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Routine Dynamics at a Cardiac First-Aid Unit: How Context, Emotions, and Identities Drive the Adaptation of Action Patterns

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ABSTRACT Emotions are a catalyst for actions. They are therefore important for developing an understanding of organizational routines as generative patterns of interdependent actions. To investigate how the performances and action patterns of routines are impacted by emotion changes brought about by alterations in the context of routine enactment, we conducted an ethnographic inquiry centring on a diagnostic routine at a hospital's cardiac first-aid unit. Our findings show that context changes from off-peak to peak times and vice versa engendered differences in the emotions of doctors and nurses because of, respectively, conformity and non-conformity between their salient identities and their situated experiences. This triggered actions that produced variation in routine performances and action patterns. Drawing on our findings, we present a grounded model that theorizes two complementary emotions and identity-linked mechanisms that explain variety and stability in action patterns. We discuss the theoretical contributions and implications of our model and findings for research on routine dynamics.

Keywords: action patterns, emotions, professional identities, routine, routine performances

INTRODUCTION

Organizational routines are patterns of interdependent actions for accomplishing organizational tasks (Feldman et al., 2016, 2021; Feldman and Pentland, 2003; Howard-Grenville et al., 2016; Howard-Grenville and Rerup, 2017). While routines are often stable, enabling consistent and efficient task accomplishment, their action patterns are

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subject to change (Pentland et al., 2011; Turner and Fern, 2012). To develop a better understanding of adaptations in action patterns, this article focuses on the understudied role of emotions. Because a routine is enacted by 'people who think, and *feel* and *care*' (Feldman, 2000, p. 614 – *emphasis* added), one would expect emotions to affect the way it is performed, potentially influencing its action patterns (Baldessarelli, 2021; Salvato and Rerup, 2011). As research on routine dynamics has tended to either overlook emotions or to pay only indirect attention, it offers but an initial glimpse into the role of emotions. Early work suggests that emotions may facilitate routine performances and may be instrumental to the continuity and breakdown of action patterns (Grodal et al., 2015; Melhem et al., 2025; Salvato and Rerup, 2018; Zbaracki and Bergen, 2010).

Yet, the precise influence of emotions on the performances and adaptations of action patterns remains an area requiring systematic investigation and theory development (Baldessarelli, 2021; Karali, 2021). We address this gap, drawing on three well-established ideas in the literature on emotions. First, emotions are dynamic, that is, they are temporary reactions that arise, unfold, and dissipate with how a change in context triggers people's subjective experience of it (Frijda, 1986; Lazarus, 1991). Routines scholars have yet to theorize how emotion dynamics influence routines. Second, emotions have valence (they can be positive or negative) and intensity (they can be of high or low strength) (Elfenbein, 2007; Russell, 1980). The effect of context-triggered differences in the valence and intensity of routine participants' emotions on routine performances and patterns remains to be unpacked. Third, emotions research holds that they drive actions by motivating one's readiness to act, that is, general preparedness to engage in functionally appropriate action in a specific context (Frijda, 1986; Weiss and Cropanzano, 1996). Routines research has still to engage with emotion-action mechanics to sharpen understanding of the process by which emotions drive routines.

This study started with the aim of examining and theorizing how situational and emotional dynamics influence the enactment of a routine in the ever-changing context (Aroles and McLean, 2016; Birnholtz et al., 2007) of an organization. This is a vital endeavour for developing a full, fine-tuned understanding of variety and stability in action patterns that get things done in organizations (see also Goh and Pentland, 2019; Howard-Grenville, 2005; Kahn and Rouse, 2021; LeBaron et al., 2016; Sele and Grand, 2016). To guide our inquiry, we formulated the following question: how do changes in the context of interdependent actions influence routine participants' emotions and the dynamics of a routine? Our fieldwork comprised an ethnographic investigation of a diagnostic routine enacted by doctors and nurses at a hospital's emergency medical unit, which was prone to frequent changes in context because of back and forth cycling between off-peak and peak periods. Because the changes in context were accompanied by changes and differences in the emotions of doctors and nurses, the setting was ideal for our inquiry.

Fieldwork revealed differences in how the diagnostic routine was enacted during peak and off-peak periods. In the peak-period context, the diagnostic routine's emotion-driven performances included new enabling actions for faster patient diagnosis and greater patient comfort. This produced variety in the routine's patterns of actions. As we probed what we were observing further, we discovered a critical dynamic that we had not contemplated at the outset of our investigation. Namely, it became evident that the professional identities of the doctors and nurses played a key role in regulating their emotions and actions in the wake

of context changes. As discussed later, this provided novel insights into the micro-dynamics of variety and stability in routines, showing how context, emotions, and identities come together to affect the patterning of interdependent actions. We conceptualize our findings through a process model of variety and stability, which enriches the field by articulating how the dynamics of change in context, salient identity, and emotions can produce actions that result in different action patterns in different contexts.

Based on the process model, the discussion section of the article develops three important sets of contributions to the literature on routines. First, furthering the current understanding of routines, we theorize routines as interdependent action patterns shaped by how the context and the participants' salient identities influence their lived experiences and emotions. Second, advancing the emerging work on action paths in routines, we unpack how variations in routine participants' emotions lead to the expansion and contraction of action paths. Third, deepening our knowledge of differences in routine performances and the adaptation and reproduction of action patterns, we articulate how shifts in context trigger changes in routine participants' salient identities, regulating their emotions and actions.

We begin by reviewing the literature to highlight the gaps and to ground our work theoretically. We then describe the empirical setting, methods and the analysis of data. Next, in the findings section, we present an interpretive account of the emotions and identity-linked mechanisms underlying the routine dynamics we observed. In the discussion section, we articulate our study's theoretical contributions by showing how our findings and theorizing advance the literature on routine dynamics. We conclude by taking stock of the study's limitations and identifying future research directions.

THEORETICAL BACKGROUND

Context and Routine Dynamics

A processual perspective is gaining traction, which conceptualizes routine dynamics in terms of action paths and patterns (Danner-Schröder and Geiger, 2016; Feldman, 2016; Goh and Pentland, 2019; Sailer et al., 2024; Turner and Rindova, 2018). A path describes an ordered sequence of actions (Goh and Pentland, 2019). The repeated enactment of some paths and the closing of others establish a recognizable action pattern that participants recognize as the correct way of performing a routine (Feldman, 2016; Goh and Pentland, 2019). While patterns are inherently recursive, meaning that they are repeated, each individual performance of a routine carries the potential for variation (Feldman and Pentland, 2003). Because a change in context may result in the changing of a pattern over time, routines exhibit 'pattern-in-variety' (Cohen, 2007). From a processual perspective, analysing the relationship between context, actions, paths, and patterning is crucial for developing an understanding of the dynamics of stability and change in organizational routines.

Several studies have examined the effect of context's cultural, socio-material, technological, and temporal elements on how participants interpret and perform routines (Bertels et al., 2016; Geiger et al., 2021; Howard-Grenville, 2005; Sele et al., 2025). By and large, these studies have conceptualized the relationship between organizational context and routine enactment in terms of embeddedness, leading to the insight that context is an important driver of routine stability and change

(Howard-Grenville, 2021). It is within the set of material and symbolic organizational arrangements represented by the context that routines receive their meaning and scope in an actual situation of action. This conceptualization has two important implications. First, context operates as a sensegiving framework – it affects the way in which routine participants understand the situation they find themselves in and (re)enact action patterns (Feldman and Pentland, 2003; Howard-Grenville and Rerup, 2017; Turner and Rindova, 2018). Second, context provides a 'lexicon of possible actions' (Pentland, 1995) – it defines the boundaries of correctness and thereby enables or constrains the choice set of actions available to routine participants.

Overall, this body of research highlights how contextual elements influence routine performances to shape the paths and patterns of routinized action. However, we currently know little about how changes in context influence routine participants' lived experiences and emotions, and with what consequences for a routine's action paths and patterns. We review next research that has touched upon the role of emotions in routine dynamics.

Emotions and Routine Dynamics

Studies of the dynamics of routine change (Dittrich et al., 2016; Glaser, 2017), conflicts and truces in routines (D'Adderio and Safavi, 2021; Zbaracki and Bergen, 2010), and routine breakdowns and interruptions (Bucher and Langley, 2016; Salvato and Rerup, 2018) suggest that routines can trigger emotions and be impacted by these. For instance, in a study of help-seekers and help-givers, positive emotions such as excitement and sympathy seemingly encouraged participants' engagement, which drove the performances of the helping routine (Grodal et al., 2015). In this way, emotions played a role in enabling effortful accomplishments that maintained the routine's pattern. In another study of procurement and project management routines (Berente et al., 2016), the role of negative and positive emotions such as defiance and enthusing, while not discussed explicitly, is signalled indirectly by the dynamics of active resistance and change and the adjustments in routines that followed. In a study of a new product development routine (Salvato and Rerup, 2018), frustration, a negative emotion, is hinted to have contributed to the breakdown of one pattern of the routine, leading to a pattern update (see also, Deken et al., 2016). Finally, in a study of a waste collection routine (Turner and Rindova, 2012), customers' positive (appreciation) and negative (dissatisfaction) emotions underpinned the consistency and flexibility of action patterns.

Taken together, past studies suggest that emotions are integral to the performing of action patterns. They appear to affect interpersonal engagement around a routine, enhancing or disrupting patterned flows of action. Interestingly, to the extent that routines require participants to regulate their emotions while interacting with others, routine performances may involve emotional labour (cf. Grandey, 2000). Routines may accordingly operate as a mechanism for emotional regulation, providing a structured way to manage workplace emotions. In the light of the above, it is surprising that there is a dearth of research on how the dynamics of emotions influence change and stability in routines. One plausible explanation for the insufficient attention paid to emotions could be that routines, being action patterns,

scholars have tended to assign emotions to the analytical background while focusing their research efforts on the unpacking of actions. Consequently, the role of emotions and changes in emotions in action-pattern performances and adaptations remains to be theorized. We review next research on emotions and actions and research on emotions and identity.

Emotions, Actions and Identities

Organization and management theorists (Fortwengel, 2023; Melhem et al., 2025; Menges and Kilduff, 2015; Zhang et al., 2024) often draw on sociology and social psychology research to define emotions as transient states of feelings that arise as reactions to the lived experiences of events and situations (Ekman, 1992; Folkman and Lazarus, 1985; Frijda, 1986; Lawler and Thye, 1999). As temporary states, emotions entail intrapersonal processes, 'when a focal individual is exposed to an eliciting stimulus, registers the stimulus for its meaning, and experiences a feeling state and physiological changes, with downstream consequences for attitudes, behaviors, and cognitions, as well as facial expressions and other emotionally expressive cues' (Elfenbein, 2007, p. 317; Scherer and Moors, 2019). They transition from activation to dissipation, as a change in context and how it is experienced triggers different emotions (Folkman and Lazarus, 1985; Scherer and Moors, 2019). Attention to this dynamic aspect of emotions is essential for a complete understanding of the relationship between contextual change and routine performances and patterning.

Furthermore, the literature on emotions discusses the valence and intensity of emotions. Emotional valence refers to whether an emotion has the quality of being positive and constitutes a pleasant experience (e.g., joy and pride), or has the quality of being negative and constitutes an unpleasant experience (e.g., frustration and resentment) (Elfenbein, 2007; Kemper, 1987). Emotional intensity refers to the strength of an emotion, which can range from low to high. Research suggests that on average, negative emotions produce more intense emotions than positive emotions (Ito et al., 1998; Catino and Patriotta, 2013). While routines researchers have begun to document the presence of positive and negative emotions during routine dynamics, the effect of changes in emotional valence and intensity on the performance of routines and the paths and patterns of actions awaits closer scholarly examination.

Furthermore, research on emotions indicates that they affect people's alertness and the urgency they perceive to act (Frijda, 2006). That is, emotions affect a person's action readiness. In this regard, whereas emotions of high intensity often engender immediate, impulsive actions because of a high state of action readiness, emotions of low intensity tend to be associated with slower, more deliberate actions. As well, emotional valence may influence action tendency, that is, the type of action readiness that is activated (Frijda et al., 1989; Lazarus, 1991). Particularly, positive emotions can motivate proactive actions and broaden the action repertoire, and negative emotions may produce defensive actions and narrow the action range (Fredrickson, 1998, 2001). To illustrate, while joy and pride can trigger actions such as collaboration and innovation, frustration and resentment can trigger actions such as complaints and confrontation.

The relevance of the mechanics by which emotions affect actions has largely been neglected when studying routine dynamics. It is conceivable, for example, that the action readiness activated by specific emotions might play a relevant role in relation to the performing and patterning of a routine. As illustration, when routine participants enact

a routine with a steady set of positive emotions, arguably their action readiness will conform with expected behaviours, making them more likely to adhere to established action patterns. Positive emotions like pride and satisfaction may in this way reinforce the habitual enactment of a routine, contributing to routine stability. As another illustration, a switch in emotions, say from positive to negative emotions, such as boredom and frustration, can alter action readiness, resulting in deviations in routine performances that alter action patterns (cf. Feldman, 2000).

It is also worth noting here that because routines are socially distributed performances, they require coordination between different roles (Grodal et al., 2015). In this regard, shared emotions of participants can create relational action readiness, enabling synchronized performances (cf. Barsade, 2002). On the other hand, emotional misalignment across participants may engender different appraisals of a situation, reducing relational action readiness and disrupting routine performance. The foregoing discussion underscores the importance of examining how the mechanics of emotions, action readiness, and action tendencies influence the ordered sequences of actions constituting a routine.

As noted earlier, we discovered during our fieldwork that routine participants' emotions seemed to be intertwined with their professional identities or self-concepts. A review of the literature on emotions (Fineman, 2000; Winkler, 2018) and the literature on identity (Stryker, 2004; Tajfel and Turner, 1986) illuminated the association we were observing between emotions and actions, and between emotions and doctors' and nurses' professional identities. The literature regards a professional identity as the set of meanings a person attaches to their role in a specific network of work-related relationships (Ibarra, 1999; Stryker and Burke, 2000). Furthermore, as professional identities embody obligations and requirements regarding the appropriate norms of conduct when in an occupational role and the ethical rights and wrongs connected to the role's execution, they are the repository of internalized role expectations.

Role expectations provide the framework for interpreting one's experiences within a role and shape one's sensitivity to contextual cues (Markus, 1977; Stryker, 2004). This is a notable point because an alignment between one's lived experience in a specific context and one's salient identity can be expected to produce emotional consonance that manifests as positive emotions. In contrast, a clash between lived experience and the salient identity is likely to generate emotional dissonance that manifests as negative emotions (Carver and Scheier, 1990; Jansz and Timmers, 2002). Regarding salient identity, the literature holds that one's multiple identities or self-concepts are organized in a salience hierarchy. The identity that is more salient can be expected to determine one's emotions and behavioural responses when they are in a specific context (Nuttbrock and Freudiger, 1991; Stryker and Serpe, 1982). This discussion is clearly relevant for the study of routine dynamics, albeit research has still to unpack the role of salient identities in the performing and patterning of routines. It suggests that by determining participants' emotions in response to the specifics of a context, professional identities may affect action readiness and actions during routine performances.

In summary, routine enactment is likely to be sensitive to the dynamic interplay of an ever-changing context, participants' lived experiences and emotions, and participants' salient professional identities. Routines research has still to analyse and theorize this

dynamic interplay for a fuller understanding of variety and stability in the action patterns of a routine.

RESEARCH SETTING AND METHODS

We gathered empirical material through an ethnographic study involving immersion in the cardiac first-aid unit (CFA) of a full-service hospital. The CFA's primary function is to provide immediate and effective cardiac care to patients experiencing cardiac emergencies, such as heart attacks, cardiac arrest, and other life-threatening arrhythmias. Cardiac (and other emergency and intensive care) units of hospitals are an emotion-rich and action-packed arena. They are the site of regular changes in affect and the tempo of work because of fluctuations in patient traffic, unexpected events, and critical medical ordeals (Isbell et al., 2020; Wright et al., 2017). The CFA thus provided an ideal setting for producing an interpretive narrative of emotions and routine dynamics.

The Empirical Setting

Ziekenhuis (a pseudonym) is in the Rotterdam-Rijnmond region of the Netherlands and has a storied history going back to the late nineteenth century. The hospital is medium-sized, with 10 surgical beds and more than 400 patient beds. To ensure the quality of healthcare, Ziekenhuis has implemented patient care pathways (PCPs) for patient groups with specific ailments, signs, and symptoms. PCPs aim to improve the efficiency of healthcare and its value for patients by shifting the focus of care delivery away from the level of hospital departments to the treatment level, so that the emphasis is on multidisciplinary healthcare management that draws on the expertise of specialists in different departments in the right order and at the right time (Schrijvers et al., 2012). One such PCP at Ziekenhuis is for patients with acute cardiac complaints (ACC). This PCP came into effect in 2011, when the cardiac specialization was taken out of the emergency aid department, and a dedicated cardiac first-aid unit (CFA) was established for treating patients entering the ACC care path.

CFA was set up as a four-bed unit adjacent to, but separate from, the hospital's eight-bed coronary care unit (CCU). In contrast to the emergency aid department, the CFA could be staffed with nurses specialized in cardiology, benefiting ACC patients. The CFA-located PCP was offered daily between 8 A.M. and 5 P.M. Although CFA had benefits, its patient-handling capacity was finite given its small size. While adequate for the handling of off-peak patient traffic, at peak times significant difficulties arose because of time and material shortages. Additionally, off-peak and peak periods could not be predicted and planned for in advance. In the time frame of this study, peak periods formed ranging from 2 to 5 days in a week. On average, these periods lasted about two and a half hours from the build-up of patients to a return to off-peak normalcy.

Our study focuses on the enactment of CFA's core routine centring on the examination of patients. We did not wait to be in the field to discover this routine – well before field immersion, in the first meeting with hospital administrators to get a mandate for

the study, the administrators identified the 'diagnostic routine' (DR) for us. They laid out and explained the DR as they saw it – their description of it was the ideal, formally espoused pattern of the routine, which found expression in standard operating procedures. In terms of the emics – etics distinction (Harris, 1990), in line with the emic approach, we identified two different patterns of the routine when doing fieldwork. We labelled the enactment of the routine in off-peak periods as the "standard pattern" because it conformed with the scripted routine that the doctors and nurses were well versed in and strove to perform. The administrators, doctors, and nurses described and explained the pattern of the routine we observed in peak periods as deviations from the scripted routine; we labelled this as the "adapted pattern", which included actions that were not part of the standard pattern.

Additionally, the administrators explained that the DR protocol – in terms of the steps to follow from patient arrival to discharge, standard operating procedures, and the explicitly documented roles and duties of the CFA doctors and nurses – was akin to the protocols in place at other hospitals. The isomorphism of medical routines is commonplace due to the use of standard medical technologies and the ease in the diffusion of medical best practices (Edmondson et al., 2001). The CFA's scripted DR as well as the patterns we observed in the field corresponded to the widely accepted definition that routines are 'repetitive, recognizable patterns of interdependent actions, carried out by multiple actors' (Feldman and Pentland, 2003, p. 95). In relation to every incoming patient, the nurses, the junior doctors (i.e., doctors either in- or not-in-training to become a specialist) and the cardiologist were the multiple actors who enacted the recognizable patterns of interdependent actions.

Data Collection

Data was collected over a 6-month period, several years after the CFA was established. It was primarily gathered by one of the authors referred to as the 'ethnographer' here. His observational focus encompassed all interactions between patients, nurses, and doctors during off-peak and peak periods. At Ziekenhuis, a senior administrator introduced the ethnographer to the CFA manager, who introduced him to the rest of the CFA crew. The staff were told that the ethnographer was doing a project on service dynamics in hospitals, because of which they could expect to see him recording his observations during the coming months. They were also asked to consider the ethnographer as one of them and to freely socialize with him during coffee and lunch breaks. It took 2 weeks for the ethnographer to feel accepted as one of the CFA team and to feel that he was oblivious to the staff as they went about their daily duties. We were conscious when preparing for fieldwork that the ethnographer's introduction into the setting could influence the staff's conduct. Therefore, throughout the fieldwork, the ethnographer kept a personal journal of experiences and feelings to foster a reflexive approach to data analysis and keep track of whether his presence was affecting what was being observed. These personal notes formed a part of the fieldnotes. Post-immersion self-reflexive scrutiny of the ethnographer's observations and personal notes indicated that the CFA staff's initial exhibition of curiosity, courteousness, and in some cases a distant friendliness had transformed into a more familiar closeness towards the end of the

first fortnight, as if the ethnographer was part of the CFA team, could be trusted, and did not merit particular attention.

Ethnographic fieldwork combined observation with semi-structured interviews. It was aimed at registering the emotions emerging in action and understanding their relationship with the actions. Specifically, direct observation involved shadowing the doctors and nurses while they were busy at work and discussing with them how particular instances (e.g., interactions and interruptions of action flows or other forms of routine breakdowns) had affected their emotions. Our observations were aimed at achieving an 'emotion ethnography' that 'can track events-in-context, as reported by key actors' (Fineman, 2000, p. 14; Frandsen et al., 2025). Fieldnotes written during and after observations and social interactions at the CFA made up the bulk of the data. The ethnographer spent 54 full (9-h) days at the unit in the time window 8 A.M. to 5 P.M. Observational material was also obtained by attending nine general, evaluative, and reporting meetings of the staff. The ethnographer digitally chronicled all fieldnotes (including more than 900 time-stamped annotations) and contextualized these with a comprehensive description of an observation-day's events, to put what was seen and heard into perspective, doing so within a 24-h window when things were still fresh in his mind. The authors further had access to the hospital's archival records concerning matters relevant to the study, including documents and memos about the history of the CFA, information and training manuals for nurses, guidelines and expectations about professional conduct and standards, and vision and values statements.

In addition, 16 follow-up interviews were conducted with representatives of different staff categories (i.e., doctors, and general and specialized nurses, and administrators). The aim of the interviews was to get the staff's perspective on subjective elements (Spradley, 2016), such as the way they experienced peak and off-peak periods, the meanings they attached to specific events and circumstances, the emotions they felt, and the motivations for their conduct. The interviews were transcribed, and the information was integrated with the observational material in a thick description. This was in the form of a layered narrative that developed as the ethnographer cycled between interim accounts and new interpretations arising from ethnographer–co-author discussions. The narrative captured the connections between what was witnessed, the ethnographer's situated experience and feelings, and the literature (Emerson et al., 2011; van Maanen, 2011). To aid the building of a fine-grained picture of the emergence and dissipation of emotions and the relationship of these to the situated actions, interactions, and the context of the observed, the narrative also recorded the subjects' facial expressions, voice intonations, body language, and overall behaviour and conduct as they dealt with the routine and the non-routine unfolding of a workday.

Data Analysis

Inductive research faces the challenge of moving credibly from observations on the ground to theoretical claims (Ketokivi and Mantere, 2010). To draw inferences that would plausibly connect our empirical material with our theoretical concepts, we

kept interpreting the data being compiled from immersion in the setting creatively and diligently (Langley, 1999; Mantere and Ketokivi, 2013). The observations and interpretations we weaved together to develop a thick description sensitized us to possible themes and theories for making further sense of the data. Overall, our analytical approach of back-and-forth iterations between empirical material and provisional findings was in the tradition of interpretive research. In the interpretive tradition we followed, researcher judgement plays a crucial role in the dialogical process between observation and theory, with interpretations being driven by the researcher rather than general empirical tendencies (Alvesson and Kärreman, 2007). Mantere and Ketokivi (2013) offer a comprehensive discussion of the differences, noting that instead of focusing on 'general empirical tendencies, interpretive scholars focus on striking and idiosyncratic examples in order to use them to evaluate and ultimately untangle theoretical problems' (2013, p. 80). Interpretive scholars, thus, rarely use coding frameworks (see Mees-Buss et al., 2022). We too did not start our data analysis with open (Strauss and Corbin, 1998) or first-order coding (Gioia et al., 2013), using instead the ethnographer's understanding of the setting and his observations of nurses and doctors interacting with patients to start a dialogue with the data (Gadamer, 1975). As well, in contrast to inductive research in which the epistemological and methodological focus is on drawing inferences from data as per prescribed normative standards, we used data for 'establishing the contextual authenticity of our reasoning' (Golden-Biddle and Locke, 1993; Ketokivi and Mantere, 2010). When we did code, this was only to systematically catalogue the emotions observed in off-peak and peak periods (discussed in the next subsection), and not to infer new concepts or theory as in inductive research. The three subsections below provide a stepwise account of the data analysis.

Step 1: Analysis of situated emotions. We combined our observational and interview data into a single dataset. To make sense of the emotions of nurses and doctors across off-peak and peak periods, we reviewed the layered narrative manually (Corbin and Strauss, 2008). As experienced emotions are expressed vocally as well as non-vocally (Sauter, 2017; Scherer, 1995), we considered what was said, how it was said, and the attendant facial and bodily expressions.

We used the circumplex model to code emotions. The model allows all emotions to be arranged in two-dimensional space, using emotional valence (positive–negative) and emotional intensity (low-high) as the axes (Liu and Maitlis, 2014; Russell, 1980). For example, we coded frustration, dissatisfaction and disbelief as emotions of high intensity and negative valence. In contrast, we coded contentment and pride as positive emotions of moderate intensity. The coding of emotions highlighted the different experiences of doctors and nurses. Positive low-intensity emotions were the norm for doctors across off-peak and peak periods. While the nurses' emotions tended to be positive and of low to moderate intensity during off-peak periods, the nurses exhibited a complex set of high-intensity negative and positive emotions in peak periods. The positive emotions we indexed were attentive, confident, compassionate, happy, interested, joyful, optimistic, pleased, proud, satisfied, and sympathetic; and the negative emotions were annoyed, anxious, disappointed, disbelieving, dissatisfied, frustrated,

pessimistic, resentful, unhappy, and worried. The authors carefully discussed these emotions, recognizing that some of them were related and tended to coincide in the field. For example, nurses' joyfulness in off-peak periods often overlapped with their being contented or satisfied. With a view to be parsimonious and consistent with the literature (Sauter, 2017), as shown in Figure 1, we aggregated the overlapping off-peak period positive emotions into three overarching categories, namely, confidence, contentment, and pride. We similarly aggregated the peak period positive emotions into the categories, empathy, happiness, and pride, and the negative emotions into the categories, disbelief (related to patients not receiving more prompt attention), dissatisfaction (related to the deficiency of resources), and frustration (related to the execution of the DR according to protocol).

Step 2: Analysis of relevance of the self and salient identities. In the process of examining the data and compiling more empirical material, we noted that the conversations among nurses and with them often included explicit references to the notions of being either a 'healthcare professional' or a 'caregiver'. These concepts usually came up when the nurses contextualized their emotions and conduct and were used by them to emphasize who they were and what they did. This sensitized us to the possibility that the emotions and actions of the nurses and doctors might be linked to their self-concepts or identities. As our understanding developed of what it meant to be a healthcare professional or a caregiver to the CFA staff, we realized that the CFA nurses and doctors differed in how they saw themselves. Whereas the consistent self-concept of the doctors was that they were healthcare professionals, nurses viewed themselves more as healthcare professionals in off-peak periods and more as caregivers in peak periods.

In the nursing domain, the healthcare professional and caregiver self-concepts have existed as role-based identities for quite a while (Allen, 2004; Apesoa-Varano, 2007; Goodrick and Reay, 2010). While not mutually exclusive, they can vary in terms of salience and thereby exercise a differential influence on nurses' conduct (cf. Wright et al., 2017; Wynd, 2003). To code the more salient identity of nurses, we first distinguished the caregiver and the healthcare professional self-concepts by considering how

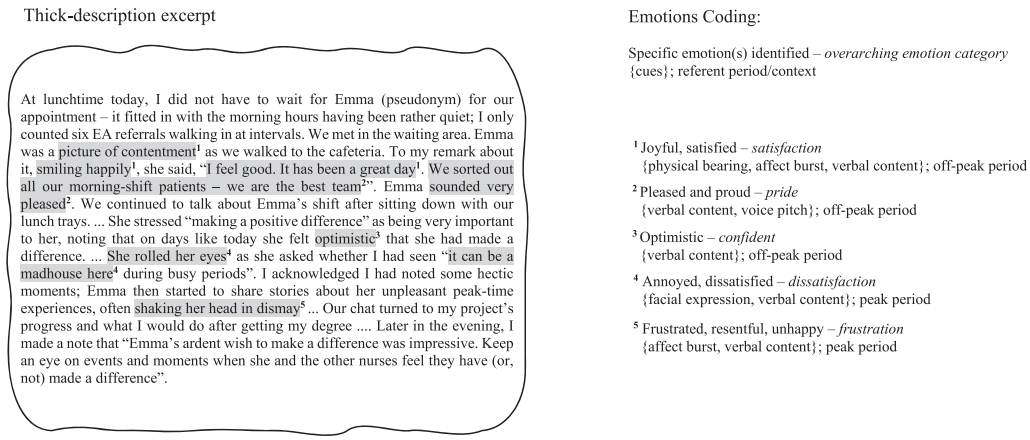

Figure 1. Illustration of emotions coding

they differed on five dimensions as shown in Table I. We then used the literature and the hospital's documents such as the vision and standards statements to gather indicators for the caregiver (e.g., prioritizing patient needs, giving patients comfort and support, and patient advocacy) and healthcare professional (e.g., fidelity to protocol, teamwork, and service efficiency) identities. Finally, we examined our observations of the staff (e.g., whether they bypassed protocol, paid more/less attention to team harmony, and focused more/less on empathizing with patients) to code which of the two self-concepts was more salient in a specific context.

Step 3: Analysis linking emotions, identities and routine dynamics. With witness-cum-recording (Willis and Trondman, 2000) showing that the nurses' healthcare professional and caregiver identities were more salient in the off-peak and peak periods respectively, we creatively questioned the relationship of this to the nurses' situated emotions and their actions as the DR was enacted. This led us to realize that during peak periods, because of the emotional dissonance produced by the disconnect between the nurses'

Table I. Healthcare professional and caregiver identities of nurses

Dimension	*Healthcare professional*	*Caregiver*
Role	Integral members of the healthcare team who work closely with doctors and other technical and administrative staff to coordinate and provide comprehensive care	On standby to help doctors, as asked; providing physical, emotional, and psychological support to patients
Ethos and values	Adherence to professional standards and medical protocols; coordinated teamwork for the clinical provision of care; respect for interdisciplinary roles, communication, and a collaborative spirit	Attention to patient's needs that is characterized by empathy and compassion; dedication to patient comfort and well-being; commitment to healing beyond the clinical aspects
Scope of activities	Assessing patients, implementing care plans, administering medications, providing direct, hands-on care, often making real-time decisions that impact patient outcomes	Nurses coordinate complex care needs, ensuring that patients receive timely interventions, proper follow-up, and smooth transitions between different stages of care
Skills and competences	Centred on clinical competence and evidence-based practice. Involves day-to-day management of a patient's care, monitoring patient progress, and coordinating care among different providers	Centred on healing and comfort. Involves building relationships, listening, providing emotional and practical support, emotional intelligence, fostering a nurturing environment
Social interaction	Nurses play crucial roles within teams as coordinators of care. They often serve as the bridge between patients, doctors, and other healthcare providers	Nurses provide emotional support, comfort, and reassurance to patients and their families, especially during times of stress, illness, or loss

situated experience and their salient identity, nurses performed ancillary actions that enabled the completion of the DR. The ancillary actions created new action paths that altered the DR's standard pattern. We then compared and contrasted the standard and adapted patterns and evaluated them in the light of the data to develop credible general inferences. To illustrate this, Figure 2 offers a schematic overview, highlighting how the field material informed the sequence of abductive inferences that bridged our observations of emotions, salient identities, and routine performances as the CFA moved from off-peak to peak periods.

To aid the reading of Figure 2, Inference 1 concludes that change from off-peak to peak period produces an incongruence between the nurses' situated experience and the expectations linked to their salient healthcare professional self-concept. Inference 2 then concludes that the experience–expectations incongruence has two consequences – it produces emotional dissonance (reflected in negative emotions) and it results in the nurses' caregiver self-concept becoming more salient (reflected in empathy, a positive emotion). Inference 3 concludes that nurses' negative and positive emotions generate ancillary actions (inter-unit coordination, intra-unit coordination and management of patients' expectations), changing the DR performances in peak periods.

FINDINGS

To briefly outline our findings, we discovered two patterns of DR performances, which we labelled as the standard and the adapted pattern. We established that these patterns

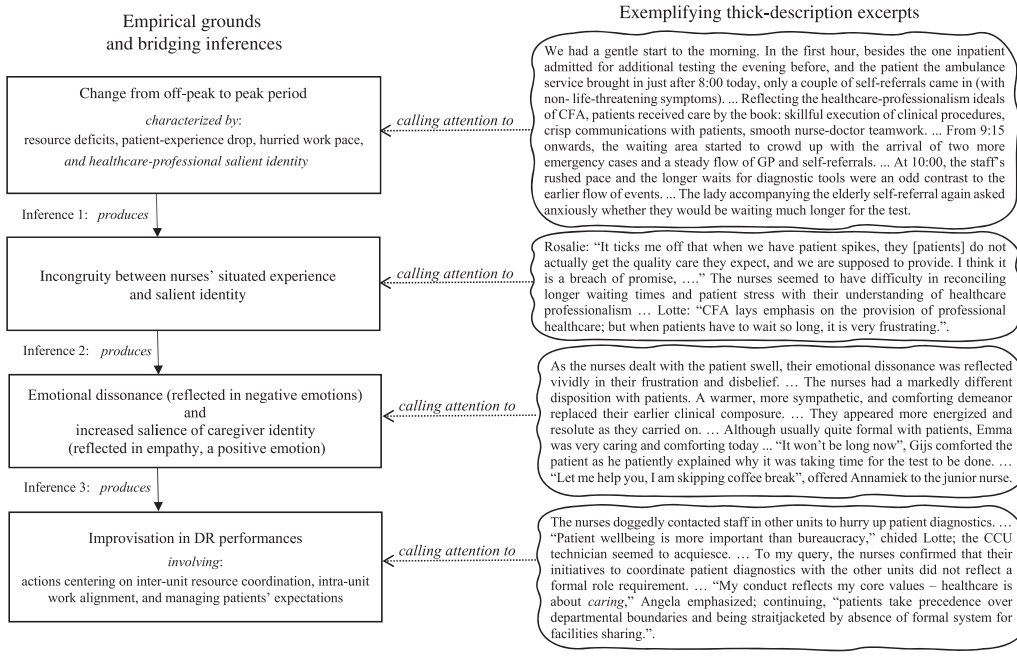

Figure 2. Examples of empirical support for inferences

were unique to, respectively, the CFA off-peak and peak periods, and that they accompanied changeovers from one period to the other. We also identified the interactions of context, emotions, and identities responsible for the two action patterns and their continuity, which we discuss below. For presentational purposes, the discussion is divided into three parts, which are further divided into layered analytical subsections. Part 1 focuses on the performing and patterning of the DR in the off-peak context. Part 2 documents how changes from off-peak to peak context affected the lived experience of doctors and nurses, emphasizing the interplay between their emotions and identities. Part 3 centres on the performing and patterning of the DR in the peak context. We end each part with a synopsis of the key findings.

Part 1: Off-Peak Context and the Standard DR Pattern

Correspondence of lived experience and salient identity expectations. The DR pattern we observed in the off-peak context was consistent with the scripted routine espoused by the hospital administrators. This standard pattern comprised a four-step action sequence: Step 1 – an arriving patient either waited or was seen immediately by a nurse, who did an initial patient assessment based on the presenting symptoms, recorded the patient's history, took the patient's blood pressure and temperature, did an ECG test, sent a blood sample to the laboratory, and prioritized the patient's examination by a doctor; Step 2 – a doctor picked up a patient folder, read through the recorded details, discussed the case with the nurse, examined the patient, and, if needed, requested additional tests (e.g., echocardiogram, stress ECG, and urine); Step 3 – once the test results were available, a doctor inspected these, arrived at a diagnosis, decided on a treatment course, and verified the diagnosis and treatment with a cardiologist; Step 4 – a cardiologist, doctor, or nurse communicated the diagnosis and the prescribed course of action to the patient: either (i) discharge, or (ii) further testing and observation, or (iii) immediate start of treatment as inpatient. Figure 3 presents the standard DR pattern visually.

The CFA exuded competence and quality during off-peak periods. The ordered pace and calm in the unit's waiting and other spaces, the methodical, expeditious examination of patients, and the attentive, expert poise of doctors and nurses epitomized the high importance attached by the CFA staff to the notion of healthcare professionalism, mirroring the unit's vision, value statements, and standards guidelines. Indeed, informal conversations and interviews repeatedly showed the pride the staff felt in commitment to healthcare professionalism as the central, distinctive aspect of the hospital. This fitted well the healthcare professional self-concept of the doctors and nurses – the likely result of selective recruitment as well as social interaction and sense-making processes. To illustrate, the unit's job advertisements put emphasis on the applicant being a '*health professional through and through*', stating this requirement before mentioning other essential qualifications for vacant positions.

The staff was unanimous about what the healthcare professional self-concept represented. It was viewed to mean a strict adherence to protocols, teamwork, and quality service to patients. For example, one doctor described healthcare professionalism as '*delivering excellent healthcare through the application of guidelines and protocols informed by the latest*

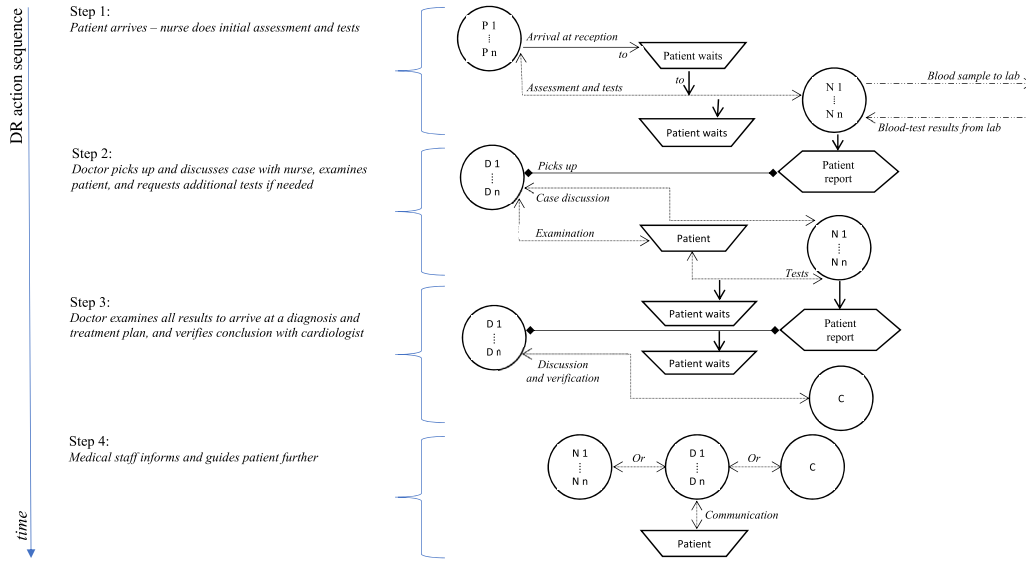

Figure 3. Standard diagnostic routine action pattern. C = cardiologist, D = doctor, N = nurse, P = patient. Round-dotted arrows represent all interpersonal interactions, including diagnostic and non-diagnostic

scientific and technical developments'. Its core elements included, as one nurse put it, '*dedicated adherence to the CFA's protocols and procedures, commitment to working as a team, and maintenance of a polite, clinical posture with patients at all times to ensure first-class service provision*'. Because correspondence between the staff's salient self-concept (viz., being a healthcare professional) and their situated experience (viz., patients receiving quality medical attention) should foster emotional consonance, it made sense that positive emotions were prevalent in the off-peak context as the staff went about their tasks.

Positive emotions and the repetition of standard DR *performances*. The staffs' positive emotions clustered into three categories – confidence, contentment, and pride. Discussions with the doctors and nurses indicated that these emotions of low to moderate intensity reflected a fit between the staff's lived experience in the off-peak context and their internalized role expectations vis-à-vis who healthcare professionals are, what they do, and how they do it. A doctor shared, '*As a healthcare professional, I see myself as doing my best using the facilities we have and following our standard procedures. Also, I want our patients to have a positive experience with the medical care we provide. When this is the case, as I believe it was today, I, our team, feel genuinely content and proud*'. Speaking about why she was more upbeat during off-peak periods, a nurse said, '*Yes, I have this sense of inner peace. It is very satisfying, as a healthcare professional; gives me pleasure in my job when we can promptly attend to our patients, diagnose them accurately, and start their treatment. This requires teamwork. At the CFA we are all highly trained, and we have the skills and procedures in place to look even after those who are severely ill*'.

The standard-pattern performances and the routine participants' situated emotions seemed intertwined, affecting one another. On the one hand, positive emotions could be discerned to undergird the DR performances; they appeared to channel the attention and energy of the participants sequentially to the interdependent actions constituting the

routine, thus propelling it forward. On the other hand, DR performances could be seen to reinforce participants' confidence, contentment, and pride. To illustrate the influence of emotions on DR performances, the following excerpt shows how a nurse's confidence, noticeable in her eye contact, smile, and voice as she talked with a patient, channelled and supported the forward movement of the action pattern from Step 1 to Step 2, and warded off a possible counterfactual performance involving the premature engagement of a doctor in a patient's examination:

> Tuesday, 10:00: Looking over the patient's history and initial tests [DR step 1], Annemiek confidently guided the patient to the waiting room, assuring him it would be best to wait for the blood test results to be included in the patient report before seeing the doctor [DR step 2].

To add more context to the excerpt, talks with the staff illustrated further how the absence or presence of positive emotions mattered for the routine's enactment, especially as regards adherence to protocol and hence the performance of the DR according to the espoused pattern. In the words of a nurse, '*When I lose this feeling of confidence, which happens sometimes, it affects my work. I can begin to doubt my patient assessments, and I may abandon protocol and look for a doctor for consultation*'. From another angle, a doctor shared, '*What we have in terms of our expertise and skills, our diagnostic protocol, gives us a sense of pride. This is important as it ensures that we continue to complete patient examinations in the same orderly way all day*'. The following Step 2 exchange between Gijs (a nurse) and Jonas (a doctor) – in the off-peak context, when both are feeling confident and content – also encapsulates the influence of positive affect on the routine's stepwise progression:

> Gijs: 'Patient A looks poorly but his basics were fine; so, I just followed protocol and did not prioritize him over the others'.
> Jonas: 'You did the right thing. These reports are all good. I don't think we need to do a stress ECG. I will go take a look at him now'.

As for the influence of routine enactment on emotions, both the completion of individual actions and the overall routine seemed to strengthen participants' positive emotions. For example, continuing with the excerpt above involving Annemiek, the Step 1 action she took led her to experience contentment, a positive emotion:

> Tuesday, 10:00: After we had escorted the patient to the waiting room, Annemiek showed satisfaction on account of the action she had taken as she explained [to the ethnographer] that the patient's history and ECG did not warrant a meeting with the doctor before the blood test results were in.

Furthermore, the following excerpt captures the contentment and pride arising from the completion of DR performances:

> Thursday, 12:30: Emma (pseudonym) was a picture of contentment as we walked to the cafeteria. To my remark about it, smiling happily, she said, "I feel good. It

has been a great day. We sorted out all our morning-shift patients – we are the best team."

To expand on the above exchange, during the lunch talk that followed in the cafeteria, Emma and the ethnographer chatted further about Emma's happy mood. She explained that because she was a '*professional nurse*', this is how she usually felt – '*it gives me fulfilment*' – when patients had been promptly diagnosed and sorted out. From the conversation, the ethnographer surmised Emma's positive emotions to be a by-product of the enactment of the DR as per her self-concept.

Part 1: Synopsis. In the off-peak context, the healthcare professional concept constituted the CFA staff's salient identity. The match between the expectations stemming from this identity and the staff's lived experience fostered emotional consonance that found expression in positive emotions of low to moderate intensity. We could interpret the positive emotions to channel forward the ordered sequence of DR actions. The positive emotions, which were reinforced by the staff's adherence to protocol when performing the routine, signalled 'a job well done', in that, the hospital had generally fulfilled its promise with regard to efficiency and patient care. A cyclical repetition of the selfsame DR performances could thus be observed in the off-peak context. The performances reproduced the recognizable espoused pattern of the DR, which in turn served as the guiding template for subsequent DR performances.

Part 2: Change in Context Triggers Change in Emotions and Action Readiness

The shift from off-peak to peak context produced noticeable changes in the CFA unit. The forming of a peak phase typically started with the influx of new cases in quick succession and/or inpatient emergencies needing immediate attention. Both staff time and physical resources such as beds and medical devices for patient examination became scarcer. As a ripple effect, patient waiting times increased for all steps of the DR's action sequence, from the initial waiting on arrival, through waiting for testing equipment and test results, to waiting to hear the diagnosis and the advised course of treatment. This resulted in the patients becoming restive as they waited for attention.

During transitions to peak periods, the CFA struggled to provide patients with a positive experience, diminishing the unit's professional-healthcare aura: the nurses' tempo became hurried, adherence to protocol became more difficult, the occasional mix-ups and errors (e.g., mislaid patient documents) occurred, and the teamwork became a bit laboured. In addition, the emotions of nurses and doctors started to show differences. This difference, as we discuss below, could be traced to the interplay of nurses' and doctors' different expectations tied to their salient identities and their lived experiences.

Interplay of nurses' lived experience, salient identity, and emotions. As the context changed, a change could be discerned in the valence and intensity of nurses' emotions. They now exhibited a set of high-intensity negative emotions, namely disbelief, dissatisfaction, and frustration, as well as a high-intensity positive emotion in the form of empathy. Whereas the negative emotions, by and large, were directed at not having sufficient

resources, inflexible standard operating procedures, and the nurses' working relationships with the administrative and other medical staff, the positive emotion was directed towards the patients. The ethnographer's lived experience in the setting and his discussions with the nurses suggested that their emotions were connected to the interplay of their salient identity and their situated experience. Because of the salience of the healthcare professional self-concept at the start of peak periods, a discrepancy arose between the nurses' identity-based beliefs and expectations and the reality they experienced in the form of resource shortfalls, patients having to wait for attention, the difficulty of adherence to protocol, and the challenge to efficient teamwork. We analytically account for the relationship between nurses' salient identity and emotions below.

Violation of salient identity expectations and nurses' negative emotions. Disbelief, dissatisfaction, and frustration emerged as nurses experienced a diminished capacity to perform the DR according to protocol and witnessed a decline in the CFA's ability to ensure the service quality implicit in the notion of healthcare professionalism. The incongruence between the nurses' situated experience and their salient healthcare professional identity engendered emotional dissonance that manifested itself in negative emotions. This is evident, for example, in Rosalie's (pseudonym) feeling of frustration about the longer time it now took to complete Step 1 of the DR, which she perceived as a 'breach of promise':

> It ticks me off that when we have patient spikes, they [patients] do not actually get the quality care they expect, and we are supposed to provide. I think it is a breach of promise, which is why I'm annoyed at times.

The divide between the nurses' identity-based expectations and their actual experience also produced dissatisfaction, which is palpable in the following fieldnote-based excerpt referring to Step 2 of the DR. In this case, the reason for the discontent was the discrepancy Gijs perceived between his expectations and the reality of resource deficits in peak periods:

> Gijs (fieldnote) – Gijs was somewhat dispirited during the coffee break today. He noted that not enough attention was being paid to the patients. Apparently, patient A had to wait an hour for the bike test [DR step 2]. Gijs was dismayed at the hospital's reluctance to invest in an additional bike for the CFA. When talking about this, his emotion showed in his body language as he shook his head.

The absence of decisional authority and the lack of voice to compel changes that could speed things up seemed to add to the nurses' frustration. In relation to the experience of the jamming up of the forward movement of the DR from Step 2 to Step 3, the following statement shows Rosalie's frustration:

> Sometimes I wish I had the qualifications for doing more without having to consult with a doctor first. It is exasperating when you are in a position to accelerate things … but you cannot proceed without the doctor's approval.

Similarly, in relation to Step 3 of the DR routine, disbelief is evident in Sophie's (pseudonym) reaction as she experiences a doctor's reluctance to discuss the diagnosis of a waiting patient with the cardiologist. With Sophie wanting the doctor to discuss the case with the cardiologist immediately, and the doctor wanting to wait till after having diagnosed a couple of additional patients, which would be efficient from the doctor's perspective, the doctor–nurse teamwork began to fray:

> This is absurd! I can't believe it; we are supposedly providing first-rate healthcare! You can't wait till you first have the test results of three-four patients!

As greater patient traffic increased the pressure to cut corners in performing the DR routine, the nurses were confronted with the hospital's strict practices and procedures being at odds with their sense of duty towards patients. The following fieldnote-based passage, which recaps a coffee break conversation with Lotte (pseudonym), illustrates the above and its role in producing negative emotion:

> Lotte (fieldnote) – Lotte apologized for her earlier grumpiness, which she attributed to the pressure she was facing to discharge patients quickly [DR step 4]. She stated she was not in this job for quick turnovers and performance metrics. She seemed to feel strongly that nurses' foremost duty is helping and supporting patients. Lotte was relaxed and reflective as we chatted, and the earlier testiness evident in her sharp tone and grim demeanor was not there anymore.

Thus, although the nurses held the CFA in esteem at off-peak times, their high regard for it diminished at peak times when they could not reconcile their expectations rooted in a healthcare professional identity with their situated experience, resulting in the arousal of high-intensity negative emotions. In other words, the negative emotions reflected disillusionment with a system that the nurses were proud of during off-peak periods, but which fell short of meeting their idealized expectations of healthcare provision.

Ascendant salience of nurses' caregiver identity and positive emotions. Besides negative emotions, empathy towards patients surfaced as a conspicuous positive emotion during peak periods. The emotion was quite evident as the nurses became noticeably more attentive to comforting patients. In contrast to off-peak periods, when the nurses were courteous but dispassionate, there was now a more personal and involved element to nurses interactions with patients. Effectively, the change of context to peak periods and the attendant hardship experienced by patients kindled the caring ethos of nurses, as illustrated in the following excerpt:

> It is irritating! The doctors are not here yet and the patients are waiting … I feel embarrassed [when]things take so long. You almost want to apologize to the patients … One has to have empathy, I believe, and you need to show understanding … Empathy, patience, ability to live someone else's feelings are very important. We must look after patients who are terrified … some arrive with infarcts. So, it is really [about] feeling and being patient.

Although axiomatic that nurses look after patients regardless of whether they have a healthcare professional or a caregiver hat on, we interpreted the nurses' frequent references to empathy to reflect an ascendance in the salience of their caregiver self-concept during peak periods. In this context, in response to a query about why her relationship with patients had a different character to it at peak times, Sophie leaned forward, nodded gently, and answered contemplatively:

> When it gets busy, I can't help wanting to do more for patients, making them feel comfortable, cared for…. We are professionals, but I am also a nurse, and I feel sorry for my patients.

Sophie's statement succinctly reflects the distinction between the nurse's self-concept of being a healthcare professional ('we are professionals') and her self-concept of a being a caregiver ('making [patients] feel comfortable, cared for'). It also neatly captures the ascendance of the caregiver self-concept as the nurses' salient identity 'when it [got] busy'. The empathy emotion and the caregiver ethos are also evident in the following excerpt:

> You need to have empathy, …, be able to weigh the situation. Especially when waiting times get very long… I look at whether [patients] have enough pillows or have a headphone. Sometimes you forget, but I try to pay attention to such things. It is important that they feel comfortable …

The foregoing highlights that during peak periods, as nurses struggled to complete the DR routine on a timely basis and witnessed the hardship patients had to bear, the incongruence between their lived experience and the expectations associated with being a healthcare professional produced negative emotions. Furthermore, their situated experience of seeing patients having to endure distressingly long waits for their tests and diagnoses resulted in the nurses' caregiver self-concept becoming more salient, producing empathy, a positive emotion, which aligned the nurses' salient professional identity with the demands of the context.

Interplay of doctors' lived experience, salient identity, and emotions. The change from off-peak to peak temporal context did not have a visible effect on the valence and intensity of the doctors' emotions. They took the buildup of waiting patients, resource deficits, and teamwork issues in their stride, even though these factors made the enactment of the DR challenging at peak times. Furthermore, they viewed the peak phases at the CFA as 'all in a day's work', temporary, unpredictable-to-plan-for periods that would inevitably dissipate. To illustrate, when reflecting on whether intervention was needed to enable staff to cope better with the demands of peak periods, a doctor's passive voice tone and poise expressed nonchalance as he explained that the administrators had concluded that it was not possible to plan for these: '*A while back, we tried to track when peak periods occur most. I had the impression that this was on Mondays. But then there were fluctuations, and we had the feeling that they occurred more on Tuesdays. But, really, one day you have more patients, and the next day less,*

and then one morning it is very quiet, and then suddenly patients stream in in the afternoon. The point is that there is never a steady inflow of patients'.

Differently than the nurses, there was no apparent tension between the doctors' lived experience in peak periods and their expectations as healthcare professionals. A sense of pragmatism seemed to play a role in conditioning how the doctors experienced peak periods and the absence of an experience – expectations incongruence in their case. For the doctors, the peak periods were short-lived, transient intervals which required practical workarounds that were consistent with and maintained their healthcare professional self-concept. For instance, when reflecting on the dearth of time and material resources during peak periods, a doctor regretted his inability to spend more time with patients with a shoulder shrug, saying matter-of-factly: '*It is purely logistics … there are six nurses … and only one doctor. And while a nurse may have to attend to one or two patients, a doctor keeps an eye on all of them. When you must spread your attention, it means you have less time per patient*'.

In response to patients' needs in peak periods, while the nurses experienced a shift in identity salience with their caregiver self-concept becoming more prominent than their healthcare professional self-concept, this was not the case for doctors. Their healthcare professional self-concept continued to be salient, as evident in the display of a uniform orientation across off-peak and peak periods that was characterized by clinical detachment, adherence to protocol, and focus on systemic efficiency. To illustrate this in regard to Step 3 of the DR, on being urged by the nurses to inspect patients' test results on a one-by-one basis to shorten a patient's wait, the doctors calmly maintained that this approach would be inefficient because it would necessitate a greater number of interactions with the cardiologist. In the words of one doctor: '*It is not possible for a doctor to devote the same amount of time to one patient as a nurse can … we need to … evaluate results, …, discuss with the cardiologist, and if needed, with other specialists in the hospital*'.

Overall, our field observations and interviews showed that the healthcare professional self-concept of doctors was salient during both off-peak and peak periods. This consistent salience of the healthcare professional identity was mirrored by consistency in the valence and intensity of doctors' emotions, which remained unchanged despite the heightened pace of peak periods. We ascribed this consistency to the continued salience of doctors' sense of self as healthcare professionals, who, despite situational fluctuations, are supposed to maintain clinical focus to ensure consistency in treatment delivery.

Doctor–nurse interactions. Across interviews and informal conversations, the doctors repeatedly praised the nurses' concern for patients' welfare, applauded their work ethic, and underscored the valuable complementary role they played in the team effort to complete patient diagnosis. A doctor noted ardently that the nurses were the animating force that kept things moving in the peak periods by '*identifying and resolving bottlenecks*', '*spotting who needed more urgent attention*', and '*taking over tasks from doctors*'. Such a sentiment was commonplace among doctors. For example, a cardiologist expressed sincerely, with a warm smile, his appreciation of the nurses, stating, '*When it is busier, they are the ones who are more on top of things*'. Such remarks positioned nurses as critical,

proactive partners of doctors, suggesting a work ethos that valued collaboration and mutual respect.

As reported above, the peak periods were characterized by divergence between the doctors' and nurses' emotions. This sometimes gave rise to awkward doctor–nurse interactions that had the potential to trigger mild irritation in doctors. To illustrate, when on one occasion Ineke (pseudonym), a senior nurse, pressed Inge (pseudonym), the doctor, to hurry up so that Step 4 of the DR could be completed and a patient waiting discharged, the following exchange took place:

> Inge: 'Everyone is doing their best!'
> [The doctor said in an irritated tone]
> Inge: 'We should come together more often.'
> [The doctor continued in a placatory tone]
> Ineke: 'Yes, sure'.
> [The nurse replied in an irritated tone]
> Inge: 'Well, there is my room, and I have a phone on which you can call me'.
> [The doctor replied in a cynical tone]

The interaction captures a tension that surfaced in peak periods between the doctors' acceptance of nurses as equal partners (see Inge's second statement above) within the healthcare professional paradigm the doctors held dear, and the need they experienced at times to assert themselves as being higher in a doctor–nurse role hierarchy (see Inge's third statement above). We interpreted such observations as a pragmatic effort by doctors to channel the intensity of nurses' negative emotions in a way that would facilitate the enactment of the DR as per protocol. The excerpt below, centring on a tense doctor–nurse exchange regarding the CFA unit's capacity, illustrates the projection of role hierarchy by a doctor:

> A doctor told a nurse that four patients is the maximum the CFA can take on, but that a fifth patient had been accepted, and that a sixth one was being mentioned. The nurse responded defensively by noting that the EA was full, which made it obligatory for the CFA to admit another patient. The doctor replied: 'Did you check whether it is really full?' The nurse replied in a somewhat cynical tone, seeming not to believe the doctor's question: 'Well, I trust them on their word'. The doctor retorted: 'I'm alone at the moment', implying he wasn't able to take on another patient. The nurse reassuringly noted that there would be room as soon as a patient was discharged. The doctor was silent for a bit and then replied somewhat authoritatively and sarcastically: 'No we will not actually', implying that if one patient was discharged, they would still have five patients instead of the norm of four. The nurse replied: 'You're right, I won't take-in anyone anymore', clearly relieved that the discussion was over.

It is apparent in the above extract that the admission of patients (Step 1 of DR) during peak periods could become an occasion for emotion-laden interactions and identity maintenance. The doctor's rhetorical probing, posing a question that implied doubt

about the nurse's claim, and the doctor's assertion of the rules, challenged the nurse's judgement while reinforcing the doctor's expectation of adherence to protocol. Such exchanges, collectively, contributed to a patterned form of interaction in which nurses' efforts to deviate from the standard routine to improve the workflow were acknowledged but also to an extent managed by the doctors.

In general, the doctors' irritations with the nurses tended to be fleeting and interaction-centred only and there was the occasional use of role hierarchy as a tool to enable carrying on as at off-peak times. We saw these hierarchy-involving micro-interactions as pointing to subtle but seemingly important identity dynamics. When under pressure, the doctors turned to their perceived higher standing in a doctor–nurse hierarchy to maintain a sense of control over the situation and to buttress their identity as healthcare professionals even as the nurses' caregiver identity became more salient.

Part 2: Synopsis. With transitions from off-peak to peak periods, the emotions of doctors and nurses started to diverge. Although the valence and intensity of the doctors' emotions remained basically unaffected as the context changed, the nurses experienced high-intensity negative emotions as well as a positive emotion by way of empathy for patients. Thus, even though both doctors and nurses found themselves in the same new context that was more demanding, they differed in their emotional reactions to it. We discovered that this was because of how doctors' and nurses' lived experiences in the changed context interacted with the makeup of their identity structures. Namely, whereas nurses' emotions were affected by a context-specific violation of the expectations linked to their salient healthcare professional identity and an ascendance in the salience of their caregiver identity, doctors' did not have an alternative professional self-concept that could have potentially led to an adjustment in their actions at peak times; their emotions remained unaltered because of the pragmatic outlook associated with their salient identity as healthcare professionals.

Part 3: Peak Context and the Adapted DR Pattern

Change in emotions and action readiness engenders ancillary actions. The change in nurses' emotions at peak times primed change in action readiness, resulting in actions that altered the standard performances of the DR. In particular, the nurses' disbelief, dissatisfaction, and frustration motivated actions that bypassed the standard DR action sequence and/or put pressure on the doctors to speed up the completion of the various steps of the DR. Furthermore, the nurses' positive emotion of empathy galvanized more personalized and sympathetic interactions with patients. As a result, the DR performances started to incorporate three types of ancillary actions that were absent in the off-peak context: *inter-unit resources coordination*; *intra-unit work alignment*; and *managing patients' expectations*. While nurses' negative emotions lay behind the first two action types, their positive emotions sparked the third action type. The ancillary actions implied extra labour by the nurses that was not part of the scripted routine and generated additional action paths directed

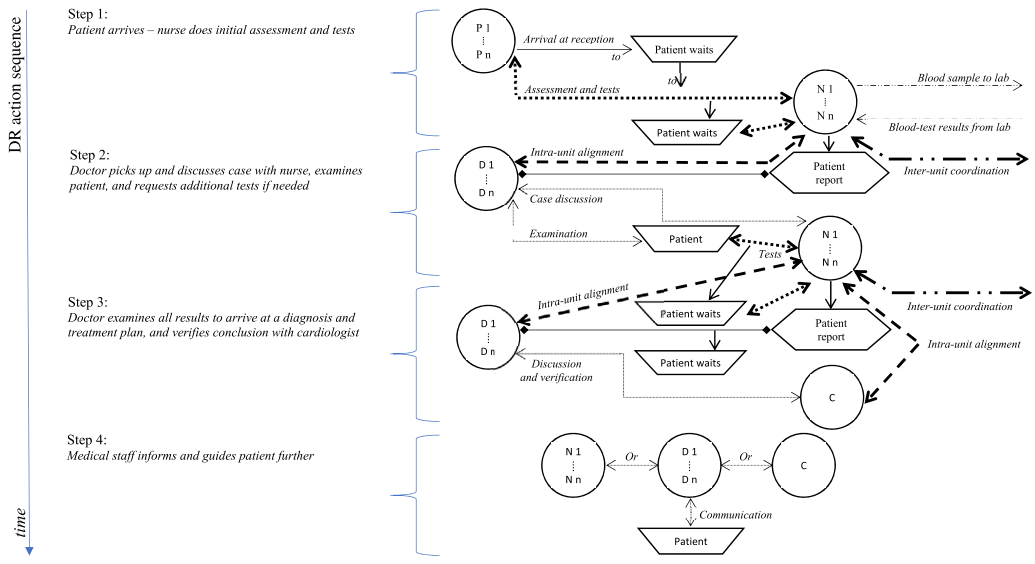

Figure 4. Adapted diagnostic routine action pattern. C = cardiologist, D = doctor, N = nurse, P = patient. Round-dotted arrows show all interpersonal interactions including diagnostic and non-diagnostic; thick round-dotted arrows show *managing patients' expectations* actions; thick dash-dot arrows show *inter-unit resources coordination* actions with lab, CCU, and cardiology dept.; thick dashed arrows show *intra-unit work alignment* actions

at enabling a speedier completion of the standard DR pattern and improving patient experience.

Besides an expansion in the number of actions that supplemented the four-step off-peak sequence of the DR, peak-time performances were characterized by more flexibility and variability, depending on whether the nurses felt the need to take a specific ancillary action. The pattern of performances had a more complex character, therefore, and we termed it the adapted DR pattern. As shown in Figure 4, the three additional types of actions in the adapted DR pattern were actions that the nurses took alongside the four steps of the standard DR sequence to facilitate its forward movement. We present next an analytical description of how nurses' negative and positive emotions energized new action paths and informed the performance of the adapted DR pattern.

Negative and positive emotions and new action paths. Negative emotions were the catalyst for *inter-unit resources coordination*. This action type saw the nurses take the initiative to arrange temporary beds for patients at the coronary care unit (CCU), negotiate the use of the cardiology department's diagnostic medical equipment, and press the laboratory to speed up blood examinations and the communication of test results. The following vignettes convey how nurses' feelings of dissatisfaction and frustration prompted them to engage in *inter-unit resources coordination* actions to facilitate the DR action sequence:

> Tuesday, 15:00: Rosalie hung up the phone testily. Slightly red in the face, Rosalie censured the lab assistant for the "unacceptable delay" in sending through the blood-test results of patient A. [Context: a patient waiting for step 2 of DR]

> Thursday, 15:30: I noted Annemiek's frustration as she finished talking on the phone with a colleague to understand whether patient B could be accommodated in the CCU. As Emma walked in, Annemiek shook her head as she anxiously told her that patient B may have to wait a while. Emma responded, "ridiculous situation", saying she would walk over to Anna, the CCU head-nurse, to find a solution. [Context: a patient waiting for step 4 of DR; CCU physically adjacent to CFA]

Negative emotions were also the stimulant behind the *intra-unit work alignment* action type. This set of actions centred on seeking to quicken the forward movement of the DR by exhorting the doctors and the cardiologist to fasten their pace of work in relation to Step 2, Step 3, and Step 4 of the DR. For example, even as the nurses went about performing Step 1 of the routine, they would now put pressure on the doctors to hurry up with Step 2. They did this in different ways – opening the door to a doctor's office and half entering it, thus signalling that there were waiting patients; keeping an eye on whether a patient's test results had become available, and making it a point to alert a doctor to these; and, rather than wait for doctors to pick up patients' folders from a designated tray, taking these themselves to doctors and justifying this by pointing to the '*ridiculously*' or '*outrageously*' long waiting times patients were having to experience.

At times, the *intra-unit work alignment* action type bypassed protocol if nurses judged it to be in a patient's interest. For instance, a nurse approved an echocardiogram for a waiting patient because the equipment was available; she obtained the doctor's approval for the test later. Furthermore, to speed up Step 3 and Step 4 of the routine, at peak times the nurses would urge the doctors and the cardiologist to meet faster to discuss patient diagnoses, decide the treatment plan, and communicate either themselves or via a nurse the diagnosis to a waiting patient. This fieldnote-based excerpt provides a picture of the emotions and the actions issuing from these:

> Thursday, 16:00: – Sophie was in disbelief. She had just been to the cardiologist's office to urge him to hurry up with confirming the diagnoses the doctor had sent through half an hour ago. When she did not find him in the office, she enquired with the doctor, who informed her that the cardiologist had stepped out briefly for an important personal errand and would be back soon. Sophie was vociferous as she told the doctor to call the cardiologist and tell him to return at once because several cases needed urgent reviewing.

Furthermore, nurses' positive emotions, especially empathy, which shaped their peak period relationship with patients, motivated the *managing patients' expectations* ancillary action type. This category of actions served the purpose of reassuring patients and helping them cope better with the delays in the execution of the DR routine. The following vignettes showcase the interplay of nurses' empathy and their corresponding actions to improve the experience of patients at different steps of the DR sequence:

Tuesday, 15:30: Rosalie is now diligently recording the medical history of patient C. On the way to her office area, she walked over to patient D, who was connected to a monitoring device. Rosalie caressed her on the shoulder, they talked, and both broke into a smile. [Context: patient C at Step 1; patient D at Step 2]

Monday, 16:30: Annemiek … still had impressive stamina. With a big, reassuring smile she soothingly told patient E that the results would be in soon and the cardiologist would look at them straight away. She asked kindly whether she could get him anything as he waited. [Context: patient E at Step 3; nurse was friendlier and more caring at peak times]

The nurses were generally more sensitive to the needs of the patients and closer to them during peak periods, keeping them informed about the delays and the imminence of the next step. During an interview, a nurse explained her peak time empathy by referring to the importance of providing comfort to patients as a caregiver: '*Well I think empathy is natural and that it is very important to comfort patients … It is heartening for a patient to know for example that they will not be waiting for too long now*'. In contrast to the healthcare professional stricture of clinical interactions with patients, another nurse confided that she felt so close to patients that she sometimes told them exactly how it was: '*I explain that we are dependent on other departments to expedite things*' and '*I tell them that the wait is indeed irritating*'.

Part 3: Synopsis. In the peak period context, the nurses' changed emotions resulted in adapted DR performances, which included three categories of nurse-initiated ancillary actions that were not present during the off-peak context. These actions constituted an effort to enable quicker forward movement of the standard DR action-sequence and to provide comforting support to patients. Although the adapted performances were more complex on account of the additional action paths, they facilitated the completion of the standard pattern at peak times. As with the standard performances, the adapted ones birthed positive emotions – the staff derived a sense of achievement from performing the additional actions, which also served to align their salient identity with the context. Annemiek noted: '*We expect to be confronted with difficult moments. And you know you are doing this to help those who really need help … This is who I am. If I can make a positive difference for our patients, it makes me happy, and proud*'. The repetition of the adapted performances continued to reproduce the adapted DR pattern and be guided by it until a peak period dissipated and the off-peak context returned along with the standard DR performances. Importantly, while the adapted DR pattern was shaped primarily by nurse-initiated ancillary actions, the doctors also affected its performance through maintaining action paths within the boundaries of the protocol. The doctors' adherence to healthcare professionalism and their steady emotions grounded the routine in its formal structure, enabling bounded flexibility rather than unrestrained improvisation. Doctor–nurse interactions showed that the doctors' stabilizing influence played a significant role in guiding the nurses' adaptive agency during peak periods.

DISCUSSION

Although there has long been interest in the role of emotions in routine dynamics (Baldessarelli, 2021; Feldman, 2000), we still do not have a clear understanding of how the performances and patterns of actions in a routine are affected by the interplay of context and emotion changes. Our ethnographic analysis of a diagnostic routine (DR) in a hospital's emergency unit revealed two distinct action patterns specific to the unit's off-peak and peak contexts, influenced by the different situated experiences of nurses and doctors. In brief, we found that in the off-peak context, the doctors and nurses recurrently performed a four-step action sequence that constituted the standard pattern of the DR. This pattern, which enabled effective task accomplishment, approximated the scripted DR espoused by hospital managers. We also found that in the peak context, the doctors and nurses recurrently performed a more complex action pattern, which included nurse-initiated ancillary actions that supplemented the standard action sequence and created additional action paths. Besides including more actions, the pattern also involved a faster pace of enactment of the first step of the standard sequence and was characterized by flexibility and variability in the performance of ancillary actions to facilitate task accomplishment under resource constraints.

Figure 5 presents a grounded model of variety and stability in the action patterns of a routine, as revealed by our analysis. It shows that the dynamic of variety and stability is explained by two basic, complementary mechanisms underlying oscillation from one action pattern to the other as the context of routine enactment changes: (A) *alignment and misalignment between routine participants' situated experience and their salient professional identity trigger change in emotions*; (B) *change in action readiness produced by emotion change results in the performance of either more or fewer actions that affect the action paths in a specific context*. Together, Mechanisms A and B present an elegant, empirically grounded theoretical basis for understanding the pattern-in-variety exhibited by routines, whereby routines display consistent, recognizable action patterns alongside variations in their performance.

When a change in context aligns the situated experience and the salient professional identity of routine participants, emotional consonance gets expressed in positive emotions (Mechanism A). These generate change in action readiness, which drives the performing of the routine's action sequence as per the institutionally espoused version of the routine, which includes fewer actions (Mechanism B) for task accomplishment. Positive emotions function as a resource, enabling standard performances of the routine. In addition, the correct performance of the routine produces a sense that organizational obligations and role expectations have been fulfilled, thereby engendering positive emotions as a by-product. However, when change in context produces misalignment between the situated experience and the salient professional identity of routine participants, emotional dissonance manifests as negative emotions (Mechanism A). These generate change in action readiness, which energizes improvisations in the routine's enactment (Mechanism B). The improvised performances entail more actions, which enable task completion in the focal context and generate new action paths that maintain the integrity of the original pattern. In addition, positive emotions emerge as a by-product, suggesting a realignment between routine participants' salient professional identity and their new situated

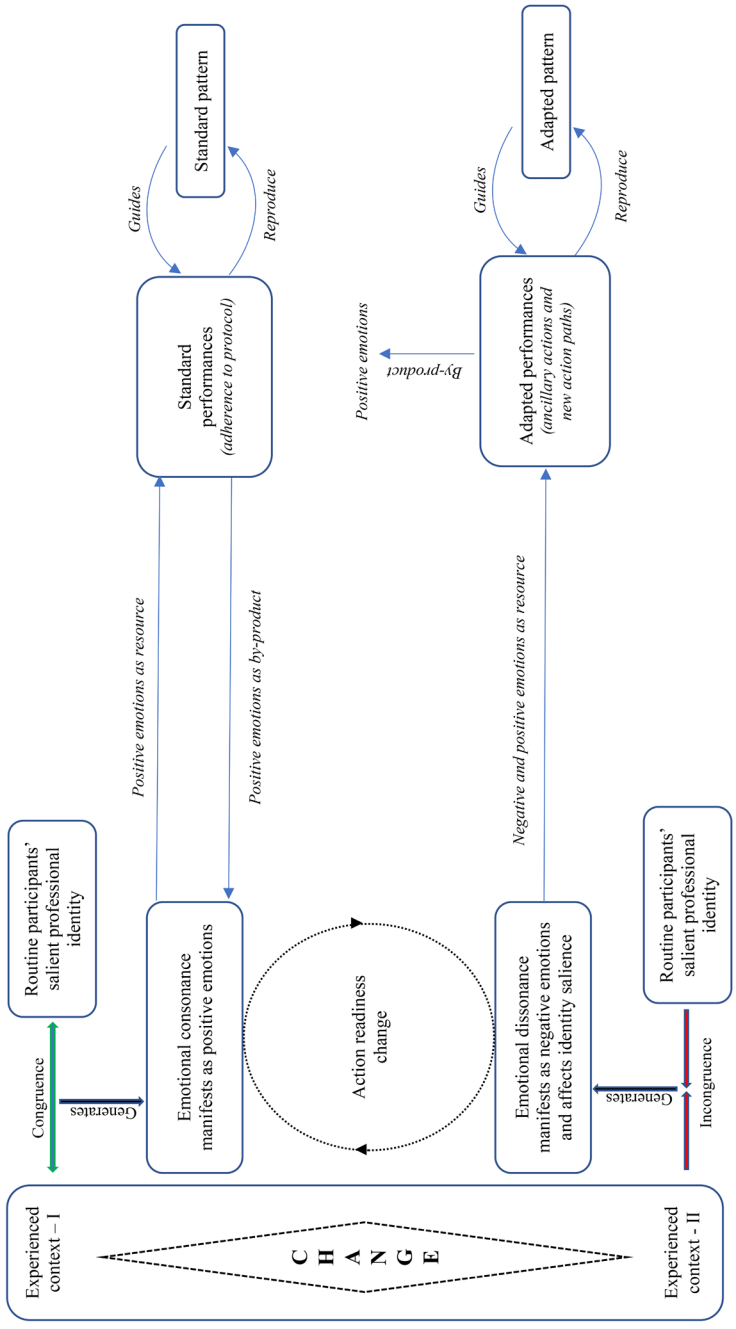

Figure 5. Variety and stability in action patterns

experience, and indicating that the additional actions that followed the emotional dissonance had 'worked'.

We discuss below the contributions and implications that can be derived from our model. We first theorize routines as context-specific action patterns, driven by the emotions triggered by the interplay of lived experiences and salient identities in a changing context. We then unpack the link between emotions and routine dynamics, exploring how emotional reactions produce behavioural outcomes that influence action patterns, and the part played by emotional consonance and dissonance in the regulation of routines. Lastly, we elucidate the role of identity in regulating participants' emotional states and the ensuing action tendencies.

Theorizing Routines as Context-Specific Action Patterns

Studies suggest that action patterns can change based on contextual needs (Bertels et al., 2016; Geiger et al., 2021), as routine participants adjust performances by adding or deleting actions. This can trigger the formation or dissolution of action paths (Goh and Pentland, 2019), and thus the emergence of different action patterns (D'Adderio, 2008; Danner-Schröder and Geiger, 2016). We add to this line of research by demonstrating an emotions-related dynamic that engenders stability and variety in action patterns. We show that contextual change triggers change in the valence and intensity of emotions, which changes action tendencies. While change in valence shapes the flow of actions in some preferred direction, change in intensity affects the urgency to act. For example, the inability to perform a routine as prescribed, because of a sudden increase in workflow, may generate frustration, that is, produce a high-intensity negative emotion. The resultant change in action readiness may lead participants to perform more / less actions to provide service as best as they can, changing action paths and patterns.

In the more complex case we examined, of intermittent spikes in workflow, professional identities of doctors and nurses played a further key role. At off-peak times, an alignment between the contextual service needs and the salient healthcare professional self-concept of the doctors and nurses functioned as a source of positive emotions that energized recurrent performances of a standard action sequence. During peak times, however, the nurses perceived a mismatch between the healthcare professional self-concept and the service needs of the situation. This engendered negative emotions and triggered their caregiver identity to become more salient. The resultant change in action readiness prompted the nurses to include additional actions in their performances to complete the diagnostic task. Our investigation thus brings to light that driven by a context-contingent dynamic of emotions and salient professional identities, routine participants' actions can produce new action paths and a different action pattern for task accomplishment. This is theoretically important. It takes us beyond the theorization of routine dynamics in terms of the unfolding of actions to explain how participants' idiosyncratic lived experiences, as shaped by their emotions and identities, play a critical role in producing variety and stability in action patterns. Relatedly, our study calls attention to the importance of considering the interplay of context, emotions, and identities when studying how and why action paths contract, expand, or shift, and action patterns get reproduced or are adapted.

Our findings are relevant for research on temporality in routines. Research has shown that time-based expectations – as inscribed in formal schedules, plans, calendars, and timelines – shape the temporal patterning of a routine (Turner and Rindova, 2012). Temporal patterns confer an internal rhythm to perform routines (Turner and Rindova, 2018) by establishing a shared 'rank order of urgency' (Kremser and Blagoev, 2021) or signalling certain contextual cues to be salient (Geiger et al., 2021). Speaking to emerging research on temporality and emotions (Hällgren et al., 2025), we show that temporal contexts can affect routine performances through their effect on emotions. Particularly, change in temporal context can result in change in emotions, prompting deviations from standard action paths. In the case that we observed, a formal structure to regulate the inflow of patients was not there. Under the circumstances, informal temporal patterning, based on the distinction between off-peak and peak periods, functioned as the main structuring device. This not only punctuated the rhythm of work but also defined the interaction order of the workplace (Goffman, 1983), that is, the set of rights and obligations underpinning routine participants' interactions. This interaction order relied on the balancing of two temporal patterns: one that emphasized the standard sequence of actions and one that relied on improvisations and workarounds for task accomplishment when work resources were scarce.

Insights from our research extend the understanding of temporal regulation when up-front scheduling fails or is missing (Kremser and Blagoev, 2021). They suggest that situated interactions may create a new interaction order in the workplace, beyond the boundaries of the routine, which extends participants' agency and allows them to work flexibly, depending on the situational demands. An informal temporal frame may enable participants to develop workarounds that become part of regular routine performances and continue to work under persistent disruptive variations and tensions. Relatedly, our findings also shed light on the potential risks and trade-offs that arise when deviations from standard routine performances occur under time pressure. From a medical standpoint, these adaptations may be double-edged – while allowing staff to cope with acute time constraints and maintain throughput, they may have a significant impact on the participants' emotions and sense of self. For instance, should staff feel unable to perform a medical routine in line with their professional expectations – for example, the expectation to provide holistic care – they may experience emotional dissonance and identity strain. This adds another layer to our theoretical argument: not only do time-related pressures and emotions alter the form of routine enactment, they can also threaten the meaning and integrity of routine participation from the perspective of those involved.

Theorizing the Link between Emotion and Routine Dynamics

We do not yet fully know how emotions affect the situated performances of routines and with what consequences for action patterns. In this regard, the findings of our study are theoretically important because they offer new insights regarding the link between routine participants' emotions and behaviours and the characterization of routines as effortful accomplishments. Scholars have argued that emotions drive valence-congruent behaviours: negative emotions can be expected to produce

negative but not positive behaviours, and positive emotions can be expected to foster positive but not negative behaviours (Cropanzano et al., 2017; Lindquist et al., 2016). This suggests that positive and negative emotions operate independently, serving different functions and addressing the differential demands of different types of events or situations (see Kiefer et al., 2022). In contrast, our findings indicate that negative emotions do not necessarily produce negative behaviours, and that negative and positive emotions can work in tandem to enable task accomplishment. In the case that we observed, a change in context that reduced the availability of work resources produced both negative and positive emotions, inducing routine participants to undertake additional efforts to accomplish the task on hand. Negative emotions of high intensity (e.g., frustration) spurred urgency to act and produced new actions to speed up the completion of the DR routine. Positive emotions of moderate intensity (e.g., empathy) played a complementary role – they engendered new actions centring on the comforting of patients to allow the routine's completion. Thus, negative and positive emotions, together, enabled task accomplishment.

As emotions turn into actions, routine performances can become either simpler or more complex, resulting in the adaption of an action pattern. We found that while positive emotions prompted actions that replicated routine performances to reproduce a pattern, negative emotions expanded the set of actions to repair the situated deficiency of the standard action pattern, thus adapting the pattern. The patterns of a routine can also differ in terms of the scope, speed, flexibility, and variability of actions in the action sequence, and in the smoothness of transitions from one action to the next. In this regard, our findings suggest that the speed at which routine performances unfold and what actions are visible to whom may matter for the triggering of specific emotions and actions. One could argue, for instance, that it was the speed of routine performances and not the number of waiting patients that led routine participants to perceive the context as peak or off-peak. This implies that the perception of a routine is not just dependent on contextual factors, but also on participants' emotions. These observations are theoretically important because they encourage us to link an action-based view of routines to an action-based view of emotions. Moreover, by showing that routine participants' emotions are essential to how a routine is enacted, our study calls attention to the value of adopting a broader approach to agency, one which not only recognizes that actors 'feel' and 'care', but also grants that emotions confer a distinctive flow to action that can influence the consistency, variety, stability, and change in action patterns.

Our findings also advance the understanding of routine regulation. Scholars conceptualize routines as regulatory mechanisms by which participants manage conflicting goals (Salvato and Rerup, 2018). Previous studies have shown that participants regulate conflict by means of truces, whereby they accept to suspend judgement on how certain aspects of a routine are performed (D'Adderio and Safavi, 2021; Zbaracki and Bergen, 2010). Our findings partly resonate with this explanation but also highlight the 'signalling' effect of emotional consonance or dissonance on regulation at the individual level. The signalling may prime and motivate participants to either repeat actions that would maintain situated consonance, or to take new actions that would help resolve situated dissonance. This indicates that besides facilitating

task accomplishment, pattern adaptations may also contribute to regulating emotional states (e.g., from negative to positive; from high to low intensity) and aligning emotional states with enacted identities. Routine patterns and identity – emotion interaction are thus mutually reinforcing. This helps explain why and how, through variations in routine performances, variety can emerge in action patterns and be maintained, rather than a routine breaking down, getting interrupted, or changed (cf. Baldessarelli, 2021; Salvato and Rerup, 2018).

The Role of Identity in Regulating Emotional States and Action Tendencies

Our model articulates a relationship between routine participants' salient identities and emotions that is important for the understanding of routines (cf. Karali, 2021). The identity literature suggests that when in a specific role, people use their salient identity as the framework to interpret their experiences (Markus, 1977; Stryker and Burke, 2000). Empirical work suggests further that while consistency between a person's situated experience and their beliefs and expectations stemming from their salient identity produces emotional consonance, inconsistency produces emotional dissonance (cf. Elsbach and Kramer, 1996; Jansz and Timmers, 2002). Extending these insights to the realm of routine dynamics, our study shows that a change in the context of routine enactment can affect the identity – emotions connection, affecting action patterns. This is theoretically important because it refines the general claim that emotions shape action tendencies by revealing the role of identity – emotions interplay.

Notably, an explanation for routine participants' different emotional reactions to the same context, as in the case that we observed, may be traceable to whether participants have more than one occupational identity (Apesoa-Varano, 2007; Wynd, 2003). Should some routine participants be more sensitive to changes in context than others, our study suggests that this may be because of an increase or decrease in the salience of their different professional identities. As compared to the nurses, doctors have a single professional identity. In the absence of change in the salience of this single healthcare professional self-concept across off-peak and peak periods, we found the doctors to be less sensitive to context changes. The theoretical significance of this is that in the wake of context changes, routine performances and patterns may change because of differences in routine participants' identity structure. This suggests, intriguingly, that whereas routine participants with a single salient identity are more likely to reproduce standard action patterns regardless of the context, those with multiple identities are more likely to generate variations in routine performances, imparting flexibility to action patterns.

Our study also provides insight into how role identities relate to one another during performances of routine tasks. Vough et al. (2013) conceptualize professional interactions in terms of role-based expectations. For professionals, roles represent an important source of self-image, and violations of role-based expectations can be costly. This offers a further explanation for the different emotional reactions of nurses and doctors during peak times. Nurses considered their role to have a broad scope, encompassing being

both a healthcare professional (salient self-concept) and a caregiver operating close to the patients (background self-concept). Doctors perceived their role to be narrower, centring on being a healthcare professional. For nurses, context shifts to peak time generated a potential break of role-based expectations (a 'broken promise') vis-à-vis their duty towards patients' care and emotional well-being, which had emotional consequences. This prompted them to enact a role identity that brought them closer to the patients – in a way, the nurses became more like 'who they served' (see also, Cardador and Pratt, 2018). Conversely, doctors, while showing signs of frustration and irritation at times, did not experience a significant level of expectation violation and emotional dissonance. When they did, they put emphasis on the doctor–nurse role hierarchy to mitigate emotional arousal.

Relatedly, Pratt and Foreman (2000) observe that in professional organizations such as hospitals, law firms, and universities, actors' professional identities can be so strong that the organization becomes most closely identified with the profession inherent to it. In such organizations, role identities are ordered to reflect how multiple identities relate to one another. The orderings allow individuals to avoid role conflict and overload by signalling which identity should be enacted under which conditions. In a hospital, the medical profession is what confers the organization its central, enduring, and distinctive identity (Albert and Whetten, 1985). Conversely, the role of nurses is often associated with doing the 'legwork'. In a relational role-identity logic, nurses' emotions may be more affected by peak times than doctors. At the same time, their role identity could be interpreted as being functional towards ensuring flexibility in the system, thus enabling the completion of the routine task under challenging contextual circumstances.

LIMITATIONS AND FUTURE RESEARCH DIRECTIONS

This article is based on a study of routine dynamics at a single organization. Although the findings emerging from the study deepen and expand current understanding in several ways, one limitation concerns the transferability or the generalizability of the study's conclusions. The study focused on an idiosyncratic context, characterized by a certain type of temporal dynamism that produced a particular display of emotion–identity–action dynamics. While in our case emotions were primarily shaped by (mis)alignment between the lived experience and the salient professional identity of routine participants, in other contexts – such as hospitality or retail – the expression of emotions may relate more strongly to organizational rules and expectations (Rafaeli and Sutton, 1990; Sutton and Rafaeli, 1988). In such settings, employees may engage in emotional labor to regulate their emotional displays according to normative expectations (Grandey, 2000). Along these lines, it would be fruitful to examine how such emotional labour interacts with identity salience to influence the performing and patterning of routines.

Future research could also examine how emotional energy and emotional contagion operate across professional boundaries within organizational routines. Building on recent sociological work that conceptualizes emotions as embedded in social interaction and institutional roles (Zhang et al., 2024), such investigations might explore how emotional

states might spill over across professional roles through patterns of relational exchange. Emotional energy – the sustained vitality and sense of alignment individuals experience in interaction – may accumulate or erode, depending on the affective tone of surrounding actors. Likewise, emotional contagion processes may contribute to either consonance or dissonance in collective task performance, shaping how routines stabilize or evolve. Attending to these relational dynamics would extend routine dynamics research by situating emotional processes not just within individual roles, but within broader systems of coordinated action.

A further interesting avenue of future research is to investigate the impact of routine dynamics and emotions on identity work and changes in professional identities (see Kho et al., 2021; Vough et al., 2013). For example, Lifshitz-Assaf (2018), while not framing her findings in terms of routine dynamics, describes a case where changing routine performances required R&D professionals to change their identity; routine change was only successful when those identities changed. More generally, cross-fertilization between the literatures on routine dynamics, emotions, and identities might generate interesting insights for understanding professional lived experiences in highly demanding settings. In conclusion, we hope that this study's findings and theorizing will generate further scholarly conversations and research.

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