected and extrapolating the different nuances of the codes that emerged. Indeed, the second author's personal experience enables us to comprehend aspects and dynamics that would otherwise be challenging for the other two authors to grasp, given their lack of familiarity with the profession and organisational context. The dual role of the second author also facilitates the acquisition of a distinctive form of knowledge. This encompasses not only the ability to comprehend aspects that often remain invisible, but also the capacity to narrate them with a depth and richness that can only be conveyed by an embedded and insider perspective. On the other hand, the ambiguity of the role played by the second author, professional and researcher, also entails certain limitations, as the interviewees may have experienced a form of subjection or discomfort in exploring topics related to work organisation, relationships with the management or personal experiences with an interviewer who is not alien to the context. In addition, the researcher herself, by listening to the interviewees' stories and identifying with similar situations, may have run the risk of anticipating or taking for granted what participants were experiencing emotionally. In this regard, the inter-professional collaboration and continuous comparison between the authors, from the initial research design to the data

collection and subsequent thematic analysis, made it possible to overcome the second author's inexperience in qualitative research methodology and to place the study within a broader sociological debate. Furthermore, this continuous exchange of perspectives allowed the second author to reflect on her own practices and work experiences with a new perspective, informed by greater awareness than she would have done without the triangulation between authors and disciplines.

Socio-demographic characteristics of participants are reported in Table 1.

The interview script was based on a careful analysis of the literature, but favouring the spontaneous storytelling of participants and the unexpected themes that emerged from their testimony. The interview script included the following essential dimensions: organizational factors, relationship with coordinator and colleagues, professional enhancement, and work-life balance. The script provided the opportunity to reflect about personal inclination towards a possible change of location or company, but also about a change of profession.

To encourage interaction and introspection, the initial phase was enhanced with photo-elicitation, which is a method capable of evoking deep emotions, memories and ideas (Glaw et al., 2017). Six photographs were selected using OASIS (Open Affective Standardized Image Set), an open-access digital set containing 900 images, where each image is evaluated on two different dimensions: *valence,* with corresponds to the degree of positive or negative affective response that the image evokes, and *arousal*, i.e. the intensity of the same response. For the present study six images were selected with intermediate values of valence and arousal. Photo-elicitation was used in the first phase of the interview and it brought out different facets of the professional's emotional experience in the working environment. Interviewees' emotions and moods were deepened in the later stages of data collection and then processed in the data analysis phase.

In addition to photo-elicitation, the interviews were also enhanced with personal accounts of a particularly stressful event experienced at work to bring out the emotional experience and delve deeply into the main theme.

The track was tested with two pilot interviews and then participants were provided, via email, with an information form containing all the information regarding the research project and the objective of the study. Before each interview, informed consent was collected for participation, registration and data processing, guaranteeing privacy and anonymity. All participants were free to withdraw from the study at any time. Dates and places for the interviews were chosen by the participants and the average duration was 60 minutes.

The interviews were fully transcribed and anonymized by eliminating all information that could allow the identification of the participants or the

hospital. Moreover, during the interviews, paraverbal or non-verbal aspects deemed significant by the interviewer were also noted; and a diary was kept throughout the research process by the second author. These aspects proved useful for holistically understanding the participants' experiences and allowing for more in-depth and accurate transcription and interpretation of the data.

Table 1. List of interviewees.

LIST OF INTERVIEWEES							
Participant	Gender	Age	Average total years of work experience as physiotherapist	Average years in Physio Unit	Working hours/week	Family composition	Dependents
FT1	Female	56	34	31	36	Cohabitant	None
FT2	Female	53	29	23	36	Divorced 2 Children	2 Children
FT3	Female	49	27	15	36	Married 2 Children	2 Children
FT4	Female	27	4	1	36	Cohabitant	None
FT5	Male	57	30	13	36	Married 1 Child	1 Child
FT6	Female	58	32	27	36 with special permit (3days/month) to assist no self-sufficient people	Single	2 Elderly parents
FT7	Female	59	34	29	36	Single	None
FT8	Male	56	31	5	36	Married 1 Child	1 Child
FT9	Female	56	35	30	25	Married 2 Children	None
FT10	Male	32	11	2	36	Cohabitant	None
FT11	Female	55	30	26	25	Divorced 2 Children	2 Children
FT12	Female	43	20	15	30	Cohabitant 2 Children	2 Children
FT13	Female	56	35	32	30	Married 2 Children	2 Children

A qualitative thematic analysis of the interviews and autoethnographic notes of the second author was conducted according to an abductive approach, through which the authors' previous knowledge, familiarity with the literature, and existing theories on the topic assisted in the exploration and interpretation of new hypotheses and concepts (Salvini, 2015). An initial thematic analysis was carried out by the second author and implemented using software for textual

analysis, Atlas.ti. To ensure the reliability and consistency of the analysis work, the coded themes and their interrelationships were then discussed among the authors through continuous rereading and comparison of the transcripts following an iterative process and triangulation.

4. Results

Five main dimensions of physiotherapists' working conditions that can produce situations of disaffection and alienation emerged from the analysis: emotional, organizational, relational, work-life balance, and symbolic. For each dimension, specific macro themes were identified with second level codes and more analytical themes were identified with first level codes (Table 2).

Table 2. Thematic analysis.

THEMATIC ANALYSIS		
MAIN DIMENSION	**II LEVEL CODE**	**I LEVEL CODE**
1. EMOTIONAL DIMENSION	1.1 CURRENT MOOD	1.1.1 Fatigue
	1.2 PREVAILING FEELINGS	1.2.1 Sense of abandonment
		1.2.2 Dejection and frustration
		1.2.3 Emotional and psychological fatigue in patient care
		1.2.4 Passion for own job
2. ORGANIZATIONAL DIMENSION	2.1 RESISTANCE TO CHANGE	2.1.1 Active listening to collaborators
		2.1.2 Willingness by managers and coordinator to seek solutions to problems
		2.1.3 Involvement of collaborators in organizational decisions
		2.1.4 Innovation
	2.2 AUTONOMY	2.2.1 Management of work plan
		2.2.2 Professional autonomy
	2.3 WORK RHYTHMS	2.3.1 Therapeutic relationship
		2.3.2 Treatment time
		2.3.3 Professional's health
		2.3.4 Covid

Continued on next page.

3. RELATIONAL DIMENSION	3.1 ROLE OF COORDINATOR	3.1.1 Empathy
		3.1.2 Defence and support of collaborators
		3.1.3 Active listening to collaborators
		3.1.4 Delegation skill
		3.1.5 Impartiality and fairness
		3.1.6 Responsibility
	3.2 TEAMWORK	3.2.1 Peer support
		3.2.2 Professional exchange and growth
		3.2.3 Resilience
	3.3 INTERPROFESSIONAL RELATIONSHIPS	3.3.1 Profile recognition
		3.3.2 Collaboration
		3.3.3 Communication
4. WORK-LIFE BALANCE	4.1 SOCIAL LIFE	4.1.1 Emotional relationships
		4.1.2 Hobby and sport
		4.1.3 Rest
		4.1.4 Distance from home
	4.2 FLEXIBILITY	4.2.1 Flexibility in single day
		4.2.2 Part-time
5. SYMBOLIC DIMENSION	5.1 PROFESSIONAL VALUES	5.1.1 Technicism
		5.1.2 Level of competence
		5.1.3 Public health value
	5.2 TYPE OF RECOGNITION	5.2.1 Verbal recognition
		5.2.2 Organizational recognition for collaborators' needs
		5.2.3 Training recognition
		5.2.4 Patient recognition

4.1 Emotional dimension

Emotional and psychological experiences related to participants' quality of work life were explored using photo-elicitation and personal accounts of particularly stressful events experienced at work. It was interesting to note how half of participants chose images with negative affective responses of valence and arousal, which naturally leads to reflecting about the condition of healthcare professionals within healthcare organizations. In this dimension, we find both elements related to professional's mood at the time of the interview, as well as references to the prevailing feelings experienced in the work environment.

It's surprising how many participants reported some form of discomfort and disaffection in the workplace, given that Physio Unit is a 'least likely' case of work alienation, being a small, non-urgent care unit. The second author wrote in her field notes:

> "Standing here in front listening to the stories of my colleagues, I think that although work-related stress and burnout are recognised as growing phenomena, to reach a percentage of 50% seems truly alarming to me as my work environment is not HUB hospital, where by definition the most complex cases are treated in high-intensity units, but rather a small, peripheral hospital treating patients with low care needs. I wonder: if half of my colleagues report feeling unwell in a relatively quiet environment like ours, how are colleagues in high intensity units doing?" (Valeria's field notes, 8th August 2023).

In the emotional dimension physiotherapists' common current mood is fatigue, which they describe as both physical exhaustion and as emotional and psychological fatigue. The latter seems to be predominant, and some interviewees attribute the cause of this discomfort to specific aspects of organizational and relational dimensions, as well as the symbolic dimension of work, such as work rhythms, interprofessional relationships, and professional recognition (further explored in later paragraphs).

In addition to the current mood, the prevailing professionals' negative feelings recounted during the interview are a sense of abandonment, dejection, and frustration. The disaffection expressed by the participants is palpable, evident in their choice of images, which immediately draw attention to the negative ones, in their resigned tone when recounting certain work experiences, and in the ironic smile when considering the possibility of change. Interviewees feel that their work and thoughts are poorly considered by managers and other professionals: this situation causes discomfort and dissatisfaction within the work environment. Like fatigue, these feelings are also linked to emerging themes in the dimensions identified during the data analysis process, such as resistance to change and relationship with the coordinator.

As a 56-year-old male physiotherapist says, a peculiar aspect of interviewees' stories is the combination of emotional and psychological exhaustion related to patient care:

> "Patients often unload their baggage of discomfort, suffering, and distress onto you, and in the long run, this leads to a significant amount of stress. Moreover, there's also an aspect related to motivating the patient, explaining to the patient, providing information, and trying to motivate them throughout the rehabilitation process." (FT 8)

The second author herself fully agrees with her colleague's statement, as we can read in her field notes:

> "Talking to my colleague FT8 makes me reflect on the daily practices of my work. The therapeutic relationship demands a considerable amount of mental and emotional energy that far exceeds physical effort. Interacting with people who face challenges and see you as the solution is a huge responsibility that engages you both professionally and personally. A full-time physiotherapist typically sees 8 patients a day, one every 45 minutes. Each patient has a specific condition that has to be managed and, above all, a personal experience of disability that has to be interpreted… At the end of the day, you often feel completely drained" (Valeria's field notes, 27th June 2023).

Further confirmation of physiotherapists' working conditions, as well as the phenomenon of intention to leave, occurs when participants are invited to reflect on their inclination towards a possible change of workplace or even profession. Most interviewees declared they had thought several times, during their experience in the Physio Unit, about changing their workplace and sometimes their profession due to prolonged periods of stress experienced in the work environment and a sense of alienation given by an incapacity to deal with negative emotions. Particularly significant is the story of a 57-year-old male physiotherapist, who consciously declares how stress accumulated in the workplace often leads him to think about abandoning the profession:

> "I've never thought about changing company, because more or less all places work like this, but I've several times thought about changing job. I think so even now. A few years ago, when I experienced a stressful situation with other professional figures, I seriously sought information on how to change. At the end you say, 'let's wait, let's see, come on, maybe things change', and you always stay here. But I always think about changing job. In the last few years I've seriously thought about it 3-4 times due to stress." (FT5)

4.2 Organizational dimension: change, autonomy, and work rhythms

The organizational dimension, along with the relational dimension, represents the most significant thematic area emerged from the data analysis process. According to the interviewees, organizational elements that most affect the quality of work life are: resistance to change by managers and coordinators,

physiotherapists' limited autonomy in managing work plans and treatment planning, and rhythms of work.

Resistance to change is negatively perceived by professionals, who interpret it as a lack of willingness by managers and coordinators to seek solutions about the problems reported by employees. At the root of this attitude, according to the interviewees, is the habit of resorting to a consolidated routine rather than facing the uncertainty and commitment that change entails, even though it could lead to organizational improvements. This continuing trend is likely to contribute to feelings of stagnation among employees who feel undervalued and lacking in career progression.

Along with this trend, another source of frustration for the interviewees is poor active listening from coordinators or managers, which manifested in a lack of involvement in organizational decisions. Being excluded from decision-making processes causes friction between employee and manager and may result in reluctance towards top-down decisions. Employees often find out about organisational changes after the decisions have been made, without being given the opportunity to provide input. This lack of employee involvement can lead to feelings of undervaluing and resistance to change, as decisions may seem disconnected from the day-to-day experiences of employees.

Frontline professionals want to play an active part into the organization and want their experience to be valued, especially when it comes from collaborators with many years of experience in the Physio Unit, as this 56-year-old female physiotherapist says:

> "Workers can point out limitations of organization, they can make proposals to improve organization, and, in my opinion, it would only be an advantage listening to employees. Listening to employees about organization, instead of just imposing an organizational method, listening to those who implement this organizational method could give you some insights for improvement, and yet this willingness is missing for unknown reasons." (FT1)

Perceived limited autonomy in the workplace also affects physiotherapists' quality of work life. Autonomy is understood by participants in a dual meaning: firstly, self-management of appointments (work plan), and secondly, professional autonomy, understood as the physiotherapist's ability to practice therapeutic activity according to the way they deem most appropriate without interference from coordinators or other professional figures. Professionals who cannot manage their own work plan experience a sense of little control over their work, which inevitably affects the quality of the therapeutic relationship,

because for example they cannot decide frequency and time of appointments in relation to patients' problems or other needs.

More relevant for interviewees is professional autonomy, because lack of autonomy complicates identity work and sometimes leads to misunderstandings with patients or physicians, also affecting therapeutic or interprofessional relationships, and causing a sense of alienation, as a 56-year-old male physiotherapist says:

> "Some patients expect you to do exactly what the physician says." (FT8)

In Italy, the physician still plays a central role in the healthcare system, with a high degree of decision-making autonomy (Sena, 2017). Patients have high expectations and trust in the physician, recognizing him or her as the institutional reference. However, the response to users' needs is increasingly based on a multidisciplinary approach, with each professional working with his or her specific skills to guarantee the patient comprehensive and high healthcare quality. In order to achieve this goal, mutual respect between professionals is essential, defining the limits of each professional's actions according to their education. If there is a lack of recognition of each other's roles, uncomfortable situations with the patient are likely to arise, undermining the therapeutic relationship and causing discomfort within the work environment, as the second author wrote in her fields notes:

> "The interviews explicitly deal with something that usually remains under the radar in everyday conversations, namely the lack of recognition of the intellectual competence of our role as physiotherapists. This brings to mind a case I recently followed where the physiatrist believed that the patient should be able to walk independently without the help of any aids. In reality, the patient could have walked independently, but with a poor performance that would probably have led to other problems in the long term. It was very difficult and frustrating to explain to the doctor and the patient that the time was not right and that the conditions were not right for independent walking. On the one hand, the doctor believed that the gait pattern would improve spontaneously; on the other hand, the patient felt that he was to blame and that he had to somehow "make an effort" to comply with the physiatrist' request. After a long and complex rehabilitation process, in which more time was 'wasted' in maintaining the relationship with the patient and the physiatrist than in concentrating on therapeutic exercise, the desired goal, i.e. autonomous and functional walking, was achieved" (Valeria's field notes, 14th July 2023).

Importantly, the organizational dimension also includes the theme of pace at work. Interviewees extensively discussed this content, bringing out different nuances and points of view. An aspect closely related to the pace of work is treatment times, which professionals sometimes describe as so pressing that they do not have time to take a break and, even more peculiarly, they cannot even think about what they are doing. This is experienced by the interviewees as a significant source of stress and alienation, not only from physical and emotional perspectives but also from a perspective of meaning.

The second author herself recognizes how, as a professional, the inability to reflect on one's work is highly stressful and alienating. According to the field notes:

> "Exactly like my colleagues, even I, sometimes out of exhaustion, find myself repeating the same exercises or the same concepts to everyone. At this rhythm, it's almost impossible to personalise the treatment, which is a fundamental element in solving the problem effectively and efficiently. Patients follow one another at such a pace that I cannot even remember their faces when I read their names, let alone the diagnosis or treatment given in the previous session. Last week I was called by the physiatrist who wanted some information about a patient I was seeing. When he told me his name, my head went black: I couldn't remember who he was! And yet he was my patient. Then I rearranged the information and managed to confront the doctor, but I can say that at first I felt a real sense of alienation from myself and the surrounding environment" (Valeria's field notes, 19th July 2023).

The lack of time for personalised care, which is essential for optimal patient outcomes, can hinder the healing process and negatively impact both the patient and the professional. It can also reduce the overall productivity of the organisation. This lack of time for reflection can foster a sense of alienation and lack of meaning disconnecting the healthcare professionals from their work, their environment and themselves. Specifically, participants describe how fast work rhythms negatively affect the relationship with the patient and the quality of treatment, underlining the perception of an organization that focuses more on quantity then quality, sometimes feeling like they're working "*on a production line*" they say, as if they were machines tested to produce a certain number of services.

A singular aspect that emerges from the interviews is the positive experience in managing treatment times during the Covid-19 pandemic. The minutes dedicated to sanitization were used by professionals to reflect on ongoing clinical cases, identify the most effective treatments compared to those yielding less results, and to update their knowledge. We find this anecdote, which was also reported by several participants, extremely interesting because,

while the pandemic is remembered primarily for its negative and often dramatic aspects, in this specific context there were some organisational reformulations that led to a certain degree of well-being among staff. The ability to slow down, to have more time to reflect on the patient's problem, to deepen the therapeutic relationship and to consult with colleagues allowed professionals to express their skills to the full and patients to feel cared for with attention and completeness. All these conditions, as opposed to alienation, allow workers to identify with the reality in which they are involved, restoring value and meaning to their work and, consequently, to themselves.

These sources of motivation and satisfaction for the worker disappeared with the end of pandemic and the restoration of old work rhythms:

> "Now that Covid is over we are right back on the chain, we work without a break, without 5 minutes, without anything. I can't even ask patients for some information because the time is up, I can't think. I always have this anxiety, this rush with a watch in my hand… this really kills me, it stresses me out a lot." (FT5)

4.3 Relational dimension: coordinator, teamwork, and interprofessional relationships

The relational dimension is other thematic area, along with the organizational dimension, on which the interviewees extensively commented. From a relational point of view, professionals report that quality of work life is influenced by coordinators, team group, and interprofessional relationships.

Participants assert that, among the characteristics of a good coordinator, empathy towards colleagues stands out first and foremost. As in the organizational dimension, the aspect linked to active listening to employees also emerges from a relational perspective. In this case, for the interviewees, active listening is understood in favour of greater defence and support of employees within a work group in which impartiality and fairness prevail. These characteristics are important to promote professionals' well-being at work and, at the same time, to motivate collaborators towards quality of healthcare.

Team group represents a key element of the interviewees' quality of work life, to which participants ascribe such an important role that they define it as decisive in decision-making processes that could even lead to a change of workplace or company, showing itself as a factor linked to intention to leave. The majority of participants firmly state that teamwork is fundamental to maintaining their jobs, because it is a source of support and assistance, as well as a platform for professional exchange and growth:

> "As for changing jobs, the group was the only thing that kept me here. If I hadn't had this group of colleagues, I would have changed job". (FT1)

The statement in this testimony is very powerful and was echoed by other participants. A good team is a driver for the intention to stay and for the retention of employees. While it may seem cliché to talk about the importance of teamwork, it's worth asking how many managers actually encourage team growth by facilitating opportunities for meetings and professional exchange.

A difficulty that professionals seem to encounter at multiple levels is the recognition of their respective professional profile, which causes discomfort and unpleasant situations with other professional figures. Moreover, because of comparisons and exchanges between different healthcare, professionals nourish a continuous growth path aimed at the well-being of the patient.

Physiotherapists and, more generally, healthcare professionals often feel less considered than physicians (Sena, 2017). Communication between these figures is often one-way and the doctor plays a role of supremacy that causes frustration and discomfort. The elements that interviewees point out as fundamental for good interprofessional relationships are communication and collaboration within the multiprofessional team, in which each member plays their part but in synergy and with a team spirit, not as individual 'players', as noted by a 59-year-old female physiotherapist:

> "I feel ignored by doctors. There isn't that crucial exchange of ideas that I have with someone else, which makes me grow, which opens up horizons that I don't have. Because everyone has their own role, I don't consider myself an expert about everything, so while on one hand, I need to talk to a doctor to clarify medical matters, on the other hand, I would like them to consult me and ask, 'There's this patient, what do you think?'" (FT7)

This is a very delicate aspect of the relationship with other health professionals, particularly physicians. Although professionals have a certain degree of autonomy in patient management, it's sometimes necessary to consult with the physician on issues that are beyond the physiotherapist's scope of practice. Conversely, the physician also needs to consult with the therapist to understand the progress of the rehabilitation process and whether the patient's problem is being resolved. A one-way exchange creates frustration in the professional, which inevitably spills over into the therapeutic relationship with the patient and may or may not determine the success of the rehabilitation intervention. Relationships are therefore triangular, and physiotherapists find themselves constantly investing intellectual, communicative and emotional

energy in all directions to avoid their own moral distress and ensure 'good' care in response to patients' needs, as the second author wrote in her field notes:

> "The labour to be recognised by the doctor and also by the patient is very tiring, relentless and with unpredictable results, like when I was working with S. (a patient who had difficulty walking). We worked together for a long time to find the most suitable device for him, taking into account both the therapeutic aspects and his personal preferences. It was exhausting, but also rewarding to find the right solution for him. When the time came to prescribe the aid, the physician decided that the aid I had chosen was not the most appropriate for S. and, without listening to my reasons, prescribed another aid that had already been tried but rejected by the user. This decision disappointed the patient and caused some embarrassment among the professionals involved and within the therapeutic relationship, in short within that triangular relationship that sociologists of work write about. Although after about a month, following a further discussion with the physician and at the explicit request of S., the aid initially chosen was prescribed, the experience left me with a strong sense of frustration which I feel has resurfaced in these weeks of interviews with colleagues who have had similar episodes" (Valeria's field notes, 15th July 2023).

4.4 Work-life balance

Within this dimension (Carreri et al., 2022), two main themes stand out: social life and flexibility of working hours. Regarding social life, interviewees reported how stress experienced in the workplace can affect emotional relationships, among both family and friends. Some professionals report often "bringing home" discomfort absorbed at work and projecting nervousness and tension onto their loved ones, or isolating themselves, confirming how current working conditions reshape the existing boundaries between work and private life.

> "I personally realize, but even hearing my colleagues speak, that patience and commitment puts into following, listening, and managing patient issues have a significant impact on activities related to family and personal life. There's less patience, less tolerance, more nervousness, and sometimes more aggression." (FT8)

Given that we spend most of our day at work, the boundary between our professional and personal lives is probably quite blurred in all professions, and it's not always easy to 'switch off' when we go home. What characterizes the healthcare profession, however, is the stress and energy expenditure that comes

from interacting with patients and their experiences of illness, as the participants' words illustrate. As the second author wrote:

> "There are days, like the last two of mine, when you just want to go home and be alone, in silence, but that's not possible if you have a family or other commitments outside work. On these occasions, you unjustifiably take out your frustrations on others, causing misunderstandings with family or friends who find it difficult to understand what it means to work closely with people and disability." (Valeria's field notes, 27th July, 2023).

Participants also report how accumulated physical fatigue at work, or problematic situations experienced during the workday, significantly impact the cultivation of personal interests and participation in sports activities, often leading to sacrifices or an inability to fully enjoy moments when an engagement or activity had been planned. A reduction in social participation can lead to a sort of alienation from society, as happens with some organizational problems described by the interviewees.

Regarding the theme of flexibility of working hours, participants understand this both in terms of flexibility within the individual workday and as a true part-time contract. It means for example a better reconciliation of work commitments with non-work commitments, but what professionals emphasize is the importance of a certain flexibility regarding needs related to a period that is not always predictable.

From personal experience, the second author herself can attest how rigid daily schedules can be a source of stress and alienation for daily workers. While shift work undoubtedly has its drawbacks, fixed hours can also be restrictive, forcing employees to concentrate all their extracurricular activities in the same time slot or at weekends. Although it's possible to request leave when necessary, most people try to avoid doing so in order to avoid disruption to the service. Furthermore, there's a lack of flexibility in terms of arrival and departure times, and the first patient appointment coincides with the start of the shift, meaning that extra time must be allowed for changing or unforeseen travel delays, increasing the total time spent at work and away from home.

4.5 Symbolic dimension

The symbolic dimension encompasses the themes of profession value and type of recognition deemed most suitable by the interviewees. From the testimonies collected, there is a certain discontent towards value, also defined as "cheap", reserved for physiotherapy. What professionals particularly lament

is being assimilated into a technical, marginal role, primarily associated with manual operations. Physiotherapy requires intense reflective practice, within which clinical reasoning plays a fundamental part in structuring a quality rehabilitation process and effectively meeting the patient's health needs.

This lack of knowledge and valorisation of physiotherapist's skills are a source of deep discomfort, demotivation and disaffection for participants, who feel like simple executors or machines, as one interviewee distinctly reported:

> "Physiotherapy isn't just about performing a few techniques, pushing with the elbow, doing a couple of stretching exercises, but reflecting together with the patient about his issue, and then reflecting individually on what you've done, what worked, and what didn't work" (FT5)

The valorisation of the profession of physical therapy is an ongoing struggle for those working in a relatively young profession, especially in a medical-centred context such as Italy (Sena, 2017). Physiotherapists are still often misunderstood and associated with massage therapists, and first-hand experience is needed to appreciate their value. It's a rapidly growing profession, strengthened by research and progressing specialisation, and increasingly important in a healthcare context characterised by a growing elderly population and chronic diseases. Physiotherapists invest a great deal of time and resources in their education, and this is not always recognised, either in terms of day-to-day work or long-term career prospects, leading to frustration and demotivation, as the second author wrote in her field notes:

> "The lack of recognition that my colleagues are talking about is something that I well understand. I've lost count of the time and money I've invested in my professional development and education. I've always strived to improve my skills and keep up to date with the latest research in order to provide the best possible care for my patients. I, like my colleagues, have rarely received any recognition, even verbal, for my efforts. Instead, my study leave is sometimes a source of irritation for my coordinator" (Valeria's field notes, 4th July 2023).

Regarding type of recognition, it is interesting to note how the economic aspect plays a secondary – although not entirely negligible – role in professional's job satisfaction and work culture. On the other hand, for the interviewees, verbal recognition of the work done by the coordinator or referring physician is a source of appreciation, as well as recognition from the patient.

> "Relationship with patients, the connection and the goals you achieve with them, their satisfaction and positive feedback… that's what, in short, keeps me going despite everything". (FT2)

This statement is of particular importance to the second author, as reported in her field notes:

> "For two months now, I have been taking care of G., a man affected by a stroke. On the day of his discharge, after two months in intensive care, G. comes to greet me. He is happy and excited, thanks me with a hug, and says: 'You gave me my life back!' At this moment, I feel that somebody finally recognizes me for my everyday effort. The recognition that patients have for your work is really a primary source of satisfaction and motivation" (Valeria's field notes, 18th July 2023).

Other forms of recognition appreciated by professionals include organizational accommodations in response to an employee's specific needs (as for example, when a collaborator asks for an extra day off due to family or health problems), and training recognition for a professional's growth (relating to a role of responsibility based on a collaborator's skills).

5. Discussion and conclusion

This research confirms the relevance of work-related stress within the professional group of Italian physiotherapists and how it has a negative impact on quality healthcare service (Bruschini et al., 2018). Interviewees described how prolonged stress situations experienced in the work environment have led them to consider the possibility of changing workplace or abandoning the profession altogether (Cantu et al., 2022). Interestingly, this was found in a 'least likely' organizational case of work alienation, given that the Physio Unit is a small, territorial, and low-intensity frontline care unit. The analysis has shown how intention to leave is linked to perception of a bad quality of work life: specifically, the compromise of professional autonomy, intense work pace, poor support from coordinators, difficulty in communicating and collaborating with other professional figures, a lack of flexibility in working hours – fundamental for work-life balance – and poor valorisation of employees play a key role (Carpi et al., 2021).

Importantly, our analysis shows how these working conditions are experienced by the interviewees as particularly alienating (Carreri, 2024). We argue that the mechanisms underlying the sense of alienation (and the intention to leave ultimately) are drawn from distinctive features of work in frontline

services. In particular, the analysis sheds light on the fatigue of emotional labour; the marginal position of physiotherapists in the service triangle in the healthcare context, which is physician-centred; the intensification of work rhythms linked to Taylorization processes of the healthcare system; and interestingly, the lack of reward mechanisms – both material ones, in terms of flexible hours, conciliation policies, and training opportunities, and above all in terms of symbolic and social recognition for intellectual labour.

Specifically, this analysis sheds light on a sense of alienation resulting from an inability to cope with (negative) emotional overload, which carries the risk of bringing home the discomfort (Hochschild, 1983). Frontline activities involve emotional work that requires the expression of emotions desired by the organisation when dealing with patients. Healthcare professionals have to understand the patient's emotions and learn which of their own emotions have to be hidden and which have to be manifested in the therapeutic relationship.

A second mechanism of alienation is also typical of the service sector, as it is related to the experience of hectic, repetitive rhythms and a lack of flexibility under neo-Tayloristic pressure (Fullin, 2021). Contemporary critical theory has highlighted the role of work (and life) times and rhythms, characterized by social acceleration, in producing alienating conditions (Rosa, 2010) but Rosa's theoretical framework is still fairly unknown in the healthcare domain (López-Deflory et al., 2023). In addition to acceleration, the demand for efficiency is a prominent feature of the experiences documented in this research. This reflects a trend toward market-oriented management and a style of progressive privatization and decentralization across the entire health sector. The objective is to achieve quality of service while reducing costs (Andrews et al., 2019).

Interestingly, the interviewees highlight that the issue is not merely physical exhaustion, although there is concern among professionals about the long-term impact of the work on the body. A substantial proportion of the work undertaken by health professionals is of a manual nature, encompassing activities such as examination and administration of medication, and face-to-face, including listening, interpretation, and mediating. However, this research highlights that all these practical activities are dependent on immaterial labour as they necessitate the employment of critical faculties, including sound judgement, open-mindedness, and the capacity to synthesise formal scientific knowledge with experiential knowledge. The nature of this immaterial labour is such that it is inherently demanding and stressful, especially when it remains unrecognised by patients and leadership roles, particularly coordinators and physicians. The main concern is that the fast pace of work does not allow sufficient time to reflect on the patient's needs and how they can be met. In their routine, physiotherapists do not fully exercise their autonomy due to the repetitive nature of their work. Additionally, they frequently adopt an executive

approach. This is due to the fact that within the healthcare services sector, rehabilitation professionals occupy a distinctive marginal position within the triangle of services (Leidner, 1993, 1996), which involves workers, patients, and leadership roles (coordinators and physicians).

As demonstrated, physiotherapists have limited autonomy in their interactions with patients. This is particularly evident in the Italian healthcare system, which is physician-centred (Sena, 2017) and, therefore, places significant constraints on the scope for physiotherapists to exercise independent decision-making. In this context of medical dominance, along with the more familiar literature on the patient/consumer sovereignty, the physiotherapist is constrained from fully expressing their professionalism throughout the client relationship (Bolton, 2005; Bolton & Boyd, 2003; Coletto & Fullin, 2018). Within this framework, the physiotherapist is undervalued and excluded from organizational decision-making processes, even during interactions with the coordinator. Our analysis suggests that physiotherapists have to constantly invest intellectual, communicative and emotional energies in all directions to avoid their own moral distress, ensure 'good' care, and ultimately make a difference to what matters to them despite the ongoing neoliberalization, bureaucratization, and technocratization processes (Krol & Lavoie, 2014; Reinders, 2008). Within this three-way power relationship, healthcare workers find themselves performing identity work from a marginal position and struggling to find spaces of micro-emancipation (McMurray & Pullen, 2008).

A particularly illustrative example of the alienating circumstances experienced by rehabilitation professionals is the metaphor of the production line, which was employed by the interviewees themselves. It is crucial to note that this metaphor reflects the necessity for their intellectual contributions to be acknowledged and esteemed (Honneth, 2002). Similarities with the Fordist vision of work are evident, where minimal value is attributed to the employee's thoughts. This is not due to a lack of recognition of their opinions, but rather because thinking is not perceived as their primary task, given the expectation to simply "do". The data collected indicate that the role of the rehabilitator is frequently reduced to a technical one, with a focus on manual or procedural operability. This is evident in the attitudes of physicians, coordinators, and, as a result, patients, according to the participants.

Notwithstanding, physiotherapists declare that they are educated according to ideals and expectations that are not satisfied, as they perceive the company as "aseptic" and primarily concerned with meeting entry-level skill requirements to "meet quotas". The training of physiotherapists, as well as other healthcare professionals, comprises complex and articulated studies aimed at acquiring specialized skills, including problem-solving and decision-making, which

require reasoning and critical thinking. These aspects delineate a responsibility that extends well beyond the execution of manual techniques or the implementation of rehabilitation protocols. However, professionals often report feeling like mere executors of decisions "imposed from above". A theme that emerged from our data analysis is a lack of collaborator involvement in organizational decisions, which stems from a lack of active listening by coordinators, managers and other professional figures.

In this regard, the participants' reports of their work during the pandemic are noteworthy for their counterintuitive nature. Interviewees recalled that the time dedicated to sanitization (15 minutes between appointments) was invested in professional development, discussions with colleagues, and reflection on clinical cases, with the aim of improving the quality of care and patient outcomes. Furthermore, during the pandemic, there was greater autonomy in managing work planning, but above all, the possibility of personalizing and varying rehabilitation pathways was available (Latzke et al., 2021). In the restoration of pre-pandemic working routines, professionals have perceived a sense of automation, whereby rigid and predefined rhythms in daily planning heavily restrict the possibility of reasoning, reflection, and individualised therapeutic intervention, resulting in discomfort, job dissatisfaction, and demotivation. This is also reflected in interprofessional relationships where everyone looks above their own "piece" and interviewees experience a sense of isolation and alienation both from oneself and from the surrounding environment. There is a lack of collaboration and dialogue, which hinders the potential for improvement and growth. The various signs of disaffection (Coin, 2024) that emerge from the interviews are intrinsically linked to changing working conditions. The lack of alignment between one's own ethics and the concrete practices of care work, the lack of involvement of healthcare professional by coordinators and physicians in their work and, more generally, the sense of dissatisfaction and stress of workers are inseparable from the current working conditions in the area of public health and social services and potentially leading to a loss of purpose and faith (Cohen et al. 2018)

In contrast, reasoning and reflection are perceived as rewarding and as conferring meaning upon the work of rehabilitation professionals. They are seen to enhance professional practice by fostering autonomy and social recognition (Honneth, 2002). The professionals interviewed indicated that the key to making healthcare service meaningful and purposeful is having time to reflect on one's actions, consider the most appropriate course of action for the patient, and autonomously cultivate a strong healthcare relationship with patients. Finally, the interviewees expressed a desire for comprehensive listening by the coordinator, which encompasses not only attention to the

professional aspect but also to the individual, their emotional state, and their mental and physical condition.

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