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Is There Balance? Mexican Medical Practitioners' Work- Life Experiences And Emotion Management On The U.S.- Mexico Border

Ana Luisa Ramirez

IS THERE BALANCE? MEXICAN MEDICAL PRACTITIONERS' WORK- LIFE EXPERIENCES AND EMOTION MANAGEMENT ON THE U.S. - MEXICO BORDER

A Thesis

by

ANA LUISA RAMÍREZ CANTÚ

Submitted to Texas A&M International University
in partial fulfillment of the requirements
for the degree of

MASTER OF ARTS

May 2017

Major Subject: Communication

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DEDICATION

Papá y Mamá, agradezco infinitamente su esfuerzo para formarme y darme todo lo que tengo, su apoyo y guía. Son mis mentores, mis amigos y mi modelo a seguir.

ABSTRACT

Is There Balance? Mexican Medical Practitioners' Work- Life Experiences And Emotion Management On The U.S.- Mexico Border (May 2017)

Ana Luisa Ramírez Cantú, Bachelor of Arts, TX A&M International University;

Chair of Committee: Dr. Ariadne A. Gonzalez

The purpose of this study is to analyze medical doctors' work-life experiences and emotional management while practicing on the U.S.-Mexico. They have varying experiences and there is a constant shift of doctors attempting to manage work and personal lives; they must learn how to cope with the emotions that derive from their profession and the added pressures of practicing medicine with precaution due to the ongoing drug war in Nuevo Laredo, Mexico. Additionally, doctors on the border treat patients from both Mexico and the U.S. There are significant pressures and tensions involved in practicing medicine, and this is even more relevant when working on the border region. This is why this study is relevant and important.

Through qualitative methodology, I acquired the experiences of Mexican doctors on the Laredo-Nuevo Laredo border. Through a thematic analysis of in-depth interviews, doctors described the difficulties they encountered when dealing with emotions at work, which gave deeper meaning to their statements.

Kidnappings, muggings, and extortions put significant constraints on doctors' occupational lives. Doctors modify their work practices, work schedules, and other daily

routines, which intersect with their work and personal lives. Doctors also displayed resilience to continue practicing on the border regardless of the violence. Doctors in my study experience Clark's (2000) border theory, developed to fill in the gaps causing criticism of other work and family theories and work-life mechanisms (Clark, 2000). In addition to the border theory (Clark, 2000) the role theory (Kahn *et al.* 1964) also describes my participants' multiple role amalgamation. This theory proposes workers, in this case, doctors, are involved in varying life roles such as employee or family member amongst other roles that sometimes are incompatible (Greenhaus & Beutell, 1985).

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This thesis would not be possible without the guidance of my thesis chair, Dr. Ariadne A. Gonzalez. It was a collaborative project by me, my thesis advisors, and my family who supported me unconditionally.

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Furthermore, I want to thank another mentor who has been there for me since I was doing my undergraduate degree, Dr. Lozano. The experiences I lived in Germany and Belgium in both study abroad trips would not have been possible without your passion and decision to make the study abroad opportunities happen. Your knowledge and academic network made Europe an unforgettable experience. Thank you Dr. Lozano for finishing this journey with me by being part of my thesis committee. Your contribution is valuable for me.

Dr. Stuart, you have been my professor, thesis committee member, and most importantly, you have been a friend. Thank you for your advice. You always made your

classes engaging with research trips to San Antonio and McAllen, where we applied what we learned. Thanks to you, I went to my first conference in UT Austin. I was so nervous, but you reviewed my presentation and made me feel confident. After that time, conferences were numerous; we went to College Station, Prairie View and Philadelphia. It is amazing how we built memories out of bus rides, bags of popcorn, dried spicy mango, and of course our conversations where you gave us valuable advice about our future. It is always fun with Dr. Stuart because he knows how to teach us life lessons in the midst of an adventure.

Dr. Kilburn and I share many passions: theater, music, and research, which is why I chose him to be part of my thesis committee. I have fond memories of his talks at Dusty Camp, where he shared wise advice to succeed in college. His talk was engaging and it helped me a lot throughout my college years. I did it all! I bought the books, read them, harvested strong relationships with my professors, and it all added up to having a successful journey. Thank you, Dr. Kilburn for sharing your advice, life experiences and making an impact in my college life.

Mom and dad, thank you for understanding and showing support. I dedicate this thesis to you because you have done everything for me. You helped me purchase books, a laptop, and anything else I needed through my career and you never charged me a penny for your love. I appreciate your help and advice. I will always cherish those long conversations with my dad and my mom's shoulder to cry on. I was never alone in this; they were always there. Thanks!

Melissa was my loyal companion throughout this journey. We spent long nights working on our theses together. We share so many memories of frustrating moments that quickly vanish when I think of all the golden anecdotes we have harvested throughout our

graduate program. The conferences in College Station, Prairie View, Philadelphia, Portland, and San Diego have been much more fun with her by my side, supporting and encouraging me. She is truly a role model, a great writer and an amazing friend. Thank you for everything. I am proud of you!

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To conclude, I would like to thank my participants for the time invested in my project. I know how busy doctors can be, but they received me with a warm smile and answered all of my questions without any restraint. I learned through experience. My first interview was not as good as the last one, but every one contributed to make this thesis a success. Thank you!

Long nights, a positive attitude, and tears of frustration and joy were involved in the process of writing this thesis. Many people said: “It is only a thesis.” Yes, I know, it is only a thesis, but it is my thesis and I worked very hard on it. All I wanted is to make myself proud, my parents, friends, and of course, my professors. I am sure I did!

TABLE OF CONTENTS

Page

CHAPTER I

INTRODUCTION

Medical doctors practicing on the U.S.-Mexico border have varying work-life experiences. There is a constant shifting of doctors attempting to manage work and their personal lives, and they must learn how to cope with the emotions that derive from their profession. However, border doctors must also deal with the circumstances of practicing medicine with precaution due to the drug war experienced in Nuevo Laredo, Tamaulipas. Additionally, doctors on the border treat patients from both Mexico and the U.S. Even though patients are considered as a topic of interest for research studies, doctors are seen as the instrument of service and have not been considered significantly (Sparks, Villagran, Parker-Raley & Cunningham, 2007). There are significant pressures and tensions involved in practicing medicine, and this is even more relevant when working on the border region. This is why this study is relevant and important.

The theories of emotional labor (Hochschild, 1983) and work-life balance (Burke & Greenglass, 1987) guide this study. These theories relate since managing emotions through techniques of surface and deep acting (Hochschild, 1983), involves making sense of thoughts or feelings where the work and life domains are impacted. Emotional labor is defined as "the management of feeling to create a publicly observable facial and bodily display" (Hochschild, 1983, p. 7), while Burke & Greenglass (1987) define work-life balance as "satisfaction and good functioning at work and at home with a minimum role conflict" (p. 751). This is a utopian definition since there are models arguing that sometimes work and life

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This thesis follows the model of *Journal of Applied Communication Research.*

interlock. These models are segmentation, spillover, compensation (Burke & Greenglass, 1987), resource drain (Lobel, 1991; Small & Riley, 1990), convergence (Wright, Sparks & O'Hair, 2013), time-based conflict, and strain-based conflict (Repetti, 1987). These models show that Burke & Greenglass (1987) statements remains strong, but are not necessarily applicable to most work contexts, especially when we take a closer look at doctors practicing medicine on the border. In fact, I discovered my participants are living all the models simultaneously. This phenomenon is supported by the border theory developed by Clark (2000).

Literature Review

History, Economics and Organized Crime in the Border

This organizational analysis is situated on the Mexico-United States border, specifically in Nuevo Laredo, Mexico, and Laredo, Texas. "Laredo-Nuevo Laredo is the main port of entry along the U.S.-Mexico border and the number two port in the U.S." (Charur, 2015). However, Nuevo Laredo has also been considered one of the least safe cities in the state (Sánchez, 2016). For the past 10 years, insecurity related to organized crime and drug war has become a factor causing tension (Sánchez, 2016). Border residents live in fear in their own city and are unable to live a peaceful life (Kilburn, San Miguel, & Kwak, 2013). Attention has been paid to the border region in fields such as public health (Su, Chad , Ming, & Pagan, 2011; Byrd & Jon, 2009) and social sciences, (Horton & Cole 2011; Kilburn, San Miguel, & Kwak, 2013; Landeck & Garza, 2003) but there is a lack of organizational communication studies in this area. Through this organizational study, I will focus on

understanding border medical practitioners' [1] work-life experiences and emotion at work as they practice medicine on the Mexico-U.S. border.

International trade makes these cities relevant for both the U.S. and Mexico. According to Correa Cabrera (2013) Nuevo Laredo is "*La capital Aduanera de America Latina,"* the custom's capital of Latin America. This is because it is located in a privileged geographical position, and it has five international bridges and an immense trade of merchandise on both ends of the border (Correa-Cabrera, 2013). The U.S. produces $3.9 billion in trade every year (Correa-Cabrera, 2013), and about $280 billion cross stretching from Del Rio to Brownsville, TX (Charur, 2015). The Laredo-Nuevo Laredo border has been named the number one port as 71 percent of the $280 billion of international trade passes through by truck, rail or air transport (Charur, 2015). In addition, "Laredo handles traffic from more than 100 countries, and it definitely is not a secret that Mexico is number one" when it comes to international trade (Charur, 2015).

Olivia Varela, executive director of Laredo Development Foundation, underlines the importance of this economic asset for the community. She said, "If we had to choose two words that define our community, those two words would be international trade" (Charur, 2015). *Los dos Laredos* or "the two Laredos" are considered as one city divided by a river since the culture is so enmeshed (Kilburn, San Miguel & Kwak, 2013, p.31).

The benefit of international trade causes a major problem for the sister cities, especially because of the access to another country's drugs and munitions. Correa-Cabrera (2013) posits the strategic location appeals for illicit trade of drugs, in addition to the important legal trade. Even though the insecurity climaxed in 2006, these issues are not new

[1] Border medical practitioners: I use the synonymous terms doctors, border doctors, medical practitioners, practitioners, physician, and medical doctor to refer to the profession.

to this area(Correa-Cabrera, 2013). Since 1984, the Sinaloa Cartel [2] used Nuevo Laredo as a bridge to traffic illegal drugs (Correa-Cabrera, 2013). Nuevo Laredo is considered a treasure for drug traffickers, and it has been the dispute between Sinaloa and Golfo-Zetas, el Cartel de los Beltran Leyva y el Cartel de Juarez" amongst other narco groups (Correa-Cabrera, 2013). All narco groups want to take control of the *plaza*[3], which is the reason for the murders, fighting and torture. These incidents caused the citizens of Nuevo Laredo to take security measures. Many people from Nuevo Laredo would prefer to move to Laredo, TX. They feel safer since the U.S. has better security measures. Still, incidents happen on both sides of the border. The difference is the news coverage these events get in Nuevo Laredo. News stories about violent occurrences in the city of Nuevo Laredo threaten the citizens (Rodriguez, 2011; Sevigny, 2002).

Despite the successful international trade happening in this border region and the benefit it brings to the community and the workforce, the presence of violence and drug war cannot be ignored. Correa-Cabrera (2013) considers Nuevo Laredo to be the epicenter of the drug war in Mexico, where the Zetas, "*un grupo criminal de corte paramilitar*," a military criminal group has transformed the lives of border residents and the intense security measures implemented in the country since 2006. Correa-Cabrera shared her experience visiting the border:

> *No obstante que Nuevo Laredo continúa siendo un paso importantísimo de mercancía hacia México y hacia los Estados Unidos, además de que es una región donde continúa desarrollándose la industria maquiladora y operando con efectividad las grandes empresas nacionales y transnacionales, se puede apreciar claramente un deterioro general de los espacios públicos, una gran afectación a los negocios pequeños y medianos y una tremenda inseguridad. En los últimos años, la violencia desmedida y la delincuencia organizada han caracterizado la vida en la ciudad y han*

2 Sinaloa Cartel: *narco* group whose drug lord is Joaquin "El Chap" Guzman. (San Antonio Express News)
3 Plaza: the zone ruled by narco drug lords. Ex: Cartel de Sinaloa's plaza belongs to Sinaloa, directed by "El Chapo".

> *determinado las leyes de convivencia entre los habitantes, quienes han tenido que cambiar sus hábitos de vida para acostumbrarse a una situación de terror constante.* (Correa-Cabrera, 2013)

As previously stated, the criminal activity does not shadow the importance this border region has in relation to international trade, but it does highlight it. Nevertheless, citizens are affected together with their businesses. The violence and insecurity experienced in the past 10 years have delineated the lifestyle of the residents who live in constant terror.

Crossing the Border for Better Services

Crossing the border is a common practice for border residents. The Department of Transportation recorded 165.7 million people crossed nationally into the U.S. from Mexico in personal vehicles or as pedestrians in 2010 (News Digest, 2011). Laredo, TX received 593,509 vehicles from Nuevo Laredo in January 2017, in addition to the 246,044 pedestrians (International Bridge System, 2017). These individuals cross to the Mexican side of the border for different reasons including work, visiting family and friends, shopping, or receiving some form of medical care (Kilburn, San Miguel, & Kwak, 2013). According to Byrd and Law (2009) individuals are crossing back to the U.S. after receiving a medical treatment or purchasing medications in Mexico. Crossing the border for healthcare is common in the border region (Horton & Cole 2011, p.1846).

Landeck and Garza (2003) claimed that 41.2 percent of Latino households in Laredo have crossed to Nuevo Laredo for health purposes. According to Hopkins *et al.*, (2010) "the global nature of the cross-border medical care industry is recent and has developed rapidly" (p. 187). This influx of American residents is beneficial and supports Nuevo Laredo's economy (Kilburn, San Miguel, & Kwak, 2013), and it is uncanny that despite the living

situations experienced in Nuevo Laredo, residents from the American side of the border continue to cross into Mexico.

Some of the reasons why U.S. citizens travel to Mexico for health services are "the speed of care, quality, and friendliness and of course the cost, which sometimes is as much as 70 percent more economical" than the services in the U.S. (Charur, 2015). Care in Mexico "offers faster relief of symptoms than in U.S. care" and Latinos believe medications are more effective in Mexico (Horton & Cole, 2011, p. 1847). Macias & Morales (2001) posit, "Most studies have found that the high cost of health care in the U.S. is the reason why patients cross the border to Mexico for their health care" (p. 78). Furthermore, Bergmark, Barr, and Garcia (2010), found that "(1) unsuccessful treatment in the U.S., (2) the difficulty of accessing care in the U.S., usually due to cost or documentation status and (3) a preference for Mexican care" are other reasons why patients seek health services in Mexico (p. 612).

American patients do not cross to Nuevo Laredo because the medical services in the U.S. are poor; it is "the doctor and hospital systems that make them come here to seek specialists" (Charur, 2015). Horton and Cole (2011), stated patients preferred care in Mexico because of the "rapidity of both diagnostic tests and therapeutic treatment" (p.1850), while "a patient may have to wait months to see a specialist" in the U.S. (Charur, 2015). In this regard, it makes more sense to cross into the Mexican side of the border and receive swift and timely medical attention and results.

Byrd and Law (2009) were interested in learning the motivation of El Paso, TX patients crossing the border to see a medical practitioner and found that visiting the medical facilities in Mexico for low cost had the highest percentage followed by the availability and accessibility to obtain an appointment. Eighty percent of the participants in this study said,

"doctors speak[ing] Spanish in Mexico" (Byrd & Law, 2009, p. 97) was also an incentive to visit a Mexican medical doctor. Similarly, Bergmark, Barr and Garcia. (2010) posited, "health professionals said their patients also preferred the quality of care in Mexico because they did not have any language barriers there" (p. 613). Language is an important factor since many Mexicans and Latinos living in the U.S. side of the border feel more comfortable speaking Spanish. This is an important cultural factor that makes patients feel comfortable and pleased with Mexican medical services. Overall, Byrd and Law (2009) found that, "when asked about their satisfaction with medical care in Mexico, 89.4 percent reported being 'very satisfied' or 'satisfied' with the care" (p. 97).

Border medical practitioners experience unique tensions that have been understudied. The clash between their work and personal lives can be difficult to manage because of how confining each can seem. A balance becomes almost impossible. In addition to this, doctors' emotions are rarely considered. Doctors reach out for emotional labor techniques involving acting to hide emotions and provide the desired medical service. Border doctors also have unique experiences compared to other doctors in Mexico and the U.S. because of the criminal activity presence in Nuevo Laredo. This influences their work practices and causes an added stress and pushes them to practice caution that involves increased security measures.

Patients and doctors come from different social groups. Communication accommodation theory (CAT) proposes that the interaction between different social groups calls for the medical practitioners to make an adjustment on verbal and non-verbal communication in order to accommodate to the patient (Giles, Coupland & Coupland , 1991). Health providers and patients speak different languages and are members of different groups; they have dissimilar perceptions on healthcare and differ in educational level or status

(Wright, Sparks & O'Hair, 2013). CAT suggests communication styles will be influenced by the perception of members of the out-group "adapting the communication in a way in which we emphasize similarities (Wright, Sparks & O'Hair, 2013, p. 31). This is called *convergence* (Wright, Sparks & O'Hair, 2013) and it is widely applied by the doctors on the border. They want their patients to be informed and feel comfortable with the procedures. By using simple terms, the patients are knowledgeable and will stay calm.

Stumbling Over a Tight Rope: Is Work-Life Balance Possible?

Organizational communication scholar Stacey Wieland (2011) argues that research on work/life balance "illuminates how individuals manage and make sense of the mounting pressure between the demands of paid work and family life" (p.163). Researchers working within the sub-field of work-life balance to discover how men deal with job loss (Buzzanell &Turner, 2003), how mothers who are artists created boundaries to separate their maternal and artist duties while working at home (Jorgenson, 1995) and the complex position women experience while they are pregnant and experience maternity leave (Buzzanell and Liu, 2005). Wieland (2011) stated even scholars struggle coping with work endeavors in their personal lives. This literature helps illuminate the creative ways that individuals construct and navigate work and life.

Work-life balance is a relevant theoretical concept for this study since medical practitioners attempt to manage their personal and work lives. They have to assume and negotiate the identities of doctor, spouse, parent, and others. Clark (2000) defines work-life balance as "satisfaction and good functioning at work and at home with a minimum role conflict" (p. 751). Conversely, Sturges and Guest (2004) confront this ideal definition and

mention the possibility roles and domains being incompatible, causing conflict. If work roles mix with non-work roles conflicts can arise.

Greenhaus and Beutell (1985) defined work family conflict as form of role combination struggle where family demands do not let work demands be fulfilled and vice versa. Specifically, they recognize three forms of work-family conflict. First, time-based conflict prevents the demands being accomplished due to the lack of time devoted to demands of one domain in comparison with the other. When tension, dissatisfaction, anxiety and fatigue are caused from one domain and do not let the other domain's demands be met, the second conflict they proposed, strain-based conflict, occurs (Repetti, 1987). The final conflict Greenhaus and Beutell (1985) proposed is behavior-based conflict. This form of conflict is present when the development of behaviors from one role does not match the other; individuals are not able to modify their behavior when transitioning from one role to another (Greenhaus & Beutell, 1985).

Edwards and Rothbard (2000) described linking mechanisms as the existing relationship between work and family constructs: accommodation, compensation, resource drain, segmentation, spillover, work family conflict, work family enrichment, work family integration (Barnett, 1998; Edwards & Rothbard, 2000; Friedman & Greenhaus, 2000; Greenhaus & Beutell, 1985; Greenhaus & Parasuraman, 1999; Lambert, 1990) and border theory (Clark, S. C., 2000). These linking mechanisms disprove work and family are independent (Blood & Wolfe, 1960; Dubin, 1973). Edwards and Rothbard (2000) define a linking mechanism as a relationship between a work construct and a family construct. Linking mechanisms can exist only when work and family are conceptually distinct. Some of these linking mechanisms were present throughout my study.

Spillover occurs when work and family generate similarities (Burke & Greenglass, 1987) with a positive association between both domains' satisfaction (Gutek, Repetti & Silver, 1976). Recent organizational research from Morgan and King (2012) suggests that "there is considerable conflict between work and family responsibilities with experiences at work spilling over into the family role and vice versa and can illicit certain emotional responses" (Bochantin & Cowan, 2016, p.367). Doctors may find themselves experiencing spillover when their spouses are medical practitioners as well. The line between work and life becomes blurry since they find themselves talking about work while in the family domain. In addition to this, spillover happens whenever doctors experience a misfortune, for example a family member passing away. Compensation, on the other hand, is another mechanism confronted by medical practitioners. Doctors attempt to defeat dissatisfaction in one domain by using their free time to gain pleasant experiences in the opposite domain (Burke & Greenglass, 1987). Burke and Greenglass (1987) define segmentation as the separation of family and work domains achieving the avoidance of conflict between them. Doctors may be able to separate both domains completely; this is hard to achieve but not impossible. When medical practitioners allocate personal resources such as time, attention and energy from one domain to the other, causing conflict, resource drain prevails. Managing to give equal time to both family and work-life can be challenging.

According to Greenhaus, Collins and Shaw (2003), work-family balance is "widely cited in the popular press" (p. 511). These same scholars state that "sometimes [work-family balance is] used as a noun (when, for example, one is encouraged to achieve balance), and other times as a verb (to balance work and family demands) or an adjective (as in a balanced life") (p. 511). Medical practitioners dedicate a great amount of time to their jobs. It is known

that in some medical areas the line between work and life is blurry since their jobs tend to be 24/7. Oftentimes, doctors must also attend to patients' calls at unusual hours.

Work-life balance represents professionals taking time off work to spend time with family (Greenhaus, Collins & Shaw, 2003). In the case of medical practitioners with a 24/7 job, this might be challenging but not impossible. Kofodimos (1993) argues that work-family balance represents an individual's desire to have a balanced life. Medical practitioners' aspiration to equilibrium brings them close to achieving work-life balance. Nevertheless, "the measurement of balance is problematic, and the impact of work–family balance on individual well-being has not been firmly established (Greenhaus, Collins, & Shaw, 2003, p. 511).

Nonetheless, Edwards and Rothbard (2000) did not settle for a simple definition of this term since they did not believe balance formed part of a work-family linking mechanism. It is not clear how one's roles and experiences cause a conflict with other roles (Edwards & Rothbard, 2000). Conversely, Mead (1994) discusses the balance and ability to perform multiple roles. Moreover, Marks and MacDermid (1996), define role life balance as "The tendency to become fully engaged in the performance of every role in ones total role system, to approach every typical role and role partner with an attitude of attentiveness and care. Put differently, it is the practice of that evenhanded alertness known sometimes as mindfulness" (p. 421).

This definition focuses on a positive role balance, and Marks and MacDermid acknowledged there should be a distinction between negative and positive. Still, other researchers like Kirchmeyer (2000), keep focusing on a positive approach when defining a balanced life as a "satisfying [experience] in all life domains, and to do so requires personal resources such as energy, time, and commitment to be well distributed across domains''

(Kirchmeyer, 2000, p. 81). Medical practitioners find themselves deciding over work and life to fulfill the various roles all at once or separate them.

Not satisfied with the family and conflict research, Clark (2000) developed a new theory to fill in the gaps and criticism. The work/family border theory explains, "How individuals manage and negotiate the work and family spheres and the borders between them in order to attain balance" (Clark, 2000, p.751). Medical practitioners are border crossers, that transition from these two settings daily and try to keep a balance to accomplish the demands of each (Clark, 2000). They cross these borders between work, but they experience some type of advantage. Research has shown that "individuals who are in jobs where they have autonomy and ability to make choices [which is the case of the medical practitioners in my study] have been shown to be more satisfied and better adjusted at work and at home" (Clark, 2000, p. 759).

Doctors Have Feelings Too

Medical practitioners on the Mexican side of the border deal with the ongoing border violence and remain active in their practice despite of it. Arlie Hochschild (1983) shed light into the term emotional labor in her groundbreaking research in *The Managed Heart*. She defines emotional labor as "the management of feeling to create a publicly observable facial and bodily display"(Hochschild, 1983, p. 7). Doctors must manage emotions and be professional. Emotional labor became a prevalent topic within both sociology and organizational communication.

Zapf (2002) states the "concept of emotion work refers to the quality of interactions between employees and clients" (p. 238). According to Zapf (2002) 'client' refers to any individual interacting with the employee, for instance, patients, children, passengers, and

guests. His study focused on emotional labor and the relationships medical practitioners have with their patients (Zapf, 2002). Zapf (2002) stated “during face voice interactions, many employees are required to express appropriate emotions as a requirement” (p. 238). In the case of doctors, they are usually self-employed, and do not have a manager or head of an organization requiring them to express certain emotions. To strive in the workplace, they have to incorporate techniques of emotional labor. If doctors are tired or do not feel enthusiastic, they should not show it because this can create a negative image of their medical services.

Emotional labor has been employed and modified in a variety of research studies (Ashforth, B. E., & Humphrey, R. H., 1993; Morris, J. A., & Feldman, D. C., 1996; Brotheridge, C. M., & Grandey, A. A., 2002). Ashforth and Humphrey (1993) altered Hochschild’s definition to posit emotional labor as “the act of displaying the appropriate emotion (i.e., con-forming with a display rule)” which differs from Hochschild’s definition. They state, “We prefer to focus on behavior rather than on the presumed emotions underlying behavior because (a) as we noted previously, it is the actual behavior or compliance with display rules that is directly observed by and directly affects service recipients and (b) as we will discuss, one may conform with display rules without having to "manage" feelings” (Ashforth & Humphrey, 1993, p. 90).

Feeling rules (Hochschild, 1983) focus on the distinction between what an individual feels and what they should feel: Doctors should care for their patients regardless of their relationship with them. Medical practitioners must decide how to manage their feelings, and this will depend on the attachment they experience with their patients. Some doctors put

themselves in their patients' situation and this may affect their personal lives since they get worried about them.

Ashforth and Humphrey (1993) "prefer the term display rules (Ekman, 1973) to feeling rules (Hochschild, 1983) because the former refers to what emotions ought to be publicly expressed rather than to what emotions are actually felt" (Ashforth & Humphrey, 1993, pp. 89-90). Medical practitioners usually display emotions in a professional way when talking to patients during their medical visits rather than showing their true feelings. Ashforth and Humphrey (1993) posited that "because display rules refer to behavior rather than to internal states, it is relatively easy for customers, managers, and peers to observe one's level of compliance with the rules" (p. 90). These rules are crucial in a doctor's life in order to manage a work-life balance and their emotions at work. In case of those being negative, medical practitioners have to hide the emotions and take care of the patients' necessities over theirs without showing or expressing their genuine feelings**.**

Medical practitioners turn to acting techniques to look for a balance between their inner and displayed feelings. Ashforth and Humphrey (1993) argued that service providers comply with expression norms or "display rules" through surface acting, deep acting, and the expression of spontaneous and genuine emotion" (p. 89). Medical practitioners' personal lives could interfere with their working environment, and therefore act in order to provide a professional service without personal emotions. Service agents, in this case the medical practitioners, are expected to express certain feelings during their medical exchange, though this causes psychological effects on them (Ashforth & Humphrey, 1993, pp. 89-90). Likewise, "Hochschild's deep acting is a means to attain the goal of organizationally desired

emotions; therefore, Hochschild's and Ashforth and Humphrey's definition do not seem to be really contradictory" (Zapf, 2002, p. 239).

Emotional labor is present on medical practitioners' everyday lives since they attempt to be empathic and put themselves in the patients' shoes to be able to understand them. They provide their services, but the feelings involved at work interfere with their personal lives because there is a lack of balance between them. Regardless of feeling tired, stressed or sad, they approach patients in a professional manner and take care of their needs as if they were their first patient of the day. Medical practitioners in the border experience these mixed feelings and go through acting techniques at some point. The management of their emotions, together with their patients' emotions potentially causes them to have an unbalance. Doctors at times act as consultants and psychologists for their patients. They not only provide a consultation, but also talk to them and hear them out. This is why it is important to understand how medical doctors on the border manage the emotions of work as well as the demands of their occupation.

Moreover, Hochschild (1983) underlines significant differences between gender and emotional labor. She argues that some cultures call women to focus on their feelings instead of their actions much more than man. Both genders treat feelings about bodies, and even patients who are used to impersonal treatment often feel disappointed if the doctor does not seem to care enough (Hochschild, 1983). Moreover, she underlines the importance of cultures inviting "middle class occupations to manage feelings in service jobs," defining their status on the social landscape (Hochschild, 1983, p. 57). Doctors are trained to show care for the patients and invite trust (Hochschild, 1983).

A medical practitioner's job involves emotional labor. Hochschild (1983) shares three characteristics of these kinds of jobs; two fall in line with medical practitioners' job duties. Emotional labor involves face-to-face or voice to voice contact with the patient (Hochschild, 1983). A second characteristic is the requirement for a worker to produce an emotional state in another person or patient (Hochschild, 1983). Doctors have to present alarming information or bad news and this causes patients to worry or feel scared; doctors help the patient manage those feelings (Hochschild, 1983). They experience a plethora of emotions including stress, excitement, sadness, and at times, even depression. They must keep their patients calm and convey feelings of trust and relaxation, causing an emotional impact.

Furthermore, contagion is experienced by doctors and this leads them to acting techniques. Hatfield, Cacioppo, and Rapson (1993) posited the definition of contagion as "as the tendency to automatically mimic and synchronize expressions, vocalizations, postures, and movements with those of another person's and, consequently, to converge emotionally" (pp. 153-154). Doctors experience anxiety and stress because they care for their patients and these sentiments' outcome is emotional contagion. Contagion occurs at an unconscious level; it is an involuntary reflex (Hatfield, Cacioppo, & Rapson, 1994; Neumann and Strack, 2000). People mimic their feelings and worries and after many years these negative feelings can lead to burnout. Iacovides *et al.* (2003) quoted Maslach (1976) who "gave perhaps the most comprehensive definition for [burnout], incorporating the physical as well as the mental exhaustion observed in every professional whose work needs continuous contact with other people" (p. 212). Some doctors have worked for over 35 years and they are already planning their retirement, while others want to work until they are incapable of doing it.

Instances where emotional labor or unbalanced work and life experiences are present can result in burnout and dissatisfaction for the job. Hochschild (1983) proposes three stances employees take on their jobs on their own risk:

> In the first, the worker identifies too wholeheartedly with the job, and therefore risks burnout. In the second, the worker clearly distinguishes herself from the job and is less likely to suffer burnout; but she may blame herself for making this very distinction and denigrate herself as "just an actor, not sincere". In the third, the worker distinguishes herself from her act, does not blame herself for this and sees the job as positively requiring the capacity to act; for this worker there is some risk of estrangement from acting altogether, and some cynicism about it—"We're just illusion makers." (p.187)

To reduce the harm from these stances, Hochschild (1983) proposes workers should "feel a greater sense of control over the conditions of their work lives" (p.187). Medical practitioners show great passion for their job, but the unbalance could create a sense of resentment towards the job. To prevent this resentment, some medical practitioners "develop a "healthy estrangement, a clear separation from self to role. They clearly define for themselves when they are acting when they are not" (p. 188). These medical practitioners are able to distinguish deep acting from just a show (Hochschild, 1983). They strive to achieve this balance and keep working until they have to retire.

Research Questions

This study seeks to contribute to the work and life literature by understanding the work experiences of medical doctors on the U.S.-Mexico border. Specifically, it aims at understanding how border medical practitioners negotiate between their work and personal life. At times they might experience various negative emotions they feel they should hide. As they care for patients, doctors reach for acting techniques involving emotional labor. In addition, the violence and criminal activity in Nuevo Laredo influences their work practices as they enact certain security measures. This generates stress that could impact their daily

work practices. With a thematic analysis of 12 interviews with medical practitioners from Nuevo Laredo, the following research questions will be answered:

RQ1: What are the work-life experiences of Mexican medical practitioners working on the TX-Mexico border?

RQ2: How do Mexican medical practitioners working on the TX-Mexico border experience emotion at work?

Methodology

In order to obtain a "deep understanding of human actions, motives and feelings" (Lindlof & Taylor, 2011, p. 9), I opted for a qualitative research method. Qualitative methods are used to describe and understand the lived experiences through "thick description" (Geertz, 1994). This form of research allows for a rich understanding of participants' voices. Qualitative research methods generate useful knowledge "through prolonged immersion in actual social settings and extensive interaction with other participants" (Lindlof & Taylor, 2011, p. 9). I was able to interact with the participants and obtain different perspectives from their lived experiences. Interactions with the participants were 28 to 66 minutes and conducted in a comfortable setting where they could expand on their shared experiences.

In this study, theory is developed inductively, which means the explanations are "tested against knowledge gained from the ongoing interaction with other participants" (Lindlof & Taylor, 2011, p. 9). Qualitative methods have helped preserve the integrity of the relationship and interaction between patients and doctors, redirecting the "agency in medical encounters" (Lindlof & Taylor, 2011, p. 19).

Through in-depth interviews, doctors shared their experiences and work practices in detail. These experiences were then analyzed thematically with particular attention to how medical doctors manage emotions. Interviews supports the data collected from quantitative methods such as surveys and help capture "the ground truth" (Gillespie, 2001; Sharf & Street, 1997). Interviews offer access to rich information and experiences help answer research questions

Interview protocol

The interview protocol was carefully crafted to answer my research questions. Questions concerning participants' work-life experiences, emotional labor techniques, and consequences of violence in their work practices formed part of a 28-question protocol for semi-structured interviews. The following are examples of questions in the interview protocol: Delivering bad news can be a difficult part of your job, can you tell me about that? How do you cope with this? How has this changed over the years? What is your experience working in a city where crime and violence are predominantly present? Tell me about an unfortunate situation you have faced due to the violence and insecurity in our city? (See Appendix A for full interview protocol)

The interview protocol was approved by the Institutional Review Board at Texas A&M International University. Conversations were diverse as several follow-up questions were conveyed. Each doctor richly contributed with input on the various topics addressed depending on their experience. Consent forms were required, and they provided information about the project and contact information in case of any questions or concerns. Appointments were made with the doctors at their private practices, Texas A&M

International University, or a local coffee shop. A total of approximately 10 hours of interviews frame the database for the project.

Elements of In-depth Interviews

In-depth interviews were utilized to obtain a full perspective from the participants. This type of interview provides meaning to the experiences shared by the medical practitioners. In in-depth interviews, both interviewer and interviewee are active: instead of asking a single question and expecting a single answer, the interviewer follows up with questions and comments on the experiences to evoke stories and openness from the interviewee (Riessman, 2008).

Through in-depth interviewing practitioners narrated their work and life experiences (Lindlof & Taylor, 2011). One interview question would evoke further stories, and the participant expanded on them. For example, when the topic of the border violence emerged in the question: *¿Cuál es su experiencia al trabajar en un ambiente donde la delincuencia está infiltrada en Nuevo Laredo?* / What is your experience working in a city where crime and violence are present prominently? Dr. Ramon and Dr. Mario narrated their experiences of being kidnapped. Other doctors like Dr. Flor and Dr. Juanita shared stories detailing robberies in their medical practices.

The goal of an interview is to gain explicit experiences instead of brief and broad statements (Riessman, 2008). Furthermore, each interview "verif[ied], validate[d] and comment[ed] on information obtained from other sources" like journal articles, or news stories (Lindlof & Taylor, 2011, p. 175). In some cases, data collected with interviewees supported statements made by additional participants. I achieved saturation after the twelfth interview; saturation is defined by Morse (1995) as the collection of data until "no new

information is found" (p. 147). Guest, Bunce and Johnson (2006) stated saturation has, in fact, become the gold standard by which purposive sample sizes are determined in health science research. Morse (1995) also expressed "saturation is the key to excellent qualitative work" however, he also admitted "there are not published guidelines or tests of adequacy for estimating the sample size required to reach saturation," yet it is still considered the best measure of qualitative data collection (p. 147).

In total, I interviewed 12 medical practitioners across a variety of ages, genders, and areas of medical expertise. Seven participants were male and five were female. The participants' ages ranged from 30 to 85 years old (see Appendix B for full demographic information). All of my participants practice in Nuevo Laredo, Tamaulipas and work in their private practice and/or local Mexican hospitals.

A key informant or gatekeeper (Lindlof & Taylor, 2011, p. 8) gave me access to most of the doctors I interviewed. According to Tremblay (1957), a key informant is "used primarily as a source of information on a variety of topics" that are relevant to the study (p.688). They are the ones who "stand guard on the "gate" the researchers would like to enter (Lindlof & Taylor, 2011, p.98). Data collection would have been even more challenging without a medical doctor introducing me to other practitioners. This in turn gave me credibility and provided a line of trust between my participants and me. I felt if I would have approached them they might have been unsure of whether to accept or not.

Two interviews were conducted in Laredo, Texas. I conducted those interviews in the library of Texas A&M International University and at a local coffee shop. I crossed the border to conduct 10 interviews, which took place in the doctors' private practices. A "protected place" (Lindlof & Taylor, 2011, p. 188) is required to conceal the privacy of the

participants and avoid interruptions of any kind. Conducting the interviews in their private practice made sense since it was the best location for privacy. However, in hindsight, alternative locations could have made the interviews less chaotic. For example, medical practitioners' phones interrupted the interview sessions on multiple occasions. At the same time, these interruptions enabled me to surmise that their job seems to be never ending.

All interviews were conducted face-to-face and were recorded on my personal iPhone. Pseudonyms were used to protect the practitioners' identities. Nine were chosen by my participants and in three cases, I chose their pseudonyms since they did not have a preference. As I listened to each interviewee, I took notes that assisted me when I conducted other interviews. I recorded their reactions and the answers that were repeated consistently. Because they felt more comfortable speaking in their native language, all interviews were conducted in Spanish. It is my first language as well and did not mind conducting the interviews in Spanish.

Because practitioners work around the clock and have an extremely busy work schedule, I realized it would be difficult to ask for a predetermined amount of time. Lindlof and Taylor (2011) suggest it is important to have a "protected time" when the participant has a free period and is not in a hurry (p.188). In some instances, I waited for hours in their private practices until they were not busy with a patient. Some doctors offered to answer the interview between patients, but I advised them I did not mind waiting until they had an hour of their time. I did not want to interfere with their work schedule and it also seemed unfair to make a patient wait. The shortest interview lasted about 28 minutes and the longest interview was 67 minutes. I transcribed all 12 interviews verbatim to facilitate the coding

process. After conducting the interviews and transcribing the data, I began analyzing the data to answer my research questions.

Thematic Analysis

I chose a thematic analysis as a form of data analysis. A thematic analysis is a narrative method focused on content and keeping it intact (Riessman, 2008). This type of analysis The interview responses were not altered from its original delivery. Narrative analysis is used in different disciplines to carry a variety of meanings and it is usually used as a synonym for storytelling (Riessman, 2008). For this study, I did line by line coding which helped me keep data organized by topics. This kind of analysis seeks meaning making and is a common practice for qualitative research. A thematic analysis of the interviews was the best method to understand my participants' experiences about work and life: . Through stories, I was able to offer meaning-making and thick description (Geertz, 1994; Lindlof & Taylor, 2011). Doctors relayed their experiences through in-depth interviews and I then analyzed the meanings embedded in these experiences.

Coding

I coded all 12 interviews by hand and without any software to facilitate the process. I wanted to be meticulous and in order to maintain a sense of closeness to the data. After thoroughly reading the interviews *352 codes* emerged. Some examples of codes are "anxiety", "frustration", "contagion', "passion", "stress" "kidnaping", "precaution" and extortion. The first codes turned into the category called "Feelings doctors experienced" And the second group turned into "Consequences of Violence." After the initial coding process codes were turned into *16 larger categories* by deciding which codes were closely related. The first group of codes turned into the category called "Feelings Doctors Experienced"

while the second became “Consequences of Violence.” Other examples of categories are border life, consequences of violence and coping. I used the constant comparative method through an iterative approach by looking at the data and the codes simultaneously. According to Srivastava and Hopwood (2009), “the role of iteration, not as a repetitive mechanical task but as a deeply reflexive process, is key to sparking insight and developing meaning” (p. 77). Furthermore, by using this method I visited and revisited the data to connect and reach a deeper understanding of the stories (Srivastava &Hopwood, 2009). I kept stories that were closely related together when creating categories to maintain their integrity. These categories were then raised and analyzed further to generate themes that will serve as chapters for this thesis: “Interlocking Life and Work on the Border” and “Doctors and Feelings” go together like bread and butter.

Positionality

Sanghera and Thapar-Björkert (2008) have argued that positionality consists of “the way in which others position the individual identity and affiliations he/she may have” (p. 553). These positions may influence whether the researcher attains positionality as an ‘outsider’ or an ‘insider’ (Sanghera & Thapar-Björkert, 2008). I was an outsider, but I could also be seen as an insider because a member of my family is a medical practitioner in Nuevo Laredo. Consequently, throughout my life, he gave me access the hardships and advantages a doctor experiences. This made me well aware of my own positionality. The life of a doctor requires sacrifice. I understood doctors work late hours throughout the week and sometimes miss family events. Some medical areas do not have a set schedule. Nevertheless, the job also brings satisfaction. Their main goal is to help their patients.

This familiarity is valuable for my study to understand the doctors' work and life experiences. However, knowing this information kept me cautious; I did not want my own experiences to lead me to deductions of what they wanted to say. This is why I was extremely attentive when conducting the interviews and analyzing the data. During the interviews, I listened carefully without interfering or interrupting to finish their sentences. As much as I tried not to interrupt it occurred a couple of times but each time I asked for further information to make sure I understood their message.

CHAPTER II

ANALYSIS: INTERLOCKING LIFE AND WORK ON THE BORDER

Border doctors shared their experiences openly, and I was able to analyze their stories thoroughly to answer my first research question. I wanted to know how border doctors manage their personal and work lives since they face challenging occupational conditions. Achieving and maintaining a balance is challenging and difficult to attain; therefore, I wanted to understand their experiences within those domains.

Uniqueness of the Border Region

The border region is attractive to medical practitioners for different reasons. Several participants have a strong connection to the border since it is their hometown and were raised in Nuevo Laredo. Despite the negative image, the border has acquired over the years, and the stories about violent acts, my participants cherish their city and remain working in Nuevo Laredo. Several doctors continue to live on the border because it is their natal city and want to succeed and provide service to their community, and others remain in Nuevo Laredo because of economic benefits the border and patients from the U.S. provide. At the same time, there are also the benefits to accessing medical equipment from the U.S. for a cheaper price that keep them from leaving. Even though several participants have had negative experiences, they have continued working on the border.

Both Dr. Mario and Dr. Maria recognize working in the border gives them access to the best of both worlds, referring to both countries. Dr. Mario mentioned the advantages of working in the border. Practitioners can order material and equipment from Laredo, TX for a cheaper price. Doctors' interest in working and living on the border is interesting. These two

doctors have experienced negative occurrences but still recognized the benefits the border provides, and according to Dr. Mario, the good outweighs the bad.

Dr. Maria, originally from Monterrey, Nuevo Leon, chose to work in the border instead of Ciudad Victoria because she and her husband saw great possibilities. "S*iempre vimos que en la frontera había más posibilidades de desarrollo."* She has a positive view of the border region. She takes advantage of having access to Laredo, TX; she orders material and artifacts from the U.S. "*Definitivamente el que tienes el acceso a material con el que trabajas a muy fácil y a costos más bajos…tienes acceso a una tecnología de primer mundo mucho más rápida que si la adquieres en México. Te evitas los costos de importación y sobretodo que adquieres el material muy rápido."*

She believes she has an advantage over doctors in other parts of Mexico because they do not have the U.S. technology they have. "*Entonces tienes acceso a una tecnología de primer mundo mucho más rápida que si la adquieres en México… Yo considero que es la mayor ventaja, donde ventajo un poquito más a los médicos de Monterrey o de más al sur."* None of these benefits were enough to keep Dr. Maria in Nuevo Laredo, since she moved to the U.S. six years ago after experiencing several phone extortions and threats. She did not want to wait for something worse to happen and decided to take her family to a neighboring city. She stated, "*...si llegan a tu oficina y llegan con fotografías de tus hijos de tu casa este con eh cuestiones muy cercanas muy personales y que de repente lo sepan entonces empiezan a amenazarte a pedirte dinero para que a tu familia o a tus hijos no le pase absolutamente nada."*

She kept working in Nuevo Laredo, and her kids continued studying in Nuevo Laredo. However, she felt safer in Laredo even though others believe the border does not

prevent bad things from happening. Five out of 12 doctors thought of moving to Laredo, TX at some point, but only two went through with their plans. Dr. Laura shared she would like to do it because she feels safer there. It is still in her plans for the future, "*Si claro que sí, yo creo que eso es algo que pasa por la mente de toda persona que vive aquí en nuevo Laredo, el hecho de poderte ir a vivir a Laredo TX y la verdad si he ido varias veces verdad, pues a comer más que nada a comer, pasar tiempo allá. Y las veces que me ha tocado ir sí, la seguridad que sientes allá es impresionante, o sea no hay comparación y si ha pasado por mi mente algún día poderme ir para allá."*

Dr. Ivana studied in Monterrey, Mexico for ten years and after she finished she came back to Nuevo Laredo. She always had the desire of working in Nuevo Laredo like her father. Dr. Ivana also liked the fact that Nuevo Laredo is small since in bigger cities "*malbaratas tu profesión,*" meaning that employers pay less for the service provided. On the border, doctors have the freedom to decide what their services are worth. Still, they do not charge too much, especially while competing with U.S. expensive service. They prefer to charge less to obtain more patients.

Dr. Laura is a special case since she arrived to the border two years ago. She is originally from San Luis Potosi, Mexico and began working on the border looking for work opportunities, after visiting a job fair at her university. "*En esa feria de plazas las mejores opciones estaban aquí en la frontera y por eso decidimos venirnos para acá para la frontera."* Dr. Laura, who is not from the border, recognizes its benefits, but also mentioned the counterpart, which is the violence, as the disadvantage of working in the border. Fortunately, she has not experienced any criminal activity. Dr. Laura appreciated the patient

influx from the U.S. She referred to the Hispanic patients coming from the U.S. as "*amigable[s]… [gente]muy placentera…yo he tenido una buena experiencia."*

Dr. Roberto recently graduated and has been working for less than a year. He is from Nuevo Laredo and heard positive things about the influx of patients, but knows there was a greater amount of patients coming from the U.S. before the violence. "*Antes había mucho más trabajo en la frontera, venia más gente de Estados Unidos."* He has positive thoughts about the border area and said nowadays things are getting better. He is cautious and takes care of his surroundings at all time to prevent anything negative from taking place. In the recent months, patients from U.S. have been losing fear since the violence is not as prominent as it was in 2002 or 2011 (Rodriguez, 2011; Sevigny, 2002). "*Ha ido agarrando confianza el paciente Americano."* Financially, he likes the outcome of his practice. Being close to the U.S. has an economic benefit in comparison with other Mexican cities. The last benefit he mentioned is accessibility to education. He wants his kids to study in a school in Laredo, TX.

The participants had mixed feelings about the border but overall, they mentioned substantial positive commentary about their city even though many experienced a violent act towards them, their families, or their patients. These situations incite the doctors to consider modifying their work practices. They must be cautious. As much as they like the border it is considered a dangerous place. In the following section these varying work practices are discussed.

Border Medical Services Worth Paying

Discussions of the differences between Mexican and American medical services prevailed throughout the interviews. Practitioners shared their opinion and their patients'

views on the matter. For example, Dr. David expressed his disdain for medical services in the U.S. by stating the service is not always available for patients, "*El servicio es muy malo, ¿Por qué? Porque hay por ejemplo, vamos a suponer yo en mi especialidad llega un niño quebrado un viernes con una manita quebrada…y que se tiene que atender…si es viernes, el sábado y domingo no hay de guardia traumatólogos entonces tiene que esperarse hasta el lunes o martes. Entonces esos niños son los que vienen para acá y aquí los atienden."* Furthermore, Dr. Laura shared a patient's opinion. "*Sí, he escuchado también comentarios con respecto a ginecología. Ginecología porque hay muchas personas de aquí de México que van y se atienden allá en estados unidos, entonces comentan que por ejemplo allá el ginecólogo no les hace más de dos o tres ultrasonidos durante el embarazo. Y acá mínimo una vez por mes. Todas esas cosas son las que marcan la diferencia."*

Mexican medical services seem to be much more patient-centered than the services acquired in the U.S. (Hirsh *et al.*, 2005). According to Hirsh *et al.* (2005), patient-centered communication emphasizes the patient being a "whole person" in relation to their psychological and social circumstances. U.S. medical services were described as fast and frivolous or as Dr. Juanita, Dr. Ramon, Dr. Mario, and Dr. Arturo said, *frío,* which can be connected to the biomedical approach in health communication, which is a medical approach based on evidence and the scientific method through laboratory tests leaving aside the patients' concerns and doubts (Schreiber, 2005; Tyreman, 2006). Doctors use the word *frío* to refer to the American service as insensible and fast-paced. According to Dr. Polo, U.S. doctors care more for the financial outcome and see the service as a business and not a relationship between the patient and them. American or Latino patients coming from the U.S. are not used to this service and are very grateful for it. Dr. Polo shared, "*El Latino del lado*

Americano, prácticamente siente la medicina como los acostumbran los Americanos, que son un número, que necesitan tener un seguro de gastos médicos, que ellos no pueden esperar nada más mas que la solución de su problema y se acabó. No puede haber amistad [o] una personalización de su problema. Ellos son técnicos, 100% técnicos…hacen lo que tienen que hacer y ahí termina. Es una relación prácticamente de business*, de trabajo."*

The quality and affordability provides patients on the US-side of the border a reason to cross and obtain health services in Mexico. Practitioners in Nuevo Laredo receive patients from Laredo, San Antonio, and Dallas, TX amongst other cities. Patients travel for hours to receive the preferred service. Some of the doctors shared rewarding experiences. Dr. Polo has a client that frequently sends injured employees because he is always satisfied with the service.

> *…ellos se accidentan y me habla [James] desde Houston [que] es anglo, y me dice: "Oye te vamos a enviar [a] dos trabajadores de nosotros, para que los sutures"… Simple sutura. Entonces yo le dije una vez: "Oyes James y ¿Por qué no buscas un doctor allá?" y me dice: "Mire doctor, cuando nosotros venimos a buscar un doctor nos dejan en urgencias más de 6 horas, ¿Sabes cuánto me tardo en llegar a Laredo? 5 horas. En menos de eso tú me los estas atendiendo y reparando… me sale más barato[y] me dices las cosas como son…*

Dr. Polo thought Houston was too far to travel to fix minor health problems, but James believed it was a benefit for the employee due to the treatment they receive. This is a benefit because it is cheaper and better and he also protects himself from legal action. James said, "*Para nosotros cuando nosotros enviamos un trabajador, el trabajador de agradecimiento sigue trabajando con nosotros nunca nos demanda, nunca pasa nada. Entonces nosotros te vamos a seguir enviando trabajadores."*

Dr. Polo recognized the advantages they currently experience. The U.S. services are very expensive ("*estratosfericamente*[4] *caros")*. Dr. Polo mentioned he read a study where there are 400 million people without health care in the U.S. This misfortune becomes a benefit for the doctors on the border since people in the U.S. come to Mexico for a cheaper and more personalized service, "… *en cuanto a sentido humanitario, entre cariño y buen trato del paciente, yo creo que nosotros somos mucho mejores que en cualquier parte*."

Dr. Roberto took care of a Houston patient who was fascinated by the services. He was only doing his job, but she felt the treatment and care were extremely personalized. The patient said she had never experienced this kind of service. Dr. Roberto stated, "*Aquí sale tres veces más barato que en Estados Unidos. Y a pesar de que ella nunca había estado en México y había cruzado se sintió muy a gusto con la atención del personal del hospital. Dice que en su vida la habían tratado así enfermeras y personal hospitalario… nunca había tenido una atención médica como la tuvo acá en cuanto a calidez en que le explicaran lo que le iban a hacer."*

She complimented the human warmth she felt while she was in the hospital. There is a difference in service because Mexican doctors take close care and treat patients accordingly, not like a number or a source of income. Dr. Flor's patients told her it takes a long time to see a specialist, especially with the time spent consulting with the nurses. According to Dr. Flor, patients have limited time to see the doctor, which is another reason they prefer to take the extra effort and cross the border into Mexico. Patients feel like it is a clinical experience instead of personalized and patient-centered relationship, which is what they look for and prefer.

[4] Estratosféricamente: word used to describe something big. In this case the doctor said the American service is too expensive.

My participants go the extra mile for their patients in order to offer outstanding medical services. They seem more inclined to using the psychosocial model proposed by Engel (1980) as opposed to the biomedical model. George and Engel (1980) stated a psychosocial model "enables the physician to extend [the] application of the scientific method to aspects of everyday practice and patient care heretofore not deemed accessible to a scientific approach" (p. 535). A clear example is Dr. David, who personally calls his patients to check up on them. Doctors are not required to do this, but he likes to show that extra care for his patients. This builds trust and the doctor-patient relationship is nurtured. The patients know their doctors care about them and will do the best to solve their problems. Dr. David's patients appreciate his calls, "*Muchas pacientes vienen de allá porque les gusto como se [les] trató. Porque…veo un paciente y pasan dos tres días y…yo les hablo "¿Cómo estás? ¿Cómo te sientes?" Entonces el paciente sabe que se interesa el doctor por el [suena el celular] porque si no creen que nomás va uno [el paciente] a darles el dinero."*

According to my participants' experiences, the Mexican culture has been defined as warm. Dr. Mario mentioned, "*Damos la bienvenida, somos más fraternales con el paciente."* Mexican doctors like to engage in small talk with their patients and give them their diagnosis without any technical jargon, so they can understand. Patients prefer this over any technology offered in the U.S., "*Tienen seguros médicos que les cubren sus procedimientos. Sin embargo, prefieren venir con nosotros, cruzar la frontera…porque le voy a brindar un tiempo. Ellos no están acostumbrados a que…les expliques la situación. Ellos dicen: "Allá el doctor es muy frío, muy cortante… [Solo me puede ver] 5 o 10 minutos, y no me va a dejar que le haga preguntas como usted."* My participants' patients prefer the service over their

comfort of staying in their hometown. They know if they come to the border, they will receive a service worth paying for.

Furthermore, doctors could not help to use the word *tacto*[5]. Dr. Laura shared the patients feel cared for in Mexico, especially the patients coming from the U.S. They often feel surprised with the medical services since the specialist has much more physical contact with the patient. Dr. Laura has children and believes it is important to render services the same manner, as she would like to receive from a medical doctor, "*Nos gusta mucho revisar al paciente, quitarle la ropa, tocarlo. Allá por ejemplo nos comentan mucho de aparatos…eso me ha dicho la gente "…allá ni siquiera lo tocaron"…la gente se va contenta con los tratos que han tenido."*

Similarly, Dr. Ramon puts himself in his patients' shoes to provide the best service possible and always thinking of his daughters. He expressed"*…yo siento que la mama…cuando los salvas…te ve como si fueras Dios… como es algo muy preciado para la mama, un tesoro porque yo también soy papa, pues realmente entiendes que te ve y la señora te ve como si fueras Dios pero al final de cuentas uno hace el entrenamiento que tiene."* The fact that some patients think of doctors as gods puts pressure on them. However, the patient must understand that sometimes things do not go as planned.

The word *frío* and fast were common words used to describe U.S. medical services. Dr. Laura heard comments about the OGBYN services in the U.S. According to Dr. Laura patients are not screened enough with an ultrasound during pregnancy. In Nuevo Laredo however, doctors check on patients at least once a month. According to my participants, services in the U.S. are quite limited. Even one of the participants, Dr. Ivana, experienced a pregnancy in the U.S. and she shared it was a scary experience.

[5] This word was translated to bed side manners.

> *…la primera vez que yo me atendí en Estados Unidos fue una cesárea programada. Para empezar te atiende un anestesista ¿Qué es eso? Un técnico que no es el que estudio, el que sabe. En mi primera experiencia yo convulsione, a mi bebe se lo llevaron a terapia intensiva por un descuido anestésico… en la segunda cesárea, yo iba con miedo. Yo como paciente y como doctora, yo iba con miedo hacia la anestesia… esa es la ventaja de estar en México, que te atiende un profesional no un técnico [exaltada].*

A Patient-Centered Culture

Drs. Flor and Ramon agreed that the U.S. culture is used to lawsuits. This is why they believe doctors have to act defensively. They avoid contact with the patient. If the patient does not feel satisfied with the service or if something goes wrong, which can happen, patients have easy access into suing the doctor. Dr. Flor said "*es una medicina muy a la defensiva."* Furthermore, Dr. Ramon shared the experience of a friend that practices medicine in Laredo, TX., "*En Estados Unidos es la ciudad de las demandas y allá todo lo que yo diga va a ser usado en mi contra. Si yo estuviera trabajando allá yo no estuviera platicando tanto. Aquí uno explica qué tiene, por qué le dio [y] qué le va a pasa… [Porque aquí] no hay tanta demanda.*"

There are many reasons why the Mexican medical services my participants offer are preferred. According to my participants, no technology or fancy hospital can compare to the personalized treatment received in Mexico. Medical practitioners expressed that patients continue to have faith in them. Additionally, the prices are much more reasonable, and three participants acknowledged that they do not care so much for the money they earn as long as they continue providing good services and leaving the patient satisfied. According to my participants, their patients are grateful and this is gratifying for the doctors.

> Dr. Juanita*: No lo haces por estarles sacando dinero ¡No! Lo haces por darles una buena atención…yo creo que por eso viene mucha gente para acá.*

> Dr. Ivana: *Algunas veces hasta se me olvida tengo no se mucho dinero ahí en los hospitales porque se me olvida ir por ellos y algunas veces no es por ganas si no es por hacer.*
>
> Dr. Mario: *Yo veo mucha consulta y tengo muchas consultas yo creo veo 15 en la mañana y 15 en la tarde pero…yo a todo el que pueda lo ayudo, y si no tiene dinero no hay ningún problema. Yo creo que eso te llega por otro lado.*

Each doctor expressed their love for the profession and how their number one priority is to provide good medical services and earning not money. Of course, money brings the doctors benefits, but they do not see it as their main goal. Dr. Mario mentioned his patients let him pay first at the stores or give him gifts. He does not care for those things, but he expressed it does feel good. It gives purpose to his work and shows that he is doing something right.

Border Work Practices: Care is Different on the Border

The work-life experiences of doctors are presented in this section. Practicing medicine on the border is unique. My analysis focuses on the changes and modifications medical practitioners experience while caring for their patients and living life on the border. The hostile environment that surrounds the Nuevo Laredo, Tamaulipas border influences medical practitioners to change and adapt to an environment of violence.

Doctors modify their work practices to manage the criminal activities occurring in their city. These modifications vary from first-hand experiences of kidnappings, robberies, and extortions to learning about violent occurrences like the ones mentioned from acquaintances through word of mouth. Overall, they practiced precaution while taking care of themselves, their families, and their patients.

Doctors working on the border have a diversity of patients. They attend patients from different countries, especially from the U.S. Overall, medical practitioners treat their patients equally, regardless of the economic status, race, occupation, or gender. Dr. Maria admits

sometimes patients can cause a bad impression and leads to an unpleasant consultation; however, she recognized every patient deserves to be treated with respect, "*Si, todas las personas desencadenan en ti ciertos sentimientos… Algunas personas te caen bien, [y] hay unas personas que son un poco desagradables pero creo que todo mundo merece respeto y merece ser tratado muy bien."*

Similarly, Dr. Ivana has had her own experiences in treating *narcotraficantes*. "*Atender a gente que tú sabes que no es buena pero la tienes que atender porque son personas."* She treats them "*Como a cualquier otra paciente."* There have been some instances, however, when she has to consider a form of special treatment to avoid problems.

> *Pues yo trato de si me doy cuenta que son malos pues no preguntarles tanto. Hace poquito me tocó también un paciente para una endoscopía con mi esposo. El chavo tenía como 4 radiecillos. Se veía súper obvio y le digo "Oiga, ¿no tiene alguien con quién dejarle los radios?," me dijo: "No, no doctora, no tengo a nadie y más vale que no conteste algo porque no quiero que se entere de nada" "No, no se preocupe usted quédese con sus radios no pasa nada." Pues ahora sí que yo creo que sí es un trato especial*

Moreover she gives another example.

> *…Dando una anestesia pues como cualquier otra a una muchachita de 19 años aquí en el hospital…todo salió muy bien, todo salió perfecto, la acababan de operar. Y en el momento que me habla mi papá… y me dice '¿Qué pasó? ¿Todo bien con la anestesia?', 'Sí papá, ya la estoy despertando' Me dice 'Ah, bueno. Ten cuidado, porque es esposa de un zeta.' [Sorprendida] En ese momento, pues la verdad que sí me puse muy estresada y yo creo que adrede pasaron cosas. La paciente reaccionó mal al despertar, se empezó a poner morada [risa]…obviamente, pues te estresas y entra una adrenalina que dices tú: 'O sea ¿Qué me va a pasar a mí? [Grita] ¡A mí!' Ya ni piensas en el paciente, piensas en ti [Exaltada] porque pues o sea esa gente no se anda con cositas.*

She takes special care of patients involved in crime, and if she knows they are *narcos,* she prefers not to ask too many questions. Dr. Ivana knows they have enough power to either get what they want or remove all obstacles that prevents them from getting it. Her husband has

been kidnapped several times. They needed medical attention, so they contacted him, picked him up, and took him out of town.

> *A mi esposo se lo llevaron para atender a un paciente particular fuera de Nuevo Laredo. Entonces yo creo que ya lo he vivido en carne propia y embarazada y pues es algo que ahorita te lo puedo decir como algo que me pasó, digo, no le hicieron daño ni nada pero simplemente…El decir 'me lo voy a llevar para que atienda a otra persona'. Ve tú a saber con quién está, cómo está, o qué va a pasar... Estamos expuestos a eso la gente buena profesionalmente está expuesta a…estar bajo la mira de la gente mala y que diga 'este bato es el que puede, el mero mero pues me lo llevó para curar a no sé quién'. Pero yo creo que a todas las especialidades porque a mi papá también ya le tocó a que se lo llevaran a operar a no sé quién. Entonces eso es lo que vive un médico de frontera… la privación de la privacidad de la familia.*

These situations disrupt my participants' lives. Dr. Ivana was scared they would harm her husband in any way. The profession takes over Dr. Ivana's life. She experiences spillover (Burke & Greenglass, 1987) because both domains interlock into one another. Work and personal life are intertwining, creating the stressful situation of fearing for her husband's well-being.

Similarly, Dr. Mario treats all the patients equally, with no distinction. He states he is a maxillofacial surgeon; he does not care about a patient's religion, beliefs, or behavior; he provides his services as needed.

> Dr. Mario: *Nosotros nos dedicamos a ver pacientes sin importar si el paciente sea delincuente o sea un servidor público, un policía…Mi situación no es juzgar a los criminales ni condenarlos, ni tampoco abandonarlos. Yo tengo que atender a todos…sea cual sea su conducta en la sociedad. Yo soy un cirujano maxilofacial, no soy ningún este policía. Tengo que salir a verlo…yo nunca me he negado a ver a un paciente.*
>
> Entrevistadora*: ¿A usted le da miedo?*
>
> Dr. Mario*: Pues, no miedo pero sí…voy con mucha precaución ¿Verdad? Trato de ir rápido y regresar rápido.*

These situations affect doctors' stress levels and well-being. After taking care of a patient involved in criminal activity, the medical practitioners implement more caution. Dr. Mario

practices caution when driving to the hospital and back home, "*Y pues sí, si te afecta porque estas preocupado del trayecto cuando vas a atenderlo y cuando sales de atenderlo…"* He explained it does affect his personal life. Even after the procedure is successful, he takes the stress back home and it affects the balance between the multiple roles he takes on daily.

Securing the Self, Securing the Site

In 2002, Dr. Ramon arrived to the border town after finishing his career in Monterrey, Nuevo Leon, with hopes of becoming a prestigious, well-known neonatologist. Slowly, he gained popularity by providing good service that built his recommendations. Consequently, a financial misconception led to a tragedy. A common stereotype of medical doctors presents them as wealthy individuals. After five years of practicing medicine on the border, Dr. Ramon was kidnapped. "*Yo tuve la mala experiencia de que me secuestraran y estuve tres días"* Dr. Mario was kidnapped for three days. He continued to narrate his experience, "*...y en esos tres días pues casi te matan, ¡Chihuahua! Porque al final de cuentas te quitan la ropa, te esposan y te empiezan a golpear, y yo creo que me pedían 400,000 dólar [es] y yo tenía de llegar aquí 5 años entonces yo les decía no… quédate con la camioneta, quédate con eso pero efectivo no tengo…"*

There is a diverse income scale depending on a doctor's medical expertise, but it is not safe to say all doctors are wealthy. This misconception has caused adversity for doctors and their families, since they become targets of kidnaps since the kidnappers perceive they are wealthy and will be able to pay a release. Dr. Ramon stood strong throughout this tragedy and expressed he was not scared of dying. He even expressed a desire to die.

> *Yo no tenía miedo, o sea no tenía miedo a morir, a morir. Uno de los muchachos, porque eran muchos güercos. ¡Oye! Cada que me pegaban me desmayaba y luego abría los ojos y decía no puede ser todavía, todavía estoy vivo. Entonces me acuerdo que uno de ellos me decía: "mátate" y me daba una pistola. Yo agarraba la*

> *pistola, y estaba esposado por delante, entonces le daba y no tronaba. Y el muchacho se reía, y luego me decía, estaban todos encapuchados y me decía: eres un cobarde porque te quieres morir… uno de ellos me dijo: "Te vamos a cortar las piernas" y me metieron la sierra. La sierra ¿Tú crees? Prender la sierra y me la ponían aquí [señala su pierna] y me salía la sangre... mira aquí me metieron uno, me metieron otra, con la sierra [mostrando sus cicatrices] Oye me la hacían, me la hacían hasta abajo hasta el hueso. Salía sangre y tu decías: "No puede ser" yo le decía: "Mátame, mátame" pues estaban todos encapuchados pero al jefecito le decía: "Máteme tú, mátame." Y él me decía: "Ya te quieres morir"[burlonamente]*

After three days of being kidnapped, he was released. He chose to stay in Nuevo Laredo but for a moment, he considered moving to Laredo, TX to obtain another job since he could not keep practicing medicine in the U.S due to legal restrictions. He wanted his family to move to the U.S. while he remained in Nuevo Laredo and kept working to sustain the family. However, his wife and daughters did not want to separate from him. In the midst of his decision, an experience in church made Dr. Ramon make the final decision. "*...llegué a la iglesia que estaba ahí que se llama Santo Niño, solo ¿Verdad? y cuando me metí estaban pidiendo por mí. "Queremos pedir por la pronta recuperación y regreso del doctor Mario Rodriguez." Veía a la gente y no había nadie conocido, entonces dije ¡Ah, chihuahua!, entonces le dije a mi esposa: ¿Sabes qué? Sí, me voy a regresar… Pero, sin embargo, el miedo..."*

He was scared but felt he had to do more for his patients. It was not the time to leave yet. What kept him strong and hopeful through the kidnapping were his patients and knowing he could help more kids. "*A mí lo que me daba fuerza son los niños que salve.*" He stayed in Nuevo Laredo and continues to enjoy his work.

Dr. Mario faced a similar kidnapping experience. The kidnappers broke into his private practice, stole his car, and took Dr. Mario with them. He was released in one day and

he got his car back. Material things come and go, but these kidnapping experiences mark the lives of the border doctors and make their experiences worth talking about.

Dr. Flor also experienced violent acts against her and her daughter. The burglars followed them home and waited for them to enter the house. Four males pointed guns at them and forced to give them their most valuable possessions. They stole money, cars, watches, televisions, and phones.

> *…nos asaltaron a mano armada. Este fue el momento más espantoso de mi vida el hecho de ver [que] va y la empuja hacia adentro… fue lo más terrible de toda mi vida: el hecho de saber qué le va a hacer a mi hija…La impotencia. Nos metieron adentro de la casa empezaron a sacar cosas, televisiones, relojes, los teléfonos, y luego como yo traía las llaves de mi camioneta en la mano, me las arrebataron y se fueron. Se llevaron también mi camioneta. Entonces fue horroroso, espantoso… sobre todo por el hecho de que me sentí con amenaza de la vida y de la vida de mi hija ¿Verdad? entonces es algo tan horrible que no se lo deseo a nadie*

Other less life threatening occurrences but equally disturbing, took place inside the doctors' private practices. An array of robberies, assaults, and telephone extortions became common practice. Dr. Ivana joked and said that if you do not experience one of these occurrences you are not from Nuevo Laredo. Eight out of 12 interviewees shared resembling occurrences related to organized crime in the city. These experiences create a desire to leave Nuevo Laredo and move to the U.S.. However, because of immigration issues, this is not a possibility. Furthermore, most doctors remained loyal to their city of origin and thought it was pointless to move into the U.S. and continue crossing into Mexico on an everyday basis as the risks would remain present. Nevertheless, some medical practitioners decided to move to the sister city, and practice in Mexico. Overall, doctors preferred to stay and take precautions rather than commute every day. These decisions varied depending on their family. For example, if they had teenagers or young children they chose to keep them safe in the U.S. while retaining their practices in Mexico.

With that being said, there are precautions and security measures doctors have implemented in their work practices to protect themselves and their patients from kidnappings and robberies.

Doctors have changed their working hours and even their attire to avoid misconceptions and be unnoticed. I noticed none of the doctors I interviewed was wearing what is deemed "professional" clothing. Interestingly, Dr. Mario wore medical scrubs. He makes a conscious effort to wear scrubs because it validates him as a medical doctor. He utilizes his medical scrubs as a protective artifact. If an emergency occurs, he is the first to lend a helping hand, but at the same time, Dr. Mario wants to protect himself. He is privileged to be a medical doctor and understands that taking care of him is important. He takes precaution, "*Pues ahora somos muy precavidos. Siempre tenemos el consultorio cerrado. Siempre que voy a una urgencia trato de irme con un uniforme, con un scrub, con un uniforme de cirugía [o] con una bata. Digo yo pues si pasa por ahí alguna cosa pues soy el doctor, tengo que atender a alguien. Trato de hacer valer mi derecho de doctor mi privilegio que tengo por ser doctor, y pues realmente creo que cuidarte no está de más."*

Other male doctors wore a button-up shirt with either brown or black slacks. The female doctors wore simple dresses or slacks with blouses. Dr. Ramon discussed this in-depth. He earned money through the years to buy an expensive car and clothes. Before his kidnapping experience, he would dress professionally to work and drive his expensive vehicle. He wore slacks, a button-up dress shirt, like the other doctors, but adding a tie, and sometimes even a professional coat or jacket. However, after being kidnapped, he began to dress casually to avoid being noticed. It has been ten years since this occurrence, and he still dresses casually. He is still fearful "*Ya ahorita como que quieres pasar desapercibido, dejé*

de usar corbata, quieres pasar desapercibido. Y mi camioneta [modelo] 2000 que antes traía nueva, tratas de… pasar desapercibido. Aprender a vivir con eso." Even though he has the money to buy expensive clothes or an expensive car, he prefers to avoid acquiring ostentatious possessions.

In this manner, they are more likely to be overlooked by criminals. Doctors have learned to live with these items to avoid the consequences of the false stereotypes about their income. It can be concluded, clothes are being used as a protection mechanism to be unnoticed. Doctors' personal lives are permeated by their jobs causing a work-life unbalance. Their work and personal lives seem to intersect even though they continuously make attempts to separate each.

Similarly, Dr. Juanita also changed her work practices. Before 2010 she would take in patients at ten at night, and at times, her work shift would not end until midnight. She was forced to change her schedule, which of course limited patients' visits.

> *Dr. Juanita: Bueno mi experiencia después del 2010 cambio totalmente aquí en [Nuevo] Laredo. Yo antes consultada hasta muy tarde, las pacientes de Laredo, TX…salían del trabajo y se venían aquí… y yo terminaba mis consultas a las 12... Pero ya ahora que empezó la violencia en el 2010…termino a las 8 de la noche ya no, ya después de las 9 ya nadie viene ¿Por qué? Por la seguridad...Pero si ha bajado, ha cambiado totalmente la vida de todos.*

Other four doctors changed their schedules as well.

> *Dr. Arturo: Pues hemos modificado nuestro horario… ahorita son las 6:30 y la secretaria ya está haciendo lo propio para irse. Hicimos esto a raíz de que hace como unos 4 años tuvimos un asalto. Asaltaron a mi secretaria, al dentista que está aquí enfrente y a la secretaria de ellos entonces modificamos todo.*

> *Dr. Maria: Si, definitivamente, por ejemplo, urgencias como te explicaba antes iba [el] domingo [a las] 10 de la noche a sacar un tapón de cera… ahora trato de que mis pacientes me puedan contactar más fácilmente…Trato de que sobretodo mis pacientes no salgan a media noche por cuestiones que realmente no sean urgencia; que no pongan en peligro su vida…ya no voy mucho a urgencias en la noche.*

> *Dr. Flor: Si, para empezar modificamos el horario. Modificamos el horario. Entrar muy temprano para tratar de salir temprano ¿Verdad? Poner más rejas y no abrir hasta que no confirmas casi casi la identidad de la persona que viene entonces eh esas poner cámaras eh.*
>
> *Dr. Laura:…Difícil en el sentido de la seguridad, de que te enfrentas a cosas que no estabas acostumbrado. De qué pues a ciertas horas de la noche no puedes andar ahí viendo pacientes porque ya está algo peligroso. O sea eso si te puede limitar un poco.*

Modifying their work hours became an important part of their daily routine, but it also became important to advise their patients of the differences between emergencies and non-emergencies in order avoid late night visits for the patients and the doctors.

According to Landeck and Garza (2003), 41.2 percent of Hispanic Laredoans cross the border to seek for health care. Dr. Juanita estimates the patient flow has decreased almost 50 percent in comparison to previous years when criminal activity was less apparent and the residents were not scared. She took security measures in her private practice like adding or intensifying security cameras on the door before entering and alarm systems to keep the practice safe when it is closed. Even with the added security measures, patients lost their belongings in a robbery that occurred recently at her practice. "*Sí, hace un mes se metieron dos individuos… y asaltaron a mis pacientes. Yo estaba aquí atendiendo a una paciente, cerramos pero a las demás pacientes sí las agredieron y les quitaron las bolsas.*" Her patients were affected not only because they lost money and possessions but also psychologically.

After the robbery, Dr. Juanita began to experience paranoia and psychosis. In fact, Dr. Juanita began to be suspicious over patients and got into an argument with one of them. Dr. Juanita explained the situation they had just experienced and apologized to her. She felt embarrassed but at the same time, she needed to take care of her patients. From then on, all patients identify themselves before entering. This is an inefficient procedure, but some

measures had to be implemented in order to try to live a peaceful life. Similarly, Dr. Flor had cameras installed since she also experienced a robbery in her practice, "*Este en el consultorio pues ya tenemos antes teníamos las puertas abiertas ahora tenemos las puertas cerradas."* She wished to have a war tank outside her office to prevent these things from happening, "*casi casi que quisiera tener un tanque allá afuera."*

In addition to work practices, doctors also change their lifestyles to prevent drawing attention and protect their families. Dr. Ivana implements some security measures in her daily life because of the situations experienced, "*Básicamente es normal cada seis meses cambio mi número de teléfono por seguridad. Mi esposo no tiene Facebook…aprendes a vivir diferente en Nuevo Laredo. No tienes carros ostentosos; hace poquito vendí mi BMW…me compré una camionetota del año y no la puedo sacar. Eso es vivir en la frontera. Mi esposo tiene un Mercedes del año y está estacionado en la cochera ¿Dime cuándo lo saca?... tienes que vivir así como que en* low-profile*."*

Despite being kidnapped, Dr. Mario remained positive. It changed his life completely. Even though he was not afraid, he executed precautionary measures as well. His attire was a visible change. His new style helped him blend in and be unnoticed, "…*vestirte lo más sencillo posible, este tratas de salir. Y por ejemplo ahorita que salgamos checar que no haya algo desconocido. O sea estar a la defensiva pero tienes que aprender a vivir, o sea tienes que aprender a ser fuerte es ese sentido, tener precauciones pero tienes que seguir con la vida y realmente yo creo que soy de los que más ha sufrido la inseguridad y no es que no tenga miedo pero tienes que seguir adelante no te puedes quedar ahí de lo malo.*"

These experiences led doctors to implement security measures to limit access to their workspaces and remain vigilant at all times. This was to prevent robberies from happening

and keep their patients safe. Security cameras and alarm systems were installed in all the doctors' offices. A buzzer to check who is coming in was another artifact used. This prevention made doctors and their patients feel safer. Whether it was clothing, schedules, or security cameras, it was all intended to separate their work experiences from their personal lives, trying to avoid violent occurrences that may affect their families.

The Importance of the Doctor-Patient Relationship

During the interviews, most doctors spoke about the importance of having a strong doctor-patient relationship. They emphasized the importance of establishing trust. They make patients feel as comfortable as possible. Wright, Sparks and O'Hair (2013) posited "Communication between providers and patients can potentially lead to successful health outcomes and improve quality of life, or it can create major problems for both providers and patients depending upon how it is handled" (p. 18). To avoid negative outcomes, my participants explain the procedures patiently and avoid technical jargon to avoid sounding superior. Dr. Polo stated Mexican doctors care for their patients trust, "*...Nosotros somos muy como dice el Americano muy* charming*, muy cariñosos con nuestros pacientes… cuando el paciente viene con nosotros realmente viene confiado de que lo vamos a sacar adelante…El acercamiento con la gente que viene con algún problema o que viene a resolver algún problema."*

Dr. Arturo believes American doctors are too cold and forget to nurture the doctor-patient relationship. He stays away from being cold and feels for the patient. This helps develop a stronger relationship, "*En lo particular no soy como muchos de mis compañeros: bastante frío… crea una barrera pues bastante gruesa entre la relación con el paciente. Si me duele y me sigue doliendo a pesar de que ya tengo tantos años no me acostumbro. Sobre*

todo porque vez que el paciente lucha contra su enfermedad y tu estas codo con codo con él. Entonces en un momento dado el fracaso de él es tu fracaso." Likewise, Dr. Juanita values doctor-patient relationships, "*Bastante, a mí me ayuda mucho. Tener todo esto de México, en la relación a medico paciente. Todavía escuchas a la persona, escuchas a la paciente allá eras un número más. Por eso yo creo que aquí todavía hay principios, hay moral, hay mucha vida familiar que en Estados Unidos se ha perdido…"*

Dr. Ramon gets attached to his patients because he meets them when they are born and remains a constant in their lives. Parents trust him because he takes care of their children since an early stage. Dr. Ramon shared, "*Realmente los vez en la consulta cada mes en crecimiento de desarrollo y cada vez que se enferman. Entonces que la mama... Se enferma él bebe y que te hablen y que le contestes haz de cuenta que es algo que ellos te, te valoran mucho ¿Verdad? Y yo creo que esa relación médico paciente es buena."*

However, Dr. Roberto, who believed all medical services provided were the same in both cities immediately shifted and admitted that Mexican doctors provide more personalized attention.

> *Yo creo que son los mismos, o sea, los servicios yo creo que son los mismos. [Pausa] Si he recibido comentarios en cuanto a la atención en la que el medico mexicano es un poquito más cálido y lleva una mejor relación con el paciente que el doctor americano. Probablemente tiene que ver el sistema de allá de demandas, seguros etc. Este, otra cosa que si es totalmente diferente son los costos. El paciente que no tiene seguro en Estados Unidos, pues los costos allá son altísimos y acá pues son accesibles para ellos.*

Although Dr. Roberto recognized the services are the same, his final thought is they might prefer the Mexican service due to the lack of warmth in a doctor-patient relationship, which he blames on the suing culture prevailing in the U.S. Patients are prone to sue the doctor which is why they avoid having a personalized relationship with the patient. Despite the

difference of opinion, all doctors and their patients agreed that service in Mexico is much more personalized and warmer.

Attempting to Balance Work and Life

Even though work-life balance is not unique to the border region, it is unique to the doctors' profession because their schedule is often never ending. Some of my participants are available for their patients at all times, which means work and family interlock at times. Several practitioners claimed to be able to achieve segmentation between personal lives and work (Burke & Greenglass, 1987), but they receive calls in the middle of the night, or in the middle of a family dinner. They have to treat their patients with the respect they deserve. Other industries such as airlines (Murphy, 2001), retail (Cho, Rutherford, & Park, 2013), or restaurants (Shani, Uriely, Reichel & Ginsburg, 2014) show a similar application of emotional labor. However, doctors live the emotional labor constantly. This might influence the relationships with their family and sometimes even their well-being causing stress. There are some mechanisms to achieve a balance between family and work; however, my participants are not necessarily experiencing them exclusively. In reality, they experience some of them simultaneously. Next, I scrutinize their experiences.

Family and work

Interesting tensions occurred when my participants discussed their families. Doctors affirm they segment (Burke & Greenglass, 1987) work and life. Segmentation is the lack of conflict between work and family domains due to a division between them. Dr. Roberto assured "*Si lo vas aprendiendo a dividir… el trabajo es el trabajo, mi casa y mi familia es mi familia."* He does not want to involve his family in his work stress, even though he is guilty of doing it sometimes. He feels like he has managed to balance both. Dr. Roberto admits it is

difficult, but he has learned how to create a balance. He is learning how to achieve this balance "*…lo vas aprendiendo a dividir… a pesar de que es una profesión humana y si tienes que aprender que el trabajo es el trabajo mi casa y mi familia es mi familia. O sea no puedes llevar a pesar de que a veces no se puede si estas consiente de eso que no se debe y si poco a poco creo que he ido logrando hacer eso."*

Later however, he stated it is with his wife with whom he expresses work problems. This is the case for most of my participants. Even though my participants directly affirm to maintain a work-life balance, they are overwhelmed with stressful situations experienced at work. Hence, practitioners revealed a productive way of releasing stress is by expressing their problems to their spouses. Talking about work serves as a coping mechanism through which doctors vent, "*Si tienes algo que contar o algo que quieras contar, este, con mi esposa principalmente es con la que platico: "Fíjate que tuve esta paciente, tal y tal y tal," "Estoy preocupado por esto, por esto otro" y pues la verdad es que me sirve bastante y de mi esposa recibo consejos adecuados que me hacen sentir mejor y más tranquilo."*

Dr. Maria firmly stated she does not like to bring any work-related conversations to her home. Her worries and successes stay at the hospital or in her private practice. However, she experiences unconventional work practices. She shared that some patients knew where she lived and would show up at her door to ask questions or request a consultation. "*A mis hijos les molesta mucho que vayan pacientes a mi casa.*" Her patients are directly situated in the middle of her personal life causing *a* spillover into her private life, which means that both family and work domains are affecting each other due to similarities between them (Burke & Greenglas, 1987; Gutek, Repetti & Silver, 1976). Dr. Maria prefers not to share work-related problems with her family. She strives to segment both domains, but the balance becomes

impossible due to the patients' behavior. She usually vents with her friends who do not know anything about the medical field, but they listen anyway.

This division of work and life gets even more complex to define when your spouse is a doctor as well. Dr. Ivana's husband is also a doctor and shares her worries and problems with him. Together, they come up with solutions and vent since they understand the terminology and the stress it can provoke. This might work for some couples, but at the same time, it blurs the division between work and family time. At the same time however, a spouse sharing the same profession knows the difficulties their partner experiences at work, which can lead to understanding. Dr. Ivana stated venting with her husband was valuable. "*Significa que nos preocupamos por nuestros pacientes, si no no hablaríamos de ellos…y desahogas.*"

Participants can often focus on what domain more than the other. Because work and family cannot easily be separated, it causes problems on both sides of the domains. The reality is that some of my participants have lost personal time while working or thinking about problems at home and vice versa. Next, I want to discuss the impact these situations have on the doctor's family.

Children

Dr. Flor's daughter complained about not spending enough time when she was younger *"¿Pero como que ya te vas? ¡No es posible que te vayas si vamos llegando!"* According to Dr. Flor, the lack of family time does affect the children psychologically. Later, she joked about her daughter not being affected since she will become a gynecologist as well, even though she knows she actually was affected. Dr. Juanitas shared her daughter also

complained and said she did not want to be a gynecologist because she wants to have time for her family.

On the contrary, Dr. David shared that none of his sons became doctors; they complained about the lack of time invested in them. He confessed they lacked a father figure. "*Yo nunca estuve con ellos."* He spent days and nights at the hospital. It definitely affected them negatively. He said his children got used to it with time. Dr. David's main reasons for working are to give their kids what he could not have growing up. He expressed "*Uno como médico se esfuerza que ustedes como hijos tengan todo entonces cuando tu estas estudiando también a que batallabas para conseguir dinero…entonces no quieres que a tus hijos le pase lo mismo."* He works hard to provide for his family, especially his kids who have had everything they need along their life thanks to this effort. Dr. David's kids are grownups now, and he hopes they value his effort.

"Las esposas se acostumbran"

Dr. David states his wife knew what she was getting herself into. He was a doctor when they started dating and he said at first it caused problems, but later she became used to the life they led and understood. "*A veces si si surgen problemas de tipo familiar porque este al principio es difícil. Pero generalmente la esposa comprende y entra a [poco claro] ya sabe entonces desde que éramos novios*." Spouses help by providing support to the doctors and by listening to them vent. Each plays an important role in practitioners' lives. Dr. Mario said, "*Si se acostumbran pero realmente tratas de no hacerlo ¿Verdad? Pero sin embargo si lo haces."* Repetti (1987) argues that a time-based conflict prevents a domain's needs to be fulfilled since there is not enough time dedicated to work and especially in these cases, to

their personal lives. Time is relocated from family to work, which makes balancing work and family a challenging feat.

Family Time

As stated by many doctors throughout interviews, a doctor's job is usually 24/7 with no time limit for the medical services they provide. There are, of course, some medical areas with more flexibility than others. Dr. Maria, for example, is able to separate her work from personal life since she always follows a schedule and her patients' emergencies "*no son tan urgentes.*"

This time constraint leads doctors to decide between work and family. They have to leave a party, or a family dinner to take care of a patient. The family feels left out and in turn, can affect their relationships. Even Dr. Juanita's grandson notices and says "*Abuelita ya te vas al hospital, tienes pacientes.*" Dr. Juanita states her family feels offended and resentful with her for leaving a birthday party.

Dr. Laura experiences the same situation of a call interfering a family dinner or outing. She mentions it as a disadvantage of the job. For example, she does not have the freedom of saying, "No I do not want to treat a patient. I want to stay with my family and watch a movie." Even though she does have the freedom, she feels the responsibility. On the contrary, one doctor that attempts to put his limits is Dr. Ramon, "*Yo trato de poner mis horarios, también porque a veces… la familia también tienes que poner un…no voy a contestar porque estoy con mi familia, sin embargo, no se puede. Hay veces que estoy con mis hijas y vamos a ir a algún lugar y ellas entienden. Les explicit que el bebe esta grave…ellas entienden."*

Dr. Ramon and my other participants try to keep work from interfering with their personal activities, but in the end, patient care always wins and they choose work. This does not mean doctors do not care for their families. They work and sacrifice their own personal relationships in order to continue building a good reputation and build references from the patients.

It is during this decision of working or staying with the family that doctors experience a battle between their multiple roles. They are doctors, spouses, sons/daughters, parents, and friends. Doctors have to manage their roles. They experience a struggle between roles (Greenhaus & Beutell, 1985). For example, while they are having fun with their families at a *carne asada*[6]*,* they might be called into work for an emergency or consultation. This is a clear example of resource drain, which means doctors are allocating their time and energy to their work instead of family (Lobel, 1991; Small & Riley, 1990). Managing between roles can be challenging.

Role-conflict: I am a woman, a doctor, a mother, a wife

According to Duehr and Bono (2006), gender stereotypes have been documented for decades. Dr. Ramon speaks about women in a stereotypical manner because of the experiences he had in his career. "*Yo veía que las mujeres el sentimiento maternal lo sacaban."* Ten women graduated with him along with three male doctors. He stated women were much more intelligent than the male doctors. However, the feelings would overwhelm them at times, and their minds would blank out and did not know what to do. "*Yo veía que se moría él bebe, y se morían ellas con él bebe…nosotros actuamos más fríamente, eso es importante."* While some research states stereotypes focusing upon the personality traits of

[6] Carne asada: In the North of Mexico it is gathering usually hosted on the weekends for family and friends where they cook a barbeque with tortillas, guacamole and salsa.

women are not quick to change (Lueptow, Garovich-Szabo, & Lueptow, 2001), it is clear that the social environment with respect to women has been changing (Duerh & Bono, 2006). For example, "motherly, soft, softhearted and excitable" did not show in the female core in De Lisi and Soundranayagams' (1990) study (p. 601).Women in the workplace are now "characterizing… less passive and submissive and more confident, ambitious, analytical, and assertive" (Duerh & Bono, 2006 p.816). Women in my study are not letting these stereotypes prevent them from practicing medicine and accomplishing their roles as mothers.

Dr. Laura recognized she has to be *multifacetica* when it comes to working and being a mother. She has to dedicate time to her family, especially her kids, to whom she dedicates most of her free time. When she gets home from work and she is tired, since she has been standing all day, her kids have needs "*Mamá quiero esto y el otro,"* she has to attend their needs and cannot use work as an excuse. She admits this situation is stressful, "*Si me provoca estrés porque…de repente si tengo mucho trabajo pues veo mucho menos a mis hijos entonces eso me provoca mucho estrés…no poder estar con ellos. Disfruto mi trabajo, las horas se me pasan volando pero cuando tengo demasiado trabajo…no los puedo ver tanto… quisiera partirme en tres pedazos…"*

Dr. Laura's mother was a homemaker, and she wanted to do that as well. However, she had the desire of becoming a doctor. She wanted what her mother had: a family, a husband, a house, but she also wanted to work. Since she had no one to show her how the path to success in mixing both worked, she learned through experience. *"Nadie te enseño como conjugarlo, entonces al momento en que todavía no terminaba mi especialidad y el embarazo, y tener una niña… fue algo muy difícil…se multiplico en trabajo*." She learned through experience. Once she had her daughter, she got the strength to do it. "*Ya que tienes a*

tu niña es algo maravilloso…no sé de donde te salen las fuerzas…" Moreover, she talks about the assumptions and criticism she received from family and friends. She overcame all the comments and accomplished her goal of becoming a doctor and housewife, "*Yo no se dé dónde pero saque mil y un fuerzas para llegar desvelada, levantarme temprano… dar más del 100% de mi…"*

Dr. Juanita was also pregnant while she went to school. "*Yo tuve a mis hijos, nacieron en la recidencia y dos nacieron aqui cuando era gineco-obstetra*." She gives credit to her husband and family members, who helped her while she dealt with the multiple roles student, wife and mother. With her family's support, Dr. Juanita was able to overcome the hardships.

Similarly, Dr. Ivana was pregnant while in school, and she recently gave birth to her second child. Her medical area and her working in private practice allow her to dedicate time to fulfill her maternal role. She values and gives time to the relationship with her baby, "*Soy pro-lactancia materna y yo creo que es algo que tengo que recalcar porque muchas mamas que trabajan en un horario corrido no tienen el beneficio de darle a un hijo la lactancia materna porque te imposibilita el estar tanto tiempo en un lugar, y yo entro y salgo de los hospitales privados, me organizo para hacer mis mi mis cosas a nivel personal verdad y no me siento asfixiada con lo que hago no me siento que me limita a hacer cualquier cosa, ya sea de a nivel personal y a nivel de mama."*

Dr. Ivana gave a good example of segmentation (Burke & Greenglass, 1987). She assured having enough time to work and spend with her family. She has some advantages though. First, her husband is a doctor too, so her family does not depend on her income. Second, Nuevo Laredo is a small city, which allows her to go home in the middle of the day to breastfeed her baby since it is a 5-minute drive. Lastly, she has a vocation to be an

anesthesiologist; she is very passionate about her job. These advantages clash together allowing the separation of her family and her work responsibilities. Research shows young workers like Dr. Ivana, take special care and value work/life balance (Lewis , Smithson, and Kugelberg, 2002; Smola & Sutton, 2002). This is due to the commitment they have to their work.

My participants struggle to find a balance between work and life. Loumansky, Goodman and Jackson (2007), argue that "For some women, the flexibility needed to juggle family responsibilities was to some extent made possible by the choice of being able to work at home or in the office" (p. 233). Unfortunately, this type of occupation does not allow practitioners to work from home. This adds to the hardship of balancing family and work life experiences.

Loumansky, Goodman and Jackson (2007) suggest women still see themselves as the 'Other' in a male dominant environment, which is the case of medicine in Nuevo Laredo since Dr. Ivana mentions there is a *machista* culture. "*Lo puntualizo, que aquí en la frontera son muy machistas. No veras a muchas mujeres exitosas…la mayoría [son] de otras profesiones pero en particular las doctoras somos muy escasas y más jóvenes."* Francis (2002) expands on this stating the "Discourses of personal agency, structural inequalities and exclusions are often ignored and the emotionality that is ascribed to women as part of their gender roles is regarded as inferior to male logic and rationality" (Loumansky, Goodman & Jackson, 2007, p. 225).

Moreover, Dr. Ivana also feels that she has struggled because she is a young woman. People have questioned her abilities to perform her job. "*Me dicen: 'Usted me va a anestesiar? Esta segura?"* Continuing with Francis (2002) statement, Dr. Ivana felt the

inferiority in comparison with her male counterpart. However, these comments have not stopped her. In fact, Dr. Ivana feels very empowered and prepared to do her job. "*Puedo presumir que soy la única, hay pocas mujeres en lo privado, la única que tiene mucha trascendencia en el área privada."* She feels very proud of herself, as she states, "*No soy ni la sombra de cuando llegue."* Even though it has only been five years, she has grown immensely with help of her father, also an anesthesiologist, but also by self-learning. Her positive experiences add up to what she has become over the years. Women in my study showed strength and leadership. They felt a sense of accomplishment with their decisions and outcomes.

Family and work are inevitably intertwined for my participants. First, living on the border comes with the burden of modifying their work practices. Second, it is evident that care is different in the border because of the violent living situations they have experienced over the course of 10 years. The violence combined with the false financial stereotypes doctors experience lead to violent occurrences such as kidnappings, muggings, and extortions. Work slowly interlaces with their personal lives, especially for the doctors that have directly experienced violence. Doctors in my study experience the work-life mechanisms of segmentation, spillover and resource drain simultaneously, and therefore I find them juggling in between total balance within work and life. This is not always a bad thing; it just means they are experiencing Clark's (2000) border theory, developed to fill in the gaps causing criticism of other work and family theories and work-life mechanisms (Clark, 2000).

CHAPTER III

DOCTORS AND FEELINGS GO TOGETHER LIKE BREAD AND BUTTER

This chapter focuses on how doctors manage their feelings and the difficult duties they accomplish. Doctors have to deliver bad news and practice empathy in order to understand the patient, which may cause stress or worry. They enact acting techniques to provide the best medical service possible for every patient. In turn, this burden can become a routine and may lead to burnout.

Contagion and Stress: Inevitable but Bearable

My participants displayed passion towards their profession. They enjoy their medical practice and are certain they chose the right path. They strongly believe it is a vocation. However, they shared the hardships they experienced.

Doctors expressed fulfillment with their career choices. They shared their stories with joy and they seem satisfied with the outcome. It is a long and challenging career and "If a student is living out the parents' dream instead of his or her own, the inner conflict can lead to unconscious sabotage" (Franco, 2013). All of my participants chose their careers for themselves, not for their parents or any other person, and they still conserve that passion that helped them survive those late nights of studying and learning. When I asked Dr. Flor if she had ever considered changing to another profession, she said she never thought of it. She was always convinced she was doing the right thing when becoming a doctor, "*No nunca, yo siempre estuve muy convencida de lo que estuve haciendo y lo sigo estando. De tal manera que estas alturas de la vida no no [risas] no cambiaría… nada. A lo mejor ampliaría algo. Alguna otra rama de las muchas que puede existir dentro de la ginecología. Pero cambiar*

así como que de dedicarme no sé qué si ahorita soy ginecóloga y me dedico a negocios no." More than anything, she is motivated to keep learning things about gynecology.

Several doctors are more susceptible than others to feel for their patients. Dr. Arturo said he is not like some of his colleagues who are cold, "*Bastante frío[s]."* He prefers to give a warm service that makes the patient feel cared for and welcomed because that builds up the doctor-patient relationship, which is valued by the patients. After spending time with the patients, he grows fond of them throughout consultation. Seeing the patients' evolution creates an attachment, and he feels like his patients' failures are his failures too. Similarly, Dr. Flor also becomes involved with her patients sometimes. "*Uno se llega a involucrar con el pacientito y le tiene tanta confianza…que lo almenas."* She grows fond of her patients and takes care of them.

Some of my participants experience emotional contagion. When contagion is experienced, doctors "Mimic and synchronize expressions, vocalization and postures…to converge emotionally" (Hatfield, Cacioppo, & Rapson, 1993, pp. 153-154). Research on emotional contagion has been conducted through various disciplines. Clinicians (Coyne, 1976), social-psychologists (Hatfield, Rapson, & Le, 2008); sociologists (Le Bon, 1896; Tseng & Hsu, 1980), neuroscientists and primatologists (Hurley & Chater, 2005a and b; Wild, *et al.*, 2003), child psychologists (Eisenberg & Miller, 1987), historians (Klawans, 1990), and animal researchers (Miller, Banks, & Ogawa, 1963), suggest that people are prone to draw on the emotions of others in a large scale at all times despite their social class (Hatfield and Rapson, 2010). In a medical perspective, Dr. Eloy shared a story when he felt contagion towards a patient.

> *…lo operamos terminamos como a la hora dos horas y en la tarde voy a verlo a su cuarto y esta la mama con él y su familia y me dice doctor Eloy me lo trajo al mundo*

> *a él y ahora me le salva la vida… porque usted me anestesio a mí y a mis hijos y a él [sin claridad] y le dije: 'Verdad cabrón que no te moriste como dijiste' …no podía abrir los ojos los tenia así [señala sus ojos cerrados… pasa el tiempo, esto es lo más bonito, y voy a HEB y vienen 4 chamacos flacos corriendo y uno dice doctor Eloy: "¿Quién soy?" Dije ¿Quién será? Pero le vi le vi la cicatriz a dije Ricardo de la tratostomia. "Raza, por el doctor vivo en este mundo." Eso mija te paga todo porque a la mejor no nos pagó, pero te paga todo lo que haces y se siente tan a gusto [se le hace un nudo en la garganta y los ojos llorosos] que allá te están viendo [señala al cielo] y hoy lloro por eso allá te está viendo Dios*

Hatfield and Rapson (2010) proposed that as a reflex people mimic their companion's facial expression, voice, posture, and movements while engaging in a conversation. Doctors engage with their patients sometimes on a regular basis, so they will eventually feel what their patients are feeling.

Dr. Laura's patients share personal information and problems with her, and it is a rollercoaster of emotions. Not only do doctors feel contagion or mimic emotions when they experience something negative, but also when they listen to their positive outcomes. However, Dr. Laura avoids contagion, which involves mimicking the patients' emotions and does not let her be affected by her patients' personal lives (Hatfield, Cacioppo, & Rapson, 1993). She admits sometimes it is hard not to cross the line between doctor and patients' lives, but it is important to her to keep the doctor-patient relationship professional. *...Mucho sentimiento pues llanto, alegrías, risas. Si se contagian los sentimientos, si se contagian ¿Cómo no?...yo trato siempre de no ser…muy efusiva ...Porque tampoco hay que brincar cierto límite que siempre debe de existir.* Dr. Laura avoids crossing the line with patients by acting and treating patients the same way and without any preferences. This is difficult because a feeling of preference might arise depending on the patient's response to her service. She hides any sentimental values. Dr. Laura stays away from favoritism, "*Si lo que yo hago es que siempre soy de la misma forma, y si tengo un sentimiento más hacia un*

*paciente pues por ejemplo el hecho de llanto no lo manifiesto enfrente de los pacientes <poco claro> me trato de esconder en un rinconcito y ya lo hago y salgo como si nada."*At times, she might experience additional emotions, but she copes with these feelings by hiding emotions to avoid contagion. She proves this method has helped her in her few years working.

Even though doctors are doing their jobs, occasionally something unforeseen happens because medicine can be unexpected. Doctors feel frustration when procedures do not go as desired. Dr. Flor experienced a case where everything seemed to be fine, but it was not, "*...recientemente hubo incluso…una cesarea…todo el embarazo había sido muy bien y a la hora que nace la bebecita veo que es un síndrome de Down. Entonces así como que este dije: "¿Pero cómo?" No lo podía creer que todo habíamos visto que estaba bien y ¿Cómo que este era un síndrome de Down?… de hecho todavía estoy preocupada porque, es una caso reciente."*

Likewise, Dr. Flor had another unexpected situation where the patient seemed stable, but it ended up being a dangerous case. She tried to find the best specialists to treat them since the case was out of her area of expertise, "…*era un supuestamente un tumorcito y salió un tumorsote. O que es algo no benigno que es maligno…también se involucra mucho con el paciente…y se preocupan y trato de buscarles los mejores tratamientos este o los mejores sub-especialistas para que le brinden un[a]… mejor evolución y… una curación."*

Experiencing anxiety, sadness and frustration can be stressful. According to Sliter, Kale and Yuan (2014) "Every employee, regardless of occupation, is exposed to workplace stressors on a daily basis" (p. 257). Even though they love their jobs and some want to continue practicing medicine until they are not able to work anymore, sometimes doctors

experience stress. Different types of stress were mentioned throughout the interviews. Some doctors stress when they do not know a solution to a problem, while others are stressed when they have too many patients. Dr. Roberto shared several stressful experiences, "*Si pues claro, imagínate tener que pasar un paciente de urgencia al quirófano…que por ejemplo…está sangrando…que lo tienes que operar rápido, porque si no va a perder mucha sangre; va a fallecer. Entras, no encuentras de donde está sangrando, los signos vitales se están alterando…Es bastante estrés y vez que se están muriendo…eso es lo más estresante."*

Doctors accumulate feelings that produce stress. Dr. Mario thinks the job carries an ongoing stress constantly carried by them, "*Yo creo que la primera desventaja de nuestro trabajo es el estrés. Nosotros somos muy sentibles a cualquier cosa que nos afecte…vamos a dejar de producir. El estrés es algo constante, que lo traes en la espalda…decía mi madre: "te estresas por tener mucho trabajo."*

Similarly, Dr. David's stress stems from the patient saturation he receives at his practice. He is fortunate to be prestigious and receive a good amount of patients, but when he receives new patients and his office is full, patients sometimes decide to leave. This causes stress because he feels rushed and would like to attend to all of his patients, but it is impossible.

> Dr. David: *...El estrés, el estrés que manejo yo es cuando se junta la gente que se te junta la gente en el consultorio...*
>
> *Entrevistadora*: *¿Más que operar?*
>
> Dr. David: *Si…el estrés de que esta la gente ahí esperando… Hay gente que van de primera vez y este yo afortunadamente tengo mucha consulta pero… me estreso de que, "Fíjate doctor que ya se fue la paciente..." bueno pues ni modo y a veces dice [mi secretaria]: "Doctor pues si ya quiere irse ya no le tocaba…"*

He said the patient overload causes him an added stress. However, later in the interview, he stated he is fortunate to have a great amount of patients; therefore, patients who leave may not necessarily affect him. His secretary even consoles him when she says, "*Doctor, pues si ya quieren irse ya no le tocaba doctor*." Dr. David tries not to think too much about it.

Dr. Mario experiences fear towards unexpected situations with patients, "*El estrés ahí lo tienes y te da mucho miedo…miedo a lo desconocido."* He even said he is always stressed because every case is different. "*En mi trabajo hay mucho estrés. Mi estrés es miedo a lo desconocido entonces cada vez que veo un bebe pues ya estoy estresado..."* Dr. Ramon's job consists of taking care of babies that are in serious or dangerous situations, which is why stress is always present. "*Yo manejo a los bebes que se ponen muy graves."*

Dr. Ramon mentioned the advantages of his job. He is doing what he loves, and it has never bothered him. He even feels despair when he is not working on Sundays or on a family vacation. He expressed his passion about helping patients and understanding them, "*Pues las ventajas: que te gusta. Que estás haciendo lo que te gusta. Primero que nada si tú agarras una especialidad… tiene que gustarte. Entonces si te gusta lo que haces…cuando no haces nada, cuando no trabajas te desesperas…pero tú lo haces… con mucho amor tienes que ver tienes que tienes que ponerte a veces en el lugar del paciente."*

Particular cases make Dr. Ramon anxious. The fact that he treats babies with the same sickness, but different perspectives that seem incurable, is frustrating for him. This also gets him down at times. He feels anguish because he lacks the knowledge on how to solve all of the cases. "*Tratas de no…pero si te deprime…a veces todos los bebes tienen la misma enfermedad pero diferentes puntos de vista y pues sientes esa ansiedad…."*

He also discussed the honor he feels when an acquaintance asks him to attend his wife's childbirth surgery, even though it also causes some anxiety. Things might get complicated, and if there is nothing to be done, he does not like the confrontation. Additionally, he shared how sad he felt when he was not able to save a baby, "*Él bebe empezó a convulsionar y al empezar a convulsionar este cayó en paro y luego cuando cayó en paro… ya no lo pudimos sacar del paro y falleció; esa noche yo llore verdad, sales del hospital y oye dame chance yo tengo mucha ansiedad… no lo pude salvar, pero hice todo por él, sin embargo…yo me fui a llorar dame chanza, me siento muy angustiado, esa fue la experiencia…"*

He felt the responsibility and guilt, but there was nothing to be done. He cried, felt anxiety and anguish, but this is something he has been working on throughout the years. He does not cry anymore, but he still feels the guilt and sometimes-even depression. The love for his profession helps him defeat these feelings.

Over the past 14 years, Dr. Ramon has learned how to live with stress. His job comes with the burden of dealing with babies when they are in a dangerous stage, which brings him a lot of stress. Stress is always present though, but he has learned how to manage it. "*Entonces el estrés ahí lo tienes y te da mucho miedo…Sientes tu donde el corazones te aprieta y te duele el pecho y tienes que aprender a vivir con eso y estar a la defensiva*."

Dr. Ramon and Dr. Arturo shared the same stress and fear of the unknown. They expressed sometimes a patient is stable but something unexpected happens preventing them from solving the problem. They feel stressed since they carry the responsibility of a patient's life and well-being. Dr. Arturo's greatest fear is not knowing what the patient needs. "*Lo que me estresa es no saber lo que tiene el paciente…."* He does not like giving a treatment or a

solution without knowing what will happen. He avoids trying something without knowing the outcome. He avoids thinking or *"Yo no sé lo que tiene, le voy a dar esto a ver qué pasa."* He prefers to diagnose the problem and offer a secure solution.

Delivery of bad news— ¡Eso es todo un arte!

Dr. Ramon's first experience delivering bad news was intense since his colleague, Dr. Fabio, did not warn him. *"¿Ya sabes tú como decirle a una mama que se le murió su hijo?" Le dije, no doctor, no sé.' Eran las tres de la mañana y me dijo: 'Ven, te voy a explicar cómo'… le dijo [a la madre]: 'yo soy el doctor Fabio, aquí el doctor Mario le va a decir algo'. Entonces así te avientan al ruedo."* He had to do it, and it was not a pleasant experience. It was his first time, but he did it "*Lo mas humanamente posible,*" using common sense and bedside manners and trying to be as calm and understanding as possible.

One of the most difficult duties doctors experience is the delivering of bad news (Bradley & Sparks, 2012). Delivering bad news is a self-learned process doctors have yet to master. Bad news is defined as information that causes a negative adjustment to the patient's expectations about the outcomes of a procedure or their health in general (Buckman, 1984). Ramirez (1996) stated doctors have a hard time managing their emotions of sorrow, guilt, identification and feeling of failure. Senior doctors in Ramirez's (1996) study assured high rates of burnout and psychological morbidity were caused by the lack of training on giving bad news.

Even after 14 years of experience, Dr. Ramon among other doctors expressed he has not gotten used to delivering bad news. "*Sigue igual…despues de tantos años."* Delivering bad news has consequences on doctor's personal lives. Dr. Arturo expressed sometimes doctors find themselves being their own psychiatrists when talking about delivering bad news

and carrying patients' worries. "*…Uno tiene que ser su propio psiquiatra y empezar a soltar eso porque si no nos desquiciamos, porque son muchos muchos los pacientes que vemos y pues tenemos que lidiar."* Dr. Arturo even calls it an art. "*Esto es todo un arte*." This was a common theme amongst my participants. He considers giving bad news an art because medical schools do not focus on teaching students about communication skills. According to Wright, Sparks and O'Hair (2013) "Communication skills training is a relatively underdeveloped part of the medical/ healthcare curriculum at most universities and colleges in the U.S. Although Dr. Arturo studied in Mexico, he shared having a similar experience. Furthermore, Dr. Laura shares her opinion about the Mexican curriculum.

Dr. Laura said there is no class where professors teach them how to deliver or cope with bad news. In the U.S., medical education is not specialized in communication skills; these are introduced briefly until midway into the curriculum. (Humphris & Kaney, 2001, p.225).

> *…Nadie te ensena ¿Verdad? No hay una clase donde diga cómo dar las malas noticias a los familiares o a los papas, en mi caso…Pero yo creo que…hay formas de empezar a acercar a los papas hacia cual es el pronóstico de los niños…desde antes tú ya vas alertando a los papas… yo creo que lo principal es hablar con la verdad desde un principio hacia los papas, y así ellos ya van a estar encaminados a lo que puede ser y lo que no puede ser. Y pues la forma es realmente pues decirlo. Decir realmente como pasaron las cosas, explicar todo y pues la verdad yo creo que ante todo es lo mejor…*

If there is something wrong with the patient or the procedure, doctors do not convey a sense of hope to the patients, or in Dr. Laura's case the patient's parents. Dr. Laura sticks to the facts and tells the truth. Most doctors maintain that the best techniques for delivering bad news are being completely honest. Something that helps Dr. Laura is that she does not like to

be *efusiva*[7] and show her emotions. However, she does not consider herself cold and heartless.

On the contrary, Dr. Ivana has a dissimilar method of delivering bad news than most of my participants. However, as time progressed, she learned how to avoid the consequences of delivering bad news. "*Te vuelves…no sin sentimientos, sino que lo vez así como que normal… aprendes a no sentir, a dejar las cosas que pasen en el hospital y no llevarte nada a tu casa."* What is interesting about Dr. Ivana is that later in the interview she contradicted herself by affirming she does in fact consider the patients' feelings. She gives bad news using bed-side manners[8], and she affirms her stance and delivers bad news "*Con mucho tacto, poniendo a la persona, a tu paciente como persona…y pensando que esa paciente tiene hijos, tiene hermanos, tiene tíos, tiene abuelitos*." In spite of showing empathy towards patient, she finished her thought by recognizing practitioners are not God, and sometimes bad news will have to be delivered regardless of their complete effort.

Dr. Roberto discusses being selective. "*Fíjate que no te voy a echar mentiras. No te voy a decir que todos los pacientes que fallecen me los llevo a la casa."* Sometimes he becomes attached to certain patients, but he tries to keep it to a minimum. Even though there is an opportunity to express empathy, he prefers to "Acknowledge the situation without really [sharing his] experiences or feelings (Bradley & Sparks, p.20). When he gives bad news to these patients, he thinks about them and about what could have been if he had done something different. It is frustrating, but it is part of the job and he is learning how to manage and divide to achieve segmentation (Burke & Greenglass, 1987). From the beginning of a

[7] Efusiva: effusive; expressing feelings of gratitude, pleasure, or approval in an unrestrained or heartfelt manner.
[8] Bed-side-manners: synonym of the word *tacto* in Spanish.

consultation, he works on the doctor-patient relationship by being "*campechano*[9]*"* and very honest. He likes patients to consider him a friend. Once he has gained their trust, he can openly discuss what the patient is experiencing with honesty.

Doctors must master the delivery of bad news in an empathetic and comforting manner, and this makes it emotionally challenging (Sparks *et al.*, 2007; Sparks & Villagran, 2010). Several participants experience the emotions of their patients because they care. Others have learned how to separate the work experiences from their personal lives. This does not mean they do not care, but they realize the importance of attaining work-life balance and attempt to segment each of these domains as much as possible.

Coping Through Hardships and Routines: Acting, Comradeship, Humor and Retirement

Is Routine Necessary?

Medical practitioners took different approaches when discussing their routines. Several doctors said routine is necessary because without it one cannot keep his/her priorities straight. However, others said their job is never a routine because they see different cases every day. For some, it has remained exciting over the years. Still, other doctors have grown tired of the routine, which can cause burnout.

Dr. Flor's job does not believe in a routine because of the variety of cases she has. She assured that even if she sees the same case, her patients are not the same and must be cared for differently. This makes her job interesting, even if she has seen a case before, it is still challenging. "*Cada paciente es diferente. Los padecimientos a pesar de ser los mismos tienen un poquito de esto o un poquito del otro. De tal manera [que] nunca va a ser rutinario."*

[9] Campechano: cheerful; friendly; good-natured.

An opposite opinion was posited by Dr. Ivana, who said routine is completely necessary. She said there are rules that must be followed. Doctors and people, in general should be disciplined, follow a schedule and accomplish their tasks and responsibilities. Of course, there is always a time when routines can break, for example when she goes on vacation.

> *No creo que haya una persona de que haga lo que se le da la gana…lo haces en tus vacaciones… a mí me enseño una maestra que quiero mucho…que el principio de la vida es la disciplina y por ende la rutina, porque si sales de tu rutina es cuando empieza a haber fallas en el sistema. No quiere decir que la rutina sea buena, algunas veces es bueno salirte de ese círculo. Pero la mayoría de las veces yo soy muy feliz, en el hospital y yo como madre, por ejemplo la experiencia que tengo es que yo no me hallo en mi casa entonces para mi trabajar, desenvolverme con los cirujanos, con mi esposo fuera de mi casa es un balance perfecto.*

If there is a lack of routine, an unbalance might happen. She expressed her routine helps her accomplish her mother and practitioner roles. She keeps equilibrium between them attaining segmentation (Burke & Greenglass, 1987).

Dr. David spoke about his routine as something tiring and negative. After 40 years, he wants to retire because he feels worn-out, experiencing burnout. However, he still has a couple of more years to go because he still enjoys helping the patients.

> Dr. David: *Si si se vuelve una rutina sales de la casa a las 9:30 o 10 y ya te están hablando del consultorio que hay pacientes. Llegas al consultorio, ves a los pacientes, vienes aquí a la una te vas y es una rutina, es una rutina. Y a veces la rutina te cansa y a veces dices ya no quiero ver más pacientes…luego dices por los dos lados estas repelando uno porque no ves muchas pacientes y luego porque ves pacientes entonces si pasa.*
>
> Interviewer: *[Risas] ¿Y si le ha pasado a usted que ya se siente cansado?*
>
> Dr. David: *Si si*

Dr. David's time for retirement is approaching because the routine is starting to bother him.

Dr. Ramon works on techniques to defeat monotony of the occupation. He tries to change his private practice occasionally to avoid feeling tired. He changes the colors of the walls and also keeps the place updated with holiday decorations. This also helps patients who are children remain calm and entertained. Additionally, he enjoys attending medical conventions every year. He visits a new place and learns new things to assist his patients. He also keeps up to date with technological updates. He recently received a new system to retain patient records. This system is much more advanced and he feels overwhelmed by it, but he has to keep updated with the new systems. "*Este es mi sistema nuevo [enseña en la computadora]. Me estresa, pero trato de que no se haga rutina.*"

Culpa Compartida

Doctors cope with the hardships of the profession through different techniques including relationships with colleagues to help them manage the difficulties the job brings. They discuss the stress and their problems with other doctors. Through comradeship, they share the responsibility of cases. They work in teams to help each other. When things become complicated, they divide the responsibility. They have a shared responsibility and guilt in case something bad happens. Doctors cope with the difficulties together. Dr. Flor stated she has several doctors with whom she associates to work with. "*Siempre tenemos a alguien…con el que estamos …asociados para ayuda de cirugía. Los que sabemos que tienen más experiencia…incluso llego a hablarles a maestros míos… "Tengo este caso… ¿Qué consejo me da? ¿Qué más hacemos?"* Dr. Flor appreciates having those relationships because she had never stopped learning. Doctors collaborate and acquire knowledge from each other. They keep their relationships tight and professional for the benefit of the patient as well as their own. She called this "*culpa compartida"* or shared guilt because it decreases

the stress and worry, "*No dejas de pensar en eso, pero si te disminuye el estrés porque al final de cuentas [en] psicología es algo que le llaman culpa compartida de tal manera en que si te reduce un poco el estrés porque te dan otro punto de vista y que eso te amplia un poquito las expectativas de ese padecimiento o de lo que puedes hacer o de cómo puedes ayudar o que más puedes hacer."*

In addition to Dr. Flor, Dr. Ramon also claimed diluting the responsibilities by working with colleagues. His specialty involves taking care of babies in dangerous stages of their birth, and it helps him have someone to share the guilt, "*Cuando uno tiene a su bebe y sale grave él bebe o hay un problema me hablan a mí y ya voy y le ayudo con eso. Para mí es un honor que me hable ¿Verdad? Y trabajar con ellos porque así se diluye la responsabilidad pero sin embargo estas en la lumbre o sea estas con los bebes graves ¡Con los bebes graves...! [Enfatizando]"*

Doctors converge to help each other and share the responsibility that the profession demands. This is a coping mechanism proposed by Cohen and Wills (1985) in their "Analysis of the coping demands presented by negative life events" (Wills, 1987, p.19). Wills (1987) posited that when people, in this case doctors, are presented with adverse life events, they respond by seeking help from members of a larger community. Doctors look for assistance amongst their colleagues to ease the frustration when things go wrong.

Coping Through Humor

Humor has been recognized by Freud (1960) as the most effective coping mechanism with curative properties. Dr. Ramon copes with the hardships through humor. Even after the tragedies experienced on the border, he stayed positive and did not change his approach to life and his work. He works with kids, which is why he uses a fun tactic, "...*Trato de*

llevármela muy relajado, y tratar de contar chistes y estar muy amenos con las pacientes, con las enfermeras, y ensenarles lo que más pueda para que ellas manejen bien al bebe…manejar un poco el estrés…a veces esta la enfermera con la jeringa y está temblando…porque estamos hacienda un procedimiento." He prefers to keep the tension and stress to the minimum by joking with the nurses and patients. This has helped him manage with difficult situations. Stevenson (1993) posits humor is used to relieve emotional pressure. According to Sliter, Kale and Yuan (2014) "The notion that humor is a valuable coping mechanism is popular in our society, and past research has also generally supported the conclusion that humor can combat the effects of stress" (p. 259; Martin & Lefcourt, 1983; Moran & Massam, 1997; Overholser, 1992).

Although the experiences with humor and shared guilt where not persistent throughout the study, they were powerful enough to mention. These are ways in which two of my participants communicately manage with the hardships of the job.

Personal Lives Hidden Through Acting

While doctors deal with the patients' cases they have to manage their own feelings. This is why sometimes doctors reach out for acting techniques. Hochschild (1983) stated most jobs "Require some handling of other people's feelings and [their] own" (p. 11). Surface acting and deep acting are used simultaneously by my participants. Surface acting is defined by Hochschild (1983) as the superficial emotions portrayed during the interaction with the client, in this case the patient, to satisfy the work requirements. The counterpart is deep acting, defined as the realistic emotions felt while interacting with the patient. All of my participants are self-employed, which means they have to create their own rules and expectations. Of course, all of them want the patient to be comfortable and feel cared for

which is why they incorporate emotional labor techniques. Larson and Yao (2005) posited, "Physicians may try to take the patient's role while applying communication skills that have been found to be effective in soothing patients and generating positive treatment results. While engaging in both, each acting method can change the dynamics of the situation, thus, reinforcing the use of the other" (p. 1104). Doctors have to manage their feelings and act to avoid portraying a negative image. They experience deep acting, once they really mean what they are depicting.

Dr. Mario believes there is a specific personality needed to become a doctor. It is a vocational job. He likes to focus on the patient and stops thinking about what is happening at home. The patient goes to his practice to solve a problem, and while he is treating a patient he momentously stops thinking about family issues. "*Tú tienes que abandonar momentáneamente ese pensamiento que te lleva a pensar en tu familia o en tu problema…tienes que enfocarte en el paciente. El paciente viene contigo a buscar una ayuda. No venía a oír un problema tuyo."* If the problem is invasive enough not to let him act, he prefers not to offer medical services that day. He is fortunate enough to have the freedom not to treat patients. He controls his schedule and is his own boss.

Similarly, Dr. Juanita hides her emotions and home problems from the patient. Dr. Juanita stated the patient should not notice if the doctor has an adversity at home. She hides those feelings and patients can trust her. Dr. Juanita's patients go to her private practice to chat and she enjoys listening and offers advice. She acts as their confidant, "*...Si tienes problemas y preocupaciones con la familia, con tus hijos, con tu esposo… ahí es donde si tienes que dar otra cara y quieres que la gente no se entere que traes un problema. Porque no le quieres transmitir un problema tuyo a la paciente, si la paciente viene con su problema,*

entonces ahí trato de jamás notárseme. No quiero que se me note que traigo un sentimiento." She employs *surface acting techniques* (Ashforth and Humphrey, 1993) to show the patient emotions that quickly turn into *deep acting* since she has such interest and care for her patients. She would not like her patients to know about her problems if they already have problems. This is why she takes caution while she is in consultation.

Dr. Roberto mentioned a parallel response to the use of acting techniques, "*Yo creo que siempre. Estés enfermo, estés amargado, enojado lo que sea. Tu a la hora de llegar con el paciente tienes que mostrar otra cara. ¿Por qué? Porque eso va depender mucho de que el paciente te tenga confianza para que lo sigas atendiendo y el paciente se sienta tranquilo y bien atendido."* In his opinion, this forges a relationship based on trust. He acts because it is necessary to give an outstanding service to the patient. He does not mind acting as long as the patient feels attended. That is the purpose of pretending. This satisfaction makes him forget about his personal problems. He experiences surface acting to make sure the patient feel good but turns into deep acting because he actually ends up forgetting. He shared, "*Fíjate que en ese momento me siento bien. O sea yo, se me olvida si andaba enojado, amargado, etcétera. Se me olvida. Yo creo es porque una:… lo primero es el paciente y lo segundo estoy haciendo lo que me gusta a pesar de lo que haya pasado unos minutos antes en ese momento estoy haciendo lo que me gusta y se me olvida."*

Dr. David admits he has to act. "*Aunque por dentro estés enojado, una buena cara."* He always demonstrates the patient that he cares for them. He dedicates enough time to each one of his patients. He cares and takes the time to check up on them by calling them a day later or two. "*Eso les gusta a los pacientes…a veces les causa admiración 'oiga doctor muchas gracias por hablarme y por interesare' entonces si…yo si lo hago muy seguido."*

Moreover, he shows them interest and builds trust. It is not professional to mix personal life with the consultation. Dr. David expressed, "*Solamente puedes demostrar que estas sufriendo cuando está sufriendo el."* If you share your adversities, the patient will feel bombarded and overwhelmed.

Several doctors assure they have learned to separate their personal lives and problems from the job. Dr. Laura assures that she never shows her emotions to her patients. She always shows a neutral but good attitude to them regardless of her feeling of sadness, anger or stress. "¡*Ah sí! Tú tienes que aprender a separar. O sea desde el momento, tú puedes andar triste, puedes andar enojado, puedes andar con muchas emociones…pero al momento que estas con los papas y enfrente de los niños tú tienes que [mostrar] una actitud buena."* She is passionate for her job and always shows a positive attitude towards her patients. She prefers to show a neutral face and for states, it is not difficult to hide the emotions because it is for the patient's benefit.

Dr. Maria stated the patients expect a service and they did not have anything to do with the doctor having problems; it is not their fault. She takes close care of the evening patients since she feels tired at that time of the day. She likes treating every patient as if it was the first one she receives in the morning when she is most energetic, "*¡Ah claro! Claro los pacientes no tienen culpa de que tú estés cansada. De que hayas tenido un mal día con tu familia. Eh, los pacientes no tienen culpa. Realmente cuando son como las seis de la tarde, siete, que ya estoy…ya me siento realmente cansada de estar trabajando, es cuando agarro más aire y trato de ser más comprensiva y dedicarles más atención a mis pacientes porque tengo que hacer un mejor esfuerzo para no dejarme llevar por ese cansancio o por esa fatiga."*

All of the participants participated in either surface or deep acting at some point in their careers. This means the interviewees have experienced worry and despair when dealing with their patients' cases. They are humans and not robots offering medical services. Certain attachment to their patients demonstrated their emotional capacity. Hoshchild (1983) proposed altruistic acting, a different approach to describe individuals concerned about other people's needs. Doctors fall into this category because they are acting in order to demonstrate how they care for their patients. However, according to their experiences, it seems most participants close off or block what is taking place in their personal lives during the consultation.

When should I retire? Ambiguity

Retirement was another controversial topic. Some doctors are tired after working for many years, but others do not want to retire just yet. After so many years, doctors might experience burnout, which leads them to retirement. Nevertheless, several of my participants are willing to be forced into retirement until they cannot practice anymore. Retirement becomes the ultimate coping strategy. Dr. Ramon believes that once you are a doctor you will always be a doctor. *"Realmente para retirarme, yo siempre le decía a un amigo que ya no trabaja que el que es doctor, siempre va a ser doctor. Pero yo me veo viejo siguiendo consultando. Yo creo que me voy a retirar cuando se me olviden las cosas, cuando no vea, cuando ya…"* Furthermore, Dr. Ramon recognized doctors should be aware of their abilities. One day they will no longer be enough to perform, "*Como los toreros hay que retirarme en el momento adecuado. Porque yo he visto doctores muy buenos que eran muy buenos y van a los hospitales y hablan Francés, no hablan español, y luego se orinan en las esquinas. Te estoy diciendo que un doctor que fue exageradamente bueno y la misma familia lo sigue*

ayudando que porque si lo sacan del hospital se muere. Pero ver tu esas cosas es bien difícil. La cosa es retirarnos…"

Similarly, Dr. Mario recognized that one day he will not have the mental ability to keep working. He hopes this happens when he is very old. "*Sé que algún día no voy a poder trabajar, pero yo pienso que sea cuando este muy grande ¿Verdad?"* He cannot bare thinking about his retirement. "*Es la muerte para mí, nunca me ha pesado trabajar. Siempre me ha apasionado… me ha gustado lo que hago."* He will do it when it is necessary. He does have a retirement plan though. When the time comes he would like to open a restaurant to develop his cooking skills.

Dr. Eloy was the oldest participant interviewed. He remains passionate about his practice. However, he admitted he has been feeling more nervous lately. Even more than when he started. "*Dios quiera que me vaya bien, ojala que le pique bien*[10]*."* He has never failed to perform the procedures, but as he gets older he feels scared and is tired. He implied retirement is approaching, "*…Ya me canse son 50 años de trabajar como anestesiólogo ¡Deja eso! El que se levanta en las noches soy ¡Yo![enfatizando] Nadie se quiere levantar. Todos los balaceados que hubo en pasados años, ni uno quería anestesiar. Aquí tenía miedo venir porque en las noches no había nadie en la calle."*

There is a tension between his desire to keep working and retire, but he finally admits it is time to retire. "*...ya trabajo menos y ya no quiero trabajar. Quizá sí, cositas chiquitas: degraditos… eso sí porque es una cosa muy sencilla. No es anestesia, es una sedación … puras cosas chiquitas sí. Pero ya, ya yo pienso retirarme. Porque estoy pensionado del seguro. Tengo buena pensión. Pues ya nadamas estamos mi mujer y yo solos.*

[10] Ojala y le pique bien: Referring to giving an injection without a mistake.

Conversely, Dr. Laura, one of the youngest participants, had a different mindset. She would like to retire once her kids are mature and settled with their respective families. She will provide an education and a place to live, but once they are independent, she would like to retire and enjoy her hobbies, "*...primero tener tu patrimonio o sea tu casa y darle la educación a tus hijos y que salgan a delante. Yo creo que ya llegara una etapa en que si mis hijos ya salieron adelante [y que] yo ya tengo cierto punto de solvencia económica…No voy a ser como doctora de setenta tantos u ochenta años que ya ni puedes ver bien…Se me hace que el paciente se merece un respeto. Saber tus limitaciones y saber ya hasta qué punto llegas y decir yo hasta aquí y las nuevas generaciones adelante.*

Several doctors want to retire young and travel to enjoy their lives. However, for others, their work is what makes them enjoy life. There was a variety of passion and compromise to the patients and their practice. Retirement can become ambiguous because there is no guideline signaling the right time to retire. Some participants enjoy their job and would like to continue being doctors until their capabilities are exhausted. There is a thin line between not being able to work due to the lack of competencies and the time to retirement.

In addition to the coping techniques mentioned above, doctors are able to use their passion for their job to cope with the hardships. Even though they have a difficult time dealing with their patients' cases, they still enjoy their medical practices. Even though several doctors want to retire soon, others do not see that day coming anytime soon. Doctors will continue to manage their feelings in order to be professional and provide medical services and most importantly, maintain an effective doctor-patient relationship.

CHAPTER IV

DISCUSSION

In the previous analysis chapters, I offer an understanding to my research questions. In this chapter, I offer my findings within the organizational communication literature to describe doctors' lived experiences on the border region. I start with my contributions developed from the interpretation of the findings in the analysis chapters. To conclude, I discuss the limitations and future research together with my final thoughts about the study.

The research study sought to answer two questions. First, it intended to examine doctors' work-life experiences and the ways in which they manage both domains (Burke & Greenglass, 1987). My analysis chapters showcased significant information concerning work and life interlocking. The second purpose was to explore doctors' emotions while working (Hochschild, 1983). They experience fear, stress and frustration at times, which sometimes lead into burnout and retirement. In the following section, I examine and discuss these findings thoroughly.

Care on the Border: A Patient-Centered Approach

Doctors' care is different on the border, especially because Nuevo Laredo has been struggling with rough patches of violence in the past 10 years. My participants mentioned circumstances when they found themselves modifying their services to accommodate to the uncertain environment in Nuevo Laredo. The comparison between Nuevo Laredo and the sister city was predominant in my participants' responses. It was inevitable for them to avoid mentioning their patients shared experiences and according to patients' experiences and doctors' opinions, medical practice in the U.S. is too fast and insensible. American doctors are "*fríos."* Wright, Bradley, and O'Hair (2013) discussed how patients believe doctors in the

U.S. do not give them enough time and attention. Doctors briefly listen to the patient's issues and quickly they call on a nurse offer a prescription (Wright, Bradley, & O'Hair, 2013). Dr. Ramon and Dr. Juanita agreed the reason why doctors do not socialize with the patients as much as patients would like is because doctors are more susceptible to lawsuits in the U.S. They are defensive because any mistake can put their license in jeopardy. Street, Gordon, and Haidet (2007) revealed physicians using a patient-centered approach present better communication skills and have satisfied patients as an outcome. According to my participants, U.S. doctors seem to employ a biomedical approach, which makes sense as to why many Americans prefer the Mexican patient-centered approach (Schreiber, 2005; Tyreman, 2006).

By crossing into Nuevo Laredo, patients receive a service they prefer over any technological advantages the U.S. might have in comparison to Mexico, which are some of the differences mentioned. Doctors in Mexico do without the expensive technology, but they offer a warm service by using bedside manners or *tacto,* which is appreciated by the patients. They practice patient-centered communication. According to my participants' patients, in the U.S. many doctors do not interact with the patient as much as they would like (Wright, Bradley& O'Hair, 2013). This is one of the many reasons why American patients travel to Mexico to receive medical attention.

Patient-centered communication is a practice that focuses on the individual "as a whole" and not only a patient; doctors consider the patient's psychological and social circumstances instead of only treating them like patients (Hirsh *et al.*, 2005; Mast, Kindlimann & Langiwitz, 2005). Smith (2002) stated, through patient-centered services doctors care uniquely for every person's individual condition or circumstance. My

participants used several of the strategies and techniques described by Roter and Hall (2004). For instance, they allow their patients to disclose the information they think is relevant (Roter & Hall, 2004). Dr. Juanita became a confidant for her patients. She mentioned that patients go to her practice to talk to her. They tell her personal stories, and finally, she offers a diagnosis. Similarly, Dr. Polo stated patients do their own diagnosis when they describe their symptoms, and he is merely the tool to help solve their problems. Other characteristics of patient-centered communication include 'motivating the patients' confidence on their assertions, discussing not only about the patient's biomedical state, but also their psychosocial needs, and finally asking open-ended questions to allow the patient to express their problems freely and guide the doctor through it all (Roter & Hall, 2004).

The service provided on the Mexican side of the border is worth paying for. A good example is James, Dr. Polo's client who sends patients from Houston because while he could be receiving medical attention in Houston, he rather be in Nuevo Laredo receiving personalized care and includes thorough explanations. At the same time, studies show that the high cost of U.S. medical services is one of the main reasons why American patients travel to Mexico to receive medical care (Bergmark, Barr & Garcia, 2010; Charur, 2015; Macias & Morales 2001). In addition, medical services in Mexico are provided by a specialist and patients often look for personalized contact with the specialist, which happens in limited periods of time in the U.S. (Charur, 2015; Horton & Cole, 2011). Finally, language was another incentive for Hispanic patients obtaining medical services on the border (Byrd & Law, 2009; Bergmark, Barr & Garcia, 2010). Native Spanish speakers feel more comfortable

speaking Spanish and understanding the doctors completely (Byrd & Law, 2009; Bergmark, Barr & Garcia, 2010).

Doctors on the Border Modify as a Protection Strategy

Doctors have to secure themselves and their patients. They must be cautious because life on the border comes with the burden of the violent occurrence that may encounter. Eight out of the 12 participants shared some sort of violence occurrence. Dr. Ramon, Dr. Mario and Dr. Ivana's husband experienced kidnappings. Other doctors such as Dr. Flor and Dr. Juanita had the misfortune of being mugged in their private practice. In turn, their patients also suffer the consequences. Dr. Arturo, Dr. Maria, Dr. Flor, Dr. Laura and Dr. Juanita mentioned modifications to their schedules. Before, Dr. Juanita would consult until midnight, which is something she cannot do anymore. My participants' schedules were affected, which impacted their patient flow since many patients can only visit their doctor after their work hours. This also affects the doctors' income since it caused a decrease in patients by 50 percent, according to Dr. Juanita.

Attire as a Protective Artifact

It is clear that the drug war intersects with their work and forces them to modify their work practices to protect themselves and their patients, yet a distinctive change was mentioned by two of my participants. Dr. Ramon and Dr. Mario spoke openly about modifying their attire to protect themselves. When doctors have to modify their lifestyles to coexist in their environment, work and life are not segmented. This means the doctors living in Nuevo Laredo experience a continuous spillover between their work-life and the living situation.

Dr. Ramon dressed to show authority and professionalism and he would wear slacks, button-up dress shirts, a tie and a coat; however, after experiencing the tragedy of being kidnapped he now prefers to dress casually to blend in and be unnoticed. He stated that doctors have learned to live with the fact that they have to hide their privileges; they must learn and accept that. Even though he was the only participant who explicitly discussed this in detail, I noticed my other participants were not wearing clothing that showed authority or high status.

Dr. Mario prefers to wear his scrubs to protect himself. Instead of worrying about his clothing or outfit of the day and being too ostentatious, he wears the medical attire to validate his medical role. If an emergency occurs in or outside the hospital, the doctor has a specific role and can help. He utilizes his privilege of being a medical doctor to protect himself. "*Digo yo pues si pasa por ahí alguna cosa pues soy el doctor, tengo que atender a alguien."*

Doctors have learned to live with this situation of holding back and acting or dressing differently to be overlooked by delinquents. Attire is a protection tool, and they find themselves forced to change in order to avoid violent occurrences. This is an added stress for doctors, since they must deal with the stressful daily occurrences of a doctor including maintaining their business, managing their patients' medical issues, emotions and problems together with their own, and protecting their medical license. These worries are added to the stressors of living in an environment where they are directly interacting with the criminals. At the same time, they also directly come into contact with criminals since they too seek medical attention and require their medical services. Their work and life intersect with their living situation and causes an imbalance even though doctors continuously attempt to

separate them. The majority of my participants had experiences dealing with this environment of violence in the border.

Looking For a Theoretical Fit: Work-Life Models

Throughout this study it was noticeable that doctors' work lives intertwine with personal lives, causing interesting work-life experiences, both balanced and unbalanced. Work-life experiences are not exclusive to medical doctors. Studies reveal employees from varying job sectors experience similar situations. Hotels illustrate a valid example (Mulvaney, O'Neill, Cleveland & Crouter, 2007). The hotel industry has historically been involved with work-family conflict (Dermody & Holloway, 1998). Presser (2004) discovered hotel management is one of the top ten jobs with no set working schedule, which leads to the family-work imbalance and unavailability of resources for both domains. These facts are similar to my findings. My participants too shared their experiences of working without time limitations while attempting to keep their patients satisfied.

Family issues were also raised by my participants when discussing time management between both domains. The job of a doctor may be never-ending. This depends on how available the doctor wants to be to their patients. My participants shared their cellular numbers with their patients in order to have access to them at all times, even during family reunions or birthday parties. Doctors experience a time-based conflict because by attending work calls or emergencies, the personal life domain is not fulfilled (Repetti, 1987). Dr. Maria does not like to mix work and life and if it was only her decision she would not, however, some patients know where she lives and have gone asking for consultation. Dr. Maria's kids feel frustrated when this spillover phenomenon occurs at their private home. Bringing problems into the family might be inevitable sometimes, and even more challenging if your

spouse is a doctor as well. However, for Dr. Ivana and her husband, the spillover does not bother them. In fact, it serves as a therapeutic coping mechanism, and it shows they care for their patients.

As I concluded my study, I considered the position where my participants stand in terms of work-life balance. Were they able to separate their family and work lives? Was it a constant intersection of both domains causing a spillover effect? They experience both which means these terms are not fully explaining my participants' experiences. Clark (2000) developed the border theory, which states individuals cross domain borders on a daily basis. There is permeability between work and life domains. This new theory seeks to provide a "Remedy [to] the criticism and gaps of previous theories of work and family" (Clark, 2000, p. 750). The theories mentioned before, such as segmentation, spillover, compensation, or resource drain offer an interesting analysis but when considering my participants' overall work-life experiences, these do not seem to directly align. After analyzing the interviews I discovered my participants find themselves crossing the border of family and work constantly, sometimes without even noticing.

In addition to the border theory (Clark, 2000) the role theory (Kahn *et al.* 1964) also describes my participants' multiple role amalgamation. This theory proposes workers, in this case, doctors, are involved in varying life roles such as employee or family member amongst other roles that sometimes are incompatible (Greenhaus & Beutell, 1985). The resource scarcity hypothesis (Jin, Ford & Chen, 2013), developed from the role theory, states individuals have a limited amount of time and energy to serve their multiple roles. I believe some of my participants have experienced this scarcity of resources because of the hardships that come with being a doctor and a parent. In addition, they take on the role of being vigilant

and careful due to the border situation of violence. Nevertheless, Greenhaus and Powell (2006) raise hope in recent studies by stating the roles can also be dependent on each other and even enriching. Because of these circumstances, the work-life experiences of my participants become much more complex. Regardless of the hardships and other violence occurrences, my participants maintain a passion for their profession and see it as a vocation.

Emotions Prevail Unnoticed

Emotional labor (Hochschild, 1983) has become a popular topic of research; however, the literature on physician-focused studies is not copious compared with the attention paid to workers in other fields (Shanafelt *et al.*, 2012). For instance, Murphy (2001) discussed how flight attendants experience emotional labor, stress and burnout due to the specific requirements the job entails. They must appear calm in situations of danger and act nicely towards all the passengers, including the unruly ones (Murphy 2001). Similarly to doctors, flight attendants have their personal lives and have to manage their acting skills in front of the passengers if they have a personal problem. Emotional labor is present on any service work that involves contact with a client (Leidner, 1999; Hennig-Thurau, Groth, Paul, & Gremler, 2006).

In terms of the emotions experienced by my participants, I found they cope in unique ways. Dr. Flor and Dr. Ramon indicated they shared guilt, "*culpa compartida,"* to dilute the responsibility and traumatic effects of the burden carried when things unexpectedly go wrong. They have a predetermined group of colleagues which whom they work with in difficult cases. Cohen and Wills (1985) posited when presented with adversities in life, doctors look for help from a larger community of colleagues.

The expression of problems amongst colleagues or even spouses and friends was used as a coping mechanism to release the stress and worry experienced in their practices. My participants admitted feeling frustrated and sad when dealing with stressful situations at work, which is a clear example of emotional labor (Hochschild 1983). This involves managing feelings to portray a required facial or bodily expression to the client while not showing their true feelings. Furthermore, they recognized the need to hide those emotions in order to build a relationship based on trust with their patients. Handling their patients' feelings while dealing with their own is challenging (Hochschild, 1983).

Doctors use *surface acting techniques* in order (Ashforth and Humphrey, 1993) to be professional and not show their personal problems. However, doctors genuinely care for their patients and employ *surface acting* techniques and utilize *deep acting* (Ashforth and Humphrey, 1993). Participants show empathy towards their patients, which is recognized by Larson and Yao (2005) as a healing process and "More than just deep or surface acting… empathy gives us a fundamental understanding of our physical and mental being" (p.1105). My participants fall into the category of *altruistic acting* proposed by Hoshchild (1983). Doctors care for their patients' needs and the acting is seamless; they tend to forget about their personal lives while in consultation.

All the stressful and worrisome situations eventually may lead to burnout. Based on Maslach, Jackson, and Leiter's (1997) results, Shanafelt (2012) stated physicians may experience professional burnout, "Characterized by the loss of enthusiasm (emotional exhaustion), feelings of cynicism (depersonalization) and a low sense of personal accomplishment" (p.1377 and see also Spickard, Gabbe, & Christensen, 2002). Dr. Eloy and Dr. David were the two oldest male participants, expressed feeling tired. Dr. is now working

less and will soon retire. Dr. David feels like his life as a doctor has become a routine, and it has become tiring. Although he is experiencing burnout, Dr. David is not ready to retire since he still enjoys his profession. They understand their time to retire is approaching, but they would like to continue as long as they are able to perform the procedures.

The younger doctors shared early retirement plans. According to *The Economist* (2009), the baby boomers have placed organizations in a predicament as they attempt to retain the younger generations who arrive with different values, attitudes, and expectations in comparison to the previous generation. Dr. Laura, 34 has plans to retire as soon as her children are independent. She expressed not wanting to be an old doctor causing pity from others.

I intend to make the audience mindful about the doctors' experiences when it comes to managing their feelings. Acting will not wipe out their feelings of worry and stress, which are challenging to manage. All my participants, however, are staying strong for now and offering the best medical services possible. Spickard, Gabbe and Christensen (2002) posited the way to avoid burnout is by taking breaks and enjoy some free time to take care of their own wellbeing. Sometimes the meetings, patients, and paperwork amongst other things can get overwhelming (Spickard, Gabbe & Christensen, 2002). Doctors in my study have hobbies such as cooking, traveling, engaging in sports activities, and enjoy going out to dinner with friends. They work hard but they are also mindful of the need to rest.

Practical Implications

Other scholars have focused their research on patients' experiences and preferences not taking into account the physician's voice (Byrd & Law, 2009; Horton & Cole, 2011; Landeck & Garza, 2003). This is why my study is important; through in-depth interviews, I

am giving a voice to medical practitioners in the border region of Nuevo Laredo, Mexico and Laredo, TX. It is important to raise awareness among doctors, patients and even individuals involved in other fields. Informing these communities about doctors' work-life experiences is important since they are at the forefront of the medical field. People seldom consider doctors management of emotions, or how their work lives might intersect with personal lives and the implications this has for their profession and their patients. At the same time, these work-life experiences are pertinent in other fields as well and not exclusive to the medical field. This study can also inform the general audiences about work-life balance intersections, emotional labor, and the strategies employed when the complexity of such exchanges take place.

The fact that doctors in my study had to modify their lifestyle to avoid being part of a violent occurrence underlines the complexities of managing both work and personal lives. The job is stressful, but we need to consider living on a border that is dealing with violence as an added stress. Doctors must modify their care practices, attire, schedules, add security measures to their work practices, and come into contact with the criminals. These occupational conditions reveal the added challenges of maintaining work-life balance.

My study also provides important information on a patient-centered approach as the best way to provide medical services. Doctors may utilize my study as a guide to indicate patient-centered communication practiced on the border since it is the preferred method of care that leads to better patient health outcomes.

Limitations and Future Research

My participants offered rich information and provided a broad understanding of doctors' experiences of living on the border and managing their work and lives. Considering there is a lack of studies that consider doctors' experiences on the border, this exploratory

study is a good start. However, the limitations of my study are presented in the following section.

This qualitative study focused on doctors that work in private hospitals and have their own practices. Although the interviews were detailed and answered the research questions, only 12 interviews were conducted, which limits the stories and experiences of doctors. This study also does not account for the experiences of doctors working in public hospitals and clinics since only doctors who own private practices were participants for this research.

Moreover, my participants were very much aware of not revealing too much information when discussing violence and criminal activity. This might have been because of fear of sharing too much information and retaliation. Although all of my participants used pseudonyms, they remained fearful of sharing information that is too revealing and might put their lives in jeopardy.

Even though they shared some hardships, it was clear doctors showcased their occupation as a favorable profession only. Something that might have restricted information from the interviews is the fact that I knew most of the doctors. Maybe at some point during the interviews, they felt uncomfortable or embarrassed to say something because they thought I could share the information with other doctors or the key informant. I was clear to tell them the interviews were confidential and their identities were not going to be revealed.

Time constraint was also present since doctors have a busy schedule and their daily work schedule are uncertain. I had a difficult time meeting with several doctors. They at times had too many patients, too many meetings, or too many calls. Even though I waited without success at times, I continued to communicate for a better time and/or place to conduct the interviews. Fortunately, they were able to find the time to meet with me without

time restrains, but I noticed something interesting during my interviews. Most of our conversations were interrupted by people entering their work office, a phone call, or by a text message. Since they are essential for the medical services they provide, they answered the calls and messages. The last thing I wanted to do was interfere with their work practices. In the future, it makes sense to try to meet with my participants outside of their work offices.

I related and analyzed my participants' work-life and emotional labor experiences. Future studies should include a variety of medical area, ages, and location of practice to contribute to the research scope. Expanding studies like mine can help us understand how doctors who reside in different border towns manage work and life.

Conclusion

Doctors' daily experiences of living on the border of Nuevo Laredo, Mexico and Laredo, Texas constrain their work lives. The kidnappings, muggings, extortions and other violence consequences affect doctors' daily lives. They modify their work practices, their schedules and other daily routines, which intersect with their work, personal lives, and the city environment.

My participants strive for segmentation, which seems the ideal separation between work and family. While attempting to separate the domains, they find themselves serving multiple roles simultaneously and they are inclined to have their work lives spillover or interlock with their personal lives or compensate one domain over the other. This is why an interesting way of looking at these intersections between family and life are through role theory (Kahn *et al.*, 1964) and border theory (Clark, 2000). Doctors reveal that work and life do interfere but it is still important to take the time to attend to both accordingly.

Through acting techniques, doctors are able to hide their emotions, but that does not mean it does not influence their personal lives. It is a cycle and the outcome of these stressful situations may lead burnout. It is important that the education and health care system offer enough training during the early stages of their careers, and that "it entails the explicit promotion of the physicians' well-being" (Spickard, Gabbe & Christensen, 2002, p.1450).

It is not only the intersection between domains that matter. It is equally relevant to consider how doctors' utilize and manage these experiences. My participants displayed resilience to continue practicing on the border regardless of the violence and other occupational conditions.

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APENDICES

A. Interview Protocol

Location:
Duración:

1. Nombre / **Name**: (pseudonimo)
2. Edad / **Age**:
3. ¿Cuánto tiempo lleva ejerciendo la profesión de médico? / **How long have you practiced medicine?**
4. ¿Cuánto tiempo lleva ejerciendo en la frontera de México con Estados Unidos? / **How long haveyou practiced medicine on the border?**
5. ¿En qué área médica se desarrolla? / **What is your area of expertise in the field?**
6. ¿Por qué escogió esta profesión?

   a. ¿Recuerda el momento en el que decidió que quería ser doctor? / **Why did you chose this profession? Do you remember the moment you decided to pursue this career?**
7. ¿Me podria platicar algo sobre sus primeros procedimientos médicos? / **Tell me a little bit about your experiences when you participated in your first medical procedure?**
   a. Se acuerda ¿Que sintió?/**How did it feel?**
   b. ¿Cómo han cambiado estos sentimientos con el tiempo?/ **How has this changed over time?**
8. ¿Es difícil no dejarse llevar por las emociones con sus pacientes?
9. ¿Cuáles son sus experiencias trabajando en la frontera?
10. ¿Cuénteme qué lo hizo decidir trabajar en la frontera? / **Tell me why you decided to work on the border**3. ¿Cuáles son los beneficios de trabajar en la frontera? / **What are some of the benefits of working in the border region?**
11. **¿Cuáles** son las ventajas de trabajar en la frontera?
12. ¿Cuáles son las desventajas de trabajar en la frontera? / **What are some disadvantages of working in the border región?**
13. ¿Cuáles son las ventajas de su trabajo? / **What are some general advantages and disadvantages of your occupation?**

14. ¿cuales son las desventajas de su trabajo?

15. ¿Se contagia normalmente del sentimiento de sus pacientes? / **Do you feel empathy when treating patients?**

16. Creo que una de las cosas difíciles de su trabajo es dar una mala noticia. ¿Cómo da una mala noticia a un paciente?

    a. ¿Cómo se siente eso?
    b. ¿Podría contar algunas de sus experiencias? / **I am sure delivering bad news is a difficult part of your job, can you tell me about that?**
    c. ¿Cómo ha logrado sobrellevar esta situación? **How do you cope with this**?
    d. ¿Ha cambiado con los años? /**How has this changed over the years?**
    e. ¿Cómo maneja o confronta estos sentimientos? /**How do you cope with these feelings?**

17. Dar ejemplo de clases en TAMIU ¿Cree usted que en su trabajo en algún momento debe ocultar sentimientos /**I have been teaching a class, and I commented with my profesor how, when teaching a class, no matter how you are feeling you must show a good attitude? Do you find yourself doing the same when you work?**
    a. ¿Cómo se siente al hacerlo y porque lo hace? /**Why do you think you do that? How does it feel?**

18. ¿Cómo define la palabra cultura? /**How do you define culture?**

19. ¿En qué sentido cree que su cultura (Mexicana, Hispana, Latina) influye en su manera de trabajar? / **How do you think your Hispanic, Mexican, Latino culture influences the way you work?**

20. Platíqueme por favor ¿Cuál ha sido su experiencia tratando pacientes estadounidenses? / **What has been your experience when treating American patients?**
    a. Cuénteme una de sus experiencias/ **Tell me about one of your experiences.**

21. Yo vivi en Nuevo Laredo toda mi vida hasta hace tres años, recuerdo ese año cuando no podíamos salir a la calle después de las 6 de la tarde. ¿Cuál es su experiencia al trabajar en un ambiente donde la delincuencia está infiltrada en Nuevo Laredo \? / **What is your experience working in a city where crime and violence are present prominently?** ¿Cómo ha cambiado o afectado su manera de trabajar la inseguridad y delincuencia que hemos vivido en los últimos 10 años en Nuevo Laredo? / **Tell me a little bit about how have you changed your way of working due to insecurity**

we have lived in the past 10 years in Nuevo Laredo.

22. ¿Ha tenido alguna mala experiencia en su trabajo debido a la inseguridad y violencia presentes en la ciudad? ¿Cuál es su experiencia al trabajar en un ambiente donde la delincuencia está infiltrada en la sociedad?]/ **What is your experience working where delinquency** a la inseguridad? / **Have you experienced an unfortunate situation due to the violence and insecurity in our city?**

23. ¿En algún momento ha pensado en mudarse a nuestro ciudad vecina? ¿Por qué sí/no? / **Have you considered moving to our sister city? Why or why not?**

24. Vivimos en una sociedad contaminada por la actividad criminal, ¿Cómo afecta esto sus niveles de estrés al trabajar? / **We live in a society corrupted by criminal activity, How does this affect your stress levels?**

25. Platíqueme, ¿qué hace en su tiempo libre? / **What hobbies or activities do you practice on your free time?**
    a. ¿Cree que estas actividades le ayudan a manejar estrés?/ **Do you feel these activities help you deal with stress?**

26. Existen personas que al llegar a casa comentan como estuvo su día, en mi caso suelo contarle a mi mamá mis problemas para desahogarme. ¿Qué opina de esta expresión de problemas en un trabajo como el suyo? **There are people that come home commenting on their daily experiences. In my case I like talking to my mother about my problems to express my worry. What is your opinion of these expressions being a doctor?**
    a. ¿Con quién comenta o desahoga su estrés y problemas de trabajo? / **With whom do you comment or express your work problems or stress?**

27. La experiencia puede llegar a cambiar personas. ¿Cómo cree que su experiencia específica (be specific here) ha cambiado su manera de trabajar? **Experience changes people, How has experience affected your work practice?**

28. ¿Cree que en algún momento su trabajo se vuelve una rutina? **Do you ever consider your work as repetitive, as a routine?**

29. ¿En algún momento ha considerado cambiar de profesión? **Have you ever considered changing your profession?**

B. Doctors' Demographics

Name A-Z (Pseudonym)	Gender	Medical area	Time practicing (Border)	Time practicing (Total)
David	M	Traumatology	30-40 years	40-50 years
Eloy	M	Anesthesiology	not disclosed	50-60 years
Ivana	F	Anesthesiology	1-10 years	1-10 years
Juanita, Flor	F	Gynecology	30-40 years	30-40 years
Maria	F	Otolaryngology	20-30 years	20-30 years
Mario, Polo	M	Surgery	20-30 years	20-30 years
Roberto	M	Surgery	0-5 years	0-5 years
Ramon	M	Neonatology	10-20 years	10-20 years
Laura	F	Pediatrics	1-10 years	1-10 years
Arturo	M	Nephrology	not disclosed	30-40 years

VITA

Ana Luisa Ramírez Cantú received her Bachelor of Arts degree in Communication with a minor in Theater from Texas A&M International University in 2011. She entered the Program of Organizational Communication at Texas A&M University in June 2015 and received her Master of Arts degree in May 2017. Her research interests include the theory of emotional labor coined by Arlie Russel Hochschild (1983) amongst other theories related to work-life balance. She wishes to continue in this line of research to apply these theories to a case based on college professors and their emotional labor and work-life balance experiences. Ms. Ramírez will also continue with this topic, however, now focusing on the patients' experiences. She also enjoys theater, acting and directing; therefore, an MFA in theater directing is also in her plans. She enjoys teaching at the college level, which is why she will pursue a Ph.D. in Communication or Anthropology.

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