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Patterns of Care, Status Differentiation, and the Reproduction of Inequality  
in Hospital Nursing

by

John William Kaiser

A dissertation submitted in partial satisfaction of the requirements

for the degree of Doctor of Philosophy

in

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of the

University of California, Berkeley

Committee in Charge:

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## Abstract

### Patterns of Care, Status Differentiation, and the Reproduction of Inequality in Hospital Nursing

by John William Kaiser

Doctor of Philosophy in Sociology

University of California, Berkeley

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Feminist scholars have established care work as a key site for intersecting systems of power. The naturalization of feminized caring legitimates the institutionalized coercion and exploitation of care work, inflecting a matrix of inequalities built up around these relations of caring labor. However, there has been little systematic analysis of the mechanisms of social reproduction through caring labor in a medical setting. This project, based on three years of IRB-approved ethnography of RNs and CNAs at work in a California hospital, addresses this gap. It analyzes the social processes in the social construction of care, illustrating how RNs created and used culture to mitigate coercion, exploitation, and subordination. Specifically, they used semiotic codes—and their respective sets of daily practices—to define what counted as “care” in particular contexts. They also delegated tasks linked with servitude to CNAs through rituals of subordination. These processes enabled RNs to assert professional power, but they also linked status differentiation to empathy/disempathy, facilitated affective structures and subjectivities of disempathy, and reproduced racialized relations of domination between themselves and the CNAs. Thus, mechanisms of empathy/disempathy reproduced inequality. This analysis identifies the limitations of professional nursing power based on the ideological dichotomization of *emotional* and *technical* dimensions of medical work and highlights how this ideology—and the structure of feelings that animate it—obscures the actual role of empathy as medical work. This research leads to the formulation of a general theory of empathy/disempathy as a mechanism that contributes to inequality. The argument is that structures of domination, coercion, and exploitation devalue and constrain care throughout the social formation. Institutions that order these power relations are organized through affective structures—and their corresponding ideologies and subjectivities—that link status differentiation to empathy/disempathy. Mechanisms of empathy/disempathy rearticulate the ideological interpellation of subjects by shaping “subject-centric” perceptions of power and determining the processes through which people produce and use culture to rationalize it. On one hand, hegemonic structures of feeling constrain capacities to care and facilitate *subjectivities of disempathy*. These subjectivities refract experiences of agency through disempathy, power, and status. On the other hand, another category of subjectivity, which I call *double-agency*, constructs experiences of agency through capacities for empathy—and estrangement from those very capacities. Consequently, processes of empathy/disempathy function as a mechanism in the social reproduction of inequality.

This dissertation is dedicated to the hospital workers whose collaborative efforts helped Willy through severe illness by “raising my spirits, and keeping me comfortable and alive,” as he put it.

# Contents

Preface

Acknowledgements

Introduction

1 The Basic Stuff of Having Heart: South Heart's Paradoxical Culture of Care

2 An Atmosphere of Normalcy: Empathy in Care Delivery

3 Don't Baby Them!: Disciplinary Practices of Care Delivery

4 Servitude and the Matrix of "Double Agency" Subjectivities

5 Professionalizing Borderwork

6 Conclusion

Bibliography

## **Preface**

This project was born at the side of my father's bed in a hospital where I observed nurses at work for the first time. Willy and I experienced firsthand the power of caring in a medical setting, the constraints on care, and the non-duality of emotional and technical dimensions of medical work. Now years later as he courageously lies in the ICU once again, the full-fruit of this project feels like the silver-lining of his illness trajectory.

Berkeley, August 9<sup>th</sup>, 2015

## Acknowledgements

Barrie Thorne made this research possible with her offering to Chair my dissertation. She guided the process, mentoring me with time, encouragement, extensive knowledge, and a mindful approach to training in which she cleverly honed in on the precise areas where I needed to grow. Our many stimulating discussions, in which she used a modified-Socratic method for mental calisthenics, helped grow ideas in the garden of my mind. She guided me through the process of data analysis, creative-yet-grounded generation of ideas, and making connections between seemingly unrelated phenomena. It was there, in those many visits to her office, that this research blossomed as a collaborative flower of both our gardens. She also taught me the tacit and explicit knowledge of caring as a scholarly activity, which guided my research as well.<sup>1</sup>

Raka Ray generously took on the responsibilities of Chair when health problems prevented Barrie from doing it any longer. This dissertation would not have been possible without her skillful advising, patience, and feedback. Her work on cultures of servitude was invaluable in helping me make sense of the contours around categories of devalued and delegated tasks. Evelyn Nakano Glenn also contributed her time, support, and intellect to support as Outside Committee Member. Her work on the intersecting systems of power and caring labor made this analysis possible. Ann Swidler trained me in sociology of culture and provided support as Chair of my Orals Committee. She also advised me on the dissertation. Her work in the sociology of culture provided a framework for my original research design and continued to inform my analysis. It also provided countless hours of entertainment as I contemplated the enigma of cultural logic. Dawne Moon advised my master's thesis and trained me in the techniques of participant observation and analysis of ethnographic data. Our many stimulating conversations in her Barrows office shaped the development of both my research agenda and my sociological imagination. Arlie Hochschild also contributed to my growth as a scholar. In particular, her perceptive feedback helped me address one of my challenges; as she put it, I generated creative lines of analysis, but had trouble staying focused and following through with them. When I contemplated taking an extended leave of absence to help my parents, she encouraged me to “keep the ball rolling.” I am grateful for her wise advice. Dylan Riley trained me in social theory. In so doing, he nurturing my interest in theories of consciousness and human freedom.

Every member of the Sociology Department's staff contributed to this project in one way or another. Elsa Tranter, Anne Meyers, and Carolyn Clark, in particular, provided crucial support. Their skillful advising guided me through the logistics of the program. Their practices of empathy produced a dialogical knowledge of my personal circumstances, which augmented their application of their other specialized knowledge.

My undergraduate mentors at Occidental College—Monique Taylor, Jan Lin, Dolores Trevizo, Elizabeth Chin, and Peter Drier—helped me cultivate my scholarly subjectivity in its formative years.

The folks at the Care Work Network provided the support and stimulation of a community of scholars. I have very fond memories of the conferences I

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<sup>1</sup> Michael Polanyi (1966) describes tacit knowledge as conducive to learning through observation, imitation, and practice.

attended.

My friends and family, did everything they could—which was more than a lot—to support me on this long, strange trip.<sup>2</sup>

Finally, the nurses with whom I worked made this research a collective intellectual process. I can only hope that my analysis resonates with their lived experiences.

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<sup>2</sup> I am refraining from naming names for fear of forgetting somebody.



## Introduction

If nurse means comforter... who will be called “nurse” when the nurse’s tasks are reshuffled? Will it be the teacher and supervisor? The bedside comforter? Or will it be those who give more humble services?

-Everett Hughes (1951)

Delegating care to people of lower status further devalues the work and the people doing it.

-Evelyn Nakano Glenn (2000)

In 1951 Everett Hughes predicted that the professionalization of nursing would involve the “reshuffling” of tasks related to care down to workers of lower status. His idea was based on an understanding that people professionalize their occupations by claiming tasks of higher prestige while distancing themselves from less-desirable tasks and “dirty work.”<sup>3</sup> Thus, Registered Nurses (RNs) would reshuffle their care work—which he described as “comforting”—onto others as RNs embraced more technical medical tasks. He reasoned that these others would take on the title of “nurse,” since it signified the social role of those who comfort patients.

According to Evelyn Glenn’s (2000) historical analysis, as nurses’ pay and status increased, more tasks involving care devolved to assistants, who are predominately women of color. Furthermore, she theorizes that the delegation of care to people of lower status further devalues both the labor and the people who do it. Therefore, the processes through which RNs distance themselves from particular bundles of caring tasks may play a key role both in nurses’ capacities to claim higher professional status and in the social construction of the racialized hierarchies that cross-cut gender and occupational statuses.

My analysis of these social processes among RNs and CNAs in a California hospital continues this line of inquiry. My findings complicate Hughes’ (1951) theory; rather than reshuffling care and dropping the title, “nurse,” these RNs both identified themselves with and distanced themselves from caring. They did so by utilizing several semiotic codes to situationally define which behaviors signified “care” and by delegating particular tasks—those associated with servitude—to their assistants.

I wanted to know how macro structures, such as race, gender, and class, were instantiated in the situated behaviors, patterns of discourse, interactions, and group

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<sup>3</sup> A different example of this shift is the relatively new position of nurse practitioner, which offers more prestige, compensation, and involves tasks conventionally handled by doctors, such as writing prescriptions. Although the first NPs were trained in the 1960s, the growth of NPs increased dramatically during the 1990s. In 1992 there were approximately 28,000 NPs nationwide and as of the year 2000 there were approximately 95,000, an increase of 240 percent (Department of Health and Human Services). According to the American Academy of Nurse Practitioners (AANP), there are more than 106,000 NPs in the United States, which represents a threefold increase since 1990. (<http://bhpr.hrsa.gov/healthworkforce/reports/scope/scope1-2.htm>).

relations of a hospital Cardiology unit, which I call South Heart.<sup>4</sup> My primary interest was in understanding nursing care as a site of micro-social processes that constitute, reproduce, and transform relations of domination and subordination, and how those relations shape cultures and practices of care. My research design asked how social institutions, cultural logics, and power structures were instantiated in the social construction of care in situated patterns of interactions in the hospital, if they were present at all. I also sought to determine how cultures of care, if they existed, shaped these processes.

I attended to the phenomenology and patterns of borderwork, including how RNs and CNAs experienced relations of domination/subordination, status, race, gender, and the meanings and valences regarding their tasks and practices.<sup>5</sup> However, I did not limit my theoretical framework and analysis to phenomenology; I compared nurses' experiences with my direct observations of practices and interactions in a grounded approach to data collection.

Research took shape with my identification of processes through which RNs and CNAs defined which behaviors signified care in particular contexts, and how they established those contexts. The RNs I studied claimed the moral virtue of care traditionally associated with emotional support while they distanced themselves from it. They minimized the skills it involved and used culture to paradoxically define the practices that counted as “really caring” as both routinized instrumental tasks, which involved a lower level of effort a disempathy, and personalized connection that required more effort and empathy.<sup>6</sup> These processes involved situationally drawing on two semiotic codes, that I call *having heart* and *basic stuff*, in a group culture that enabled them to legitimize and normalize both sets of practices.

Moreover, they used culture to regulate their level of effort and assert autonomy over their labor without dropping the traditional identity of “nurse” associated with emotive caring. Rather, they identified with the virtuousness of caring *and* the prestige of medical knowledge, using both to assert professional power. Importantly, their articulation of the ease with which they cared for patients, anchored in *basic stuff*, rather than their disavowal of caring itself facilitated their assertion of professional power.

However, these processes occurred through RNs' reproduction of relations of domination, coercion, and exploitation with their assistants. They delegated emotional labor, empathy, and bundles of tasks associated with *servitude*—tasks linked with coercion, exploitation, and domination in the structure of their work—to CNAs. But they did not always delegate them officially, and they did not relinquish the title of “nurse” or the power of moral virtue. Tensions between these RNs and CNAs, who felt coerced and exploited by the RNs, reflect these dynamics. CNAs expressed frustration that RNs delegated too much of their work and delegated it through rituals of subordination that reproduced racialized structures of domination. Thus, they contested RNs' paradoxical valuation and devaluation of caring and challenged the boundaries around the practices

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<sup>4</sup> All names are pseudonyms.

<sup>5</sup> By phenomenology, I mean the study of people's cognitive, symbolic, and affective experiences as a unit of analysis as in the tradition of Alfred Schutz (1970) and Maurice Merleau-Ponty (2002 [1962]).

<sup>6</sup> The Oxford English Dictionary defines empathy (2b) as: “the ability to understand and appreciate another person's feelings, experiences, etc.”

that signaled acceptable care. RNs thus mitigated the exploitation, coercion, and denigration of caring by reproducing those power relations in the division of labor.<sup>7</sup>

## Literature Review

This dissertation on nursing builds on lines of inquiry in the feminist scholarship of care work that extend beyond the study of nursing itself. However, in this literature review, I focus on the most relevant research – studies of hospital nursing that make care work central to their analysis. The most relevant among these are ethnographic studies of nursing in acute-care hospitals, but studies that use other methods and studies that investigate nursing in other types of settings, such as Skilled Nursing Facilities (SNFs), are also relevant. First, I provide an overview of the field, highlighting a major analytical and theoretical limitation: scholars’ homogenization and invisibilization of caring. In the three sections that follow my overview, I provide a more detailed discussion of how my analysis addresses three gaps in the scholarship: 1) understanding the micro-processes through which RNs and CNAs create and use culture to signify the practices that count as care, how their practices compare with their articulation of that culture, and how they construct occupational identities through these processes; 2) how particular bundles of tasks are devalued and delegated, how RNs and CNAs exercise agency in these processes, and how these processes impact nurses’ experiences of their work; 3) how caring is coerced and exploited—and how nurses respond, sometimes reproducing relations of domination in the process. Each of these three lines of analysis looks at social processes on the micro-level of interactions, so I concentrate on research with micro-level empirical findings, although I include others when they are relevant.

### *Overview of the Field*

Analysis of micro-level social processes such as these tend to require ethnographic methods. However, there is a paucity of ethnographies that make nursing central in their investigation of hospital work. While a number of hospital ethnographies include nurses in their analyses, there are only a few that focus on nurses’ work. Fewer still include CNAs or their equivalent. In one category of hospital ethnographies, nurses are peripheral to a more central focus, such as physicians’ work (Becker et. al. 1992 [1961]; Strauss et. al. 1995 [1985]), the organization of dying (Kaufman 2005), labor relations among many occupational groups (Sacks 1988), and “temporal orders” (Zerubavel 1979). Those studies contrast with ethnographies that focus on hospital nursing (Apesoa-Varano 2014; Chambliss 1996; Wolf 1988; Theodosius 2008; Street 1992; Gordon 1997; Allen 2001; and Smith 1992).<sup>8</sup> Other methods, such as interviews, case studies, auto-ethnographies, and social-histories, also yield findings on the everyday social processes of hospital nursing, and I include them where they are relevant.

The homogenization of ‘care’ as an analytical category is widespread in this literature. Ironically, scholars who call attention to—and challenge—the devaluation of

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<sup>7</sup>Gordon and Nelson (2006; in *The Complexities of Care*) discuss the history of “virtue” in nursing.

<sup>8</sup> Only two of these eight authors are sociologists (Apesoa-Verano; Chambliss). One is a journalist (Gordon), three are Ph.Ds in Nursing (Street; Theodosius; Wolf), and two are RNs (Smith; Allen). Three of these ethnographies took place in England (Theodosius; Smith; Allen) and one in Australia (Street).

caring sometimes reproduce the intellectual framework that makes caring and the nurses who do it invisible as truly valued objects of analysis. This framework assumes a homogenized image of care, a mythic category that is detached from the concrete processes and practices that are subsumed by it. Homogenizing care work makes nurses' caring practices invisible. In the analysis that follows, I illustrate that scholars lack of attention to the nitty-gritty of heterogeneous social processes and practices constitutes a gap in this field of knowledge. It is a critical analysis of particular weaknesses, but each of these studies also has many strengths, which I discuss in the sections that follow.

In *The Social Organization of Medical Work*, Anselm Strauss et. al. (1985), obscure, homogenize, and make invisible the very practices and nurses they claim to study. For example, they describe how “trajectory management” shapes the processes of “comfort work” but they do not attend to how care work shapes the processes of trajectory management. It is noteworthy that their many long vignettes exemplifying comfort work (107-128) are almost devoid of nurses interacting with patients, practicing actual care delivery. When nurses are mentioned, they are usually doing “medical” work (e.g. giving pain meds) rather than practicing emotional care or hands-on comforting (e.g. positioning patients). Their heavy use of the passive voice creates the impression of disembodiment, as if comforting occurs of its own accord, without nurses. In fact, their vignettes read like physicians' dictated notes rather than observations of people interacting, as if their observational lens is that of an MD. Ultimately, they manage to describe “comfort work” without including the nurses who do it. To the extent that Strauss. et. al. do acknowledge the importance of caring in the division of labor, they fail to acknowledge and account for the devalued status of the work and the people who do it. Thus, they provide a good example of research that makes caring invisible even when it attempts to analyze the social processes that constitute it.

Most of these authors discuss care without analyzing the actual practices it involves in a systematic way such as is standard scholarly practice when researchers consider an object of study to be worthy of in-depth attention. In other words, these researchers tend to not give the practices they discuss the kind of analytical scrutiny that they give to other elements in their reports. Catherine Theodosius' book (2008), *Emotional Labour in Health Care*, is an exception to the rule, as she does explore some emotional labor practices in a systematic way, even categorizing them as Therapeutic Emotional Labor (TEL) and Instrumental Emotional Labor (IEL). Yet numerous studies on nursing invisibilize the diverse and varied practices that make up “care.” Hospital care varies in so many ways – by cultural, institutional, and organizational contexts. We cannot assume *a priori* what caring is or how it occurs in situated contexts. Yet most of these scholars seem to do just this.

In *Beyond Caring*, Daniel Chambliss (1996) describes four abstract “meanings of care” but does not attend to how individual nurses or groups of nurses experienced or practiced them. He describes how nursing has a “distinct moral core,” which includes “a combination of care, professionalism, and a subordinate position, and the style of the profession is obviously female” (88), but does not analyze how nurses articulated these abstract categories in daily practices. Rather, he uses these abstractions and ideal typologies to analyze ethical dilemmas and conflicts between occupational groups without ever having analyzed caring. He manages to discuss gender and ethical

dilemmas of “the nurse” without a phenomenological component. It could be said that he claims to move the conversation “beyond caring” without getting there in the first place.

Similarly, Pam Smith’s (1992) study of emotional labor describes nurses’ experiences with different types of patients, “ward sisters” and team work, teaching curriculum, and so on within the “care versus cure” dichotomy that homogenizes caring itself. She discusses the emotional labor of nursing, including limited discussion of individual nurses’ experiences of it in particular types of situations, without illustrating what the concrete practices of caring entail, processes involved in various categories of care work, or patterns of interactions and relations that shaped emotional labor. In other words, she describes “the emotional labor of nursing” without analyzing nursing work itself. This is because she focuses on the way nursing is devalued vis-a-vis medicine:

My conclusion was that, at City Hospital, nursing continued to be seen as women’s natural work, devalued and de-skilled because it drew its status and prestige from biomedical knowledge associated with medical techniques and procedures which treated diseases rather than people (51).

Framing her study as “caring is devalued in relation to biomedical knowledge” paradoxically further devalues nursing in the sense that it homogenizes the diverse caring practices it involves. That is, biomedical knowledge monopolizes the analysis; defining caring in relation to medical work precludes defining care in relation to itself. It narrows the parameters of analysis and theoretical framework.

In *Conflicted Health Care*, Ester Carolina Apesoa-Varano (2014) obscures caring practices because she defines care abstractly and denies nurses agency by claiming that that *nobody* had time to care due to organizational constraints. She describes how the practitioners she studied articulated the false dichotomy of “care versus cure”:

While the nurses in Hospital General espoused the importance of emotive caring in treating patients, they hardly had the time to deploy this strategy, much less accrue and advantages or benefits from it, *nor did they seem to want to*. The nurses I spoke with sought to reconcile biomedical knowledge and skills with emotive caring in the practice of nursing (8).

First, she states that nurses valued caring but did not have time to “deploy” it as a “strategy” to increase their occupational status vis-a-vis other occupational groups in the hospital. But later she says that caring did not work as a strategy, because all the occupational groups used caring that way. She interprets the discrepancy between nurses’ stated valuation of caring and its devaluation as a “strategy” to mean that caring was only ideological. For example, she states that “...it [caring] is an aspect of hospital work that nobody has time for and everybody subordinates to curative interventions” (9). *Nobody* has time for? *Everybody* subordinates to medical work? Nurses experienced a lack of organizational support for care, could not practice it as much as they wanted, and found that it did not work as a strategy for professional status. Does this mean that caring was only ideological, they simply did not practice any form of care, ever? This is in fact her assertion. Yet she defines caring abstractly and parenthetically:

When practitioners spoke of caring *for* patients, the ideal of caring became harder to uphold, as the practices associated with emotive caring (e.g., interacting with patients at an emotional level, spending time with patients, and consoling patients who are anxious, confused, angry or in pain) ranked second to the cure orientation that dominates work in Hospital General (15).

“Interacting with patients at an emotional level,” “spending time with patients,” and “counseling patients” are in fact too abstract to indicate what caring entails. Almost anything could count as “interacting on an emotional level.” Unfortunately, she does not provide anything close to a detailed analysis of nurses’ practices, whatever it is that they actually did “have time” to do. Perhaps the time constraints at Hospital General really did limit nurses’ practices to only “providing physical treatment.” After all, nurses “felt overwhelmed by immediate bedside needs,” so “emotive caring remained up for grabs” (62). But I think that is unlikely.

In fact, her data suggests otherwise. For example, she describes a nurse who was “overwhelmed and could not be the ‘caring nurse’ everyone wanted her to be” (62). She felt that all her patients were “needy” and she “could not think of doing anything else beyond the basic stuff.” However, note that this nurse also said, “some days it’s just a drag and today is one of those,” and “on days like these I have to prioritize and make sure they are OK physically, cause that is the most important thing.” This nurse’s description of her experience as “some days its just a drag” indicates that not *every* day was like this. What were the other days like? Did she do more than the “basic stuff,” more than “make sure they are OK physically?” I do not know, because the author did not provide the analysis.

Most of these scholars convey that they hope to help raise the status of nurses and of caring. Yet only one of these studies, Theodosius (2008), analyzes caring practices in a systematic way that makes them visible. Why the absence of analysis and attention to the nitty-gritty around nurses’ actual practices of care? I would argue that because care is already devalued and naturalized in the larger culture, these scholars are simply reproducing the larger cultural pattern. Additionally, several of these researchers were nurses, and faced the challenge of making the familiar strange. In my own research, I was a more or less a stranger to the hospital, with the perspective of a volunteer rather than a native practitioner. My experiences as a child and adult caregiver to both my parents also taught me to recognize nuanced aspects of caring as physically/emotionally non-dualistic and important. Lastly, my mentor, Barrie Thorne, helped me develop the skills necessary to observe and analyze the nitty-gritty of micro-social processes with an eye to the instantiation of macro-social variables within them.

In this project, I strove to make nurses’ caring practices visible, attend to nurses’ experiences of them, and analyze them in a systematic way. This was challenging as many of the practices and experiences I studied were ineffable and integrated into the taken-for-granted social world of the staff. In the following sections, I discuss three specific gaps in the literature and how my project contributes to these three lines of analysis.

### *How Nurses Use Culture*

My line of analysis regarding how nurses use culture to define care and shape their practices come from Everett Hughes' (1952) work on the processes through which people in a given occupational site determine the boundaries around their work, particularly their acceptable "level of effort and product:"

I think it is good to start one's investigation of any line of work with the assumption that there is some struggle of wills or of consciences or both over the level of effort and product... it is better stated, in a general way, as discovering the processes, social and psychological, by which levels of effort and product are determined in various kinds of work and in various kinds of organization for work (302).

How nurses set their "acceptable levels of effort and products" involves how they define their work. In order to determine how hard they work, they must determine what their "product" is, particularly regarding bundles of caring tasks, which are less-rigidly defined than schedules of doctors orders. How they define caring impacts their level of effort, making them more- or less-tightly linked. Additionally, definitions of which practices signify caring may link caring with bundles of medical tasks and vice-versa, such that level of effort refers to various dimensions of work in both spheres, making them non-dichotomous.

None of the writers in my review explore processes related to nurses' agency in using cultural material to define the nature of their care work and shape their practices of it. The studies illustrate that nurses' definitions of their work vary, but this variation is organized foremost around the relative dominance of either caring tasks or medical tasks, and the scholars do not show how nurses use these definitions situationally to actually shape their practices. For example, in *Nurses' Work, the Sacred and the Profane*, Zane Wolf (1988) found that nurses subscribed to a medical frame over a caring frame for interpreting the healing process: "nurses viewed the efficacy of medications in a magical or unexplainable way and often did not consider the possibility that other care-giving actions or self-healing could have been responsible for improvements in a patient's condition."<sup>9</sup> Looking at nurses' definition of care in such a broad way doesn't get at the ways nurses actually use culture to have agency and shape their work. There's another level here that is not being explored.

Some scholars have called attention to how nurses have to problem-solve to deal with issues they face, but their approaches erase nurses' agency to some degree. Annette Street (1992), in *Inside Nursing: a Critical Ethnography of Clinical Nursing Practice*, describes how nurses can be oriented to "quick-fix" problem-solving that applies to tasks and patient problems:

Nurses rapidly learn that they have limited time within any shift...nurses experience constant stress caused by the need to complete tasks, to cope with emergencies, and to relate with patients. It appears that the capacity to organize

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<sup>9</sup> Wolf's (1988) finding differs from what I found: the nurses I studied recognized that their care-giving facilitated patients' healing.

tasks and the capacity to spend time in developing therapeutic relationships with patients are both unspoken values of nursing culture, which often causes dissonance for nurses. However, both of these values contribute to a valuing of problem solving. Nurses who are trained to respond rapidly and competently to emergencies develop a problem-solving “quick-fix” response to both tasks and patient problems (271).

She locates the development of a “quick-fix” orientation within nurses’ responses to the stress caused by constraints of the temporal order and contradictory demands. Street mentions “values,” which are part of culture, but she posits a somewhat deterministic model – here are the conditions, and thus nurses are forced to do such and such. It’s not that this approach is wrong, but it invisibilizes a part of nurses’ agency – how they shape their work on the unit through their group culture. They are not mere victims; they use cultural material to shape the conditions of their labor and thus participate as actors in the hospital.

Scholars commonly identify organizational and temporal constraints as the causal factors that limit nurses’ caring practices, that their work is not organized around what Steve Lopez (2006) calls “organized emotional care.” Focusing solely on nurses’ coercion, exploitation, and emotional labor, many scholars obscure the power of nurses to articulate “caring” in ways that set limits on their practices. When scholars do analyze power and agency in nurses’ discourses of caring, it is in how nurses strategically use the ideological virtue of caring in occupational boundary work and jurisdictional politics or labor struggles (Chambliss 1996; Apesoa-Varano 2014). However, conceptualizing external constraints as *always* the limiting factor on practices also defines nurses as victims of oppressive structures rather than agents who exercise control over their labor power within given constraints. In other words, scholars assume that, because nurses value caring and they highlight external constraints on their caring practices, that they do not therefore exercise agency by setting their level of acceptable effort or defining what counts as acceptable care. According to this framework, nurses’ agency lies in claiming a homogenized discourse of “caring” for occupational empowerment, but not in redefining “caring” to *limit* or otherwise increase control over their practice of it.<sup>10</sup>

Scholars do acknowledge that nurses sometimes “withhold care,” and that the threat of sanctions, including psychological tension, makes this practice largely untenable as a strategy. For example, Apesoa-Verano (2014; 82-83) states that “the dilemma of withholding caring was hard to resolve, mainly because practitioners believed in how important caring skills and caring work are for health and healing.” She explains how the “dilemma of withholding care” is itself a coercive and exploitative force, thereby highlighting the limitations on nurses’ agency vis-a-vis resistance. However, her unit of analysis—individual nurses—does not attend to how groups of nurses may mitigate the coercive power of this dilemma itself by collectively redefining the meaning of their work *as a group*. My work illustrates how nurses exercised agency by using culture to increase control over their caring practices... as a group.

Assuming that nurses *never* have enough time or that their technical work *always* dominates caring is deterministic and reduces nurses’ agency to individual action. It also

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<sup>10</sup> Note, for instance, Chambliss’ (1996; 87) statement, “nursing ethics, then, is the ethics of powerless people.”



ignores what nurses do when they do have time.<sup>11</sup> It is easy to overlook periods of relative freedom in the temporal order, because nurses are so busy so much of the time and because they—and researchers—seldom allow for any softenings in exploitative hospital regimes, as if those regimes must be totalizing in order to be morally-reprehensible. But this ignores the question of how nurses, working together as a group, may exert control over their temporal constraints. For example, Eviatar Zerubavel's (1979) study, *Patterns of Time in Hospital Life*, found that nurses asserted control over the temporal order by permitting flexibility in adhering to schedules of administering medications. In my work, I found that nurses experienced periodic breaks that provided important opportunities to replenish their energy. Furthermore, nurses explained that some days were “heavier” than others and that their caring practices ebbed and flowed accordingly. My direct observations confirmed this: one of the biggest constraints on their caring practices was the stress and rushing caused by higher patient acuity. Thus, the argument that time and technical medical work *determine* nurses' caring practices should be reframed to consider nurses' agency in defining and regulating their own practices within given institutional, structural, and historical conditions.

Street (1992) discusses nurses' response to institutional oppression by talking about nurses' “resistance,” yet posits this as an individual process, as nurses go through various stages of consciousness-raising, and furthermore fails to discuss what resistance actually looks like, and what changes it affects. Yet, like other scholars, she recognizes one form of group resistance: union organization and struggle. Suzanne Gordon's (1997) work, *Life Support*, also discusses agency solely in the form of labor unions, ignoring nurses' agency in their daily practices on the unit floor.

The tendency to analyze nursing as a dichotomy between emotional caring and technical medical work is also apparent in this literature. In that framework, particular bundles of tasks, which are defined as “medical,” are seen as not entailing emotional labor or caring in their practice and occur in temporal separation from them. This does not mean that scholars do not identify a link between the two. For example, scholars have analyzed how caring facilitates and is, at times, integral for medical work (Strauss et. al. 1985, Theodosius, 2008), that getting to know patients is essential for nurses to “know” them medically (Weinberg, in Nelson and Gordon 2006), and that “positive forms of emotional labor” have important consequences for patients' physical outcomes (Smith 1992; 143-45).

Said dichotomous analytical framework defines nursing in terms of these two categories—emotional and technical—and the dynamics between them, because it reproduces the dominant ideologies and structures of nursing, transmitted through the nurses (and others) under study. That is, researchers draw conclusions about analytical categories rather than investigating the social processes that constituted them in the first place.<sup>12</sup> An exception to this tendency is Apesoa-Varano (2014; 56), who identifies the dichotomy between caring and medical work as false: “the ‘cure’ versus ‘care’ dichotomy

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<sup>11</sup> For instance, Apesoa-Varano (2014) states, “time was always in short supply for nurses” (83).

<sup>12</sup> This issue parallels—analogously—the challenge that Mohanty (1991) identifies in assuming what constitutes a category, such as “women,” before analyzing the processes that produce it.<sup>12</sup> Specifically, she highlights how feminists sometimes begin their analyses with categories premised on a particular image of a third world woman who is a victim (dependent, oppressed, traditional) rather than an agent. This defines women as a homogenous group outside social and historical contexts.

shared by the practitioners I spoke with *artificially separated two interconnected spheres* of their work, which reproduced the occupational status hierarchy of Hospital General.” Analytically, this dichotomy is also problematic because it homogenizes the category, “care,” limiting researchers capacities to study the nitty-gritty of what it involves.

### *The Devaluation of Caring Labor*

While many authors discuss aspects of nurses’ care work that are devalued, they do not illustrate these processes as they occur in daily interactions on the unit floor. Several authors discuss how hospitals or larger societal structures devalue emotional support, such as Smith (1992; 53-55), as she found that technical wards more valued than wards that employed less technical skills. Theodosius (2008) and Gordon (1997) both discuss how the hospital restructuring that happened in the 1990s (both in the United Kingdom and the United States), wherein care was organized to promote “efficiency” and maximize profit, served to devalue emotional care. These authors note how there was simply very little time allotted for emotional care in the new hospital structure, and nurses increasingly were pressured to focus on the “physical” tasks of patient safety.

Other scholars discuss the devaluation of emotional support and “comfort work” in various ways. Strauss et. al. (1985) illustrate that much “sentimental” and “comfort” work is not recorded in official documentation. They describe how the comfort work done by nurses, in particular, is often invisible—not just in official records but also to patients—*despite the skills and labor involved*:

Comfort work often requires considerable knowledge about physiological functions, much skill, technique, and art; even meeting hygienic needs can be important in its therapeutic implications. Yet the patient may regard this work or assistance as non-technical, ordinary or just being nice or helpful. Even close monitoring and assessing of discomfort-relieving procedures and medications can be quite invisible qua work. Hence, the oft heard criticism, “the only thing nurses do is pass out pills,” shows little awareness that monitoring and assessing may accompany this seemingly menial task (108).

In their analysis, care work is visible and valuable to the extent that it resembles the relatively more technical work that MDs do. Implicit in this statement is that comfort work should be more valued because of the technical knowledge it requires and because of its “therapeutic” benefit. Thus, they use a biomedical framework to highlight the paradox of skilled and valuable, yet invisible, nursing care. This reflects a gendered and medicalized bias in both their conception of health and in their analytical categories.

In nursing homes and hospitals, the elision of particular tasks from official records is well-documented.<sup>13</sup> For example, in an ethnography of nursing homes in which he worked as a nursing assistant, Timothy Diamond (1992) observed that the official record-keeping in nursing homes leaves out and therefore obscures the majority of caring labor done by the staff. He argues that management does this in their attempts to rationalize care according to the logic of business profitability. Lopez’ (2006)

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<sup>13</sup> On the level of policy, Kaufmann (2005) discusses how Medicare reimbursement policies define what counts as “medical,” constraining patient care by setting boundaries around payment.

comparison of a nursing home guided by a professional philosophy that did not support staff's care practices with one whose philosophy explicitly valued care illustrates how the refraction of capitalist institutions through situated organizational cultures assigns value to care by defining particular tasks *as work* through documentation practices. While Lopez does not use the term "dirty work," he makes the case that organizational policy may define particular tasks, such as "spending time with patients" and "talking with patients" in ways that support workers' emotional selves by constructing conditions in which those practices are more highly valued.

"Dirty work" also formed a bundle of tasks that was commonly devalued, in a process that Everett Hughes theorized in the 1950s. He conceptualizes jobs as bundles of tasks held together by one person under a single name. He asks why the tasks in a nurse's job are all performed by a nurse given that "not all the tasks in the bundle require the same degree of kinds of skill" (313). There is a connection between what happens on the "frontiers" of work and what holds bundles of tasks together. According to Hughes, changes in material conditions arise with the introduction of new technology, which opens up new, more prestigious tasks for nurses (*ibid*). This increases the distance between the most prestigious and the dirtiest tasks in the bundle. Nurses, he says, like any professionalizing occupational group, will attempt to consolidate bundles of more prestigious tasks and hand the bundles of less prestigious or pleasant tasks to assistants. This reflects Hughes' approach to the birth of professions, "the process of turning an art and an occupation into a profession often includes the attempt to drop certain tasks to some other kind of worker" (314). When bundles of tasks are resorted, social roles also shift. Thus he asks, if nurses are known to do the work of bed side comforting, who will be called "nurse" when this task shifts to another worker?

Anselm Strauss et. al. (1985) point out that any task could potentially be defined as dirty, or undesirable:

While whole bundles of tasks may be regarded as physically or socially unpleasant or distasteful to perform (and so certain persons or classes of people are delegated to do this work part-time or totally) nevertheless, literally any arc of work can have dirty aspects— if not right now, then later under different circumstances (247).

Some of their most useful theoretical insights include the potential role that structural, organizational, ideological, and trajectory conditions may have on the boundaries between dirty work and satisfying work (250). One especially interesting point is that the psychological impact of dirty work may be mitigated when it is transvalued upward as when "nurses' comfort tasks are regarded as therapeutic work, especially when these require skill and experience." Also of relevance is their mention that politics, what they call "positional debates," may have an impact on which bundles of tasks are defined as dirty (251). While they delineate types of "dirty work," they do not analyze the social processes through which it comes to be construed as such.

As Hughes theorized, one of the processes of devaluation of particular care tasks that I found in my research was through the delegation of said tasks. Although a few authors mention that emotional labor sometimes gets delegated to social workers or counselors (Theodosius, 2008; Apesoa-Varano, 2014), none of them explore how RNs

delegate particular tasks to nursing assistants. In my research, I found that RNs systematically delegated to nursing assistants particular types of tasks, such as emotional labor, “dirty work”, and tasks or interactions that involved relations of domination/subordination with patients in which the patient had more power than the nurses. These situations involved the nurse feeling like a “waitress” or a “servant,” for example: having to empathize with or respond to demanding patients, responding to patients’ call lights, or bringing certain things to patients that they request. Also, I noted that staff characterized particular patients in certain ways, and these typologies shaped the value of the tasks in relation to these types of patients. None of the scholars address the situated processes of devaluation.

Delegation was only one of the ways that particular bundles of tasks became devalued. Racialized rituals of subordination was also part of this process. My research shows how RNs would “boss” the CNAs with an air of superiority, talk about how CNAs are “lazy,” and ask them to do too much work. These rituals further devalued the bundles of tasks that RNs were delegating, in the way RNs spoke to CNAs during their delegation of tasks. Also, when nurses were stressed and tired, they would often devalue tasks that required more labor (emotional or physical) or any task that was considered not urgent. This happened on a cultural level: when RNs were busier, they used cultural codes to discount or minimize patients’ emotional needs and to disempathize.

Devaluation of particular tasks, whether it be through delegation, through relations of domination/subordination, or through RN’s use of cultural codes to lower their level of acceptable effort, was a complex process. It shaped nurses’ identities and shaped patient care delivery. Yet none of the scholars in this field have studied it in a systematic way.

### *The Exploitation and Coercion of Care Work*

Although several lines of analysis address the coercion and exploitation of nurses’ caring labor, there is a paucity of empirical research on the situated processes through which coercion and exploitation occur in hospitals. The first line of analysis identifies nurses’ occupational subordination to physicians as a key factor in their coercion and exploitation. Scholars have established that nurses’ contemporary struggle with relations of subordination vis-a-vis physicians is rooted in a long history of institutionalized sexism (e.g., Reverby 1987; Group and Roberts 2001; Moore 1998). According to Benjamin and Curtis, “students [of the old hospital-based nursing schools] entered nursing schools already expecting that women would defer to men, and, therefore, that nurses would defer to doctors” (74). Physicians also feared that nurses would “successfully compete for social respect and resources,” so they strove to maintain their power over nurses for strategic occupational reasons in addition to structures of male domination (Gordon 2005; 66).

These structures and institutions of subordination facilitate physicians’ coercion and exploitation of nurses’ labor. For instance, Street (1992) found that rituals of subordination were connected to coercion in the hospital she studied, as the following anecdote from a nurse illustrates:

Nurses accept a lot of this [subordination from MDs] because they don’t have enough self-esteem. They take unnecessary crap from doctors. They don’t believe

that they have professional knowledge and skills...they need to be able to stand up for themselves and not be held responsible for medical decisions that are wrong because they are afraid of the doctors or because they want them to like them...Nurses are still expected to go and find things for medical staff as if their own work was not as important...Often doctors don't bother doing their work properly because they know that a nurse will come along and finish it for them (204).

In this account, lack of professional power is the source of nurses' coercion ("finding things for doctors" and "finishing their work for them"). This perspective does a good job of explaining the coercion that nurses experience directly from physicians. It is also an important piece of the puzzle in explaining the coercion and exploitation of nurses' caring labor.

The coercion and exploitation of nurses' caring labor is linked to processes that maintain the boundaries around multiple relations of domination and subordination, including the MDs. These processes define status and power as the capacity to not care. That is, labor which does not involve the freedom or power to *not care* disqualifies the care giver from access to status/power. The capacity to withhold care, to be free from the responsibility to care constitutes privilege and power. Although the act of caring in itself is discrediting, to use Erving Goffman's (1963) term, the discrediting itself arises out of assumptions about what the act of caring signals regarding one's capacity to not care. When the inability to not care is interpreted positively it conveys moral virtue. When it is interpreted negatively it conveys servitude. In my research, I observed that when RNs delegated devalued tasks they also delegated the relations of servitude in which those tasks were performed. Furthermore, the act of delegating such tasks reproduced relations of servitude between themselves and the CNAs. The work involved in doing the delegated task signaled the CNA's status as "servant," and the act of delegating the task associated with servitude signaled the RN as "master." In this way, the nature of the actual work involved in bundles of tasks mattered, not so much in terms of their difficulty, type, function, or anything inherent to the work itself, but because it signaled the *power relations*, such as servitude, that structured the performance of those tasks.

Researchers have provided evidence that an occupational identity based on caring—what some call the "virtue script"—is incompatible with the professionalization of nursing. Sioban Nelson and Suzanne Gordon (2006) argue that:

Much of the contemporary 'virtue script' trivializes what are in fact complex skills. It makes the caring that nurses give appear to be feeling as opposed to cognitive work and thus it paves the way for nice—rather than educated—women, or men, to replace the educated, experienced nurses who, we believe, are critical to patient care (12).

They call attention to the way sexist assumptions about nursing frame it as non-technical and define nurses as "nice" rather than knowledgeable, skilled, etc., and how this limits nurses' occupation power (e.g. Apesoa-Varano 2014). They challenge the dichotomy between the "feeling" and "cognitive" dimensions of care, arguing that framing nursing as emotional care is an obstacle to professional status. Therefore, "caring" acts as an

ideology that facilitates nurses' coercion and exploitation because it reduces occupational power by constraining professionalization.

According to Lydia Moland (2006), the ideology of caring enables others to subordinate, coerce, and exploit nurses and to discipline nurses who challenge this exploitation:

If nurses depict themselves as responding to a higher moral calling, they are likely to be taken advantage of by those who view their own occupations more pragmatically. It will be easier to pay nurses less, consult them less, and ignore their low levels of job satisfaction if it is believed that what is truly satisfying about the job is its opportunities for selfless altruism. The care vs. cure distinction, it seems puts nurses at a distinct disadvantage, leaving them open to exploitation (in Nelson and Gordon 2006; 56).

The ideology of caring legitimates nurses' subordination and exploitation. Consequently, these scholars acknowledge the practical and strategic utility in abandoning "caring" as an occupational identity in order to facilitate professionalization. As Apesoa-Varano (2014) puts it:

It seems as though evoking the importance of emotive caring has been abandoned as a preferred occupational strategy, even though it still exacts a symbolic—and psychic—toll in the hearts and minds of nurses and practitioners alike (8).

The move away from caring reflects Hughes (1951) assertion that nurses would distance themselves from caring in their professionalization process.

However, missing from this conversation is an analysis of the processes through which caring becomes the devalued source of coercion, exploitation, and occupational subjugation in the first place. As Evelyn Nakano Glenn (2000) reminds us, to the extent that the professionalization of nursing involves devaluing and delegating care, it does not solve the fundamental problem of the devaluation, coercion, and exploitation of the work and whoever ends up doing it. So, the professionalization of nursing based on eschewing care could very well exacerbate racial and class inequalities as well. In this sense, gaining power by progressively delegating and/or dropping care is analogous to the increase in privilege that Italians experienced when they became white (Waters 1990); members of the given group gained power by moving up the hierarchy, thereby reinforcing those power structures rather than challenging them.

In my research I observed that RNs delegated devalued bundles of tasks to CNAs in order to free themselves from relations of servitude. When they did so, they reproduced those relations of servitude, only now they stood in the dominant rather than the subordinate position. However, this reversal did not free them from the social and psychological tension of those relations of domination. Being dominant increased their occupational power, but it also increased their labor, now in the form of maintaining their dominance. Dominance-maintaining practices required energy due to constant friction and the practices required to protect their tenuous legitimacy, which included rituals that reiterated CNAs' subordination. Moreover, their domination exacerbated the emotional

labor needed to care, especially within the emerging context of heightened tension, coercion and exploitation, making positive experiences of caring even more elusive.

In order to understand the processes through which caring labor is coerced and exploited—and how nurses experience it—we need to analyze the nitty-gritty of the practices, cultures, and structures of feeling involved. Researchers who investigate the role of emotional labor in these processes do just that. For example, in a comparison of three nursing homes with similar objective characteristics but different organizational cultures, Lopez (2006) argues that when policy supports workers' humanistic care practices – a situation he calls “organized emotional care,” workers do not experience the estrangement from their emotional selves that Arlie Hochschild (1983) argues obtains in situations where organizations control emotional labor.

Catherine Theodosius' (2008) found that, in addition to using emotional labor to produce elicit a particular emotion or experience in patients, nurses also used their emotions in the process of addressing ostensibly purely physical needs, such as pain reduction. She conceptualizes this type of labor as “instrumental emotional labor (IEL).” She explains that it's “purpose is to successfully facilitate the clinical nursing procedure in a way that minimizes pain and discomfort and maximizes the healing process of the patient's physical body (162-63). Importantly, she illustrates that even apparently purely physical types of care have an emotional component and that they necessitate emotional labor. For instance, giving the impression of competency in ostensibly non-emotional technical medical work requires emotional labor:

In IEL the emotions experienced by the patient are concerned with the potential threat to his physical body. The patient is therefore concerned with his personal safety. The emotions elicited from the nurse are concerned with her performative achievement in her skill and clinical competency, and thus are directly concerned with her evaluation of her skills in respect to her identity as a nurse (162).

On the surface, her analysis challenges the dichotomy between emotional and physical aspects of caring as well as the dichotomy between caring and medical treatment. First, she illustrates that “physical” and “technical” medical tasks occur within an emotional field of some kind. Second, nurses do the work of recognizing when patients are anxious about their bodies and they respond by managing their own emotions to provide reassurance in the form of clinical competency. In other words, they do the labor of adapting their emotions to communicate clinical competency and thereby provide emotional support.

In this sense, IEL is similar to the work MDs do in order to maintain calm and give the impression of clinical competency, which notoriously utilizes *detached concern*. IEL implies the practice of empathy, because nurses must recognize patients' feelings (anxiety). However, IEL does not in fact attend to empathy in interactions in which practitioners try to recognize—and understand—patients' feelings and experiences in the moment, because practitioners may routinize the embodiment of clinical competency, thereby providing emotional support without actually empathizing with individual patients. This is why the routinization of IEL among RNs resembles the practices of *detached concern* conventionally associated with MDs.

Theodosius' other category of care, Therapeutic Emotional Labor (TEL), describes practices of empathy within the context of interpersonal relationships between nurses and patients:

In order to promote the psychological and emotional wellbeing of the patient in a way that facilitates their movement towards independent healthy living. TEL is dealing with emotions that are directly concerned with expressions of self-worth and personal identity of both the patient and the nurse, elicited from their interactive relationship... TEL may involve the nurse encouraging the patient to express and talk about their feelings and concerns while managing their own emotions. It is predicated on the belief that disclosure and discussion of personal and private problems is therapeutic for the patient... (147).

TEL describes empathy in terms of getting to know patients' individual experiences and biographies, which is distinct from IEL, as IEL concerns nurses' relatively routinized recognition of patients' need for reassurance regarding practitioners' clinical competency. Both TEL and IEL overlap with my finding that nurses use culture—in the form of *having heart* and *basic stuff*—to shape their care delivery practices. To some extent, the sets of meanings, feelings, and practices involved in *having heart* overlap with TEL, while *basic stuff* and IEL also overlap somewhat. However, Theodosius' analytical categories, TEL and IEL, are essentially Weberian (1958; 59) ideal types and illustrates them with empirical evidence, whereas I observed situated instantiations of these and other forms of emotional labor within group cultures and patterns of interaction and analyzed the social construction of them.

My analysis of the coercion and exploitation of nurses' caring labor builds on these lines of analysis and addresses gaps, particularly in scholarly knowledge of macro variables in situated, micro-processes. I show how customer service policies discipline nurses to overextend themselves and work overtime by enabling patients to report them if they are not "satisfied." I illustrate how relations of servitude coerce nurses into empathizing with "demanding" patients, and how RNs coerce and exploit CNAs by delegating to them and reproducing relations of servitude. I analyze the emotional labor involved, not just in providing emotional support but also in using empathy to discipline patients, eliciting their compliance while also maintaining patient satisfaction.

Furthermore, I illustrate how processes of "double-agency" subjectivation exploit nurses by facilitating their experience of agency through caring, the exploitation of which is made invisible because it feels autonomous and self-motivated by compassion and empathy, in contradistinction to caring according to customer service policies, which they find coercive. Unlike the exploitation involved in "deep acting," the exploitation that works through these subjectivities did not require the "exhortation" or "imagination" that produces the appropriate emotions. Rather, this form of exploitation of emotional labor occurs through nurses' experiences of agency. Consequently, although it required labor, it did not require "acting," because the feelings were already there.



## Methodology and Techniques of Data Collection<sup>14</sup>

Data collection for this project involved three years of IRB-approved participant observation in a large, urban hospital in California. In order to gain access to this hospital, I contacted the Director of Volunteer Services and the Nursing Manager, explained the nature of my research, and solicited their permission to observe hospital workers in a nursing unit while working as a student volunteer. The Director of Volunteer Services and I discussed the options as to which nursing unit would be the best fit. The cardiology unit where I was placed was ideal, because the nursing work necessitated more specialized training than medical/surgical units without the intensive life support conditions of an ICU. This particular combination highlighted the social dynamics related to the emotional and technical dimensions of care that are present, in various forms, in all types of nursing units. Additionally, the cardiology unit, like most units in the hospital, employed Certified Nursing Assistants (CNAs), an essential group in my research design. Although my official data collection took place only on this unit, I also volunteered on a medical/surgical unit in the same hospital. My personal work as a volunteer on the medical/surgical unit provided an informal point of comparison for my observations and analysis of the cardiology unit.

Writing my field notes involved techniques that Bob Emerson (1995) describes in *Writing Ethnographic Field Notes*. I integrated jottings into my daily observations, which did not disrupt the flow of interaction as much as one might think. This was due, I believe, to the fact that charting was a large part of nurses' work. If anything, my jottings seemed to help me gain rapport, as if it signaled to my participants that I was going something meaningful. When the opportunity presented itself, I went out to my car to take more extensive notes on my laptop or adjourned to a quiet part of the hospital to elaborate on my jottings. I was extremely careful to protect the anonymity of my participants, which I accomplished by using aliases and coded language in my notes and by being mindful that they remained securely on my person at all times. To that effect, I limited the amount of notes on my person by leaving already-written notes in my car or at home rather than bring them back into the field. I obtained informed consent from those I observed. Finally, I used the program, Atlas.ti, to code my data.

My status and role as a volunteer mostly facilitated—but also constrained—the observations I was able to make. My volunteer duties included assisting the staff with limited tasks, such as answering call lights and phones at the nurses' station, fetching supplies, visiting with patients, and greeting family members. Answering call lights gave me the opportunity to sit at the nurses' station and observe the work happening there. Fetching supplies and running errands took me throughout the hospital, giving me familiarity with other departments and personnel. When visiting with patients, I had the chance to build rapport with them and observe care delivery interactions from their perspective. Greeting visitors included offering them coffee or tea and talking about their experiences. These duties helped me build rapport with the staff, patients, and visitors. The nurses showed much appreciation for my help, which facilitated rapport. I often enjoyed enough autonomy to direct my attention to observations of my choosing.

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<sup>14</sup> Michael Burawoy (1991) defines “methodology” as “concern” with “the reciprocal relationship between data and theory” (271).

However, these tasks sometimes took up large amounts of time, constraining my ability to freely observe. I compensated for this obstacle by dedicating more time in the field.

The nurses with whom I worked were welcoming and friendly from the beginning. My personal biography also facilitated rapport; I told them about my experiences caring for my parents and this helped them understand my motivation to learn about their work. Most of my interview data came from informal conversations rather than formal interviews. Informal conversations were more conducive to their work flow. They were also more naturalistic, enabling me to gain insights and ask questions that would not otherwise be possible. I was mindful to not interfere with their work. I checked in with them regularly to ensure that I was not getting in their way. During particularly busy periods, I abstained from asking questions or making conversation, instead broaching relevant topics at a later time. This often occurred in the break room. After a couple months in the field, I learned that the break room was an invaluable place to talk with the staff. This happened one day when I brought food to share with them when they took their breaks. They were very grateful, so I continued to share food, coffee and conversation with them when there was time for it. These informal conversations resembled those which would naturally occur between an inquisitive volunteer and these nurses. I never encountered any problems or complaints with any of my participants in the course of my research.

Volunteering not only helped build rapport, it also gave me a unique point of view and positionality. It created the kind of access to back stage interactions otherwise accessible by “going native,” or working as a member of the staff. Yet I was neither an RN nor a CNA. My existence outside these groups excluded me from occupational group politics and other limitations in observational perspective that would have accompanied my research as one of these types of workers. At the same time, volunteering gave me a role in the division of labor, a chance to contribute that I would not have enjoyed if I made my observations simply as an invited researcher. In other words, my method gave me the best positionality available for the observations I wanted to make. While positionality and biography constrained “pure objectivity,” as they do for researchers in all disciplines, I utilized the scientific method to verify that the patterns that cohered in my analysis were strongly supported by my data, and that my data accurately reflected empirical reality.

My grounded approach, in the tradition of Barney Glaser and Anselm Strauss (1967), helped me avoid taking my categories of analysis for granted and making *a priori* assumptions as to the social contours of “care.” This methodological issue parallels the mistake that Chandra Mohanty (1991) identifies as assuming what constitutes an analytical category, such as “women,” before analyzing the processes that produce it.<sup>15</sup> Specifically, she highlights how feminists sometimes begin their analyses with categories premised on a particular image of a third world woman who is a victim (dependent, oppressed, traditional) rather than an agent. This defines women as a homogenous group outside social and historical contexts. Mohanty calls this the “third world difference” and attributes its origins to western feminists’ assumption of a monolithic framework of patriarchy (54). Post-structural studies in the construction of gender identity take a site of

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<sup>15</sup> Barrie Thorne (1993) makes an analogous point in her observation that a framework of “difference” homogenizes gender categories, defining the object of analysis according to *a priori* assumptions, thus obscuring instances of “similarities” across genders (and the social processes that construct them).

activity, such as labor, and analyze how practices in that site “produce,” or socially-constitute, “men” and “women.”

Post-structural methodologies, which begin with situated social processes, mitigate the problem of categorical *a priori* assumptions. In these studies, gender, for example, is used as a category of analysis in the sense that processes through which it is socially-constructed are the object of study, situated within a given set of social relations.<sup>16</sup> Along with post-structuralism, interpretive phenomenological analysis in the tradition of Alfred Schutz (1970) and Maurice Merleau-Ponty (2002 [1962]) also informed a methodology that helped me avoid taking my categories of analysis for granted. Phenomenology underscores the importance of understanding participants’ own experiences of their social worlds. This methodology resonates with feminist scholarship’s emphasis on the subjectivities of both researcher and participants.

My understanding of the myth of pure objectivity in scientific observation comes from feminist scholars who debunk the myth of pure objectivity. For example, Jane Flax (1987) recognizes the utility of a deconstructionist approach to research while Donna Haraway (1988) elaborates the need for situated knowledge, reasoning that multiple perspectives are better than an ostensibly objective view, which she calls the “god-trick.” Feminist scholars highlight the importance of methods that involve recognizing the power structures that shape epistemologies, particularly which types of knowing are defined as legitimate and authoritative. Good solutions to the problem of power in systems of knowing involve recognizing and valuing personal experience as knowledge and challenging the gate-keeping role of dominant definitions of legitimacy, however they are constructed (“objectivity,” “theory,” “knowledge,” etc.).

Feminist scholars thereby illustrate the dichotomy between theory/knowledge and emotion/experience to be a false one that reproduces structures of inequality and domination. For example, bell hooks (1994) highlights the need to connect theory *with practice* and situated experience:

There is a link between the silencing we experience, the censoring, the anti-intellectualism in predominately black settings that are supposedly supportive (like all-black women space), and that silencing that takes place in institutions wherein black women and women of color are told that we cannot be fully heard or listened to because our work is not theoretical enough (68).

hooks’ identification of “theory” as a measure, or code, for validity helped me observe the social processes that constructed technical medical work as *knowledge* and caring medical work as *natural*. In Patricia Hill Collins’ (2000) articulation of the two interrelated levels of knowledge that exist between Black women intellectuals and their communities, she highlights the epistemological importance of both theory and personal experience:

The commonplace, taken-for-granted knowledge shared by African-American women growing from our everyday thoughts and actions constitutes a first and most fundamental level of knowledge...Experts or specialists who participate in and emerge from a group produce a second, more specialized type of

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<sup>16</sup> For example, see Leslie Salzinger (2003)

knowledge...The two types of knowledge are interdependent. While Black feminist thought articulates the often taken-for-granted knowledge shared by African-American women as a group, the consciousness of Black women may be transformed by such thought (34).

The structures and processes of knowledge-production the Collins describes among African-American women were an important element in my method. They refer to production of knowledge, or “data” in my case, through dialogical collaboration rather than “objective” positivism. Although I did not include my participants in the writing or editing of this manuscript, my data emerged through dialogical conversations, as well as a method that involved regularly testing the accuracy of my observations and analysis against the experiences of my participants. I employed the deductive/induction “circle of science” to formulate and evaluate my nascent theories throughout my three years of field work. I viewed my observations with an attitude of skepticism and an ethic of care guided my ethnography.

My method included an epistemology based on an ethic of care, similar to that which Collins describes as essential in the production of dialogical knowledge. This care-based knowledge is rooted in valuing emotional expressiveness and personal experience. According to Collins, these knowledge systems are extremely important in Black women’s capacities to analyze their own social locations, which she links to their positionality vis-a-vis structures of domination/subordination (35). Importantly, Collins reminds us that scholarship is not an individual enterprise; our situated perspectives constrain as well as enable and pure objectivity is ideological. In my method, epistemologies that include communication of personal experience—both researcher and participants—and that validate emotion as a source of knowledge are essential for social analysis.

At the same time, I recognized the limitations of an interpretive phenomenological analysis that relies exclusively on subjects’ conscious experiences or narratives in research. This methodological consideration reflects Susan Bordo’s (1993) critique of what she calls the “paralyzing anxiety” in feminism, which emerged as a consequence of the deconstructionism practiced by scholars such as Flax and Haraway. She argues for the need to move beyond the postmodern desire for what she calls a “view from everywhere” as opposed to a “view from nowhere.” While attending to people’s experiences as valid sources of knowledge in research is important, interpretive phenomenological analyses that attend only to people’s conscious experiences/feelings may be limited by people’s own accounts of their experience, how they feel, and what they believe.

For one thing, conscious narratives do not necessarily reflect what individuals actually experience. Put another way, they reflect one level of experience. According to some scholars, meanings and feelings of which we are consciously aware may not only be the tip of the iceberg compared with those which are inaccessible to us, they also distort our conscious experience of “reality.” For example, sociologists as diverse as Pierre Bourdieu (1977; 1984), Jack Katz (1999), and Richard Biernacki (1995) analyze culture’s effects on social processes by attending to individuals’ embodiment of it. Furthermore, scholars, such as Ann Swidler (2003), who focus on semiotics identify subconscious processes in who people make meaning. In her analysis, there is coherence

in individuals' contradictory use of culture in how it provides solutions to contradictory institutional arrangements. She observes that culture which is well-integrated into social life is more taken-for-granted and subconscious. According to Nancy Chodorow (1999), unconscious feelings, images, and fantasies are biologically-given human conditions of possibility for meaning-making:

The capacities that enable us to create personal meaning—capacities for transference, projection, introjection, and unconscious fantasy—are innate human capacities that develop and unfold virtually from birth, in a context of interaction with others (14).

Chodorow describes how psychoanalysts work to uncover these subconscious experiences, which are not as readily observable by conventional methods of direct observation or interviewing. While such psychoanalytic analysis was beyond the scope of this project, I attended to the role of feelings in the social processes I observed. Rather than assuming that my participants' conscious, semiotically-available experiences encompassed the whole of the social processes I studied, I compared these experiences with my direct observations of their practices and interactions, with an eye to the emotional fields and structures of feeling through which they occurred. This involved a dialectical method in which my dialogical data and my relatively positivist data informed one another. I found this "dialogical-positivist" method efficacious in achieving what Peter Berger (1963) calls "debunking," or making visible the social institutions, structures, and ideologies which people, including scholars, take for granted.<sup>17</sup>

Finally, my capacity to practice empathy in the field, or what I call *field empathy*, was a key component of my research methodology. It augmented my observations and analysis of what Raymond Williams (1977) calls "structures of feeling" and what Randall Collins (2008) describes as "emotional fields." Field empathy was both a cognitive and an emotional practice. Recognizing, resonating with, and understanding, in context, my participants' emotions increased the observational visibility of individual participants' emotions, emotional fields, and structures of feeling in the hospital. In this sense, it is analogous to the technologies of observation, which make particular phenomena observable in natural science research.

Field empathy also facilitated my capacity to practice reflexivity in my research. Prus (1996) describes how reflexivity facilitates intersubjective coherence between theory and method:

Through interaction with others and by taking the viewpoint of the other with respect to oneself, people develop capacities to become objects of their own awareness. By attending to the viewpoint of 'the other' (what Mead [1934] terms 'role taking'), people are able to attribute meanings to their own 'essences' and to develop lines of action that take themselves (and other objects) into account (15-16).

Reflexivity is thus closely linked with the kind of epistemology that Collins (2000) describes as at work in dialogical knowledge-production. Successfully practicing

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<sup>17</sup> Berger, Peter. 1963. *Invitation to Sociology*.

empathy and reflexivity in the field required that I manage my feelings of vulnerability, anxiety, fear, worry, pain, contraction, sadness, depression, chaos, meaninglessness, emptiness, tension, anger, frustration, expansion, joy, excitement, and elation. This was challenging because the intense structure of feeling, organized around suffering and fear, that I encountered in the field triggered these emotions in myself.

This suffering—and the scary emotions associated with it—emanated from patients and their visitors, which influenced workers’ emotions through what Melanie Klein (1952) calls, “projective identification,” a process in which individuals’ irrational emotions are transmitted to others. At the same time, hospital workers brought with them their own intense emotions, such as anxiety and detachment, related to the multiple challenges of caring for patients, which they transmitted to patients and to each other. These feelings permeated the hospital in a kind of baseline tension, punctuated by less-intense moments. Unspoken feeling rules discouraged displays of a range of affect, such as crying, excitement, and anything that could appear close to a loss of calm or control.

Maintaining the empathy necessary to make my observations as accurate as possible took considerable effort and time. Practicing empathy increased my vulnerability to the destabilizing effect of patients’ and workers’ emotions. Since the dominant structure of feeling in the hospital did not support the integration of such feelings into social interaction or expression, they felt doubly-threatening. I found that regularly dedicating at least a few minutes to meditating before and during my field work helped me remain calm, focused, and open to my participants’ experiences. Nevertheless, the emotional and physical demands of practicing empathy required that I take periodic “vacations” from the field.<sup>18</sup>

In chapter one, “The Basic Stuff of Having Heart: South Heart’s Paradoxical Culture of Care,” I analyze my finding that there were several—somewhat contradictory and somewhat complementary—semiotic codes at work in the hospital. The organizing dynamics of these codes, including *having heart*, *basic stuff*, *rushing*, *customer service*, *servitude*, and *medical safety* shaped which practices signified care. When the logic of *having heart* organized a given interactional context, nurses experienced a form of caring that defined it according to personalized attention to patient’s needs and feelings. In contrast, *basic stuff* shaped nurses’ experiences of caring by defining the parameters around “needs” to indicate their instrumental, physical dimensions. Thus, *basic stuff* signified care with routinized practices of instrumentalized empathy and emotional support constituted through emotional fields of intersubjective distance.<sup>19</sup> A high level of effort according to *basic stuff* meant keeping patients safe, which required disciplinary knowledge of patients’ physiology. On the other hand, a high level of effort when *having heart* meant keeping patients safe *and* providing emotional support.

In chapter two, “An Atmosphere of Normalcy: Empathy in Care Delivery,” I analyze how RNs and CNAs used semiotic codes to provide emotional support, and how these codes facilitated and constrained their practices. *Having heart* signified care

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<sup>18</sup> Throughout this research, a force, which Susan Krieger (1991) calls “individual creative vision,” animated my work. According to her, “the idea that we know the world because we have vision, and each a different vision, is different from the idea that the world is known through selected abstract concepts. Concepts can be detached from the individuals who use them, and passed around, adopted, or discarded. Vision is more complex. It works as a whole and is developed from within” (54).

<sup>19</sup> My usage comes from Randall Collin’s (2008) conceptualization of “emotional field.”

through practices of empathy and emotional support constituted through emotional fields of intersubjective connection. These behaviors were linked to the recognition of patients' needs as emotional as well as physical. A high level of effort in contexts of *having heart* meant providing personalized emotional support, which involved knowledge produced through dialogical relations with patients. In contrast, nurses embodied *basic stuff* to regulate their acceptable level of effort and emotional labor, and establish contexts for care dominated by instrumentalized definitions of patients' physical—and *rationalized emotional*—needs. I analyze how nurses used both codes to reduce patients' anxiety, to help patients cope with dependency, and support patients by connecting with them. I also illustrate how the code they used affected the structure of these three processes.

In chapter three, "Don't Baby Them!: Disciplinary Practices of Care Delivery," I analyze how RNs and CNAs used culture to empathize and disempathize with patients as means to disciplinary ends, such as eliciting patients' "compliance," organizing their work "efficiently," and keeping patients "safe." Specifically, I illustrate processes through which nurses used disciplinary empathy and disempathy to mitigate experiences of servitude, including the emotional labor, power relations, and the status denigration it produced. Nurses used semiotic codes, practices, and emotions to establish contexts for care defined by empathy and disempathy. Disempathy pushed the boundaries around what counted as care in the eyes of nurses and patients. For example, sometimes the behaviors of *basic stuff* signified *rushing* or *doing it for the money* instead. The same behaviors signified either code depending on context and the situated perspective of those involved. Nurses disciplined patients, rationalizing their needs and regulating their emotional involvement with them, but these processes largely occurred in response to organizational constraints and relations of servitude.

In chapter four, "Servitude and the Institutional Matrix of 'Double-Agency' Subjectivities," I analyze nurses' contradictory valences vis-a-vis their tasks and the social processes through which they defined particular bundles of tasks as highly-valued and defined others as undesirable. They associated the least desirable tasks with relations of servitude, something they linked to types of tasks as well as the structures and interactional contexts in which they occurred. Servitude required borderwork between subjectivities of caring-constitutive-professional status and caring-constitutive-servitude. Their borderwork between these subjectivities and the tasks (and people) associated with those subjectivities organized the dynamics between cultural elements, including semiotic codes, practices, emotions. I also illustrate how institutionalized affective structures rooted in relations of exploitation constituted "double-agency" subjectivities. Nurses resisted customer service policies, scripts, and drills, experiencing agency as controlling their caring labor. Double-agency enabled nurses to experience agency through caring as a self-directed, autonomous practice of empathy and compassion. Unlike emotional labor, caring through these subjectivities did not require the "exhortation" or "imagination" that produces "deep acting." Rather, this form of exploitation occurred through nurses' experiences of self and agency; it did not require acting, because the feelings were already there. However, it also necessitated more emotional labor, as they struggled not to care.

In chapter five, "Professionalizing Borderwork," I analyze how RNs asserted professional power by delegating tasks linked with servitude to their assistants. I show that the most devalued bundle of tasks consisted of those that gave nurses relatively less

control over their practices of empathy and disempathy and required considerable emotional labor. This was the bundle of tasks linked to servitude. These devalued tasks contrasted with the most prestigious tasks—assessing patients medical needs and statuses—which gave nurses much control over their practices of empathy and disempathy, required less emotional labor, and accrued value from their association with the professional status of physicians. They used rituals of subordination to maintain the racialized structure of servitude that subordinated CNAs to RNs. Shadow rituals established a symbolic order of domination and subordination while face-to-face rituals of disempathy and control enacted RNs professional power in interactions. This chapter thus illustrates how RNs claim to professional power was predicated on their capacities to pass servitude onto CNAs and to maintain the boundaries around the two groups.



# Chapter One

## The Basic Stuff of Having Heart: South Heart's Paradoxical Culture of Care

In this chapter, I analyze discursive patterns among Registered Nurses (RNs) and Certified Nursing Assistants (CNAs). I wanted to understand how these RNs and CNAs used culture to define which practices signified care and to identify valences for the tasks that these forms of care involved.<sup>20</sup> I found that these RNs and CNAs used several emotionally-charged semiotic codes then they talked about their work.<sup>21</sup> These codes—*having heart*, *basic stuff*, *rushing*, *medical safety*—organized, controlled, and anchored one another in patterns organized around nurses' status differentiation and their valences regarding more- and less-valued dimensions of care work.

The concept “borderwork” is useful here. Barrie Thorne (1993) describes how borderwork, helps us analyze social relations that are maintained across boundaries (ethnic, gender, etc.) without “diminishing the participants' sense of cultural difference and of dichotomized [ethnic, gender, etc.] status” (64).<sup>22</sup> Nurses' borderwork occurred within the larger context of contradictory institutional arrangements and was instantiated in practices of code-switching between *having heart* and *basic stuff*. Nurses used these codes to define emotional support and assert claims as to how it should be practiced, or in other words, to define what counted as good or acceptable care. *Having heart* signified care in terms of empathy, the embodied affect and mental attention given to cultivating an emotional field between nurse and patient that generates dialogical knowledge about that patient.<sup>23</sup> It also signified a relatively high level of effort in providing emotional. In contrast, *basic stuff* allowed nurses to practice good care without attending to emotional fields of empathy or utilizing a relatively high level of effort. In other words, it established care delivery contexts characterized by instrumentalized definitions of

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<sup>20</sup> “Nurses” includes all these groups. Sometimes the category “CNA” includes LVNs for the sake of simplicity. “Nursing assistants” likewise includes both CNAs and LVNs. All names are pseudonyms. I limit other identifying details in order to provide as much privacy protection as possible for the people I discuss in this work.

<sup>21</sup> Ann Swidler defines *semiotic code* as “a self-referential system of meanings in which each element in the system takes its meaning not from its inherent properties or from some external referent, but from the meanings created by the code itself” (2001; 162).

<sup>22</sup> *Borderwork* was Originally developed by Fredrik Barth (1969).

<sup>23</sup> Empathy involves both cognitive-semiotic and emotional components. Jodi Halpern describes the practice of empathy as: “an essentially experiential understanding of another person that involves an active, yet not necessarily voluntary, creation of an *interpretive context*” (77). Empathy requires affective “resonance” as well as the cognitive skills of “affective imagining.” Halpern defines resonance as, “spontaneous affect that is similar to another's affect, such as feeling anxious around an anxious person or instantly light-hearted in the presence of a joyful person” (79). It is not a cognitive-semiotic phenomenon. On the other hand, affective imagining involves the cognitive work of grasping the other's experience and imagining how the other feels. This cognitive work is not theoretical, but experiential, emotional reasoning similar to that which Carol Gilligan (1982) observed in *In a Different Voice*.

patients' physical and emotional "needs." They used *basic stuff* to regulate their emotional labor, ease psychological tension, create autonomy over their care work, mitigate coercion and exploitation.

Paradoxically, these RNs both valued and devalued emotional support in their culture of care. They talked about how it was the most important thing they did for patients, but devalued the skills it required. Additionally, they legitimated and normalized the practice of emotional support as *basic stuff*, while presenting themselves as *having heart*, at least in front stage contexts. As I show in other chapters, *basic stuff* devalued emotional support because it anchored other practices, including the devaluation of emotional support vis-à-vis medical knowledge, the rationalization of patients' emotional needs, disempathy, and delegating care to CNAs through rituals that reaffirmed their racialized subordination. Despite distancing themselves from the less-desirable dimensions of emotional support (e.g. "dirty work," servitude, emotional labor for low-status patients) and the work it involved, RNs constructed subjectivities based on group identification with the moral virtue of *having heart* and with the prestige of their medical knowledge.

In the analysis that follows I first discuss three dimensions of the contradictory institutional arrangements in which these processes were situated. Second, I analyze two core values of nursing culture: "emotional support" and "medical safety." Third, I analyze the cultural paradox I have identified, and compare how RNs and CNAs articulated the codes *basic stuff* and *having heart*. Fourth, I analyze how RNs and CNAs used another code, which I call *rushing*, to define the boundaries around acceptable care practices, construct, and contest occupational identities based on the moral virtue of *having heart*.

### **Contradictory Institutional Arrangements**

The nurses who worked on South Heart faced these contradictory institutional arrangements: 1) the constitutive rules of medical safety conflicted with the rules of emotional support; 2) the rules of emotional support were themselves contradictory—nurses were expected to provide standardized care to all patients, yet in practice they needed to empathize with each patient's personal experience; and 3) nurse-patient ratios, higher patient acuity, and "efficient" market approaches to staffing systematically limited resources available to care. I use Ronald Jepperson's (1991) definition of "social institution":

An institution is then a social pattern that reveals a particular reproduction process. When departures from the pattern are counteracted in a regulated fashion, by repetitively activated, socially constructed, controls—that is by some set of rewards and sanctions—we refer to a pattern as institutionalized (145).

In this view, institutions are analytically distinct from formal organizations, though institutions may be organized formally. Institutions are instantiated in micro, interactional processes, as Bob Bellah, et. al. (1992) observe:

An institution is a pattern of expected action of individuals or groups enforced by social sanctions, both positive and negative. For example, institutions may be

such simple customs as the confirming handshake in a social situation, where the refusal to respond to an outstretched hand might cause embarrassment and some need for an explanation; or they may be highly formal institutions...institutions always have a moral element (10).

Care delivery in this hospital occurred in a formal organization, but was organized through several institutions. Moreover, these institutions cross-cut each other in contradictory arrangements that produced patterns of situational contexts for care delivery. Nurses faced a fluid but patterned set of challenges, because these institutional arrangements systematically constituted particular types of situations. These institutions played a key role in reproducing structures, which I define as relatively stable patterns of social relations and interactions, of care delivery.

Ann Swidler's (2003) work in the sociology of culture provides a framework for my analysis. In addition to her insights into how people use culture, she theorizes the linkages between culture and institutions. She argues that:

There can be social debates about the codes that signal various traits or properties so that the content of a semiotic system can shift, while its underlying "point"—what it seeks to convey—remains pretty much constant...In some cases, institutional orders may remain stable while the semiotic codes in terms of which they operate shift. In other cases, a semiotic code may be adapted to convey new meanings, linking it to a different institutional order than the one in which it originally made sense (2001; 206).

On one hand, the underlying point of the semiotic system I studied was "care" while the content of the system included the various behaviors and conceptions of care signified by semiotic codes, such as *having heart* and *basic stuff*. Swidler suggests that when behaviors that signify the underlying point of a semiotic system shift far enough away from the original sets of behaviors, the underlying "point" may shift as well. The important role of institutions in shaping the structures of care—and the types of situations nurses faced—was apparent in how nurses produced and used culture to define which behaviors signaled institutionally-acceptable practices.

#### *Medical Safety and Emotional Support*

These RNs often described emotional support as a daily challenge that competed with medical tasks. Concentrating on medications, for instance, was important because of the risks involved in giving them to patients. Yet, concentrating on medications made it difficult to perform the tasks of emotional support. The nurses acknowledged the tension between their emotional support tasks and their medical tasks. They described how emotional support and medical tasks conflicted with each other, competing for limited time and energy. "Giving meds," for example, contrasted with "talking" to patients, as if they were bundled into two separate categories comprised of tasks of a contradictory nature. Note, for example, how such a boundary distinguished medical tasks and emotional support tasks in this conversation with Nicky, a younger RN:

She pauses for a minute before responding to my question about what she does

that helps patients the most, “I think I spend the most time giving medications... Being able to actually talk to patients, having the time to talk about stuff. I think the most important is, yeah, talking with them. Sometimes they just need someone to vent to or talk to.”

Note how Nikki first considered the importance of giving medications, but took her time to think about it and decided that while she spent more time giving meds, it was not as important as “being able to actually talk.” She added that what patients “really” wanted to talk about was “what they’re scared of” regarding their experiences as a patient. She explained that it was hard to talk while giving medications, because “you really have to concentrate.”

### *Standardized Customer Service vs. Personalized Care*

Hospital customer service policies were signified by acronyms such as “C.A.R.I.N.G.” and “A.I.D.E.T.”<sup>24</sup> These policies attempted to codify the standardization of behavior through scripts. The aim was for each nurse to treat each patient as similarly as possible. In the following somewhat-comedic interaction, two nurses and I were in a patient’s room discussing a “Service Excellence Standards” administrator who was there to drill them on a script for “delivering very good care:”

I’m in a room with an RN and a CNA. Through the doorway I see a tall, elegant-looking woman standing at the desk. She looks high-status.

Amber, an RN, says she [the woman] is rounding with them to make sure they do it correctly. She follows nurses around to make sure they do the entry [script] right, “knock knock. Hello...May I come in. I’m such and such. I’m going to do such and such to you. Is that OK? And then you write your name on the board. Just an introduction and proper entry and proper exit.”

Me: “but won’t people just do it that way cause she’s watching?”

Sasha, a CNA, replies, “she’s not here to ridicule or give bad scores. She’s here to just make sure that when we do get observed we’re doing it correctly...”

I ask what they call it.

Amber, “AIDET.”

Sasha confirms, “AIDET. Yeah.”

I say “Acknowledge, Introduce...”

Amber adds to the acronym, “education.”

“But you forgot the ‘D,’” says Sasha.

They can’t remember the D... Amber begins to look at the card behind her ID... but then she remembers, “Duration.” She says she can demonstrate it, “hi Ms. Moom, how are you doing today?” She says this in an extra sweet voice.

Sasha stops her, reminding her that “first you knock at the door.”

Amber, “yeah, but I’m already standing in here.”

Sasha, “ok, right...right.”

Amber takes a deep breath and continues, “..and then...what’s the ‘E’ stand for?”

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<sup>24</sup> These policies ostensibly applied to all hospital workers. However, hospital administration disciplined nurses but not MDs for failing to “satisfy the customer.” See the Appendix for a description of these acronyms.

(I note that she didn't do the duration...!).  
Sasha says, "'E' is...uh..."  
Amber recalls, "Educate."  
I begin to ask about the 'D,' but we're interrupted.

At this point in the conversation, Lanette, a CNA, enters and asks us if we heard about the teacher who molested her student. The situation was getting downright hilarious at this point: Amber and Sasha were trying to figure out what AIDET was, when Lanette enters (without using the AIDET script), and then all three of them proceed to gossip about a sex offender in front of two patients (who couldn't speak English). This vignette highlights the discrepancy between customer service policies and informal practice. Nurses tacitly opposed the hospital administration's attempts to standardize their work with such scripts, by playing along and then forgetting them.<sup>25</sup>

Instead of implementing the formal rules for one another they enforced their own informal codes of care.<sup>26</sup> In fact, they experienced administrators as limited in their ability to supervise them, because much of their care work took place in the relatively private spaces of patients' rooms. Nurses worried more about *patients* reporting them to the administration. Patients reported them for "not caring." Patients did not evaluate "caring" by the standards of AIDET. Ironically, the standardization of care enforced through customer service policies actually got in the way of nurses developing rapport with their patients; patients perceived scripted interactions as insincere, and scripts constrained nurses' capacities to practice empathy. Meanwhile, personalized care helped to prevent "non-compliance" and patients' complaints to hospital administration.

### *Corporate Organization of Care*

California law mandated a maximum ratio of four patients to one RN in this type of Cardiology unit. Hospital management didn't officially assign RNs more than four patients, but they kept the total number of staff, including CNAs, Ward Clerks, and Relief Nurses at a minimum. When the patient census was high, there were more support staff working in the unit, so nurses felt that the work was easier. Their work was actually more difficult when there were fewer patients. For instance, when the census was low, the RNs did not have a Relief Nurse to help them with their patients and allow them (the RNs) to take breaks. Furthermore, when patients had higher acuity, the Relief Nurse would help the assigned RN provide care so she or he would not fall behind. This was not factored into the hospital's staffing formulas, because staffing assumed that each RN could actually handle four patients consistently. Additionally, RNs routinely, but unofficially, assigned CNAs more patients than policy permitted. In general, the hospital management maintained the minimum amount of employees on hand, in order to make it more "efficient." According to Flynn, an RN:

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<sup>25</sup> I rarely observed a nurse openly give the impression that she "didn't care" about a patient's emotions, even in back stage interactions. This was because their informal culture included discursive codes that provided alternative frames of reference for valuing which practices counted as good care, which I will elucidate later in this chapter.

<sup>26</sup> Nurses' informal practices and hospital policies resemble what James Scott (2012) calls "vernacular" and "official" orders.

“When you look at the corporate machine and how it limits the caring and makes more of a system out of it... so we don’t get the caring in there, even though we fight to keep the caring in there. That’s what the fight is. *Caring takes time. And time is money to the corporate machine.* It’s all that!... So that’s why we’re [the California Nurses Association] always fighting [for better patient ratios].”

RNs also said that their patient acuity—the level of patients’ illness and needs for care—was higher than it used to be. For example, this topic came up when I asked Bonita, an RN, if there was anything she felt that kept her from giving the care she wanted to give:

“You’re short of manpower because there is so much work and you’re so drained out. Not enough time... [Patients] are very sick now... You do a lot of things that doctors do. We do a lot more than we used to. I did nursing since 1968, and this is a lot of work. We’re working almost like doctors... and there’s a lot of medication that you can give to the patient. Before there were only a couple of choices.”

Rising patient acuity and the increasing complexity of medical treatments to which Bonita refers constrained nurses’ ability to provide care, particularly in the context of nurse-patient ratios and limited staffing. Yet the hospital management’s customer service policies, among other hospital publications, stated that the administration valued quality care and expected the nurses to consistently provide it to patients.

### **Core Values**

In this context of contradictory institutional arrangements, the nurses had their own values which they used to organize and regulate the care that they provided. Emotional support and medical safety were both core values that nurses espoused. When they talked about what they did that helped patients the most, nurses emphasized emotional support over medical safety.

#### *Emotional Support*

In a majority of my conversations with RNs, CNAs, Licensed Vocational Nurses (LVNs), Unit Clerks, Monitor Techs, and patients, “emotional support” dominated talk of “medical stuff.” For example, I asked 64 RNs, CNAs, and patients, “what is the most important thing nurses do that helps patients?” 50 of them included some aspect of care that was not “medicine” in their first response.<sup>27</sup> On the surface, it may appear unsurprising that the RNs extolled the value of the emotional support they provided patients. However, given the high prestige of their cardiology expertise, why didn’t they cite the importance of their medical knowledge instead?

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<sup>27</sup> I asked RNs and CNAs, “what is the most important thing you do that helps patients?” I asked patients, “what is the most important thing nurses do that helps you?” 12 out of 16 RNs, nine out of nine CNAs, and 29 out of 39 patients emphasized some form of emotional care when they articulated their responses. Data from these conversations constituted a portion of the overall data for this chapter; the rest came from other conversations and direct observations in my field work.

After all, nurses needed specialized training to work on this Cardiology unit. They believed that contemporary nursing required more knowledge of medications, physiology, and technology than in the past, especially on units such as theirs, where many patients were recovering from open heart surgery, hooked up to chest tubes, on telemetry (heart monitors) and otherwise closely monitored due to the mercurial nature of cardiovascular diseases.<sup>28</sup> A belief in the power of the medical treatments they administered accompanied a sense of professional pride. Doctors' orders largely organized their official daily rhythms, and their right to "pass meds" was the sharpest boundary distinguishing them from their assistants, the unit clerk, and the monitor tech. In the division of labor, their medical knowledge provided a degree of professional authority over most of the other staff.

At first I interpreted the dominance of "emotional support" as a reaction to the marginalization of patients' emotions in the organization of medical work. I also saw it as an expression of gendered ideologies, as a reflection of the importance of emotional support in facilitating their medical work, and as a genuine belief in the importance of emotional support in healing as an end in itself. Continued analysis, however, produced more complex findings—social processes of borderwork through which the RNs defined "care" in particular ways both mitigated the coercion and emotional labor that the care involved, yet still enabled the nurses to claim its moral virtue.

### *Medical Safety*

Not all RNs emphasized emotional support when they talked about the most important thing they did for patients. A few described helping patients in terms of instrumental medical tasks. For example, when I asked Bonita, a senior RN in the unit, "what is the most important thing you do for patients?" she replied:

"Make sure they're ok. Assess them really carefully."

"How do you do that?" I ask.

"You check their biological status. The physical things that they need. When you're giving medication make sure you're giving it to the right patient. The efficacy of the medication. Make sure it's working. With me, I continuously assess them. Because one minute they'll be ok and one minute they'll be bad. Especially in cardiology."

"So what's the most important thing you do for patients?" I ask again.

"Just look at them clinically and make sure clinically they are ok. They are depending on you. Anything that happens to them, you're responsible."

There was nothing in her response like the emotional support that most of the other RNs described. Bonita's emphasis on keeping patients safe illustrates their core value of "medical safety". *Medical Safety* necessitated "medical stuff," such as assessing patients,

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<sup>28</sup> RNs required more medical and technical training in order to work on this unit than on others, such as the more common Medical/Surgical units.

administering medications and treatments, monitoring their reactions to such medications and treatments, and coordinating work among other hospital personnel. It defined nursing in terms of risk management and knowledge. *Medical Safety* signified nurses' *knowledge* of medical science and the high risks and responsibilities involved in not making mistakes. But it was more than a core value. As I illustrate in the following sections, RNs used it as a semiotic code to anchor other codes and define emotional support as "basic stuff."

### **Cultural Paradox: Valuing and Devaluing Emotional Support**

These nurses valued emotional support in terms of its importance for helping patients, but they also devalued emotional support in terms of the skills it required and, in practice, defined patients' needs as instrumental, thereby limiting the amount of emotional support they provided. Nurses never verbalized that they did not value patients' needs for emotional support, but they worked to rationalize these needs in practice and thus regulate their own emotional labor. Even as they rationalized patients' emotional needs, naturalized the skills involved in providing emotional support, and mitigated the work it involved, they also said that emotional support was the most important thing they did for patients. This enabled them to construct higher-status caring subjectivities through claiming the moral virtue associated with caring, while distancing themselves from the lower-status dimensions, ie: "dirty work," emotional labor, and relations of subordination.

In the following conversation, RNs talk about how they used their own emotions to support and manage patients' emotions.<sup>29</sup> This conversation took place in the unit's break room, a backstage space where the nursing staff relaxed on their breaks. Here they spoke of things that they mentioned in whispers, if at all, in more public areas, such as the nurses' station, or the "desk," as they called it. Three RNs and I were eating dinner when I asked them the question: "what is the most important thing you do for patients?" This vignette illustrates the paradoxical theme in which RNs both valued and devalued emotional support:

Rosie responds first, "encourage them, motivate them. A lot of them, when you motivate them it helps them get better."

Another nurse, Nitta, adds, "to give them hope. Look at Mr. 42. He's getting better. He looks better. He has depression. Yeah, I get so happy when I see a patient walking, [when] you think they were never going to make it."

Turning to the first nurse, I ask, "what things do you do to motivate them?"

She replies, "mostly verbal things. You know. I talk."

Nitta adds, "let them talk, you sometimes just be a listener."

I ask, "Do you feel like you have enough time to talk with patients?"

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<sup>29</sup> Erving Goffman (1959) differentiates between "front stage" and "back stage." In front stage performances, people strive to keep up appearances of "certain standards" (107) while back stage permits a behavior that contradicts those standards (112). The break room in the unit I studied qualifies analytically as a "back stage," although it could be considered a front stage to the extent that members of the nursing staff maintained a performance that they "really cared" for an audience comprised of other members of the staff.



“I feel so happy when I have time, then I feel so guilty when I don’t have time and cannot talk with the patient, because you really have to watch your time. You have to know how to budget your time or you will be so way behind.”

“What are some of the things that make you get behind?”

“A lot of emotional things. Lots of them have lots of demands...”

Jasmine comes into the room and complains of being stressed and tired. She just finished a 12 hour shift and this is her 5<sup>th</sup> day working a combination of 8 and 12 hour shifts. She relates an anecdote of how fried she is, “I was looking for my Vocera [a walkie-talkie thingy that hangs around their necks] for like 20 minutes then I realized it was already on my neck!!” She begins gathering her things to go home [staff kept their belongings in the break room]. She stands looking in the fridge and finally admits that she can’t find her “lunch bag.” After another minute of searching she exclaims, “its already in my hands!”

One of the other nurses comments, “you’re so tired!”

Lana, another RN, joins us and I ask her the original question.

“In general?” She says.

“Yeah.”

“Emotional support,” she quickly replies. Turning to the others, she adds, “We’re cheerleaders half the time, aren’t we? That’s what I felt like with Ms. Green- a total cheerleader. But if you don’t know the medical stuff you could kill them!”

They laugh.

The words “encourage,” “motivate,” “give hope,” “talk,” “be a listener,” “emotional support,” and “cheerleading” highlight the value these RNs placed on the emotional dimensions of care. They defined care in terms of supporting—and managing—patients’ emotions. As this vignette illustrates, practices like listening, talking, and motivating revolved around getting the patients to recover, to move, to improve. And they accomplished these ends with emotional support. However, the skills that emotional support required were not considered *knowledge*. Lana’s description of nurses as “cheerleaders” was particularly significant in this regard. With somewhat self-deprecating humor, she called attention to the devalued status of emotional support in care work. At the same time, by contrasting “cheerleading” with the knowledge of *medical safety*, she devalued the knowledge and skills that emotional support required. Such expressions revealed nurses’ conflicting emotions of modesty and importance, self-denial and actualization, expertise and self-criticism.

Informal unit culture provided material that nurses used to control their level of effort and create autonomy in their work. They accomplished this by informally defining what constituted good nursing care and using these definitions to construct caring subjectivities. Thus, a statement, such as “you have to know how to budget your time,” because “lots of them have a lot of [emotional] demands” could violate the official code but did not violate their informal codes. “Supporting” and “managing” patients’ emotions were conceptually distinct, but not contradictory. These nurses shared the daily experience of situations in which they had to withhold care in order to follow “doctors’

orders.” They shared a political understanding that contextual factors, such as a lack of organizational resources, heavy patient ratios, and high patient acuity, constrained their capacity to meet each of their patients’ needs for support *and* keep up with doctors’ orders. This collective construal of their predicament provided a unifying sense of group solidarity. While not meeting patients’ needs could have potentially threatened the identities of individual nurses, the unit culture somewhat buffered this. Through RNs’ daily uses of semiotic codes, they constructed a subjectivity of a “good nurse,” which helped them feel that it’s okay to not always meet patients’ needs.<sup>30</sup>

#### *How RNs Articulated Basic Stuff and Having Heart*

RNs’ paradoxical valuing and devaluing of emotional support was particularly evident in a dominant discursive pattern in which two semiotic codes, *basic stuff* and *having heart*, signified emotional support with two distinct sets of behaviors. Although these codes both emphasized the importance of attending to patients’ emotions, they differed in the assumptions about what emotional support included. *Having heart* signified care in terms of the embodied affect and mental attention given to cultivating an emotional field of empathetic inter-connection between nurse and patient, while *basic stuff* defined care in ways that made it easier to do, required less effort, rationalized patients’ needs and managed their emotions. *Having heart* signified nurses’ emotions—the authenticity and strength of their motivation to care—and the ineffable dimensions of emotional contexts in which “instrumental” tasks and practices occurred. Such ineffable dimensions of care delivery included interpersonal connection, empathetic awareness of patients’ experiences, and the appropriate responses to them.

The point of divergence between these codes was not whether emotional support was important in the abstract, but what qualified as “good care” and what level of effort it required. *Having heart* emphasized nurses’ own affect and their ability to connect with patients emotionally, even if this necessitated a higher level of effort. *Basic stuff* defined caring as routinizable tasks, such as “providing ice water” and “encouraging patients,” and permitted them to be done with less attention to the emotional fields in which they were performed. This did more than minimize the ineffable aspects of care in favor of concrete tasks. By separating those tasks out from their emotional contexts, it created cultural grounds for the assumption that performing the tasks themselves constituted caring, independent of how they were performed. In this sense, the unit’s culture split nurses’ care work into two bundles of tasks – one that consisted of tasks, and the other consisted of emotional fields of connection. These dimensions of the unit culture enabled RNs and CNAs to identify with *having heart* even when they limited their level of effort to fit the contours of *basic stuff*.

Both of the codes *basic stuff* and *having heart* minimized and naturalized the knowledge involved in emotional support. The following conversation, wherein several RNs are comparing the *knowledge* of medical stuff to the *common sense* of emotional support, highlights this:

I remark that nursing can be challenging and Chelsie, an RN, replies

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<sup>30</sup> There were, however, limits to this. Whether they supported or managed patients’ emotions, RNs could not give off an impression that they “didn’t care” about patients without facing the threat of social sanctions, even within their own group.

“body, soul, and mind.”

I ask, “what is the most important thing you do that helps patients get better?”

Chelsie answers immediately, “show up!!”

Another RN adds, “give meds.”

Edith, a nurse practitioner, says that for her it’s to “show up mentally,” to “really be there.”

Chelsie butts in, “that’s why I said body, mind, and soul.”

Edith continues, “the most important thing is to not multitask, but to focus on what you’re doing and do it well. And when you’re busy and feel you have to leave a patient’s room, to stay and ask them is there anything you can do for them and listen to what they say.”

Then Chelsie emphatically states, “...it’s the basic, basic, basic stuff...because that makes them feel better.”

I ask, “what kind of basic stuff.”

“The basic, basic stuff,” she reiterates.

Rosie, the unit secretary, adds “that they have ice water and that the bed is clean.”

Chelsie adds, “that they’re taken care of.”

Edith states, “a lot of times I feel as RNs they train you in this scientific knowledge of meds... patients don’t want you to know that so much, because what they really need is to feel comfortable, to feel safe, to have food, and to be at peace.”

Emotional support was a highly-valued end in itself— the most important thing they did for patients— yet talk of caring as *basic stuff* and *having heart* naturalized and devalued the skills it involved, especially compared with *medical safety*. These RNs could *know* medications, but “knowing” how to help patients feel better was not considered *knowledge*. Rather, the nurses articulated it as “basic, basic, basic stuff.” They were specific examples of a more abstract aspect of care that she described earlier, “to really be there.” The ambiguity of discourses of care reflected more than a general polysemous quality of language. It was an abstract dimension of discourse with situational sub-texts. Talk of the “scientific *knowledge* of meds” contrasted with articulations of care as *not* knowledge: “showing up mentally,” “to really be there,” “focusing,” “[make sure patients have] food,” “body, soul, and mind,” “basic stuff,” and “have ice water and a clean bed.” In fact, not once did I observe any of the nursing staff refer to caring as “knowledge” or “skill.” Nurses’ minimizing of the skills involved in emotional support was surprising, because my direct observations of it identified a range of techniques, strategies, emotional labor, knowledge, and skills. For instance, providing comfort within the constraints of hospital work required complex skills, such as remaining calm and controlling stress under conditions that were sometimes difficult.

These two codes signified “really caring” with two distinct sets of practices. For instance, Chelsie’s abstract description of caring as “basic stuff” framed it as ambiguously both important and simple. She didn’t explain what “basic stuff,” “taken care of,” or “body, soul, and mind” entailed. Such abstract language could have included just about anything, from something as concrete as giving patients “ice water” to something as abstract as “body, soul, and mind.” At the same time, “show up” presented both concrete (literally “to show up to work etc.) and abstract (to be present emotionally and mentally). Edith articulated a concrete description of care, in “focusing on what you’re doing,” and “when you’re busy, stay and ask if there’s anything you can do for them and listen.”

Interestingly, it was the nurse practitioner who framed caring as more important than “the scientific knowledge of meds.” She defined caring in terms of knowing what patients “really need” and attending to those needs. Recall that she said, “patients don’t want you to know that [scientific knowledge of meds] so much, because what they really need is to feel comfortable, to feel safe, to have food, and to be at peace.” She contrasted knowing patients’ “real needs” with *medical knowledge*. She didn’t talk of knowing what patients really need as knowledge, but she tacitly espoused an epistemology of care that challenged the codified epistemology of medicine. Note the dichotomy of care and medicine here. Her authority to challenge the dominance of medical knowledge came, ironically, from *knowing* the medical stuff. Ultimately, it gave her the power to use her knowledge of what patients “really need” to elevate caring vis-à-vis medicine.

Yet how did nurses know what patients really needed? In what sense did they “know” how to help patients “feel comfortable, to feel safe, to have food, and to be at peace?” Unlike the codified knowledge of medicine, the knowledge of care— signaled by both codes— was tacit, ineffable, and linked to power dynamics that shaped how nurses “knew how to know” their patients. In terms of power relations, *basic stuff* facilitated nurse-patient relations according to what Michel Foucault (1977) calls the disciplinary *power-knowledge* of modern institutions.

In contrast, *having heart* constituted relations of interconnection in which nurses oriented to patients as sources of knowledge, rather than as objects of nurses’ own knowledge. This “other-knowledge” involved emotional fields of connection analogous the synchrony of musicians who are jamming in the groove. These processes of knowledge-production more closely resembled what Patricia Hill Collins (2000) calls “dialogical relationships” than Foucault’s disciplinary power-knowledge. Collins describes “dialogical relationships” as those in which “changes in thinking may be accompanied by changed actions and... altered experiences may in turn stimulate a changed consciousness (30). *Having heart* signified the embodiment of empathy and the mutual production of knowledge through intersubjective transference created through practices of empathy. Note that Belenky et. al.’s (1986) care-based epistemology differentiates between determining truth through relations of separation and impersonal processes versus through relations of connection and processes shaped by empathy. Thus, “knowing how to care” included the emotional, cultural, and cognitive conditions of possibility for acquiring knowledge of a particular patient based on that patient’s own subjectivity.

This highlights the importance of empathy in the production of knowledge about patients. Ultimately, *basic stuff* claimed that nurses could “really care” without orienting

to patients as subjects, while *having heart* claimed that nurses had to orient to patients as subjects in order to “really care.”

### *How CNAs Articulated Basic Stuff and Having Heart*

Certified Nursing Assistants (CNAs) also used *basic stuff* and *having heart*. Unlike RNs, CNAs did *not* minimize the skills involved in emotional support as much as RNs did. They tended to not dichotomize instrumental and emotional aspects of care, instead challenging how RNs “rushed”—giving medications without empathy or emotional support. However, like the RNs, they had trouble articulating the ineffable dimensions of care that comprised *having heart*. They talked about concrete and ineffable practices, but the ineffable dimensions of care remained largely taken-for-granted. In other words, these ineffable dimensions involved practices that were naturalized, tacit, and submerged by other codes. For example, I asked Emina, a CNA, what was the most important thing she did for patients. She responded:

“Just give them care. Make sure they’re safe and they’re cared for.”

“How do you give them good care?” I ask.

“Just watch over them...”

This short conversation exemplifies the taken-for-granted quality of culture that has been integrated into daily practice and experience.<sup>31</sup> Note how Emina articulated two variations of care—“Just give them care” and then “...they’re cared for”—as if they were self-explanatory. When I asked her to elaborate on how she gave care she succinctly replied, “just watch over them.” She did not go into further detail, or seem to want to elaborate on “just give them care.”<sup>32</sup> In fact, my attempt to solicit elaborations often led to confusion as to what I was asking. It was as if they assumed further elaboration were unnecessary, as if “care” itself communicated all that needed to be said. These ineffable dimensions of “care” were part cultural assumption, part affect. For instance, when I asked Angela, another CNA, what was the most important thing she did for patients, she simply replied “get them comfortable.” In this case, “getting patients comfortable” resembled the ineffable discursive pattern – particular aspects of “care” eluded articulation.

Even when nurses elaborated on how they helped patients, conversations revolved around concrete practices and tasks, such as “giving hope,” “listening,” or “putting on soothing music.” This was apparent in the following conversation I had with Frida, another CNA, about the kinds of things that helped patients:

“A lot of things that are not happening here. They need to be eating healthy... They need to have a peaceful environment. They need to

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<sup>31</sup> Swidler (2003) makes the observation that when culture is well-integrated into people’s lives, it is largely invisible, sub-conscious, and taken-for-granted.

<sup>32</sup> Her mention of “safety” was situational, as she was “sitting” for a patient at the time of our interaction. This comment was an interesting blend of care and safety, and shows that CNAs also talked about how they kept patients safe. They did not keep patients safe with medical *knowledge* however, as RNs did.

be at peace. They are constantly woken up. They don't sleep. What I also do to give very good care is... we have the option of putting soothing music on the TV. Patients who are not so independent as to want to watch TV, the ones that are just laying there, I will turn music on. Its very relaxing music. And it usually helps to relax them. Unless they say no. Also, I usually try to be quiet, not to bother them."

Like Edith (the nurse practitioner from a previous vignette), Frida talked about care in terms of "what patients really needed." She was also thoughtful in her remarks, including subtle atmospheric elements like "peaceful environment," "putting on soothing music," and "trying to be quiet." The unmet needs she mentioned highlighted organizational/institutional problems (not allowing patients to sleep) that were largely beyond her control. She then articulated care as concrete emotional support practices aimed at ameliorating organizational problems (soothing music, being quiet).

Many of the concrete methods of care delivery that CNAs (and other nurses) mentioned could readily appear "basic," involving only mundane, instrumental tasks. Yet, my direct observations provided evidence that apparently instrumental tasks, such as getting patients physically comfortable, had important emotional effects, which depended on the emotional field in which they occurred. These included but went beyond what Strauss et. al. (1993) call sentimental "comfort work." The tempo, tone, and overall emotional texture of such "comfort work" could lift patients' spirits, reaffirming their humanity and desire to live, or it could dehumanize and dishearten. Nurses acknowledged this at some times, and not others, depending on the situation. Frida, the CNA, did acknowledge the emotional aspects to tasks, when I asked her more directly about the most important thing she did for patients:

When I perform bed baths, I try to incorporate massage into it a little. That's very important. When I'm rubbing the lotion on I try to pay good attention to it.

Her emphasis on "pay[ing] good attention" when giving patients bed baths mirrors Edith's statement earlier about "showing up mentally" with patients. "Showing up mentally," "to really be there," "to pay good attention" are practices of focusing mental attention in order to empathize and convey particular emotions to patients. "Paying attention" and "really being there" facilitated nurses' capacities to empathize and to provide personalized emotional support. Consider, for example, the following words, articulated by Ida, another CNA:

To be there for them. Listen to them. Their problems. I know we're very busy but don't ever rush it. Take their problems very serious and listen. If you're paying attention to them they know you're paying attention. Be a good listener and have heart.

While this CNA talked about "listening" as a practice, she situated it within the broader emotional and mental work of "paying attention" and "having heart," which she

mentioned both before and after her statement about being a good listener. “To be there for them,” “paying attention to them,” “showing up mentally,” and “paying good attention” were all articulations of ineffable dimensions of care that were present in *having heart* but not in *basic stuff*. And, as I illustrate in other chapters, both CNAs and RNs switched between *having heart* and *basic stuff* to construct subjectivities around valued-dimensions of their work, mitigate emotional labor, keep up with their schedules, adapt their care to different types of patients or to a change in the circumstances of a particular patient’s care.

### “Rushing”

CNAs challenged RNs’ use of *basic stuff* in particular types of situations. They used a code of *rushing* to challenge nurses’ claims to power and status by critique both their care-delivery practices and their inner-motivation to care.<sup>33</sup> Interestingly, CNAs did not use *rushing* to police one another. *Rushing* was a common criticism that CNAs lodged against RNs. They articulated these critiques in a discursive pattern that contrasted *rushing* with *having heart*, to which they held RNs accountable. *Rushing* contrasted with “really being there” and “focusing” on patients, not simply because it took time to pay attention to patients’ needs, but because these constituted fundamentally different affective-mental states. On the surface, *rushing* appeared to be a temporal concept—trying to accomplish something in a given amount of time—but it signified an affective state as well. For example, a nurse could “rush” to a patient’s room in response to a call light or she could give medications to a patient with rapid efficiency without rushing. This paradox was what Lanette, a CNA, described in her response to my question about the most important thing she did for patients:

When they ask for something, to come there faster than they expect. Or ask them if they need something before they have to ask. You spend time with them in the room. You don’t just come in and rush in. [Instead] ask, “what can I do for you?” Because I may not be back for a little while. That attention span is really important.

Note that she said, “come faster than they expect,” and then talked about “spending time” in a way that was connected to “attention span” and not “rushing” into the room. Arriving to a patient’s room “faster than they expect” differed from rushing in interactions with patients. These CNAs saw *rushing* and *having heart* as mutually exclusive. They described the impossibility of practices such as “paying attention” or “really being there” while also rushing.

It is significant that so many CNAs and LVNs critiqued RNs for rushing. Rushing was a problem, they said, because it prevented RNs from practicing the ineffable dimensions of *having heart*. That is, their articulation of *rushing* was code for “not caring.” Furthermore, according to CNAs, when RNs rushed, it created more work for them. In this sense, rushing was an informal practice that RNs used to delegate empathy and emotional support to CNAs. This was true even when RNs delegated tasks that could be defined as non-emotional. As described above, the popular conception of a dichotomy

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<sup>33</sup> This finding is analogous to what Apesoa-Varano (2014) found: occupational groups, including RNs, Therapists, and MDs, used an ideology of care to assert their power and status in the hospital.

between instrumental and emotional aspects of care is largely ideological, because there were clearly emotional dimensions of ostensibly purely instrumental tasks, such as positioning, bathing, or feeding patients. Caring was linked to temporal rhythms: time spent with a patient, the giving of one's presence, one's attention, one's emotional and physical energy. Thus, *rushing* signified lack of empathy, authentic motivation, and immoral practices, not just a quick or efficient pace of working. In essence, *rushing* was an ideology of care that CNAs used to resist their coercion and exploitation at the hands of RNs.<sup>34</sup>

*Rushing* was part of the unit's cultural resources, so RNs could draw on it, too. But they seldom used it to critique each other or CNAs. When they did apply it to their own work it was usually a self-directed criticism accompanied by guilt at not meeting patients' needs for care, usually emotional support. Importantly, rather than critique CNAs for rushing they tended to critique them for *not* rushing. For example, Lanette described how she had been reprimanded for "staying too long with patients:"

The Filipinos told some girl I know who works here. She [her friend] said, 'they're talking about you behind your back, saying you spend too much time with your patients. And you talk too long, and you talk too much and you talk too loud.'

As a practice, rushing symbolized RNs' dominance and reiterated CNAs' subordination. RNs could rush, which by definition meant doing less empathy and emotional support and delegating patients' needs to CNAs, but CNAs also rushed—in order to do the work what RNs' delegated to them. Thus, CNAs were sanctioned for "spending too much time" with their patients because, paradoxically, time spent with patients was time not doing the work RNs delegated to them.

However, RNs did use *rushing* to criticize MDs. MDs rushed with patients, using disempathy instead of empathy and emotional support. For example, Nicky, a young RN, told me:

"Doctors have a lot of power. In nursing school we make fun of doctors."

She describes how her teacher impersonated a doctor, coming in to a patient's room and asking 'how you doing?' very fast, then saying 'doing great keep it up!' And rushes off. She says this is a joke among the nursing students.

She says that doctors "deserve respect" because they have "tons of knowledge..." Then she adds, "but we know a lot too." She explains, "most of the time when you call a doctor and you tell them what's wrong, you give them a suggestion. And usually they're just like, ok, go ahead!"

She shows me the back of her ID card. It reads 'SBAR,' which is the list of things RNs report to the doctor: the Situation, the patient's Background, her Assessment, and what she Recommends.

She says, "the doctors don't know what's going on. The first time I was like,

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<sup>34</sup> CNAs used of an ideology of care resembles Apesoa-Varano's (2014) finding that RNs used an ideology of care, unsuccessfully, to construct professional identities and assert power vis-à-vis other occupation groups in the hospital, such as physical therapists.



‘wow! they just believe everything I say!’”

According to Nicky, one facet of this MD’s power was freedom from the responsibility to care. This was freedom from the responsibility of emotional support and the emotional labor that it required. Instead of recognizing their patients’ feelings and providing emotional support, MDs delegated care—empathy and emotional support—to RNs. This is one of the reasons that RNs valued “patient education” so highly; they found it was important to explain to patients what was happening medically, because MDs did not do it enough. In my direct observations, MDs often rushed with patients, failing to empathize and provide emotional support, even in the form of answering patients’ questions about their medical conditions, procedures and so on. It appeared that MDs set the example for RNs, who appeared to emulate their practices of disempathy and rushing.

To some extent, *rushing* put boundaries around how low RNs could set the bar for their practices and level of effort, because both patients and CNAs used it to discipline RNs’ practices, holding them accountable to customer service policies and conceptions of care signified by *having heart*. However, this did not stop RNs from using *basic stuff*, which facilitated the lowering of that bar by defining care in terms of routinizable tasks decontextualized from emotional fields of empathy, to legitimate their emulation of MD’s practices of disempathy and rushing. The grey area—and the tension—between these codes thus reflects the larger power dynamics through which nurses used them. At the same time, the existence of the discourse of rushing was evidence that the legitimacy of caring as *basic stuff* was not completely institutionalized. Rather, the boundaries around RNs’ acceptable level of effort were subject to contestation from CNAs, patients and their families, and hospital administration. Conflict—and the threat of sanctions—arose most often when patients or their family perceived nurses as not motivated by authentic feelings of compassion.

Furthermore, while organizational forces made it hard not to rush, both RNs and CNAs used *basic stuff* to normalize rushing. They created moral leeway, defining practices that could otherwise signify *rushing*, as care instead; they constructed group identities based on practices of *basic stuff* (and rushing) around the moral virtue linked to “caring.” Furthermore, CNAs elevated their moral virtue in opposition to RNs who rushed, and RNs did the same by calling attention to MDs who rushed. In other words, despite the tensions between the RNs and CNAs, they experienced solidarity in their mutual benefit from upholding the reality that the practices of *basic stuff* signified an acceptable type of care and level of effort. In this sense, they linked care with what Catherine Theodosius (2008) calls “instrumental emotional labor” (IEL) and minimized its connection with “therapeutic emotional labor” (TEL).

## **Conclusion**

In this chapter, I analyzed patterns of discourse related to three semiotic codes, *having heart*, *basic stuff*, and *rushing*. I also explained how RNs and CNAs articulated them in relation to other discursive elements. Contradictory institutional arrangements constrained RNs from consistently providing personalized emotional support and keeping up with doctors’ orders. So they redefined “caring” in ways that they could achieve but

still claim status from caring, as well as status from identifying with their medical work. While the RNs prized emotional support as the most important thing they did for patients, they used culture to define “really caring” with a lower acceptable level of effort. A discursive paradox took shape in how they underscored the central importance of providing emotional support, while at the same time minimizing the skills involved in doing it, and rationalizing patients’ needs to limit their emotional labor. On one hand, they described emotional support as if it were more important than their medical tasks. On the other hand, they described patients’ emotional needs as troublesome obstacles in their work. Likewise, they lamented that medical tasks marginalized emotional support, yet took pride in their medical knowledge and expressed the value of “medical stuff” in keeping patients safe.

The semiotic code of *basic stuff* helped nurses cope with contradictory institutional arrangements, psychological tension, such as guilt, frustration, empathy burnout, and physical exhaustion. Within the shifting power structure within the hospital, nurses used care to negotiate power and control. Through their use of semiotic codes, they constructed caring subjectivities that linked them with moral virtue. RNs used *basic stuff* to claim the status of caring while they signified care with practices that made it doable with a lower level of effort and less emotional labor than *having heart*.<sup>35</sup> In the next chapter, I analyze these practices, illustrating how RNs and CNAs provided emotional support with *having heart* and *basic stuff*.

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<sup>35</sup> Yet they did so in ways that reproduced hierarchies of race and the devaluation of care work, as I show in chapter five.

## Chapter Two

### “An Atmosphere of Normalcy:” Empathy in Care Delivery

As I illustrated in chapter one, the nurses on South Heart talked about emotional support as if it were a kind of medicine. Like the doctors’ orders they administered, “giving hope,” “motivating,” and “encouraging” were tailored to the specific needs of each patient. And they agreed that these dimensions of care helped patients heal. In this chapter, I analyze my direct observations of empathy and emotional support in RNs’ and CNAs’ care delivery practices. I address the extent to which *having heart* and *basic stuff* were instantiated in these patterns, but I attend to other dimensions of the interactions as well.<sup>36</sup> When possible, I include both the nurses’ and the patients’ experiences of these interactions in addition to my direct observations. I also illustrate how culture shaped these practices.

A signature characteristic of the unit’s culture was that it provided capacities to empathize as well as the autonomy to control the emotional labor that empathetic caring required. This was due to the multiple—sometimes contradictory—conceptions of care, which shaped individual nurse’s practices of care delivery. The semiotic codes *having heart* and *basic stuff* both signified practices that counted as care in the eyes of these RNs. These codes defined care in terms of the emotional fields through which nurses practiced care delivery and in terms of nurses’ motivations and levels of effort. Thus, they used culture to provide emotional support while mitigating the coercive and exploitative dimensions to some extent.

As an analytical category, these practices of empathy entailed cognitive-semiotic and emotional components. As Schwalbe (1992) explains, empathy requires knowledge of the other’s situation and feelings as well as motivation to take the position of the other. The latter dimension of empathy is also called “resonance,” which is known by the popular heuristic, “placing yourself in another person’s shoes.” According to Jodi Halpern (2001), resonance is: “spontaneous affect that is similar to another’s affect, such as feeling anxious around an anxious person or instantly light-hearted in the presence of a joyful person” (79).<sup>37</sup> In my observations, resonance operated through what Randall Collins (2004) calls face-to-face “interaction rituals.”<sup>38</sup>

I also observed the second dimension of empathy, or what Halpern (2001) calls “affective imagining.” This refers to the cognitive and emotional reasoning necessary to understand peoples’ feelings and experiences in context:

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<sup>36</sup> Using a method of grounded theory, I observed interactions for general patterns inductively rather than looking for specific *a priori* categories. Many of these observations occurred before my discourse analysis produced *having heart* and *basic stuff*. This facilitated my method. Later in my research I enjoyed the benefit of observing interactions deductively as well. These deductive observations confirmed some of the earlier patterns, and I began noticing them more, at which point I was able to test my emergent theories about the dynamics between specific dimensions of these interactions and situational variables.

<sup>37</sup> Similarly, Melanie Klein (1952) theorizes that people transmit emotions to one another through what she calls “projective identification”

<sup>38</sup> Resonance in interactions can be thought of as a modified version of what Émile Durkheim (2001) calls “collective effervescence.”

Insofar as resonance involves little cognitive content of its own, it is insufficient for grasping another's distinct emotional point of view...recognizing that a patient is angry is insufficient for achieving empathy. Rather, empathy seeks to discern what, specifically, the patient feels angry about (79).<sup>39</sup>

According to Halpern, empathy requires both resonance and affective imagining, and both dimensions involve emotions.<sup>40</sup> The following analysis looks at these dimensions of empathy in care delivery, and illustrates their link with *having heart* and *basic stuff*.

My approach to the analysis of emotions in comes from Arlie Hochschild's (1983) study of emotional labor. She synthesizes Erving Goffman's (1959) dramaturgical approach with Charles Darwin's (1955) "organismic" model of a biological self in order to theorize the embodied mechanism that experiences the signal function of feeling. Her theory of emotion conceives of it in relation to behavior: "I posit a sense of what is there, impermeable, to be "done to," namely, a biologically given sense related to an orientation to action" (232).<sup>41</sup> Hochschild sees emotion in terms of orienting to action. However, this does not mean that it does not also have a primary orientation to social interaction and relationship. A slightly-modified articulation could state that this "biologically-given sense" is related to an orientation to socially-mediated action. Accordingly, human action is fundamentally *interactive*.<sup>42</sup> The fundamentally affective nature of cognition, thought, and communication accounts for the central importance of empathy in the social organization of society.

First, I analyze how nurses helped reduce patients' anxiety by creating an "atmosphere of normalcy." Second, I analyze how nurses helped patients cope with dependency by constructing instrumental and emotional needs. Third, I analyze how resonance facilitated emotional support through the cultivation of interpersonal connection with patients.

### **"An Atmosphere of Normalcy"**

This section illustrates how the practices of both *basic stuff* and *having heart* provided emotional support by assuaging patients' anxiety, reducing uncertainty, and mitigating the depressive dimensions of dependency.<sup>43</sup> In each of these processes, nurses

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<sup>39</sup> According to Halpern (2001), "rather than feeling what, specifically, another feels...the listener *imagines* how the experience feels. However, the kind of imagining involved in empathy is unified, or made coherent, through the same kind of linkages involved in dreaming or sexual fantasies" (92). Thus, empathy works through the personal meaning-making processes that Nancy Chodorow (1999) calls "transference."

<sup>40</sup> For example, empathy involves what Daniel Goleman (2006) calls, "social intelligence."

<sup>41</sup> This conception of "sense"—capacities feeling—signifies a pre-socialized aspect of consciousness, much like George H. Mead's (1977 [1934]) concept of the "I" (vs. the "me") in *On Social Psychology* and Émile Durkheim's (1914) formulation of the "ego self" (in contrast to the moral self) in the "Dualism of Human Nature."

<sup>42</sup> This view resonates with Karl Marx' premise that human nature, to the extent that we have one, is that we are inherently social beings who cannot live in this world without the social formation, which is necessary in order to produce our means of subsistence.

<sup>43</sup> This overlaps somewhat with Laura Nathan's (1990) finding that cancer patients and their families used four strategies to cope with the stress of cancer remission: 1) The direct/action-oriented strategy involves recognizing the situation & doing one's best to address it. (2) The conscious normalcy pattern involves

helped patients by “normalizing” their troubling experiences of illness and hospitalization. However, they did not normalize these experiences in the sense of making them normative or by convincing patients’ that they should “toughen up” and somehow cope with these “normal” aspects of hospital life. Instead, they used their own emotions and styles of interaction to transform patients’ perceptions of their situations.

One way nurses helped reduce patients’ anxiety was by embodying a spirit of calm. Their embodiment of calmness facilitated individualized care to each patient while mitigating the emotional labor this required. But they did so through different causal pathways. Emotional connection coupled with empathetic attention to patients’ experiences characterized *having heart*. For example, this patient articulated how nurses lifted her spirits when she was depressed:

“They have such positive attitudes. The other day I was really depressed and they would come in and go ‘no, no, no you can’t do that.’ So there’s one nurse that comes in, her name is Jessie, do you know her? I love Jessie, I LOVE her. She comes in and changes my bandage. She has such a soft voice and she sings a really great song for me. Isn’t that cool.”  
I ask if those things are important for healing.  
“Yeah, they are.”

Her description evokes “sentimental,” nurturing behaviors traditionally associated with nursing. Such dimensions of care figured prominently in behaviors of both *having heart* and *basic stuff*. The difference lies in whether nurses applied such behaviors in a routine way or personalized them to individual patients.

Furthermore, both sets of behaviors constructed what one patient described as “an atmosphere of normalcy.” In the following conversation, a particularly observant patient, named Franzia, articulated how the nurses kept her from “freaking out.” She described how their styles of interaction reassured her that her illness was routine and treatable without minimizing her experience of it. In these processes, nurses communicated meaning through emotional fields and skillful communication about her condition:

Franzia continues by saying that it might sound strange, but sometimes the nurses provide her with an atmosphere of normalcy. Even though she knows that what’s going on with her is totally ridiculous, they keep it really calm, at a level where nobody is panicking. She says that because they keep calm it allows her to stay calm, even though she may be panicking because she is intelligent enough to know what’s going on physically... and they are good at diffusing and calming things down and giving you enough information so that you feel like you know what’s going on with your situation, but they try not to overload you.

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acknowledging the cancer & subsequent remission, yet relegating this knowledge to the back of the mind, & continuing the life that existed prior to diagnosis. (3) The denial/suppression mode refers to attempts to handle the situation by not facing the true circumstances. (4) The escapist strategy is an attempt to distance oneself from all reality -- especially the realities of cancer, cancer remission, & the lifestyle changes that have accompanied the cancer experience. Also, see Brandon Berry (2014) for an analysis of three patterns of *cognitive support work* that family members employed to minimize confusion and disorientation for people with dementia.

She says she's been hemorrhaging for 48 hours and has every right to be freaked out, but they've been really calm and her "throwing blood clots all over the place hasn't freaked them out." So it doesn't freak her out or at least helps her stay calm. She says she's doing it without anti-anxiety meds, because they're keeping her calm... what freaks her out is not knowing what's going on, and if they do a good job informing, then it takes the fear factor away.

The care that produced "an atmosphere of normalcy" for this patient involved both *having heart* and *basic stuff*. Even though Franzia knew that the gravity of her illness was "totally ridiculous," the nurses "kept it really calm, at a level where nobody was panicking." By embodying calm, the nurses sustained an emotional field of calm between themselves and Franzia. They used their emotions to create an interpersonal dynamic that enabled Franzia to remain calm herself. She explained that, because they kept calm she could stay calm, and that she would be "panicking" otherwise.

The nurses she described drew on *basic stuff* to create emotional fields of calm by using routines to embody calm and communicate it to her through emotional energy. This shows how they cared for patients by embodying a spirit of routine in their work that was not emotionally-detached. The image of detached hospital workers signifies a *lack of caring* in popular culture. True, emotionally-distant demeanor may alienate patients. However, behavior that did not attend directly to patients' experiences but was *not* emotionally-distant, indifferent, or vacant actually helped patients when it created an "atmosphere of normalcy."

The following interaction occurred between the same patient, a CNA named Lanette, and an RN named Angela. It juxtaposes the interactional styles of these two nurses in order to illustrate behaviors that signified *having heart* and *basic stuff*:

While changing gloves in a patient's room, Lanette (a CNA) came in...I leave the room to get a box of gloves and when I come back, Lanette is still in the room and the patient is sitting on the edge of her bed, head down, eyes closed and not talking. Lanette is taking her blood pressure.

The patient coughs a couple times and Lanette says, "I swear it never fails. Whenever I take blood pressure in the evening, patients always cough. I don't know why that is..."

Franzia replies "oh, its just your luck..." in a tone tinged with empathy.

Lanette says, "yeah, and it messes up the machine...please don't mess up, please don't mess up, please don't..."

The patient says something and Lanette says "uh huh."

Then the patient coughs and Lanette says, "you've got a tickle in your throat, drink some water or something."

When Lanette finishes and leaves the room I ask Franzia if she wants anything. "No." Knowing that I'm interested in nursing, she adds, "we [patients] depend more on the nurses than on the doctors...because it's the hands on... talk about interactive care! That's where it comes from, not from the doctors."

Angela, an RN, comes in and, looking at the patient's arm, says, "Nadine [another RN] got the IV started," in tone of approval or satisfaction.

The patient replies that she did, but that she had to stick her four times to do it. The nurse says she's "not surprised, not surprised at all."

Franzia says she guesses most of her veins are splitting, or floating away or flattening out.

Angela reassures her that she knows (in a calm, soothing and empathic voice). She then asks if Franzia would like some ice and the patient says, "yeah," and hands the nurse a pink, plastic pitcher sitting on her tray, asking her to fill it up. This nurse has a very different demeanor than Lanette...more serious and focused yet calmer. The nurse takes it and begins to leave the room, says, "ok" in a spunky voice, and leaves.

I am struck by the contrast between Angela and Lanette. Angela speaks in a calm voice, addresses the patient, and connects more with what she might be thinking or feeling. Lanette seems more occupied with her own work, getting her vitals done. It's a fairly subtle distinction, because Lanette also sounds "caring" when she speaks. She is friendly and she jokes...but it sounds impersonal, not attending to the patient's experience.

Both Lanette's and Angela's style of interaction illustrate how nurses created "an atmosphere of normalcy." Lanette used humor and routine without focusing on this patient's situated experience, while Angela attended to Franzia's experience. They involved different styles of empathy. Both styles helped normalize this patient's experience by creating an emotional field of calm. Lanette's style of interaction reflects some behaviors of *basic stuff*. Instead of attending to Franzia's cues, which expressed her experience in that moment, Lanette focused on her own routine, interacting with a fast-paced tempo. She commented on the problem of getting an accurate reading of Franzia's vital signs and called attention to Franzia's coughing in a way that could have made her self-conscious and feel bad.

However, in a style typical of this CNA in many interactions with patients, she used a light-hearted, humorous tone of voice that normalized the problem as routine instead. The tone of Franzia's reply, "oh, it's just your luck," suggests that rather than alienating her, Lanette's style created a sense of routine. An instrumental task—getting her vital signs—became a chance to lighten things up. Lanette's talking to the machine, "please don't mess up...", could have alienated Franzia, but it conveyed the sense that everything was alright because of the way she did it—with humor and playfulness. Lanette oriented more to her instrumental task than to Franzia, but she didn't "objectify" or ignore her, evidenced by responding to her query and attending to her cough. Note that she acknowledged her coughing, but assumed it resulted from a "tickle in her throat" and suggested that she drink some water without asking her what was causing the cough.

Presuming to know what patients experienced without orienting to them as authorities of their experiences, recognizing their emotions, valuing those experiences, and being emotionally-available signified *basic stuff*. But this doesn't mean that it didn't provide emotional support. For instance, the fact that Franzia later asked for water

suggests that Lanette's comment may have been helpful, exemplifying how this style of care helped patients. In this case, it created a sense of normalcy, which helped in part by distracting patients from their fears. Given the gravity of Franzia's illness, *overly* "sentimental" forms of care might have made her feel worse by drawing attention to the severity of her predicament and solidifying that reality. This interaction also illustrates how patients sometimes cared for the staff, as Franzia did when she said, "oh, it's just your luck," with a tone of empathy. Caring for the nurses was another aspect of normalcy, as it helped patients get their minds off of their anxieties.

Although Lanette's humor and friendliness provided emotional support, it was not exactly embodied *heart*. This is because the difference between practices of these codes lie in their intersubjectivity, how nurses connect and relate with patients, and not in whether they provided emotional support or appeared friendly or kind. This becomes apparent when I compare Lanette with Angela. Angela was more serious, more focused, and calmer than Lanette. She didn't use humor and she wasn't particularly light-hearted. But she oriented to Franzia's experience by focusing her attention on her and using a calm, slow tone of voice and interactional tempo. These behaviors signaled empathy and emotional availability. Although she begins the interaction by focusing on the IV, she attends to Franzia's experience of the procedure, saying that she was "not surprised at all" that it took Nitta four tries to start it. Her tone of voice conveyed empathy and the words signaled that she knew Franzia's personal situation. When Franzia commented on this situation—"she guesses most of her veins are splitting, or floating away, or flattening out"—Angela recognized her concern and reassured her that "she knows." Again, her soothing, calm tone provided reassurance. This exemplifies how *having heart* created an "atmosphere of normalcy" by providing emotional support through emotional fields created through orientation to this patient's personal experiences and feelings.

In addition to communicating meaning directly through emotional fields, nurses also created an "atmosphere of normalcy" through the art of communicating information about patients' conditions. Recall that Franzia said, "...giving you enough information so that you feel like you know what's going on with your situation, but they try not to overload you." Nurses communicated knowledge about patients' conditions with both *basic stuff* and *having heart*. In *having heart*, nurses personalized communication for each patient. The amount of information patients wanted to know and could emotionally handle varied. In Franzia's case, they tailored their communication to her need to know what was happening to her without knowing too much, which depended on her emotional and mental state at any given moment. Accomplishing this art of communication called for *having heart*, because nurses needed to ascertain her capacity and her desire to receive information in each interaction in order to gauge their response and "titrate" their communication accordingly.

At the same time, nurses used *basic stuff* to communicate without tailoring the flow of information to each patient's personal capacities. They did so by conveying meaning through tone of voice in a way that reassured patients who were given bad news in a way that mitigated that news regardless of differences between patients. Delivering bad news about a patient's condition without *having heart* saved the time and emotional labor needed to know and to attend to patients' personal capacities to handle the information. However, it could present an image of not caring and it could cause emotional upset, creating the need for more emotional labor. For example,



I asked a female patient, “what do you think helps you the most?”

“That they’re nice, kind nurses. I always compliment them a lot. They have a hard job. They have four people.”

I ask if feels like them being nice and helpful has helped her get better.

She nods her head with certainty, “They can really encourage you. And they can say stuff that will scare you to death!!” She laughs at this.

“Like...?” I ask.

“They’re trying to help you...if you do this it will rip open all your stitching” (the stitching on her chest from the heart surgery).

*Basic stuff* mitigated these complications by routinizing the emotional tone of communication. Specifically, nurses could deliver bad news with a reassuring, confident, and comforting tone without tailoring the information to patients’ individual emotions in a given interaction. Tone of voice, rhythm, and tempo conveyed meaning through routinized emotional fields. This meaning was distinct from the symbolic content of the words spoken, and it framed potentially upsetting news in a way that cushioned its emotional impact. Thus, the meaning of words, such as “there are spots on your lungs,” could depend on the emotional field.

How empathy shaped the meaning and emotional impact of bad news is evident in the following interaction between a physician and a patient named Mr. Orr. Physicians also helped sustain an “atmosphere of normalcy.” This MD used *basic stuff* to tell a patient with prostate cancer that he had “spots on his lungs.”

I walk into room X... the patient’s name is Mr. Orr. He is 85, but looks younger. We talk awhile, mostly he tells me about his time in WWII and how things were different then compared to now. I enjoy this interaction.

A doctor walks into the room. He says “hi” to me and walks around to Mr. Orr’s bedside. He grasps the patient’s hand in an extended handshake without the shaking. The interaction seems warm. His tone is positive, and present, though somewhat short.

He tells Mr. Orr that he has prostate cancer (the patient already knew this) but that there are some “spots on his lung,” so they need to do a biopsy.

Orr is beginning to say something but the doc cuts him off, asking if he is a smoker.

“45 years ago,” Orr answers.

The doc expresses uncertainty about the spots, saying that prostate cancer doesn’t usually do that.

He put his hand on my shoulder as he walks past, saying, “sorry to interrupt your visit.”

Before he leaves, the doc tells Mr. Orr, “we’ll take care of this [cancer]” in a very relaxed, confident tone. A casual tone, even. But not dismissive. It seemed to reassure the patient. I felt reassured. Even if the doc knew the cancer would kill

him before long, the confidence might have helped Orr's state of mind.

Now with the doc gone, Orr is processing the news with me. He tells me he has lived a full life, "how much longer can I expect to live?" I hear a tone of acceptance. He didn't seem upset by the news of "spots on his lungs." I would guess that his attitude may be independent of the doc's reassurances, but it's hard to say. But Orr didn't express consolation in the doc's ability to beat the cancer. It was more like reassurance in accepting death itself. But perhaps the doc's tone helped him with this. Maybe reassurance, calm tone, etc, has an impact that extends beyond specific content. Maybe the doc's reassuring demeanor helped the patient relax around his own fate, even though the doc was reassuring him about beating the disease and not about dying peacefully.

This patient was 85 and had prostate cancer with some complications. Yet the MD expressed a confident attitude towards about condition. Some of his behaviors—positioning himself next to the patient's bed, shaking his hand warmly, and using a reassuring tone of voice—signify *having heart*. The doctor embodied calm and employed skillful communication to create an atmosphere of normalcy for this patient. However, note that right after he told Mr. Orr that he had "spots on his lungs," Mr. Orr began to say something and the doctor cut him off to ask him if he was a smoker. This exemplifies how hospital workers embodied *affective routines* that shaped intersubjectivities. In this case, a physician attempted to empathize without orienting to patients' present experiences, characteristic of *basic stuff*.

According to Daniel Chambliss (1996), hospital work is often routine to workers simply because they do it regularly. Everett Hughes (1994) makes a similar observation:

In many occupations, the workers or practitioners (to use both a lower and a higher status term) deal routinely with what are emergencies to the people who receive the services. This is a source of chronic tension between the two. For the person with the crisis feels the other is trying to belittle his trouble; he does not take it seriously enough. His very competence comes from having dealt with a thousand cases of what I like to consider my unique trouble. The worker thinks he knows from long experience that people exaggerate their troubles. He therefore builds up devices to protect himself to stall people off... (Hughes (1994): 66).

Like the physicians Hughes describes, nurses had "devices to protect" themselves and to "stall people off." And their work was routine because they did it regularly, as Chambliss observed. However, the unit's culture provided material for them to actively routinize their care, as well, in order to mitigate *servitude*.

While Chambliss and Hughes highlight the tensions caused by the collision of workers' sense of routine with patients' sense of emergency, my observations illustrate how routines also provided a structure for emotional support. Drawing upon the certainty of those routines while also attending to patients' unique needs was a balancing act that involved practices drawn from *having heart* and *basic stuff*.<sup>44</sup> On this unit, caring in light

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<sup>44</sup> One of the dangers in this dance of improvisation and routine was that some patients may not respond well to overly routinized or scripted styles and that "sentimental" care had the potential to exacerbate

of uncertainty involved both routine and improvisation, but uncertainty took shape in not knowing when routines would not work with patients. Both sets of behaviors above — *embodying calm* and *skillful communication*— used routines to create emotional fields that produced meanings and emotions of normalcy. On one hand, nurses used routines to directly communicate calm. Routines of this sort were embodied repertoires that helped them deal with uncertainty while mitigating emotional labor. But they shifted codes and reestablished contexts of interaction when routines led to impressions that they “didn’t care,” conflict, or the threat of sanctions.

### **Emotional and Instrumental Care**

Nurses also used affective routines and structures to improvise personalized responses to patients’ experiences. Routine embodiment of particular emotions, such as calm, provided a framework for the empathy of *having heart*. When nurses “had heart,” they generated responses to patients’ idiosyncratic needs and experiences, and they did so from a repertoire of emotions, practices, routines, and knowledge. “Really being there” with patients could itself be a routine that helped them, as this observation of Angela, CNA, and a patient named Lany illustrates:

I’m visiting with Lany while Arlene, RN is dressing a wound. Angela, CNA, comes in right as I ask Lany if she needs help.

Angela picks up my query with alacrity, “Lany, do you need help...to eat? Do you need help?”

Lany replies with a little, unintelligible grunt that nonetheless conveys that she needs help but doesn’t want it, or doesn’t want to need it, or simply isn’t excited about eating...

Asking, “what’s on there?” Angela lifts the lid, shows her, and says, “its....uh... Salisbury steak and mash potato.”

Lany murmurs “hmm...”

Angela says “you like that.” Its half question half statement.

Lany makes a face of slight disgust and Angela says “I know, you’d like a sandwich, huh.”

Lany whines a little and says, “not today.”

Angela acknowledges her, “not today, ok...” It seems like she thinks Lany doesn’t want to eat dinner.

But then Lany asks if she can cut it up and Angela says in an upbeat voice, “oh yeah, sure!” She sounds very enthusiastic, as if she’s happy she can help. Then she asks, “so you need help to...uh...feed you?”

Lany looks uncertain and shrugs, suggesting she doesn’t want help. She seems down.

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patients’ anxiety experiences by calling attention to their illnesses. I discuss these themes in chapter three.

Angela says “that’s OK, I’m going to cut it up.”

Lany says, “that would be great if you did.”

Angela replies, “oh yeah,” with enthusiasm. She turns to me and asks, “you’re going to stay here for a while? You want to talk to her?” I have a feeling that she’s going to delegate this work to me!

Lany answers before I can, “oh yeah, that’s my friend!”

I say, “yeah,” that we’re hanging out.

Then Angela asks if I can help Lany eat while I’m here. Her tone suggests that she doesn’t *expect* me to do this. Now she says to the patient, “John is going to be here, ok, Lany? He’s going to help you. Thank you John!”

Arlene has just finished the dressing and tells Lany, “you can eat your dinner now,” washes her hands and leaves.

This vignette illustrates how nurses cultivated rapport with patients and used this relationship to provide emotional support. This involved knowing what patients needed and how to respond. To some extent, patients’ needs were made predictable by patterns organized by illness trajectories and hospitalization. The anxiety induced by illness, hospitalization, and a feeling of losing control was common. So was depression. Yet patients’ personal experiences, personalities, and emotions were idiosyncratic, even within these patterns. As one senior RN told me, “you can never tell how a patient will react to a situation.” Like physicians, they tried to transform uncertainty in their work into certainty. However, unlike physicians, nurses used culture to anticipate and respond to *emotional* uncertainty.

In this example, Angela established an emotional field of personal connection. She initiated this connection right away when she asked, “do you need help...to eat. Do you need help?” Her interactional rhythm and her tone of voice conveyed empathy, concern, sincere desire to help. When Lany grunted unenthusiastically, Angela expressed curiosity about the food and lifted the lid, thereby entering Lany’s experience. Lany didn’t seem too happy about the salisbury steak, though Angela seemed to think that she liked it. It didn’t matter, however, because Angela was orienting to this patient’s cues. She doesn’t miss the next one, a facial expression of disgust. She stated, somewhat presumptuously though possible based on prior interactions, that she knows Lany would like a sandwich. Again, it didn’t matter that she got it wrong, because she was sustaining an emotional field of connection. The question of whether she needed help eating seemed to make Lany feel more depressed. Angela skillfully helped by saying “that’s OK, I’m going to cut it up.” It wasn’t clear what she was saying was OK. It seemed to apply to whatever was bothering Lany and help her feel better, evidenced by the shift in her countenance and tone of voice, her new willingness to eat, and her acceptance of help eating. Angela’s practice of *having heart* is apparent at this point in the interaction.

This interaction also illustrates how nurses helped transform dependency into normalcy by normalizing dependency. Patients who were not used to depending on others for daily self-care often had trouble with their newfound dependency. Reactions such as depression, self-consciousness, humiliation, frustration, and anger were common. In the vignette above, Angela’s “talking” with Lany transformed an “instrumental” task—

helping a patient eat—into emotional support. Lany's acceptance of Angela's offer to feed her accompanied an apparent reconciliation of her dependency, a form of normalcy. However insignificant it may appear, such reconciliations were important in patients' experiences. And nurses recognized this. They used empathy in practices, such as "talking" and "listening," to create knowledge about patients' needs. For example, in the following conversation, Penny, RN, told me about the importance of these practices in helping patients want to get better:

Good patients [are] patients that want to get better. Go talk to Mrs. 86. Mrs. Lucy. She's very depressed, but I won't tell you why cause she doesn't want anybody to know and I respect her for that. But go talk to her. Say 'hi,' see if she wants to talk."

I ask if that's something she does as a nurse, talk with people who are feeling down.

"Of, course. Of course. We're here to listen."

I ask if they have time for that.

She says, "well, you can cut the conversation kind of short but in a proper way... in her case, you'll see why. I make extra time to talk with her because I felt like she needed it. She's a nice lady. You should go meet her."

Note how this RN "made extra time" and used her own emotions to personalize her delivery of emotional support (I make extra time to talk with her because I felt like she needed it"). Sometimes patients simply refrained from asking for help. There were various reasons they "went without," as one patient told me. In any case, some nurses recognized this and attempted to ascertain such patients' "true" needs. For example, in a conversation with several nurses about how they knew what patients needed, Rosie, RN, emphasized that nurses had to be "sensitive:"

I point out that sometimes it must be hard to know what patients need.

Rosie says, "that's how you be sensitive."

The first nurse says, "some patients, they don't ask."

Rosie adds, "some are used to being independent their whole life that they hate asking."

Emotions like "sensitivity" were powerful "technologies" of observation and nurses regularly used them to observe, assess, and know patients' needs. But unit culture interacted with these emotions in the social construction of needs. Sometimes needs were constructed as distinctly emotional and sometimes they were seen as only physical. However, ostensibly purely physical needs, such as helping patients eat, bathe, use the toilet, and move, could entail emotional components. And when they did, they could

potentially involve an enormous amount of emotional labor.<sup>45</sup> Whether physical tasks were purely instrumental or were non-dichotomously linked with emotions depended on how nurses used culture and their emotions to construct patients' needs, thereby establishing the context for care. In contrast to *having heart*, *basic stuff* tended to minimize the emotional dimensions of physical needs. In this construction, physical needs required instrumental tasks or they involved the kind of routinized support that could be done without attention to individual patients' emotions. Culture thereby shaped relations of separation and connection between nurses and patients.

In order to provide emotional support, nurses had to "know" their patients. They used unit culture to shape their emotions and their relationships with patients in order to know them. Codes of care provided two main frameworks for this knowing. *Having heart* constructed this "other-knowledge" as a recognition of patients' emotions and needs—orienting to the patients' own experiences as source of knowledge in itself. "Knowing how to care," therefore, also included the conditions of possibility for acquiring this other-knowledge—knowledge of the patient based on the patient's own knowledge. Empathy constituted through an emotional field of connection produced the kind of embodied, tacit knowledge needed to know patients in order to "really care." Nurses used their repertoires in this way to build relationships that served as contexts for knowing their patients.

Some patients preferred more nurturing types of care while others preferred a more instrumental style. However, even when nurses provided no-frills instrumental care, emotional support was still involved. One aspect of this was the care instantiated in being "sensitive to" what particular patients preferred. In fact, knowing what style of interactions patients wanted—or what would work best with particular patients—was itself an important dimension of care that required considerable skill and emotional labor. Another was that "instrumental" needs and their corresponding tasks had emotional impact. For instance, from this patient's perspective, purely instrumental support was indirectly a form of emotional support:

I ask what he thinks is the most important thing they do for him.

He replies, "anticipate. they..." He stops to cough, then continues, "when they walk through that door...they bring a hundred percent of who they are for me and only for me. It doesn't matter if they just got their butt chewed, they're in the middle of a divorce, whatever. When they walk through that door into this room, I am their one and only focus."

I ask about the emotional support, are they good at that.

He responds, "yes and no. They make their half of the job enjoyable, so that sitting at this end, right? Because to be quite honest, from my perspective, I don't care. I've got a problem. I need it solved. Emotionally, if they are trying to solve my problems, they are emotionally solving my problems."

"By solving your..." I offer, trying to get clarity.

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<sup>45</sup> When RNs delegated "physical" tasks to CNAs they also delegated this emotional labor, an important process which I analyze in chapter five.

He says, “solving the ‘oh my god, I can’t move my foot’ sort of thing.” He grunts as he positions himself a bit.

In fact, my direct observations highlight that “instrumental” tasks, such as giving medication, feeding, and positioning, were always constituted through an emotional field of some kind or another, even if those fields were not personalized or empathetic. How nurses performed these tasks consequently had some kind of emotional impact, whether negative or positive.

### **Emotional Support through Connection**

In this section I focus on how nurses “connected” with patients, particularly through the emotional resonance of empathy, and how this facilitated emotional support and rapport. Rapport and connection unfolded around the challenges posed by patients’ differing, idiosyncratic personalities and constraints on nurses’ time and energy. Furthermore, each patients’ moods were potentially unstable due to the strain of illness and hospitalization. Nurses used culture and emotions to deal with these challenges. Unit culture presented three main strategies for connecting with patients. One was to embody routine styles of interaction that did not shift much from patient to patient, but which nonetheless facilitated rapport. Second was to get to know patients and build rapport by attending to patients’ personal interactional styles, emotions, and experiences. The third was to deprioritize the importance of connecting or simply not try to connect at all. They also used culture to construct “patient types” that they used to mitigate the challenge of patient idiosyncrasy.

A common-yet-elusive need among patients was to feel connected to hospital workers who were involved in their treatment. Nurses, in particular, were patients’ lifelines to the mysterious, uncertain, and often scary workings of modern medicine. One RN’s comment that patients felt anxious if they thought their nurses “didn’t care” reflects these circumstances:

I ask how they know they are giving a patient good care.

Chelsie replies, “you can tell.”

I ask how.

She says, “you can tell by their emotions and just by looking at them.”

Angela, a CNA, adds, “they might tell you they feel better.”

Chelsie says, “or they will tell you, because they feel so insecure if they think their nurse doesn’t care. Like eating in a restaurant, that this waiter may probably spit on my food. Something like that.”

Relations of connection and separation with nurses shaped patients’ experiences. For example Cristi took it personally when they didn’t talk and joke with her:

When the conversation ebbs I ask her if she felt like she could trust the nurses.

She replies “yeah. Only some of them its so repetitive what they do that they don’t have that bedside manner that a lot of patients like.”

“Bedside manner?” I ask.

“That’s what I call it. Like talking and joking. Not just ‘its all about business’. A lot of them, its repetitive so that’s what they do. And they lose that...their personality. They lose that. and that makes me feel uncomfortable. I’d rather them talk to me, not just keep it...they come in here and you’re just looking at the TV cause they’re just doing their little thing.”

“So its easier to trust them when they’re joking?”

“Yeah cause otherwise its like ‘what did I do?’ what did *I* do to piss her off or what did I do to put her in this mood. That’s how I feel. But I know I didn’t do anything so I just keep my mouth shut.

According to this patient, a sense of routine among nurses increased her experience of separation and anxiety. This also illustrates how intersubjectivity shaped patients’ own emotion work as they struggled to cope with their experiences of hospitalization. An emotional state of separation, for example, increased anxiety and prompted the need for more emotion work to remain calm. In the interaction above, Cristi’s emotion work included trying to *not feel* like she ‘pissed someone off.’

From nurses’ perspective, on the other hand, either too much connection or separation with patients could threaten their ability to establish and sustain a suitable working relationship with them. Even when they didn’t establish or sustain emotional connection, they usually needed some form of rapport in order for their work to proceed. Otherwise, they ran the risk that patients would not “comply” with their execution of “doctors’ orders.” Additionally, a lack of rapport could also make working with a patient generally unpleasant. This did not mean that nurses *always* connected emotionally with patients, however. The practices that nurses used to connect with patients shaped how processes of connection unfolded. For example, sometimes a routine approach to building rapport was inadequate and a nurse had to shift in order to orient more to a patient’s personal experiences. The following conversation highlights this predicament:

I ask Chelsie her how are her patients today.

she replies, "pretty decent. i just have to go with the flow, because they're some patients who...you know... are..."

“What do you mean? what kind of patients?”

"You know. Like difficult patients. If you disagree with whatever they're saying, you just have a terrible...its like a little more TLC. And i'm good at that. I know how to do that."

“So they're difficult patients so you have to give them a little more TLC?”

"Oh, yeah, yeah. Absolutely. And I know that. I know how..." *I think she doesn't want to appear as if she's having "trouble" taking care of any patients.*

I ask why they're difficult.

"Sometimes they're very needy and all that. Just go with the flow, whatever they



need. Yeah."

Connecting with “difficult” patients under circumstances of coercion and exploitation was a common problem.<sup>46</sup> In such circumstances, nurses often found it challenging to *have heart*. Yet the routines of *basic stuff* sometimes did not suffice either. Chelsie regularly practiced *basic stuff*. In my direct observations, she used routines to “mini-max” care work, to get efficient results with less effort than the personal attention of *having heart*. But she altered this strategy when she had a “difficult patient.” She provided more “TLC,” using behaviors signified by *having heart*. “Going with the flow”—catering to patients’ demands—also made such interactions easier for nurses.

Thus, giving a difficult customer-patient extra “TLC” instead of challenging his patient behavior was, from the perspective of phenomenological analysis, more complex than simply exploitation or coercion.<sup>47</sup> It can be seen as an act of agency within the larger context of coercion. Interestingly, in contexts defined by coercion, nurses did not have to present an authentic, caring motivation. This is because, as I show in chapter four, an informal code of *servitude* modified *having heart*, which created the understanding that customer service policies unfairly gave patients too much power, dictating that nurses please patients rather than provide emotional support as they saw fit. Sometimes they used strategies, such as “golden rule” to view “difficult patients” in an empathetic light—they were needy because they were anxious or sick, et cetera. These processes mitigated coercive hospital policies to some extent by providing nurses with their own ethics and accountability for caring.

Connecting was easier when nurses’ and patients’ interactional styles, personalities, or moods, complemented one another. Consider the following interaction between a patient and Lanette, a CNA:

I introduce myself to a patient getting ready for “discharge.” Lanette is taking her vitals one last time. The tone of the interaction is friendly, playful, upbeat, and fast-paced.

I ask, "you happy to go home, huh?"

"Yes. It was nice. The stay was nice. Everybody was lovely. But its time to go."

At that Lanette giggles and says, "the way you sound, you sound all phony 'it was lovely, now its time for me to go..." She speaks so quickly, its hard to catch what she's saying. She sounds accelerated, like she had too much coffee.

The patient says, “stop it!” in a playful tone.

Lanette says "thank you all for everything..." mimicking her. They laugh. Lanette continues teasing her, "all you guys was lovely..." but stops to clarify that she’s teasing, “just the way you said it was funny..." The patient is smiling. her spirits are high. And it seems they have some chemistry...

Lanette tells me, "I like her. I’m going to miss her. She's heck of funny. Her and I

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<sup>46</sup> Like the customer service policies that coerced smiles and insincere scripts, these coercive dimensions of “connecting” are analogous to what Hochschild (1983) found among flight attendants. I analyze contexts in which nurses experienced their emotional labor as more or less *laborious*, and how they used culture to mitigate coercive and exploitative forces by claiming autonomy over their work while sincerely caring for patients and find dignity in their work.

<sup>47</sup> These informal ethics reflect the role of emotional support in the status of nursing as a profession.

got along just like that (snaps her fingers) when we first met...you don't meet too many patients you can have fun with and joke around with.

Everybody be all serious. She makes a deeper, angry voice, 'Get out of my room. Nothing's funny here! I'm in pain!' They both laugh heartily.

The vitals machine beeps and the patient, happy with the numbers says, "oh, everything's cool. Hey!"

In a quieter, more serious voice Lanette rambles off some numbers and says, "room 98. Now let me go take that lady downstairs before Bonita has a baby. I don't want her to have a baby. She's 67 years old!" She's joking about one of the RNs who had asked her to transport a patient.

They laugh heartily.

Rapport was easier when personalities meshed. At the same time, patients' "cooperation" and "compliance" was a condition for rapport. In fact, nurses defined "nice" or "friendly" patients as those who "complied":

In the nurses' lounge, Nitta mentions one of the patients and says, "isn't she nice!"

I agree and then ask if that makes it easier to help patients who are friendly like that.

She replies, "oh yeah!" with certainty and adds, "because they're more compliant."

Friendly patients made it easier for nurses, and friendly nurses made it easier for patients. When patients did not "comply" with nurses' plan of treatment, rapport quickly disintegrated. Well-liked, charismatic patients were those who "went without" and "didn't bother" the nurses by "asking for too many things."

The emotionally-destabilizing experience of hospitalization complicated the challenge of connecting, because attempts to connect could actually cause emotional upset. Sometimes nurses tried to connect with a patient without using the necessary knowledge, skill, or style of interaction for that patient. This vignette illustrates the unfolding of an interaction in which an RN used *basic stuff* in a failed attempt to build rapport with a patient:

I'm visiting with an older patient named Bree. A phlebotomist comes in and says, "hi," in a neutral tone of voice. She goes up to the side of the bed opposite me and says she has to draw some blood. There is an expression of warmth, a slight smile on her face. Bree looks pained at the mention of blood draw and says something about how they already drew blood.

The phlebotomist says she knows and that she is "always the bearer of bad news," that people are never happy to see her. She says this with a slight touch of humor and empathy.

A CNA comes in to fix the call light, which is stuck on "call."

An RN named Gardenia comes in and walks over to my side of the bed and tells Bree she has her medications.

Bree says, "alright."

The RN hands her a tiny, clear plastic cup with some pills in it as the phlebotomist finishes prepping her needle. Then the patient begins to swallow the pills right when the phlebotomist inserts the needle into her arm. Bad timing! I'm afraid she might choke...At this point, there are three workers and me in there.

The RN tells Bree in a baby voice, "look at all these people in here. You're *special!*" I'm sure she was trying to be comforting, but the tone sounds patronizing.

Now the RN and CNA are gone and the phlebotomist comes over to my side of the bed to draw more blood. Bree turns her head away as the needle goes in this arm now. She looks like she could cry. Later she tells me that she doesn't know why they needed it on both sides, adding that she could have "just about cried." After the phlebotomist leaves I ask her, "what is the most important thing the nurses do for you?"

She thinks about it then says, "they joke, like that lady (the phlebotomist)." She adds that some are better than others and that some are real bad (at telling jokes).

I was unclear about what she meant until the same RN comes back in.

She asks me if I'm "sitting" for Bree and I say that no, i'm visiting with her.

Then she says more loudly to the patient, "John's visiting with you! You're *special!*" Again, this sounds patronizing and makes me uncomfortable.

Gardenia asks if she still has any stomach pain like earlier and Bree replies that she wouldn't if she got the meds she needs (on time). But adds that the pain is not bad now.

Gardenia says, "ok" and begins to walk out the door as she says "bye."

Bree calls out to her, saying that she's been forgetting a lot.

(Earlier Bree told me her memory isn't good, that it got bad a couple weeks ago. I sensed that she was concerned about it so I asked her if she told a doc or nurse. but she hadn't.)

Gardenia comes back and stands at the foot of the bed and says, "I forget a lot too!" This appears to be an attempt at joking, but it sounds insensitive and dismissive. The patient looks a bit confused. she is trying to tell the RN about something that concerns her and the nurse is joking. She tries to explain that she's been having trouble remembering things. It takes a couple tries until Gardenia begins to see that this is a legitimate concern, at which point she leans forward and her demeanor changes, becoming more serious and focused.

She says, "ok" in understanding and empathetic voice, adding that she will write a note for her doctor. She says "ok" and leaves.

I note that the information the patient conveyed wasn't very detailed compared with what she told me earlier. Perhaps she needed more time or she was thrown off by the nurse's attitude. After the nurse leaves I ask Bree about her experience of the interaction.

She replies, "when she said that ['I forget a lot too!'] I almost said forget about it." She is visibly upset by this nurse's attitude.

This interaction highlights some of the practices—and the skill they involved—through which nurses tried to connect with patients. In this case, Gardenia was not very successful. Her attempts at joking ('I forget a lot too!') and comforting ('You're

special!') this patient made her feel worse. When nurses attempted to connect with patients, they had to do so skillfully to avoid such problems.

Unlike building rapport through *basic stuff*, *having heart* involved empathizing in order to orient to each patient's particular experiences, needs, and emotions. This orientation involved specific ways of practicing skills, such as talking, listening, joking, which occurred within—and help to constitute—particular emotional fields. For example, this patient describes the “art of questioning”:

I ask Ms. Sanchez if she will miss the nurses when she goes home

She replies, “oh yes, especially Angela”(RN), adding that Angela is “special.”

I ask why.

She says Angela talks with her and spends more time with her. And she asks good questions. She knows the ‘art of questioning.’

I ask her to explain further why Angela is different from the others.

She mentions a time that Angela gave her a massage after the patient complained that her shoulder was hurting. She didn't ask her to massage it. Angela offered on her own.

Pennylane comes in, sits on the edge of the bed facing the patient, who is sitting in a chair. She says she is sorry to interrupt our conversation and adds that John is a good conversationalist. She asks her questions of patient satisfaction; do you feel the nurses have been responsive etc. Mrs. Santos answers them favorably.

Pennylane doesn't joke or laugh much in this interaction.

She leaves and I ask the patient how Pennylane's way is different from Angela's.

She says Angela would spend more time. She elaborates that the nurses are often in a hurry, but that she understands, they have a lot to do.

Connection was more than rapport or “getting along” when it was constituted through emotional support. A key part of the process was establishing emotional fields through empathy, attentiveness, emotional presence, and slower tempos and rhythms. Note that this patient first described how Angela knew the “art of questioning” then how she offered to massage her painful shoulder. When I asked her to compare Angela with Pennylane, she said Angela “would spend more time.”

## **Conclusion**

In this chapter, I analyzed my direct observations of emotional support practices in care delivery, including how *having heart* and *basic stuff* were instantiated in these processes. Nurses helped patients by creating an “atmosphere of normalcy” with routines and by orienting to patients' personal experiences. Their ability to sustain particular emotions such as “calm” was key in assuaging patients' anxiety. There were limitations in nurses' capacities to use *basic stuff*'s to address patients' emotional needs. Sometimes they shifted codes, using *having heart* when *basic stuff* was not enough to create an atmosphere of normalcy. Furthermore, unit culture shaped their interpretations of patients' needs. Whether patients' “physical needs” were purely instrumental, or included emotional dimensions, depended on the code that they used to establish the context for care in that situation. When nurses were using *having heart*, they constructed physical needs as including emotional dimensions. On the other hand, *basic stuff* defined

physical needs as purely instrumental, and minimized the importance of emotional fields of interpersonal connection when addressing patients' emotional needs as well. Thus, which code nurses used determined the context for meaning-making and practices of emotional support.

## Chapter Three

### Don't Baby Them!: Disciplinary Practices of Care Delivery

“A good patient is one that just lies there.”  
-Jasmine, RN

“They tell you you're the boss then tell you what to do.”  
-Mr. Bernie, Patient

Both RNs and CNAs managed patients' emotional needs and “disciplined” patients into compliance using culture, affect, and practices. They used empathy and disempathy to manage patients' needs and their responses to those needs.<sup>48</sup> These disciplinary practices were responses to contradictory institutional arrangements, which constrained their capacities to consistently meet patients' emotional and physical needs and devalued bundles of tasks linked with laborious emotional support, less-desirable patients, and relations of subordination (i.e. servitude). Structural factors shaped patterns of nurses' disciplinary practices of care delivery through the *power of the situation*; they systematically produced situations marked by external constraints on nurses' capacities to empathize and deliver care. These arrangements precipitated what Sara Ruddick (1998) observes as the tendency to “rationalize” needs to make them compatible with available resources. Nurses used disciplinary empathy and disempathy to stay on schedule and maintain distance from less-desirable, devalued dimensions of their work.<sup>49</sup> Additionally, they used patients' race, social status, and ability-level to rationalize their needs, further devaluing some types of patients and work of caring for them.

“Needs assessment” shaped patterns of disciplinary empathy and disempathy. Needs assessment, the process through which nurses defined the “reality” of patients' needs, also established appropriate types of care for those patients. Ideologies linked to systems of race, class, gender, and ability shaped these practices, because nurses utilized cultural assumptions provided by such systems to assess patients' needs. This assessment process was anchored in the semiotic codes, *don't baby them!* and *basic stuff*, which nurses used to rationalize patients' needs. *Don't baby them!* was a code that RNs and CNAs used to legitimate limitations on the emotional support they gave to patients. It used a medicalized framework to define a lower level of care as good for patients' healing process. *Don't baby them!* was thus anchored in *basic stuff*, which constructed patients' needs as if they were solely instrumental, not emotional. These processes

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<sup>48</sup> Nurses' use of this culture of disciplinary empathy and disempathy is loosely analogous to what Greta Foff Paules (1991) found among restaurant servers, who “view the customer as something to be processed” (36).

<sup>49</sup> The power of the situation makes situations powerful in constraining empathy. My findings support those of John Darley and Daniel Batson (1973), who found that a situational factor—time—determined which seminary students stopped to help somebody in need on their way to deliver a short sermon. The students who were told that they were going to be late felt “rushed” and, consequently, did not stop to help.

legitimated and normalized practices that could otherwise be defined as unacceptable (e.g. *rushing*).

Furthermore, hospital administration's use of "Patient Satisfaction Surveys" to measure patient's experiences institutionalized the practice of disempathy with patients who could not fill them out, report nurses, or elicit empathy. Indeed, nurses who did not practice disempathy with these types of patients faced the sanctions associated with falling behind schedule. This institutionalized disempathy further devalued care work for these types of patients. The devaluation of these types of patients in turn devalued the work of caring for them. Thus, empathy, or capacities to recognize and respond to others' feelings and experiences, may be used to discipline and control as well as to care. This conceptualization challenges the dichotomy between care and control, recognizing that care may be constituted through control and that control may be constituted through care.<sup>50</sup> The analytical categories "disciplinary empathy" and "disempathy" describe empirical patterns in my data, but the work of several scholars helped me to make theoretical sense of those empirical observations.

In the spirit of Beth Quinn's (2002) work on disempathy, I conceptualize empathy/disempathy as social process, rather than simply an ideal type. She found that men constructed masculinity through their *effortful* practices of *not* recognizing or attending to the feelings of women whom they objectified when "girl watching." She thus attends to the role of emotions, culture, and "self" in the social construction of empathy/disempathy, and links disempathy to the social construction of gendered subjectivities. In my analysis, disempathy may be intentional, but it also works unintentionally as structures of feeling shape nurses' cognitive and emotional subjectivities.<sup>51</sup>

This chapter illustrates processes through which people rationalize the morally-problematic, and hence emotionally-troubling—dimensions of inequality. These processes are the social counter-part of what Timothy Wilson (2002) describes as the psychological workings of the "adaptive unconscious." Wilson argues that this phenomenon provides individuals protection against the everyday vagaries of emotional life. It mitigates the force of negative mental-emotional formations by reworking people's narrative understanding of their experiences. He describes the process in these terms:

One of the most important lessons from social psychology is that people are masterful spin doctors, rationalizers, and justifiers of threatening information and go to great lengths to maintain a sense of well-being. And the psychological immune system operates largely outside of awareness (155).

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<sup>51</sup> Michel Foucault's concept, *subjectivation*, refers to how relations of power are the condition of possibility for the development of self, awareness, and "agency." Power creates subjects who reproduce—and transform—relations of domination through action experienced as their own will (1980). In contrast to Foucault's model of *subjectivation*, Stanley Milgram (1975) sees people as autonomous until they become agents of another's will. In a state of autonomy, we do not see ourselves as acting out the will of another whereas in a state of agency, he writes, "you see yourself as the instrument of the execution of another person's wishes." A synthesis of Quinn (2002), Foucault (1977), and Milgram (1975) yields what I call *disciplinary empathy*: "the recognition of another's feelings/experiences in the process of constituting that person as an object of knowledge and as an agent of one's will."

Wilson argues that the adaptive unconscious also prevents us from knowing our “true” feelings; rationalization-induced illusions come between I and I, making each of us “a stranger to ourselves.” Jonathan Haidt’s (2006) articulation of a Buddhist psychology of mind offers another image of this phenomenon:

Our minds are loose confederations of parts, but we identify with and pay too much attention to one part: conscious verbal thinking... because we can see only one little corner of the mind’s vast operation, we are surprised when urges, wishes, and temptations emerge, seemingly from nowhere. We make pronouncements, vows, and resolutions, and then are surprised by our own powerlessness to carry them out (22).

This describes the psychological mechanism for rationalization, but it is also the mechanism of ideology. Processes of rationalization power ideologies. Note that Louis Althusser (2001 [1971]) states, “ideology represents the imaginary relationship of individuals to their conditions of existence” (109). In this sense, ideology is the sociological dimension of the mind’s adaptive unconscious rationalizing power and inequality. Put differently, it is the cultural content of the psychological mechanism.

In my analysis, subjectivities of disempathy constituted through relations of domination facilitated social and psychological processes of rationalization. Specifically, disempathy shapes how people use culture to rationalize their agency—and responsibility—in morally-problematic relations of domination and inequality. Thus, disempathy makes us “strangers to each other.”<sup>52</sup> Similar to what Quinn (2002) found, these practices of disempathy were in some respect intentional. As she puts it:

Gender differences in interpreting sexual harassment stem not so much from men’s not getting it, but from a studied, often compulsory, lack of motivation to identify with women’s experiences (394).

This form of disempathy required emotion work in order to not resonate with patients. However, I found that disempathy was also unintentional, routinized by everyday practices and cultural codes that defined good care in terms that did not necessitate resonance or affective imagining in particular contexts. Furthermore, contradictory institutional arrangements facilitated structures of feeling that constrained empathy. In this sense, disempathy was not the “studied, often compulsory, lack of motivation to identify” but was more like patterned situational contexts in which empathy did not feel right. Finally, subjectivities of disempathy enabled both an intentional “lack of motivation” as well as a less-intentional inadequacy of emotional-cognitive skills necessary for both dimensions of empathy.

In the following analysis, I first analyze patterns of disempathy, followed by patterns of disciplinary empathy. I attend to both nurses’ and patients’ experiences throughout my analysis, illustrating how practices of disciplinary empathy and

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<sup>52</sup> Disempathy makes it more difficult to get to know a person and easier to operate on assumptions of the other based on ideologies and cultures of power. This affective structure reproduces inequality by creating and maintaining divisions between groups structured by power relations.



disempathy unfolded in interactional processes. I also analyze how nurses legitimated these practices, “softening” them, using race and labels, such as “confused” and “drug seeker,” to discredit patients as reliable sources of knowledge about their own needs, and disempathizing with patients who were less likely to complain or fill out patient satisfaction surveys. Third, I analyze how nurses used the semiotic code, *don’t baby them!* to rationalize their practices.

## **Disempathy**

In this section I analyze patterns of disempathy, which I define as “not recognizing or responding to another person’s feelings or experiences.” Disempathy included practices of “bulldozing” – a dominating interaction wherein nurses ignored patients’ cues of discomfort and pain—as well as practices in which nurses altered their behavior somewhat in response to patients. Bulldozing was painful to observe. Bulldozing happened in situations where nurses had more power and patients had less power and were more vulnerable. For example, bulldozing happened when patients were less physically or mentally able, or did not have family members present. In these interactions, patients experienced a lack of control and physical or emotional pain/discomfort, while nurses ignored their cues. The nurses had a job to do, and bulldozing made their work go faster. Yet this pattern could also have ramifications that created more work for nurses later, for example, if family members arrived and complained about the treatment. The following vignettes include several patients who were labeled “confused” or “drug seeker,” because these represent the types of patients with whom nurses most readily disempathized. Not only were they less-likely to complain, they were also discredited as reliable sources of knowledge about their own needs. Therefore, it was easier for nurses to legitimate their practices of disempathy with such patients.

The following interaction took place between Mr. Bernie, an older patient, and the charge nurse. I was helping him organize his things in the midst of a flurry of activity as the nurses moved some patients to another unit which had been temporarily closed. The head charge nurse came in and noticed that the patient was sitting on the edge of the bed:

Glenda, the charge nurse, comes in looking for something. She notices that Mr. Bernie is sitting up. She lowers the bed down despite him protesting that he wants it up. Then she lifts his legs with her arm under his knees, and, with her right arm behind his back, rotates him and lays him down.

As she does this, a device that is sitting on the bed near the foot begins beeping loudly. The patient winces in pain as Glenda moves him and he looks in the direction of the sound. It’s clear to me from my position that he is looking at the source of pain, and I hear him say something about his back hurting.

But Glenda doesn’t hear that and she tells him not to worry about that sound.

He replies, "it’s my body!" and Glenda begins to understand that he is in pain...

But now he is already lying down...she covers him up and leaves. She didn’t once ask him anything. She was talking during it, saying nice things in a sweet voice, but not in a way that included him, but rather as a kind of softening of her otherwise rough care.

Once she leaves I ask if he wants anything...he does. I think he realizes that I will respond to his requests, as he asks me step by step to place the table, the IV, and the bedside commode in particular positions near the bed....After he is finally situated, we talk. I ask him about the nursing care he has received. He tells me, "they'll tell you you're the boss, then tell you what to do." Before long he begins to look sad and remarks, "I worked my whole life, got a house, and this is what I have to look forward to?!" He looks depressed now. He asks me if I should be doing something else. I sense he wants me to leave, so I do.

This interaction highlights an important difference in how nurses and patients experienced care in interactions. From Mr. Bernie's perspective, this was not good care, because Glenda did not listen to him. He had little control in the situation. From Glenda's perspective, she was keeping the patient safe by following a policy that beds should be low and patients should not sit on the edge of their beds because they could fall, which was why she lowered the bed and laid him down. She practiced *medical safety* by embodying *basic stuff*, which enabled her to define his needs in purely instrumental terms and deliver "care" without recognizing his feelings. This made the procedure more efficient for her, but emotionally and physically painful for him. It was not that Glenda believed that *having heart* was unimportant. In fact, she generally presented herself as a nurse who valued patients' emotions. For example, she tried to initiate a program to include a personalized biography in patients' charts in hopes that the staff would personalize their care for them.

Yet her position as senior charge nurse constrained her capacity to practice empathy, because she was responsible for daily operations as well as the safety of all the patients on her unit. Additionally, she was responsible for her unit's patient satisfaction scores, which was a factor in her motivation to implement the program I mentioned above. These constraints were compounded by the larger context in which this interaction occurred: another unit, which had been temporarily closed due to low census, had reopened, and the nurses were busy moving patients who had been brought to South Heart back to that unit. The nurse manager was even on the floor helping out. An "atmosphere of triage," marked by a sense of urgency and more stress among the staff, facilitated bulldozing and other forms of disempathy. While the ebb and flow of patient census and acuity and nurse staffing levels sometimes created situations of heightened "triage," urgency and stress were built into nurses' daily care work as well, as I discussed in chapter one.

This vignette illustrates a general pattern: their experiences of urgency and stress constrained nurses' capacities to empathize and embody *having heart* and facilitated disempathy and *basic stuff*. At the same time, the "cause" of disempathy lies not in individual nurses' personalities but in contradictory institutional arrangements. Interestingly, Mr. Bernie made a related observation when he said, "there's so much structure here, it's amazing anything ever gets done." By making an "atmosphere of triage" a reality of daily nursing, contradictory institutional arrangements created the conditions for practices such as bulldozing. In light of the high-pressure imposed by their responsibility for patients' safety, nurses utilized disempathy to facilitate safety.

But disempathy could create more work later in the form of patient dissatisfaction or complaints to administration, including sanctions. To avoid the threat of sanctions,

nurses sometimes softened their practices of disempathy, as Glenda did: “She was talking during it, saying nice things in a sweet voice, but not in a way that included him, but rather as a kind of softening of her otherwise rough care.” In my observation, she did not intend to hurt him. Rather, she failed to notice that he was in pain because she was rushing and focused on “softening” her actions instead of listening to his exclamations. This “softening” was necessary because Mr. Bernie was the kind of patient who could potentially discipline her; he was mentally-able, privileged with cultural capital, whiteness, and middle-class status. Furthermore, his wife often visited him and the presence of family members gave patients power vis-a-vis nurses, doctors, and hospital administration. Nonetheless, it is clear that he felt wronged by Glenda’s bulldozing, as evidenced by his comment, “they’ll tell you you’re the boss, then tell you what to do.” Note that he did not blame Glenda as an individual. Rather, he understood her actions in relation to the hospital as a system. This was his way of making sense of his own lack of control in an organization whose rhetoric stated that patients “came first” and that caring included empathy. Furthermore, rather than challenge his subordination, he became depressed. Thus, nurses used practices to “soften” bulldozing and they minimized the risks it entailed by drawing on the code of *medical safety*, as my previous analysis illustrated regarding the risk of “falling.”

When nurses used *medical safety* to legitimate disempathy, they reproduced medicalized conceptions of particular dimensions of care, such as “fall risk” and “feeding.” This medicalization of care legitimated and normalized disempathy by discrediting patients’ capacities to act autonomously. To some extent, the status of “patient” itself already involved a degree of discrediting, since patients entered the hospital because they were ill and needed expert knowledge and help. However, it was especially powerful when patients were also labeled “disoriented” or “confused.” The following interaction illustrates how an RN “babied” a patient named Thelma to elicit her compliance and then used *medical safety* and the label “confused” to legitimate feeding her against her wishes:

Aliza, a young, white RN is standing at the side of an elderly black woman's bed. Right away I notice that the patient has her hand on the nurse's forearm. The nurse is trying to feed the patient some ice cream. The patient, Thelma, is pushing her arm away, saying "no" and "this ain't right." Her lips tighten in anticipation of the spoon's approach. The patient pushes feebly while the nurse forces the spoon into her mouth as she tells her she needs to eat. This happens over and over again for about five minutes.

*I begin to feel uncomfortable. It's clear that this patient doesn't want to eat the ice cream. But the nurse keeps pushing the spoon up to the patient's closed lips.*

At one point Aliza tells Thelma, "I know. This ain't right," in a tone that's more patronizing than empathetic. In fact, she seems confident that her behavior *is* right.

I ask, "I'm confused why you're still feeding her when she doesn't want to eat." "She needs the nutrition," she replies with certainty, adding, "that's one of her [the patient's] lines, 'this ain't right.' She won't eat anything." Then she says that the patient is "disoriented."

Then, in a patronizing, babying tone, she tells the patient, "ok, just five more bites."

Again the patient pushes it away, repeating, "this ain't right," tightening her lips as the spoon approaches. Then she says, "don't take advantage!" in a weak voice. Finally she takes a tiny bite.

Aliza tells her "good." She sounds like she's speaking to a child. After three more bites she puts the spoon down, picks up a little carton of juice, and says, "this is apple juice."

Thelma replies, "I don't want any" as she puts her hands up.

Aliza repeats, "this is juice" and moves it towards her as the patient pushes harder, almost hitting Aliza.

Aliza turns to me, "this is when I stop, when they start hitting." She then takes a napkin and begins to wipe dry skin off the patient's lips. The patient resists this, too. Aliza puts a dab of vaseline on her finger tip and tries to rub it on the patient's lips. The patient moves her head to the side to avoid it.

Aliza "encourages" her: "this is vaseline. It's for your lips. It's chapstick, not food." The patient replies, "I just want to rest!"

Liz manages to wipe her lips with it a little before leaving.

After Aliza leaves I ask the patient if she doesn't want to eat. She repeats that she just wants to rest, so I leave.

Out at the nurses' station, I say to Aliza, "that must be hard, huh?" I try to sound empathetic.

She replies flatly, "no. Its my *job*."

Patients often "refused" or resisted nurses' attempts to do things to their bodies. Nurses assumed that the treatments they applied were necessary and good for patients. When patients refused them, they were seen as both "non-compliant" and irrational. Thus, non-compliance discredited them as good patients, illustrating what Talcott Parsons (1951) argues regarding the importance of "wanting to get better" in the "sick role." However, patients sometimes challenged the nurses'—and the doctors'—interpretations of what they needed to do to "get better." Such challenges threatened hospital workers' authority as well as the flow of their work. Nurses could more readily discredit less-powerful patients, such as the one in this example. Aliza rationalized and legitimated force-feeding this patient by discounting Thelma's own ability to make decisions—"she's disoriented"—and by claiming that she knew better what the patient needed—"she needs nutrition." She interpreted the patient's refusal as irrational because it resulted from disorientation; Thelma needed nutrition, so refusing to eat was a sign of her disorientation, illustrating what Rosenhan (1973) describes as the power of labeling. From the patient's perspective, the RN was "taking advantage" of her lack of power in a situation she defined as unethical—"this ain't right."

In contrast, Aliza's comment, "it's just my job" suggests a view that such interactions were routine and not morally problematic. But that does not mean they were not emotionally-challenging. Her reply could have been a defense mechanism she used to mitigate the dilemma of balancing her responsibility for this patient's medical safety ("she needs nutrition") against the emotional labor of feeding the patient against her wishes. In fact, I rarely heard nurses talk about their work as "just a job" and those who

did could be stigmatized, especially by patients, as “doing it for the money.” Such potentially difficult ethical dilemmas were commonplace dimensions of everyday nursing care. RNs gave each other relative autonomy in deciding how to act in such situations. This was evident in my conversation with Jasmine, RN, about the previous interaction. Careful to protect Aliza’s anonymity, I asked Jasmine if she thought it was alright to force patients to eat when they refused:

She replies that it’s not clear. There’s not a policy about it. So it’s up to each individual nurse. She says she wouldn’t do that to a patient. If a patient doesn’t want to eat, she wouldn’t make them. She then asks me if I felt uncomfortable. I say “yeah.”

She replies that my own emotions are the indication that it’s wrong.

I mention that the nurse in question said the patient was “confused.”

She replies, “you should think of the patient as a family member” and “listen to how you feel about it.”

She goes on to explain that sometimes patients don’t want treatment and that some nurses don’t like patients who are non-compliant. But then she says that “if a patient is confused, they need to be forced a little sometimes.”

Jasmine’s statements of “there’s no policy about it” and “[she] wouldn’t do that to a patient” call into question Aliza’s use of *medical safety* (“she needs nutrition”) to legitimate her disempathy and the action of force-feeding. According to Jasmine, nurses used their own emotions rather than policy in such situations. In fact, such moral reasoning was part of their daily care work. And while there was no clear policy, semiotic codes such as *medical safety* and assumptions about types of patients provided cultural material that nurses used in their moral reasoning. Note that Jasmine said she would not do what Aliza did, that she would instead try to treat the patient like her family member. Yet this practical ethic did not preclude her belief that “if a patient is confused, they need to be forced a little sometimes.” This illustrates the power of the label “confused” to legitimize disempathy.

Nurses also minimized the risks of disempathizing by matching its practice with patients who appeared less likely to report them to administration. These types of patients tended to be less able to communicate, not have family present, were labeled “confused,” or were otherwise discredited, as in the case of “drug seekers.” The following vignette illustrates how disempathy was normalized and legitimated in an interaction between two CNAs and an ostensibly “confused” elderly, male patient:

Tereza, CNA, comes in pushing a Dynamap (a machine for measuring vital signs). She looks unhappy, like she doesn’t want to be there. She says ‘Hi Mr. Jones. I’m going to take your blood pressure and then help you.’ But she is speaking too quietly for him to hear. I’ve been visiting with him for awhile and I know that he is hard of hearing.

He tells her he can’t hear her.

She repeats what she said, but not much louder.

I tell her that she will have to speak up for him to hear her because he’s hard of hearing.

But she snaps at me sharply, “he’s just confused!”  
*‘Just confused!?’ I think to myself. He didn’t seem confused at all during the HOUR we spent talking.*  
She takes his vitals, still not speaking up, not saying much. Then she tells him “I’m going to turn you and clean you up.”  
He says, “I can’t hear...understand you!”  
So I repeat, “you’ll have to speak up for him to hear you!”  
She snaps again, “I know!” Her tone is defensive and irritated.  
But then she *does speak up* a little, at least for the next few lines. Unfortunately, that doesn’t last. Her voice lowers again and again he can’t hear.  
Before she turns him and cleans him up, she calls Bert, CNA, in to help her.  
He doesn’t look very happy, either. They move to standing at either side of the bed. I’m still sitting in my chair, which I’ve moved back, away from the bed to give room. Bert is on the opposite side, facing me. He also talks to the patient in a low volume that the patient can’t hear.  
As he helps Tereza roll the patient he asks me, “are you supposed to be in here?”  
*I’ve rarely been asked such a question in such a tone by any of the staff...*  
I reply, “yeah. I’m visiting with him.”  
He tells me that I’m not “visiting,” that I’m “sitting” and that he didn’t know volunteers were allowed to “sit.”  
I say volunteers are allowed to visit. I tell him I’ve been doing this for a couple years. He says he knows, he remembers me from the other unit. He is half smiling, but his tone of voice is annoyed, confrontational.  
*I’m not sure why he’s confronting me like this, but I get the feeling that he doesn’t want me in the room.* I tell him that if he doesn’t want me here, I’ll leave. He replies that he didn’t say that. With a strange intensity he says that if I’m in the way, he will tell me.  
Tereza begins to lower the head of the bed down so they can turn him and clean him. As the bed goes down, the patient screams loudly. He calls out, “too fast!...too much!”  
But Tereza ignores his pleas. She keeps her finger on that button and the bed keeps going down. She doesn’t stop once. It feels like it’s taking forever for it to end, and his screams continue until the bed is totally flat. Once he’s down all the way and not screaming, I ask her if he has gotten pain meds. [Ideally, patients get pain meds before their pain is this bad, and if the coordination of care is working well, they get the meds before being turned and cleaned, or before going to a test etc.]  
At first I think she is going to ignore me, but she replies that it doesn’t matter, that “he always screams like this.” She adds, “he’s just confused.”  
Bert again says something to him in a normal volume, but the patient can’t hear him so I decide to tell Bert that the patient is hard-of-hearing.  
But he doesn’t let me speak, interrupting sharply, “it doesn’t matter!” He leaves soon after that. Tereza finishes up the job, putting fresh blankets on the patient. She says something to him but again he can’t hear her. She leaves.  
I continue to visit with him for a couple more minutes.  
He looks like is a little in shock, a little dissociated... I need to go write my notes,

so I tell him I have to pee.

He says I can go here, in his restroom. *This strikes me as a lucid idea. Not something a “confused” person would say.*

I tell him I have to use the other one and he asks why, which is also a question I wouldn't expect from a “confused” person. It's a logical question, because I could actually use his restroom if I wanted to use it.

As I left, I thought about this interaction in terms of the administration's concern with “Patient Satisfaction Scores.” The goal of increasing patient satisfaction with the “care experience” had consequences for nurse-patient power relations. For one thing, patients whom staff perceive to be unable to fill out the surveys or give feedback and who did not have family present were more vulnerable to relations of domination/subordination. Nurses tended to empathize with patients who could voice their opinions, fill out surveys, report nurses to administration, and who were seen as credible. Such patients were more powerful, and they tended to escape the worst disempathy, such as the bulldozing in the above vignette. The label “demented” made this patient an unreliable source of knowledge about his own pain. In other words, it called the authenticity of his pain into question:

Back at the desk, I ask Nelly, Mr. Jones' RN, about the patient's pain... She tells me he's demented. *I'm not sure what this has to do with him being in pain.*

*Perhaps she thinks that his screaming is not an authentic sign of pain.*

I communicate in two different ways that he seemed quite clear when I talked with him. She finally acknowledges this possibility, but seems convinced that he's confused. She tells me he's “interesting” because he's a retired radiologist and has a “bunch of lawyers taking care of his estate.”

There were limits to how much racial, class, or gender privilege mitigated the force of disempathy. Neither Mr. Jones' apparently high-class status nor his whiteness or gender protected him from disempathy, because he was labeled “confused,” and his hearing impairment confirmed the label for workers who interacted with him. Furthermore, he did not have someone present who could advocate for him.

On the other hand, race facilitated disempathy and relations of domination/subordination for some African-American patients who were labeled “drug seekers.” Like the label “confused,” “drug seeker” provided grounds for disempathy by discrediting patients as reliable sources of knowledge about their own needs. In my observations, all the patients who were labeled “drug-seeker” were African-American. Identifiers like “homeless” and “off the street” were code words for “Black drug-seekers.” For example:

I ask Bonita, RN, if she thinks AIDET helps with patient satisfaction.

She shakes her head 'no' slightly and says, “I give them their cranberry juice, they'll be satisfied.”

I ask, “so if you get them what they want, patient satisfaction is better?”

“Of course.” She adds that, “it's the kinds of clients we have here, from the street.

If you don't give them what they want, you're no good.”

Other nurses expressed similar sentiments, linking this particular type of patient with feelings of frustration at having to “wait” on them. Some devalued these types of patients because their needs were not authentic and because they saw them as demanding and ungrateful. The devaluation of the patients also devalued the practices of caring for them. It is evident in Bonita’s statement that she used *basic stuff* to define caring for such patients in terms that lowered the acceptable level of effort and signified care with instrumental tasks: “I give them cranberry juice, they’ll be satisfied.” Caring for clients “from the street” was a common source of frustration for nurses, as is evident in the following conversation, in which several RNs complain about “drug-seekers:”

I comment that today a nurse said one of her patients just wanted drugs and I ask if that’s common.

Jan says, “yeah.”

Chelsie offers, “they just claiming they’re feeling this or feeling that, to have access to the hospital...and then whatever the patient says, it’s real. Right?”

Jan says “you have to follow it”

And the doctors write the orders for that?

Chelsie says, “oh absolutely! Yeah.”

I ask how they know which ones are drug-seekers.

Chelsie’s reply, “you know them,” suggests that it’s obvious.

“How do you tell?”

Jan, “just by the way they ask for it [pain meds] or they’re laughing on the phone and they say they’re in pain. You know then.”

Chelsie adds, “then they get mad if you don’t give it to them. And they will tell you, ‘I like my Morphine.’”

“But they don’t look like they’re in pain...?” I ask.

Jan confirms this, “uh huh.”

They compare this hospital with another hospital where they work.

Chelsie says, “our population here, they’re a lot sicker, because of the demographics. It’s totally different in this area.”

Jan, “yeah. I agree. In Vanilla Hill they’re all Caucasian, older, no drug addicts there.”

Chelsie, “it’s totally different.”

“They’re not as sick?” I ask.

Jan, “they’re sick too, but it’s a different sick. It’s because they’re old. That’s why they’re sick. Here we have a lot of renal [kidney failure], drug-addict patients.”

I ask if it feels different to take care of the different demographics.

Jan says that it does and I ask how.

Jan tells me: “the people who do drugs are not as appreciative of your care as people who are really sick. So basically we’re their waitress...you’re getting them food, you’re getting them Morphine, right?”

I ask, “So you have to treat all the patients the same, even the drug addicts...?”

Chelsie confirms this: “absolutely. It doesn’t matter.”

I ask how they do that.

“There’s no preference. We’re used to it.”



Jan agrees and Chelsie adds, “it doesn’t even bother us anymore.” Bonita comes in and I joke, ‘Bonita had a really good patient today.’ *I’m referring to the drug-seeker, Ms. Brenda, to see how they respond.* They chuckle. Bonita replies with humor, “that’s why I told John, ‘take her! Take her!’” Chelsie says, “that’s why I couldn’t wait, I had to bring my patient down right away. It was consuming all my time.” Confused, I ask if she means the same patient. “Oh, no. There’s another one. Like Brenda.” “Another drug addict?” “Yeah...I mean, all of them are.”

They described how they determined when patients “just wanted drugs” and were therefore not authentic or valued patients. At first Chelsie made it seem obvious, “you just know them.” But my inquiry prompted them to share three strategies they used to determine “drug seekers.” The first was “the way they ask for it [pain meds].” Statements such as “I like my Morphine” revealed a fondness for the drug, and patients’ “true” motives. The second involved observing discrepancies between patients’ behaviors, such as laughing, and their complaints of pain. This signaled that their pain was not authentic. Third, was that these patients “get mad if you don’t give it [Morphine] to them.” They contrasted these types of patients with older, “Caucasian” patients at a hospital in a wealthier city, Vanilla Hill, adding that there were no “drug addicts” there. When I asked them how working with the two types of patients felt, these RNs echoed Bonita’s frustrations above. For example, Jan said, “the people who do drugs are not as appreciative of your care as people who are really sick. So basically we’re their waitress.”

Their situated definition of “care” in this conversation reflects *medical safety* and *basic stuff* because they defined it terms of instrumental tasks, “getting patients food...[and] Morphine.” Using these codes to define care enabled them to claim that they gave all patients the same care. For instance, when I asked if they had to give the “drug addicts” the same care, Chelsie replied, “absolutely. It doesn’t matter,” adding that “there’s no preference.” The other RNs also agreed that they were “used to it” and “it doesn’t even bother us anymore.” This was particularly interesting because they claimed that they gave them equal care while also describing how these types of patients were frustrating and not authentic. In other words, they devalued these patients and their care, but insisted that this did not affect their *care practices*.

Although every nurse whom I asked agreed that they treated all types of patients the same, my direct observations illustrate that in practice they disempathized with “drug-seekers” and other types of less-valued patients. In addition to disempathy, there was evidence that they also tailored their medical treatments, such as the dosage for pain medications, for “drug seekers.” The following vignette details a series of care delivery interactions between an alleged “drug seeker,” an RN, and an MD. To preface, the MD who originally prescribed this patient’s Morphine was not the doctor but his associate and he gave her a relatively low dose, two milligrams. The patient, Ms. Brenda, insisted that 2 mg was not enough for the pain from her back surgery. She kept asking for more pain medication, which confirmed to the nursing staff that she was indeed a “drug seeker:”

I’m visiting with Ms. Brenda in her room.

She says, “I kept wondering why, if I’m getting all these heavy drugs for pain, why I don't feel nothing. Someone told me today I was only getting 2 milligrams! No wonder I’m not feeling nothing. 2 mg! I don’t want them to think I’m in here trying to push the drugs. The doctor told me Friday that his associate would be here over the weekend and “tell him anything you want, you can have it.”

Bonita, RN, comes in and the patient asks when she can get another shot of Morphine.

Bonita tells her firmly, “no, you don’t get a shot anymore.”

The patient asks, “why?” in a flat, edgy tone.

Bonita: “so your body will build up the...”

Ms. Brenda cuts her off, “no. first of all they ain’t been giving me nothing. When I found out how many milligrams, I said ‘what!?! No wonder I keep feeling pain.’ They ain't given me nothing.”

Bonita replies, “mmm,” and doesn’t concede. She repeatedly ignores the patient’s comments about her pain and about the inadequacy of the dose.

Out at the desk I ask Bonita what is the usual dose.

She gives me a look that says, ‘can you believe this patient!?!’ Then she tells me there is no ‘usual dose.’

I say “it sounds like she's not getting enough.”

Bonita whispers, “she's a drug addict.” And looks at me again as if to say ‘that’s all there is to it.’

I so “oh.”

Then I ask her how she knows.

She replies, “it’s in the history [in her chart].”

Later Ms. Brenda is standing at the desk, telling the nurses that her pain meds are too low. She sees her doctor coming and exclaims, ‘oh there’s Dr. Green!’ and chuckles.

He tells her, “here I am...here I am...I was thinking about you.”

She reiterates what she's been saying about the 2 mgs and adds, “you know good and well you weren't giving me nothing.”

He replies, “OK...hold on...” He says he had his associate come because he knew she was going home but since she’s still here he wants to “give her what she needs.”

She retorts, “well if I hadn't of asked for you, I wouldn't have seen you now...”

She seems frustrated with him as they talk about whether he came earlier, as the nurses said. At one point she turns away from him as he’s talking and Bonita disciplines her, “Ms. Brenda! The doctor is talking to *you!*”

He clarifies, “I was coming to talk with you before I left...and adds “ want to fill out your prescription. What do you need?”

“I need something...” but stops and says “can we go in the room? Everybody's...” she is upset because all the staff at the desk are staring at her. She and the MD go into her room.

I ask Bonita about the interaction.

With exasperation she tells me, “we have a lot of that kind of caliber of patient.”

I ask why.

Bonita replies, “when they run out of money to buy drugs, they come to the

hospital...they don't have insurance and the hospital cannot refuse...that's a social problem!"

"So how do you know when somebody is doing that?" I ask.

"Oh you know. Oh yeah. Oh yeah."

Back with Ms. Brenda, I ask about what happened and she tells me, "I bet they can't wait for me to leave so they can talk." She tells me that the doctor gave her a prescription for eight milligrams. I note that is four times what she was getting. I ask if he explained why she only got two milligrams.

She says, "he said he didn't do it. Somebody else [his associate] did it and Dr. Green thought I must have asked for that [two mg dose]."

The label, "drug seeker," shaped nurses and doctors interpretations of patients' behavior, facilitating disempathy whether or not said patients were actually in fact "seeking drugs." The boundaries around what counted as drug-seeking versus authentic pain were quite blurry, because even patients with real, physical pain wanted pain medications. In other words, almost any patient could be construed as a "drug seeker" based on their desire for pain meds. Thus, the deciding criterion was whether a given patient's pain was "real." In addition to the three strategies I mentioned above, nurses and doctors used assumptions about patients' race and class to assess the authenticity of their pain; race (Black) and class (poor, "off the street") informed those strategies.

Race and class thus shaped patients' access to pain medication. Alleged "drug seekers" who had legitimate pain faced a catch-22: the more they complained about their pain and the need for medication, the more they confirmed the nurses' and doctors' belief that they were "drug seekers." This process was evident in the vignette above. In Ms. Brenda's case, it appears that she was in fact not receiving an adequate dose of Morphine, because her own doctor increased it fourfold when he became privy to the situation. However, it is also possible that Dr. Green "gave her what she wanted" so she would leave the hospital.<sup>53</sup>

The label "drug seeker" facilitated Bonita's practices of disempathy, including her dismissal of the patient's pain, her feelings about the situation, and the legitimacy of her experience more generally. For instance, in the following interaction, which occurred about midway through the scenario, Bonita denies the patient's view of the situation:

Bonita is flushing Ms. Brenda's IV when she jerks her arm a back bit, exclaiming, "its burning!"

Bonita replies a bit defensively, "OK that's why I'm doing it real slowly."

Ms. Brenda says, "some nurses will do it and you don't feel it and some burn you up!"

The nurse responds, "mmm hmmm. Yeah. It's the normal saline is the one that burns."

The patient says, "I'm just saying, some nurses do saline, it don't burn."

Bonita sounds skeptical, "uh...i doubt it though."

Ms. Brenda says Dora and them have done it and it don't burn."

"Dora who?"

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<sup>53</sup> Patients sometimes refused to leave when their MD officially discharged them. The nurses and doctors tried to avoid these situations.

“The one that’s a registered nurse on this floor.”

Bonita replies, “the red one...?” It seems like she isn’t really listening.

As the patient tries to clarify, the nurse interrupts her loudly, “so I’m going to pull it out in about ten to 15 minutes, OK?”

The patient responds with “maybe...”

Bonita repeats, “maybe,” as she laughs, sighs, then scoffs, repeating the word, “maybe.”

Ms. Brenda seems to make up her mind about staying, “look, go tell whoever, I’m not leaving....”

Bonita tries to convince her to leave, saying “it’s better to recuperate at home.”

The patient replies that it’s better if they give you something to recuperate with, “after they made your lung collapse.”

Instead of responding to the patient’s comment, Bonita says, “look at you, you’re all Christmassy already.” [She is wearing a long, red gown over her hospital gown, and a slightly darker red beanie.]

The patient retorts, “I don’t *feel* Christmassy.”

When the patient claims that other RNs flush the IV without it burning, Bonita does not respond to her point, but instead says “it’s the normal saline is the one that burns.” When the patient again tries to get her idea across, Bonita says, “I doubt it.” When the patient mentions a specific RN, Bonita’s response, “the red one?” seems confused, as if she were not listening. Her disempathy becomes even more apparent when she interrupts Ms. Brenda in a loud voice. Note that she adds “OK?” to the end of the statement to “soften” it and give the patient a sense of control by creating the illusion of empathy. But Ms. Brenda tells Bonita that she’s not going home [until she gets enough pain medication], and Bonita appears to not take her seriously. When the patient tries to express the authenticity of her pain by referring to her surgery, Bonita ignores her and changes the topic to the patient’s clothing, “you’re all Christmassy already.” Such practices differed from the “bulldozing” I analyzed in the previous interactions, which involved less able-bodied and “confused” patients, because Ms. Brenda exercised enough power to challenge the staff’s disempathy.

As seen in this section, nurses’ devaluation of certain patients led to their marginalization of these patients’ care, along with their devaluing of the care work involved in caring for these patients. Nurses did not want to empathize or provide emotional support for such patients. Furthermore, their discrediting of certain patients meant that they did not value these patients’ opinions, or see them as sources of knowledge about their own needs. Patients who lacked power were also less able to fill out Patient Satisfaction Surveys, or have credibility if they complained to the administration about a particular nurse. Thus, the institutional arrangements facilitated and normalized relations of disempathy in the unit.

### **Disciplinary Empathy**

In addition to disempathy, both RNs and CNAs also used disciplinary empathy to elicit patients’ “compliance” and facilitate their work, while also maintaining rapport with patients. Disciplinary empathy included practices to bring patients’ behavior in line with doctors’ orders, hospital policies, or with nurses’ tasks more generally. It enabled them to

control the flow of tasks and maintain dominance in the interaction while eliciting compliance. In other words, empathy “greased the wheels” of nurses’ efficient accomplishing of tasks. Nurses could use disciplinary empathy instead of disempathy when patients were considered “difficult” or had “illegitimate demands,” in order to accomplish necessary tasks. Disciplinary empathy helped nurses to prevent falling behind schedule and mitigating the emotional labor involved in caring.

This pattern was a response to the organization of hospital work – if the nurses did not use empathy to discipline patients, they faced the threat of sanctions, since they would fall behind schedule, or patients would report them. Therefore, disciplinary empathy was institutionalized. It was built into nurses’ daily care work, and was commonplace.

The following conversation highlights how one CNA, Shaniqua, disciplined a patient while providing emotional support to facilitate it. Shaniqua and I were sitting with a patient whom she described as “confused” from a stroke. Her job as a “sitter” was to keep the patient from falling, and she came “down to his level” by using his first name, in order to keep the patient safe:

Shaniqua explains that she helps to care for this patient by “connecting” with him.

I ask her how she “connects” with this patient and she tells me that she uses his first name. He kept getting out of bed, which posed a fall risk. But he wouldn’t respond to her requests that he not get out of bed without her help. But then when he tried to get out of bed and walk to the bathroom, she used his first name and told him, “Henry, you can’t go to the bathroom. Get back in bed.”

He responded differently that time, she explains. There was some kind of recognition in his expression, and he said “oh, ok Margo.”

Now this CNA’s name is Shaniqua, not Margo. Margo is the name of his wife, she tells me. So he got back in bed, thinking that his wife was with him, telling him to do so.

Shaniqua describes that she “came down to his level” by using his first name, instead of his last name. Curiously, she mentions that she didn’t use his first name when the RN was in the room.

I ask why and she explains that management wants the staff to use the patients’ last names. She points out that some of the Filipino nurses call older patients “Mama.”

We talk more about how she makes patients feel comfortable and how it helps. She tells me how one patient opened up to her about a domestic violence situation she was in, which had led her to overdose on pain medication. The patient was afraid to tell the nurses. Shaniqua had the time to connect with this patient when she was “sitting” for her.

Shaniqua’s use of empathy provided emotional support through *having heart*—she oriented to the patient’s personal experience and individualized her care. But it also disciplined the patient; she constituted him as an agent of her will. *Having heart* enabled her to accomplish her medical task, keeping the patient from falling. Thus, this illustrates

how nurses used empathy to discipline patients by connecting with them and providing emotional support.

Hospital power structures facilitated nurses' use of empathy to discipline patients, yet these same power structures could also constrain it as well. Since nurses needed patients to comply with certain procedures in a timely way and since higher-status patients could complain to the administration if nurses did not empathize with them, nurses used empathy in order to get patients to follow their directions. Nurses sometimes used empathy to discipline patients for their own safety, as seen in this vignette. Furthermore, the hierarchy within the hospital power structures enabled the CNA in this vignette to connect with the patient in ways that the RNs couldn't. "Sitting" was a lower-status task that only CNAs did – RN's never "sat" with patients. Shaniqua could "come down to [the patient's] level" because she was a CNA, and "sitting" sometimes gave CNAs more time and energy to *have heart*. Yet the hospital policy of not using patients' first names constrained this CNA's ability to empathize with the patient, so she disregarded the policy. Even though she observed that RNs regularly broke the "last name only" policy, she was wary of using this patient's first name in front of her bosses.<sup>54</sup>

This next example of an RN's use of disciplinary empathy highlights a general pattern in how nurses used empathy to discipline patients. This RN used empathy in order to maintain a relation of power with the patient – to subordinate his wishes and experiences to her agenda. In this interaction, Bonita, RN, focused on her bundle of medication tasks without much attention to Mr. Haines' cues:

Bonita comes into the room of an older male patient. It is dinner time and a tray of mostly untouched food sits in front of the patient, who is sitting in a chair and talking on the telephone. Bonita is holding an inhaler and standing several feet in front of the patient, with the tray dividing them. She waits while he talks on the phone. She looks bored. After a couple minutes, he hangs up the phone and says "he had triple bypass."

Bonita replies, "oh?? Who's that?"

"My brother in law...triple bypass... That's nothing. I had four of them!" He chuckles.

Bonita replies, "you had four. Yeah..." Her tone is not very enthusiastic and she sounds distracted. Her attention is on some things in her hands. It looks like medicine.

He says, "I had four."

She continues, "you had one more than he did." Still seems distracted from the conversation.

"Yeah," he adds.

"MR. LANE!" She barks loudly and sharply, like a drill sergeant, getting his attention as she hands him an inhaler. "FOUR! Four puffs, OK? OK?!"

*I find it odd that she uses this tone of voice, as she already had his attention. It's a rough break from the conversation they were having, though it didn't seem like*

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<sup>54</sup> Sometimes connecting and *having heart* also violated the group's own informal codes. The most common pattern was RNs reprimanding CNAs for spending *too much time* with patients.

*she was really into it anyhow...*

“I hope so,” he replies wryly, and begins puffing on the inhaler.

“That tastes a little bit different,” he says.

She replies, “I’m going to give you something to rinse your mouth with, OK?”

She looks around for the item.

As she looks, Mr. Lane jokes, “a fire hose?!” with an easy laugh.

She is easily within earshot, but seems not to hear. Instead of responding to his joke, she says, “wait, let me get a sputum....one second.” She leaves the room.

Bonita’s attention was on her doctors’ orders. She could have responded to his joking but her focus was on her long list of tasks, including locating a sputum bag for him to spit into. This vignette illustrates how disciplinary empathy involves the RN setting the tone and controlling the flow of the interaction, while still maintaining some rapport with the patient. Clearly, this RN empathized in order to facilitate her tasks. Note how she used what I call “tag” questions, such as “OK?”. For example, “FOUR! Four puffs, OK? OK?!” and “I’m going to give you something to rinse your mouth with, OK?” Tag questions facilitated compliance because they brought patients’ attention to the nurse’s task at hand and they gave patients a sense of control in the interaction. Nurses used them often when practicing disciplinary empathy.

### **How Nurses Used “Don’t Baby Them!” to Rationalize their Practices**

More was not always better when it came to caring for patients. The following conversation illustrates a belief that was quite popular among the nurses— providing too much care could actually *harm* patients:

Angela, RN, says: “It’s like, if I can wipe my own butt and someone’s trying to wipe it for me, like ‘no thanks,’ that’s embarrassing, I’d rather wipe my own butt if I can...but some people are like that. ‘I can do it myself.’”

This RN expressed how too much care can harm patients’ sense of self. In the following conversation, Jenny, an LVN, acknowledged how too much care, or “babying,” can harm patients’ both psychologically and physically:

Jenny, an LVN, says, “but babying adults is treating them like kids. Giving them toys, putting barrettes in their hair. Even if I put a towel in front of them for a bib, I say, ‘can I put a towel in front of you? Is that ok?’...Otherwise you just treatin’ them like a baby. I don’t want nobody do me like that...”

I ask, “is it also like pampering them?”

“Well, you take away from them. For example, (in a really sugary, sweet voice) ‘hi Miss Johnson, how are you today?’ [patient says] ‘oh I don’t feel too...’. ‘oh you don’t feel good, well maybe you don’t feel like eating.’ You know? And then I’ve had some patients, you in an start feeding them and they’ll eat. And I’ve seen nurses doing that and I ask ‘can she eat?’ and they say ‘I don’t know.’ And you give them a spoon and watch them, and they’ll feed themselves. And you go, ‘oh god, I’ve been taking away from her. Standing there feeding her.’”

“Taking away?” I ask.

“you take away...if you don’t use it you lose it. So I’m sitting here like this, and you’re feeding me... but if you feed somebody, you taking their strength away cause you’re not allowing them to do it themselves.”

Here, Jenny is linking independence with health – dependence on the nurses was a sign of patients’ lack of health. She also constructed it as a deprivation of patients’ personhood. By babying patients, nurses were doing them a disservice. In the following conversation, Bonita, RN, articulates a framework of health based on independence:

I ask Bonita about babying patients.

“Baby patients? What do you mean? I don’t know. Like babying them makes them dependent on you. You don’t want them to be dependent on you. You want them to be self...self...you know, self supporting, because you’re trying to get them ready to go home. So you try to make them do things for themselves.”

“To be independent,” I offer.

“Yeah. Yeah. Why would you baby them. You don’t baby them.”

“You have to tell them, these things [self-sufficient behaviors] are good for you. You have to do it yourself. You have to feed yourself.”

So its never good to baby the patients?

“Oh no...cause you want them to be independent. They’re going home.”

Nurses also talked about babying patients as hindering their recovery from surgery. As Jong, CNA, explains in the following conversation, babying patients can get in the way of their recovery after surgery, since they have to move in order to get their bodies working properly:

In the break room with Jong, CNA.

She says heart patients are technically more difficult, that many CNAs cannot take care of heart patients because there is special knowledge required... She adds, “you have to get them [heart patients] moving!”

I ask what kind of emotional care she provides the heart patients.

She replies, “you can’t! If you do we will both die!”

Confused as to the meaning of this, I ask her to explain. She says she is joking, but that you have to get them moving so they will get better and get out of the hospital. You can’t be too easy on them. You don’t want them to stay here.

Besides, she adds, the heart floor is really expensive... She “talks straight” with the heart patients, telling them what they have to do and getting them to do it for themselves - bathing, walking, etc.

Emotional support posed a problem, not just for patients, but also for nurses who had to keep up with their schedules and conserve their energy: “If you do [give emotional care to the heart patients], we will both die!” Jong is calling attention to the fact that providing emotional support to patients could be very time-consuming and tiring.

Patients’ needs for emotional support could threaten nurses, particularly patients who “want to be babied.” The following conversation I had with two RNs and a CNA



illustrates this theme:

Amber, CNA, contrasts patients who are “shy” and don’t want to call for help with “some [patients who] think they are in a hotel.”

Chelsie, RN, who is also sitting at the table, says “some want to be pampered.” When I ask her to elaborate, she replies in a tone of exasperation that some are “anal.”

Franky, RN, comes in and I tell him we are discussing how some patients feel like they are a burden and some think they’re in a hotel. I ask how he tells the difference.

Chelsie rejoins, “they ask for a lot of things. They’re anal.”

Franky says, “you have to be careful, you can spend all of your time in there.” He elaborates that when he’s in there [with a patient] he asks, “do you need anything else?” so he can “do it all at once.”

Chelsie says, “especially bad are the homeless...”

I ask what she means.

She replies, “they want to be pampered.” Amber agrees.

I ask Franky how he knows when a patient wants to be pampered.

He replies, “after a few minutes with patients, you get to know them.” He says again, “you get to *know* them.”

These nurses described how certain types of patients were particularly problematic: patients who are “anal,” patients who “want to be pampered,” patients who “think they are in a hotel.” Franky’s comment “you have to be careful, you can spend all your time in there” speaks to the nurses’ limited time, and he shared a strategy he used to make the care work more efficient (“do[ing] it all at once”). Patients had more needs than the nurses could handle, so it was important for the nurses to control these needs. In this conversation, they were drawing a line between legitimate needs vs. illegitimate needs. If nurses thought of patients as “anal,” or “wanting to be pampered or babied,” it made it easier to disempathize and rationalize a lower level of care.

On the other hand, nurses could construe any patient as overly demanding or needy:

I overhear Gay, RN, telling Jasmine that one of her patients is a VIP. Then she remarks sarcastically, “everybody is a VIP.”

Jasmine says “oh yeah” in agreement.

I ask if that’s like saying that they think they’re in a hotel.

Faye nods and says, “like bending over backwards for everybody.”

Jasmine adds playfully and smiles wryly as she bows, “yes your majesty!...want some grapes?”

In this conversation, these three RNs acknowledged the power dynamics at play wherein nurses were expected to respond to patients’ every need or every request. Patients’ needs could be never-ending. Nurses felt they had to keep patients’ satisfied, according the customer service policies, and they felt subordinated at times by these policies. In this context of a system that set the patients up as bosses, *don’t baby them!* was a semiotic code that nurses could use to rationalize a lower level of effort.

Even when nurses wanted to help patients who they saw as deserving, and for whom they felt compassion; they felt there were simply just too many needs. Nurses had to set limits, as Nitta, RN, describes in the following conversation:

I ask Nitta why some patients are needy and some aren't.

"Well you know, people have different pain thresholds. And those people are low threshold, so they are in need of, you know, constant attention, or they are patients probably alone at home, so they get *here*, they seek attention....

"And here they are served, they're talked to, they're cared for, so they kind of..."

"Like how do you be caring for different patients?" I ask.

"Well, we could try to make ourselves available, but we have to set limits, to make sure they understand we have other patients, and how we wish we could sit down and give them everything that they need, but....there's limits to it, unfortunately."

One way the nurses set limits on their labor was by using the code *don't baby them*. Even when patients were seen as "deserving," as Nitta describes above, nurses could draw on this code to limit emotional support, empathy, and attention.

While *don't baby them* set limits on nurses' work, sometimes nurses practiced babying as a means to the end of facilitating patients' compliance, which they viewed as the only acceptable form of babying. In the following vignette, Lanette, a CNA, criticized what she described as nurses babying patients, while babying a patient herself to elicit compliance:

She [Lanette, CNA] says, quite loudly, "hold still Mr. Phillis! (in a voice that sounds like she is working with child who is squirming). Please!! Baby, baby please hold still for Lanetty. Please, Mr. Phillis, please hold still. Its not going to be very long (in a pleading voice). Please hold still. See, I can't get a stupid blood pressure cause you're moving! (the patient looks pretty non-responsive, but is moving his arms quite a bit). Hold still. I know it hurts."

She continues to tell me, "I like the patients here. They aren't as needy like on other units. Some of the nurses here treat them like babies. But who is going to do all this when they go home? Some of them just baby them and baby them.

It appears that this CNA is babying the patient: "please!! Baby, baby, please hold still for Lanetty." And it may seem contradictory that this CNA is saying that it's not good to baby patients while she is babying a patient, yet nurses accepted this form of babying, because it helped to reduce their labor by eliciting compliance from patients. In contrast, Lanette is critiquing the kind of babying that added "extra" tasks onto an already heavy workload.

On the one hand, nurses could gain something by babying patients because it increased compliance and patient satisfaction. Patients were often scared, and sometimes they liked to be "babied." Yet on the other hand, babying patients could be dangerous, as it could increase patients' expectations of care given, thus putting more demands on nurses' limited time and energy, as well as impeding their healing and their sense of self.

More than anything, *don't baby them!* was a powerful code that they could use to rationalize care and disempathize with patients.

### **Conclusion**

In this chapter I analyzed nurses' practices of disempathy and disciplinary empathy, and their use of *don't baby them!* to rationalize patients' needs. These processes made nurses' work more "efficient" given their imperative to stay on schedule and increased their control in interactions with patients, while sustaining the impression that they were delivering good care. This analysis illustrated how disempathy and disciplinary empathy were practices that nurses used as responses to institutional arrangements that constrained their time and energy while expecting consistently high patient satisfaction.

Disempathy, in particular, occurred with lower-status and less-powerful patients – the types of patients who were less able, less likely to complain or fill out patient satisfaction surveys, did not have family present, or were labeled "confused" or "drug seeker." Disempathy was normalized and legitimated when patients were discredited as reliable sources of knowledge about their own needs. Additionally, nurses "softened" disempathy through practices that gave patients the impression of empathy or feelings of control in interactions. Further, such practices—and the institutional arrangements in which they occurred—further devalued patients and the work of caring for them. In the next chapter I analyze processes through which patients, their families, and hospital administrators coerced nurses' empathy, which they experienced as servitude.

## Chapter Four

### Servitude and the Matrix of “Double-Agency” Subjectivities

You have to be plastic [flexible]. I’m glad she’s leaving! She is so rude! Treating us like a *servant*. I don’t want to take care of her.

-Chelsie, RN

The customer is always right...I think its wrong.

-Bonita, RN

Now my focus turns to the social processes through which patients, their families, and hospital administrators disciplined nurses by reinforcing the institutionalized coercion of nurses’ capacities for compassion and empathy.<sup>55</sup> Customer service policies, such as C.A.R.I.N.G. and A.I.D.E.T., provided institutional means for patients and their families to discipline nurses into relations that resembled “servitude.” These processes were characterized by conflict as nurses and patients both attempted to exert control through relations of domination and subordination. This chapter includes examples of the boundaries around what nurses defined as coercion and exploitation. Additionally, I illustrate how nurses’ capacities for compassion and empathy were sites for exploitation and processes of subjectivation.

I begin by analyzing structures of domination, coercion and exploitation as seen from the eyes of these nurses. This includes how hospital administration—patients—coerced nurses’ empathy and care work. Nurses experienced *servitude* when they had to empathize with “difficult” patients. I then analyze how customer service policies institutionalized this coercion, enabling patients to discipline nurses. Lastly, I illustrate how nurses’ capacities for compassion and empathy were sites of ideological interpellation that constituted *double-agency subjectivities*. These subjectivities facilitated the exploitation of nurses’ caring labor, because it linked nurses’ experiences of agency to caring which felt self-motivated and as originating in their own compassion in a way that obscured exploitation. The experience of empathy in double-agency felt especially autonomous next to the coerciveness of servitude and customer service policies.

#### Coercion to Care

Patients disciplined nurses to empathize and respond to their needs in two main ways. In the first, “difficult” patients made demands that nurses defined as illegitimate, tried to “dictate the care,” and denigrated them. In the second, patients disciplined nurses with the threat of labels, such as “doing it for the money,” which stigmatized and sanctioned nurses whom they felt were not motivated by authentic feelings to care.

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<sup>55</sup> I use Evelyn Nakano Glenn’s definition of coercion as “physical, economic, social, or moral pressure used to induce someone to do something” (2010: 6).

### “Difficult Patients”

Nurses had to care for “difficult” patients on a regular basis. They labeled patients as difficult when patients were “demanding,” “non-compliant,” or generally unpleasant. Behaviors that signified “demanding” often took the form of asking for too many things, asking too frequently, making unreasonable requests, or otherwise trying to exert more control than what nurses felt was acceptable. Boundaries around when and how patients asked for something were a theme in nurses’ experiences of frustration, coercion, and exploitation. For example:

I ask Jasmine, RN, how she likes being a nurse.

She replies, “sometimes I’m like, ‘I don’t want to be a nurse’ because patients and their families are always asking for something—even chasing after me down the hall—even though I just said five minutes ago that I would get it for them. I’d like to be a doctor. You just come in and say what you have to say then leave.”

Her comparison of nursing with doctoring highlights the power structure of *servitude* in nursing. MDs enjoyed the freedom to exercise autonomy and control with patients. This was a freedom from the responsibility to empathize and to respond to patients’ demands or needs. “Coming in, saying what you have to say, then leaving” were behaviors that signified the ease and higher status that accompanied the freedom from institutionalized expectations to care. MDs were not “servants.” Not only did they occupy a higher status, but their status carried the *privilege of disempathy*. This involved their power to control boundaries around care. They could leave when they chose and they could disagree with patients or say “no” without the threat of sanctions. In fact, the *privilege of disempathy* made saying “no” largely unnecessary, because patients and their families seldom “chased after them down the hall.”

In contrast, the risks of conflicting with patients disciplined nurses into empathizing with them, coercing nurses into recognizing patients’ feelings and their demands. For example, according to Chelsie, RN:

"People are very needy...yeah." She laughs loudly.

I ask what kinds of things they need.

She says, "sometimes they don't like their food, they want their pain medication, they have type A personality."

She talks about how you can’t disagree with difficult patients, that she “goes with the flow.”

“Go with the flow,” I repeat.

"Oh yeah. Make your day easier. Otherwise, if you don't get along...then it’s going to be bad...they want things a certain way. You don't want conflict.”

Chelsie’s experience reflects a larger theme in talk of care. When patients were “needy,” nurses used empathy to avoid conflict. In this case, Chelsie “went with the flow” and gave difficult patients more “TLC” in order to avoid conflict. Conflict involved the risk that a patient would report them to either the charge nurse, the nurse manager, or an even higher administrator.<sup>56</sup> And since gendered institutions of care shaped expectations of

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<sup>56</sup> Some of these nurses had friendship-like rapport with charge nurses and the nurse manager. Getting

nursing, “pleasing the customer” meant attending to their feelings, their desires, and their requests. For instance, Jasmine, an RN, described the lack of autonomy involved in a structure that constituted patients as “bosses”:

“This patient is very demanding,” she tells me. “She wants things placed in particular ways according to her specifications. Things like her cup...” She explains that end-of-life-care patients are more like that.

I asked her if she has to do everything patients want.

“Yeah,” she replies. “They’re the customer. They’re the boss.”

She says that the hospital wants the nurses to treat the patients like that. She sounds resigned. Apparently there is nothing she can do but perform the requested tasks.

Empathy involved recognizing this patient’s desire to have her things “placed in particular ways according to her specifications.” This highlights how apparently instrumental tasks, like moving a cup, involved empathy. And even such a menial task involved coercion. She did not feel free to disempathize, which would have involved not recognizing or responding to this patient’s requests.

To mitigate feelings of servitude, nurses subtly encouraged patients “to be nice” by defining demands as “legitimate” and “illegitimate.” They empathized and responded to legitimate requests but found ways to disempathize with and contain illegitimate requests while minimizing conflict. For example, I when asked Jasmine, “what are good patients?,” she told me this:”

Good patients are those who "don't ask you for stupid things, but only for legitimate things."

"Like what?" I ask.

"Like how to work the TV control" (this is an example of a legitimate question).

I ask her for an example of stupid things.

She tells me about a diabetic patient who kept asking for juice, even though the patient already had juice and she told the patient that her blood sugars were too high to have more, but the patient kept asking.

She tells me that she has to answer the call lights for these kinds of requests. She adds that some nurses don’t answer sometimes, thinking the requests aren't important enough to respond to, thinking it’s not necessary.

Then she says, "good patients are ones that just lie there."

Jasmine’s sentiment that “good patients are ones that just lie there” may appear callous, but it is understandable within the given structures of *servitude*. Like many of these RNs, Jasmine cared a great deal about patients, and it showed in her daily interactions with them. In fact, she may have cared too much in the eyes of some of the other RNs, who

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reported to an administrator higher than the manager was especially threatening for nurses who had personal familiarity with the manager but not with higher-ups. Getting reported to the charge nurse or manager could be more problematic for nurses who didn’t have good rapport with them.

bullied her.<sup>57</sup>

Nurses also empathized under duress of coercion in order to stay on schedule. Keeping up with their schedules depended on how compliant their patients were. Carrying out doctors' orders called for patients' compliance with them, and compliance was elusive without a good working relationship with patients. Compliance was so important that nurses sometimes defined "nice" patients in terms of compliance:

In the nurses' lounge Nitta mentions one of the patients and exclaims, "isn't she nice!?" She sounds very happy about it. I agree and then ask if it's easier to help patients who are friendly like that. She replies, "oh yeah!" with certainty, and offers, "because they're more compliant."

It's not clear whether this patient was "nice" because she was "compliant" or was "compliant" because she was "nice." Either way, good rapport facilitated compliance, and nurses used empathy to elicit compliance. In a sense, the compliance imperative gave patients leverage in the power dynamic. They disciplined nurses into empathizing with them, whether or not they used that leverage consciously, because of how the system was set up. When nurses fell behind their schedule of orders, they faced increased risks of making medical mistakes. As one RN told me, "anything happens to them [patients], you're [RNs are] responsible." The anxiety and strain of staying on schedule was a common source of stress. The imperative to elicit compliance from patients necessitated that RNs empathize even when this required an exceptional amount of emotional labor. Thus, institutional arrangements coerced these nurses to empathize.

When patients were difficult, nurses routinely used empathy to build rapport, diffuse tension, and avoid conflict. The emotional labor this required depended on the type of difficult patient. Patients who were "mean" as well as "demanding" necessitated the labor of coping with the degradation of abuse and relations of domination in addition to the emotion management required to demonstrate compassion. "Mean" patients most readily evoked talk of care as *servitude*. The presence of family members compounded the sense of coercion:

In the breakroom, Chelsie is complaining that a patient's daughter "yelled at her."

I ask if she can yell back at the patient if the patient yells at her.

She says "no! that's why we get so much verbal abuse."

Bonita adds, "yeah, patients and family abuse us. You just have to relax, take a deep breath."

I ask why they can't stand up for themselves.

Bonita feigns agreement with hospital policy, "the customer is always right," in a

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<sup>57</sup> Jasmine visited a therapist for help with the pain this caused her.

tone that belies her disagreement with it. “I think its *wrong*,” she adds emphatically.

Roxy, the ward secretary, emphatically adds, “*very wrong*.”

I ask if it’s changed.

Bonita answers, “before, the patients were more friendly.”

Chelsie adds, “and they were less sick. Maybe these kinds of patients would still be in the ICU [back then].”

Chelsie continues to relate what the patient’s daughter told her,

“ma’am you are making her blood pressure go down.”

The others are listening intently. One of them sounds indignant, “really!?”

Chelsie finally exclaims, “she yelled at me!” in a sad, hurt voice.

One of the nurses says definitively, “the daughter is mean.”

Chelsie then says that the daughter demanded she come back in three hours to check the blood sugar again.

Bonita says, “they are dictating the care.”

Chelsie continues her story. She says that “with this kind of patient you can’t say anything to them. They will flip you around and turn you in to the administration.”

Bonita adds “they will complain to the administration that we are mean.”

Chelsie, “so what I did was just say ‘ok, alright,’” in a sing song voice feigning submissiveness. “You have to be plastic [flexible]. I’m glad she’s leaving! She is so rude! Treating us like a *servant*. I don’t want to take care of her.”

Nurses’ capacities for compassion and empathy were sites of subjectivation, which occurred through institutionalized structures of feeling. On one hand, coercion was institutionalized through customer service policies, which constrained nurses’ freedom to not care even in circumstances of duress and abuse. Recall how Chelsie could not “say anything” to the patient, because the patient might “complain to the administration” that she was “mean.” This required an emotional flexibility to sustain submissiveness while recognizing patients’ feelings, an experience that resonates with Carolyn Steedman’s (1986) description of empathy in contexts of coercion:

You come to know that you are not quite yourself, but someone else: someone else has paid the price for you, and you have to pay it back. You grow small, and



quiet, and take up very little room. You take on the burden of being good, which is the burden of the capacity to know exactly how someone else is feeling (105).

Steedman's description of empathy as the "burden of being good" provides a framework for understanding subjectivation in nurses' experiences of coercion. It highlights how institutionalized relations of domination transformed their capacities to empathize into a "burden." For example, Chelsie was disciplined into "being good," and allowing the patient to dominate her, constituting Chelsie as an agent of her will. Coercion was evident in the form that the threat of sanction took; if she did not allow herself to be disciplined, she could be labeled as "mean" and reported to the administration.

Although this did not indicate a "culture of servitude" arising "out of labor relations in the home," it reflects what Ray and Qayum (2009) call "rearticulated" institutions and relations of servitude: "the institution and relations of servitude endure or are rearticulated, whether the person involved is called a 'domestic worker,' 'nanny,' 'housekeeper,' or 'babysitter'" (194). My analysis highlights the role of rearticulated servitude in patterns of care delivery, status differentiation, and the reproduction of inequality.

Servitude constrained nurses' capacities to practice empathy and to deliver care. Patients' demands occurred within a set of institutional arrangements that made caring a source of intense anxiety and guilt. RNs were responsible for patients' medical safety as well as their physical and emotional needs. Anxiety about the risks of "medical mistakes" compounded anxiety about the threat of sanctions and anxiety about building rapport with patients. These anxieties combined with guilt and attached themselves to patients' physiological statuses as well as their needs, constituting patients as symbols of those intensely unpleasant emotions. Under these circumstances, anxiety could become resentment, which required more emotional labor to manage. They had to ease these psychological tensions of anxiety, guilt, and resentment in order to do their work. Nonetheless, they still experienced physical exhaustion and empathy burnout. Note that "dictating the care" was linked with control over medical tasks in this interaction.

Tasks, especially when grounded in the presentation of clinical competency, gave RNs a basis for empowerment in interactions with patients. Although their "orders" came from higher-ranking MDs, they believed that they "knew a lot too," and they influenced how doctors wrote their orders for patients. They used the authority of doctors' orders and their own knowledge to mitigate relations of servitude. But, as the vignette above illustrates, this did not always prevent patients from taking control of the situation and making demands. Customer service policies gave patients' grounds for making demands, controlling the interaction, and expecting nurses to empathize, even when it involved medical stuff ("dictating the care").

"Good" patients didn't ask for things, and "nice" patients were compliant and "appreciative." Caring felt less like servitude when patients were "nice," "talkative," and "appreciative." For example:

In the breakroom, asks Jasmine, "is your assignment OK?"

"Yeah. Not bad today. The patients I have, they are all female in their 40s and 50s, but they're nice. Talkative. Appreciative."

“Right,” Charisse interjects knowingly.  
“It really makes the difference,” Jasmine says.  
“Yeah,” Charisse agrees.

“Appreciative” patients reciprocated nurses’ efforts through an economy of gratitude by decreasing the emotional labor it entailed. They exchanged appreciation for care. The kindness that patients “gave” to nurses helped maintain a boundary between nursing as dignified profession and nursing as servitude. “Nice” patients reduced the palpability of servitude in interactions as well. Nonetheless, nurses still experienced coercion when caring for them, because caring for “nice” patients occurred within the context of disciplinary arrangements that linked feelings of compassion with guilt, anxiety, doubt, and the burden of responsibility. RNs could feel the effect of these threats even when they were already doing more than their schedules or physiology safely permitted.

### “*Doing it for the Money*”

Nurses faced the threat of sanctions when patients sensed a lack of authentic motivation. In such cases, the impression that a nurse “didn’t care” was signified by “doing it for the money” rather than doing it out of “compassion.”<sup>58</sup> Contexts defined by “doing it for the money” constrained rapport, triggered opposition, and constituted a step in the processes leading to patients reporting them. For example, a patient, named Bethane, described how she could tell when nurses were “spiritual” or “doing it for the money:”

“The ones that are spiritual...they don’t do it like it’s rote. They’re gentle and they pat your head and they smile and reassure you with kindness that you gonna make it.”

I ask, “but not all the nurses do that kind of stuff?”

Bethane replies, “some of them come in, they are into their little shift stuff, and I immediately think, ‘I don’t like you, cause this is a *job to you.*’ And I mean, whatever you’re doing in this world, do it with *zeal*...and do it with *love*...I knew that *they* were going to help me. The ones that are rote, I knew they just did it cause the job pays good. They’ll come in and say ‘alright I’m your nurse’ (she says this in a harsh-sounding tone) and I’m thinking like, ‘no, go.’ I’d rather take my chances than have them in my room.

Bethane articulated the common sentiment that good nurses were those who did it because they “cared” and not “as a job.” Talk of good and bad nurses often framed the difference in terms of assumptions about their motivation, and constructed a dichotomy between love and money. However, more readily-observable behaviors signified these types of nurses as well. For example, Bethane described good nurses as “spiritual” and identified them by how they *felt* and behaved; they were “gentle” and “reassuring,” “kind,” and “patted her head.” She felt some form of love from them, which made

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<sup>58</sup> Viviana Zelizer (2005) provides evidence that despite people’s fear of mixing intimacy and money, we do it regularly and go to great lengths to regulate relationships between the two, “the mixture of caring and economic activity within households takes place in a context of incessant negotiation, sometimes cooperative, other times full of conflict” (165). She argues that “in negotiating the economic conditions of care, participants are also defining meaningful social relations” (207).

concrete behaviors like “patting on the head” count as care rather than patronization. In contrast, the nurses who did it “for the money” did not convey those feelings of love. “Rote” described her emotional experience of indifference or lack of compassion among nurses. “Rote” accompanied an emotional style that defined the interaction as purely instrumental, signified by their focus on “little shift stuff.”

Behaviors linked with *efficiency*—routines, instrumentalized emotional styles, and focusing on tasks—were themes in talk of nurses who “didn’t care.” For some patients, these behaviors made nurses seem like “machines.” According to Cristi, another patient, the nurses on South Heart were less like machines than those in the post-surgery recovery room downstairs:

She tells me, “they are so fast and efficient, its like a machine. Some of them are fun and joke around and stuff, but a lot of them are focused. Especially in the room after the surgery. They do everything in there. Tubes are everywhere. Wires. You have to know what you’re doing to be in there. But yeah they’re really focused. Especially down there.”

I ask how she would compare the nurses here with the ones down there.

She says they are a little “looser” up here.

“Looser?” I ask.

She explains, “I mean they’re focused and they do their job, but they’ll joke with you and they’ll talk with you. The other place is like business. Me and my friend were joking around laughing...I had two male nurses, no female nurses there, and it was like, ‘ok they’re here! Stop whatever was going on!’ Cause it would get all business-like in the room. They just did their job. They didn’t care...they’re like machines. Its just boom, boom, boom.”

In Cristi’s experience, the “joking and talking” that signified “care” contrasted with the behaviors that signified “not care:” “focused,” “fast and efficient like a machine,” “business-like,” “just did their job,” and “boom, boom, boom.” Later in the conversation Cristi described how “machine-like” nurses *felt* differently from the nurses who “cared.” In fact, nurses who “just did their job” created an emotional field of distance that prompted her to feel like she “did something wrong:”

“Like talking and joking. Not just ‘its all about business’. A lot of them, its repetitive so that’s what they do. And they lose that...their personality. They lose that. and that makes me feel uncomfortable. I’d rather them talk to me, not just keep it...they come in here and you’re just looking at the TV cause they’re just doing their little thing.”

“So its easier to trust them when they’re joking?”

“Yeah cause otherwise its like ‘what did I do?’ what did *I* do to piss her off or what did I do to put her in this mood. That’s how I feel. But I know I didn’t do anything so I just keep my mouth shut.

The behaviors that signified “just doing their job” to patients revolved around lack of personal connection and emotional fields of distance. Nurses expressed indignation at patients’ perceptions that they were just “doing it for the money,” and they didn’t like the threat of sanctions that it could involve. Nurses dealt with this problem by “bringing patients cranberry juice.” That is, they defined the boundaries around do-able care in terms of instrumental tasks. To some extent, nurses and patients found common ground in such tasks. Recall Bonita’s earlier comment, “I bring them cranberry juice and they’re satisfied.” According to Jasmine, RN, she didn’t “usually get a chance to sit down and talk with patients,” but she responded to their requests:

I’m usually very timely with everything. I’m never late. I usually do things right away. If they say they need something, water, anything, I get it right away. I don’t do anything else but get their water. So they are usually pretty satisfied with me as a nurse.

Although there was always potential that patients would hold nurses accountable to higher expectations for emotional connection, nurses found that they could define care in terms of the instrumental tasks of *basic stuff*, at least up to a point. In this sense, “instrumentalizing” care involved emphasizing the positive impact of instrumental tasks rather than the emotional fields in which they were performed. Thus, instrumentalizing care helped to satisfy patients who might critique the nurses for lacking authentic motivation, while it mitigated nurses’ emotional labor and feelings of servitude.<sup>59</sup>

As a discourse, *servitude* was organized in resistance to the coerciveness of “caring,” or having to empathize with patients when nurses felt that they should not have to empathize with them. In situations where nurses felt that they were being treated as servants, they redefined what was appropriate care. In such contexts of “unfairness,” the imperative to “really care” dissipated, freeing nurses from the guilt of not doing enough for patients. Care in these cases was disciplinary rather than empathy and emotional support. This discourse of servitude freed the nurses from the standards of care signified by authentic desire to alleviate suffering and connect emotionally (*having heart*) in those contexts.

*Servitude* anchored *basic stuff*, because it provide moral justification for defining “care” with a lower level of effort – empathy constituted through routines and emotional distance, and freedom from authentic inner motivation. Nurses used it to convey indignation at being coerced to empathize. Nurses used it to define the contexts in which nurses had to *have heart* according to the type of coercion present. It created the grounds for not having to “really care” when coercion surpassed tolerable levels. Thus, they used

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<sup>59</sup> Patients did not always “make demands” or report nurses when they “rushed,” focused on their tasks, or failed to connect with them. This was due in part to patients’ abilities to empathize with nurses, whom they observed struggling within what they construed as difficult circumstances. Interestingly, patients were sometimes cognizant of nurses’ predicaments and they tried to care for them by showing appreciation, “going without,” and altering their expectations of care. They also refrained from reporting nurses because they were afraid of the repercussions, or of receiving worse care.

*servitude* to mitigate their experiences of coercion, and to gain more control over their care work.

At the same time, they did not use *servitude* to openly oppose “difficult” patients. Even when they practiced disempathy, they had to sustain the impression of at least one form of caring in the front stage at all times. The fact that nurses used a discourse of *servitude* to morally condemn coercion—and used empathy to discipline patients, as I showed in the previous chapter—did not prevent subjectivation from also occurring through empathy. This was because the oppositional, consciousness-raising discourse of *servitude* defined its relations in terms of experiential coercion, but not in terms of the kind of exploitation that occurred through “double agency” subjectivities.

### **The Matrix of “Double-Agency” Subjectivities**

Hospital policy to care equally for all patients institutionalized nurses’ experiences of empathy and self through relations of domination. Administrators tried to standardize care through drills that enforced customer service policies. But these drills did more than try to standardize care; they attempted to discipline nurses into feeling compassion. They did this through practices that attempted to *interpellate* nurses as caring subjects. According to Louis Althusser (2001 [1971]), ideology constitutes subjects through interpellation: “all ideology hails or interpellates concrete individuals as concrete subjects, by the functioning of the category of the subject” (117). In this case, these customer service policies and their drills were ideological both in the sense of “representing the imaginary relationship of individuals to their real conditions of existence” (109) and in their constitution of nurses as subjects. However, they did not constitute a subjectivity that experienced agency as willing subjects of that ideology, *per se*. Rather, they paradoxically constituted a “double agency” subjectivity through which they experienced agency as a repudiation of that ideology, of that interpellation. This differs from the process Althusser (2001) describes: “the individual is interpellated as a (free) subject in order that he shall submit freely to the commandments of the Subject” (123).<sup>60</sup> That is, nurses formed these subjectivities in oppositional relation to customer service ideology, not outside it.

Mechanisms linked with empathy/disempathy shaped the constitution of these subjectivities. Nancy Chodorow (1999) argues that people experience meaning through innate capacities of transference, projection, introjection, and unconscious fantasy:

Insofar as we are talking about individual subjectivity, cultural meaning does not “precede” individual meaning. From the earliest infancy, meaning is emotional as well as cognitive. Creation of personal meaning and the potential for emotionally resonant experience antedates the acquisition of language (76).

Chodorow’s (1999) theory of affective meaning-making helps explain how mechanisms of empathy/disempathy rearticulate the ideological interpellation of subjects. For

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<sup>60</sup> In contrast to Louis Althusser’s (1971) theory of *interpellation* and Michel Foucault’s (1980) theory of *subjectivation*, Stanley Milgram (1975) sees people as basically autonomous until they become agents of another’s will. In a state of autonomy, he claims, we do not see ourselves as acting out the will of another whereas in a state of agency, “you see yourself as the instrument of the execution of another person’s wishes.”

example, in the following vignette, an administrator, Madeline frames Angela as a nurse who “will provide very good care.” Madeline encourages her identification with empathy and compassion through practices defined by “customer service excellence standards”:

I see an older, white woman standing at the desk. Her clothing and style look high-status. I ask Angela, RN, who she is.  
She replies that she's the "AIDET" lady.  
I ask her what that means.  
She explains, "it's this thing that the hospital made up that's supposed to help patient satisfaction. You go in there, you....AIDET stands for Acknowledge, Introduce, Duration, Education, and Time...no...Thank you. You introduce yourself. you tell them, how long you're going to be there...I'm your nurse. I'm going to take very good care of you...um... you have to say that somebody's going to be coming in every hour. make sure they have all their stuff, like their call lights. and then you thank them...so she's making sure we do it right."  
Just then Madeline comes up and asks Angela if she's ready to do it. *I sense that she isn't happy about it. she seems nervous.*  
Angela says “ok” and suggests going to her patient in 42.  
Madeline says "lets go and see how that patient's doing."  
I say maybe I can come and see if they need anything.  
I follow them into the room. On the way I ask her what she does here.  
"I am one of the Service Excellence Coordinators. I work with the staff on their AIDET and patient satisfaction. Try to make sure everything goes well."  
As we walk down the hall she turns to Angela, "you're going to remember this, right Angela?" She sounds like a school teacher testing a young child.  
"Yep" she replies confidently, but without enthusiasm.  
She knocks on the door then opens it, saying, "Hi Ms. E-, how are you?" Angela sounds sweeter, more upbeat and eager than her usual.  
The patient begins to say something but Angela doesn't really let her talk, "you remember me? Angela, from last night..."  
"I do remember..." replies the patient.  
Madeline introduces herself, "I'm Madeline and I'm rounding with Angela tonight."  
Angela says, "so, you know the drill. the whole hourly rounding. every hour we're going to be coming in checking on you...(I never hear any of them tell patients about hourly rounding)...you know I'm kind of new, two and a half years being here as a nurse...um.."  
Madeline chimes in, "but a good nurse, but a good nurse."  
Angela builds on that, "a very good nurse. And we will all take very good care of you. You've had a good experience here, right?"  
The P says quietly, "more or less," but Angela doesn't give her much time to talk, as she quickly says, "I know its not *fun* to be here...but...(again, the patient says 'more or less,' but Angela doesn't give her time) we're not too bad. right?" She chuckles... *Angela seems nervous. This whole thing feels AWKWARD!! It seems like the patient can tell this is scripted, too. She looks uncomfortable with it. As*

*Angela talks with the patient about her food and care plan, she eases into her usual informal style, which appears strikingly since and skillful in contrast with the script.*

...Looking at Madeline askance, the patient asks, "what kind of...why are you...?" Madeline says, "well. I am one of the service excellence coordinators. And I um, believe that all of our nursing staff gives very good care. But I *love* to hear it from the patients from time to time."

The patient replies flatly, "uh huh." *She seems skeptical.*

Madeline reiterates that she thinks the nurses are all excellent and that she just likes to hear it from the patients. *It sounds as if she's trying to brainwash her into thinking the nurses are all "excellent."*

As Angela writes her care plan on the wall, Madeline and the patient talk about how she's starving because she can't eat before her surgery and it was postponed a day. *Madeline's empathy sounds more genuine the longer she talks with the patient, though she continues her rhetoric of "excellence."*

By the time we leave, the patient sounds comfortable, and says, "it was a pleasure to meet you."

Madeline replies, "well, nice to meet you as well, and thank you...for allowing us to come in with you and um...Angela will be here to make sure you get *very good* care this evening."

Later I overhear Angela prepping another RN for the drill.

What Robert Merton (1968) calls the "manifest function" of such drills was to standardize care, while the "latent function" was to interpellate individuals as subjects. Ironically, this administrator's attempt to enforce "very good care" instead created an emotional field of awkward formality when informal personal connection was necessary. Note, for instance, how the patient warmed up to Madeline only after she talked with her for awhile about her experience. Despite Madeline's persistence at framing the patient's experience in terms of her "service excellence" agenda, she herself became increasingly genuine as she listened and empathized. She appeared more sincere in her attempts to empathize in the brief instances of more personalized informality which punctuated her script. As her capacity to empathize grew, so did the patient's level of comfort with the interaction, which seemed very low at the beginning. And an increase in Angela's ability to connect with this patient followed the same pattern; she built rapport through informal connection but not through formal scripts, which created emotional distance and distrust instead.

Such ideological drills and scripts did not in actuality do a very good job of enforcing standardized care, and nurses did not discipline each other into performing AIDET or adhering to other customer service policies. Quite the opposite; they gave each other autonomy over their practices of care delivery and tried to mitigate relations of subordination vis-à-vis patients. In nurses' experience, *patients* were cause for concern, because *patients* reported them. But patients did not report them for not following AIDET. In fact, nurses felt that such scripts constrained them from delivering the care that patients wanted. In their eyes, the standardization of care increased the likelihood that patients perceived nurses as insincere, as was evidenced in the interaction above. Additionally, they did not believe those policies helped with "patient satisfaction." For

instance, I asked Bonita if she thought AIDET helped with patient satisfaction, and she shook her head “no” slightly and replied, “I give them cranberry juice, they’ll be satisfied.” When I asked another RN about the patient satisfaction surveys, she told me they were “bogus.” Angela was only a bit nervous about being observed, because administrators were scary. Yet this AIDET drill was not actually a source of concern for the nurses. They went along with it and then forgot about it.

At first glance, one might think that nurses’ subjectivation only occurred through the AIDET drills and customer service policies, yet nurses’ tacit rejection of these policies ironically resulted in nurses’ further exploitation. They believed that in *not* submitting to these policies, that their style of care for patients was their own choice, out of their own compassion. This made it seem that their own empathy and compassion were not sites of coercion or exploitation when they experienced it through their “autonomous,” self-motivated desire to care – even when it was enforced by strong feelings of guilt.

Nurses knew that the hospital’s customer service policies were not in touch with what patients’ needed – and that their own empathy gave them insight to know better what their patients’ needs were, and their compassion motivated them to provide for patients. Because they had the capacity to empathize, nurses often overextended themselves to meet patients’ needs, even when they were exhausted. If they did not overextend themselves, they felt guilty, because they felt compassion and had the capacity to empathize. They could not just “turn off” their compassion. Thus, the nurses’ compassion and empathy were sites of subjectivation, through a kind of “reverse psychology,” in which nurses rejected the customer service scripts, and believed they were avoiding coercion and exploitation. This led nurses to identify these feelings as their own, while the hospital was actually extracting more labor from them through these processes.

This coercion was internalized through subjectivities. “Double-agency” subjectivities exploited nurses by facilitating their experience of agency qua empathy and compassion, the exploitation of which was made invisible because it felt autonomous and self-motivated in contradistinction to caring according to customer service policies, which they found coercive. Thus, unlike the exploitation involved in the emotional labor of “acting,” the exploitation that worked through these subjectivities did not require what Arlie Hochschild (1983) calls the “exhortation” or “imagination” that produces “deep acting.” Saba Mahmood’s (2005) critique of performativity frameworks is relevant here. In her ethnographic study of the women’s mosque movement in Cairo, she builds on poststructuralist performative models that conceptualize agency in terms of corporeal semiotics (e.g. Butler 1993):

The mosque participants do not understand the body as a sign of the self’s interiority but as a means of developing the self’s potentiality...One might say that for the mosque participants, the body is not apprehensible through its ability to function as a sign but encompasses an entire manner of being and acting in which the body serves as the developable means for its consummation. In light of this, it is important to ask whether a theory of embodied performativity that assumes a theory of linguistic signification (as necessary to its articulation) is adequate for



analyzing formulations of the body that insist on the inadequacy of the body to function as a sign (166).

Mahmood (2005) attends to how the lived experiences of the people she studies, specifically their orientation to their own bodies and emotions not as signs, but as means to piety. She challenges the argument that action expresses meaning but does not constitute “interiority” (e.g. Butler 1990). Thus, her analysis illustrates how the very premises that give reductive frameworks of performativity their explanatory power also create their limitations.

Since exploitation occurred through nurses’ experiences of agency; it did not require acting, because the feelings were already there. It did necessitate emotional labor to manage the emotional dissonance caused by experiences of agency which were linked with alienation of the very capacities that made that agency possible. Double-agency also required emotional labor, not to exhort empathy, but to reign it in. For example, the following vignette illustrates one variation of how this process unfolded. This conversation describes a common coercive and exploitative situation. It also exemplifies how high the bar was set in terms of the emotional labor required to feel like they were doing enough:

In the breakroom, Jasmine asks Mary Lu how she’s doing.

Mary Lu says that she was having a good day, “thinking, wow! I could actually get out of here on time.”

Jasmine interjects, “don’t think that cause it won’t happen!”

Mary Lu continues to relate how a patient came back from his thoracentesis at 3:10 and she had to do vital signs and call and confirm that his x-ray had been done and then his condom cath fell off and she had to settle him and pull things out from under him and she was about to leave and give her report and “all that set her back from getting out on time.” And then the patients’ family told her, “where’s his hearing aids!? He doesn’t have his hearing aids!”

At this point she says, “they probably think I’m callous but I told them, ‘don’t worry, we’re going to find them!’”

She relates how she went to give her report and told the on-coming nurse to help with it, “cause I’m not going to go looking all over for his hearing aids at 3:25!” (her shift ends at 3pm at which point she is supposed to “give report” to the nurses on the next shift who are taking her patients). She ends her story by pointing out that she only had five minutes to give report by then, “so of course I was late getting out anyway.”

I say, “technically you’re off duty at that time, right?”

She explains that she was but they expect her to drop everything, because they [the family] are panicking, and just start helping them.

She continues, “but I knew there wasn’t enough time to give my report, so I said ‘we’re [the other nurses are] going to help you find them. We’re going to do everything we can, I just have to go talk to somebody,’ and I went and gave my report.”

We see Mary Lu struggle with her compassion, empathy, and sense of responsibility for this patient's needs. She was trying to "turn off" her compassion, but was concerned that the patient's family would think she was "callous" for not finding the hearing aids despite the fact that she was off the clock. Her concern about giving off an impression of "callousness" was linked to her subjectivity, to empathy and compassion. She recognized their anxiety—"the patient and his family were "panicking"—and she wanted to help them. But she also wanted to not want to help. She tried to reduce her empathy and compassion when her shift ended. She used a "discourse of unfairness" to try to convince herself that she was not "callous" for doing so. This highlights the tension between compassion and coercion that was part of nurses' daily experiences.

## Conclusion

Nurses were disciplined into empathizing with the "demands" of "difficult" patients by customer service policies. They faced the threat of external sanctions if they did not appear to care. Avoiding external and internal sanctions required emotional labor. They used *basic stuff* and a discourse of "unfairness," anchored by a code of *servitude*, to control the emotional labor and level of effort required to avoid sanctions.

However, they also faced the threat of internal sanctions, because the "external" institutional arrangements also worked through their capacities for compassion, the desire to alleviate suffering. These nurses *wanted* to help alleviate patients' suffering. But their compassion made them vulnerable to coercion, exploitation, guilt, and overextending themselves. Paradoxically, emotional fields through which they experienced an "autonomous" subjectivities were also the emotional fields through which they experienced a colonization of their compassion. Recognizing patients' feelings and needs made it hard to not feel compassion for them, especially when patients were "nice." Whether patients were "nice" or "difficult," nurses systematically faced a catch-22: face exploitation and overextend themselves when they *had heart* or face the threat of disciplinary sanctions for not demonstrating compassion when they delivered care as *basic stuff*.

Nurses' talk of *servitude*—along with *don't baby them!*, *basic stuff*, and *medical safety*—provided cultural material that nurses used to mitigate the coercion and degradation of customer service policies by establishing contexts for acceptable types of care. These relations involved power dynamics between themselves and patients: patients who "dictated the care and disciplined nurses into empathizing. The behaviors that signified servitude—abuse, dictating the care, illegitimate demands—were also interactional patterns constituted through power relations. Nurses' borderwork between their prestige as professionals and their degradation as servants involved using—and embodying—codes in order to establish contexts in which the behaviors that mitigated servitude also counted as "really caring." In the next chapter, I turn to the key role that delegating tasks associated with servitude to their assistants played in RNs' occupational power and status.

## Chapter Five

### Professionalizing Borderwork

It's totally different now; the nurse is working like a doctor.

-Bonita, senior RN

In this chapter, I analyze how RNs asserted professional power by distancing themselves from institutionalized constraints on their capacities to define and regulate their practices of empathy. This involved delegating abject tasks associated with servitude to their assistants and normalizing practices of disempathy, which resembled the *detached concern* notorious in the behavioral patterns of MDs and in medical culture.

The way RNs delegated tasks linked with servitude to CNAs caused a lot of conflict between these two groups, which impacted care delivery. Although the official division of labor assigned less-valued tasks, such as feeding, positioning, and cleaning patients, to CNAs, these RNs also used informal practices to delegate a bundle of tasks—and the relations of domination and subordination in which they were embedded—linked with servitude. There were two categories of tasks linked with servitude. In the first category were tasks that tended to put the nurse in a position of subordination with patients. That is, subordination was a part of the task itself. Nurses used terms like “servant,” “waitress,” and “slave” to describe how this felt. It included things like responding to patients’ call lights and having to empathize with “demanding” or “mean” patients or get them the things they requested. In the second category, tasks which were already devalued, such as feeding patients, became linked with more strongly with servitude when the nurse performed them in contexts of little control or autonomy, when the tasks involved devalued patients, and when RNs delegated the work through rituals of subordination. Rituals of subordination also exacerbated the feeling—and relations—of servitude that were already linked to tasks in the first category.

RNs’ did not always delegate through rituals of subordination, but these rituals were intertwined with these informal practices. The first category of rituals occurred in face-to-face interactions in which the RN used body language and voice to enact dominance when delegating. The second category occurred through indirect practices, such as “passing by a [patient’s] room with a [call] light on but not going in, thinking that the CNA can do it,” “regulating when CNAs could take their breaks/share the break room with them,” “assigning CNAs more than the legal number of patients,” and “not showing up to help CNAs bath patients,” that maintained relations of domination/subordination, sometimes in the process of delegating tasks. The CNAs’ descriptions of these rituals evoked indignance, anger, and frustration. They described how RNs’ “bossed them around,” “over-used” them, “assumed that you’re not very intelligent if you’re a CNA,” “refused to work as a team,” “delegated everything,” “refused to do some types of care,” “OK. I need this and I need that” [in a stuck-up, demanding and needy voice], “looking at every move I make,” and delegated tasks that they should do and then sat at the nurses’ station hanging out and talking.

In my direct observations I noted that sometimes RNs resembled MDs in how they communicated with the CNAs—displaying dominance through an authoritative tone and through disempathy. In other words, my observations confirmed what the CNAs told me; the RNs used rituals to maintain relations of domination and subordination. To this outsider’s perspective, it was clear who the boss was in such interactions. What was not so readily apparent was that backstage, these RNs used their occupational power to bend the rules, coercing these CNAs to do the most detested work and to do more of it. In the process of distancing themselves from the work of servitude—work that gave them the least control over their practices of empathy—they reproduced relations of servitude between themselves and the CNAs.

These processes were professional borderwork. Rituals of subordination were demonstrations of the kind of disempathy that MDs use to assert their dominance and which protect MDs from exploitation, coercion, and emotional labor vis-a-vis their patients. On some level, these RNs recognized that MDs’ power to control their own practices of empathy, particularly the institutionalized legitimacy of regularly disempathizing with patients, protected MDs from the kind of coercion and exploitation that made all but the most highly-valued tasks in RNs’ work—those linked with assessing patients’ medical needs and statuses—potential loci of servitude.<sup>61</sup> These nurses complained about subordination vis-à-vis patients much more than they complained about subordination to doctors.

Delegating servitude eased RNs’ experiences of coercion, exploitation, and subordination because it positioned CNAs as buffers between themselves and the problematic tasks, interactions, and relationships of servitude, but it did not ease the institutionalized constraints on their power to legitimately regulate their own practices of empathy and to practice disempathy. It did, however, enable them to practice disempathy with their CNAs. In this sense, they became less like servants and more like doctors.<sup>62</sup>

In the following analysis, I elaborate on these points and deepen this discussion. In the first section, I illustrate processes of valuing and devaluing particular tasks, explain why some were more valued than others, and servitude’s place in these processes. In the second section, I analyze the processes and systems through which RNs delegated less-valued tasks, particularly the bundle of tasks most closely linked with servitude, to CNAs. In the third section, I discuss how professional power was constructed through RNs’ use of rituals of subordination and the delegation of servitude in borderwork between themselves and CNAs.

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<sup>61</sup> It was the tasks linked with assessing patients’ medical needs and statuses rather than *patient safety* that were so highly valued, because some of the tasks linked with safety were devalued, such as sitting” for patients who were “fall risks.” That is, some tasks that kept patients safe were also linked with servitude. Also, RNs valued emotional support ideologically, but their valuations of the tasks it involved were situational, for example, they depended on the legitimacy of patients’ needs and the amount of time/energy available in the moment to provide emotional support.

<sup>62</sup> However, this did not give them any leverage vis-à-vis the MDs they worked with. This is because their power to delegate servitude was anchored in their medical knowledge. While their medical knowledge gave them a basis to claim what resembled professional power in relation to their assistants, who did not have that kind of medical training, it provided no basis to claim it in relation to the physicians. Nurses’ knowledge of medicine, combined with knowledge of their patients, gave them grounds for influencing physicians and asserting power informally, but not officially.

## Servitude and the Devaluation of Tasks

In my analysis, the status of a task, say as “dirty” or “prestigious,” resulted from processes that linked the concrete action involved in the task to the structure of social relations and system of meanings in which it occurred. Nurses interpreted and applied systems of meaning in ways that determined which tasks signified low or high status. Some tasks, such as “wiping butts,” could be said to be naturally “dirty.” The assumption of naturalness was sometimes evident in how nurses talked about these tasks. For example, when I asked one CNA, “what is the difference between the [RN and CNA] nursing positions?” she replied, “CNAs do the dirty work. That’s me. We wipe people’s butts. LVNs and RNs give the medicine.” This CNA links the two occupational roles with a very-high and a very-low status task to which they are linked, and the source of the status of each is taken-for-granted. But sometimes nurses challenged the link between this natural order and how the tasks were valued. In the conversation below, a monitor technician named Patti describes how RNs did not like “cleaning” and “feeding” patients:

She says she sees a lot of nurses doing it for the money. A lot of students go into nursing, but they don’t want to do it. She says it’s not an easy job to do. And people suffer because they don’t get the proper care. Because nursing is patient care, it’s not just giving medications. You have to clean them and stuff... “like they’re a baby.”

“What’s good care?” I ask.

She replies, “you cant just give them medication. Before they go to bed, you have to clean them. You cannot just pop a pill in their mouth and leave them there. Sometimes you have to feed them....cause usually nurses just give medication and stuff [but] they have to do all kinds of stuff and a lot of them don’t want to do that [less-valued tasks].”

“Cleaning” and “feeding” are naturalized as women’s work by society-wide ideological systems of meaning (DeVault 1991). Although Patti did not challenge the *naturalization* of these tasks, she challenged the *devaluation* of them – for example, when she contrasted “just popping a pill in their mouth” with “cleaning” and “feeding patients.” She framed giving medications, which was usually a high-status task, in a way that minimized its prestige: “just popping a pill in their mouth.” This illustrates how a high-status task (medications) can be devalued when the RN doing it is devalued based on her lack of care. Patti does not question the naturalness of “cleaning” and “feeding” patients “like they’re a baby” but she disrupts the dominant order of valuation. Administering medications could be devalued when it was linked with unethical practices, such as rushing. Importantly, her challenge to the status hierarchy of work also disciplined RNs, at least in speech, into doing the devalued tasks, which she links to “care,” by reproducing the dichotomy between medicine and caring (“nursing is patient care, it’s not just giving medications”). In the process of destabilizing the naturalness of medicine as higher status and feminized care as lower, she reproduced this dichotomy and the ideological gendered system of meaning.

However, ostensibly naturally-dirty work, such as wiping patients’ butts, was not always the most devalued. Having to empathize with “demanding” patients upon their

request was the least-valued task, and the one most closely associated with servitude. There were also other tasks linked to servitude. These constituted a *bundle of tasks* linked with meanings, feelings, and relations of servitude. This bundle of tasks included those which gave nurses relatively-less control over their practice of empathy. On the other hand, the most highly-valued bundle of tasks—those linked with assessing patients’ medical needs and statuses—included those tasks which gave nurses relative control over their practices of empathy.

The structural context in which tasks were performed determined nurses’ autonomy and control over the practice of empathy. Responding to patients’ requests contrasted with tasks initiated by CNAs themselves, not in the sense that the tasks themselves were of a fundamentally different type, but in the structure and meaning of the work. CNAs had relatively more autonomy over work that was not initiated by patients’ requests or delegated by RNs. The result was that the same task, such as giving a patient blankets or helping her use the toilet, was less denigrating when it occurred through autonomy, when the CNA initiated it rather than responding to a patient’s or RN’s request. In this second bundle of tasks—those initiated by CNAs—their relative autonomy helped to raise the status of the work because mitigated the denigration linked to servitude. For instance, in the following conversation, Roxy, a unit secretary who once worked as a CNA, describes practices that elevated some of these tasks through autonomy, thereby reducing the low-status, subservient dimension of them:

I ask Roxy what’s included in the official job description for CNA.

She explains, “you get report from your nurse. Go into your patient’s room. Introduce yourself, that’s courtesy. You tell them what you want to do, don’t just touch the patients. Give your patient some water. If it’s somebody that needs water, you serve them water. Make sure when you come out of every room you wash your hands. And working PM it’s always dinner time. If they need to sit up, you sit them up. Some people like to wash their hands before dinner. If the patient needs a commode you made sure it is on the side of the bed. Every two hours you go around.

Bonita, RN, interjects, “every hour.”

Roxy continues, “every hour now, for everybody. Especially CNAs. They call you most for those things, so if you go around they won’t be calling you... For patients who really need help [i.e. not ‘walkie-talkies’], you make sure you turn them. Cleaning their mouth, combing their hair, cleaning their nose. It makes them feel better so you do those little little things. After taking vital signs, if you note any fever, you report it to the nurse immediately.”

There was a hint of dignity in Roxy’s voice as she told me about how a CNA’s work should be carried out. A sense of autonomy and control over the work were linked with the skill in doing it well. For example, she said “introduce yourself, that’s courtesy” and “tell them what you want to do, don’t just touch the patients” were protocols of customer service (the Acknowledge and Introduce of AIDET), but she uses them as practices to craft a subjectivity of dignity linked with personalized care. Exercising autonomy over

tasks, such as “serving” water, framed them as proper practice of care rather than as subservience. Note how she highlighted patients’ individual needs after first naming the routine task: “Give your patient some water. If it’s somebody that needs water, you serve them water.” Similarly, she noted that some patients liked to wash their hands before eating, thus reframing this type of request from a “demand” to evidence that she knew how to care because she knew her patients’ habits and needs.

After describing these practices Roxy explained the importance of checking on patients regularly in the context of reducing the number of calls they made: “[round] every hour...especially CNAs. They call you most for those things, so if you go around, they won’t be calling you.” Hourly rounding was a practice she used to increase her autonomy, shifting the structure of the work to be more CNA-initiated. This decreased the feeling of servitude that accompanied responding to patients’ demands and transformed otherwise devalued tasks into meaningful practices through which she constructed a subjectivity based on the dignity of caring. However, there was often not enough time for CNAs to preempt patients’ requests by rounding. For example, when CNAs were assigned “only” the official maximum of eight patients, they had just seven and a half minutes per patient for “hourly rounding.” And this figure did not include time responding to patients’ and RNs’ calls. Furthermore, they were sometimes assigned more than eight patients and they found it difficult to refuse tasks that RNs delegated to them, which I discuss in the following section.

CNAs experienced moments of autonomy vis-à-vis hospital policy and vis-à-vis RNs, particularly when they were doing tasks that did not involve empathy or interacting with either RNs or patients. For example, Frida, CNA, described she carried out the policy on changing bed sheets daily:

Some things are just more important than others at certain times. For example, we are supposed to change the sheets everyday. If a person tells me they don’t want it done and it doesn’t look dirty anyway, and it looks like brand-new white, clean then I just won’t do it. But if it’s soiled and has all kind of food and crumbs and sweat and feces and everything then I’m like I have to change that right now. So there are things we’re supposed to do that might not be necessary but they want you to make sure it gets done.

This illustrates a type of autonomy created because RNs managed CNAs’ work in order to reduce their own workload. This is why RNs did not always enforce official policies. In this example, policy called for changing the bed sheets, even though they were not soiled. For this CNA, autonomy meant she could exercise judgment regarding when and how to do these types of tasks. This reduced her workload, freeing time for more important things, such as checking vital signs and insulin levels on schedule, helping patients use the toilet before making a mess in the bed, and responding to RNs’ requests. Like the RNs, CNAs faced time constraints caused by a lack of organizational resources. The autonomy that CNAs enjoyed reflects a division of labor organized around RNs’ attempts at regulating their own workload in addition to the borderwork around their professional status, and sometimes RNs did not want to micro-manage CNAs. These patterns highlight the role that delegating tasks linked with servitude played in RNs attempts to distance themselves from servitude in order to construct and assert

professional power based on their capacity to regulate their practices of empathy and disempathize with CNAs.

### **How RNs Delegated the Bundle of Tasks Linked with Servitude**

RNs' delegation of tasks to CNAs occurred through an official division of labor as well as through informal practices. However, the boundaries between the official division of labor and these informal practices were constituted through micro-politics and highly-contested. The Charge Nurse could assign CNAs up to eight patients according to California law. These were usually patients who required more assistance than the "walkie-talkies," which was what nurses called patients who could walk and talk on their own. CNAs helped their assigned patients with "assisted daily living" (ADL). ADL tasks included eating, bathing, moving/positioning, using the toilet, and various things patients requested/needed that did not involve medications. Although CNAs could not dispense medications or answer patients' questions about them, they regularly checked patients' vital signs and insulin levels. In both the official division of labor, the work of CNAs was organized around a bundle of devalued tasks that were not all linked with servitude. In contrast, in the unofficial division of labor that RNs instituted through implicit legitimation of informal practices, involved more tasks linked with servitude as well as the construction of relations of servitude between RNs and CNAs. These processes were apparent in the unit's "call light system," which they used to respond to—and regulate—patients' requests.

#### *The Call Light System*

My first exposure to the official division of labor between CNAs and RNs occurred while working at the desk answering patients' "call lights." When patients called for help, a designated phone rang and displayed the patient's room number. The unit secretary, who sat to my immediate right, taught me the basic protocol: say "how may I help you?," find out what the patient needs, and reply with, "OK. I'll tell your nurse."<sup>63</sup> There was a large white board on the wall about fifteen feet behind me that listed all the beds on the unit along with the name of the patient in each bed, the patient's RN, and the patient's CNA. I turned around to see who the patient's nurse was and then used the same phone to deliver the message. If the patient did not have a CNA, I called the patient's RN. My calls went to nurses' voice-activated "Voceras," which hung around their necks. They answered these calls over half the time, and I often had to leave a message. Sometimes the patient called back, because the nurse did not respond to the call. In such an event, I was to call the CNA or RN again. When I was not answering call lights, the unit secretary did so, unless the patient census was low enough for the hospital to not staff a secretary, in which case the nurses answered them.

But whether I was to call the RN or the CNA depended on the type of request and task involved. This alerted me to what was included in CNAs' official tasks. For example, a unit clerk named Debby instructed me:

I ask Debby, one of the unit clerks, "when I'm answering call lights, when do I tell the RN and when do I tell the CNA?"

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<sup>63</sup> This system was confirmed by all of the nurses whom I asked about it.



She replies, “tell the CNA if it’s stuff like “blankets, bathroom, water, most stuff. Most stuff, tell the CNA. Versus meds, changing dressings, if the patient wants to call the doctor...tell the RN. Only if the patient has a CNA assigned. If not, if it’s primary nursing, then call the RN.”

As this clerk explained it, I was to call the RN with anything related to medications; while nearly everything else (“most stuff”) went to the CNA. This called my attention to the division of labor in how a particular bundle of tasks was delegated to CNAs. This bundle of tasks was “responding to patients’ requests,” both when patients called the desk and when patients made requests directly to CNAs in person. As I illustrated in previous chapters, patients’ requests could easily seem like burdensome “demands” to RNs, because they threatened to derail their schedules, because limited resources and too many high-pressure tasks made requests seem “illegitimate,” and because responding to requests felt like servitude. Delegating patients’ requests for help to CNAs, whether directly (e.g. “asking” them to do it) or indirectly (e.g. rushing, ignoring a call light) exacerbated these sentiments and further devalued this bundle of tasks. This was true even when CNAs felt that such “demands” were “legitimate needs,” such as emotional support. For example, Frida, CNA, was telling me about her experience of poor teamwork with RNs. She talked about how the organization of her work prevented her from “talking” with patients:

We do have a lot of patients. You can’t give that much special attention to each patient. For example there was a patient who was trying to talk to me on this ward and I was getting irritated... ‘cause I have to go, I have things to do. I gotta do certain things by certain times and I’m like ‘I don’t have time to hear this’ and then I feel a little bad...but you know what, the hospital is not designed for people to have people to talk to. To make connections. So that’s not part of the job description. It’s not built in [to the organization of their work], so that’s why there’s not any time for it.

Frida felt “a little bad” at getting irritated when a patient tried to talk with her, and she identified how the organization of her work constrained “connecting” with patients, making it “not a part of the job description.” This illustrates the emotional labor involved in face-to-face interactions with patients, whether or not those interactions were initiated by a call. Talking with patients required emotional labor, especially when the nurse was pressed for time. But *not talking* with patients also required emotional labor. Importantly, face-to-face interactions with patients increased this labor no matter how the nurse handled it. Patients’ calls for help usually exposed the nurses who answered them to more work than the singular, original request directly involved. Put another way, ostensibly singular requests usually involved other requests as well as emotional labor and time, making them anything but singular. The fact that any interaction with a patient could threaten a nurse’s limited time and energy made managing the number of interactions—and control over how they occurred—central. This in turn devalued the task of responding to call lights as well as the actual work patients’ requests involved.

Thus, the official division of labor, in which RNs delegated patients’ requests to CNAs, increased CNAs’ emotional labor, but this labor itself was only one of the causes

of the delegation and devaluation of these tasks.<sup>64</sup> In addition to the labor involved, responding to patients' "demands" was associated with servitude. In addition to the emotional labor and time it entailed, this "patient-initiated" bundle of tasks was devalued because it shifted control over the work away from nurses and towards patients. When patients called nurses, they were "dictating the care" to some extent, telling them what to do. Thus, this division of labor—and the corresponding system for answering call lights—reiterated CNAs' subordination because it delegated to them tasks linked with servitude. This relation of servitude was exacerbated because CNAs did not exercise the authority to refuse patients' requests. Yet RNs mitigated the problem of servitude by not responding to calls (when there was no CNA assigned or available) until they were ready to do so or by refusing to respond at all if they thought the requests were illegitimate. As one RN described it:

She tells me about a diabetic patient who kept asking for juice, even though the patient already had juice and she told the patient that her blood sugars were too high to have more, but the patient kept asking. And she has to answer the call lights for these kinds of requests. She adds that some nurses don't answer sometimes, thinking the requests aren't important enough to respond to, thinking it's not necessary.

What counted as worthy of a response was largely up to individual RNs, within certain constraints. They strove to regulate their accessibility to patients and their responses to patients' "demands" through the call light system. However, when they refused to answer such calls, they faced another problem: patients called repeatedly, making more work for the unit clerk or whoever was answering call lights. The clerk, whose job demanded a great deal of multitasking, was never happy when patients called repeatedly, nor was anybody else for that matter. Even if patients' requests were legitimate on some level, calling too often stigmatized them, making them seem less legitimate unless they were what the staff considered truly urgent.

Although the clerk could play "gate keeper" to some extent, answering then ignoring a patient's request, this was not common practice. There was little she could do to screen out calls when patients called too often, at least not without threat of sanctions.<sup>65</sup> After all, a patient who was "able" and "alert" enough to call could potentially report them for neglect. Since the majority of calls related to requests that

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<sup>64</sup> This was in addition to the physical labor such tasks involved, which could be considerable, especially when positioning or transferring patients. While the physical dimensions of these tasks were officially recognized and documented, the emotional labor that physical tasks required was not, similar to what Timothy Diamond (1992) found in skilled nursing facilities.

<sup>65</sup> Policy dictated that patients had access to the hand-held control that they used to call the desk. Nurses took this seriously, it seemed. It was on their check list of priorities when they checked on patients in "hourly rounding" and they made sure patients had it before they left the room otherwise. But sometimes patients did not have access to it. Also sometimes it came unplugged from the wall. Usually when it came unplugged it automatically notified the desk with a beep and wouldn't stop until someone fixed it. However, sometimes the device didn't work even though it was in the wall. Although this could theoretically be one way to limit calls, I never observed the staff intentionally limit patients' access in these ways.

CNAs could answer—as opposed to calls regarding medications, which were usually for pain meds—delegating this work to them was the most effective method for regulating the boundaries between RNs and these less-valued, problematic tasks.

CNAs could not so easily refuse these tasks. Refusing a patients' request was tantamount to refusing to help an RN, because the work devolved to her in such a scenario. This situation reflects how CNAs experienced relations of subordination/domination vis-à-vis patients and RNs whereas RNs experienced relations of subordination/domination vis-à-vis patients and MDs.<sup>66</sup> In contrast, when RNs refused to answer—or ignored—call lights, the work fell onto CNAs. Edith, RN, candidly described this in terms of “the increasing use of CNAs”:

So we never used to have CNAs. I think having them made a lot of people cut down on their responsibilities. Now you will have an RN pass by a room where a light was on and they wouldn't answer it because the CNA is going to go. So now its like if the patient needs something, “oh, let's send the CNA.” I think in some ways it's a really good thing. It depends on who your CNA is because some CNAs are excellent. You don't need to tell them anything, they just do it. And then you have some people [CNAs] where I feel, ‘I'd rather just do it myself,’ kind of feeling.

The fact that tasks were delegated does not mean that they were always completed. The delegation of tasks shifted the burden of the responsibility for it off the RNs and onto the CNAs. Whether or not it was actually done mattered in some situations more than others. For example, non-completion of a task was a problem when the task came back around to the RN (e.g. patients calling the desk repeatedly until the clerk asks the RN to do it).

### **Rituals of Racialized Subordination**

RNs enacted rituals of disempathy that reiterated CNAs' subordination. These occurred indirectly, by constructing a symbolic order of subordination, and directly, in face-to-face interactions in which tone of voice and body language communicated RNs' dominance over CNAs and their power to disempathize with them. CNAs expressed frustration that RNs delegated too much and did so in ways that were denigrating. Race usually surfaced when CNAs talked about being “bossed around” or “over-worked.” A majority of the CNAs—and the two LVNs—were Black. One was Tibetan, one was White, and one was Filipina. Interestingly, all them except the Filipina CNA mentioned race, always linking it with rituals of subordination and the delegation of servitude.

These were racialized rituals of power and professionalizing borderwork, because they maintained the boundaries around RNs' claims to professional status, which was based on their capacity to exert control over their practices of empathy and disempathy. They constructed these capacities in relation to the constraints on CNAs' capacities to control their own practices of empathy, which were constraints that the RNs themselves created. These RNs used the rituals to maintain and legitimate the structure of their

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<sup>66</sup> RNs' subordination to MDs was qualitatively different, because MDs were not present in a supervisory position in the unit like the nursing staff. Although they gave orders to RNs, they also relied on RNs for information about their patients, so RNs exercised a degree of practical power, if not authority, over MDs.

professional identities and they asserted their professional power through these rituals, in effect “doing professionalism.”

In the next section, I analyze how RNs created a symbolic order that reiterated CNAs subordination. Then, in the last section I analyze how RNs used rituals in face-to-face interaction to assert their professional power and maintain the boundaries around it.

### *The Symbolic Order of the Division of Labor*

The boundaries around CNAs’ autonomy, occupational status, the valuation of tasks were visible in how RNs delegated and enforced the rules. RNs exercised enough power in the daily operation of the unit to define the rules. The line between official hospital policy and unofficial practices was fuzzy, and informal practices had a quasi-official, if contested, quality. For example, it was well-known that these RNs regularly assigned CNAs more than eight patients, as Roxy describes:

This is the unit where you get more patients [than is legal]; 14 to whatever patients. They [CNAs] have a contract with the state. They can’t get more than 8. They [RNs] are technically violating that rule. They know it is against this contract. That’s why some people [CNAs] are very reluctant to come here. It’s one of many reasons why people don’t like coming here.

The informal practice of assigning CNAs more than the legal maximum number of patients was a ritual of subordination that also directly shaped the division of labor. As Roxy’s statement illustrates, these RNs were somewhat notorious, even among people who worked in other units, for delegating too much to CNAs. According to one CNA, who usually worked in an Oncology Unit but sometimes “floated” to Heart South, “...because as CNAs we don’t give medications, so they [RNs] feel we can have more patients.” In fact, an aversion to working with these RNs was common among the CNAs and LVNs with whom I spoke. Based on my conversations with nurses and staff on other units, I determined that the behaviors they cited—delegating too much, air of superiority, “bossing,” and disempathy—seemed to be extreme versions of behaviors among RNs in other units. Interestingly, the same sets of practices among physicians would be seen as normal, as acceptable, as a sign of professional competency, or would not be seen at all. What can account for this group’s relatively severe treatment of CNAs?

The specialized technical medical training required to work in the cardiology unit provided the status-prestige basis for RNs’ to perform professional power by reproducing relations of servitude with their assistants, but it did not determine it. One way to look at this case is that it is a more pronounced version of a pattern that scholars have observed in nursing more generally. For instance, Susan Reverby (1987) identified these conflicted dynamics in the history of nursing as far back as the 1890s:

Hospitals continued to search for a cheaper way to staff their nursing services and still make sure all the technical and bureaucratic tasks were performed. In turn, the nursing leadership continued to argue that nursing students should not be forced to provide hospital nursing services, unless in was part of their supervised clinical training, and that graduates, as “professional” nurses, should not have to perform the hospital’s dirtiest tasks. The obvious solution, for both the hospital’s

management needs and nursing's professional quest, was to increase the number of lower-paid subsidiary nursing and housekeeping personnel...Nursing was finally forced by circumstances to take a position on the critical question of how to control and use another level of nursing personnel: the issue it had struggled over since the 1890s. Many graduate nurses [the equivalent of today's RNs] continued to protest against any acceptance of such workers, still fearful they would take away their jobs both inside and outside the hospitals. After much protest and debate, in 1936 the joint boards of the national nursing associations finally approved licensure for such workers (193).

Reverby thus provides evidence that the process Everett Hughes (1951) described as professionalization through the delegation of less-valued bundles of tasks has been a feature of nursing for quite some time. As Reverby states, "nursing's "success" in its quest for greater control was built on the limiting and degrading of others" (195). In a sense, this historical trend highlights the fundamental significance of relations of servitude to nursing's occupational subordination. In this case, we should expect to see various instantiations of servitude, normalized as legitimate occupational relations, throughout nursing practice environments. Thus, the cultural dimensions of servitude in the hospital division of labor likely vary with the situated contours of nursing contexts.<sup>67</sup>

Another possible factor in this group's harsh treatment of CNAs worth mentioning is that some of them could have reproduced a "culture of servitude." In their analysis of "cultures of servitude," Ray and Qayum (2009) state:

In one sense, empirically, children in servant-employing households, whether they are masters or servants, learn class and gender domination and inequality at home and practice them in the world (199).

Heart South's core group included several RNs who had been working together for a long time. A majority of them were of Filipina ancestry, as was the Patient Care Coordinator (head charge nurse) for the unit and the Nurse Manager, who also oversaw a neighboring unit. However, there was at least one non-Filipina (Korean) nurse in the core group as well. Additionally, there were a number of younger non-Filipina nurses (Chinese, White, Korean) who were not in the core group, but were regular members of the unit team and experienced solidarity with the more senior core members. The unit clerks were Black and the monitor technicians were Filipino.

The solidarity of the core group and their rapport with the Nurse Manager almost certainly increased their occupational power in the hospital, enabling them to legitimate—to some extent—practices usually defined as acceptable among physicians but not nurses. These were practices linked to relations and cultures of servitude. These RNs expressed frustration, indignation, and anger with dimensions of their work that felt like servitude, as I discussed in the previous chapter. Yet they reproduced those very relations with their assistants. The explanation that they reproduced a Filipina culture of servitude accounts for this; they were familiar with and even comfortable in the dominant position, but being in the subordinate position was something they strove very hard to

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<sup>67</sup> This is analogous to Ray's and Qayum's (2009) finding that cultures of servitude in India "are shaped by particular historical configurations of structural economic/gender/spatial...inequalities" (188).

avoid. In any case, it could be said that the crucial factor in their claim to professional power was having CNAs to whom they could pass their own subordination, thereby creating the structures and cultures that were essential for the practices that signaled professional status.

In my direct observations, I noted an interesting pattern among the CNAs: they all tended to rush, except for Amber, who was the only Filipina CNA. When RNs rushed, they indirectly delegated work to CNAs. Thus, rushing symbolized RNs' dominance and reiterated CNAs' subordination. But when CNAs rushed, it was in response to RNs' delegation of labor, and it signified their subordination. This is why CNAs were sanctioned for "spending too much time" with their patients. For example, Lanette described how she had been reprimanded for staying too long with patients:

The Filipinos told some girl I know who works here. She said, 'they're talking about you behind your back, saying you spend too much time with your patients. And you talk too long, and you talk too much and you talk too loud.' I said 'well, I'm here for them [the patients]. I'm not here for the employees. And I can't go to patients' rooms and go "what do you need?"' (in a whisper). They need to hear me speak... And I went to the supervisor and she said, 'well you do stay kind of a long time with patients and sometimes I wonder if it slows you down.' I said, 'Trace, it does not slow me down. Because when I get out of here [out of a patient's room] I don't want to be called like 10 or 20 times.

Usually, nurses worried about not spending enough time with their patients. They experienced guilt and psychological tension because of it. So it is significant that this CNA was sanctioned for spending too *much* time with patients. Like all of the other CNAs except for Amber, Lanette often rushed, not in the sense that she didn't spend time with patients, but in the sense that she embodied a nervous emotional style. This contrasted with the relaxed ease with which Amber moved about the unit. Whereas the other CNAs appeared to be behind enemy lines, Amber seemed right at home. Fong, a Tibetan-American CNA expressed frustration and indignation at being told when she could take her dinner break. She told me that the Filipina RNs did this in order to exclude her from sitting at the table with them when they were eating. This was doubly frustrating for her, because the temporal slot in question would have been a better time for her.

#### *Face-to-face Rituals of Subordination*

My direct observations confirmed what these CNAs told me; RNs used ritualized practices in interactions to signify their dominance and CNAs' subordination. They also used these rituals to legitimate those relations by imitating physician's displays of power. Indeed, I observed that sometimes RNs resembled MDs in how they communicated with the CNAs—displaying dominance through an authoritative tone and disempathy. For example, when I asked Frida about what affects co-worker support, she replied:

They (RNs) usually assume that you're not very intelligent if you're a CNA at least that's what it seems like by the way they treat you. I reported one of the nurses, because she kept repeating things to me and I told her that I heard her. It's

the way they say it, “OK, I NEED THIS AND I NEED THAT” [in a stuck-up, demanding-yet-needy tone]. I don’t like that. I’ll report it. Or instead of communicating with me [about a conflict regarding division of labor] they’ll go to the charge nurse and then the charge nurse will call me.

The tone of voice Frida describes (stuck-up, demanding) and attitude (assume you’re not intelligent) were common themes among these CNAs. These qualities characterized RNs’ practices as they delegated tasks to CNAs. Another dimension of these rituals was RNs’ refusal to work as a team. For instance, Jane, an LVN, compared working with CNAs to working with RNs:

“If I go to a CNA and I want her to help me out.... Lets work together, I’ll get the bed, you make the bath.” She talks about trying to work with the RNs. She relates an anecdote: Frida’s doing all the blood pressures, all the temperatures, and bowel movements on twelve patients, and she goes in to check a patient’s blood sugar and the patient’s RN says, “can you pack so and so’s things?”

Frida continues, “and I’m like, ‘hey, wait a minute. I’m doing the blood sugars right now.’ And the RN’s like, ‘oh. Well, when you finish...’ and I’m thinking ‘oh, my god, that burns me up!’ Are you [the RN] too good to go in their and pack your patient’s clothes? Go pack up the stuff and take it instead of sitting at the nurses’ station going bada bum bada blahm, budam budam baladum [imitating Filipina nurses speaking Tagalog]. Go pack those clothes up and take them over there while you’re waiting for me!’

I asked her who was officially responsible for “packing up the patient’s clothes.” She replied that “the RN was responsible for her patient, but that she can delegate. But you don’t delegate *everything!*” It was common to hear CNAs imitate Filipina RNs speaking Tagalog. I interpreted this racist practice as an expression of frustration and as a sign of their belief that race mattered in their experiences of subjugation, coercion, and exploitation. These CNAs, even the White one, identified race with these rituals of subordination and the delegation of servitude. For some of them, the experience of was also linked with the types of subjugation that define Black Americans’ experiences of racism. For example, Jane also told me that RNs “delegate too much work” to her and then “sit at the nurses’ station” talking in Tagalog, which she imitated with some nonsensical words in a cadence that slightly resembled it. She connected the race of the RNs to her race and to her experience of slavery:

She tells me that she experienced slavery in Texas when she was a little girl and that she doesn’t want to do that anymore. A truck would come pick her up before sunrise and she would have to stand because it was so packed full of people, all standing. And it would take them out to the cotton fields and she would pick cotton until the sun went down and get paid a dollar for a hundred pounds. She adds, “my mom said, “if you want to pee, pee in the bag. If you want to spit, spit in the bag. If you want to shit, shit in the bag.’ Anything to get it heavier.”

Jane's experience racialized subjugation is especially significant due to the fact that the RNs whom she primarily identifies it with were not White, but Filipina. Furthermore, most of them were first generation immigrants. Her description of working as an LVN on this unit as comparable to her experience of slavery highlights the function of subjugation in facilitating exploitation through coercion. This exploitation involved both emotional, mental, and physical labor. For example, the following conversation is part of a longer vignette in which Sasha, a CNA, and Franky, an RN, argued over how Franky called Sasha from down the hall—interrupting her work—in order to enlist her help in moving a patient, which Sasha thought he could do without her:

I see Sasha down the hall passing meal trays and I ask her about what happened with Franky. She lets out a sigh “ohhh!” And explains that he wanted her to stop taking blood sugars and help him, but that she needed to take the blood sugars before patients' dinner arrived.

Then she adds, ‘they think that because we’re CNAs that we do all the labor around here, like they’re too good to put a little sweat into it. But I’m taking blood sugars. I feel that that’s more important right now...Franky could have helped the patient by himself, too. He got an attitude because they love to put all the hard labor on the CNAs. Even when they are busy we drop what we are doing to make the RNs load a little lighter.

When RNs delegated the physical labor of positioning or moving patients they also delegated the emotional labor involved in managing their practices of empathy with patients, as well as the experience of servitude. When the delegation of this work involved rituals of subordination, as it did in this example, it reiterated relations of servitude, making the cut even deeper. Relations of domination presented a barrier to teamwork and good communication between nurses (and between nurses and other occupational groups). Note how Franky called Sasha from down the hall, interrupting her work, which devalued what she was doing, “taking blood sugars,” which was an official task for CNAs. This is why the “hard labor” that made these CNAs the “foundation of labor in the hospital” included the emotional labor required to cope with relations of servitude, in addition to the hard labor of “moving patients.”

## **Conclusion**

In this chapter, I analyzed how RNs asserted professional power by delegating tasks linked with servitude to their assistants. I showed that the most devalued bundle of tasks consisted of those that gave nurses relatively less control over their practices of empathy and disempathy and required considerable emotional labor. This was the bundle of tasks linked to servitude. These devalued tasks contrasted with the most prestigious tasks—assessing patients medical needs and statuses—which gave nurses much control over their practices of empathy and disempathy, required less emotional labor, and accrued value from their association with the professional status of physicians. They used rituals of subordination to maintain the racialized structure of servitude that subordinated CNAs to RNs. Backstage rituals established a symbolic order of domination and subordination while face-to-face rituals of disempathy and control



enacted RNs professional power in interactions. This chapter thus illustrates how RNs claim to professional power was predicated on their capacities to pass servitude on to CNAs and to maintain the boundaries around the two groups.

# Chapter Six

## Conclusion

My research leads to the formulation of a general theory of empathy/disempathy as a mechanism that contributes to inequality. I have argued that structures of domination, coercion, and exploitation devalue and constrain care throughout the social formation. Institutions that order these power relations are organized through affective structures—and their corresponding ideologies and subjectivities—that link status differentiation to empathy/disempathy. Mechanisms of empathy/disempathy rearticulate the ideological interpellation of subjects by shaping “subject-centric” perceptions of power and determining the processes through which people produce and use culture to rationalize it. On one hand, hegemonic structures of feeling constrain capacities to care and facilitate *subjectivities of disempathy*. These subjectivities refract experiences of agency through disempathy, power, and status. On the other hand, another category of subjectivity, which I call *double-agency*, constructs experiences of agency through capacities for empathy and estrangement from those very capacities. Consequently, processes of empathy/disempathy function as a mechanism in the social reproduction of inequality.

This conclusion begins with a summary of my findings. Second, I provide an in-depth discussion of my argument and supporting evidence. Lastly, I discuss the ramifications of my findings for the social organization of healthcare, and nursing in particular.

### Summary of Findings

The RNs’ I studied asserted professional power and claimed higher status by delegating less-desirable bundles of tasks, such as the emotionally-laborious tasks of empathizing with patients under conditions of coercion and exploitation, and others tasks associated with servitude, to their assistants. Distancing themselves from these tasks and delegating them to CNAs mitigated the coercion and exploitation of their emotional labor. Furthermore, delegating tasks to CNAs through rituals of subordination reiterated the devalued nature of the work. Asserting their power to legitimately disempathize with patients went hand-in-hand with the disempathy that animated their rituals of subordination. These displays of dominance reinforced RNs’ higher-status, linking their occupational power to their ability to regulate their practices of empathy and disempathy, which was key in challenging their own subordination to hospital administration, doctors, and patients. However, it also pushed the boundaries around how much game they could run on the institutions of subordination and on their assistants before the threat of sanctions interfered.

The RNs used culture, in the form of semiotic codes and the practices associated with those codes, to mitigate the threat of sanctions. They used *basic stuff* to signal “caring” with routinized forms of emotional support that required a lower level of effort than the empathy of *having heart*. At the same time, they situationally talked of *having heart*, thereby claiming the moral virtue linked with more intensive practices of empathy and compassion. Additionally, they used *basic stuff* to claim the authority of “working

like doctors.” They accomplished this interactively through displays of disempathy resembling that of MDs and defining good care the presentation of clinical competency through what Catherine Theodosious (2008) identifies as “instrumental emotional labor.” These uses of culture exerted a force towards the normalization of their practices. While this countered institutionalized forces, it did not prevent CNAs from wielding a discourse of care-as-*having heart* as an ideological weapon against RNs’ similar to what Carolina Apesoa-Varano (2014) found in her study of hospital occupational groups.

Thus, these RNs reshuffled their less-desirable bundles of tasks, but not in the way Everett Hughes (1951) predicted. They neither stopped identifying with the moral virtue of *having heart* nor delegated empathy to another group of workers who then became the new “nurse,” as Hughes theorized. Although they delegated less-desirable tasks—namely those that involved the coercion and exploitation of empathy—to their assistants, they could not ultimately delegate away the institutionalized “task” of empathizing when the lines between agency and servility blurred, making them indistinguishable.

Thus, delegation further devalued and constrained care while the disempathy through which it occurred exacerbated racial and class divisions between the two groups. The delegation of care was constituted in a structure of feelings that facilitated RN’s and CNAs’ rationalizations of patients’ needs as well as RNs’ rationalizations of their dominance over CNAs. This was particularly significant, because RNs reproduced relations of domination and subordination with their CNAs even as they decried how their own subordination to other groups caused coercion and exploitation of their emotional labor and organized to challenge it politically. This analysis therefore provides empirical evidence, and of the micro-processes in particular, for Glenn’s (2000) observation that the delegation of care to people of lower status further devalues the work and the people doing it.

### **Empathy/Disempathy and the Structure of Social Reproduction**

Mechanisms of empathy/disempathy create a structure of feelings and a subjectivity through which individuals experience agency in terms of status, power and disempathy. This enables people to use culture to rationalize inequality. Without capacities for empathy, people operate on assumptions about others that are informed by cultures of power, enabling the dehumanization and domination of them. It constructs relations of domination in everyday interactions, and normalizes them. Power structures reward these everyday practices of disempathy, because the institutionalized power to disempathize is linked with higher social status.

Therefore, affective structures organized around empathy/disempathy contribute to inequality as the embodied, experiential nexus that mediates cultures of domination and their everyday practices. Vectors of domination in multiple spheres work through empathy/disempathy, differing in form and content, but not in fundamental structure. The RNs’ I studied challenged the relations of servitude that subordinated them to hospital administration, patients, and MDs, and coerced and exploited their capacities to empathize. Everyday micro-politics on the floor gave them a degree of power to shape the given reality about which practices signified acceptable forms of care. However, structures of disempathy animated a subjectivity that conflated the positive experience of agency with disempathy, power, and occupational status.

These subjectivities facilitated RNs' rationalization and normalization of power, both experientially and symbolically.<sup>68</sup> In constraining empathy, subjectivation through the experiential hegemony of disempathy also constrained their ability use reflexivity to recognize and transform their institutionalized domination of CNAs. Rather, disempathy facilitated the rationalization of power in care delivery and in the division of labor.

This dissertation has shown the following processes central to this structure of social reproduction:

- 1) Processes that naturalize the feminization of caring also normalize the institutionalized coercion and exploitation of care work and the systems of domination/and subordination built up around them;
- 2) the structural coercion and exploitation of empathy create social relations of servitude;
- 3) bundles of tasks which occur within relations of servitude are defined as less-desirable;
- 4) work that involves servitude is constructed as less-desirable and of lower occupational status;
- 5) servitude—and the coercion and exploitation of empathy that it entails—inflects status hierarchies with an experiential affective structure;<sup>69</sup>
- 6) the institutionalized power to disempathize structures occupational status groups, or classes, thus constituting and defining, analytically, classes in terms of their relationship to empathy/disempathy: higher status is linked with the legitimized power to disempathize;
- 7) as a social mechanism, empathy/disempathy enables and reproduces a class structure in which the relative dominance of a given group is refracted through subjectivities of disempathy;
- 8) subjectivities of disempathy form through institutionalized affective structures;
- 9) these subjectivities enable people to create and use culture to rationalize/normalize their own dominance and privilege vis-a-vis subordinated groups, even when the privileged challenge their own subordination to others;
- 10) empathy may transform relations of domination while disempathy reproduces them;
- 11) empathy is an essential component of care, as it produces the necessary dialogical knowledge and relationships for caring labor;
- 12) the cultural, cognitive, and emotional skills of empathy also facilitate compassion and the translation of compassion into caring practices and social relations;

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<sup>68</sup> In Michel Foucault's concept, "subjectivation," power relations constitute the conditions of possibility for the development of self, awareness, and "agency." Power creates subjects who reproduce—and transform—relations of domination through action experienced as their own will (1980). In his framework, there is no "self" that exists prior to the constituting power of discursive formations. There are only "subjects" constituted through relations of domination and *discursive formations*. As *subjects* we enact those relations through discourse, believing that we act through a pre-discursive autonomy unless we sense external constraint. Thus he argues that such "autonomy" is illusory; the "self" that acts is constituted through "discursive formations."

<sup>69</sup> This corroborates what Ray and Qayum (2009) found in their study of cultures of servitude.

12) relations of domination, exploitation, and coercion constrain people's capacities to empathize and care;

As Evelyn Nakano Glenn (2000) argues, when disadvantaged people are paid to do care work, it tends to further devalue care and those doing it. To the extent that care work is devalued, she argues, fewer people want to do it, which further deteriorates the working conditions and status of labor, increasing strain on those who do it. She concludes that “the devaluing of caring contributes to the marginalization, exploitation, and dependency of care givers” (Glenn 2000: 84). My findings support Glenn's claims, empirically with data on micro-processes, about the causal linkage between the cultural and institutionalized devaluation of care and the material relations of coercion and exploitation in which it occurs. Distancing themselves from devalued dimensions of care was integral in these RNs' claims to professional status. Yet delegating tasks linked with the coercion and exploitation of empathy to CNAs further devalued caring and exacerbated divisions between the groups.

This research calls attention to an important pattern of social reproduction: challenging relations of domination in one vector tends to reproduce or intensify relations of domination in another.<sup>70</sup> This is caused by another, key, factor in reproductive processes—multiple, intersecting lines of power structure individuals' experiences of self and society through membership in both dominating and subordinating groups in ways that naturalize and normalize domination, as it flows from the privileged and powerful to the less-powerful—itself as an everyday fact of life, something taken-for-granted, as if it were “human nature.”<sup>71</sup>

The mechanism that people use to protect themselves from emotionally-damaging experiences, namely, the “adaptive unconscious” (Wilson 2002), also facilitates the creation and use of culture to rationalize/normalize power and inequality. And disempathy facilitates the rationalization mechanism of reproduction. Looking at the problem of social reproduction in terms of empathy/disempathy highlights the nexus of affect, cognition, and culture. In some limited way, cognition and affect are like vessels holding meanings and feelings. But they are more interesting, analytically, as processes that determine patterns of meaning and feeling. Subjectivation structures the patterns in how these cognitive and affective processes shape meaning making and behavior. Since subjectivities may be more or less capable of empathy, the social determinants of subjectivities of empathy—and subjectivities of disempathy—matter. Relations of domination, coercion and exploitation produce affective structures and subjectivities of disempathy. Disempathy facilitates individuals' use of culture to rationalize inequality. This is about how particular types of subjectivities shape meaning making and behavior.

This cultural logic of social reproduction is organized around patterns in the use of culture, which are linked with the structure of the structures of given subjectivities.<sup>72</sup> Variations in the empathy-structure of subjectivities shape patterns in how people use

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<sup>70</sup> For instance, Dawne Moon (2004) found that “in seeking to create church as a transcendent haven from politics, members inadvertently reasserted the (political) hierarchies that structured daily life” (230).

<sup>71</sup> What Georg Lukács (1971 [1968]) describes as “reification.”

<sup>72</sup> This is loosely analogous to a distinction Ann Swidler (2003) makes about culture being more than its content. She analyzes how people use that content rather than the content itself. Similarly, I analyze how the structure of our cognitive and affective capacities shapes how we put them to use and how they shape the social formation.

culture in ways that either intensify or soften relations of domination, because empathy plays a key role in whether—and how—people use culture to creatively rationalize inequality. The precise type, category, or structure of empathy-subjectivities depends on a confluence of factors, such as the form that domination, coercion, and exploitation, how those relations are legitimated, normalized, and naturalized, if at all, cultural-historical context.

The point is that disempathy plays a role in social reproduction by enabling people to paradoxically rationalize and challenge relations of domination, normalizing their own privilege while challenging their perceived subordination. Each particular system of power relations, and their nodes of intersection, has its own cultural material (assumptions, narratives, ideologies, etc), which people use to rationalize its existence and their own existence, as well as its institutions. Structures of empathy/disempathy criss-cross these systems, constituting affective structures in which people experience agency-constitutive-disempathy, power, and status. These subjectivities are marked, as an analytical category, by limited capacities to empathize in both the purely-affective (resonance) dimension and the affective-cognitive-semiotic (affective imagining) dimension. And these subjectivities facilitate the rationalization of inequality.

Each particular system of power relations—e.g. race, class, gender, and ability—has its own cultural material, such as assumptions, narratives, ideologies, rituals, structures of feeling, etc., which people use to rationalize the existence of power and their own existence in relation to it. Reproduction of these systems depends on the hegemony of disempathy in the social formation, and therefore on the devaluation of care. The affective structure of reproduction operates by linking how individuals use cultural material in each system with capacities for—and practices of—empathy/disempathy. These practices reproduce divisions between groups, because empathy is a condition of possibility for getting to know a person and building solidarity. Furthermore, empathy facilitates, while disempathy constrains, people’s everyday practices of debunking ideologies.

Care a key site for the reproduction of interlocking systems of race, class, gender, and ability. As Joan Tronto (1995) argues:

Virtually every political debate in the United States comes down, sooner or later, to a desert claim that grows out of the "work ethic": that people are entitled to what they have because they "earned it." The care ethic posits a very different set of standards for desert: people are entitled to what they need because they need it; people are entitled to care because they are part of ongoing relations of care (146).

This is a call to value an ethic of care that is linked with our universal human condition of interdependency, which itself arises from our fundamental, given needs and capacities for care.<sup>73</sup> Such an ethic of care in political debate is, in a sense, the ideological counterpart to experiential structures of empathy when it comes to social transformation.

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<sup>73</sup> Garland-Thomson (2002) argues that “disability itself demands that human interdependence and the universal need for assistance be figured into our dialogues about rights and subjectivity” (17). Building on themes found in Nancy Fraser’s (1995) work, which articulates the gendered logic of capitalist welfare states, Evelyn Nakano Glenn (2000) argues that care is devalued because social citizenship is defined

However powerful are the politics of consciousness, debunking the ideologies of the power systems does not address the affective structures and subjectivities that also animate these systems.<sup>74</sup> Linking empathy with value, status, and power—in daily practices, in the institutionalization of affective structures, and in the embodiment of subjectivities—promises synergistic counter-hegemony. It facilitates the deconstructive debunking of the ideologies that normalize, legitimize, and enable inequality. It is a counter-veiling *force*, and in the literal sense of the emotional energy it provides, to rationalization. Lastly, empathetic social institutions constitute subjectivities in which people experience agency, “power” and “status” through equality, cooperation and care. This is the kind of power that Thich Nhat Hanh (2007) observes as the power of “nonself” and “nondiscrimination:”

Nonself doesn’t mean that you don’t exist; it means you are not a completely separate entity. A lot of our suffering is born from the discrimination between self and others and our notion of a separate self (26).

In the final analysis, then, processes of empathy/disempathy are key mechanisms that contribute both to inequality and to the transformation of it.

### **Implications for Nursing and Health Care**

My research illustrates that the social reproduction of inequality in health care is linked to shifting semiotic systems of “care.” As Ann Swidler’s (2001) work suggests, when behaviors that signify the underlying point of a semiotic system shift far enough away from the original behaviors, the underlying “point” may shift as well:

There can be social debates about the codes that signal various traits or properties so that the content of a semiotic system can shift, while its underlying “point”—what it seeks to convey—remains pretty much constant...In some cases, institutional orders may remain stable while the semiotic codes in terms of which they operate shift. In other cases, a semiotic code may be adapted to convey new meanings, linking it to a different institutional order than the one in which it originally made sense (206).<sup>75</sup>

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according to myths about independent, productive workers rather than in terms of relations, responsibilities, and rights of care. Heidi Hartmann (1981) also theorizes how ideologies normalize the feminization and denigration of individuals’ need for care.

<sup>74</sup> For example, Paul Willis (1977) argues for the key role of ideology in how working-class kids reproduced their own subordination through their resistance to domination. He explains their failure to overcome “limitations” and to “penetrate” ideologies in terms of a lack of consciousness. However, this framework cannot explain how/why they reproduced relations of domination through racism and sexism and the role this played in their reproduction of their own subordination. What’s missing is a theory of how mechanisms of empathy/disempathy rearticulated their interpellation through the rationalization of their power linked to racial and gender privilege.

<sup>75</sup> The underlying point of the semiotic system I studied was “care” while the content of the system included the various behaviors and conceptions of care signified by semiotic codes, such as *having heart* and *basic stuff*, and their related practices.

To the extent that the practices that signify valued types of care are defined by instrumentalized conceptions of patients' needs—and technical “skills”—without empathy, to what extent has the system's content shifted enough that the underlying point is no longer “care” in the actual sense of the word? To what extent have the institutions themselves changed? Instead of the “reshuffling” of care and the redesignation of “nurse,” that Everett Hughes (1951) predicted, nurses may fundamentally redefine what counts as care more in terms of *basic stuff*. In such a scenario, patients' emotions—and the need for empathy in medicine—become more abjected as they are shuffled around the interstices of the institutionalized division of labor.<sup>76</sup>

My research speaks to the contemporary debate among nurses and scholars regarding the identity of the nursing profession. One of the points of debate concerns the extent to which nurses should claim the *emotional* dimensions versus the *technical* dimensions of medical work for their professional identities. On one hand is the argument that the popular imaginary of MDs as the brains of cure and RNs as the hearts of care is an ideology that obscures the technical medical knowledge involved in nursing. Accordingly, the path to professional power and status involves identifying with their technical medical work and distancing themselves from their emotional labor. This is the trend we see in status differentiation among RNs (higher status linked with technical intensity, such as ICU nursing).<sup>77</sup>

Yet, both the ideology that naturalizes caring in nursing, and nurses' attempts to challenge it by asserting professional status based on technical work as skilled/valued and care work as unskilled/less-valued reproduces inequality and further devalues empathy and caring as “unskilled” work. As Evelyn Nakano Glenn (1992) observes:

Comparable worth accepts the validity of a job hierarchy and differential pay based on ‘real’ differences in skills and responsibility. Thus for example, it attacks the differential between nurses and pharmacists but leaves intact the differential between nurses and nurses' aides. Yet the division between ‘skilled’ and ‘unskilled’ jobs is exactly where the racial division typically falls.<sup>78</sup>

As Glenn argues, the reproduction of racial inequality intersects with mechanisms of class inequality.<sup>79</sup> Of particular significance is that status differentiation based on definitions of caring as unskilled/less-valued reproduces the ideological false dichotomies—instrumental/emotional, emotional/physical, and technical/emotional—in health care, and in the social formation more generally. That is, status differentiation based on the dichotomization of emotional/technical dimensions of care work operates by

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<sup>76</sup> I apply Anne McClintock's (1995) conceptualization of “abjection,” to highlight how, despite nurses' management of patients' emotional needs, which included minimizing and marginalizing them, they could not completely distance themselves from them in their daily practices.

<sup>77</sup> Pam Smith (1992) found this pattern of status differentiation in how student nurses valued their clinical stints on various units.

<sup>78</sup> Glenn, Evelyn Nakano. 1992. “From Servitude to Service Work: Historical Continuities in the Racial Division of Paid Reproductive Labor.” p. 72.

<sup>79</sup> Monique Taylor's (2002) analysis illustrates how the disconnect between dominant culture and the realities of “constrained economic and political opportunities” is a mechanism in the construction of race (177).



animating those ideological dichotomies. And those ideologies reinforce the normalcy of naturalized, devalued caring. This reifies the structure of class status as it is linked to the institutionalized freedom to not care.

The political debates and occupational tensions regarding the substance of nursing's professional identity reflect the centrality of care, particularly, empathy/disempathy as a mechanism of inequality. Conflict between nurses and other occupational groups also reflect the centrality of nurses' power to exert authority over their practices of empathy in their claims to professional power and status. My analysis of the social processes I observed on the unit floor highlights the limitations inherent in asserting professional power based on the dichotomy between emotional and technical dimensions of medical work, and the relative devaluation of empathy.

Instead, professionalization based on the non-duality of emotional and technical dimensions of medical work—and the valuation of empathy's key role—might enable nurses to exert control over their labor, to mitigate coercion and exploitation, transform power relations, and meet patients' needs for care while transforming rather than reproducing inequality.<sup>80</sup>

Despite the apparently-antiquated status of empathy in contemporary nursing politics, I suggest that the institutionalized power to define and regulate their practices of empathy—and to shape the structures and conditions of their work so they reflect the value of care—is an important factor in nurses' professional status. Moving beyond the false dichotomy of care/medicine and valuing empathy's fundamental role in the social construction of health and well-being may be a path to increasing professional power vis-à-vis administrators, physicians, and insurance companies.

Finally, nursing's professional claim to empathy, rooted in how care constitutes health and well-being, could prompt an increase in the value of caring more generally. That is, professional power—based on the non-duality of empathy/medicine and the institutionalized valuation of clinical empathy—could enable nurses to set standards for the practices of other practitioners, such as physicians, and for insurance companies, and hospital administration, as well. In such a scenario, nurses play a key role in transforming the fundamental structures of health care in this country.

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<sup>80</sup> This is not in opposition to knowledge of medications etc. Quite the opposite; professionalization based on the non-duality of empathy and technical work would give nurses more authority over how to apply medical treatment as well, because empathy plays a constitutive role in the application of technical work.

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