

Altering Care: Gifts and Emotion in Nursing Practice within a Czech Nursing Home

Rosie Read

Introduction

The past fifteen years have seen enormous transformation to structures of social security in central and Eastern Europe. The universal frameworks for the provision of healthcare, employment, housing, education, and so on established by the socialist governments of the region in the post-war period have been substantially privatised, abolished or otherwise re-organised since 1989. The socio-economic and cultural impacts of these wide scale changes continue to be researched and debated. Ethnographic research has shown that these transformations have generated new forms of economic vulnerability and marginalisation (Einhorn 1993, Humphrey 1995, Bridger *et al* 1996, Pine 1998, Haney, 1999, Kovács and Váradi 2000, Hellum 2001, Kideckel 2002, Nazpary 2002). In some cases alternative networks of material support that existed under socialism have been strengthened (Szalai 2000, Pine 2002, Nash 2003, Kaneff 2002). As this work reveals, changing forms and sources of support are as much cultural and ideological as they are economic. In this chapter I focus on ideas about care and caring obligations as an area in which the ideological and the economic are inextricably entangled. For just as the guarantee of social security was the key to a socialist modernity which claimed to 'care' for all its citizens, so the 'post' socialist restructuring of social security raises questions about the changing ways in which 'care' is conceived of and practiced in the everyday. In particular, it prompts consideration of the processes by which

caring practices and obligations come to be associated with, or disconnected from, the state.

The chapter examines the caring labour of nurses in a Czech nursing home for the elderly. It focuses on the shifting meanings and practices of this form of care, along with its relationship to reforms to the health care system in the post-1989 era. Nurses' daily labour embodied distinctions between idioms of care associated predominantly with the state (on the one hand) and kinship (on the other). However in recent years the decentralization of the health care system in the Czech Republic has helped unsettle the previously taken for granted boundary between state care and kin care in nursing practice. In the nursing home I consider, nurses were increasingly expected to perform as part of their work the emotional forms of care normatively associated with kin relations. I aim to explore why some nurses felt that their control over their own labour was weakened as a result, and to unravel the ways in which ideas and practices of patient care became increasingly fraught. The concept of emotional labour, originally formulated by Arlie Hochschild (2002 [1983]), informs the orientation of this article considerably. Hochschild used the term to denote the processes by which service workers are required to manage their emotions to create a particular ambience for the customers they serve, such as a feeling of well-being, safety, comfort, etc. In Hochschild's formulation, emotional labour is usually part of the job, the "emotional style of offering the service is part of the service itself" (2002: 194). As such emotional labour is part of what the worker exchanges for a wage, and is therefore as alienable and commoditised a form of labour as physical labour within capitalism.¹ In the case I consider however, the question of

¹ Hochschild's theory of emotional labour has been developed by later scholars. See for instance Adkins (1995, 2002), Adkins and Lury (1999) and Bolton and Boyd (2003)

whether nursing work should or could incorporate the management of emotions or emotional identification with the patient was openly contested. Indeed, the changing ways in which emotional care was constituted within different kinds of exchange is central to my analysis here. I therefore use the term emotional care in the place of emotional labour, to denote quite simply a form of emotional work which has no automatic relationship to wage labour, and which may or may not be considered part of a nurse's duties.

Health care reforms after 1989

Towards the end of 1990, plans for dramatic reform of the structure and funding of the Czechoslovak health care system were put in place. Prior to these reforms, the hospitals and other health care facilities were in public ownership, administered through a centralised system and funded from general taxation revenues. The new initiatives sought to decentralise radically this system, partly through the abolition of regional health authorities. Measures to make primary health care centres legally and financially autonomous were pushed through in the early 1990s, and the management of all but the largest primary health care centres (with a capacity of 6000 beds or more) were privatized (Garcés *et al*, 2003: 355, Marée and Gronewegen, 1997: 60, Raffell and Raffell 1992). Patients were given the freedom to choose their GP and the right to direct access to specialists. A compulsory health insurance scheme was also introduced, which currently comprises several companies, and is funded through individual and employer contributions, or state contributions for citizens with no taxable income. Insurance companies fund health providers on a fee-for-service basis. In addition to these insurance payments, health care funding also comprises contributions from state and local government and individual/charitable contributions.

It was in the context of these reforms to the health care system that the Home of St. Charles Borromeo (Domov sv. Karla

Boromejského) came into being in the mid-1990s. The building which currently houses this institution on the outskirts of Prague had been the property of the Borromeo order of nuns from its original construction in 1858 to its appropriation by the communist government in the mid 1950s. Under property restitution laws brought into effect after socialism, the Borromeo order applied for ownership of the building. That this claim was successful was due in no small measure to the fact that the nuns were keen to establish a nursing home on site, intended to increase Prague's capacity for provision of non-specialist medical and nursing care for elderly and/or infirm patients. Their proposal fitted well with the government's vision of privately owned and autonomously managed health facilities.

After a long legal process, the nuns regained ownership of a large building in dire need of major repair. From the outset the congregation actively sought, and was heavily reliant upon, state and charitable sponsorship to finance the reconstruction and refurbishment of the institution. The institution formally opened in 1996, and its nursing home has a capacity of roughly 90 beds. There is also a convent area where about 15 nuns live permanently, about half of whom are in retirement. In addition, the Czech prison service manages a low security women's prison within one wing of the building. The prison service's involvement in the institution is a complex one, which I do not have space to describe fully here. It is sufficient to explain that during the early 1990s the prison service was keen to collaborate with the nuns' project and establish a prison on the site, for, prior to its appropriation by the communist government, the building had been a female penitentiary, managed by Borromeo nuns. In return for permission to found a new facility on site, the prison service contributed to the cost of refurbishing the building.

Nursing staff consists chiefly of qualified nurses (*zdravotní sestry*), semi-qualified nurses (*ošetrovatelky*) and unqualified

nurses, or nurses' assistants (*sanitařky*). Nuns may also work in the nursing home as nurses or nursing assistants (again, depending on their level of training). Nurses with any level of qualification who are not nuns are referred to as *civilní* or civil nurses, a definition I retain here for the sake of clarity. Prisoners, on completion of a three-month training course in nursing skills, are permitted to work as nursing assistants at the busier times of day. Patients are mostly elderly women from Prague, who have been referred to the nursing home from one of several larger Prague hospitals following an operation or by their local social services, who have deemed them in need of nursing home care, either on a temporary or a more permanent basis. The nursing home is not intended to be a permanent care home; patients convalesce whilst their needs are assessed, and after some months may move back to their home or on to an old people's home. However, patients who have nowhere to go, or whose condition is worsening terminally, may stay for an extended period of up to several years.

Most of my time during fieldwork was spent in the nursing home, assisting nursing staff in their daily tasks. On duty on any one of three wards was typically a head nurse, three or four nurses or nurses' assistants, one of whom might have been a nun, and two (trained) prisoners, collectively responsible for the care of 35-40 patients. Whilst the nursing staff worked as a team and the atmosphere was mostly jolly and convivial, there were tensions between nurses, which were occasionally expressed directly but were mostly discernable through looks, gestures and murmurs, or verbalised when relevant colleagues were not present. Some of these tensions – the ones I am going to discuss here – hinged on divergent practices and understandings of adequate and appropriate nursing 'care', and particularly, what kinds of obligations nurses had to patients. These kinds of differences were evident in

relationships between civil nurses, nuns and the managers of the institution, and so it is these parties I focus on here.²

Civil nurses

Civil nursing staff in the nursing home ranged in age from 18 to 60. The majority of them were women between the ages of 30 and 50, who were married and had children, who lived fairly locally and were qualified nurses. There were also some younger women in their late teens and early twenties, some of whom had moved to Prague from rural areas in order to work. Their lack of qualifications and experience meant that they earned an extremely low wage, and many tended to leave the nursing home within a few months to move on to more lucrative areas of employment. The older nurses proved the more enduring employees, since their qualifications and experience brought double or three times the wages of their younger counterparts.³ As much because of their age as their formal qualifications, older civil nurses exerted an authority over younger ones, and felt it appropriate to give instructions and

² Discussion of prisoners' positioning within the nursing home and discourses of care are beyond the scope of this article. This is because the female prisoners were positioned quite differently within the discourses of care and work that I discuss here. Whilst prisoners were employees of the nursing home, their work in this context was an explicit part of a program of rehabilitation particular to the prison regime within the institution, which in itself requires considerable analysis beyond the scope of this paper. See Read (2005) for a discussion of prisoners' experiences of the institution.

³ Wages were calculated according to qualifications and experience. Older nurses tended to have both, younger nurses tended to have neither. Fully qualified nurses (*zdravotní sestry*) had studied nursing for four years and passed the *maturita* (or high school) examination, usually at age nineteen. They were paid a basic wage of around 10,000 Kčs a month (or around £250) plus bonuses for the number of years experience after this. *Sanitařky*, or nurses assistants, either had no nursing qualification at all or had undertaken and passed the three month training in nursing skills provided by the institution. Their basic wage was around 4,000 Kčs a month (or about £80), plus bonuses

advice in all aspects of the work at regular intervals. Younger nurses often resented and sometimes resisted this, but were obliged to put up with it until (after several months) they had earned the respect and trust of the older nurses sufficient to be considered *šikovná*, or competent.

In the main, the older, qualified or semi-qualified nurses had undertaken training in the 1960s and 1970s, and gone to work for most of their careers in various large Prague hospitals. They had trained and become experienced nurses within a particular climate within the health service, in which nurses' primary duty towards patients involved attending to their medical requirements, ensuring that the patient was washed, fed and given medicine appropriately, and keeping the patients' environment hygienic. Sociologist Alena Heitlinger has undertaken several studies of nursing in the Czech context in the 1970s, 1980s and 1990s. She maintains that within the socialist health care system there was a marked tendency to prioritise the physical and biological aspects of health and illness to the neglect of social and environmental factors. Nursing practice was heavily focused on the treatment of patients' medical conditions, and Czech nurses did not perform the emotional care of communicating and empathizing with patients and creating a warm and supportive environment of care. Instead, she claims, there was an entrenched and pervasive culture of indifference towards patients' emotional well-being amongst nurses and other medical staff. For instance, sociological surveys of Czech hospital practices in the 1970s found that more than half of nurses' working time was devoted to 'basic care' (e.g., making beds and assisting patients with personal hygiene) and that little time was spent talking to patients (on average about 15-20 minutes per day) (Heitlinger 1998: 129). A much greater period of time was spent talking to other nurses, physicians, cleaners, cooks and patients' relatives. In addition, in the course of their vocational training Czech students learned

practically nothing about empathy and communication with patients, or about independent nursing judgements...clinical practice emphasized routine care (such as feeding, bathing or skin care of patients) and the correct performance of specific procedures (Heitlinger, 1998: 128, see also Heitlinger, 1987)

The older nurses' approach to patients and the guidance they gave younger, less experienced nursing assistants tended to reflect this model of nursing focused on physical care and routine procedure. However, nurses would not have agreed with Heitlinger that this constituted a failure to care for patients fully and properly (1998: 128). On the contrary, it signified their competence and professionalism. An emotional, empathetic identification with patients was in most cases inappropriate, since it implied a personal and ongoing social relationship. Yet formally speaking, the nurses did not see the care they provided as personalized, they were caring on behalf of their employer in the first instance, and ultimately, of the health service – the abstract, collective structure through which the state provided citizens with the medical care they needed. Whilst it was important to care to the best of one's ability, the impetus for that care was social and collective, and did not come from them personally. The nurses saw their work as thoroughly commoditised; their labour and expertise was exchanged in return for a wage.

By contrast, emotionally inflected care was more readily associated with kinship obligations to husbands, partners and children. Being a supportive wife and mother and managing domestic tasks was seen as an ongoing labour of love, a strong source of pride and self-respect for older nurses, and something to which younger ones aspired. This labour was also exhausting, endless, and frequently taken for granted. Nurses often spoke of feeling that they had little time for themselves in their personal

lives. They complained of feeling like 'servants' to their kin, who constantly made demands on their time and energies. Being a mother and housewife was a source of pride and exhaustion, love and drudgery from which one could not disentangle oneself.

Many of the kinds of tasks nurses performed at work resembled those they performed at home, such as feeding, washing and dressing patients and keeping their environment clean and tidy. The nurses recognised this similarity and the transfer of skills from one domain to the other. Thus younger, unmarried nursing assistants were assumed to be less competent at the job not merely because they lacked qualifications, but because they couldn't bring the ability to handle people and manage things that the older nurses had gained by virtue of being housewives and mothers. But whilst the *skills* in each sphere were similar, the *feelings* and attitudes normatively associated with each were not. Work was a qualitatively different kind of activity to the labour of love performed out of an enduring sense of obligation to close kin within the home. The feminised labour of nursing could be objectified, divorced from the self and exchanged.

However, there were some occasions in which nurses' work was given a more 'personal' flavour. For instance, patients' friends and relatives would sometimes bring nursing staff gifts, usually of chocolate, flowers, and sometimes of alcohol. These gifts would be presented to nurses in recognition of the kindness and patience with a particular patient. Implicitly, gifts might just as easily be an attempt to ensure or maintain those qualities vis-à-vis the patient (c.f. Patico 2002). For example, one patient brought her own supply of teabags, and needed to enlist a nurse to make tea for her a couple of times a day. Her daughter brought a box of chocolates to 'thank' the nurses for making the time to give this specialised treatment to her mother. The relatives of patients who were seen to be particularly demanding also gave presents to nurses as a way of recognising that this was the case and expressing their gratitude.

These exchanges made the nurses' work personal, if only temporarily. The gifts were intended to appeal to nurses' feelings, and they succeeded. The nurses might, for example, thank the relatives by saying how much they enjoyed looking after patient X, or remarking that patient Y made them smile every morning. In addition, most nurses had 'favourite' patients with whom they might sit and talk in the quiet afternoons. These were patients with whom nurses claimed to have an 'understanding' (*my se rozumime*), and with whom they could joke, gossip and sometimes use the informal form of you (*ty*). If these were patients with few visitors or relatives close-by, nurses might do small shopping trips for them, or ensure that their personal laundry was cleaned. However, these personalized relationships were only recognised and indulged at times and in ways which suited the nurses. 'Favourite' patients could not rely on preferential or sympathetic treatment all the time. In other words, there were moments and transactions in which nursing as commoditised labour could be transformed into something more like a labour of love, but nurses sought to contain them.

Nuns

Although there were relatively few who lived there permanently, the nuns nevertheless exerted a strong presence within the institution. Whilst nuns themselves might not always be seen, many of the corridors within the nursing home were adorned with posters, leaflets and calendars conveying religious proverbs and bible quotations, or advertising the times of mass at the local church. Most people agreed that that the institution was very much the nuns' project.

The age range of nuns resident in the institution was quite broad. The oldest generation of nuns in retirement had taken vows during the pre-socialist era, the youngest had done so after 1989, and a middle generation had entered convent life under socialism,

almost always in secret. This latter group – women between 35 and 60 – often assumed positions of considerable responsibility and authority, within the institution and the broader congregation. Needless to say, nuns' ideas about and ways of practicing 'care' were shaped from very different historical and contemporary circumstances and experiences from those of civil nurses. Indeed, nuns spoke about and performed care in ways which tended to cut across the distinctions between state and kinship obligation that civil nurses took for granted. This was due partly to their vocation, and partly (especially for the middle generation) to the experience of socialism.

Borromeo nuns take four vows: poverty (*chudoba*), chastity (*čistota*), obedience (*poslušnost*) and merciful love (*milosrdenství*). This last vow is the defining feature of the congregation; a pledge of life long devotion to the 'most needy' and 'most wretched'. The Borromeo order was founded in France in the 17th century, and the first sisters of the congregation moved to the Czech lands in 1837. Over the next century, the congregation founded a wide range of schools, hospitals and orphanages in different Czech regions. In accordance with the restrictions on religious orders implemented by the post-1948 communist government, all of these institutions were nationalised. Nuns were required to relinquish them to the new state, and forcibly relocated to convents in remote rural locations. Nuns who had already taken vows were permitted to continue wearing congregational gowns, but initiation into religious congregations became a serious offence, carrying a prison sentence. Borromeo nuns continued to take vows secretly however, and some nuns were able to work in hospitals and old people's homes, in the border regions as well as in more urban locations. It was imperative for them to keep their identity as nuns a secret, not only at work, but even from their own kin. Households suspected of being secret convents were frequently subject to surveillance by the secret police. Unsurprisingly then, the generation of nuns who had taken

vows in the socialist period, particularly in the harsher political climates of the 1950s, 1970s and 1980s, had experienced the socialist state as an unjust and repressive regime. They spoke of convent life during these times as an intensely close, supportive community; a sanctuary against state persecution. Not being able openly to acknowledge their faith and living a 'double life' in which their vocation was entirely secret was seen as the most difficult and painful aspect of this period by many sisters. The 1989 revolution was a liberating moment, after which it became possible for nuns to re-forge a public space for themselves. The generation of nuns who might be said to have suffered the most under socialism were now in a position to define and shape the outlook and activities of their congregation.

Restitution of property to religious institutions in the 1990s often generated controversy in the Czech Republic, giving rise to the idea that the church was motivated primarily by a desire for material gain. Religious groups in turn defended their position by claiming that they required property as a base for their charitable activities. Certainly, the establishment of the nursing home at the institution was motivated, at least in part, by the Borromeo congregational vow to provide merciful love to the most needy and wretched. In the context of this construction of 'care', nuns tended to describe patients as vulnerable, isolated and lonely, as people in need of sympathy and understanding. For instance, the Mother Superior described the care patients could expect to receive in the nursing home as follows:

Many elderly patients live through the closing moments of their lives in our home. At this point in his life a person needs, above all, care and the quiet, loving presence of others. This means, more than anything else, to be in attendance, to attend the ill person and his family during this difficult period in life's path. ... Many people in contemporary life have inadequate help,

company, care and love from other people. Destitute is he, who in the midst of old age, illness and death, has no one.

Note that this representation of 'care' and 'need' differs radically from that of the civil nurses. Patients are figured not as the rightful claimants of state-funded and administered medical expertise, but as people requiring and receiving a much more personalized, emotional and spiritual kind of care. Moreover, this act of caring was sometimes represented in terms of kinship obligation. As in other orders, entering a convent constituted an attempt to join and re-create a spiritual family. Borromeo nuns' renunciation of biological motherhood was by no means a rejection of motherhood per se. As one nun explained to me,

By making the vow of celibacy we become...the spiritual mothers of people who may never otherwise encounter Lord God or eternal salvation. So the vow of chastity has a particular strength, a dynamic quality; it isn't about being 'fossilized' or [adopting] some mad way of life, it is truly a gift from God which we accept and reciprocate.

Whilst not all nuns used the kinship idioms invoked here, most described the work of looking after patients as a labour of love; it entailed personal commitment, empathy, attentiveness, devotion and patience. Sister Božena, a nun in her early forties who often worked in the nursing home, remarked that civil nurses tended to lack these qualities. Further, this failure to care in a personalised, empathetic manner was due to the fact that civil nurses were lazy – they only wanted to do the 'bare minimum' physical and medical care. She laid the blame for this firmly at the door of the socialist system; socialism had never required workers to invest personally in their work, and as a result had made them lazy. This stereotype of socialism as responsible for making Czechs idle and passive was one I heard often, both within and outside the

institution. Sister Božena's adaptation of it, however, highlights the tensions around 'care' under scrutiny here. Božena was unequivocally of the view that the nurse's commitment to patients extended beyond attention to physical condition. A desire to care in emotional and social ways, if not in spiritual ones, was part of the job, not an added extra. Nurses should be willing to talk and listen to patients, understand their pain and attend to their individual needs and requests.

Patients

Patients' backgrounds were varied. All were resident in Prague, and almost all were elderly widowed women. Most lived on state pensions, and the costs of their stay in the nursing home were covered almost entirely by national health insurance, or their local authority (depending on how they had been referred to the nursing home). In some exceptional cases patients had their fees paid by their families only; the children or even grandchildren of the patient had reached a private arrangement with the managers of the nursing home, whereby their relative might stay for a specified period of time - in rare cases, indefinitely. Usually, however, patients were admitted for a three month stay only, renewable on the basis of their physical and medical condition. It was notable that patients without children, who were either widowed or single, often tended to be patients whose stay in the nursing home was extended whilst they waited for a place in an old people's home. Patients with children were able to rely on their support, in turn enabling them to return to their former residences and ways of life, even though their practical or physical independence was less than before. Patients with children therefore tended to move through the institution more quickly. On the other hand, patients with children and families nearby were usually unhappy in the institution, since they felt forsaken by their kin by the very fact of being in the institution. As in other parts of central and eastern Europe, younger

grandparents are important members of the family who often assume a great deal of responsibility for looking after grandchildren whilst parents work. As they become older and more physically feeble, grandparents expect to be cared for in turn by their children and grandchildren. I was told on many occasions that it was generally seen as morally questionable (if not reprehensible) to 'put one's grandma in an institution'. On the other hand, it was also widely recognised that elderly and infirm grandparents may require full time care which their kin were unable to give. Herein lay tensions between some patients and their offspring. Patients without children tended to feel less abandoned, and therefore more willing to accept their circumstances.

In either case, patients mostly expected institutional, nursing home care to come in a medicalised, emotionally detached form. They anticipated that nurses would be concerned with their physical illness or ailments, which in daily practice meant being examined, treated, washed and dressed and generally 'physically processed' in a neutral and de-personalised manner. When I first began fieldwork, for instance, I was struck by the fact that patients did not object to being undressed, washed and dressed in front of each other in the shower room. Institutional practices such as these were accepted as standard and complied with uncomplainingly. This is not to say that patients did not wish for personalised or individualised care, but simply that they tended not to assume they would get it. Like their friends and relatives, patients often sought to involve nurses in gift-exchange type transactions as a means of appealing to nurses' good will and compassion. Most commonly, they offered nurses food brought in by their relatives (such as biscuits, chocolate, cakes, sweets and coffee). Patients also made 'gifts' with words; they offered heightened and enthusiastic praise to nurses by repeatedly telling them how *hodná* (kind / good), *šikovná* (competent / able) or *laskavá* (obliging / sweet) they were,

thereby making it possible to continue to appeal to those very qualities

Whilst their expectations of institutionalised care converged, patients' perceptions of the nuns were notably diverse. Most patients were young adults in the 1950s, a decade in which the communist government waged its heaviest propaganda war against the Catholic church (and religious orders) as a way of diminishing it as a focal point for socio-political resistance. Patients' reactions to nuns were quite polarized. They were a generation for whom faith and religious affiliation were highly politicized and socially divisive. Some were suspicious of nuns, and did not desire their company or assistance. When I probed why this was so, I was told that nuns were not to be trusted or believed, and that they were certainly not as holy as they claimed to be. Patients who were practising Catholics, however, had nothing but admiration and respect for the nuns, and claimed that nuns were more devoted carers than civil nurses⁴ But these sentiments, if expressed at all, were done so in a whisper.

Management

The most senior member of nursing home management was the Mother Superior, assisted by the head doctor and a head nurse, both of whom were employed in a civil capacity. The Mother Superior and the head nurse were in their mid-forties, the head doctor in his early sixties, and all three had worked in the Czech health care system for several decades. Though their views on nursing and care differed, all three perceived the need to be actively developing patient care, in order to attract charitable funding on which the nursing home depended. The income generated from

⁴ The numbers of patients claiming an active faith (those who called themselves *věřící*, or believers) varied, but on average constituted between 20 and 35 percent of patients. Of these, about three quarters were Catholic, and around a quarter were of Protestant faith

health insurance payments was insufficient to cover all costs, and as a result, the Mother Superior and the head doctor were regularly engaged in applying for funding grants from national and international charitable foundations. To a lesser extent they were involved in seeking corporate sponsorship and individual charitable donations. In these financially insecure circumstances, they argued, complacent staff could not be tolerated. Nursing home staff had to demonstrate that they had a good relationship (*dobrý vztah*) with patients. All nursing home personnel were on annually renewable contracts, and it was not at all uncommon for staff to have their contracts terminated. The reasons for this, the head doctor explained, were usually that the member of staff in question did not have this 'good relationship' with patients. The Mother Superior also argued that it was not simply a question of having the right qualifications:

There are nurses who might function very well in hospital, but who cannot tolerate this kind of work with old people... These people are unable to form a relationship with patients. From a practical point of view, I would like to develop forms of care for patients, [including] ways of offering psychological and spiritual support to the long term infirm. It's important to get rid of the sense of anonymity that patients can feel.

Thus from the management's point of view, good nursing entailed emotional and psychological, as well as physical, care. Significantly, emotional care was defined by them as a standard part of the job, rather than as something 'extra' or additional to regular duties.

Tensions and ambiguities in daily practices

In daily life in the nursing home, these alternative notions of appropriate patient care articulated with each other in complex and subtle ways, resulting in tensions and stresses rather than outright

confrontations. These surfaced in what people did as much as if not more than in what people said.

Whilst the managers and the nuns might have rather different ideas about appropriate nursing care from the civil nurses, the fact was that the latter performed the care on daily basis. Nuns worked only intermittently in the nursing home, and managers were seldom around to oversee nurses' work. On the other hand, civil nurses were aware of managers' expectations of nursing staff, and this awareness generated considerable anxiety and resentment. All civil staff were concerned about keeping their jobs in what was perceived to be a time of growing unemployment and economic uncertainty. Yet older and more experienced civil nurses also felt that managers made quite unreasonable demands on staff. They interpreted the requirement to 'have a good relationship' with patients as a thinly disguised attempt to increase the workload, and ensure that nurses never got a moment's rest on a 12 hour shift. This was because, for the older civil nurses, 'having a good relationship' meant multiplying the kinds of demands patients could normally make on nurses' time and energies. It conjured an image of the nurse-patient relationship as one in which nurses were more socially and morally entangled in patients' well-being, a relationship more commonly associated with kinship. Indeed, it necessitated treating patients like kin insofar as nurses would effectively become patients' servants, constantly on call to attend to individual needs and requests and never able to say no. As well as undermining nurses' professional authority and expertise, it left them working harder for the same amount of money. These sentiments were intensified in the knowledge that nurses' salaries had not kept pace with the dramatic increases in the cost of living since 1989. Work within the emerging commercial sector was better paid; nurses often noted that they would earn better money working as shop assistants than as nurses in the state sector, even given their qualifications and years of experience. In the face of

these economic pressures and inconsistencies, the older, more experienced civil nurses complained of being required to work even harder for the same money.

Of course, nurses had always performed emotional care for patients, as I have shown, but as an added 'extra' on top of the standard physical care. They were able to maintain control of this labour by separating it from routine duties, containing its performance to particular patients at particular times of day and transacting it as part of an informal 'gift economy'. This control was weakened once emotional care was expected as part of the job for which nurses were paid. This led to confusion and tension amongst nursing staff over how to conduct relationships with patients, which became evident in various ways. Some of the older civil nurses who felt most aggrieved periodically stopped going to sit with 'favourites', and instructed younger nurses to do the same. In the place of this activity, civil nurses would defiantly busy themselves with unambiguously physical tasks like recording patients' temperatures and weight, dusting and tidying bedside cabinets, or cleaning wheelchairs. These small-scale, pointed attempts at re-asserting control over labour were not organised or long lasting, but they were sincerely felt by the civil nurses who engaged in them. More generally, the divisions between physical and emotional components of nursing became starker in civil nurses' conversations. Colleagues who were seen to be spending too long at patients' bedsides might be accused of being work shy. This criticism was levelled at the younger nurses by the older ones, but also at nuns by all civil nurses. As one young civil nurse said of a young nun with whom she worked,

she spends all her time holding patients hands and comforting them, but in the meantime everybody else on the shift is left to do all the real work.

This idea of physical care being 'real work' and emotional care being 'window dressing' was increasingly articulated by civil nurses; it allowed them to defend the familiar boundaries of nursing practice, even though many of them continued to perform emotional care. The moral and cultural distinctions between work and home were also strongly affirmed by some civil nurses, often in conversations about nuns. Hence, an older nurse remarked,

Why should she want to devote her whole life looking after these people [the patients]? I don't understand it. She has given up the right to have children of her own in order to look after patients.

Non-comprehension of the nuns' renunciation of marriage and (biological) children was common amongst civil staff, but these statements also express a reluctance to accept the idea of emotional investment in relationships with patients on the part of the nuns, such that patients could be as important or valuable as children.

Nevertheless, emotional care was enacted through personalised practices which in reality varied enormously from day to day, context to context, and nurse to nurse. In everyday terms emotional care was slippery, rarely concretely defined or articulated. Civil nurses certainly did not always agree about where to draw the line and tensions were most evident when older civil nurses disagreed amongst themselves about how to care. One of the most experienced older nurses, Jaroslava, liked to bring in her own homemade cake to serve to patients, with coffee, after their midday meal, a task for which she relied upon the assistance of her colleagues on the shift. This was Jaroslava's own way of personalising her work, but it generated considerable resentment amongst other civil nurses. For this was not a 'private' or contained transaction between Jaroslava and a patient of whom she was fond, but special treatment of all patients, which fellow colleagues were obliged to participate in, and even support. However, Jaroslava herself was an older nurse with a great deal of experience, which

made challenging her more difficult. She was also good friends with a more senior nun, sister Božena, who had been known to praise her for the kindness and understanding she showed patients. In these circumstances, other nursing staffs were not prepared to criticise Jaroslava openly. But they felt she undermined their stance vis-à-vis emotional care, since her actions appeared to endorse the view of management that all patients should expect personalised treatment, all of the time.

Concluding remarks

I have explored how 'care' became a contested activity within daily life in the nursing home. Most of the civil nurses had trained and worked in a context in which nursing care did not reflect their personal concerns for the patient, but a collective, state obligation to meet the medical needs of the public. Unofficially emotional care was practiced, but in contained contexts. But in recent years the Czech health service has been subject to a range of structural and economic reforms which have left health care providers more autonomous and less financially secure. In this climate, previous understandings about caring practices and the kinds of social relationships it reflected have been de-stabilised. In the institution I have considered here, the impacts and challenges of broader economic reforms were further intensified by the presence of nuns who had different perspectives on nursing from those of the civil nurses. Managers and nuns envisaged patient care as inclusive of emotional care and performance of the latter was part of the contract. Whilst most of the older civil nurses who worked in the nursing home sought to keep emotional care contained and separate from physical care, this distinction could only be maintained so long as emotional care was transacted through gift exchange practices operating informally between nurses, patients and patients' friends or relatives. Once emotional care was constituted as a standard part of wage labour (thereby making emotional care

into emotional labour), this was a challenge to nurses' control over gift exchange. However this has not resulted in its disappearance of gifting in this context, but its transformation, as recent developments indicate.

Since my original fieldwork in 1998-9 (on which this chapter has been largely based), the nursing home has become increasingly pro-active in seeking out alternative sources of funding, with no small success. In 2003, charitable donations constituted a third of its total funding.⁵ Two full time fundraisers are currently employed by the institution to consolidate and expand the existing base of corporate donation and sponsorship and organise fundraising events and activities. Yet despite its illustrious national and international corporate sponsors (including *Česká Spořitelna*, a leading Czech bank, GlaxoSmithKline and Unilever), over half of the charitable funding of the nursing home comes in the form of individual donations from the families of patients. As one of the fundraisers explained, it was the quality of care that motivated relatives to donate money, which was 'above standard' (*nadstandardní*). This notion of above standard care is implied in the institution's ever-proliferating publicity material.

All of our employees...strive to create a feeling of home for our patients. A home where they are warmly welcomed, where their rightful demands and wishes are respected, and where they are esteemed and treated with human dignity in their old age.⁶

⁵ According to 2003 figures, total state funding of the institution was 7,207,000Kčs. Sponsorship and donations amounted to 2,342,000Kčs, and grants to 429,000. *Výroční zpráva za rok 2003* (2003 annual report) in *Informační listy* (Guide), 2003, *Domov svatého Karla Boromejského* (Home of St Charles Borromeo), Prague.

⁶ *Informační listy* (Guide), 2003, *Domov svatého Karla Boromejského* (Home of St. Charles Borromeo), Prague, p 3

Here we see an explicit pledge to provide much more than simply physical care. There is a guarantee of emotional labour; patients' feelings and sensibilities will be attended to as well as their sicknesses. Cultural notions of 'standard care' and 'extra' care have been transformed insofar as the commitment to provide physical, social, emotional and spiritual care, all as part of the service, is also an invitation to recognise this achievement by making a donation – the bank account details of the institution are printed on all its publicity material. Thus gifts continue to be given in exchange for the emotional, above-standard forms of care provided. However, gift giving is now fully formalised and explicit, rather than informal and personal, and the gifts are as likely to be donations of money to the institution as a whole, as presents to individual or small groups of nurses. Further research is needed to reveal the complex ways in which this process has impacted on practices of emotional care on a day to day basis. But what is clear is that this formal rationalisation of giving has further weakened nurses' prior command of gift exchanges. As one nurse remarked to me, "there has always been sponsorship. But it goes downstairs now [to the managers], not to us".

Bibliography

- Adkins, Lisa (1995) *Gendered Work. Sexuality, Family and the Labour Market*. Buckingham: Open University Press.
- Adkins, Lisa (2002) *Revisions: Gender and Sexuality in Late Modernity*. Buckingham: Open University Press.
- Adkins, Lisa and Celia Lury (1999) 'The Labour of Identity: Performing Identities, Performing Economies', *Economy and Society*, 28(4): 598-614.
- Bolton, Sharon C. and Carol Boyd (2003) 'Trolley Dolly or Skilled Emotion Manager? Moving on from Hochschild's Managed Heart', *Work Employment and Society*, 17(2): 289-308

- Bridger, Sue, Rebecca Kay and Kathryn Pinnick (1996) *No More Heroines?* London: Routledge.
- Einhorn, Barbara (1993) *Cinderella Goes to Market: Citizenship, Gender and Women's Movements in East Central Europe*. London: Verso.
- Garcés, Jorge, Francisco Ródenas and Stephanie Carretero (2003) 'Observations on the Progress of Welfare-State Construction in Hungary, Poland and the Czech Republic', *Post-Soviet Affairs*, 19(4): 337-371
- Haney, Lynne (1999) 'But We Are Still Mothers': Gender, the State and the Construction of Need in Postsocialist Hungary', in Michael Burawoy and Katherine Verdery, eds., *Uncertain Transition. Ethnographies of Change in the Post-socialist World*. Boston: Rowan and Littlefield, pp.151-187.
- Heitlinger, Alena (1987) *Reproduction, Medicine and the Socialist State*. London: Macmillan.
- Heitlinger, Alena (1998) 'Czech Nursing During and After Communism', in Vittorio Olgiati, Louis Orzack and Mike Saks, eds., *Professions, Identity and Order in Comparative Perspective*. Onati: International Institute of the Sociology of Law, pp.123-148
- Hellum, Nina (2001) '*Ljubovnica* in Arkhangelsk – Ambiguity in Extra-Marital Relationships' in Haldis Haukanes, ed., *Women After Communism Ideal Images and Real Lives* Bergen: Centre for Women's and Gender Research, pp 131-146.
- Hochschild, Arlie (2002) 'Emotional Labour', in Stevi Jackson and Sue Scott, eds., *Gender. A Sociological Reader*. London: Routledge, pp.192-196.
- Humphrey, Caroline (1995) 'Creating a Culture of Disillusionment: Consumption in Moscow, a Chronicle of Changing Times', in Daniel Miller, ed., *Worlds Apart. Modernity through the Prism of the Local*. London: Routledge, pp 43-68.

- Kaneff, Deema (2002) 'The Shame and Pride of Market Activity: Morality, Identity and Trading in Postsocialist Rural Bulgaria' in Ruth Mandel and Caroline Humphrey, eds., *Markets and Moralities: Ethnographies of Postsocialism*. Oxford: Berg, pp. 33-51.
- Kideckel, David A (2002) 'The Unmaking of an East-Central European Working Class', in Chris Hann, ed., *Postsocialism: Ideals, Ideologies and Practices in Eurasia*. London: Routledge, pp.114-132.
- Kovács, Katalin and Monika Váradi (2000) 'Women's Life Trajectories and Class Formation in Hungary', in Susan Gal and Gail Kligman, eds., *Reproducing Gender: Politics, Publics and Everyday Life After Socialism*. Princeton: Princeton University Press, pp 176-199.
- Marrée, Jörgen and Peter P. Groenewegen (1997) *Back to Bismarck. Eastern European Health Care in Transition*. Aldershot: Avebury.
- Nash, Rebecca (2003) *Restating the Family. Kinship and Care in the Czech Republic*. Unpublished PhD thesis: University of Virginia.
- Nazpary, Joma (2001) *Post-Soviet Chaos: Violence and Dispossession in Kazakhstan*. London: Pluto Press.
- Patio, Jennifer (2002) *Chocolate + Cognac: Gifts and Recognition of Social Worlds in Post-Soviet Russia*. *Etnos* 67 (3): 345-368
- Pine, Frances (1998) 'Dealing with Fragmentation: The Consequences of Privatisation for Rural Women in Central and Southern Poland' in Sue Bridger and Frances Pine, eds., *Surviving Post-socialism: Local Strategies and Regional Responses in Eastern Europe and the Former Soviet Union*. London: Routledge, pp 106-123.

- Pine, Frances (2002) 'Retreat to the Household? Gendered Domains in Postsocialist Poland' in Chris Hann, ed, *Postsocialism: Ideals, Ideologies and Practices in Eurasia*. London: Routledge, pp.95-113.
- Raffell, Marshall W., and Raffell, N (1992) 'Czechoslovakia's Changing Health Care System', *Public Health Reports* 107(6): 636-645
- Read, Rosie (2005) 'Scopic Regimes and the Observational Approach: Ethnographic Filmmaking in a Czech Institution', *Visual Anthropology* 18(1): 47-64.
- Szalai, Júlia (2000) 'From Informal Labour to Paid Occupation: Marketisation from Below in Hungarian Women's Work', in Susan Gal and Gail Kligman, eds, *Reproducing Gender: Politics, Publics and Everyday Life after Socialism*. Princeton: Princeton University Press, pp 200-224