Advances in Social Science and Culture
ISSN 2640-9682 (Print) ISSN 2640-9674 (Online)
Vol. 8, No. 3, 2026
www.scholink.org/ojs/index.php/assc

Original Paper

Practice and Dilemmas of Junior Doctors in the Construction of Therapeutic Landscapes in Pediatric Hematology: From the Perspective of Emotional Labor

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Received: February 29, 2026 Accepted: April 22, 2026 Online Published: May 7, 2026
doi:10.22158/assc.v8n3p1 URL: http://dx.doi.org/10.22158/assc.v8n3p1

Abstract

Therapeutic landscapes are dynamic systems co-constructed by physical environments, social landscapes, and symbolic landscapes, which play a critical role in patient recovery and professional experiences of medical staff within medical spaces. As a special medical field with high emotional load and high social attention, the construction of therapeutic landscapes in the Department of Pediatric Hematology relies not only on the professional guidance and decision-making coordination of senior physicians such as chief physicians and attending physicians, but also on the frontline participation and daily practice of junior doctors including interns and residents. Based on the therapeutic landscape theory of health geography and emotional labor theory of sociology, this study takes the Department of Pediatric Hematology as the research setting, adopts methods of participant observation, in-depth interviews, and grounded theory coding, and systematically analyzes the specific participation modes of junior doctors (interns and residents) in activating physical spaces, maintaining social relationships, and practicing symbolic interactions. It further reveals the dilemmas they face under factors including emotional labor pressure, institutional constraints, hierarchical power restrictions, and uncertain professional identity, and then proposes optimization paths from four dimensions: spatial support, institutional guarantee, emotional empowerment, and capacity building. The study finds that junior doctors are the daily producers and stable maintainers of therapeutic landscapes in the Department of Pediatric Hematology. Their deep-acting emotional labor helps create a warm and trusting therapeutic atmosphere, while surface acting and defensive tendencies weaken therapeutic effects. The participation dilemmas of junior doctors are essentially the combined result of structural pressure, identity tension, and unequal spatial power. Strengthening the participation of junior doctors in constructing therapeutic landscapes has important practical significance for improving

doctor-patient relationships, enhancing the warmth of medical services, and promoting the physical and mental health of medical staff.

Keywords
Intern, Resident, Therapeutic Landscape, Emotional Labor, Pediatric Hematologic Diseases

1. Introduction

In recent years, research on therapeutic landscapes from the perspective of health geography has gradually shifted from natural environments and community spaces to medical settings. Hospitals are no longer regarded merely as technological spaces for diagnosis and treatment, but as therapeutic fields co-shaped by physical environments, social relations, and symbolic interactions (Gesler, 1992; Kearns & Milligan, 2020). The pediatric hematology department constitutes a highly distinctive medical space due to the long treatment cycle, frequent invasive procedures, vulnerable physical and mental conditions of children, and high anxiety levels of family members. Its therapeutic landscape is characterized by complex tensions: care coexists with discipline, trust is intertwined with misunderstanding, and emotional engagement is balanced with self-protection (Zhou et al., 2023). In this context, the emotional labor of medical staff serves as a core bond connecting physical space, social relations, and symbolic interactions, directly determining the quality and stability of therapeutic landscapes (Grandey, 2000; Chen et al., 2025).

Existing studies have mostly focused on the leading role of senior actors such as chief physicians and head nurses in constructing therapeutic landscapes, or treated medical staff as a homogeneous group, rarely examining differences among medical workers of various ranks and identities (Zhou & Grady, 2016). In fact, in the teaching hospital system in China, interns and residents constitute the main frontline clinical force. They undertake basic tasks including daily ward rounds, medical documentation, doctor-patient communication, procedural assistance, and patient accompaniment, representing the group with the highest frequency and longest duration of contact with children and their families. However, this group widely faces multiple pressures: uncertain professional identity, heavy workload, high risks of emotional exhaustion, marginalized power status, and insufficient economic rewards. Their emotional labor strategies, spatial practice patterns, and engagement in therapeutic landscapes differ significantly from those of senior physicians (Lo et al., 2018; Zhang et al., 2020).

Current research on junior doctors has concentrated on single topics such as job burnout, disciplinary pressure, and professional adaptation, yet has not placed them within an integrated framework of therapeutic landscapes to systematically explore their engagement mechanisms, constraints, and optimization paths. Accordingly, this study takes the pediatric hematology department as the research setting and focuses on interns and residents. From the interdisciplinary perspective of emotional labor and therapeutic landscapes, it addresses three core questions:

①How do junior doctors participate in the construction of therapeutic landscapes in the pediatric

hematology department?

②What practical dilemmas and structural barriers do junior doctors encounter in the process?

③How can institutional improvement and spatial governance enhance the capacity and sustainability of junior doctors' engagement in therapeutic landscapes?

2. Theoretical Foundation

2.1 Therapeutic Landscapes

The concept of therapeutic landscapes was formally proposed by Gesler (1992), initially used to explain the positive effects of place environments on health and well-being. With the advancement of research, scholars have gradually broken through the limitations of physical determinism and shifted to a relational perspective, arguing that therapeutic landscapes are a dialectical result of the interaction between physical environments, social landscapes, and symbolic landscapes. Rather than inherent attributes of space, they are dynamically generated through subjective interactions (Conradson, 2005; Andrews & Evans, 2008). Kearns & Milligan (2020) clearly pointed out that a complete analysis of therapeutic landscapes must include all three dimensions—physical, social, and symbolic—none of which can be omitted.

In medical field research, therapeutic landscapes have been widely applied to the analysis of hospital spaces. Zhou et al. (2016) summarized therapeutic landscapes in Chinese hospitals as a complex of power operation, emotional interaction, and spatial practice. Zhou et al. (2023) systematically reviewed the theoretical evolution of therapeutic landscapes and noted that therapeutic effects in medical spaces rely on interpersonal interaction and emotional support. Studies related to pediatric hematology have shown that therapeutic landscapes are collectively constituted by physical elements such as ward design, public facilities, honor walls, and puncture rooms; social elements including doctor-patient relationships, family mutual assistance, and medical collaboration; as well as symbolic elements like verbal communication, emotional expression, and physical interaction (Li, 2024). However, existing literature has generally overlooked the fundamental role of junior doctors in this process.

2.2 Emotional Labor

Emotional labor was proposed by Hochschild (1983), referring to a form of labor in which individuals actively regulate their emotions and exhibit specific external expressions to meet organizational and situational requirements. It includes three strategies: surface acting, deep acting, and genuine emotion expression (Diefendorff et al., 2005). In the medical field, emotional labor is a core form of labor for medical staff. Long-term, intensive emotional labor can easily lead to job burnout, emotional exhaustion, and psychological alienation (Chou et al., 2012; Kim, 2020).

Most domestic studies on emotional labor among medical staff have focused on nurses, while insufficient attention has been paid to hierarchical research on physicians. Peng et al. (2023) reviewed the theoretical context of emotional labor and pointed out that emotional labor in medical settings is characterized by compulsion, high frequency, and high risk. Guo et al. (2021) distinguished the

conceptual differences between emotional labor and affective labor, emphasizing that the term "emotional labor" is more suitable for medical scenarios. For junior doctors, some studies have revealed that they generally adopt surface acting, accompanied by weak professional identity and significant emotional exhaustion, but have not linked these findings to therapeutic landscapes (Chen et al., 2025; Zhang et al., 2024).

3. Research Design

3.1 Study Subjects and Case Site

This paper defines junior doctors as interns and residents in the Department of Pediatric Hematology. Specifically, interns refer to medical undergraduates who have not yet obtained medical practitioner qualifications and are in the stage of clinical rotation; residents refer to junior physicians who have completed undergraduate education, are in standardized residency training or master's studies, and undertake daily clinical diagnosis and treatment tasks. Interns rotate among different departments every two weeks during their clinical practice, while residents rotate every four months. This study includes five interns and five residents.

Table 1-1. Overview of Medical Staff

ID	Gender	Education	Background	Professional Rank Working Years
N1	Female	Master Candidate (Respiratory Medicine)	Resident Physician	2 years
N2	Male	Bachelor (Standardized Training Resident)	Resident Physician	2 years
N3	Female	Bachelor (Standardized Training Resident)	Resident Physician	3 years
N4	Female	Bachelor (Standardized Training Resident)	Resident Physician	3 years
N5	Male	Master Candidate (Respiratory Medicine)	Resident Physician	2 years
N6	Female	Undergraduate (Anesthesiology)	Medical Intern	Intern
N7	Female	Undergraduate (Clinical Medicine)	Medical Intern	Intern
N8	Male	Undergraduate (Clinical Medicine)	Medical Intern	Intern
N9	Female	Undergraduate (Anesthesiology)	Medical Intern	Intern
N10	Female	Undergraduate (Pediatrics)	Medical Intern	Intern

This study adopts a qualitative research paradigm and selects the Department of Pediatric Hematology

at G Hospital in Guiyang City, Guizhou Province, as a single case site. This department was chosen because the hospital boasts regionally representative medical diagnosis and treatment capabilities, its moderate scale facilitates in-depth fieldwork, and the researcher has established trust relationships with participants through long-term preliminary investigation.

3.2 Research Methods

This study adopts a qualitative research approach, with data collected from participant observation, in-depth interviews, and documentary analysis. The research was conducted in the Department of Pediatric Hematology of an affiliated hospital of a university. A total of 17 field investigations were carried out, each lasting 5 to 8 hours. Ten junior doctors were interviewed, including five medical interns and five resident physicians. Meanwhile, supplementary materials such as departmental institutional documents, medical records, communication notes, and ward spatial photographs were incorporated into the research. Classical grounded theory coding techniques were employed for data analysis, including open coding, axial coding, and selective coding in sequence, so as to refine core categories and construct the theoretical framework (Glaser & Strauss, 1967).

4. Specific Practices of Junior Doctors in the Construction of Therapeutic Landscapes in Pediatric Hematology

In the specialized medical setting of pediatric hematology, characterized by prolonged treatment courses, high emotional strain, and intensive care demands for child patients, the therapeutic landscape is not exclusively shaped by spatial design or the authority of senior physicians. Rather, it is gradually formed and maintained through the sustained, subtle, and routine practices of frontline medical practitioners.

As the largest workforce in the department with the longest on-the-job hours and the most frequent interactions with child patients and their families, interns and resident physicians, despite occupying a relatively marginal position in the medical hierarchical power structure, undertake fundamental, supportive and routine pivotal roles in activating physical landscapes, sustaining social relationships, and practicing symbolic interaction.

Their practices extend across multiple venues such as physicians' offices, inpatient wards and temporary examination rooms. Within seemingly trivial and repetitive auxiliary diagnostic and treatment work, they transform functional medical spaces into caring therapeutic sites, reconcile strained doctor-patient relations into trustworthy and dependable social bonds, and translate rigid clinical norms into warm symbolic expressions. This enables the therapeutic landscape to evolve from an abstract theoretical concept into a perceptible, accessible and immersive real-world experience.

4.1 Physical Landscape

From the perspective of physical landscape practice, junior doctors do not participate in spatial planning or resource allocation. Instead, they endow medical spaces with emotional significance and therapeutic value through continuous presence, frequent utilization, daily maintenance and interactive

engagement. The Department of Pediatric Hematology adopts an open-style physicians' office accessible to family members. Public facilities such as microwave ovens and refrigerators are available for families of young patients. While this layout improves convenience, it also keeps the office in a state of high interaction and public exposure all year round. As permanent occupants of the office, resident physicians stay on site almost all day to process medical records, write disease course documents and implement medical orders. They do not regard the coming and going of family members as disturbance, but develop natural tolerance and acceptance through long-term coexistence.

N1: We always ask interns to have meals together and never make them share the cost of takeout. We were once interns ourselves.

This statement reflects the mutual-aid culture among junior doctors, which naturally extends to doctor-patient interaction. The open office is no longer merely a functional venue for performing medical tasks, but an important carrier of materialized care. Junior doctors allow young patients to rest briefly in the office and help their families heat meals and store personal belongings. Imperceptibly, they turn the cold office space into a family-like place filled with daily life atmosphere and a sense of security. In ward spaces, junior doctors undertake basic work including daily ward rounds, condition observation, documentary recording and operational assistance, and repeatedly inform family members of safety norms. Such careful reminders maintain the safety and order of wards, turning them into a stable and controllable therapeutic environment.

N2: They need to pay attention to dietary hygiene and cleanliness. Fruits should be soaked in light salt water and then rinsed with warm water. Peeled fruits such as bananas can be eaten without washing.

Even in temporary examination rooms, enclosed high-pressure spaces concentrated with invasive procedures, junior doctors still engage in therapeutic practice through comforting and accompanying patients. Faced with the intense fear and pain caused by bone marrow aspiration and lumbar puncture among children, resident physicians express their inner feelings directly. Unable to change the procedures themselves, they try their best to relieve children's suffering through gentle consolation and body position fixation, infusing genuine humanistic care into this highly disciplined space.

N3: Young children are afraid even of blood collection with such thin needles, let alone such intimidating pricks inserted into the body to extract cerebrospinal fluid. Some children are even scared to lose control of their bladder and bowels, which is really distressing to witness.

Administrative affairs such as admission and discharge procedures, examination appointments, specimen delivery and information communication are all undertaken by junior doctors. These seemingly trivial procedures connect outpatient departments, wards, examination rooms, duty rooms and off-campus family accommodation into a continuous therapeutic space. The therapeutic landscape thereby breaks through physical boundaries and forms an extended, inclusive and supportive integrated spatial system.

N1: Apart from nurses, we have the most contact with patients.

N2: Patients always come to me whenever they have questions, because my senior colleague is on

leave and I am the only doctor in our group.

It is evident that junior doctors' practices in physical spaces are not passive implementation. Instead, they integrate scattered medical spaces into a continuous, stable and reliable therapeutic landscape by maintaining frequent presence, undertaking overall coordination and delivering meticulous care.

4.2 Social Landscape

In the construction of the social landscape, interns and resident physicians stand at the intersection of a relational network involving doctors and patients, medical staff, and patients' families. They maintain relational balance within the setting through buffering, connecting, accompanying, and coordinating. As such, they serve as daily builders of doctor-patient trust, key implementers of medical collaboration, and implicit promoters of mutual support among family members.

Unlike chief physicians who establish trust through professional authority, junior doctors build trust via long-term, repetitive, and close-distance interactions. Resident physicians are assigned to specific child patients on a long-term basis, familiar with their disease progression, personal traits, and family circumstances, and develop genuine emotional bonds through continuous care.

N5: Many children and their families are on close terms with us. We often feel sorry for these young patients, so we treat them wholeheartedly and sincerely, hoping that they can recover.

N6: The little girl I am in charge of in Bed 4 is only three years old. She suffers from leukemia complicated with severe bronchitis. I even worry about her after going home and think about her at night.

Junior doctors are always the first to respond to family members' anxiety, doubts, and even complaints. They patiently explain diagnosis and treatment procedures, medication regulations, and dietary taboos, translating professional knowledge into plain language and reducing misunderstandings and conflicts caused by information asymmetry. Due to limited clinical experience and weak professional discourse power, interns tend to remain reserved and compliant when facing doubts. When criticized by superiors and family members, their emotional restraint stems from their disadvantaged position and self-protection, yet it objectively prevents conflicts from escalating and maintains the basic order of the therapeutic environment.

N10: I dare not talk back. I can only nod and apologize honestly. Otherwise, they can easily make things difficult for me. I have to endure it. After all, I only stay in one department for one or two weeks, and I just want to finish the internship and leave soon.

N6: In other departments when the workload is heavy, I feel that some patients and their families simply vent their bad moods on us, and we dare not say anything in return.

Within the medical collaboration system, junior doctors act as a core link in implementing medical orders and transmitting information. They establish a high degree of tacit understanding with nurses through medical communication notebooks, bedside handovers, and real-time checks. Resident physicians also undertake teaching responsibilities, and their daily work clearly reflects the mentoring mechanism within the department.

N2: Mainly I teach interns how to write medical records and handover forms. I also take them along during ward rounds, and ask them to deliver blood samples when they are free.

N9: I am an introverted person, but after spending a long time with patients, I have gradually become more outgoing.

It is evident that through their relational practices, junior doctors construct a social landscape of reconciliation, trust, and mutual assistance among doctors and patients, medical colleagues, and patient families, laying the most fundamental relational foundation for healing.

4.3 Symbolic Landscape

At the practical level of the symbolic landscape, junior doctors continuously convey therapeutic meanings and shape a mild, stable, and trustworthy atmosphere through verbal expression, emotional performance, physical interaction, and identity presentation. In the pediatric hematology department, where children are physically and mentally vulnerable, fearful and sensitive, and their families carry intense anxiety, symbolic care often builds a sense of security more rapidly than clinical procedures alone. Junior doctors frequently adopt gentle, encouraging, and child-friendly language. They squat down to communicate with young patients in a soft tone, relieving fear through praise and comfort.

In terms of emotional performance, emotional labor lies at the core of symbolic practice. Faced with family members' incomprehension, non-cooperation, and even criticism, junior doctors mostly suppress negative emotions through surface acting and maintain professional courtesy, while enduring genuine and intense inner pressure and emotional distress.

N7: If I am reprimanded sharply in front of many people, I may stay calm and show no reaction at the moment, but I will keep thinking about it for days afterward and become emotionally strained.

N9: The family member said I knew nothing and was unfit to be a doctor … Deep down, I did not want to have any further contact with them.

Although such emotional restraint arises from self-protection, it objectively maintains the stability of the therapeutic setting. When confronted with children's suffering and families' helplessness, they are more inclined toward deep acting, offering sincere empathy and concern. Their emotional investment goes beyond professional obligations and evolves into genuine emotional bonds.

N2: I still worry about her after going home and keep thinking about her at night.

N1: These children are pitiful. The disease is complicated to treat with a long course, and I truly understand their hardships.

Such genuine emotional involvement naturally manifests through tone, facial expressions, and behaviors, becoming the most therapeutically powerful element within the symbolic landscape. Body language also serves as a vital form of symbolic practice. Nonverbal cues such as patting, gentle touching, smiling, eye contact, and squatting down to communicate compensate for the limitations of verbal expression and convey safety and acceptance to young patients.

In addition, junior doctors' steady performance in teaching, collaboration, and routine duties sends messages of professionalism, reliability, and responsibility to patients and their families. This endows

the symbolic landscape with both compassion and authority, achieving emotional comfort while maintaining clinical order. Their symbolic practices are understated and unforced, yet embedded in every greeting, explanation, and consolation. Therapeutic meaning accumulates subtly over time, eventually forming a gentle, resilient, and dependable symbolic healing system.

Overall, junior doctors' participation in constructing the therapeutic landscape of pediatric hematology is not power-led, decision-oriented, or planning-driven. Instead, it is immersive, routine, and grounded basic practice. Without relying on positional authority or resource control, they transform functional medical spaces into therapeutic venues by activating physical spaces, sustaining social relations, and conveying symbolic meanings. They reconcile tense and complicated interpersonal dynamics into networks of trust, and wrap rigid clinical norms in warm emotional expression.

Their work is trivial, subtle, and often overlooked, yet it forms the most solid, enduring, and patient-oriented foundation of the therapeutic landscape. It directly shapes the warmth, quality, and stability of the healing environment, and profoundly influences the treatment experience and recovery process of children patients and their families.

5. Dilemmas of Junior Doctors' Participation in the Construction of Therapeutic Landscapes

Although junior doctors' engagement in the construction of therapeutic landscapes possesses irreplaceable fundamental value, they commonly confront multiple dilemmas in daily practice, including structural pressure, identity tension, power constraints, emotional exhaustion, and insufficient resources. These restrictive factors intertwine and accumulate continuously, rendering their participation unstable and unsustainable. Some junior doctors even gradually turn to perfunctory passivity and defensive withdrawal, making it difficult for them to maintain long-term, proactive, and compassionate therapeutic practice.

5.1 Dilemmas of Emotional Labor

In terms of emotional labor, junior doctors are generally trapped in a dual predicament: they can no longer sustain long-term deep acting, while surface acting keeps intensifying. The Department of Pediatric Hematology is a special setting with highly concentrated emotional needs and constant emotional stimuli. Children's physical suffering, families' severe anxiety, repeated fluctuations in disease conditions, and various sudden crises together create an intense emotional burden. Junior doctors must constantly regulate their emotions to cope with complex situations, remaining in a state of long-term emotional overdraw that easily leads to emotional exhaustion and job burnout.

Meanwhile, deep acting requires sufficient security, respect, and a sense of value as emotional support. In actual work, however, junior doctors frequently encounter incomprehension, distrust, and even groundless accusations and complaints from family members. Their continuous emotional investment rarely receives positive feedback, prompting them to gradually turn to self-protection and perfunctory passive surface acting.

N1: Most of these children are pitiful. The disease is complicated to treat with a long treatment cycle,

and I truly understand their hardships. Yet sometimes family members fail to understand or cooperate, and our sincere efforts are hardly recognized.

In addition, medical institutions consistently require medical staff to maintain an outward demeanor of enthusiasm, patience, and constant smiling. In reality, negative emotional stimuli occur frequently, creating an ever-growing conflict between institutional emotional rules and inner true feelings. Prolonged exposure to this state easily triggers emotional dysregulation and self-alienation, further widening the psychological distance from child patients and their families.

At the institutional level, there is a stark contradiction between high-intensity disciplinary constraints and severely inadequate resource support, which becomes a major obstacle restricting junior doctors' effective participation in constructing therapeutic landscapes. Medical interns face frequent department rotations, while resident physicians follow a 24-hour on-duty system. Excessively long working hours, insufficient rest, and persistent energy depletion make it difficult for junior doctors to maintain stable emotional dedication and meticulous spatial practice.

The lack of economic and rights protection further exacerbates this dilemma. Interns receive no salary at all, yet they still need to pay internship fees and cover rental expenses on their own. Resident physicians endure heavy workloads with low subsidies. The sharp contrast between high work intensity and low remuneration significantly weakens their professional identity and willingness to engage proactively in therapeutic practice.

N2: Our salary is low, the workload is heavy, pressure is high, but the reward is very little.

More importantly, the realistic context of high medical risks, heavy burden of proof, and low trust from families forces junior doctors to develop a strong defensive tendency to avoid professional risks. They tend to speak less, intervene less, and rigidly follow procedural norms at work. Their willingness to offer proactive care keeps declining, and the room for flexible problem-solving continues to shrink, directly weakening the warmth and effectiveness of the therapeutic landscape.

5.2 Marginalization of Professional Status

At the level of identity and power, the marginal professional status and lack of discourse power make it difficult for junior doctors to independently and effectively participate in the construction of healing landscapes. The student identity of interns and the early career status of resident physicians jointly result in insufficient professional authority. They suffer from low trust and weak persuasiveness in doctor-patient communication, making it hard for them to effectively dominate symbolic interaction and relationship construction.

Within the bureaucratic hierarchical power structure, junior doctors are at the bottom rung. They have extremely low participation in diagnosis and treatment decision-making, lag behind in obtaining key information, and face enormous pressure at the implementation level. They remain in a passive and obedient state in spatial practice and relationship coordination, with little room to exert their subjectivity and initiative.

Meanwhile, the full-time supervision of patients' families, random inspections by senior physicians,

and the constant looming risk of medical complaints force junior doctors to frequently switch among and struggle with the triple roles of professional practitioner, service provider and learner over the long term. This further amplifies the complexity and pressure of their emotional labor.

N3: We treat patients earnestly and take our responsibilities seriously, yet sometimes family members distrust and misunderstand us, and even cast doubts on our work. We feel wronged too, but we have to hold back our emotions and explain things patiently.

N4: As resident physicians, we are supervised by senior doctors from above, need to guide interns below, and meanwhile answer all kinds of questions raised by patients' families. Most of the time, we dare not speak or act freely, for fear of making mistakes and being criticized.

5.3 Spatial Practice

At the level of spatial practice, the sustained pressure from open spaces overlaps with the sense of powerlessness in enclosed spaces, further restricting junior doctors' healing practice.Open doctors' offices lack basic privacy; family members can enter and exit at will, frequently interrupting work and venting their emotions arbitrarily. This keeps junior doctors in a perpetual state of tension and makes it difficult for them to engage in sincere, devoted in-depth emotional labor.

In enclosed operational spaces such as puncture rooms, junior doctors often witness young patients enduring severe pain yet are unable to alleviate it effectively. The intense sense of powerlessness and guilt accumulates continuously, forming latent emotional trauma that is hard to resolve.

N1: The hardest part is feeling the foreign body sensation of such a thick needle inside the child's bone. The child is in great agony, and we feel distressed watching it, yet we can only finish the procedure as quickly as possible. The sense of powerlessness is overwhelming.

N2: The office is always crowded with people, and family members walk in anytime to ask questions. It's nearly impossible for us to calm down to think or offer sincere comfort. Long-term exposure to such an environment easily leads to burnout and mental fatigue.

Even in extended department spaces such as duty rooms, junior doctors cannot achieve genuine relaxation and rest. Institutional pressure and anxiety over patients' conditions linger constantly, worsening their state of physical and mental exhaustion.

N6: We can never get proper rest during night shifts. We may be called up at any time. Even lying on the bed in the duty room, our minds remain tightly strung, and we cannot relax at all.

N7: I am exhausted every single day, physically worn out. Most of the time I can only respond and nod mechanically, though I have already run out of energy long ago.

5.4 System Support

From the perspective of competence and support, the lack of systematic training and comprehensive support deprives junior doctors of the necessary capabilities and resource guarantee to participate in the construction of healing landscapes.

The current medical education system overemphasizes professional knowledge and operational skills, while key competencies such as doctor-patient communication, emotional regulation, child psychology,

and healing discourse receive insufficient systematic training. Most junior doctors have to grow through constant trial and error.

Hospitals generally lack targeted mechanisms for psychological counseling, emotional support, and trauma intervention. The long-term accumulation of emotional pressure tends to trigger depression, anxiety and job burnout.

N8: Medical school barely teaches us how to communicate with the families of pediatric patients or regulate our own emotions. We have to figure everything out on our own after entering clinical practice. There is no professional counseling when pressure builds up, and we can only bear it alone.

At the same time, performance, merit evaluation and assessment systems excessively prioritize diagnosis and treatment efficiency as well as research achievements. Soft values such as emotional labor, relationship maintenance and healing contributions have long been overlooked, which further weakens the internal motivation of junior doctors to take the initiative in constructing healing landscapes.

6. Conclusion

Based on the healing landscape theory in health geography and the perspective of emotional labor, this study takes the pediatric hematology department as the research site, and systematically explores the practical forms, internal logic and practical dilemmas of junior doctors (including interns and resident physicians) in participating in the construction of healing landscapes. The findings indicate that although junior doctors occupy a marginal position in the medical hierarchy and lack core dominance in spatial planning, diagnosis and treatment decision-making, and power allocation, they have become the fundamental supporting force for the formation, operation and maintenance of the healing landscape in pediatric hematology departments through immersive, daily and grassroots practical participation. At the physical landscape level, with high-frequency presence, spatial connection and meticulous care, junior doctors transform functional spaces such as open office areas, wards and examination rooms into healing venues embedded with a sense of security and daily vitality, integrating scattered medical spaces into a continuous and supportive holistic healing system. At the social landscape level, they establish relational networks of doctor-patient trust, medical collaboration and family mutual assistance through long-term companionship, patient communication and mediating coordination, maintain relational balance in the context of power asymmetry and high emotional tension, and lay the core relational foundation for healing. At the symbolic landscape level, they convert professional diagnosis and treatment into perceptible care symbols via gentle discourse, empathetic expression and physical comfort, and shape a stable, warm and resilient healing atmosphere through the alternation of surface acting and deep acting. Rather than relying on professional authority and institutional power, the healing practice of junior doctors embodies the abstract healing philosophy in tangible daily experiences for child patients and their families in a subtle, repetitive, intimate and persistent way, which directly determines the temperature, texture and stability of the healing

landscape.

At the same time, junior doctors are trapped by the overlapping constraints of structural, identity-related, spatial and systematic dilemmas in their participation process. In terms of emotional labor, deep acting cannot be sustained due to the lack of positive feedback and psychological security, while excessive surface acting exacerbates doctor-patient estrangement and personal emotional exhaustion. Institutionally, the conflicts between high-intensity job rotation, 24-hour shift work, low welfare security and inadequate reward mechanism keep them in a long-term state of energy depletion and value deprivation. From the identity and power dimension, marginal professional status, absence of discourse power and multiple role conflicts force them into passive obedience and self-protection in professional practice, making it difficult to exert individual subjectivity. Spatially, the persistent exposure in open office spaces intertwines with the sense of powerlessness in enclosed operational spaces, continuously triggering psychological stress and latent emotional trauma. In terms of support system, insufficient systematic training in communication and emotional regulation skills, the vacancy of psychological counseling and trauma intervention mechanisms, as well as the long-term neglect of soft values such as emotional labor and relational maintenance further undermine their initiative to engage in healing landscape construction. The mutual reinforcement of these multidimensional dilemmas renders junior doctors' healing participation unstable and unsustainable. Some even fall into perfunctory coping and defensive withdrawal, which not only hinders their own career development, but also impairs the overall operational effectiveness of the healing landscape in pediatric hematology departments.

In summary, junior doctors act as indispensable daily constructors of the healing landscape in pediatric hematology departments, whose intrinsic value runs through the whole process of spatial activation, relational maintenance and symbolic care. Their practical dilemmas essentially reflect the drawbacks of the medical bureaucratic hierarchy, unreasonable resource allocation, biased performance evaluation system, and the long-term neglect of the value of emotional labor. Only by recognizing the fundamental role of junior doctors and breaking away from their realistic institutional and spatial constraints can we truly construct a warmer, humanistic and more sustainable medical healing landscape.

7. Discussion

This study incorporates the long-overlooked group of junior doctors into the analytical framework of therapeutic landscapes, breaking through the limitations of previous research that focused primarily on high-status actors, physical environments, or macro-structural factors. From a micro-practice perspective, it reveals the "bottom-up" generative mechanism of therapeutic landscapes, offering a more complete and practice-near theoretical approach to understanding the therapeutic nature of medical settings. Traditional research on therapeutic landscapes has tended to emphasize the dominant role of spatial design, institutional arrangements, and authoritative actors, while neglecting the junior doctors who constitute the largest workforce, have the most frequent contact, and perform the most

numerous actions at the clinical frontline. This study confirms that therapeutic landscapes are not the result of planning and design, but are gradually generated through day-by-day companionship, explanation, reassurance, and collaboration. The seemingly trivial practices of junior doctors are precisely the key vehicles through which therapeutic qualities are actualized. This finding addresses the “grassroots practitioner” gap in therapeutic landscape theory and pushes research in this field from spatial-structural analysis toward everyday practice analysis.

Regarding the interactive relationship between emotional labor and therapeutic landscapes, this study further clarifies that the emotional labor of junior doctors is not merely an individual psychological adjustment behavior but a social practice embedded in space, relationships, and power. Surface acting maintains order in the field but brings about emotional alienation and job burnout; deep acting activates therapeutic meaning but is highly dependent on a sense of security, respect, and positive feedback. The high-emotional-load context of pediatric hematology creates a trajectory of“investment-depletion-withdrawal”in the emotional labor of junior doctors. This also explains, at the practical level, why some hospital spaces, despite being well-designed and equipped with complete systems, still lack a therapeutic atmosphere: care cannot be mandated through discipline alone but requires recognition and protection of the emotional value of practitioners.

From a practical perspective, the dilemmas faced by junior doctors reflect the structural biases prevalent in current healthcare systems that prioritize “technology over care, efficiency over emotion, and authority over grassroots.” Interns and resident physicians are at the starting point of their professional life cycles. The communication styles, relational attitudes, and value identifications they acquire during clinical practice will directly influence their long-term professional conduct and the overall character of medical services. If they are forced to engage in therapeutic practice under conditions of chronic suppression, defensiveness, and exhaustion, this will not only harm their physical and mental health but will also transmit negative effects to doctor-patient relationships, compromising the treatment experiences and recovery outcomes of child patients. Therefore, enhancing the therapeutic participation capacity of junior doctors is, in essence, a crucial step toward optimizing the healthcare service system, strengthening humanistic care, and promoting the health and well-being of children.

Future healthcare space optimization and management reforms should genuinely shift from a “disease-centered” to a “person- and relationship-centered” approach. Institutional arrangements, spatial design, training systems, and evaluation mechanisms should fully acknowledge the value of emotional labor, recognize the foundational contributions of junior doctors, and provide them with adequate emotional support, more reasonable workloads, clearer role definitions, and timely positive feedback. Only then can grassroots practitioners shift from “passive execution and defensive self-protection” to “active care and stable investment,” enabling the therapeutic landscape to cease being an abstract spatial concept and become a tangible, dependable, and sustainable experiential reality throughout the entire diagnosis and treatment process.

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