

Labour and Love: Competing constructions of ‘care’ in a Czech nursing home

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Former socialist states of central and eastern Europe created and maintained extensive frameworks for the universal provision of housing, employment, health care, education and other forms of social security. The contraction and restructuring of social security systems over the past fifteen years has, as much ethnographic work has revealed, generated new forms of economic vulnerability and marginalisation (Humphrey 1995, Bridger et al 1996, Pine 1998, Haney 1999, Kovács and Váradi 2000, Helleum 2001, Kideckel 2002, Nazpary 2002) and strengthened alternative forms of material support and dependency (Szalai 2000, Pine 2002, Nash 2003, Kaneff 2002). These transformations make the present an interesting moment to examine changing ideologies of care. Universal entitlement to social security was central to socialist modernity, and the means through which socialist states claimed to ‘care’ for their citizens. Official discourses tended to downplay or ignore the role of kinship, households, and personal networks in providing care in a range of forms. Since 1989 however, the upheavals associated with the transition to market capitalism have introduced a wide range of new discourses on care, which profoundly reconfigure the state’s obligation to care vis-à-vis that of the family, the private sector, charities, NGO’s, etc. In some cases, such as the one I will consider here, the very meaning of caring practices themselves have become contested as a result of the fragmentation of previously distinct ideologies of public and private care.

This paper explores nursing practice in the Czech Republic. It will examine how nursing work was constituted within the socialist health system, a social security structure which provided universal medical assistance. Health care was defined as rational, progressive and scientific, and nursing care was heavily focused on treating patients’ physical problems and symptoms. The emotional and social needs of patients were left out of this model, and widely assumed to be a private responsibility of patients’ family members and friends. However, the re-structuring of the health service since 1989 has diversified understandings of nursing care, as I examine with particular reference to nursing of the elderly and infirm. Drawing on an ethnographic study conducted in a Prague-based nursing home, I explore conflicts which were generated by an attempt to redefine nursing in ways which incorporate forms of emotional support not previously seen as part of a nurse’s duties. This resulted in disputed interpretations of the extent to which nursing practice embodies and extends the state’s caring role.¹

Through this discussion, I hope to highlight two further points. Firstly, that the flexible cultural categories of public and private are constituted in everyday practices, which in turn inform competing ideologies of appropriate, ‘modern’ nursing care. To put it another way, I demonstrate that public and private are “embodied practices of the modern self” (Brandtstädter, this volume) which define nurses’ identities in relation to different versions of modernity. Secondly, I hope to emphasize how definitions of ‘modern’

nursing care change over time. They are the outcome of shifting historical processes which simultaneously operate to identify ‘outdated’ or ‘non-modern’ caring practices. In broader terms this supports the point made by Brandtstädter (this volume), that the relationship between official knowledge and local practice, or what Scott (1998) calls *techne* and *mētis*, is hegemonic and always requires interrogation.

Health care and socialist modernity in Czechoslovakia

The right of free health care for all was a key component within a broader vision of socialist modernity, in which poverty and exploitation were to be eradicated, and the state undertook to ensure a high standard of living to all citizens through the universal provision of housing, education, employment, social security, and health care. The period immediately following the end of the second world war and the 1948 communist take-over was characterised by the unification and consolidation of national health care provision. A comprehensive social insurance system making provision for sickness, maternity and old age was brought into being through the National Health Insurance Act of 1948. Hospitals, clinics and health spas were also nationalised. In 1951 this process was consolidated as health care became the joint responsibility of the Ministry of Health, regional and national committees and productive enterprises and later in 1966 health insurance was formally replaced with the universal right of accessibility based on citizenship (Heitlinger 1987: 75-76). From this point until the early 1990’s, all health care facilities were publicly owned, centrally administrated and funded solely from general taxation revenues.

This modern socialist health system approached health in a rational and scientific manner. In particular, health care tended to focus on physical and biological aspects of health and illness, rather than social or environmental ones. Government ministries, officials and medical practitioners typically utilised scientised and apparently neutral and objective forms of address in engaging with members of the public over health matters. An often cited example of this is the way in which the Czechoslovak state pronatalist agenda from the 1960’s onwards, in seeking to halt demographic decline and ensure sufficient future labour power, appealed to a notion of women as ‘natural’ child bearers, or as biologically suited to motherhood (Heitlinger 1987: 53, 82, see also Nash 2003 and Wolchik 2000). But in other fields of medicine too, there was a tendency to focus on the physiological, and whilst researchers and medical practitioners sometimes acknowledged the problematic nature of this model, they were not always clear what was to be done about it. For instance, a Czech researcher in the 1980’s criticized the cardiovascular diseases national research plan for failing to consider environmental factors in sufficient depth.

In theory we acknowledge that the decisive factor in determining the quality of health is the environment. However, in practice we act in the opposite way, by looking for the essence of health problems in molecular biology and immunology, at the level of biophysical and biochemical factors, that is, only at the level of micro-world (sic). Perhaps we think it would be very ‘unscientific’ to designate polluted environments, disturbed interpersonal relations, lack of physical activity,

disorder in one's workplace, smoking, alcoholism, and so on, as the causes of health problems. (quoted in Heitlinger 1987: 83).

While the prevalence of biologicistic models of health and illness within medical discourse was clearly not particular to socialist Czechoslovakia (or indeed, socialist countries), the political climate of state socialism inhibited effective challenge to their dominance. Whereas in democratic capitalist contexts powerful medical discourse has historically been subject to challenge by voluntary associations, pressure groups, and social movements, in Czechoslovakia, as elsewhere in the Eastern block, the state exerted control over the activities of these associations through the umbrella National Front. Moreover, through central planning the state exerted strong influence over the definition of medical 'needs' and determined the organisation of resources to meet them. Economic priority was given to health services focused on maintaining and reproducing a healthy and productive workforce. Non-productive members of the public, such as the elderly, disabled or mentally ill, were in practice not always guaranteed an equivalent standard of care to productive ones. For instance, certain complex and expensive surgical procedures were not performed on citizens of retirement age (Heitlinger 1987: 95).

The socialist health system and the models of physical and biological health which dominated it can be seen as a form of *techne*; a rational and rationalising form of state knowledge and planning (Scott, 1998). But in spite of the fact that the health system was centralised and controlled from the top, it is important to recognise that *techne* was also incorporated into the everyday practices and identities of both the medical profession and the general public as users of health care services. It has been claimed, for instance, that medical practitioners tended to view patients as passive recipients of health care treatment – one contemporary commentator described the relationships between doctors and patients as 'totalitarian' (Heitlinger 1987: 105), a perception that recurs today (Spritzer 2004). At the same time however, the guarantee of free health care became a powerful cultural expectation which patients could and did mobilise in their engagement with medical professionals. As the First Chief Nurse of the Czech Republic has described,

nurses and general practitioners were pestered, criticized, and maligned by patients for their inability to assure this [constitutional] right. Sometimes a patient dictated his requirements for therapy in spite of their absurdity and complained to the Central Committee of the Communist Party, demanding sanctions against the health workers because as a tax-payer, he had the 'right to health' (Heitlinger 1998: 131).

As modern socialist health care operated with scientific models of healthy citizens requiring rationalised physical care, so it inevitably excluded alternative understandings of health, need and support. It was the private sphere of kinship, friends and personal networks which became the focus for emotionally inflected and socially embedded care. Indeed, this separation reflected a series of oppositions between care as state-administered social security on the one hand and sources of support provided through personal networks such as family, friends and close colleagues, as much Czech

ethnography shows. Nash (2003) for instance has explored how state benefits in the form of welfare for poorer families continue to be ideologically constructed as totally separate from economic and material support provided by kin, a distinction which contributes to the generation of moral idioms of dependency on or autonomy from the state (Nash 2003). In a parallel fashion, health care was spatially and morally distinct from care offered in the home by the family. This created problems for the chronically ill and the elderly, for whom the state provided few services enabling them to remain at home or within their communities. The options were either to face permanent residence within a state health institution (such as a hospital, old people's home or occasionally, a nursing home), or to rely fairly exclusively on the care and support of their families. The absence of home-delivered care services meant that the long term ill often remained for months if not years within mainstream hospital wards. According to some figures, the chronically ill took up seventy percent of hospital beds in Prague in the early 1990's (Heitlinger 1998: 142). Furthermore, the cultural and moral opposition between state care and home care for the economically non-productive members of the public was such that institutionalisation was often represented as the result of an individual having been abandoned or rejected by kin.

Health care reforms after 1989

The collapse of socialism heralded major structural changes to Czechoslovak health care system, which was quickly identified to be in need of liberal modernisation. Towards the end of 1990, plans for dramatic reform to its structure and funding were put in place. New initiatives sought to radically decentralise this system and introduce the principle of competition within and between health services. The abolition of regional health authorities and new measures to make primary health care centres legally and financially autonomous were pushed through in the early 1990's, 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). In this new system patients were to be treated as consumers, endowed with the individual freedom to choose their own doctor and the right of direct access to specialists. A compulsory health insurance scheme was also introduced, 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 central and local government as well as individual/charitable contributions.

These processes of economic decentralisation in the early – mid 1990's were concurrent with the growth of new and increasingly critical challenges to existing state health and social care policies. The pervasive medicalisation of the long term ill, elderly and disabled which inhered within the prevailing tendency towards institutionalisation as the key form of state provision for these groups was subject to a range of criticisms from state ministries, policy makers, NGO's, and academics. Some of these actors called for changes to the law to enable families and individuals caring for an elderly and/or disabled family member to receive greater and more effective material support from the state.² This period also witnessed a rapid growth of so called 'home care' agencies providing post-operative, rehabilitation and palliative care, and employing qualified and

experienced nurses, as well as social workers, physiotherapists, and care assistants to provide this care to people in their own homes, or in some circumstances, in hospices (Heitlinger, 1998: 143). At the same time it became both possible and increasingly necessary for health care institutions to seek out alternative sources of funding to supplement national insurance payments for their services. This was also a significant catalyst for changes to ideologies of care within such institutions, as I hope to demonstrate in my discussion below.

The nursing home

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 in 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 1950's. Under property restitution laws of the brought into effect after 1989, 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, thereby increasing Prague's residential capacity for elderly and/or infirm patients requiring non-specialist medical and nursing care. At this time, the Ministry of Health sought to support and encourage the establishment of independent health facilities which were to be autonomously administered and financed within a newly decentralised health care system.

After a long legal process, the nuns regained ownership of a large building in 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 nursing home formally opened in 1996, with a capacity of roughly 90 beds. There is also a convent area for the nuns, where about 15 nuns live permanently, about half of whom are in retirement³. Nursing staff consist chiefly of qualified nurses (*zdravotní sestry*), semi-qualified nurses (*ošetřovatelky*) 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 clarity. 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 local social services, having been deemed in need of temporary nursing home care. The nursing home is not intended as a permanent care home; patients convalesce whilst their needs are assessed, and after some months may move back to their home or on to more permanent residential accommodation. However, patients who have nowhere to go, or whose condition is worsening terminally may stay for an extended period of up to several years.

On duty on any one of three wards were typically a head nurse, four or five nurses or nurses' assistants, one of which may be a nun, collectively responsible for the care of 30-40 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. Tensions often hinged around alternative understandings of appropriate nursing practices and the nature of nurses' obligations to patients. These differences were especially evident in relationships between civil nurses, nuns and the managers of the institution.⁴

Caring for bodies, embodying care: the 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, many 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 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.⁵ 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 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 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 1960's and 1970's, and gone to work for most of their careers in various large Prague hospitals. They had trained and become experienced nurses within the context of the socialist health care system, in which a nurses' primary duty towards patients involved attending to medical requirements, ensuring that the patient was washed, fed and given medicine appropriately, and keeping the patients' environment hygienic. Nurses' perceptions of appropriate care in the nursing home reflect the findings of Alena Heitlinger, a sociologist who has undertaken several studies of nursing in the Czech context in the 1970's, 1980's and 1990's (1998, see also Benoit and Heitlinger 1998). Heitlinger argues that nursing practices focused heavily on the treatment of patients' medical conditions, and that Czech nurses simply did not see emotional work, i.e., communicating and empathizing with patients and creating a warm and supportive environment of care, as part of their job. 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 1970's 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 and Benoit and Heitlinger 1998)

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, the nurses would have strongly disputed the implication within Heitlinger's analysis that this constituted a failure to care for patients fully and properly (1998: 129, Heitlinger and Benoit, 1998: 1108). 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, the health service – the abstract, collective structure through which the state provided citizens with the medical care they needed. Their duty, within this structure, was to promote patients' physical and medical well-being to the best of their ability.⁶

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 not merely because they lacked formal qualifications, but because they couldn't bring to the job the competencies and abilities that the older nurses had gained by virtue of being housewives and mothers. But whilst the skills in each sphere were similar, the feelings 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. Nursing care was not associated with emotional investment, but with the dispassionate medical judgement and competence which was the hallmark of a modern health care system.

However, there were some occasions in which nurses' work was given a more 'personal' flavour. For instance, patients' friends and relatives would sometimes bring gifts to nursing staff, usually of chocolate, flowers, and sometimes alcohol. These gifts would be presented to nurses in recognition of their kindness and patience towards 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's help to make a cup 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 sometimes 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 usually succeeded. 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 chat informally. If these were patients with few visitors or relatives close-by, nurses may do small shopping trips for these patients, or ensure that their personal laundry was cleaned. Thus whilst formal, physical nursing tasks allowed the nurses to invest in a positive, autonomous sense of self-as-worker, the practice of sitting with favourite patients was a context for the extension of a more relational side of nurses' identities. Such relationships with patients resembled family relations and enduring forms of social obligation and exchange. Patients were treated as if they were relations or close friends of neighbours. In this way, nurses extended kinship into the work place through creating discrete and contained spaces in which kin-like relationships could be recognised and performed. However, 'favourite' patients could not rely on preferential or sympathetic treatment all the time. These personalized relationships were only recognised and indulged at times and in ways which suited the nurses, which was usually when there were no formal physical duties to perform.

Thus nurses' daily practices embodied both rational, physical care, and socially embedded emotional care; the two constantly recreated as separate and distinct. Indeed, we might say that the nurses behaved as modern socialist women, extending the *techne* associated with the modern socialist health care into their labour in the 'public' sphere of work, whilst also reproducing an entirely separate domestic world of kinship obligation and personalised relationships. For the nurses, these two worlds, and the female person associated with each, were to be kept apart. However, as I will show, this separation was disrupted by the nuns in various ways.

Care as vocation: the 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 than 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) 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'. Founded in France in the 17th century, the first sisters of the Borromeo 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 parts of the Czech lands. In accordance with the restrictions on religious orders put in place 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, both in the border regions as well as in more urban locations. It was imperative for them to keep their identity as nuns a secret, both at work, and 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 1950's, 1970's and 1980's, 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 to openly 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 1990's often generated controversy in the Czech Republic, rousing accusations 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 most 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 of the institution 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.

Nuns thus developed an entirely different vocabulary to that of civil nurses in referring to patients and care. Patients were 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, such as motherhood. 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 nuns described the work of looking after patients as a labour of love; it entailed personal commitment, empathy, attentiveness, devotion and patience. In the nuns' idioms of care, there were no clear boundaries between the public care of the state, and the private care of kinship. Rather, caring was always a vocation; a public act which corresponded to a deeply-felt personal obligation and commitment.

Improving patient care: care as service

The different perspectives of older civil nurses and nuns, which were rooted in their contrasting historical experiences vis-à-vis various ideologies of care, were sharpened and entrenched by the managers responses to the new decentralised economic context of health care in which the institution operated. The most senior member of nursing home management team 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 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. Whilst their views on nursing and care were not necessarily all of a piece, all three perceived the need to be actively developing and improving patient care in order to attract a range of different forms of funding for the institution. Since the income generated from health insurance payments was insufficient to cover all costs, managers were regularly engaged in seeking funding from charitable sources, as well as corporate sponsorship and grants from national and international foundations. The success of these activities depended in different ways on demonstrating the high standard of care that the institution offered to its patients, both in terms of physical care (e.g., the effectiveness of new methods of rehabilitation and physiotherapy), as well as social or emotional care. Increasingly, the managers spoke in terms of the importance of recruiting nursing staff who were motivated and energetic, most crucially, personnel which had 'good relationship' (*dobrý vztah*), a 'humane approach' (*lidský přístup*) in their relations with patients. The latter came to be seen as central to the project

of attracting charitable donation from patients and their relatives, as well as larger commercial organisations and charities.

All nursing home personnel were on annually renewable contracts, and it was not at all uncommon for staff to have their contracts terminated if they were deemed not to have a 'good relationship' with patients, as the head doctor explained to me. 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 the altered economic context of health care and the need to attract alternative forms of funding for the nursing home involved constructing patient care in ways which were fundamentally at odds with the socialist techné of health care. In the context of competition between health units and services, the patient and their relatives emerge as active consumers within the health market, making personal choices about forms of treatment based on perceptions of quality of service. The nursing home as a health care provider was required to actively demonstrate the quality of this care in order to secure charitable funding and sponsorship. Rationality, science and models of physical health are no longer the hallmark and goal of a modern health service. Instead, the new discourse of nursing care highlights the importance of sentiment and empathetic identification with patients, alongside clinical and medical competence. Emotional care was increasingly seen as a standard part of the nurse's job.

Fractured caring practices

In daily life in the nursing home, these alternate notions of care articulated with each other in subtle and complex ways. The majority nursing staff were civil nurses, nuns worked only intermittently in the nursing home, and managers were seldom around to oversee nurses' work. Nevertheless, civil nurses were acutely aware of managers' expectations of nursing staff, and this awareness generated considerable anxiety and resentment. All civil staff were concerned to hang on to 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 the effect of these demands was to increase the workload, and ensure that nurses never got a moment's rest on a 12 hour shift. As the older nurses saw it, 'having a good relationship' effectively multiplied the kinds of demands patients could normally make on nurses' time and energies. These women were dismayed at the image of the nurse-patient relationship which the management appeared to project, in which in which nurses were ever more socially and emotionally entangled in patients' well-being, constantly on call to attend to individual needs and requests and never able to say no.

The civil nurses objections to this image took different forms. Nurses frequently complained that they were being required to perform extra labour for the same amount of money. And since their salaries had not kept pace with dramatic post-1989 prices rises, and work within the commercial sector that required none of their expertise was significantly better paid, why should they take on more work for the same pay? These claims of exploitation gave way, at times, to grievances that the important skills of nursing were being devalued within the new model of the nurse-patient relationship. For many nurses, particularly the older ones who had trained in the 1970's and 1980's, the *odstup*, or formal 'distance' between patients and medical personnel was necessary and desirable. It enabled nurses to make dispassionate judgements in the best interests of patients' physical welfare. After all, a nurses' job was not to make patients 'feel good', but first and foremost to help them get better. This view of the value of nursing was wedded to dominant models of modern health care which prevailed within the socialist health care system, but were increasingly discounted within the new model of patient care which the nurses were required to work to. Accordingly, in addition to feeling economically exploited, many nurses felt profoundly de-modernised. For whilst nurses had always performed emotional care for patients, as I have shown, this was not previously seen as a formal part of the job but was construed rather as a set of informal activities which were kept separate from routine duties of physical care. This bracketing of emotional care facilitated the dominant identification of nursing practice with the modern, rational, scientific values of the socialist health system, in which dispassionate clinical knowledge and skills were of principal value. This linkage of nursing with socialist modernity was threatened in the managers' new model of patient care, in which physical care on its own was deemed insufficient and emotional care became formally incorporated into nursing tasks. Many civil nurses saw this shift as heralding a significant downgrading of their skills and experience.

In daily practices, this generated 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 were small-scale, unspoken demonstrations through which nurses drew attention to the importance and value of physical and technical nursing competencies. Such protests were not organised or long lasting, but they were intense and sincerely felt by the women who engaged in them. More generally, the divisions between physical and emotional components of nursing became starker in civil nurses' conversations, and the value and significance of the former was emphasized at the expense of the latter. For instance, 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 as proper work and emotional care as an indulgence was intermittently articulated, allowing civil nurses to re-assert the familiar boundaries of nursing practice, even though many of them continued to perform forms of emotional care. The moral and cultural distinctions between work and kin were also strongly affirmed by some civil nurses, often in conversations about nuns. As 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 expressed frustration and a reluctance to accept the idea of an emotional investment in relationships with patients on the part of the nuns, such that patients could be as important or valuable as children.

Those nuns who worked in the nursing home saw the importance of maintaining good working relationships with civil nurses, and were seldom publicly critical of civil nurses' practices of withdrawing emotionally from patients and focusing on their physical care. But the more senior nuns did on certain occasions express to me a certain frustration with civil nurses' attitudes towards patients. Sister Božena, a nun in her early forties who took on regular shifts in the nursing home, remarked to me that civil nurses tended to lack the qualities of empathy and kindness that were, in her view, crucial to nursing care. Significantly, she felt that the civil nurses' tendency to see nursing in terms of physical care was not a mark their professionalism, but indicated their laziness. Civil nurses only wanted to do the 'bare minimum'. The blame for this, she asserted, lay with the former socialist system and the working attitudes it had perpetuated. Under socialism workers had never been required to invest personally in their work, and this had made them complacent and indifferent as a result. 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, crystallizes the tensions around 'care' under scrutiny here. For in this representation of nursing care, emotional identification is re-positioned as a norm, and its absence a 'bad practice' which, far from reflecting clinical professionalism and the rational boundaries of state care, signified laziness, complacency and indifference. Whilst sister Božena had no doubt held these views for a long time, from the point of view of the post-1990's reform of the Czech health system and the changing ideologies of care within the nursing home and the health care system more broadly, her opinions were entirely consistent the new hegemonic ideals of quality and service which now governed the Czech health service.

Transforming care: techne and mētis

Post-1989 transformation to state health care in the Czech Republic has had, and continues to have, a significant impact on ideologies of nursing care and nursing practices, particularly as they relate to nursing services for the elderly, the long term ill and the disabled. Under socialism, health care constituted a form of techne, a rationalised

form of planning through which the socialist state provided care for citizens. As *techne*, health care was dominated by models of health which focused heavily on physical and biological symptoms and treatments, and tended to disregard the social and environmental context in which they existed. This helped reinforce distinctions between forms of care associated with the state (which were rational, modern, and applied equally to all regardless of context) and those associated with more personal relationships and networks, such as kin, friends, neighbours and close work colleagues (which were socially and contextually embedded). Care for the elderly and infirm, for instance, was strongly divided between residential care within state institutions, and care in the home performed by kin and other personal relations.

Post-1989 reform of the health care system transformed state care in various ways. Decentralisation of health care facilities coupled with growing criticism of existing health and social services paved the way for the reformulation of ideologies and practices of care. Authoritative medical discourse was subject to new challenges by various state and non-governmental organisations aiming to alter the form and content of caring services. Most crucially, from the point of view of this paper, the cultural boundary between state and non-state forms of care was fragmented, as caring provision previously located within personal networks and the private sphere were given formal recognition and received government and/or charitable funding.

As a particular instance of this more general trend, this paper has focused on the changing character of nursing practice within a residential care home for the elderly and infirm. I have tried to show how the caring practices of (particularly the older) civil nurses', which made sense within *techne* of socialist health care, came to appear increasingly out of step with the new models of appropriate patient care adopted by the nuns and the managers of the institution. The latter developed not only as a result of the nuns' spiritual calling, but also in response to an altered economic context of patient consumer choice and competition between health care providers for charitable and commercial, as well as state, funding, which make it imperative to demonstrate the high quality service they offer. In these circumstances, civil nurses were required to demonstrate their flexibility and commitment to meeting patient needs, which were re-defined (particularly within the nuns' ethic of merciful love) to be emotional and social as well as physical. Thus the embodied practices through which nurses re-created and maintained distinctly public and private forms of nursing care were directly defied. In this process, nurses' identification of their practice and expertise with modern health care as a part of the socialist system is challenged. Instead, the nurses' performances of physical care, formerly part of *techne*, come to be seen as *mētis*, i.e., a 'bad' practice left over from the socialist era which inhibits the ongoing development and improvement of patient care. Equally, the informal practices of emotional care previously kept distinct from the state, become *techne*, as emotional care is formally incorporated into a nurse's duties. This demonstrates that relationship between state knowledge and local practice is always the product of shifting historical processes and hegemonic understandings of modernity, public and private personhood, and embodied practices.

¹ Ethnographic fieldwork in the institution was conducted in 1998-9, 2004 and 2005.

² See for example 'Pečující rodina, a co dál?'

³ In addition, the Czech prison service manage a low security women's prison within one wing of the building. 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. The prison service's involvement in the institution is a complex one, a full exploration of which is beyond the scope of this paper. In short, the prison service had from the early 1990's become made significant financial contributions to the costs of refurbishing the building in return for the permission to establish a small prison facility on site. This collaboration is explained by the congregation and the prison service alike in terms of a 'return to tradition', since prior to its appropriation by the communist government in the 1950's, the building had functioned mainly as a female penitentiary managed by Borromeo nuns on behalf of the state.

⁴ Analysis prisoners' and patients' experiences of the nursing home is beyond the scope of this paper, although I briefly discuss some aspects of patients' engagement with nurses below. To a certain extent, the tensions around care that are the focus of this paper proceeded independently of patients' and their relatives' expectations of institutional nursing care, although the latter were of course part of social relations and daily realities within the home. Equally, female prisoners were positioned quite differently (from civil nurses and nuns) in relation to these tensions, since their caring work was an explicit part of a program of rehabilitation particular to the prison regime within the institution, discussion of which would require considerable analysis for which there is not space here. See Read (2005) for further discussion of patients' and prisoners' experiences.

⁵ Wages were calculated according to qualifications and experience. Older nurses tended 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. At the time of my original research in 1998-9, 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.

⁶ Another way of saying this is that the civil nurses did not perform emotional labour. The concept of emotional labour, originally formulated by Arlie Hochschild (2002 [1983]), denotes 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 commodified a form of labour as physical labour within capitalism. See Adkins (1995), (2002), Adkins and Lury (1999) and Bolton and Boyd (2003) for further discussions of the concept. Whilst emotional labour was not part of nursing practice as historically constituted in the socialist health care system, the nuns and managers of the institution increasingly saw emotional identification with patients as central to a nurses' duties, and this generated tensions and conflicts as I go on to discuss in depth. In the light of these conflicts and contested boundaries I 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 nurses' duties.

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