Exploring the Dynamic Emotive Experience During Transformational Change in Health Care Organization: A Case of a Medical Teaching Institute in Peshawar, Pakistan

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Abstract
Current research shows the role of emotions during change but lacks interpretive approach to study the way emotional meanings are assigned as situation emerge and unfold during transformational change. This study aims to explore the way various organizational actors give meaning to their emotions in relation to emergent situations generating various actions and reactions in one of the medical teaching institute in Peshawar. Unlike extant research, this study investigates emotions during radical and transformational change by (re)conceptualizing public sector reforms as a dynamic, processual, multidimensional, complex, and longitudinal change process. It also demonstrates the way interpretations and subsequent emotional experiences are shaped by previous failed change. This paper uses a qualitative research method with a social constructionist approach and defines emotions in a specific situated relational context. Data has been collected through twenty-two in depth semi structured narrative interviews from various organizational actors. A thematic narrative analysis has been performed on the entire corpus to see common patterns of emotions in specific context in individual narratives. Findings show that strong and mixed emotions – frustration, anger, fear, hopelessness, mistrust, and hope were produced when the employees felt threatened about their vested interests and experienced sadness, bewilderment, disappointment, feeling inferior when they felt excluded and marginalized during the change process. Theoretically, this study contributes to the current literature by exploring dynamic emotions during radical transformational change process and demonstrates the lens of emotions as a 'resource' to understand the micro-processes involved during the change process since it highlights main issues at stake. Moreover, it (re)conceptualizes public reforms as a change process, which helps to understand the human aspect in the change process. This study has utility for change managers to understand sensitive issues and subsequent emotions for designing appropriate strategies for effective change management.
Keywords: Transformational change, emotions, narratives, public sector, medical teaching institutes

It has long been established that change has three main components: cognitive, affective and behavioral but the affective component has often been sidelined in the literature (Szabla, 2007; Smollan & Sayers, 2009) mainly due to the dominant rationalistic approach to study organizations. The traditional change management theories excluded emotions and viewed change as a static and an objective phenomenon. These theories made detailed plans to control

emotion to better manage the change process since they were seen as problematic. Vince and Broussine (1996, p. 3) criticize models of change which over-emphasize rationality and ignore emotionality and "complexity, ambiguity and paradox." Indeed, change triggers emotions whereas transformational change provokes even stronger emotions as employees experience the processes and outcomes of transformation reflected through various metaphors, such as, 'rollar coaster' and 'grief cycle' (Kelliher & Parry, 2015; Smollan, 2014). Despite of the recent growing interest in the study of emotions during change, it is limited to investigating its nature, causes and consequences rather than exploring and understanding the complex, dynamic, and longitudinal nature of emotions as situations unfold and emerge over time (Giaver & Smollan, 2015). Less is known about the way people give meaning to various emergent situations during change particularly when change is radical and transformational though large scale changes in organizations are frequent (Piderit, 2000; Yabome, 2017). Hence, this study addresses this knowledge gap by using the lens of emotions to understand the meaning making of various organizational actors in relation to multifaceted aspects of a radical and transformational change process as it evolves over time.

This study has been conducted when radical reforms were being introduced in the medical teaching institutes in Khyber Pakhtunkhwa that provoked resistance and inertia at various fronts which was also covered by media. This study (re)conceptualizes public sector reforms as a radical and dynamic transformative change process that involves coping with several pressures both from within (e.g. embedded power and interests of the stakeholders and lack of resources) and outside the organization (e.g. political, economic, technological and so forth) (Chreim, Williams, & and Coller, 2012). This study concentrates in exploring the pressures built from within the organizations due to the radical change; however, findings do demonstrate the outside influences, such as, the healthcare reform structure borrowed from developed countries, the top-down change initiated by the recent government in the KPK, and so forth. For this qualitative study, the focus is on the internal aspects of the radical change whereas the factors outside the organization provides a useful context in which changes are induced in the public organizations. It should be noted that public organizations operate in an environment that is more strongly influenced by the government decisions (Kelliher and Perry, 2015). Research shows that healthcare reforms have brought major transformations in their structure, functions, and practices (Brock, Powell, & Hinings, 1999; Lynn, 2001). This has created additional complexities in the underdeveloped countries since they face additional challenges, such as, poor management, lack of competency, insufficient accountability system, and lack of innovation that elevates the significance of this study. This highlights the complexities involved in the change process characterized through dynamic interactions,

competing interests, and subsequent relationships of purposeful actors (such as physicians, nurses, pharmacists, administrators, and so forth) that makes the transformational change process a complicated phenomenon in hospitals (Lee & Weiner, 2012) generating several emotions and resistance. In healthcare organizations, securing transformational and radical change should be seen as a top priority for its financial sustainability and in providing quality and timely healthcare (Hunter et al., 2015). Further, emotions influence the cognitive process and can behavioral implications (Klarner et al., 2011) which makes it a significant topic to study in the context of healthcare.

Also, the quantitative methods remained dominant to study emotions during change that limit our understanding of dynamic emotions during change that emerges and evolves over time. Qualitative research is meagre and limited as they have investigated change as a single event (Keifer, 2005) with few exception (e.g. Giaver & Smollan, 2015). These studies, however, have barely investigated change when it is radical, transformative, and when it is seen as enforced. Prior researches based on surveys impose emotion categories (Dasborough, Lamb, & Suseno, 2015) that de-contextualize emotions (Fineman, 2004) and has treated emotions and change as inseparable whereas the interpretive approach to understand change reveals that emotions is an inherent component of change (Klarner et al., 2011; Dasborough et al., 2015). The way people assign meaning to change suggests that emotions could co-exist that could be even contradictory (Ellis, 1991). We argue that transformational change is complex and dynamic, and emotions are inherent in this process that helps us to 'see things differently' (Hochschild, 1983) and in more depth. Hence, we concentrate on what these emotions are about? How various stakeholders interpret their emotional experiences during change? What meaning they assign to their emotions in relation to various emergent issues as change evolves and unfolds over time? This study is an attempt to find answer to these questions.

This paper is structured as follows: it begins with a literature review highlighting the deficiencies of investigating emotions during change with the theoretical perspective of emotions as social construction and change as dynamic followed by the exemplary context of the study. The next section discusses methodology signifying the use of interpretive and narrative approach to study emotions during radical change. We then present the findings highlighting specific emotions in situated relational context. Finally, the paper closes with discussion and conclusion.

Literature Review

Very often, emotions have often been used interchangeably with affect in the change management literature and beyond. 'Affect' include both emotions and moods whereas moods are "generalized feeling states

that are not typically identified with a particular stimulus and not sufficiently intense to interrupt ongoing processes" (Brief & Weiss, 2002, p.282). Hence, this study differentiates affect, moods and emotions, and defines emotions as social and relational construct reflected in everyday language and embodiment (Lupton, 1998; Fineman, 2008). Emotions could be defined from a range of perspectives that begin with the positivist view to social constructionism and ultimately to post modernism, and it is important to clarify the theoretical stance a researcher takes in defining emotions since it has both theoretical and methodological repercussions. Research shows that organizational change is charged with emotions. It includes both negative emotions, such as, anxiety, sadness, anger, insecurity and frustration (Keifer, 2005; Giaever & HellesØ, 2010) and positive, such as, excitement, confidence, contentment and hope (Kiefer, 2002; Saunders & Thornhill, 2002). Such positive and negative emotions could result into either engagement or resistance to change (Piderit, 2000); however, more emphasis has been given to negative emotions to minimize resistance to change. On the contrary, Härtel and Zerbe (2002) suggest that it is actually a myth to think that negative emotions would lead to resistance. This shows that the findings that whether or not negative emotions lead to resistance are inconclusive.

Conventionally, resistance is seen as 'irrational', a 'collateral damage' of change endeavors, a counterproductive phenomenon, and a main culprit for increase in cost and change failure (Pieterse, Marjolein, & Caniëls, 2012). There is another stream of research that argues that resistance should actually be treated as a valuable resource since it can help to identify hidden information for a successful change implementation process (Beer & Eisenstat, 1996; Waddell & Sohal, 1998, Ford & Ford, 2010). Further, there could be constructive input in the form of 'voice' that was wrongfully perceived as resistance by management (Bryant, 2006). Nevertheless, research fails to take into account the positive intentions of the resistors (Fleming & Spicer, 2003). Often, negative emotions are associated with uncertainty, feeling of loss and injustice whereas positive emotions are produced when there are opportunities and the outcomes of change is perceived as valuable (Giaver & Smollon, 2011). Research in the health sector in particular indicates that change can lead to increased stress and negative work outcomes due to increased work pressure, responsibilities and work timings (Clare & Emma, 2015). The response to change depends upon the way individuals give meaning to the change process and it is these different meanings that create complex dynamics of resistance (Pieterse et al., 2012) or engagement traditionally reflected through employee emotions.

A substantial amount of research on emotions during change has addressed discrete emotions and emotion categories (Dasborough et al., 2015) that contradicts with the view that emotions are dynamic, and

more than one emotions can co-exist highlighting the complex nature of emotions (Fineman, 2005). Others have tried to determine the causes, types, antecedents of emotions and its outcomes during change (Keifer, 2005). Hence, research on emotions during change mainly concentrates on employee behavior as an outcome of emotions (Klarner, Todnem, & Diefenbach, 2011) that the change management theories aim to manage or control for effective implementation of change management strategies. This creates a partial understanding of the change process (Bryant, 2006). The perspective and the interpretation of the employees during change is crucial to understand dynamic change as it unfolds over time and the lived emotions associated to these perceptions and interpretations that the current research lacks (Klarner et al, 2011). The dynamic approach to transformational change helps to explore issues at stake involved in the change process at the micro-processual level that has been often overlooked in the conventional literature mainly due to the dominance of the positivist tradition (Tsoukas & Chia, 2002) both in healthcare research and beyond (Lee & Weiner, 2012). This requires conceptualization of change as a dynamic process (Armenakis & Bedeian, 1999; Tsoukas & Chia, 2002;) and multifaceted phenomenon (Weick & Quinn, 1999) unlike conventional view of change as static (Orlikowski, 1996) and as an epiphenomenon (Tsoukas & Chia, 2002). This is in line with the very basic definition of transformational change, which is "multidimensional…(and)…departs radically from an organization's past precedents, aims at large-scale readjustments, and is complex" (Lee, Weiner, Harrison, & Belden, 2013, p. 116). This creates a possibility of producing a range of emotional experiences (Giaver & Smollon, 2011) where emotions should be defined as a process based upon individual's interpretations and not as a specific moment that could be quantified and measured through scales (Fineman, 2005).

Giaver and Smollon (2011) argue that the longitudinal studies on emotions and change are mainly dominated by quantitative studies that have surveyed emotions during different times of change process. Only a few have used mixed and muti-methods approach in the public and health care sector (Clare & Emma, 2015; Hunter et al., 2015). Such studies have inherent limitations since emotions are viewed as static and not processual that moves from one stage to another in a rather predictable fashion. The qualitative longitudinal studies of emotions during change that aims to address the emotional experiences of the individuals and during repeated change is meagre (Klaner et al., 2011; Lee et al., 2013) though it reveals a range of emotions (e.g. Clarke et al., 2007) based on individual's perception and interpretation about evolving change (Dasborough et al., 2015), when there is a change in culture (Smollan & Sayers, 2009; Richa, Chandrasekaran, & Gupta, 2011). This methodological issue has been taken into consideration since this paper adopts a narrative approach that addresses both the longitudinal nature of change and the associated dynamic emotions tied with the emergent and

routine issues. Hence, this study adresses the research gap of exploring dynamic emotions during transformational change through narrative mode of enquiry. The next section explains the context of the study.

Context of the study

In 2015, the provincial government of KPK approved MTI Reforms Act, 2015 with the aim to minimize governmental influences and to provide best health care facilities by getting rid of a conventional bureaucratic structure. In the initial stages, reforms have been introduced in the three main teaching institutes that will gradually extend to all other public hospitals of the province. These reforms have transformed the entire structure of the hospital. Board of governors comprising of ten members have been introduced to administer and manage their respective medical teaching institution for a period of three years. The board takes the decision based on mutual consensus otherwise the decision is made on the basis of majority votes.

The introduction of board of governors has altered the power structure of the medical institutes by shifting it from individuals to board of governors who are now directly accountable to the government. The board provides strategic direction to the teaching hospitals and is responsible for general management and administration of the medical institutes. The board has also been empowered to form several committees, such as, executive committee, finance committee, recruitment committee and any other such committees or sub-committees, if and whenever required. The board also appoints full-time hospital director also known as a chief executive, a medical director, a nursing director, and a finance director for a maximum period of three years who are accountable to the board of governors. The chief executive is responsible for all the non-clinical functions of the hospital whereas the medical director takes care of all the clinical functions in the hospital. This shows that the reforms have made the hospitals more autonomous, which mean it will remain under the public system, but it will release them from 'stifling bureaucracy and politicization' (Javaid, 2016). The powers have now been given to the board of governors and senior staff instead of the CEO only and will be held to account for their own performance instead of being controlled by Department of Health and Finance (Javaid, 2016).

Further, all consultants working in the public hospitals clinics, imaging facilities, and laboratories are given an option to either do their private practices within or outside the hospital. Those who choose to do private practices within the hospitals are compensated whereas those who choose to carry on their private practices in their own private vicinities can do so. Duty hours of the doctors have been extended from 8:00 a.m. to 4:00 p.m. instead of till 2:00 pm and biometric attendance systems has been introduced to monitor doctor's attendance and work timings.

Prior to the MTI Act 2015, all the four medical teaching institutes were managed by the chief executives themselves. The chief executive used to look after the clinical and management functions of the teaching hospitals with the assistance of medical superintendents and deputy medical superintendents. Also, deans of major public hospitals used to request the induction of trainee medical officers (TMO) to Postgraduate Medical Institute (PGMI) which was responsible for the induction, curriculum designing and training of TMOs. Now, a central induction committee hires trainees and the role of PGMI in this regard has diminished. Finally, the government now evaluates the performance of all the medical teaching institutes by the standards set by the government. Thus, the reforms have not only tremendously altered the bureaucratic structure, functions, and powers of different stakeholders but have also increased their accountability.

Research Methodology

Collins (1998, 190) argues that researchers who are "committed to making a real contribution to the study and practice of change and its management should adopt interpretive approaches to highlight "issues surrounding change". Hence, a qualitative approach has been used to gain deeper insights into the phenomenon under investigation with an epistemological stance of social constructionism (Saunders, Lewis, & Thornhill, 2009). Data has been collected through in-depth semi-structured narrative interviews from 22 respondents up to the point where theoretical saturation was reached.

Table 1. *Sample composition*

Doctors including assistant registrars	6
Nurses	5
Paramedics	7
Technicians	4
Total	22

A topic guide was prepared keeping in view the research questions of the study (Kvale & Brinkmann, 2009; Saunders, Lewis, & Thornhill, 2016). The main interview questions asked were: How MTI is different from previous reforms? What is your view about the changes introduced under MTI reforms? How has your experience been about these changes? How do you feel about these changes? Respondents were probed to explore responses further whenever required to explain the research topic better (Saunders et al., 2016), and to narrate their lived experiences in detail (Reissman, 2008), that is, can you please tell us a little more about what happened? Do you have further examples of this? How they are different today? etc.

The narrative approach helped to better understand the nuances of the lived experiences and interpretations of individuals involved in the

change process over time as reflected through their retrospective experiences (Reissman, 2008). A rich sample of doctors, nurses, paramedics and technicians through snowball technique was selected (Creswell, 2013). According to Akinson & Klint (2011), "snowball sampling can be placed within a wider set of methodologies that takes advantage of the social networks of identified respondents, which can be used to provide a researcher with an escalating set of potential contacts" (p. 1044). Respondents who participated in this study helped to gain access to other potential respondents who could have given rich qualitative data in the form of stories related to various emergent situations during change.

Data has been analyzed through thematic narrative analysis in pursuit of search for meaning (Reissman, 2008) and to understand the inductive themes embedded within participant narratives (Bryant, 2006). The data analysis was conducted in two main steps. First and foremost, narratives were identified in the text which is a highly interpretive process and requires (re)reading of the data several times. The data set generated different genres of narratives with varied lengths ranging from a small paragraph to more than a page. Boudens (2005, p. 1289) suggest that all narratives have the following features in common that: a specific incident or connected series of incidents with a clearly identifiable beginning and an end; a temporal ordering of events or occurrences within the incident; an indication of the teller that the events described are causally related; and a change in the situation, or in at least one of the characters over the course of the story. Hence, this criterion was used to identify various narratives in the text.

As a second step, these narratives were given a basic code to capture the essence of the narratives. Codes are defined as "a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data" (Saldaña 2009, p. 3). These codes were assigned through process coding in the first cycle of coding. Process coding is particularly used for those who search for "ongoing action/interaction/emotion taken in response to situations, or problems, often with the purpose of reaching a goal or handling a problem" (Corbin & Strauss, 2008). These process codes were then categorized under similar themes based on a general pattern (Reissman, 2008) or a themal/thematic coherence (Van Dijk, 1981). Similar themes were assigned a thematic code followed by a thematic category. The entire analysis process is demonstrated in Table 1:

Table 2. *The process of analysis adapted from Reissman (2008) and Saldaña (2009)*

Step 1: Identifying narratives in the text	Boudens (2005) criteria of defining narratives includes stories, habitual, hypothetical,

	counterfactual narratives, and chronicles
Step 2: First level coding	Process coding
	Organizes the entire corpus and attempt to attribute meaning to a phenomenon
Step 3: Second level coding	Pattern coding
	Considered as a meta-code to develops themes and thematic codes developed through identifying patterns
Step 4: Third level coding	Theoretical coding
	Helps in theory building by combining themes to reach a higher level of abstraction

The identification of narrative and the coding process is shown in Table 3 and the coding process is demonstrated in figure 1.

Table 3. *Example of the coding process*

Identifying a narrative in the text (shown in italics)	Process coding	Pattern coding	Theoretical coding
There are no evident benefits for the patients and the hospital staff. The only benefit that I could see is that they have extended the working hours of the doctors, so the patients now get more consultation hours apart from that this system is blind in many aspects. You see, *when you do not get listened or heard, and when there is injustice then the people have to stand. This is exactly what we did. We went on strike and we went to the court. They should have listened to our suggestions; and they should have paid attention to our suggestion.* This system is going to fail. It is an ideal system based on the ideas of a few people and neglecting the actual situation. It can succeed if they still let us in the loop and keep us there and listen to us. We want to make this hospital a better place.	*Lack of involvement in the change process*	*Feeling excluded*	*Feeling of exclusion and mistrust*

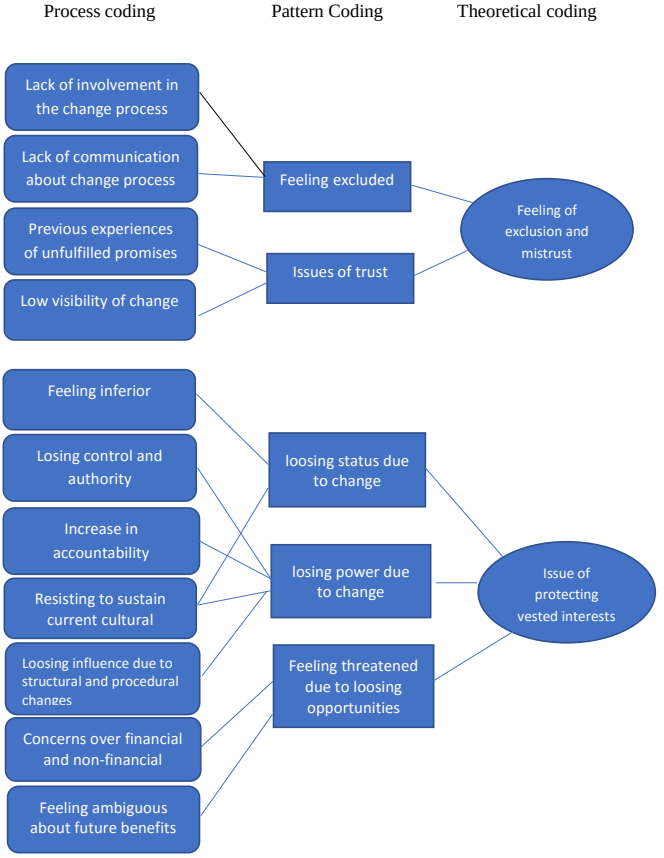

Figure 1. the coding process

The process of analysis was facilitated through the use of the software – NVIVO, which assisted in data management and is not a substitute for human interpretation and analysis. Computer software for textual analysis are "not a substitute for thought…Computers don't analyse data: people do" (Weitzman & Miles, 1995, p.3). Also, Kvale & Brinkman (2009) argue "computer-assisted programs for textual analysis have not been developed for many other forms of interview analysis, such as, narrative and discursive analysis" (p. 199). They further highlight towards the dangers that the coding programs may become a preferred method of shortcut analysis and ignore the rich variety of modes of interviews and their analysis. Further, the identification of narratives and the coding process was shared with the co-authors to ensure and enhance validity of the analysis. The next section discusses the findings.

Findings

The reforms in the public hospital visibly demonstrated emotional experiences (i.e. frustration, anger, fear and hope) when power, status, cultural practices were threatened. Also, organizational

actors experienced sadness, bewildered, disappointment, and felt inferior when they felt excluded and marginalized during the change process. Findings demonstrate how meaning making process produced different emotions.

Issue of protecting vested interests

Findings of the study show that all the organizational actors had their own emotional subtleties that led to specific actions and reactions to the change process. For instance, doctors and nurses were found to be resistant to abide by the extension and monitoring of work timings and carrying out private practices in the hospital primarily because they used to spend more time in their private clinics earlier. The change had threatened their opportunities to possible financial benefits from their private practices causing anger and frustration. In this regard, doctors also demonstrated anger over the introduction of bed management system in the hospital since it altered their control, authority, and influence of giving priority in allocating beds to their own private patients rather than the public patients of the hospitals. Contrarily, doctors interpreted reforms as a move to eradicate their power and to sabotage their private practices that produced anger, frustration, and fear. They tried to legitimize their unwillingness to accept and support reforms by giving two main excuses – insufficient staff to cope with too many patients, and lack of resources to manage private practices within the hospital.

In similar way, TMOs expressed their anger over abolishing PGMIs thus resulting in the doctors' strikes and their refusal to attend OPDs. Nurses and paramedics were also concerned about their financial benefits. Significantly the change threatened the unions of different groups in the hospitals, mainly TMOs, who had a history of going on strikes whenever their demands were unmet. This provoked fear and a sense of uncertainty among various organizational actors about protecting their self-interests.

> "Different strikes took place at different time from involving different parties due to the introduction of MTI reforms from time to time. Sometimes, the government says that the salary will be fixed then the government creates issues regarding transfers. Then the union goes on strike regarding this issue. Every category of employees has their own union. Sweepers have their own union; nurses have separate union; peons (office boys) have separate; and doctors have a union of their own". (Nurse)

Along with power, there was also an issue of a status the doctors had been enjoying since long. Doctors who were assistant professors refused to abide by the extended work hours and the additional duties

that emerged due to change in job structures. They argued that they were senior to senior registrars and had already performed the assigned duties earlier. On the other hand, senior registrars insisted that the doctors should perform their duties thereby creating tension between the two groups. In one such situation, the head of the department had to intervene and offer her services voluntarily to perform the duties of senior doctors to manage the situation.

> "The assistant professors and senior registrars have to perform duties equally; but the assistant professor refused to do so because they think they are more senior than registrars. But the senior registrars insist that the assistant professors must do their duty as required." (Doctor).

Interestingly, these power and status issues are rooted in deep cultural values and practices, often observed in the Eastern societies with wide power and status gap. The transformational change threatened these cultural practices too for which organizational actors took different actions to sustain it. Cultural practices are about 'how things are done around here' (Martin, 2002, p. 3) and include set of assumptions, beliefs, values, norms, customs, structures, rules, and traditions (Schein, 2004) that shapes the behavior of the individuals (Smollan & Sayers, 2009). A change that threatens the cultural practices are often met with volatile emotions, excuses, and strong resistance (Steinke, Dastmalchian, Blyton, & Hasselback, 2013). The following narrative clearly shows the way a doctor tried to be against extended and monitoring of work timings. He argued that it would affect work-life balance and would raise security concerns for the doctors who work till late at night.

> "…The first shift will begin from 8:00 a.m. to 4:00 p.m., second from 4:00 p.m. to 12:00 a.m. If you are implementing this schedule, it means you are destroying their prospects of second job. Then, there are parents who had already left their children at school. If you are doing your duty up to 4:00 p.m. then who will take your children home? How will females get home at 12:00 a.m. in the night? What about their pick and drop?" (Doctor).

In addition, the new structure had increased the responsibility and accountability of the doctors and the other hospital staff that they have been avoiding for long. The new structure and processes facilitated to take action against a hospital staff in case of negligence and malpractice instead of the previous extended process that often did not materialize. The following narrative shows the lack of taking responsibility and accountability of the hospital staff actions that has become a practice, which the reforms challenged.

> "The prevalent culture has been that of avoiding responsibility. There has been little, if any, discipline or accountability at all. Because the senior faculty does not observe moral standards; the junior doctors play by their own rules. Most of the lower staff have been appointed through political favors. They are afraid that if a system of accountability is set in place, there will be consequences for their actions." (Doctor).

Though most of the organizational actors had a negative view of change; there were others who believed that the old-fashioned practices and the prevailing power and status of the doctors must be eradicated since it was perceived as a barrier to quality care in the hospital.

> "…the current professor-centric model must be changed. It only serves vested interests! In rest of the world, the titles of professor are academic or honorary. They not related to patient care" (Paramedic).

Importantly, individuals interpreted reforms on the basis of their vested interests and showed actions and reactions that ranged from making excuses to legitimize resistance to going on strikes and shutting down the medical care services to the daily patients creating chaos. Emotions were manifested as employees felt threatened of losing their self-interests. The underlying issues has been the sustenance of status qou.

Feeling of exclusion and mistrust

Overall, individuals in organizations felt excluded and marginalized since they felt that they were not involved in the change process. Therefore, the change appeared to be enforced. Much of the research on change management recommends involving staff in the change process to gain their commitment and to minimize resistance (Burnes & James, 1994). Here, employees sought involvement in various ways: they wanted to be heard, contribute, and give suggestions. Their lack of involvement produced anger, frustration, and a feeling of injustice, leading to resistance in the form of strikes and legal actions as depicted from the following narrative.

> "When you do not get listened or heard, and when there is injustice then the people have to stand. This is exactly what we did. We went on strike and we went to the court. They should have listened to our suggestions; and they should have paid attention to our suggestion." (Doctor).

Organizational actors argued that the reforms have been directly borrowed from the United Kingdom and implemented in the context of the KP without any consideration of the contextual significance. They felt inferior when a sample reform was taken from another country and imposed upon them without their participation.

> "MTI is exported from the UK. Why bring reforms from the West? Here, we have very capable people who can design a far superior system? They will have knowledge of the local problems. They will be able to communicate with the concerned parties,and incorporate their suggestions and reservations" (Technician).

A series of unfulfilled promises in the past had also created an environment of mistrust. It had sparked nervousness about future, and dissatisfaction on the design and implementation of these reforms. It reflects their feelings towards the change often shaped by the way the change initiators had handled the change process over time.

> "…the only thing missing was that it did not transfer the benefits to the employees. And if the employee does not get what they are promised, this system is also going to meet similar fate as happened before (Paramedics).

Further, the hospital staff did not see any difference between the current and previous reforms in practice apart from extended work timings and the introduction of board of governors to run the hospital. Failure to see the change in practice indicated that these reforms would fail too.

> "I do not see any specific difference between these and previous reforms. Only the duty time of the doctors has been extended to 4 o'clock. Management council has been replaced by board of governors. Free availability of medicines was mentioned in the reforms but has not been realized yet" (Doctor).

Some of the participants complained that the reforms lack clarity in terms of the way it would be materialized. Lack of detailed policies and procedures had created a perfect space for ambiguities to generate and flourish since individuals tried to make sense of policies and procedures based on limited information that they had about reforms. The ambiguities have created a feeling of uncertainty, anxieties, and nervousness among the employees, particularly doctors that prompted many to prevent the reforms from succeeding.

> "Unfortunately, the doctors and other people who do not accept and oppose this system are trying their best that this system doesn't succeed. They even went to court against these reforms, but they lost there. They are afraid

and think that this system will create problems for them" (Technician).

Some of the doctors are concerned about the overwhelming number of patients that visit the hospital daily and how they will be managed under reforms. The IBP would allow doctors to do their private practices within the hospital instead of working in their own private clinics. This bewildered the doctors on how the private patients would managed in the hospital as shown in the following narrative.

> "…you have to keep in mind that at least 500 surgeries take place daily in all the hospitals in our city. It can even go up to 600 to 1000. If you are planning to bring these patients into this hospital, it will be in private sessions. If you are providing private services, then where will you arrange the staff for it? Who will sterilize the equipment for them? Where we are going to admit them? (Doctor).

On the contrary, a few took a positive approach and suggest to give time to the reforms to materialize.

> "The jobs under MTI are not well defined. But we must give it time. Because the doctors do not get financial support, there is nervousness and anxiety among the doctors and they are not sure what will happen to them in future".

The lack of clarity in knowing and understanding the change process have allowed various organizational actors to interpret situations and reforms differently. Also, this has allowed them to use ambiguities in the change process to manipulate situations and emotions and to legitimize their actions. The feeling of being marginalized due to lack of involvement in the change process has also been the main issue to instill various negative emotions.

Discussion, Conclusion and Recommendation

In this study, we have shown the manifestation of emotions during a transformational change process in one of the medical teaching institutes in KPK, Pakistan as part of the public reforms, and the way different actors interpreted situations; hence, producing several and mixed emotions. It addresses the call of contemporary researchers to explore dynamic emotions that are processual in nature during the change process through qualitative methods since it remained an under researched phenomenon (e.g. Kiefer, 2002; Klarner et al., 2011; Dasborough et al., 2015). Over the course of the article, we have shown that unlike previous research that has studied discrete emotions (e.g.

Giæver and Smollan, (2015), and has defined change as a one-time event (), this study shows the dynamic nature of emotions during radical change process.

Also, this study demonstrates that (re)conceptualizing public sector reforms unlike previous studies as a dynamic and transformational change process helps to understand emotionally sensitive issues through the interpretive lens of emotions. This study shows various emotions, both negative (i.e. anger, frustration, sadness, fear, uncertainty, mistrust), and positive emotions (i.e., hope) has emerged in relation to the issues that were of emotional significance to the respondents or were a consequence of the manipulation of situations by specific actors. Previous studies have explored negative emotions only in particular though general concepts, such as, resistance and not emotions that ignore individual's interpretation in relation to situational and relational aspects (Giaever & HellesØ, 2010). The aim of this study was not to find which emotion existed rather to understand its role in the dynamic change process. Hence, emotions (whether negative or positive) became a 'resource' (Vince and Broussine, 1996; Fineman, 2008; Dasborough et al., 2015; Manzoor, 2018) and an invisible asset (Eide, 2005) to understand and challenge the way we think about the 'rational' change process that needs to be managed. This means that emotions should not be seen as destructive rather a 'tool' to understand the way people interpret situations (Manzoor, 2018).

Methodologically, this study contributes in using a narrative approach to understand the lived experiences of the stakeholders affected by the transformational change process unlike previous research. It helped to access the human emotions since narratives are 'emotionally charged' (Gabriel, 2000). The narrative approach used in this study takes into consideration the methodological gap of studying emotions as a one-time event that several researchers (e.g. Giaver & Smollan, 2015; Dasborough et al., 2015) have highlighted since narratives are longitudinal in nature. However, future research could employ an ethno-narrative approach – a combination of ethnography and narratives – to observe emotions *in situ* and the meaning making process of the research participants.

Practically, implementing transformational change has always been a complex process and a difficult business (Greenhalgh *et al*., 2012). In this study, the feeling that change is being imposed upon them as well as the lack of communication with the hospital staff created room for politics of change. In addition, the understanding of the cultural context is crucial for the policy makers to understand that different cultures respond differently to change. Change could be acceptable and negotiable in cultures where change is the norm whereas it could be unacceptable and is considered to be a barrier that needs to be 'dealt with' or 'managed' (Ford, Ford, & Amello, 2002; Van Dyke & Soule, 2009).

Also, future research could explore the interconnectedness of culture, emotions and transformational change since change is not possible without a change in the norms, values, beliefs and practices (Steinke *et al.*, 2013). Also, the performatory role of emotions in the context of transformational change should be explored to investigate how emotions are used and induced in others to manipulate situations for self-interests and how emotions are shared for collective actions. This research includes various voices of the internal stakeholders', but it will be useful to include the voices of the patients too since they are the key beneficiaries of the healthcare reforms. Also, the same study could be conducted again in future to understand how emotions changed over time as the transformational change progressed.

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