CARE AND EMOTIONS: GENDERING THE EXPERIENCE OF NURSES IN AN ONCOLOGY DEPARTMENT

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2009

CARE AND EMOTIONS: GENDERING THE EXPERIENCE OF NURSES IN AN ONCOLOGY DEPARTMENT

Thesis submitted to the

Institute for Graduate Studies in the Social Sciences

in partial fulfillment of the requirements for the degree of

Masters of Arts

in

Sociology

by

Öncel Naldemirci

Boğaziçi University
2009

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of Nurses in an Oncology Department

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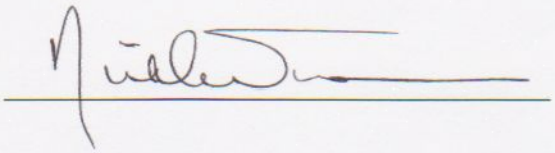

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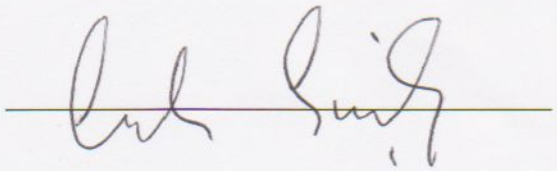

October 2009

Thesis Abstract

Öncel Naldemirci, "Care and Emotions: Gendering the experience of nurses in an oncology department"

This thesis aims to illuminate the nursing practice through nurses' narratives which are collected during an ethnographic research in the oncology department of a state hospital in Istanbul. The nursing is thought and designed to be a profession for the care for patients and the professionalization of care is contentious. Nurses are considered to perform a gender-neutral, technical, task-oriented profession due to their education; however, care is an area which is fraught with emotions, ethical considerations and unpredictable encounters. This thesis investigates how nurses act in the specific care relations, manage their emotions, found an ethical repertoire through narratives and open up a creative and collective space between professional and familial care.

Detachment is examined in terms of non-display of emotions and of certain self-reflexivity of the nurses during their practice and discussed as a particular emotional labor. Also, the ethics of care as narrative is discussed to show the contextual, relational and changing nature of care.

The main argument is that nurses fill the voids of their profession(alization) by particular ways of knowing, experiencing and practicing and that their experience is gendered in both personal and professional domains.

Keywords: Nursing, emotions, detachment, ethics of care, narrative, death.

Tez Özeti

Öncel Naldemirci, "Bakım ve Duygular: Bir onkoloji bölümündeki hemşirelerin cinsiyetli deneyimleri"

Bu tez, hemşirelik pratiğini, İstanbul'da bir devlet hastanesinin onkoloji bölümünde gerçekleştirilen etnografik bir araştırma sırasında toplanan anlatılar aracılığıyla aydınlatmaya çalışıyor. Hemşirelik hasta bakımı için düşünülmüş ve tasarlanmış bir meslek olmuştur ve bakımın profesyonelleşmesi tartışmasız olmamıştır. Hemşirelerin aldıkları eğitimle cinsiyetin belirlemediği, teknik, iş odaklı bir meslek icra ettikleri düşünülür, fakat bakım duyguların, etik düşünmenin ve ne olacağı belirsiz karşılaşmaların alanıdır. Bu tez, hemşirelerin özel bakım ilişkilerinde nasıl hareket ettiğini, duygularını nasıl yönlendirdiklerini, anlatılar aracılığıyla etik bir repertuarın nasıl oluşturulduğunu ve meslek olarak bakım ve aile bakımı arasında kolektif ve yaratıcı bir alanın nasıl açıldığını araştırıyor.

Hemşirelerin hastalara bağlanmaması; duyguların belirli bir şekilde gösterilmemesi ve hemşirelerin kendilerini pratikleri esnasında düşünmesi olarak incelenmiş ve özel bir duygusal emek olarak tartışılmıştır. Ayrıca, anlatı olarak bakım etiği, bakımın değişken, bağlamla ve ilişkiyle ilintili doğasını göstermek için ele alınmıştır.

Bu tezdeki temel argüman, hemşirelerin mesleklerinin (ve meslekleşme süreçlerinin) boşluklarını özel bilme, deneyimleme ve pratik etme şekilleriyle tamamladığı ve bu deneyimlerin hem mesleki hem de kişisel anlamda cinsiyetli olduğudur.

Anahtar Kelimeler: Hemşirelik, duygular, bağlanmama, bakım etiği, anlatı, ölüm.

Acknowledgements

I would like to thank my advisor Nükhet Sirman for her encouragement, her guidance and belief in my research. She always helped me when I was lost. I would like to express my feeling of gratitude to Meltem Ahıska. I enjoyed special time with her during long weeks of reading and discussing. She always helped me to ask further questions. I owe very much to Elizabeth Herdman and Leyla Şimşek, both nurses who engaged in social sciences and provided me with help in the areas where I was not knowledgeable. I would like to thank Belgin Tekçe for her insightful criticisms. I became more interested in medical issues thanks to her courses and her dynamism.

The research that this thesis requires could come about only thanks to the scholarship I have been granted by TÜBİTAK. I am deeply indebted to their support.

I owe very much to my family, they provided all 'care' I needed while thinking about 'care'.

I would like to thank Can Altıntaşlı. He informed me with his professional experience and encouraged me to think about care and nursing. My debts are owed to my dear friends Onur Günay, Neşe Ceren Tosun, Ekin Akalın who encouraged me in my work. I am also indebted to the help of Güzin Özkan.

I would like to express my feeling of gratitude to all nurses who trusted and accepted me in the wards and talked about their personal and professional stories. I am indebted to all health care team and Blue Angels in the department where I conducted my research. I would like to acknowledge the permission given to me by İstanbul İl Sağlık Müdürlüğü.

To my mother who struggled to recover from cancer

CONTENTS

CHAPTER ONE

INTRODUCTION

Care as women's work

The entry of women into paid workforce, demographic changes, especially ageing, and medical and bio-technological developments give prominence to the social, economic and political significance of care. "Who will take care of whom?" is no longer only a private issue that can be "intimately" handled at home. Care is much more needed in the world than before. Moreover inequalities are globally reshaped: scholars of the field are already familiar with the migration of care workers, especially women, informalization and under-remuneration of care (Ehrenreich and Hochschild, 2004; Eder, 2006). Inequalities have been reshaped around care. According to Hochschild (2003) there is a "care deficit" in the world. While the population with chronic illnesses increases in number, medical institutions and professionals fall short of supplying the demand for care. The number of nurses per patient is far from the ideal, and not only in underdeveloped or developing countries, but also in developed countries (Helman, 2007). Western countries recruit doctors and nurses from all over the world, and many enterprises organize the mobility of health care team from one country to another: this global trend also impacts the migratory flows.

Like many other countries, Turkey has been witnessing a drastic change in its health system. Recent health reforms in Turkey encourage technocrats to decrease health expenditures (Keyder, Üstündağ, Ağartan, Yoltar, 2007), that is also reflected

in the low employment of nurses. This policy leads to crowded wards with low employment of health care team. One major obstacle to the employment of nurses in public hospitals is the KPSS examination that does not seek to evaluate the practical and professional knowledge and competence of nurses but depends on knowledge on some irrelevant domains such as mathematics, literature and so forth. Therefore, it is a good illustration of the "deskilling" of nurses: many nurses spend years to achieve this test and wait for practicing.

Nurses, as the main professional care workers in the modern health system, have long experienced subordination, deskilling, undervaluation and disempowerment in the work place (Group & Roberts, 2001). However, recent increasing workload crystallizes the problems. Not only does the necessary physical labor increase, but emotional and ethical matters also escalate. The nursing profession is so undefined and unprotected in the medical hierarchy that many different forms of practical and experiential knowledge, merits and problems pass invisible.

To quote McDowell (1999); "the emphasis needed to shift to the characteristics of work rather than the workers, to explore the ways in which gender-specific traits and characteristics are attributed to men and women through the work they do"(p.48). Gender shapes, and is shaped by work. Care as work continues to rely on predominantly a gendered division of labor. Modern health service involves paid professionals, educated in formal institutions and endowed with a form of 'scientific' knowledge, requiring special equipment and environment. The cure is considered to be about 'doing' whereas care is seen as a 'banal' process of everyday life (James, 1992). The most striking difference between care and cure is the gendered division of labor (Porter, 1991). Since the professionalization of cure and

care, medicine has been a predominantly male occupation whereas nursing care has long been considered as one of the archetypal female occupations. According to a patriarchal ideology which posits men as rational, scientific and instrumental, women are reduced to their maternal functions, seen to be 'naturally' emotional, caring and subordinate. Therefore, as As McNay (1999) underlines, "women's entry into the workforce has not freed women demonstrably from the burden of emotional responsibilities" (p.16).

As Marshall (1994) points out,

> The sociological theorization of gender has relied heavily on the 'modernization' story- the differentiation of spheres, the increasing division of labour, the separation of public and private spheres, and the 'functional' specialization of women in 'reproductive' work. This has been at the expense of a more adequate consideration of the potential of modernity to imagine new possibilities for women, which would entail working through the double-edged character of the differentiation of spheres, seeing openings for new means and contexts of identity formation. (p. 28).

Modernity imagined *possibilities* for women: today as feminist scholars have shown, women are imagined to be citizens only through being good mothers for the nation[1]. Similarly their participation to work is seen to be possible only "if social functions equal natural functions, to do certain work is simply to do women's work" (Delphy, 1989, p. 82). Nursing, educating, caring are seen to be 'women's work', and women are ideologically encouraged to perform this work outside the home. While modernity emphasizes the differentiation and separation of public and private spheres, two distinct spheres remain paradoxical in terms of the professionalization

[1] For further discussion, two illustrating articles would be: Afsaneh Najmadi, "Crafting an Educated Housewife in Iran," *Remaking Women: Feminism and Modernity in the Middle East,* ed. Lila Abu Lughod (Princeton University Press, 1998) p.91-125 and Nükhet Sirman 2005 "The Making of Familial Citizenship in Turkey", in Keyman & İçduygu (eds.) *Challenges to Citizenship in a Globalizing World: European Questions and Turkish Experiences,* London: Routledge

of women. To solve this paradox, modern health organizations endeavor to make professional nurses out of 'mothers' by providing them with technical education. However, there is a spectre that haunts the professionalization of nursing: care as women's labor. Women are ideologically associated with the home and emotionality, and men with the workplace and rationality. Women are supposed to have the know-how of care, not only because they are considered essentially, naturally suitable for it, but are also socially, discursively and materially reinforced to gain this 'knowledge'. Hence, Molinier ironically says: "...it would suffice therefore to put "real" women wherever the suffering takes place and they would know what to do, simply because they are women..."[2] Thus, it is not far fetched to try to apply Pateman's argument about the political status of women to their professional status: "they have been excluded and included on the basis of the very same capacities and attributes" (1992, p19). They are vulnerable, emotional, and caring; therefore they must stay at home unless they are needed for these very characteristics in the workplace.

Theoretical Framework: Emotions, emotional labor and narrative.

The 'traditional' nursing practice was to perform the functional tasks of clinical nursing under the control of the medical authorities and emotional detachment was a professional criterion for nurses (Fine, 2007, p.41). This approach was challenged by the increasing importance of emotional and ethical responsiveness of nurses and by new theories like New Nursing. Terms such as empathy, intimacy, holistic care,

[2] "...il suffirait donc de mettre de "vraies" femmes partout où la souffrance s'exprime et elles sauraient comment faire, tout simplement parce qu'elles sont des femmes..." P. Molinier (my translation, 2003, p.9)

emotional care, commitment, and closeness were proposed and practiced in order to re-shape nursing profession (Williams, 2001). For instance, the New Nursing attempts to include what is excluded from the very beginning of professionalization, by redefining nursing care by addressing the emotional character of care (May, 1991). However, it is not an easy attempt; it has to include the gendered and biased history of nursing. Considering care as an emotional activity and disposition becomes problematic in three aspects among others: Emotions have been considered "as potentially or actually subversive of knowledge" (Jaggar, 1989, p.145). Therefore, during the professionalization of nursing, emotions are denied in order to found a rational, empirical and action-oriented profession. Also, emotions are seen as passive and at odds with knowing defined by the male-biased, socially contingent and empirico-analytical scientism. Therefore, as Hall (1989) argues, nursing knowledge that is based "in part on their [nurses'] situation as women in a patriarchal society and in part as women in a specific gender-defined occupation" (p.228) is also rejected because emotions escape the rational, empirical, scientific paradigm of knowing. Furthermore, emotions are seen to be inappropriate for universal morality, they are considered to be natural and unable to construct an ethical thinking. This is to deny the fact that, as Jaggar (1989) underlines, "just as values presuppose emotions, so emotions presuppose values" (p.153).

The term "emotional labor," coined by Hochschild (1983) was an important theoretical endeavor to understand the labor involved in managing emotions. Her analysis has founded emotional labor as the effort workers, especially in the increasing tertiary sector, make to use their feelings in appropriate ways and acceptable visible emotional displays. Hochschild (1983) argues:

> This [emotional] labor requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in

> others-in this case, the sense of being cared for in a convivial and safe place. This kind of labor calls for a co-ordination of mind and feeling, and it sometimes draws on a source of self that we honor as deep and integral to our individuality. (p. 7)

As this quotation underlines, the idea of self is important in Hochschild's conceptualization. However, in order to show the great range of emotional expression of certain bodies, the circulation of and working on/with/through emotions, I rather concentrate on the subject formation of emotions in a particular context instead of focusing exclusively on personal and professional selfhood of nurses.

Moreover, Hochschild's term "transmutation" suggests that private feelings turn into organizational displays through training and supervision. Her conceptualization re-invokes emotions into the domains from which they were excluded. Nevertheless, I would argue that Hochschild's conceptualization escapes the complexity of this very "transmutation", overestimates the external control of emotions and pays scant attention to particular contexts, such as care situations, which may radically differ from each other. The main purpose of this thesis is to inquire about the professional problems the predominantly female nurses face. How they deal with their emotions, and 'emotional work', how they are dynamic, knowledgeable agents in the regulation and management of feeling, which social and psycho-social strategies they use to defend their profession as a 'multivariate and skilled' profession in the Turkish context, in which until very recently (02/05/2007) nursing has been legally considered as 'women's work,' are main points of interest.. I think that nurses' stories create an area of critique of the unequal gender regime in which they are embedded and doomed to act. The work narratives of nurses also serve to illuminate aspects of practices and experiences that surround a particular,

chronic and fearful illness such as cancer. By attempting to hear silenced voices of nurses, it is possible to rethink the so-called cold, calculative, efficient hospital environment in a different way.

In this objective, this thesis will theoretically engage in five parts: Firstly, it will highlight through my field work story, how nurses' voices are under the control of the medical, male, and bureaucratic authorities. Secondly, with particular attention to daily encounters and practices, it will elaborate on "doing gender" theorization and show how nursing is a gender-defined and gendering profession. Thirdly, the detachment of oncology nurses will be examined as a specific way of working on/with/through emotions, and I will describe these efforts in a context and discuss theoretically the use of emotional labor. Fourthly, this thesis will deal with the ethics of care as narrative practice and highlight how nursing can be an area where ethical thinking as narrative challenges the professional ideals of nursing care and invokes emotions as important sources of knowing, acting and practicing. Finally, death in the clinic will be analyzed according to these perspectives and nurses' attitudes towards the dying patients and their relatives will be shown to be both gendered and productive of a gendered ethical practice that needs to be recognized.

The Field

Any medical department could be a site of research for above mentioned concerns. However, my purpose about emotions, ethical concerns, encountering death, and knowledge and experience pushed me towards the oncology unit. My preference for the oncology department has several reasons. Firstly, my concern about human vulnerability, care and illness has started after my mother's being a cancer patient.

As a young sociology student full of ambitions and seeking a career, I had not thought about the significance of interdependence and care. My mother's becoming a cancer patient contributed to my rethinking of human relations outside the infertile dichotomy of autonomy versus dependence. Secondly, after Sontag's brilliant essay (2003) we came to think of cancer as more than a disease, it is a metaphor: the circulation of this metaphor is as real as the physical reality of disease. Cancer patients coming to the oncology unit are full of anxiety, fear, and sorrow. It happens that they are more demanding or reacting than other patients. Nurses who take care of cancer patients are expected to be responsive to this very circulation of metaphor and emotions. Thirdly, the oncology unit in which I conducted my ethnography is an old one, where oncology doctors and nurses and other health care professionals are quite experienced; therefore the number of patients never decreases. There tends to be more patients than health care teams and available services, such as beds, trolleys and rooms. Thus, encounters happen in all spaces of unit, they are not confined to wards or rooms. Finally, I have to stress that cancer may be difficult to diagnose unless patients have specific symptoms or have a basic medical knowledge. I am told that many cancer patients in the fourth stage "come too late" to the unit because they do not know about medical affairs. Therefore, death in the clinic is not rare and as "there is nothing left to do", nurses spend more time with the patients than doctors do.

Methodology and Data Collection

With the objective of exploring nurses' experiences in practice, I conducted ethnographic research and collected qualitative data from a group of nurses working

in the oncology department of a large and well-known hospital in Istanbul. I was introduced to the nurses by my acquaintances within the *Blue Angels (Mavi Melekler),* which is an organization constituted mostly by middle aged, middle class women. Most of them have been cancer patients previously and after having recovered, they share their experiences with patients and help nurses and patients' families in the oncology department. They welcomed my research and were quite helpful in the process of my adaptation into the hospital environment. After fulfilling the requirements of the local authority of Health Ministry (*İstanbul İl Sağlık Müdürlüğü*), my fieldwork was conducted using semi-structured interviews-both in depth and focus group- and involved approximately twelve months of observation in many parts of the unit. My interviews aimed to collect nurses' life stories in relation to their professional motivations, education, family relations, and work experience.

It is worth noting that any ethnographic research starts with a formula, a design and a large number of questions, these form a vade mecum that is inevitably doomed to fail. Fields are not passive welcomers, they "do" change research. My interviews reflect the work time of nurses, they are inevitably influenced by them, and my endeavor to listen to them whenever they were free of their duties and willing challenged any form of previously structured interviews. While one had to go back to work, another nurse was starting, taking the interview back or forward. Although my questionnaire was semi-structured, it kept being endlessly restructured.

Data Analysis

Although the use of narratives for research purposes has gone on in an informal way for very long and has had its place in nursing and medical practice, it is relatively

recent in nursing research. Many anthropologists, harking back to narratives as reflections and tales of people's experiences, have challenged mostly Western medical definitions, categories and procedures[3]. Quantitative researches show us that caring, especially for suffering and dying patients generates a significant amount of personal emotional stress, traumatic work experiences, and difficult interpersonal relations[4]. I would attempt to keep in my mind the following questions, formulated by White (1987): how nurses translate knowing to telling, how they narrativize fragmented and emotionally scattered experiences, and how the coherence, integrity, fullness and closure of an image of life are negotiated.

Paying attention to Ricoeur's insights (1984) to analyze collected narratives, I started by a naïve reading of texts to grasp their meaning. In the sections where I was personally touched, I moved to structural analyses, categorizations, and themes. Finally I attempted to give a comprehensive understanding of what I was told in a specific environment.

I would argue that in depth look into how nurses narrativitize their work experiences contributes to understanding their gendered experience in three crucial ways, among many others: Firstly, as I attempted to discuss the gendered character of nursing, a spectre is haunting nursing profession: it is nothing but the underestimated, devalorized, invisible, and evidently unpaid, work and knowledge of women. When nurses start to talk, they do not hesitate to negotiate or confront their private and work experiences, for instance, answering a question about changing

[3] Two major examples would be Arthur Kleinman's *The Illness Narratives: suffering, healing and the human condition* (1988) and Margaret Lock's *Encounters with Aging: Mythologies of Menopause in Japan and North America* (1993)

[4] To cite some examples; Loriol M. (2000) *Le Temps de la fatigue.La gestion du mal-être au travail,* Paris; Anthropos; Ekstedt, Mirjam,(2005) *Burnout and Sleep,* Karolinska University Press, Stockholm, "Moral stress and burnout: Qualitative content analysis", *Nursing and Health Sciences* (2003), 5, 59-66

shifts a nurse talks about her marriage. This creates a space, if not a gulf, in the apprehension and narration of care as profession. Different demands, difficulties and strategies of female nurses, once narrativized, can challenge the banalization of nursing qua women's work.

The second contribution of looking at nurses' narratives would be to show how and when 'places' turn into 'spaces' of creating meaning through narratives.[5] For instance, a nurse in the ward waiting for patients to come for blood tests narrates a success story, a story of long years' work experience. When there are no patients around, she does not hesitate to see the ward as her living room and to narrate her life as a difficult one, fraught with responsibilities as a wife and as a mother. Silences, changing tones, shifting genres would be important to see how nurses, with their narratives, mark places. What, where and when to narrate are questions which lead to the genderedness of nursing. Stewart (1996) says, in her brilliant work, that "the 'space on the side of the road' stands as a graphic model to think with. It narrativizes social and moral orders and makes a text not just an object of knowledge but the very place where the social code is continually dissolved and reconstructed" (p.38). Following this point, I would like to call these specific rooms where nurses do not hesitate to talk about their work experiences among themselves, where even nurses working in different sections drop in and start a conversation, *echo chambers*. These chambers are created by stories.

Thirdly, collecting and interpreting narratives could lead to understand the relation of temporality and narrative in a specific context. Narratives are landmarks in the long journey that nurses take in detemporalized technicalization. Nursing is

[5] I refer to Kathleen Stewart's discussion (1996).

reconstructed as a scientific discipline, yet it tends to remain as practice. Its time is not the same as medicine. As Bourdieu (1990) puts it;

> Science has a time which is not that of practice. (…) Scientific practice is so detemporalized that it tends to exclude even the idea of what it excludes. Because science is only possible in a relation to time which is the opposite of that of practice, it tends to ignore time and so to detemporalize practice (p.81).

Nurses are in continual conversation with their own practice, with their own experiences and with patients and their experiences; they are committed to knowing patients in order to care for them. Therefore, in contrast to technicalization and detemporalization, as MacLeod (1993) argues,

> Their [nurses'] stance with the patient is always a temporal one, drawing from the past, being in the present and acting toward the future. Time imbues the interpretative process of noticing, understanding and acting. Their interpretation always happens within a particular situation, with its particular temporal, spatial and historical nature and demands. Their knowing is neither timeless nor context-free (p.194).

To explore this temporality, it is crucial to listen to how nurses narrativize this specific temporality, to define the breaches to the scientific order these narratives represent, and to recognize what I call the spectre that haunts this temporality.

On the other hand, observations are important to see first hand regularities, encounters and tactics, to allow their narratives to take me to another context. Not only would I be familiar with the world they talk in and through, but also I would share a part of their experience. It is quite instructive to listen to nurses in their work place, where they exchange stories.

CHAPTER TWO

TEXTS AND BUREAUCRACY: How to Start Fieldwork with Nurses in a Medical Institution? Male Doctors, Male Bureaucracy, Female Nurses?

Introduction

> The social sciences are talking sciences, and achieve in texts, not elsewhere, the observability and practical objectivity of their phenomena. This is done in literary entreprises through the arts of reading and writing texts ...and by 'shoving words around' (Garfinkel et al, 1981, p.133 cited in Czarniawska, 2004)

If one seeks to conduct anthropological research in a public hospital in Turkey, every step of the researcher is telling a story in its own. Public hospitals are crowded, noisy, and chaotic, but it is not to say that hierarchy, bureaucracy and control mechanisms of the institution do not maintain an order which is reluctant to open its doors to an outsider. Where to start, how to find key informants, to whom and how to explain your research project become major landmarks of a long journey. Even before starting fieldwork, it is possible for a researcher to write pages of notes. It is significant and informative to be self-reflexive when conducting research. This is neither a superfluous, nor decorative endeavor for the rest of the fieldwork; it challenges research questions, theoretical premises and methodological perspectives.

In this chapter, I attempt to discuss the processes through which I had to pass to be able to conduct fieldwork. I describe firstly my first steps in a woman's world, among "blue angels" and nurses, and secondly my encounter with the (male) bureaucracy of a medical institution. As you remember, Kafka's *Castle* appears as an insightful description of the absurdities of the impersonality of bureaucracy. My aim

is to show how 'personal' bureaucracy can be and how impersonality appears to be a strategy of avoiding a researcher's request whenever "personal" relationships are no more sustainable. Finally, I will elaborate on theoretical and methodological aspects of these processes with regard to my main endeavor to understand nursing work.

Angels' world

> Gender is always there – a latent, omnipresent, background factor in every communicative encounter, with the potential to move into the foreground at any moment, to creep into our talk in subtle and not-so-subtle ways. (Holmes, 2006, p.2)

In order to conduct ethnography with nurses in an oncology department of a well-known hospital of Istanbul, I got in contact with a voluntary group helping cancer patients. This group is called *Mavi Melekler* (Blue Angels) with reference to nurses who are metaphorically seen as 'white angels'. This group predominantly consists of middle class, middle aged women, who had cancer or relatives who experienced cancer. Their main agenda is to visit patients in wards, to listen to them, to give them advice about the disease, share their own experiences of the illness, of therapies[6], and to offer some tips about hygiene[7] and diet[8]. This humanitarian group is there to share their experiences. Their presence in the wards is quite welcome by patients and their relatives. They serve tea after lunch and do not hesitate to chat with patients and their relatives.

[6] Chemotherapy and radiotherapy are periodic and difficult processes. Many patients, even though they are not hospitalized, come to the wards to get the necessary medication; it causes long hours of feeling of exhaustion and nausea.

[7] During radiotherapy, patients are advised not to take shower.

[8] Folk knowledge about what to eat and to drink is pervasive in the case of cancer. Also, the mass media gives unceasingly tips for diet. Blue angels and patients go over these tips, such as eating fruit; drinking herbal tea are discussed.

However, outside wards, Blue Angels work very differently; they help patients, especially newcomers in the bureaucratic procedure. Following procedures is not easy for many newcomers to the oncology department: patients, or more commonly their relatives, since patients are exhausted and wait in the corridor, have to consult firstly the archives section, register and "open a file" (*dosya açmak*) or retrieve their file for further procedures, and take many "barcodes[9]" to consult their doctors, for tests, in sum for everything in hospital. A patient is a number, in fact a sum of numbers.

Blue angels help nurses, and the hospital team in getting patients to respect the long queues and in accelerating many steps required to get treatment. While they are eager and caring in wards, during these bureaucratic procedures, they use a very official and cold voice; let's say that they put themselves in the position of "knowing state bureaucrats", and the blue uniforms that they wear allow them to act as "powerful" as the professionals in the hospital. Unlike their attitudes in the wards, the Blue Angels shout, scold and despise patients who do not or can not follow the instructions.

My first step in the hospital was through the Blue Angels with whom I started to work "as a young male researcher". My youth and maleness, as well as my status as a student, provided me the first step. I had time and space to observe the hospital environment. I accompanied them in many sections of the oncology department. The hospital team and many patients knew them, and Blue Angels were not restricted in terms of access to different sections of the hospital. It was surprising that they were with a young man, but I was never questioned about my presence. I explained my research proposal to them, and although they did not really pay

[9] What they call "barcodes" are specific etiquettes with a series of lines of varying width that can be read by optical scanners, they are put on papers, test tubes etc. to identify patients.

attention to my explanation, they encouraged me to be with them, by adding at every occasion that "hospitals are really important to understand *sociologically*". I was welcome as a "student", as a "son", as a "young man who has too much to learn".

The Blue Angels introduced me to the nurses. Many nurses thus welcomed me easily. I told them about my research. Older female nurses were warm, and talkative, but the younger ones seemed to be indifferent to my presence. During my first day among the nurses, an older female nurse, to break the silence told a short, funny and implicitly sexual story to accept me in their environment. She said;

> Seeing you, listen to what I remembered. [She smiles] While I was working in the emergency ward, the boyfriend of a friend came to see her, but it was so crowded that I put him in the queue, I tried to give him an injection! [She laughs] "Wait sister, I am a friend of somebody here" he said. How could I know, you can't imagine how I laughed[10]

Listening to this story which sounded funny but absurd, younger nurses smiled and took a look at me. I was a stranger, a man but this story helped me be accepted. A man may either be a lover or a patient according to her story[11]. I was neither a lover to one of them, nor a patient; silence in the first encounter was because of my "unknowable" situation of a researcher. This "ice-breaking story" paved the way for others and older nurses were eager to tell stories while younger ones continued to talk among themselves. Stories are more efficient than any other possible bureaucratic permission; they are quotidian, contextual, gendered and open a space for the dialogic creation of meaning. This story constitutes an emerging frame that develops and easily absorbs the new event (my arrival in department, for instance). This story, even if it could have happened differently, was a verbal contract

[10] Seni görünce, bak aklıma ne geldi. (gülümseme) Acilde çalışırken bir arkadaşın sevgilisi gelmiş ama o kadar kalabalık ki sıraya soktum, az kalsın iğneyi yapıyordum (gülüyor)"Dur abla, ne yapıyorsun ben falancanın arkadaşıyım" dedi...Ben ne bileyim dedim, ama nasıl güldüm.(gülüyor).

[11] Another possibility is to be a male colleague, which was definitely not my situation.

regulating my presence. As Bruner (1990) claims, "stories are especially viable instruments of social negotiation" (p.9 cited in Czarniawska, 2004), so our negotiation was hidden in this story: I could be there, among them but if I did not respect and inform them correctly, they could punish me, by giving me the injection, for example. My gender was reminded me, implicitly, through an anecdote; however, it was not exclusion, but a narrative reiteration of our standpoints.

My second step was to talk in depth with nurses about my research project. They were not initially concerned about why a young male researcher was seeking to understand their work. My endeavor appeared to them useless and superfluous, but during the long hours of conversation where I explained my project, they started to discuss nursing with me and among themselves, and ended up changing their mind, congratulating me for studying nursing, posing new questions and challenging my research questions. I have to confess that having read large amounts of qualitative research about nursing and nurses, I was quite enthusiastic about their work, that is their daily, sometimes tiring, and sometimes very monotonous task. Through these discussions and stories, I questioned my idealization of nursing. Rather than looking for sensational stories, epic tactics versus strategies, exemplary solidarities, dramatic performances of power relations; I started to note what was really happening everyday in wards.

My first observations and interviews took place in this environment. I was 'shadowing'[12] them in their daily activities and in their rest times. During informal discussions, female nurses shared with me their ideas about life in the hospital, encounters with patients, and the difficulties of their work. Although they talked about "stress", "emotional burden", they were reluctant to see emotional labor as part

[12] Shadowing involved observing and noting participants' interactions and activities for continuous periods. I attempted to ask questions to participants *in situ,* being attentive to their work, inviting them to make commentaries about their activities. For an elaboration of "shadowing", see McDonald, 2005.

of their daily work. They accepted that there were "emotions" circulating in their work place but they were not a component of their work, they were the "extra" of their work experience. To make the emotional labor clear for them, I explained the external control of emotions, certain displays. External control of emotions appeared to them in contrast to what they thought about their 'real' emotions. Their emphasis was on the authenticity of emotions. In my review of the literature before starting my fieldwork, I was thinking in terms of Hochschild's theorization (1983) of 'emotional labor', through which I was hoping to apprehend the genderedness of the nursing profession and women's invisible experiences, underestimated knowledge and unpaid labor. My clumsiness was obvious; nothing in the field fitted my former conceptualization. Nevertheless, I was given many questions, descriptions, and hunches about gender. Although they were not reluctant to talk about their lives outside the hospital, the fact that I was a man prevented them from sharing intimacies with me, especially jokes, which were probably sexual and jokes about other colleagues.

However, their lives outside, their gendered experience of being a double care-giver (being wife, being mother, and taking care of elderly people at home) did not cease to appear in their narratives of care and nursing. Following my questions about care, the ideal of care, ethics of care, they started with canonical definitions, which were not free representations of their practices (Nelson & McGillion, 2004), then in time, they challenged these ideals by contesting primarily the organization component of care with reference to James' definition (care = organization + physical labor + emotional labor, 1992), emphasizing "tiredness", bodily discomforts, and the overload of patients per nurse.

The first steps in the field during which I respected ethical rules concerning the intimacy of patients and work time and the confidentiality of nurses, my presence -the presence of a young man among female nurses did not escape the attention of doctors. Later when the Blue Angels introduced me to the chef of the clinic, Doctor S., I did not understand immediatly that my research took a different path.

Male doctors, male bureaucracy.

> What men were doing was relevant to men, was written by men about men for men. Men listened and listened to what one another said. (Dorothy E. Smith, 1987, p.18)

Doctor S. is a prestigious oncology doctor and has a good reputation in the department. He has a good communication record with the Blue Angels. He was very friendly to me as well. He was pleased to meet and discuss with me. When he asked about my research project, he was very curious about "a young male sociologist's academic endeavor", however, my concern about care work, nursing practices, and emotions did not please him. He started to try to change my mind, my research area. He advised me to conduct research firstly with patients, then with doctors. I was quite aware of the fact that my research was neither 'scientific' nor relevant in his eyes. In his view, care, nursing, emotions were uninteresting topics for research. My discourse changed as well, I began to talk about the social and economic importance of care, of cancer as a disruptive disease necessitating specific care, the shortage and workload of nurses and so forth. Our informal speech became very formal, underlying the economic, technical, sociological aspects of nursing. It was a rupture in our conversation; I was no more a "brilliant university student", but a "lazy-minded young boy who did not know too much". He even advised me to do research about patients and offered a methodology. Today, many social researchers in medical

areas are aware of the fact that doctors, medical experts, especially male doctors may deem themselves powerful and knowledgeable enough so as to impose their research ideals to social researchers. Cure, care, illness are accepted as over determined, that is to say, as organic, psychological, and social phenomena; nevertheless medical authorities do not cease to push social science researchers to the periphery of the medical area[13]. The fact that I was young and had no medical expertise opened a space for him to try to manipulate my research. There was another issue, I would argue: like the doctor who does not want Darmon to listen to anorexia patients (2005), Doctor S. did not want a stranger to be in their intimacy, among nurses. It was very ambiguous: he did not consider nursing as an important area of social research, but he seemed also annoyed about the possibly dangerous stories I might hear, and of my very presence. This was not particular to Doctor S.; many people that I met in the hospital, especially men, found my research superfluous but they were still curious about what I was told when I was with nurses.

After having seen my reluctance to change my research, he reminded me that I had to pass through the bureaucratic screening of the authorities. He wrote a brief note introducing me, signed it and sent me to talk to the assistant of the director of the hospital, Doctor M. This short text marked an important break. Without totally neglecting me, Doctor S. wrote our personal relation on paper, but by writing it, he ceased to play an active role in my research. When he first met me, he was eager to help me with bureaucratic procedure, which was easy to arrange locally (*hallederiz*), and then my research became suddenly something to be declared to the

[13] I refer to Muriel Darmon's (2005) brilliant essay about her self-reflexive discussion of her fieldwork. Attempting to conduct research about anorexia, she consults a male doctor who reproaches her very severely, humiliates her in terms of her sociological knowledge and sociology as discipline as well, advises her to conduct research on the social perception of anorexia, rather than listening to patients.

administration. The letter was the materialization of a certain liminality, it marked the transition from a personal to an impersonal way of getting permission.

Herzfeld (1993) stipulates that bureaucracy, "despite its claims to a universal rationality, its meanings are culturally specific" (p.47). This small letter showed me that these doctor-bureaucrats construct an informal and very cultural web among them in order to accelerate operations, and that would not be the case for me. A letter starting with "*Dear Brother (Sevgili Kardeşim) M.*" was marking a fraternal contract in the everyday process of an institution. This language was familiar to me, and it was nothing but an "unwillingly written recommendation letter in a patronage relationship". If I had changed my research, there would have been no need for such a letter. It was the first time that I noticed institutional, bureaucratic silencing of nurses by a pervasive male voice. With nurses I was listening to stories, their stories, whereas with doctor-bureaucrats, verbal communication was no more possible; I was given a text, finishing any personal relation.

Bureaucrats' World

> Why do some people apparently become humorless automatons as soon as they are placed behind a desk? (Herzfeld, 1993, p.1)

M., like many bureaucrats in the hospital, was a doctor; therefore he was present in his office for few minutes and went to his other office to see the patients. I waited many hours to see him. On the first day he did not come to his office, nor on the second day. The third day, I could meet him in his office where other doctor-bureaucrats were having breakfast. I was obliged to talk in front of 7-8 men to whom my presence was disturbing their resting time. Doctor M. was quite indifferent, did not really listen to my purpose, had a look at the letter of Doctor S. and told me to

write a petition and bring a letter from my thesis advisor. When I tried to explain my plan to conduct an ethnographic research among nurses, the other male-doctor-bureaucrats stopped talking and started to stare at me. The fact that I was a male researcher interested in nursing amused them, they smiled. My 'youth' was the excuse of such a research[14].

I wrote a brief letter about my research, asked a letter from my advisor as quickly as possible to be able to start my fieldwork 'officially' because nurses started to present themselves as "state officials" and underlined that having an official permission would be better. They did not stop chatting with me during their break time, but I was no more comfortable in the wards, nor were the nurses. With this event, they remembered or had to remember the "ruling relations" of the hospital.

Once the documents were ready, I waited for a meeting with Doctor M. for several days but I could not get in touch with him; he was either in the clinic or receiving other doctors in his office. I decided to directly consult the director of the hospital, taking the risk of not being welcome. His secretary, who was in her early twenties listened to me, I explained my research project in a very 'scientific' way in order to make myself accepted. She took my documents and entered the office of the director. She came back in few minutes and told me that I had to go first to the "İl Sağlık Müdürlüğü", the local authority of Turkish Ministry of Health in Istanbul. After several weeks, I was really in a real bureaucratic procedure.

When I went to the 'İl Sağlık Müdürlüğü', I first consulted the information desk where employees spent time and energy to discuss the procedure that I had to pass through, whom I had to talk to and where to start. I talked with many bureaucrats who did not hesitate to make jokes with puns like "*Do you want to be*

[14] I have to confess that my unconformity to "hegemonic masculinity" is another reason for their amusement. My gentle manners, my thin body are deviations from the masculinity in their mind.

with nurses?" "*Look at him; he wants to work on nurses"*[15] adding very eroticized and indecent smiles. Then I wrote another petition there and went to the archives section to get a number for it without knowing why. I was told to give my documents to the *Strateji Geliştirme Merkezi* (Center for Developing Strategies). I started to look for this center; my itinerary became Kafkaesque enough since this center was indicated to be at the end of a corridor, yet this corridor had no end but gave on a half-stage. Finally, I found the office where there was a new secretary to whom I explained my purpose. She looked at my documents very briefly and did not consider them to be sufficiently 'formal' without even reading the content. She handed me a model and asked a letter from the administration of my university. Then, I prepared a new file, asked a new letter from my university, and gave it to them. While waiting for a possible answer, I continued my fieldwork without any formal interview. However, the nurses were not willing to share their critical points of view, their stories which could be challenging since my presence became problematic. The personal relations we developed before the bureaucratic procedure were in crisis.

Three weeks later, I had a phone call and I was told to change the format of my questionnaire. I had designed my research as an ethnographic one, now I was expected to change it from a qualitative to a quantitative research. It was crystal clear that the authorities did not want me to "talk" with nurses, they insisted on the survey model. In order to get the permission to "be there", I prepared a survey. I could write what I had to say, focusing on my observation notes and informal talks as well. Then, they invited me to sign a protocol. I care about the ethical issues and I think that protocols are important to protect intimacies, and confidentiality, especially in medical areas. However, the protocol that they gave me was not concerned about

[15] "*Hemşirelerle mi olmak istiyorsun?", "Bak bu çocuk hemşirelerle çalışmak istiyormuş"*

ethics; it aimed mainly to protect the public hospitals from castigation and to control research at every step. Two clauses in the protocol are specifically important to highlight. One clause says that the researcher works together with an official from the institution[16], which means that not only are the independence, and confidentiality of the researcher impossible, but also a researcher can be there only as a state official, like an inspector. The second clause is about data: it states that collected data will be scrutinized by the authorities and can be sanctioned[17].

Closure of a field or shifting research?

I thought about two weeks whether to continue or give up my research. I could arrange anonymous and outside interviews with nurses, but it was against my specific aim to study daily practices, and collective and individual stories at the work place. Going to another, maybe private, hospital was an option: but since I had developed a personal relationship with nurses at this oncology unit, I was hoping to continue.

When I questioned the secretaries of the Center about these clauses, they answered me that it was just a bureaucratic procedure, a "text" and that in fact they neither provided any official from the institution, nor controlled the data. I was surprised, but understood the mechanism: if you present everything as "correctly" as indicated in texts, you can become somehow free in the field. The mechanism of getting permission is bureaucracy par excellence, only the procedure matters.

[16] "Her çalışmanın biri Sağlık Müdürlüğü personeli olmak üzere en az iki yürütücüsü olacaktır."

[17] "Çalışma yayın/tez haline getirilmeden önce Sağlık Müdürlüğünün ilgili şubesi tarafından verilerin analizi değerlendirilecektir. Toplum sağlığı açısından sakıncalı verilerin yayınlanması kısıtlanabilir."

After acquiring 'official permission', nurses, especially those who really wanted me to conduct this research, were relieved. I explained my strategy, they agreed with me and said that there was no sense in "filling in the blanks" of a survey, and except one nurse who was recently enrolled, all consented to narrate their work experiences and to be recorded. However, in order to break the impersonal, cold face of protocol, I had to rethink my research.

Multiple sites of ruling

Nursing has had a rich but sad history of disempowerment in terms of discrimination on the basis of gender.[18] As Gamarnikow (1978) puts it, "the family as a symbol for the nurse-doctor relation contained within it this contradiction: it gave women access to a non-industrial job, but at the same time deferred to medicine in setting it up and defining its limits" (p.114). The design of the medical profession as men's occupation and nursing as an auxiliary, a handmaiden to doctors reproduces patriarchal subordination. In addition, the subordination of nurses is reinforced by the bureaucratic hospital system (Bunting & Campbell 1990). Nurses have to face two conflicting ideologies of professionalism and domesticity (Hughes 1990). Ferguson (1984) criticizes bureaucracy as construction of male domination through an abstract discourse of rationality and procedures. Following this argument nurses are "feminized" facing oppressive male power, and therefore care practices are contaminated with the bureaucratic control.

The starting point of my research was to peruse the ideological construction of nursing through specific attention to care practices, group and individual

[18] There are many perspectives to put this discrimination; for instance Merwe (1999) underlines the discrimination of nurses on the basis of race, class, gender and rurality; following my field story, I emphasize gender.

narratives, invested and unnoticed emotional labor. However, 'ruling relations', as Smith (2005) defines them are "forms of consciousness and organization that are objectified in the sense that they are constituted externally to particular people and places" (p.13), are unavoidable in any research in organizations. Besides the fact that the subordination of women as nurses can be depicted and discussed in terms of actual and everyday lived experiences, these "ruling relations" must be taken into consideration; "texts" must be carefully perused and thought in relation to nurses' narratives. The standpoint theory postulating that women's lives might be considered to be a meaningful, epistemological and objective starting point (Smith, 1987) contributes to our understanding of the problematic situation of professional, institutional care in a new light. I wish to suggest that nursing must be treated in terms of both everyday experiences lived by nurses and "*multiple sites of ruling*"[19] in which they experience. Nursing's *esprit de corps,* as feelings of group belonging and solidarity derived from a sense of the position nurses occupy as a subordinate category within the hospital, are remarkable in confronting "ruling relations", limits, power relations, and the gendered division of labor. After noticing the change in the discourses of nurses when the male doctor's bureaucracy gets in the picture, I attempted to follow the traces of these transformations. My real endeavor was to show them my open mindedness and critical understanding and to make crystal clear that my young male body was not a part of the male bureaucratic *esprit de corps*, and

[19] Smith notes ""The institutional order of the society that excluded and silenced women and women's experience is elucidated from women's standpoint in the local actualities of our every day/every night world as they are organized extra-locally, abstracted, grounded in universalized forms, and objectified. The phrase "relations of ruling" designates the complex of extra-local relations that provide in contemporary societies a specialization of organization, control and initiative. They are those forms that we know as bureaucracy, administration, management, professional organization, and the media. They include also the complex of discourses, scientific, technical, and cultural, that intersect, interpenetrate, and coordinate the *multiple sites of ruling." (my emphasis,* 1990)

that I was there neither for their re-disempowerment and surveillance, nor as one of the “academic “experts” who generally tend to employ the language of economic, technical and legal rationality, an idiom which is usually far removed from the everyday experience of caring.” (Sevenhuijsen, 1998, p.79) While collecting nurses’ narratives, I had to be more attentive than the time preceding my bureaucratic adventure, especially to narrative enclaves in which nurses were embedded, to their closures and to my shadowing.

CHAPTER THREE

"DOING" GENDER IN WARDS: the embodied experiences of nurses

Introduction:

That nurses are women and women are nurses is what inevitably social sciences with a feminist engagement problematize. Historical studies highlight how and through which stages and struggles nursing has become a profession and how it is subordinated to the medical male authority (Group & Roberts, 2001). Subordination and silencing of what is experienced, known and transmitted by women since they are women by the medical, male and rational discourses, can be revealed only through a critical feminist methodology (Ehrenreich&English, 1992). From the very beginning of nursing as an area of care outside family and kinship sociality, nursing has reflected a specific gender relationship.[20]

In spite of changes in nursing (deontological modifications, biotechnological novelties, entrance of male nurses and the increase in the number of women doctors, bureaucratic positioning and so forth), it is still common to witness that a patriarchal ideology resists change and continues to shape nurses' bodies and imaginations in their work place. Evidently we can see that male nurses are still very few, or, not surprisingly, numerous in certain more prestigious departments. These increases in the number of women doctors and male nurses tend to hide the gendered division of labor in the medical team, and yet it is not truly successful: the struggles and problems of women doctors show that they are still *persona non grata* in certain

[20] For instance, Gamarnikow highlights how the Victorian family imaginary paved the way for a gendered division of labor in hospitals (1978).

contexts (Pringle 1998); on the other hand, the efforts that some male nurses make to protect their masculinity in a "women's work" show that nursing is still highly related to gender (Evans, 2003).

Today, after the presence of male nurses and the technicalization of nursing, we have to move to meticulous analyses of what is masked in everyday life in order to note that the gendered division of labor persists and female nurses are much more implicitly subordinated to the male dominance in the wards. Looking in depth at the embodied nature of work, at how daily practices and encounters reshape some bodies in specific places, and following the traces of which knowledge and experiences are pushed to the margins and which ones get stabilized at the very heart of the medical work are the two important issues of this chapter in order to ponder upon power relations and hierarchies in wards and to demonstrate that women and their knowledge are constantly outside, unseen, devalued or simply invisible. With this objective in mind, I attempted to examine firstly how "doing gender" is an important concept to think nursing as a gendering process.

Doing gender

West and Zimmerman (1987), with the objective of proposing a new understanding of gender as a routine accomplishment embedded in everyday interaction, argue that "doing gender involves a complex of socially guided perceptual, interactional, and micropolitical activities that cast particular pursuits as expressions of masculine and feminine "natures" (p.126)". Gender is not unchanging, once acquired and accomplished; it entails an ongoing performance under specific structures. As Davies (2003) puts it, "it (doing gender) suggests active performance and subjectivity-

bringing our attention to the ways in which gender relations are (constantly created, maintained and contested in interaction and daily life" (p.720). This dynamic ground is where power relations constantly shape bodies, discourses and relations.

Taking blood "gently"

During my field work, I had the chance to witness many daily scenes among nurses, and between nurses and patients. Let me go over some examples to discuss how femininity is "done" in daily encounters: I spent several work days in a specific medical environment; that is, in the ward where nurses take blood from patients for different blood tests. In oncology departments, periodic blood tests are crucial, therefore during the cure, patients pass through this unit several times. I sat down in a corner where I could observe while they were encountering patients one after another. Each nurse faces more than 200 patients per day; therefore, at the end it was possible to note particular gendered patterns.

Nurses working in the blood test unit (*Kan alım*) start taking blood at 8 o'clock in the morning and the first 3 hours are quite loaded. Patients come with a standard document organized and signed by doctors; they are supposed to take the necessary tubes and queue number in another stand, and then wait to enter this unit. A "blue angel" works at the entrance of the room to check the queue numbers, the documents and the tubes. Some patients forget taking tubes, many do not know about it, the blue angel, therefore, helps people follow the procedure.

Once entering the unit, a patient stays before the nurses for about between 30 seconds and 3 minutes, depending on the difficulties to find the proper vein. This temporally limited confrontation of nurse and patient is indicative in terms of nurses'

practice; however, it is difficult to articulate this very practice without recourse to Bourdieu's concept of habitus. Patients are given typical standardized documents and are reluctant to give any personal information unless nurses talk; that is to say, nurses are there not only to do a specific work, but also to behave in a certain manner after seeing patients' bodies, habits and look. They face bodies before they face patients. As Bourdieu (1990) repeatedly elaborates on it, "bodily hexis is political mythology realized, *em-bodied,* turned into a permanent disposition, a durable way of standing, speaking, walking, and thereby of feeling and thinking (pp. 69-70)." Nurses have a practical sense of knowing how to get in contact with these bodies, how to behave, what to do.

An important aspect in this medical encounter is that gender plays an important role. Nurses are women, they get easily in contact with women rather than men; they start to chat much more easily with women than with men, they are willing to call women patients with close kinship terms ("*my sister, my mother, my aunt*[21]*").* Class differences are much more easily challenged on the basis of being a woman. It is common to hear nurses giving advice to women about menopause, breast amputation and so forth. They are eager to talk about gendered parts of body, and to share secrets.

It is true that destabilizing gender relations may entrench conventional patterns of behavior: women who are supposed to be caring for family members, once expected to perform the same behavior in the work place, invoke certain familial or kinship bonds, at the same time they challenge masculine domination by taking more time with women and not hesitating to denigrate men. Men are quite open to jokes; when they are afraid, when they talk, their masculinity is challenged

[21] *"Kardeşim"," annecim"," teyzecim". It is worthy noting that these kinship terms are used by many people in daily talks to create an intimacy, or they are just formulas which are repeated without any specific reason.*

by nurses. The more a man does not fit hegemonic masculinity, the more he is challenged:

I don't like talkative men, men are supposed to talk very little[22].
Now you are in my hands, see now how many tubes of blood I will take from you![23]

Nothing to do with gender!

My first questions during interviews were to understand the motivations that nurses had before starting their education and whether they saw any relation between nursing and being a woman. Some of the nurses I interviewed answered that their family had influenced their decision, and encouraged them to "have a profession" (*meslek sahibi olmak*). Selma's account illustrates how nursing can be considered by certain families:

> Q: How did you decide to be a nurse?
> S: I did not want it [to be nurse], really, but I am not complaining now, I can say that I like to work as a nurse but at that time, it was for familial reasons, in order to have a profession in a short time.
> Q: Familial? Did your father or mother have an influence on your decision?
> S: Especially my father, [he wanted me] to have a guarantee, [he said that] I could study what I liked afterwards… [It was due to] his insistence.[24]

Selma's account is one example, but it is not an isolated one. Many other female nurses said that their families' eagerness for their daughters to become nurses, had an impact on their decisions. As I mentioned in the introductory part, women are encouraged to perform certain professions which are seen to be suitable to their

[22] Böyle çok konuşan erkeği sevmem, erkek dediğin az konuşacak.

[23] Şimdi düştün elime, bak gör kaç tüp kan alacağım senden

[24] -Hemşirelik mesleğini nasıl seçtiniz?
-Yani, çok isteyerek sayılmaz aslında, şu anda hani şikayetçi değilim, severek yapıyorum sayılır ama o zaman hani ailevi sebeplerden dolayı kısa yoldan meslek sahibi olmak için oldu biraz.
-Ailevi dediniz? Annenizin, babanızın etkisi oldu mu?
-Babamın daha çok, hani elinde garanti bir şeyin olsun, daha sonra nereyi okumak istersen okursun...Babamın ısrarıyla.

gender. Similarly, Esra talked quite proudly about her two older sisters who were also nurses and indicated that they were influential on her decision. However, male nurses are unwilling to talk about their families' role or impact about being a nurse. Hasan, who was quite sarcastic about his talking to a male researcher about his "weird situation", avoided my question with a joke. He referred to the legal change of calling men nurses:

> You talk about nursing/you call me a nurse but… [Silence] I did not choose to be a nurse; the state made me a nurse! [He laughs][25]

Hasan is not exceptional in his sarcasm about being called by the name of nurse among other male nurses. He considers nursing strictly as a profession, as a type of work. He refuses to talk about any emotional, ethical or abstract components of his daily work. Like other male nurses, he prefers to talk about macro issues concerning health care institutions, public hospitals, about low wages, organizational failures and politics. His joke about the state underlines a specific change in Turkey. Before 2007, men could not be nurses *de jure;* although they had the same training with their female counterparts and did *de facto* the same job, they were *sağlık memuru* (health officials). With the change in the law, they became nurses over night. His joke points out this change.

Other female nurses talked about their desire to study medicine and their inclination towards nursing only after their failure in passing exams. Therefore, nursing as a career was chosen with frustration even though they claimed that nursing was as important as medicine.

After considering different accounts about motivations, we can argue that many women are still encouraged to become nurses despite some difficulties like

[25] Hemşire diyorsun ama (sessizlik) Ben hemşireliği seçmedim, beni devlet hemşire yaptı!(gülüyor)

night shifts. These are gendered difficulties, not only is working at night socially stigmatized for women, but also practically it is exhausting since women are supposed to take care of children and household.

Nevertheless, after relating to their families' pressures, female nurses were reluctant to see any relation between nursing and being a woman: most of them thought the arrival of male nurses was hilarious and saw this as a very good change. It was crystal clear that none of the interviewed wanted nursing to be considered as 'women's work'. "It is a 'profession'", they proclaimed even though I had not said anything contrary. This claim is quite understandable since the abstraction of profession is concocted through a gendered hierarchy; the professional is imagined to be the man, the disembodied and the universal. A 'women's work' can not be a profession unless it is shaped according to these biased criteria. As Acker (1990) puts it, the gendered nature of jobs and professions is masked by obscuring the embodied nature of work. Therefore, answering the following questions about daily work, emotions and ethical decisions, they harked back to this very genderedness of their profession. Giving injections was an important issue. Fatma said,

> When they [male nurses] came, we wondered about what we would do, we laughed, he holds an injector for example, he holds it like a brute [she laughs] he can not…do it aesthetically, but now it is ok., they learnt it.[26]

Holding like a brute is my translation; the expression in Turkish is more gender indicative. *Odun* means firewood in Turkish, and *odun gibi* is used especially for men who do not have manners or any *finesse*. By a certain detour, Fatma highlights a certain posture in everyday practice; it is difficult to find veins for injection, especially with cancer patients who have chemotherapy. It entails therefore a certain

[26] Geldiklerinde ne yapacağız diyorduk, dalga geçiyorduk aramızda, iğneyi tutuyor mesela, odun gibi tutuyor (gülüyor) elinde şey yapmıyor…hiç estetik falan yok diyorduk, şimdi gayet iyi, çok güzel uyum sağladılar.

attention and subtlety. Besides, it is well known that many people are scared of injections. Aliye said:

> At the beginning, patients want us [female nurses] to give them an injection, since our hands are light, then they got used [to male nurses].[27]

Although female nurses reject any relation between their gender and nursing, they do not hesitate to refer to an aesthetic, which is very much related to a perception of female softness, subtlety and *finesse.* They claim that they have these abilities, inscribed on their bodies. It is important to note that any finesse could be suspicious if it is to face more than 100 patients per day. It would not be an exaggeration to say that considering the work load and rapidity that is demanded of them, they are comparable to assembly-line workers. Nonetheless, they still consider themselves as having a certain bodily finesse.

Another area where gender haunts their everyday is when they talk about emotions and see a relationship between nursing and emotions. As I discuss emotions and emotional labor in the following chapter, let me mention here only their willingness to see emotions as a component of their daily work. Male nurses' accounts are very poor of a certain vocabulary of emotions; they did not share with me their stories and thoughts about how to deal with emotions in the work place. Wages, patients' education, major factors of cancer were much more preferred topics. I do not argue here that they have nothing to do with emotions or they do not feel, but I can insinuate from my standpoint that men do not talk too much about their emotions, and do not acquire such ability, such a language, especially among themselves. However, most of the female nurses, although they have differing attitudes towards being emotional/working with emotions, claimed that emotions

[27] Başlarda hastalar biz yapalım istiyorlardı, elimiz hafif olur diye, sonra alıştılar.

such as fear, sorrow or anxiety are present in their practice; many, however considered being emotional to be a professional failure. Emotionally detached or over-involved, they talked about emotions sticking to their bodies. Their bodies are open to emotions in their accounts, not only on the surface (to be smiley, to look calm) but also inside (holding it inside/*içine atmak*, not being able to leave them in the work place/*işyerinde bırakamamak*): the genderedness of their bodies is remarkable in this respect. They did not always consider this openness to be a failure, but a certain requirement when working with people, for communication, for care. After first putting nursing as a gender neutral profession, Esra's account reveals how nursing is gendered:

> Women are a little bit more meticulous, more caring...Therefore, they may be more sensitive. At least for communication, even though we sometimes see the contrary in our profession...We know people who are not emotional, who do not behave sensitively, they will always exist, but in general, it is like this, I think women are more caring, because they have a maternal insinct, they are more giving, more sensitive, their attitudes are always different. They are more emotional than men.[28]

Doctors are men, are nurses handmaids?

After discussing a few examples about the gendered aspects of nursing in daily encounters, it is now time to move to interactions between people from different *esprits de corps*, collective bodies, from different positions in the gendered division of labor. Nurses do not cease to reiterate that they are neither "recognized", nor

[28] Kadınlar birazcık daha detaycıdır, daha özenlidir...O yüzden birçok konuda daha hassas olabilirler. En azından iletişim açısından, her ne kadar meslek grubumuzda bunun aksini de görsek...Bu konuda çok duygusal olmayıp, çok hassas davranmayanları da biliyoruz, onlar her zaman olacaktır ama genel anlamda öyledir, kadınlar daha özverilidir diye düşünüyorum, çünkü bunda annelik içgüdüsü vardır, daha vericidir, daha hassastırlar, o yüzden yaklaşımları her zaman daha farklıdır. Erkeklere göre biraz daha duygusal bakarlar.

respected. Although policy statements contain clauses indicating that nursing is not considered as a profession, the resentment and misrecognition the nurses feel are much more shaped in the daily interaction required by the hospital routine.

Doctors

Doctors in the oncology department are predominantly male and except routine counseling, senior doctors do not spend time in the wards. Junior doctors, albeit present in their offices, are more likely to stay there until they are solicited. Nurses regulate all work in the wards, from organization (shifts) to specific tasks (injections, providing pillows, palliative therapy, etc). However, they are strictly expected to defer to doctors' orders with regard to caring plans and also to doctors' demands concerning the care and in-hospitalization of the special patients of the doctors. After many interruptions during the interview with Selma, the chief nurse, she said:

> S: Excuse me, here there is always something to do, we do everything. Where were we?
> I: We were talking about the (hands-on) care of patients.
> S: Ok, there are hospitals where care is given. I don't say that it is not the responsibility of nurses, but conditions must be better. There must be more nurses, not three nurses for 40 patients, otherwise therapies would be impossible to carry out. Here we are burdened with other tasks besides care. There is a special section called medical secretariat but they do not employ medical secretaries, we do their job as well. Documents, many irrelevant things, you take care of them. Why? Because there is no definition for this profession. Doctors say that…For instance, one day a doctor, whom I like very much, sent me a patient whose file was missing. I had a look at the office, at the archives, but I could not find it. I thought that maybe junior doctors took it to study it. I called back to ask, but this doctor, before listening to me started to yell: "Do you want me to leave my patients and come there to look for the file? It is not my job". Looking for files is not my job either. Patient's file is missing, whose job is it to look for it? There is nothing like this. But patient needs it, how will he do without his file? Finally, the patient went to the archives, and found it. There must be job definitions but you do it whether you like it or not, for patients' sake, so as not to have problems yourself. You do it whether it is your job or not, you

> do many absurd things. But this is really absurd: "it is not my job!" it is really neither mine (she laughs)[29]

Selma's story is quite indicative: firstly, she underlines the un-defined nature of nursing; it is due both to the insufficient numbers of nurses and health care team and the pervasive understanding of nursing as handmaiden to medicine. As depicted in her account, there appears always something which challenges any regularity at work place. Work, in the name of order, organization, and hence profit, has been conceptualized as a human activity where any unexpected happening, event, obstacle is not welcome. Following Lacanian understanding of real as that "which is impossible to symbolize", the real of work is the unexpected, the surprise, the un-working of the system which resists a pre-given solution with conventional methods. A sudden breakdown of a machine, a patient's unforeseen death, and a missing file can illustrate how pre-given working regularities fail. It creates an uncomfortable situation where actors have to think about a solution. Nurses are thought to be the first ones in the oncology unit to solve daily problems, which, like in this account, seem to medical authority as worthless. "Doing everything" in wards is therefore linked to doing gender. The expression in Turkish "*çekip çevirmek*" is used

[29] S: Kusura bakma, burası böyle, her şeyi biz *çekip çeviriyoruz*. Nerede kalmıştık?
I: Hasta bakımından bahsediyorduk.
S: Ha, yapıldığı yerler var. Hemşirenin görevi bu değil, yapmamalı demiyorum ben. Ama yapılacaksa şartların düzeltilmesi lazım. Yani 40 tane hastaya 3 hemşire bakmaması lazım çünkü tedavisini yapamaz o zaman yani. Burada biz hasta bakımının haricinde şeylerden sıkıntı çekiyoruz biz, işte tıbbi sekreterlik diye bir bölüm var ama böyle bir alım yok. Sen sekreterin işini de yapıyorsun. Evraktır, şudur, budur, ya da alakasız görevin olmayan bir sürü iş yapıyorsun. Niye? Çünkü meslek tanımın yok ki. Doktor diyebiliyor mesela geçen gün sevdiğim, iyi anlaştığım bir doktor...Sabahleyin hastanın dosyası kaybolmuş, buraya bana göndermiş, birkaç yere baktım servise arşive ve bulamadım. Aradım asistanlarınız da olabilir mi diye, çalışma yapıyorlar çünkü onlar alıyor bazen, sabah gerginliğiyle arar aramaz, daha ben söyleyeceğimi söyleyemeden, "işte ben polikliniği bırakıyım" "hasta bakmayı bırakıyım da dosya mı arayayım? Benim görevim değil". Dosya aramak benim hiç görevim değil ona bakarsanız. Hastanın dosyası kaybolmuş, bu kimin görevi? Böyle bir şey yok ki. Sonuçta ama o hastanın sorununu halletmek zorundasın, o dosyayı bulamazsa, nasıl muayene olacak, nasıl tedavi olacak, nasıl işini halledecek? En nihayetinde hasta gitmiş bakmış, yok demişler ama arşivden çıktı. Şeyi bu olmamalı, tanımı belli değil ama ister istemez yapıyorsun, hastanın işi hallolsun, sorun yaşamayayım diye. Yapıyorsun görevin olsa da olmasa da bir sürü saçma sapan işi de yapıyorsun. Ama şu saçma yani "benim görevim değil." Benim de değil o zaman (gülüyor)

especially for household work and by women. It means that they provide labor for many little things so that order is sustained. Their labor is not noticed unless the real of work can not be managed.

A naïve reading of this story shows also a certain power relationship in everyday life: doctors enjoy giving orders to the nurses and expect them to be their handmaidens, even outside the medical requirements. However, nurses are not supposed to think about any orders they are given. Ilke talked in detail about why nurses know more about the patients than doctors, as did many other nurses: they share more time with the patients, and they know their bodies, previous treatments, illness, their relatives' attitudes and so forth. Ilke complained about doctors' reluctance to see their knowledge to be as important as theirs:

> When a doctor makes a mistake you have the chance to correct it, if you know it and if you are allowed to tell it. But when we say here "Sir (*doktor bey*), there is a mistake", they say (imitating, angry) "why do you intervene? You decide yourselves?" It is always like this: "Do you know too much, you?" Then you stop it immediately. Even when you know, let's say that I know, when I send back the patient to see her doctor, I am treated by "What is it to you?!" (He says :) "I wrote this order, you, you will do it."[30]

As Ilke puts it clearly, in everyday life, most doctors are not eager to hear any objection from nurses and their knowledge stemming from knowing the patient or the procedure is silenced. Imitations of doctor by nurses show us a gendered power relationship: doctors may behave to nurses as rudely as they want.

[30] Doktor bir hata yaptığı zaman senin düzeltme şansın var, biliyorsan ve sana da bu yetki verilmişse. Ama...biz burada "doktor bey bir hata olmuş" (doktoru taklit ederek, sinirli) "Ne karışıyorsun da, kendi kendinize iş..." Böyle oluyor, "sen çok mu biliyorsun?" oluyor. O anlamda tık diye kalıyorsun. Bilsem de şu var, hadi tamam bileyim diyorsun, geri gönderdiğim zaman "sana ne?" tepkisi karşılaşabiliyorum. "Ben bunu yazdım onayladım, yapacaksın."

Patients

Harking back to Gamarnikow's (1978) triangular analogy, patients are children with a powerful father/doctor and a caring and disempowered mother/nurse. Despite the rejection of nursing as gendered profession, ongoing interactions with patients are doing gender. Many nurses agree that patients prefer to ask them questions, further information and help. They say that patients are afraid of doctors' reactions; however, they respect doctors. As Çağla puts it clearly:

> There is fear more than respect. [Patients think] "If he does not take care of me, what can I do?" If they go to another doctor, this doctor may say "why did you come to me?" Patients think that everything is in the hands of the doctors. The nurse has to take the care. Or [they think] "If one does not do the job, the other will."[31]

Patients believe in the authority of the doctors, they hesitate to discuss it; however, nursing is not an area of skill and necessity: care is not seen as valuable as cure. Therefore, many patients are reproducing the same gendered attitudes towards female nurses. Although male nurses mention the misrecognition of their profession in terms of low wages, they do not tell stories about disrespect. Umut puts it in an amusing tone:

> Many patients think that I am doctor; they dare not ask questions (he laughs)[32]

Women on the other hand are quite aware of the fact that their gender matters in explaining disrespectful attitudes towards them as one of them witnessed:

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[31] Saygıdan çok korku var. "Ya bana bakmazsa, ne olur, başkasına kime giderim?" Diğer bir doktora giderse, atıyorum, "Niye bana geldin, o bakıyormuş sana" diyebilir. Doktorun elinde olduğunu düşündükleri için her şeyi, hemşire ne olursa olsun bakmak zorunda ya da bakmazsa öbürü bakar, öbürü bakmazsa öbürü yapar.

[32] Beni hala doktor zannediyorlar, çok bir şey soramıyorlar (gülüyor).

> One of my colleagues got really angry. There was a relative of a patient, he really tortured her. He was coming every ten minutes, asking something, shouting "you don't help". Until morning, she was really suffocated, exhausted. Then in the morning the doctor came, look at me, this was the posture (imitating, getting in a respectful posture) "Sir"[33]

There appears a certain ambivalence in patients' attitudes towards nurses, although nurses are considered more readily available for help, they are also seen as unskilled and easy to question. Selma claimed that during shifts they did not have security because especially after a sudden death, the relatives of patients accuse nurses. She said that many times nurses were even physically attacked. At this point, it is important to note that doctors also witness the harsh reactions of patients' relatives; however, nurses are much more open to aggression and accountability.

After going through doctors' and patients' daily attitudes especially towards female nurses, it is inevitable to take gender into account; nursing has been constructed in a gendered hierarchy, and its genderedness has been objected to by nursing scholars, feminists, pedagogists in order to universalize the meaning and importance of care in society. Nevertheless, a patriarchal imaginary reshapes bodies in wards so as to reinforce subordination daily.

Care as women's unceasing job

West and Zimmerman (1987) discuss three major resources for doing gender: recruitment to gender identities, sex and sexuality, and the division of labor In this section, rather than following the traces of sex-role socialization which might not be

[33] Bir tane arkadaş çileden çıkmış. Hasta yakını, hasta değil ama, yapılmamış işkenceler yapmış, on dakikada bir gelip gidiyormuş, yardım etmiyorsunuz bağıra bağıra. Sabaha kadar çileden çıkartmış arkadaşı. Nefes aldırmamış. Sabahına doktor geliyor. Hareket şu (ayağa kalkıyor, eğiliyor, önünü ilikliyor) "Hocam"

irrelevant since the debated contribution of Gilligan in the conceptualization of care, I would depict and discuss how nurses are doing gender in wards by emphasizing the continuity of the embodiment and imaginary of female nurses between two spheres, which are thought to be distinct.

I asked both male and female nurses to describe one work day in detail. Men did not spend time to start and finish their narrations; for four male nurses that I interviewed in depth, the distinction was crystal clear between work time and private time. Women, on the other hand, started and finished their work day "at home", while passages from work place to home were not marked. Selma mentioned that she was taking care of her parents, Beril talked about her son and his sadness when she left for work. Naile, as a single woman in her forties, marked her work day by her tea rendez-vous with her elder mother, and she did not hesitate to talk about her exhaustion to be caring both at home and at work. Seher, a single woman in her early fifties, said that she took care of her grand-son until her daughter returned from work. Neriman's narration of her work day was indicative of the load and continuity of care work:

> My husband is a doctor; he comes home, and rests. I finish my work day, come home, wash my hands and go to the kitchen, at the same time; I take care of my child. My husband wants to rest since he is tired, he does not take care of our child. All the weight is on my shoulders. With all this exhaustion, you come here to restart to work (…) Let me tell you my routine: I wake up 5:30 in the morning, I iron my husband's clothes, if we have uniforms to iron, I can do it only in the morning (she laughs), otherwise I do it in the weekend. I prepare my child's clothes and bag since he goes to a crèche. I take a shower; I put order in the flat if it is messy. Then, while putting my clothes on, I wake my husband, he only wakes up, brushes his teeth, and puts his clothes on. I wake up one hour earlier. At 6:45 we leave home, at 7:00 we are at hospital. Then here's a routine start. My first sentence everyday is "I don't feel like working today" (she laughs). I really don't feel like working. Then the work here. [34]

[34] Kocam doctor, o eve geliyor, dinleniyor. Benim mesaim bitiyor, eve gidiyorum, elimi yıkıyorum yemeğe giriyorum, çocuğumla ilgilenmek zorunda kalıyorum aynı zamanda. Eşim o yorgunluğuyla dinlenmek istiyor, çocuk konusunda da bana çok yardımcı olamıyor. Bütün yük benim sırtımda oluyor. O yorgunlukla gelip sabah burada devam ediyorsun. (…)Ben size şimdi rutinimi anlatayım:

As Neriman's account shows, many nurses highlight the continuity of care work and the similarity of work which is done in the hospital and at home. Not only are tasks similar, but also attitudes seem to be in a continuum. The timeframe of narrative is cyclical. Household work and care work continue at home, what changes is the name women are given; at home they are wives, mothers, daughters, in the hospital they are expected to be as caring as at home, but with differing work realities. This relationship haunts their discourses on nursing. They are expected to be "professional", to perform a "day's work" which is imagined on men's dispositions, bodies and roles. However, their bodies carry different experiences, both negative and positive. "I don't feel like working today" is quite challenging: it challenges the definition of "work" (what does it mean to work?), the double burden of care work, and the devalorization and silencing of care work' characteristics.

For a further step

Gender is more determining in nursing than it is supposed to be. In this chapter, I attempted to depict and discuss how women are encouraged to perform professional care work since they are women, but performing this work provides them with an ongoing performance of femininity, through which they become subordinated to a gendered organizational work. Nursing is deemed to be a profession; however, this name can not prevent it from challenging the very abstract, rationalized definition of

5,30da uyanıyorum, eşimin kıyafetlerini ütülüyorum, formalarımız varsa ancak sabah o saatte ütüleyebiliyorum (gülüyor) Haftasonuna kalacak ya da. Çocuğumun kıyafetlerini çantasını hazırlıyorum, kreşe gideceği için. Duşumu alıyorum, ortalıkta bir dağınıklık varsa onu topluyorum. Kendim giyinirken eşimi uyandırıyorum. O sadece kalkıp dişlerini fırçalayıp kıyafetlerini giyiyor. Ben onden bir saat once uyanıyorum. Yediye çeyrek kala evden çıkıyoruz. Yedide burada oluyoruz. Sonra buranın rutini, zaten benim her sabah ilk lafım "Hiç çalışasım yok benim bugün" (gülüyor). Hakikaten çalışasım yok, çünkü enerjim olmuyor. Sonra burası başlıyor.

the profession. Here, I outlined especially the subordination of nurses in terms of gender roles and underlined their negative experiences. Yet considering gender as doing, as Davies (2003) put it, "equally signals its transformative status, indicating that relations can be changed" (p.721). We have to concentrate on the unpredictability of ongoing-ness and shifts in the rigid gender inequality. In which areas do women feel empowered, skillful and knowledgeable? The following chapters would hopefully support my main argument, and my further emphasis on emotions, ethics of care and death would attempt to discuss in which domains the gendered experience of nurses fills the voids in the rational, medical and male discourses and practices.

CHAPTER FOUR

DETACHMENT OF ONCOLOGY NURSES: Rethinking emotionality and death in hospital

Introduction: Nursing, caring, emotions.

> Solving problems of disease is not the same thing as *creating health and happiness*. This task demands a kind of wisdom and vision which transcends specialized knowledge of remedies and treatments and which apprehends in all their complexities and subtleties the relation between living things and their total environment. Dubos (*italics added,* 1979, p.26)

To define specific features of biomedicine, Gaines and Davies-Floyd (2003) highlight that "biomedicine exhibits a hierarchical division of labor as well as guides or rules for action in its social and clinical encounters. Its fundamental principles, generative rules, and social identities mirror the discriminatory categories of the wider society" (p.3). Nursing is the example par excellence to illustrate this gendered division of labor in the modern hospital system (Gamarnikow, 1978; Porter, 1992). Today, nursing is still predominantly practiced by women although male nurses are increasing in numbers (especially in certain departments where physical force is deemed to be important, like in psychiatric departments (Evans& Frank, 2003)) and are legally supported to engage in nursing (for instance, the nursing law has changed in 2007 in Turkey to allow men to be named nurses).

Defining the nursing profession is quite complex (Hilton, 1997) because medicine is considered to be about 'doing' and science, whereas care is seen as a 'banal' process of everyday life. The rational evaluation of skills as objectively quantifiable leads also to undervaluation of some skills, especially those which are very connected to women and emotions (Thornley, 1996). Therefore, nursing scholars have challenged this very taken for grantedness of "caring = emotions=

women" equation and attempted to redefine nursing qua skilled labor and profession and reformulate the emotional component of care and guidelines and ideals of emotional involvement. Nevertheless, it is obvious that during the professionalization of nursing, emotions are seen to be something in need of being handled "rationally." In other words, emotional experiences are treated "as either a weak and handicapped appendage to reason or as another 'means' to serve organizational ends" (Mumby& Putnam, 1992, p. 471).

Therefore, in this chapter, I endeavor to discuss how detachment, which is considered to be a lacunae of emotion in common sense and a frequent source of complaint about nurses by their patients, entails a particular type of emotional labor and how it is deployed to handle work place problems concerning the impasses of working on/with/through emotions in a rationally organized and sanctioned place, and particularly to open a 'therapeutic' space for oncology nurses who have repeated confrontations with seriously ill patients and death. Following these questions, firstly I review ways of examining emotions in nursing. Secondly I focus on the shift from 'place' to 'space' through emotions and how detachment re-invokes 'place(s)'. Thirdly, some emotional deadlocks faced by nurses are examined to show how ideals of nursing ethics concerning emotions fail and are reshaped around detachment. Then, I attempt to speculate on the detachment of oncology nurses in front of death and what it can possibly mean, by referring to Jankélévitch's conceptualization of dying in three modes (1966). Finally, I discuss the concept of detachment and intimacy in their very relation to gender.

Theoretical Discussion: Working on/with/through emotions?

Albeit diverse, several theories and methodologies serve to emphasize the relevance of emotions in the field of nursing, that contains "emotional zones" (Fineman, 1993). Strauss *et al.* (1982) define 'sentimental work' as "an ingredient in any kind of work where the object being worked on is alive, sentient, reacting" (p.254) and describe analytically its components. Bolton (2001), using Goffman's insights, highlights "the importance of a nurse's ability to manage emotion and to present the desired demeanour in a number of health care settings" (p.85). Molinier (2003), going back to discussions of *metis* and *phronesis,* emphasizes how an ethics emerge from the consideration of emotions in work places. The important proclivity, however, has been to use Hochschild's (1983) conceptualization of emotional labor: she uses the term emotional labor "to mean the management of feeling to create a publicly observable facial and bodily display" (p 7), and uses the example of flight attendants. Emotional labor is sold for a wage and therefore has an exchange value; and through training and supervision, emotional laborers are subjected to a degree of control. Emotion work, unlike Bolton's (2001) Goffmanesque perspective that defines it as 'face work', has a different meaning in Hochschild's theory: she "uses the synonymous terms emotion work or emotion management to refer to these same acts done in a private context where they have use value" (1983, p.7). Albeit criticized, her concept is widely used by many researchers in the nursing area (James, 1992; Smith, 1992; Staden, 1998, Bolton, 2000; Henderson, 2001). Here, I would like to emphasize two points: firstly, as Lopez (2006) puts it, Hochschild, while castigating the emphasis put on 'surface acting' of interactionists by stipulating 'deep acting'

with reference to Stanislasky's theory, overestimates the control of managers and false consciousness, and underestimates workers' agencies. Secondly, as Sass (2000) argues, if emotional labor is cast as external use and control, then "emotional labor can only be a self-alienating experience with negative personal consequences" (p.331).

Detachment may be defined as the act of disconnecting, as indifference to the concerns of others, and it seems at odds with the definition of nursing in terms of caring since caring, even if not essentially emotional, is doomed to invoke emotions such as fear, helplessness, sorrow, anxiety and compassion in varying degrees. I must note that I use the term "detachment". Nurses talk about "professional calmness", "being emotionally at a distance", "not being emotionally involved", and "coldness". I would argue that detachment is a particular way of working on/with/through 'bad' emotions. As Ahmed (2004) highlights, "if good emotions are cultivated, and are worked on and towards, then they remain defined against uncultivated or unruly emotions, which frustrate the formation of the competent self" (p.4) Detachment is therefore, as nurses' accounts underline, neither apathy, nor total indifference, but instead provides a way of caring while protecting one's emotions and perception of self. Still following Ahmed's point; I would argue that *detachment is not the absence of emotion, but a different emotional orientation towards others.*

Nursing is based on a fragile balance: nurses are expected to 'care about' and 'take care of' patients while disassociating themselves from the suffering of the patients. Their tasks and continuous daily contact with the patients render emotional distancing difficult. Detachment serves to protect this equilibrium. However, this is not to say that detachment is solely a type of 'face work' or an organizationally or bureaucratically ruled 'emotional labor'. Although the analytical use of these

concepts may be illuminating for specific research purposes, here, I concentrate on the complexity of working on/with/through emotions by emphasizing the performative aspect of detachment. Performance is not a type of acting which would be another way of putting on a face. Rather, performance, following Butler's perspective (1993), is not a simple fact or static condition of a body, but goes through a forcible reiteration of norms. Even though there are always lacks or excesses in performance, actors negotiate the ways to approximate or challenge the norms, to appropriate these; while reiterating, they become. Performing to be a professional nurse challenges the view of a static management of emotions. Deep and surface acting can be considered in continuum. Performing detachment inevitably leads to a professional habitus which is varyingly incorporated and experienced by nurses, but performance in itself creates a way of doing in daily encounters.

Detachment is also a particular work strategy used by female nurses who have to behave in rationally defined organizational rules that insist on efficiency, while as women, they are expected to be emotionally reactive in daily encounters. To be reactive is not to be active in the sense that they are not supposed to know through or act upon their emotions. Detachment may be seen as a gendered strategy since male nurses define nursing strictly as a profession and put a clear cut boundary between their personal and professional lives. Moreover, like many male doctors, they said that they were expected to be task-oriented whereas female nurses reported that they were considered by patients to be 'cold-blooded', 'heartless' or 'indifferent' if they were concentrated solely on their tasks. "You become a *heartless woman* in their eyes if you do not smile, if you just do your job" said Seher to underline the 'something more' which is demanded from female nurses. Women are supposed to work on/with/through emotions as part of their femininity. However, listening to

emotions is not the criterion imposed on their professional habitus. Female nurses, therefore refer to a detached way of caring in order to re-claim their skills and a better position in the hierarchy of the hospital.

Emotional spaces

> *Les tragédies que ces jeunes filles côtoyaient professionnellement ne les aguerrissaient pas le moins du monde contre les menus drames de leur vie personnelle. De Beauvoir (1964, p.114)*[35]

If at 7:50 am you enter the oncology department which is a spatially small but crowded unit, set apart from the main hospital building: you notice immediately the long queues in front of every desk where patients are expected to get numbers, barcodes and appointments, and you begin to feel the heat and humidity, emanations from living bodies. Those who are going to have radiotherapy are told not to take a shower and the air is stagnant in narrow, labyrinthine corridors. Outside, the morning can be fresh: but inside, waiting people are anxious, sad; some are ready to cry, some are already angry and ready to yell. Others are quiet and thinking with frozen eyes, while some are chatting with each other, in a slow, muted voice as if they were talking about something shameful or catastrophic. You see stretchers with patients in the corridors, you can not be sure if they are still alive; some moan loudly, occasionally, maybe to remind themselves. Living bodies are together with dying bodies, patients look with fear and anger to the ones on the stretchers. At 8:00 clerks start work: they give patients' files which are in the archives section, and numbers for new queues. Silence turns into a cacophony of whispers and sudden calls over the loud speakers. Queues in front of desks start to diminish. Nurses who have been on

[35] Tragedies that these girls witness professionally do not at all harden them against the small dramas of their personal lives. (my translation)

the night shift open the doors of wards that separate corridors of doctors' offices (*poliklinik,* they say) from wards (*yataklı servis*). Putrid effluvia from wards are now mixed with the odor pervading the corridors. Doctors are present in the department from 8:00 till noon break, while the nurses are there all the time in shifts, in the wards, in chemotherapy section, among anxious waiting, suffering bodies, angry and frustrated relatives. Nurses are there, and have to be here and there. They move from one place to another, sometimes quickly, sometimes with visible exhaustion and fatigue in their bodies. Somebody looking for a flight attendant smile can say that there is no "emotional labor" according to Hochschild's definition of the term (1983). Emotional labor is however in the personal attachment to specific patients and not always visible; it can nevertheless be heard: changing tones in small conversations during the performance of ritual tasks, routine courtesies, helpful advice, even though they have to be quick. Despite nuances in voices, these do not represent all the interactions between nurses and patients, it is more often possible to hear nurses talking in an aloof, cool, even cold voice.

I tried to describe how a certain 'place' turns into an emotional 'space'. Hospitals are not 'places' where only scientific rational actions take place, according to medical requirements. Hospitals are also spaces where feelings, emotions, aspirations, activities, sensual perceptions are around. It is true that hospitals are created to be places responding to particular tasks and encounters. However, although space is thought to be an objective problem, it transcends its rational measurability: space is what place comes to be in time, fraught with lived experiences, haunted by former emotional encounters and prone to bear new ones. Hospitals form a miscellany of emotions that emanate from the apprehension and experience of vulnerability.

Doctors can remain isolated in their offices, in their places and task-centered actions, and they spend limited time within this space. Nurses, however, are exposed to this emotional space according to their tasks. Detachment is a way of getting away from emotional 'spaces' where they are expected to be responsive. But the hospital as place is organized through tasks that are to be accomplished according to a rationale. This rationale is independent from patients or their relatives' emotions. Albeit angry at a patient or very touched by her suffering, a nurse can not stay in the office and enjoy distance; she has to go there, do her task and still remain at a distance. To "keep up" carrying out their tasks, they are to be 'detached' from this emotional space where the doing of emotions is pervasive. Beril has just started to walk home, not only to get away geographically from her work place, but also from this emotional space. She said:

> The patients in this Unit are tense. I say alright uncle, alright aunt, but they keep shouting out: what kind of hospital is this? I get upset, but act as if nothing has happened. But anger remains with me. I started to walk nowadays, from home to work, from work to home and it helps. [36]

Another way of detaching from emotional space is again to create "places" at the micro level, where they are- at least physically- away from this emotional burden. They turn this emotional space into places that they make a part of their work. It was very hospitable on their part to accept me in their "places" and very indicative that interviews followed the traces of detachment: from the very beginning of the interview, they highlighted that they were not indifferent when they were encountering the suffering patients and their anxious relatives, and that they felt sad, angry, emotionally exhausted *nolens volens*, but also that they could not show these

[36] Buranın hastaları sinirli oluyor, tamam amcacım, teyzecim diyorum, bağırıyorlar; "ne biçim hastane bu böyle?" diyorlar, sinirleniyorum ama hiçbir şey olmamış gibi yapıyorum...Ama o öfke benimle kalıyor. Artık yürümeye başladım, işten eve, evden işe, işe yarıyor. (Beril)

feelings *there*. Instead they come to "their" places where they can talk about "other things", about daily events with or without importance, but also about their feelings. At this point, my emphasis is neither exclusively on a clear cut boundary between space/place, frontstage/backstage, nor on strictly managing emotions in the work place and releasing repressed feelings in privacy. I would rather argue that emotional spaces provide nurses with certain attitudes, being there but seeming to be on another plane with the patients; detached from people's pain, singularities, but also with a certain self-reflexivity; not reacting, performing detachment, becoming detached, but also thinking of a possible place in order to get out of this space which enclaves, limits, shapes their sense of personhood and their bodies as well as emotions that stick to them.

Their eagerness to talk to me during their breaks in the courtyard is instructive: they wanted me to share their reflection of others and their practice, not their self-reflection. Many interviewees insisted that they focused neither on their own feelings nor on patients' emotions; but made an effort to concentrate on tasks, on the routine of practice like while making an injection.

> Even if the patient is very sad or crying, you can't stop, you shouldn't stop, and there is a certain routine in this job. You become really sad for some but you can not sit down and cry with her. You find a way out and you go on. I don't look in their eyes for instance, I concentrate on my task. (Naile)[37]

Picturing a person occupied with a routine action is very instructive: once her gestures and mimics stabilize, then the routine of action overwhelms, and she forgets herself in her action. Working with people, on the other hand, is a constant reflection on others and oneself, and anything which comes to mind comes with its bodily

[37] Hasta üzülse de ağlasa da duramazsın, durmamalısın, bu işin bir akışı var onu yapmalısın. Gerçekten sen de üzülüyorsun bazılarına, ama hepsiyle oturup ağlayamazsın. Bir yolunu bulup devam ediyorsun. Gözlerinin içine bakmıyorum mesela, işe konsantre oluyurum. (Naile)

expressions, which are not always suitable for the context. A nurse is not welcome to laugh even when the situation is extremely funny, for instance. To be detached relax bodily thinking, remembering, reassessing, reacting; the habitus is bracketed while perceptions within this space culminate. As Naile put it, she was not aloof to the patient's sorrow, but she required a way out so as not to be absorbed and lose her professional attitude in the sea of her sorrow. She was very aware of patients' demands for compassion; however, "suffering with" is seen as an obstacle to continue to perform her job. As many nurses repeatedly put it, nurses do not think of themselves as competent listeners, "sufferers with". They allude to compassion as another work which remains to be named and paid. Many demanded a 'psychologist' in their unit to listen to patients' emotions, and also listen to nurses. One of the nurses put it clearly:

> There are things that you share emotionally with patients, but it is not often because of the work load. If you are one-to-one, you find a way to console her. I don't think it is correct but responding to her demand….Maybe we need another education for that, to be able to be responsive to…For instance we need a psychologist in our unit, for patients, their relatives and for us as well. We have to have therapies. I believe in it. Maybe we must not do it with what we learn in schools, through experience. There must be several successive sessions of therapy. You don't know how to answer, how to behave.[38]

They emphasize this job as an expertise which emotional labor can involve. It is not surprising to hear nurses talking about psychology as a remedy to all human sensibilities although they say that they learn appropriate ways to work

[38] Duygusal olarak paylaştığın yerler de oluyor ama çok paylaşmıyorsun yoğunluktan dolayı. Birebir paylaşırsan da kendine göre bir şey bulmaya çalışıyorsun artık, onu rahatlatacak. Çok doğru olduğunu düşünmüyorum ama sonuçta ne cevap vereceğini... ayrı bir eğitime tutulması lazım belki de, o açıdan ne cevap vereceğimizle ilgili ya da hemşirelerin...mesela bizim klinikte bir tane psikoloğun olması lazım, hasta, hasta yakınları ve bizim için. Sonuçta terapi görmemiz lazım. Ona inanıyorum yani ben. Sen de bu konuda çok şey değilsin ki...okulda öğrendiğinle, tecrübeyle öğrenilmemeli belki. Aralıklarla belki seanslar düzenlenmeli, terapi yapılmalı. Bir süre ne cevap vereceğini, nasıl davranacağını sen de şaşırıyorsun.

on/with/through emotions after years of experience[39]. Today, we know that many aspects of social life are being psychologized and pathologized. Nurses have blind spots in this respect: even though they are very aware of the fact that most patients look only for daily routine consolations, nurses consider it as extra work. However, they put it as the work of experts such as psychologists. Nurses think of their emotional responses as being incongruous in hospitals and not befitting hospital work. One way to accept emotions in the hospital environment is to push them into the domain of psychology.

In this disempowered status within the health care team, they do not think of emotional sharing as laudable, they do not conceive of an ad hoc 'emotional literacy'[40]. Not to be disposed to listen, however, is not to be deaf. They hear, they listen to patients, even though sporadically, and depending on shared experiences (being young, a woman or mother, for instance) and time.

Detachment is an attitude which is acquired in practice, in the density of emotional spaces; however it is quickly translated into principles of profession in narrating their career.

To be detached paves the way for reflecting twice: firstly on one's personhood under certain circumstances, then on its bodily repercussions, social and cultural meanings, misunderstandings. To be over-involved, in nurses' view, may pave the way for malpractice or burn-out; detachment, however, contributes to remain self-reflective during the performance of tasks.

[39] Nurses reported me that two months before my research, a psychologist conducted a survey in the unit, therefore they referred to the psychology as the most important discipline for their help in the work place, they even successfully used psychological terminology in their accounts (manic depression, burn-out (*tükenmişlik sendromu*), paranoid, anxiety and so forth) instead of putting their feelings in simple words. This shows that their discourses are constantly shaped through varying templates provided by previous interactions.

[40] I use Susie Orbach's term which means the ability to read emotions, to engage in mutual empathetic relationships. (Orbach, 1999)

Emotional deadlocks

In the oncology department, especially in its wards, many cancer patients are in the terminal phase since patients in critical situation are accepted there. Doctors check their tests, control their medication but the administration of therapies and their daily care are under the control of the nurses. Nurses start to spend time with patients who change physically and that, very quickly. Nurses see these dramatic metamorphoses over time, which change them as well, and make them rethink their education, their training and their experience. Nurses' rest rooms are echo chambers where they chat about daily encounters, about their fears and the changes they themselves undergo, and where they tell stories and make jokes that outsiders can not easily understand. Jokes are about suffering, death and their own emotions, and are sometimes quite sardonical.

Once questioned about emotions, the majority of interviewees talked about professionally detaching themselves form patients. Some (especially newly enrolled nurses) stipulated that they always had to have a professional attitude, which, in their terms means to be detached while working, not to be too much intimate;

> Being emotional and being professional are two different things. We can not cry with every cancer patient, of course, but depending on situation we empathize with them[41] (Feride).

Others, those who were more experienced than the recently recruited, talked about detachment as an ideal, but their narratives continue with a breach, a counter-example, a story in which they see themselves emotionally "over-involved". Emel, after talking meticulously about the advantages and importance of detachment, ends her narrative with an account of a series of patients to whom she was attached;

[41] Duygusal olmak ayrı bir şey, profesyonel olmak ayrı bir şeydir. Her kanser hastasıyla ağlayamayız tabii ki ama yerine göre empati kuruyoruz.

> I had a patient, she was the same age as me. She had a tumor in her kidney. [Silence] Filiz [She remembers the name of the patient] she had even given me her necklace. I was really sad, because she was one of the patients that we knew would die, but yes, I am still keeping this necklace. But if I had not taken it, she would have been very sad."[42]

As Emel's story illustrates, emotional involvement is not always a negative experience and may create a close relationship. However, it is important to note that the very basis of a possible relationship (same age, gender, regional backgrounds; similar life experiences) is also an important reason to be detached. Beril says that after being a mother, her emotional experience had changed:

> Death does not affect me anymore. Wherever it happens...I can only not bear children's death, especially after having given birth. Adults, even if they are young, do not touch me anymore[43] (Beril).

Nursing ethics do not allow them to be "over-involved". Nursing educational books encourage future nurses to develop a particular kind of relationship with patients, "an official but warm" occupational relationship[44]. At the start of their career, they experience fear, anxiety and notice that what they learn from school books provides neither sufficient, nor exhaustive guidance for daily experiences; practice challenges all taken-for granted rules:

> For example, you become fearful that your relatives will get cancer, that you yourself will be ill. You investigate even when a trivial thing happens, you become paranoid. Then it passes. In fact, there are many phases, especially in oncology nursing. It is different from other services. Later, there is the phase where you experience a strange remorse, you feel sorrow. Finally,

[42] Bir hastam vardı, benimle aynı yaştaydı. Onun böbrek tümörü vardı. (es) Filiz. (adını hatırlar gibi) Hatta bana kolyesini vermişti, ben çok üzülmüştüm, çünkü kaybedeceğimizi bildiğimiz bir hastaydı ve evet, o kolyeyi ben hala saklıyorum. Ama almasaydım o çok üzülecekti.

[43] Artık zaten ölüm olayı çok fazla etkilemiyor beni. Nerede olursa olsun...Sadece çocuklara dayanamıyorum, o da doğum yaptıktan sonra. Büyük hastalarda, genç de olsa şey yapmıyor, çok fazla etkilemiyor yani.

[44] "Hemşire hasta ilişkisinde anne-baba—kardeş-arkadaş gibi birincil ilişkiler yerine, resmi fakat sıcak bir mesleki ilişki olmalıdır." (Page-23) Emine Çakırcalı (Yard. Doç.Dr) 2000 "Hemşirelik Süreci", "İletişim ve Öğretim İlkeleri", in *Hasta Bakımı ve Tedavisinde Temel İlke ve Uygulamalar,* İzmir Güven& Nobel Tıp Kitabevleri, İzmir

> this is the worst; you go through a phase where you become indifferent to life. Outside, when something particularly sad happens, you don't react. You see the worst here, because you see death here continuously, because you see four "exed" in a night, because four patients die, many things begin to seem unimportant to you. How can I say....you acquire a strange mentality. You start not to worry a lot, but that passes too, I believe all these pass. If I may say this for myself, and actually as I hear from many of my friends too, you return to normal life after a while, after some years.[45] (Selma)

"Getting used" to suffering and death is considered to be the final phase according to nurses; it is seen to be the consequence of work experience. Selma schematizes this process of managing emotions through work, but this is not exclusive to work. Some emotions affect life outside the work place. Fear reaches herself, her relatives; indifference is not reserved to work experience, a "general" indifference emerges everywhere. Fear, remorse, sorrow, indifference, strangeness and some feeling of normality, step-by step, succeed each other. In her account, coming to the stage of normality entails time but also requires major work with emotions in giving them meaning and re- directing them. She posits this process also as a kind of professional habitus, by reminding herself at the end that her colleagues go through these stages as well. In other words, according to her schema, it is a professional journey into a specific work place, and somehow 'normal' and necessary detachment eventually leads to an equilibrium. Managing emotions goes hand in hand with a certain sense of personhood which oscillates between extremes (fear, sorrow vs. indifference), and

[45] Mesela yakınlarının kanser olmasından korkuyorsun, kendinin hasta olmasından korkuyorsun, sürekli ufak bir şey olsa araştırma yapmaya başlıyorsun, paranoyak gibi oluyorsun. Sonra o geçiyor. Aslında evre evre, özellikle onkoloji hemşireliği özellikle, diğer servislerde daha farklıdır tabii. Daha sonra, bir dönem, acayip vicdan azabı, üzüntü yaşıyorsun. En kötüsü en sonunda hayata karşı böyle biraz umursamaz olduğun bir dönem geçiriyorsun. Dışarıdaki hayatta özellikle, üzüntülü bir şey olduğu zaman çok şey yapmıyorsun. Burada en kötüsünü görüyorsun, ölümü sürekli gördüğün için, bir akşamda 4 tane "ex" gördüğün için, 4 hasta öldüğü için, birçok önemli şey sana önemsiz gibi gelmeye başlıyor, çok önemli değilmiş gibi, böyle bir...nasıl diyim...acayip bir ruh haline giriyorsun. Çok fazla dertlenmemeye falan başlıyorsun ama sonra geçiyor, bütün bunların geçtiğine inanıyorum. Kendim için değerlendirirsem, arkadaşlarımdan da dinlediğim böyle gerçi, bir süre sonra normale dönüyorsun belli bir yıldan sonra.

then a certain professional habitus contributes to detachment, which is not the same thing as indifference, since indifference means also the loss of humanity, a certain way of positioning oneself in the larger community.

> For example patients in their 20s are coming here. They are young lads, very fit, handsome or recently married, they have children, they come, then you see them waste away. Time passes, he comes and goes, gets in the [chemotherapy] sessions, and if finally he dies in the ward, you don't lose your humanity in this profession. They say nurses are very callous [or insensitive] very indifferent…You are calm, that's true, but you don't show your sorrow, perhaps you don't show it in front of the patient, but there are times when you go back to your office, and then you cry. You cannot show this to the relatives of the patient. You cannot sit and cry with the patient. They criticize this a lot. They say you are heartless. For example, I am a very emotional person, and felt this a lot of times, but at the end you cannot sit and cry with them. Otherwise, you cannot be in this profession. You feel sad, because you do not lose *your humanity* altogether[46] (Selma).

There are particular ways of exploring nurses' emotional experience; a significant method may be to analyze metaphors (Froggatt, 1998). A staff nurse coins the metaphor of a "curtain" during a long focus group session. She says:

> Yes, it is as though they [patients] were not there at the moment. For a moment, you say something, call out to your friends or make a joke; a joke just to feel better emotionally while you are working, something, and it is as though there was no patient there at that moment. You work in difficult circumstances, you make jokes to relieve the tension and sometimes, I really believe this, while you are talking, it is as if this curtain is suddenly drawn.[47] (Ilke).

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[46] Geliyor mesela 20-25 yaşında hastalar geliyor. Geldiği zaman gayet kapıya sığmayacak kadar delikanlılar mesela, genç, yakışıklı ya da yeni evli, çocuğu var bilmem ne, yatıyor, eridiğini görüyorsun yani. Aradan zaman geçiyor, geliyor, gidiyor, seanslara giriyor, bilmem ne, en son k(p)usup da serviste ex olursa eğer, sonuçta insanlığını kaybetmiyorsun ki bu mesleğin içinde. Hani diyorlar ya hemşireler çok katı, çok kayıtsız...Soğukkanlı oluyorsun, bu doğru ama sen belli etmiyorsun, belki hastanın yanında belli etmiyorsun ama içeri girip ağladığın zaman da oluyor. Onu hasta yakınına gösteremezsin ki. Oturup sen onunla birlikte ağlayamazsın. Bunu çok eleştiriyorlar, mesela çok katı yürekli, bilmem ne...Mesela ben çok duygusal bir insanımdır, çok olmuştur ama onlarla oturup ağlayamazsın sonuçta. O zaman bu mesleği yapmaman lazım, yapamazsın yani. Üzülüyorsun, çünkü insanlığını hepten kaybetmiyorsun.

[47] Evet, bir an onlar yokmuş gibi. Bir an bir şey söylüyorsun, orada hasta varmış gibi gelmiyor o an, arkadaşına sesleniyorsun ya da bir espri yapıyorsun, çalışırken kendini duygusal anlamda iyi hissetmek için espri yapıp bilmem ne. Zor bir ortamda çalışıyorsun rahat geçmesi için karşılıklı espri yapıyorsun ama bazen gerçekten hastalara, ben buna inanıyorum, bir şey konuşurken birden sanki o perde çekiliyor

"Curtain", with a naive reading, may mean separation of at least two localities, and has especially a visual connotation. One can neither look at, nor see the other section. Not very surprisingly, one possible translation of care in Turkish is *bakım,* which refers etymologically to *bak-mak* (to look at, to look after, and to take care of). Also the widespread expression in Turkish "curtain being drawn" (*perde çekilmesi*) means becoming blind. Good describes how medical students learn to see in a particular way (1995). Unlike physicians who begin "by entry into the human body" (Good, 1995, p.72), nurses learn to focus on the surface of bodies in order to engage in hands-on care. "Curtain" underlines a particular way of looking at, and not seeing the patients and of coping with stressful circumstances within a team work. The 'curtain' metaphor reinforces detachment. However, as I argued before, this detachment paves the way not only for a certain way of working in a group, but also for self-reflectivity:

> In fact, they can easily hear what we say, because it is out in the open, and she is just there, she sees, knows, hears everything, sometimes even something we shouldn't say. Sometimes we wonder, are we too happy? You feel bad because you know that they hear[48] (Ilke).

'Curtain' does not mean total indifference; it is not a 'wall', nor a 'hedge'. Curtains may be easily drawn back. They say that they are conscious, self-reflective about the curtains they put up. Curtains blur rigid boundaries between backstage and frontstage, and render them contiguous: detachment/curtain is a particular way of coping with emotions since emotions are neither suitable in this work place, nor approved by nursing principles and ideals.

[48] Aslında onlar bizim ne konuştuğumuzu duyuyor çok rahat, çünkü orta yerde, her şeyi görüyor, biliyor duyuyor. Hatta bazen söylememiz gereken bir şeyi bile...Hatta bazen çok neşeli miyiz acaba? Bildiğin için kendini kötü hissedebiliyorsun.

Emel, another nurse in her late twenties, says she pays more attention to emotions than her colleagues and underlines more clearly the backstage and frontstage boundary in her interview:

> I don't cry in front of patients, I go back to the office, I breathe deeply and then I intervene [calm down relatives]. At least to calm the relatives or get in contact with them, we have to be calm[49]

To be calm and dispassionate is a leitmotiv in the accounts of several nurses. It is also emphasized in nursing education books[50]. Even though nurses repeat these templates, they resituate these abstract pedagogic and theoretical dicta into a context, into their practice. These dicta are challenged personally and by groups. A certain balance is required: to be involved emotionally but not too much, to suffer, but professionally. However, nurses never describe themselves as indifferent; in their view, nursing as profession entails calmness, a certain type of detachment, but indifference is an aberration, an *effet pervers* of an ideal mode of balancing one's emotions. Emel says:

> We have to be calm, yes, but at the end everybody here is doing all they can while someone is dying here. Even when we know that we are *helpless*, this does not mean that we are indifferent or treat death as though it is routine. Yes, death appears to be viewed as a routine concept here, but it is never like that. Because from the entry of a patient to this place till they leave or die, we are the ones who take care of them constantly. [51]

[49] Hastaların yanında ağlamıyorum, odaya çekiliyorum, derin derin nefes alıp veriyorum, daha sonra müdahale ediyorum. En azından hasta yakınını sakinleştirmek için ya da onlarla iletişim kurmak açısından tabiiki soğukkanlı olmak gerekiyor."

[50] For example; Emine Çakırcalı (Yard. Doç.Dr) 2000 "Hemşirelik Süreci", "İletişim ve Öğretim İlkeleri", in *Hasta Bakımı ve Tedavisinde Temel İlke ve Uygulamalar,* İzmir Güven& Nobel Tıp Kitabevleri, İzmir. and Ayşen Hovardaoğlu& Leyla Şenocak "Chapter I" *Meslek Esasları ve Teknikleri,* third edition, Hatipoğlu Yayınları, Ankara

[51] Soğukkanlı olmak zorundayızdır evet ama sonuçta burada bir hasta vefat ederken herkes elinden geleni yapıyor, her ne kadar çaresiz olduğumuzu bilsek de ama bu hiçbir zaman bizim kayıtsız olduğumuz anlamına gelmiyor ya da hiçbir zaman (dalga geçer gibi) "öldü", evet ölüm burada çok sıradan bir kavrammış gibi karşılanır ama hiçbir zaman öyle değildir Çünkü o hasta buraya yattıktan taburcu oluncaya kadar ya da vefatına kadar sürekli onunla ilgilenen bizlerizdir.

Death and detachment

Emel's account opens a space for another elaboration of the work in managing emotions. : to be "helpless", to assume that one is helpless when the end is near, but in practice to continue to care fully for the patient. Here, the nurses' narratives lead me to argue that care and cure, nursing and medicine can differ radically; and what seems to be detachment can be or at least narrated to be, another way of looking at death. It is the cultivation of an ambiguous attitude towards dying: not denying it, but requiring curtains, accepting it on the horizon but not ceasing to intervene now.

Jankélévitch invites us to think of dying in three modes (1996): dying in third person (*one*[52] dies*)*, dying in second person (*you* die) and dying in first person (*I will* die). Death in the impersonal mode is abstract and anonymous; it is at the same time the death of everybody and nobody. Biomedicine is interested in this mode of dying, in understanding death in an impersonal way by masking the tragedy of death. Death in second person is the confrontation with the death of an 'other person'; it underlines the singularity of dying and the relationality of an I and a you. Death in first person is impossible to enunciate in the past tense (I died), uncertain in the present tense (I am dying) but obvious in the future tense (I will die).

We could argue in this framework that for nurses in inevitable daily contact with the patients, attaining equilibrium between these three modes is extremely difficult. The time spent together, the several encounters with the patients during the period of treatments render death in the impersonal mode impossible. Yet, "You die and I will die" is an emotionally loaded statement.

[52] Jankélévitch refers to the pronoun "*on"* in French; this pronoun has several implications: it may be used instead of "*nous" (we*), or in order to emphasize the action without precise reference to the subject of the verb . It is possible to translate in English as a passive mode (for e.g." on prétend que..." into "it is claimed that...") but here, I freely tanslate it with *"one"* in order to insist on impersonality.

Biomedicine, as rooted in western "tenacious assumptions" (Gordon, 1998), has specific ways of seeing, reading and writing (Good, 1995) and intervening. In the hospital setting, "instead of realising the older ideal of a meeting between two sympathising people, there emerged a submissive yielding of the body to the authority of another person." (Figlio, 1977, p. 277) And, as Kleinman (1995) puts it, "physicians are not educated to feel humble in the face of sources of suffering that cannot be reversed or to place limits on the utilization of powerful technologies."(p.34). There is something "soteriological" in medicine as it has been institutionalized; there remains a hope whatever the situation is. "Sickness, death, and finitude are found in the corpse, in the human body. And salvation, or at least some partial representation of it, is present in the technical efficacy of medicine." (Good, 1995, p.86)

Medical interventions are quite ambiguous in the terminal phase in the oncology department and the technical efficacy of medicine is problematic. Selma, while talking about tensions with the doctors, told me to turn off my tape recorder and she said that some doctors gave some patients' relatives "needless hope" (*gereksiz ümit veriyorlar, yaşatacağım hastanı diye*) while patients were in the fourth stage with metastasis and in a very critical situation. She said that some doctors even demanded money from relatives of patients in return for the promise of saving them. However, when the patients die, and the relatives can not find the doctors anymore, they blame nurses. She said that doctors should not give hope, but instead help patients and their relatives to face the reality: the possibility of death.

Not only Selma, but also many other nurses agree since they are much more involved with patients than doctors, they see the process of dying; they prepare themselves to accept the coming of death. However, it is not a passive acceptance of

death: death is on the horizon, but not there yet. Medical language lacks the means of talking about death. As Figlio (1977) highlights "medical language lost the ability to communicate the symbolic meaning of disease, just as medical techniques focused down upon the physical lesion and lost the capacity to recognize it"(p.285). However, the tragic waiting for death requires giving meaning to life and death. Religion, which provides nurses with an important vade-mecum in Iran to face death (Iranmanesh *et al.,* 2009), is not an obvious reference to give meaning to life and death in the unit where I conducted research.

Neither doctors nor nurses can answer the specific questions of the patients, but doctors have the chance to avoid these questions due to their periodic and authoritative interactions with the patients. Nurses, *nolens volens* (*ister istemez,* another common expression that they all use), are with the patients who see death at the horizon all the time, and have to listen to the questions, that are not easy to answer.

> For example, there was a patient; we had the chance to chat a lot. [She said:] My life was going beautifully, I married my children, I lived well. She is narrating, I did this, I did that...Was this really the time? I said to her, if what matters is to have lived a good life, you did... At the end, there is an end to life. We are all going to die; there is nothing to be done. To have lived this long, she was very old, she was in her eighties, if you have lived well up to eighty, that is luck.[53] (Selma)

For Selma *having lived long and beautifully* is a retrospective way of thinking about life and in a sense a way of welcoming death. Not only do nurses attempt to rethink life with death on the horizon, but also to realize their practice's relevance:

> One patient got an allergy, we sent her to the ward, the patient died [not conscious], no respiration but there is a pulse, we try hard, because the

[53] Mesela bir tanesi demişti, daha uzun süre sohbet etme imkanımız olmuştu. Çok güzel gidiyordu hayatım, çocuklarımı evlendirdim, çok güzel yaşadım, anlatıyor böyle, şöyle yaptım böyle yaptım. Sırası mıydı? Ben ona...önemli olan bu yani; güzel bir hayat yaşamak, yaşadıysan...eninde sonunda bunun sonu bu yani. Hepimiz öleceğiz, buna yapacak bir şey yok. Bu yaşa kadar, bayağı yaşı da vardı, seksen yaşında falandı, 80 yaşına kadar güzel yaşayabilmişsin, bu bir şans.

> reason is not cancer, this is a different situation. The doctor...I was really surprised that day, from a distance of one meter, he says, "we thought that she would live 8 months, she lived 8 years [silence] she can't be resucisitated," but we really made an effort, and then the patient came back [to life] and left walking. We were really happy. You are worn out, but when you see the patient healing, it is really another thing.[54] (İlke)

> In fact, the goal is not to save a life, but it is to enhance the quality of life. If a patient is conscious, to make him/her happy, if not, to give him/her physical comfort.[55] (Beril)

Even though Beril's account seems to be an ideal picture and Ilke's is an epic story, death is not always easily faced. Narratives tend to depict an ideal, detached way of coping with death. I described two processes: "getting used to it" and "putting up curtains". However, with the coming of death, and their inability to answer questions about death, detachment re-appears as a coping strategy:

> In internal medicine, in surgery, it is possible; the nurses have a better psychological situation. "I will go home and it will be finished." They (patients) ask "Nurse, when will this end?" You do not know what to say. I do not know. I remain silent.[56] (İlke)

Encountering the death of an "other" is emotionally loaded for nurses: anxiety, fear, sorrow, even grief, especially when a close relationship with the patient is developed. Nurses are not always eager to see themselves in these dramatic scenarios where they are expected by the patients and their relatives to fulfill specific roles: they sometimes deny or fear death in first person (I will die also), sometimes feel helpless

[54] Bir tane hastamız alerji geçirdi, geçirdik, servise geçirdik, hasta ex olmuş, solunum gitmiş ama nabız var, çabalıyoruz,çünkü bunun böyle olmasının nedeni kanser olduğu için değil, ekstra bir durum gelişmiş. Doktor bey...ben çok şaşırmıştım o gün, bir metre öteden, "zaten biz buna sekiz yıl ömür biçtik, sekiz yıl yaşadı...(es) artık dönmez" diyor ama biz gerçekten çok çabaladık biz ve hasta döndü ve yürüyerek gitti. Biz o kadar mutlu olduk ki...Yıpranıyorsun tamam ama iyileştiğini görmek apayrı bir şey.

[55] Aslında amaç hayat kurtarmak değil, o andaki hayat kalitesini yükseltmek. Onu o, hasta farkındaysa mutlu etmek, farkında değilse bedensel huzuru sağlamak.

[56] Dahiliyede, cerrahide olur, rastlayabilirsin, onların psikolojileri de daha rahat oluyor. "Geçip gideceğim evime, bitecek". "Hemşire hanım ne zaman bitecek bu?" diyor, ne diyeceğini bilmiyorsun. Bilmiyorum. Susuyorum.

with the idea that nothing can be done, sometimes they are really sad because they know the patients but do not know death:

> Especially when the end is near, at the time of dying, the patient and the relatives want the nurse to be with them all the time, hold their hand, and just stay. They expect too much. They expect so much that they expect the impossible. What we can do is limited. It hurts. Not to be able to do anything, not to be able to do something while they are waiting for something."[57] (Kevser)

Intimacy vs. Detachment, and the gendered reality of care

After elaborating on sources and effects of detachment, the emphasis must be put on this concept's relation to gender. We know that detachment and distancing from patients were valued ideals in the genealogy of the nursing profession (Menzies 1960), and Florence Nightingale endeavored to institutionalize the nursing profession under the control of the doctor and paid specific attention to distance between patients and nurses in order that nursing might be a vocation suitable for women (Woodham-Smith, 2006). Therefore, detachment has had, from the very beginning, a connotation of acceptable gender roles and relations. Women, since they are women, are expected to face the reality of care as a task fraught with emotions, without however being involved too much with those who are suffering and dying. Detachment has been a general mode for the distancing tactics of nurses to reduce emotional costs. In emotional spaces like hospitals, the iron cage of rational organization does not leave room for emotional interactions. Detachment is very

[57] Özellikle son dönemi yaklaştığında, o ölüm anında , hasta ve hasta yakınları istiyor ki hemşire gelsin bizim başımızdan hiç ayrılmasın, elimizi tutsun, öyle dursun. Çok şey bekliyorla, o kadar çok şey bekliyorlar ki imkansız olan şeyleri bekliyorlar, bizim de sonuçta yapabileceğimizin sınırlı olduğu şeyler oluyor. Arada kalmak da insanı çok üzüyor. Bir şey yapamamak, o insanların bir şey beklediğini göre göre bir şey yapamamak.

strongly rooted in the genealogy and everyday of nursing practice, and yet it is seen by textbooks to be a technical, even technocratic issue. Therefore some nursing scholars attempt to get rid of detachment by putting the emphasis more on the importance and contribution of intimacy and empathy to provide a better care.

In the previous sections, my endeavor has been to show that detachment is not only a technical issue but reflects some experiences at the work place, an important repertoire needed to continue to practice nursing. Also detachment is not a lacunae of emotions, on the contrary it is a constellation of emotions in a balanced manner to cope with the work place realities. Looking for 'levels', 'functions' and 'quickly generalizable principles' of detachment is dangerous since it attempts to quantify the unquantifiable. The research must move to understand the social fabric in which nurses painfully learn to sustain a balance between total indifference and over-involvement. Herdman's (2004) reference to Mestrovic's conceptualization of postemotional society is indicative: in a period where emotions tend to be separated from actions and where emotions tend to be manufactured, standardized and commercialized, "how do nurses express sorrow, empathy or compassion in an environment that marginalizes and subordinates them?" (2004, p.101)

Detachment or intimacy are two categorizations which are doomed to fail to describe the gendered experiences of women who are placed in subordinate positions where they are expected to refer to womanly expressive aesthetics, emotions, and ethics of care as a professional vade mecum, they are simultaneously urged to reject these skills which are constantly marginalized and subordinated.

"How does a woman who is supposed to be emotionally literate come to be a detached nurse?" is an important question that can be answered in the experiences

of female nurses both at the work place and in the home. Selma gave a long account of her practice; I prefer to quote her to depict a larger picture:

> People always say that nurses can not be good wives, in my opinion good wives are among nurses, they are so many around me, they are so giving and altruistic…In their family life, at work, until getting married towards their parents, after marrying towards their husband, children…But after a while, it is full, they are really tired. People coming here want you to be always helpful. Here it is so busy that if you try to help one, you can't do other tasks which are expected from you, you can't do it. Then they do not stop complaining, saying "she didn't help." If somebody gets sick at home, you must take care of her, and you can not bear that your children, your husband or your parents get sick. You are extremely bored of seeing sick people at work, and then when you go home, you don't want to see sick people. You are sad here; you don't want to see a sad person at home. During my last shift some patients' family members were talking "look at this nurse, she smiles!" Especially they [family members] do it very often, not because my colleagues are bad and I am good, they say the same thing to all nurses. I know from experience. [They said that:] "The other nurse was sulky" then I said: "If it were you in the middle of so many sad people, you would not smile easily either." Then [they said:] "But you should be smiling!" there is an idea like this. They all expect you to smile; however, it is very reciprocal, if they communicate a negative energy to you, if they always insult you, if they always complain about something, then you manage to smile only to a certain degree. In a shift of 24 hours, at 00:00 pm, you are exhausted; you are done with your patience. If they were more understanding, I mean the family members, and we can't expect it from patients since they are patients…We have more problems with family members than with patients here. If they behaved more moderately…They almost consider us as their slaves.[58]

[58] Sürekli mesela, belki duymuşsunuzdur, hemşireden eş olmaz derler, bence en iyi eş hemşirelerden oluyor yani, çevremde çoktur yani, o kadar fedakar ve vericiler ki...Aile hayatlarında da, işte, evlenene kadar ailede, evlendikten sonra eşlerine, çocuklarına... İşte belli bir şeyden sonra doluyor yani, o kadar çok üstüne geliniyor ki...Dışarıdan gelen insanlar sürekli senin yardımcı olmanı bekliyor. Burası zaten o kadar yoğun ki sen buradaki işinden ayrılıp onun peşinden koşturmuş olsan buradaki iş aksıyor, yapamıyorsun. Sonra bir sürü "yardımcı olmadı" falan söyleniyorlar. Evde mesela biri hastalansa onunla mecburen sen ilgileniyorsun ve evde mesela annen baban olsun, eşin çocukların olsun, birinin hasta olmasına tahammül edemiyorsun. Artık o kadar bıkmışsın ki akşama kadar hasta görüyorsun zaten, akşam eve gidince hasta görmek istemiyorsun. Burada zaten yeterince mutsuzsun, evde mutsuz bir insan görmek istemiyorsun. Geçen nöbetimde mesela hasta refakatçileri kendi aralarında konuşuyorlar, "aa işte bak bugünki hemşire hanım güleryüzlüymüş, geçen gün..." Özellikle bunu çok yaparlar.Ben iyi olduğum için ya da öteki kötü olduğu için değil, herkese aynısını yaparlar yani, yıllar içinde tecrübeden bunu anlıyorsun. "Şu şöyle yapmıştı da, çok asık suratlıydı da" Ben dedim: "Bu kadar mutsuz insanla beraber siz olsaydınız eminim bir süre sonra siz de artık rahat gülümseyemezdiniz." "Biz zaten...sizin güleryüzlü olmanız lazım", hep böyle bir şey var. Senin hepsine çok şey davranmanı bekliyor insanlar, halbuki karşılıklı, o sana sürekli negatif bir elektrik yüklerse, sürekli hakaret ederse, sürekli söylenirse, bir yere kadar yapabiliyorsun. 24 saatlik nöbette, gece 12'de sabrın bitmiş oluyor...Belki de o da birazcık anlayışlı davransa, hastadan bunu bekleyemezsin, o hasta çünkü,...Bizim en büyük problemimiz burada, hasta yakınları. Hastalardan çok onlar problem çıkarıyor. O da ılımlı davranabilmiş olsa...Kölesi gibi görüyorlar burada neredeyse bizi.

Selma highlights three important aspects: firstly, she sees a parallel between being a nurse and a good wife, to overcome the pervasive criticisms in common sense that see nurses as too detached to be a good wife. She harks back to women's characteristics like being altruistic, but she refers to her 'entourage' in order not to essentialize these attributes. Secondly, she ties her emotional exhaustion with her family life where they are also expected to be caring. Nursing both at home and at the workplace consumes their energy, she says. Then, detachment appears neither as a tactic nor a professional attitude, but an outcome of living in a certain emotional space that shapes their emotions, and bodies; it is not the absence, but a disabling accumulation of emotions. Finally, she insists on the power relations and the mutual character of so-called emotional literacy: nurses are the first ones to be attacked, complained, insulted, criticized by the patients, their relatives and doctors, and therefore they endeavor to distance themselves from these emotional spaces.

Conclusion

In this chapter, I attempted to highlight some points about emotions and death in the hospital environment through nurses' narratives of detachment experiences. Hospitals are *emotional spaces*. Nurses, in order to fulfill their rationally organized tasks, have to transform this space into a place where they must disassociate from the patients and their relatives, and manage their emotions. However, *emotional deadlocks* are not easy to solve for nurses. Coping with emotions through personal and professional strategies is a never-ending process. Detachment is one way of self-reflecting and balancing nurses' dilemmas. Gordon (1998), by talking about western tenacious assumptions argues that "social relationships are also seen as a potential threat to freedom. Emotional involvement with other people can deplete the self" (p.

37). But the self is nothing but processual and intersubjective, and gender is an active factor in these processes. Also, nursing paves the way for a specific position towards death, a constant acceptance of death as an inevitable future, causing a broad range of emotions. Detachment serves to provide a ground where two seemingly opposing attitudes may find a place: continuing to care until death comes while keeping in mind that it will come.

CHAPTER FIVE

ETHICS OF CARE: a narrative and textual practice in nursing

Introduction

Conducting ethnographic research in a medical institution with specific attention to care practices requires having key informants, an acquaintance with bureaucratic procedures and organization, and an awareness of analytical conceptualizations, keeping all the while in mind the fact that these conceptualizations are quite intertwined. Care has been discussed with reference to various perspectives and questions. One way has been to reveal and discuss the emotional component of this specific work and attitude; care, especially care as paid labor like nursing, entails emotional labor (Hochschild, 1983; James, 1992; Staden, 1998; Bolton, 2000; Sass, 2000; Henderson, 2001; Lopez, 2006). Focusing on emotions highlights how the medical environment is relegated to rationality and that there is nearly no place for emotions. Care has also been discussed in terms of gender: care-givers in the family and also in professional areas are predominantly women, and care continues to be seen as 'women's work' and, as surely constitutes an important area of feminist inquiry (Gamarnikow, 1978; Porter, 1992; James, 1992). Nevertheless, care with its reference to physical labor cannot be apprehended without bodies, that is, 'hands-on care', body-to-body intervention, dirty work, openness to contagion show the limits and risks, and the embodiment of care work (Fine, 2005; Morgan, Brandth, and Kvande, 2005). Additionally, care has also philosophical and political connotations; it becomes an area to think alterity, difference and intersubjectivity, and to rethink

the ethics of justice, the universalized and abstracted theorizations of morality (Clement, 1996). These perspectives are not mutually exclusive, but underline how elaborately care can be discussed, and how "care is a complex, contested, multilayered concept" (Fine, 2007, p. 4).

This chapter aims to discuss the ethics of care as 'narrative practice' and to describe how a rich repertoire of ethical considerations becomes available through narratives. Nursing education provides nurses with ethical concerns, a certain ideal of care. However, this very ideal of professional care is challenged by work realities. I will describe how a new ethics of care comes to be reformulated through narratives.

Ethics of care as practice

The ethics of care is generally discussed on the face of ethics of justice which has an abstract approach and underlines the assumption of human separateness and equality as a priority, whereas the ethics of care is understood within a contextual approach, emphasizing human connectedness and maintenance of relationships as a priority (Clement, 1996). This comparison challenges justice, morality, and autonomy by showing that ethical decisions are made on the basis of universal principles and this neglects the relational, contextual and interdependent nature of ethical thinking. However, this duality of the ethics of care versus the ethics of justice reproduces public/private, body/soul, man/woman, dependence/autonomy, universal/contextual, difference/equality dichotomies. Sevenhuijsen (1998) attempts to understand the ethics of care in a different way, not necessarily comparing to the universal moral principles and rules; she says: "the ethics of care is a *practice*, a particular manner of perceiving and deliberating, rather than a matter of simply finding a series of rules or

principles and applying them to clear-cut moral dilemmas." (*My emphasis,* p. 15). What are the implications of considering the ethics of care as practice? Which complexities can such a perspective highlight?

Time

Seeing the ethics of care as practice paves the way for taking 'time' into account. Nursing scholars tend to define nursing in many ways (Hilton, 1997); one important dichotomy is science versus art. Nursing was born as handmaiden for male medical authorities, women were supposed to use their 'tacit skills' and "aesthetics" (Tyler&Taylor, 1998) in a public organization in addition to their domestic work (James, 1992). The main metaphor was the family; the father-mother-child imagery was to be resuscitated in the doctor-nurse-patient relationship. As Gamarnikow puts it, "the family as a symbol for the nurse-doctor relation contained within it this contradiction: it gave women access to a non-industrial job, but at the same time deferred to medicine in setting it up and defining its limits."(1978, p.114) On the one hand, nursing care is seen by reference to a powerful medical voice, as an unskilled or semiskilled activity and a timeless category. As Florence Nightingale puts it; "a woman cannot be a good and intelligent nurse without being a good and intelligent woman" (cited in Woodham-Smith, 2006). Nursing attitudes, ethics, and activities are seen to follow from the timeless category of women. On the other hand, nursing is the care of 'strangers', since "it is with the care of strangers that the history of nursing lies" (Nelson, 2000, p.1). The knowledge, experience and concomitant skills, which are 'transmuted[59]' from the domestic to the institutional, are under strict

[59] I use Hochschild's term "transmutation" to conceptualize emotional labor. She says: " By the grand phrase "transmutation of an emotional system" I mean to convey what it is that we do privately, often

regulation, sanction, dependence and subordination vis-à-vis the medical authority: nurses are to be educated to be able to work as if they were *tabula rasa* in their professional care relations. This is not to say that nursing education does not provide practical knowledge, important ethical considerations; it is obvious that nursing education is a significant key and an important political tool for nursing activists to cope with the deskilling process. Nevertheless, the problem is that the ethics of care is in constant change in time and space, depending on encounters and contexts. Responses to varying situations require much more personal, singular and collective (in the sense that they work in groups) considerations and forms of knowledge, and these are not always coterminous with the ideals they learn in a timeless vacuum that education is. A leitmotiv-like formulation which emerges in many accounts is that nurses can not work according to the education they acquired, and that they feel rather frustrated. This formulation is widespread in the accounts of recently enrolled and/or highly educated nurses. Ferhunde is in her early twenties and has a bachelor degree. She was recently recruited to the oncology unit and had been working for three weeks by the time of the interview. In a focus group where she was the "freshman", her account was quite dynamic, and had a frustrated and regretful undertone. She says:

> I have recently started to work. As nurse with university education. What we learnt (at university) were care plans, patient care plans. You make plans for each patient, then you go on with it, it is pretty easy. (…) Then I came here, I said "oh my god!" how would I do these with such a workload? What I am taught is surely good, pretty, of quality, it is what it has to be, but you can not do it here. There are many kinds of insufficiency. If we were able to carry it out, I wish I were able to apply what I learnt at university.[60]

unconsciously, to feelings that nowadays often fall under the sway of large organizations, social engineering, and the profit motive." (1983, p.19)

[60] Ben yeni işe başladım. Lisans mezunu hemşire olarak. Bize öğretilen bakım planlarıydı, hasta bakım planları. Her hastaya bakım planı uygularsın hatta hastaya bakım planını sürdürürsün. Geldim buraya, Allahım dedim, o yoğunlukta nasıl yapacağım bunları? Bana öğretilen tamam güzel, hoş, kaliteli, gerçekten olması gereken, ama burada o şeyi uygulayamıyorsunuz.. Çok farklı yetersizlik var.

Nursing is reconstructed as a scientific discipline, yet it tends to remain a practice, its time is not the same of medicine. Nursing time is "dominated by the temporal culture of medicine, a culture rooted deeply in clock time, which is both a precondition and a vital tool for medical science" (Jones, 2001, p.153). Doctors are trained to seek the timeless disease entity beyond time. Illness is a disruption of time while disease tends to remain in a detemporalized, universal knowledge of science. However, nurses are to care for the sick in time. Therefore, nursing can not be merely the observation of the timeless disease; it has to handle its outcomes, transformations and experience. Every confrontation of a nurse with a patient is a question of time, whatever the quality of the relationship is. It may be a poor or a rich relationship in terms of the emotional and physical involvement with the patient; nevertheless two subjectivities go together in a temporality. Class, ethnicity, personality, singularity of the patient are important as well as the nurse's ability, disposition, and will; but these do not prevent them from sharing time. At this point, it is worth remembering Nancy's (1991) allegory to conceptualize 'being-with':

> Passengers in the same train compartment are simply seated next to each other in an accidental, arbitrary, and complex exterior manner. They are not linked. But they are also quite together inasmuch as they are travelers on this train, in this same space and for this same period of time. (p.7)

The suspension between relation and non-relation as the ambiguity of being-with goes through a change when singularities are exposed. Inevitably, in certain cases, being-with ends in being-in-common; it depends both on time and on the singularities exposed. Selma, a young but experienced nurse, puts it very clearly:

> In our clinic, some patients may stay a long time, radiotherapy, sometimes they stay more than a month, sometimes even more.(…) When there are too

Keşke uygulayabilsek, keşke ben üniversiteden çıktım geldim buraya, keşke öğrendiklerimi uygulayabilsem.

> many patients, it (closeness, intimacy) does not happen. But whether you like it or not, this does not mean you privilege some patients, but with young patients, it happens more, your heart is touched.[61]

"Passengers in the same train compartment" come to know each other; when I say they come to know I am very aware of the limits that are both deontological and contextual, but what I want to emphasize is that "care of the stranger" becomes, in *time*, "care of the *less* strange." This is a way of working when working is quite difficult. A female nurse says:

> There was a patient, he was anxious/nervous but he began to know me in time, even though he made other nurses suffer, he was docile with me.[62]

To see this discussion of practice and time differently, it is possible to interpellate Levinas for whom time is always concerned with relationship (Lavoie *et al.*, 2006; Clancy & Svensson, 2007). According to him, "physical suffering in all its degrees entails the impossibility of detaching oneself from the instant of existence. It is the very irremissibility of being" (Levinas, 1989, p.39). Suffering harks to the ungraspability of death and marks the end of the subject's 'virility'. In this impossibility of retreat, one faces the Other (death) and the other (the one who is there). An intervention to the sufferer of the other can be physically palliative, but does not prevent 'the fact of being directly exposed to being'. Whatever the nature and form of the involvement of the care-giver, responsibility creates a bond between time past, present and future in a nurse-patient encounter. Although mundane tasks have different meanings in the institution as a part of paid care work (James, 1992),

[61] Biz de uzun bir süre yatabiliyor bazı hasta, ışın tedavisi, bir aydan uzun süre yattığı, daha da uzun süre yattığı zamanlar olabiliyor, Hasta sayısı çok olduğu bu çok fazla olmuyor. Ama ister istemez mesela genç hastalara karşı, belki doğru değil yani bu, hastayı ayırmak olarak değil ama, daha şey oluyorsun, ister istemez daha yüreğin sızlıyor yani.

[62] Bir hasta vardı, huysuz ama gel git zaman içinde beni tanımış, diğerlerine kök söktürse de beni dinlerdi.

these routine activities restructure time, which is cut from clock time for the suffering patient.

Nurses tend to narrate their work day in a particular form: they emphasize the chronology of activities; they give details of these activities in relation to the clock time. It is not without practical use. Many activities such as providing an extra pillow, checking routine of wards may not sound important to an outsider, but it is significant for the nurses in the wards where it is possible to remember the clock time only thanks to task rituals (like changing serums, giving a palliative injection). These routine rituals restructure time for nurses, patients and their close relatives (*refakatçi*), and they recreate a temporal framework. Redundancy of "no time" in many accounts of the informants highlights that nurses create a new temporal framework to be able to continue according to the clock work. Their tasks restructure time in the wards by enabling them to continue to 'work' and by reminding others in the wards of the necessity of this framework.

After emphasizing the creation and control of time by nurses in the course of their daily work, it is quite important to note another aspect: bureaucratization of practice. By this term, I refer to relatively recent changes in the management of nursing practice. The majority of nurses do not hesitate to complain about the amount of documentation required at every step of their work. Nurses have to note in files whatever they do in wards, from the names and dosages of medicine to material needs, and especially about procedures which are not directly useful in their practice. Selma, a nurse mainly working in the office, ironically says that nurses become 'secretaries' and that they consume their time with documents, files and signatures. Also nurses are responsible in new regulations such as quality control, they have to be bureaucratic, in the first sense of the word. It is to say that they work as if they

were in ‘bureaus’ and, regulation and documentation become more important than before. Bureaucratization of practice leads to the re-organization of tasks that are eligible according to the requirements. This inevitably increases the accountability for action-orientated tasks but also makes important components of care as practice invisible.

“As if…”

Sevenhuijsen (1998) underlines that “the feminist ethics of care has more to gain from the idea of a processual self, a self which is continually in the process of being formed; moral identity is continually being developed and revised through this process” (p.56). Considering the self in process, therefore exposed to time, challenges any attempt to freeze morality, gender, and profession as finished categories. Any particular situation and singular encounter question a universal morality, the taken-for-granted gender roles and professional necessities. Morality and gender are neither exclusive nor timeless. Gender is present in every social practice, and it is in process. There can be no fixed morality in daily life.

Many female nurses say that in particular encounters and especially when they do not know how to continue to work, they think of their close relatives, of certain “as if clauses”: “I do it as if my mother or my child was a cancer patient”. “As if” clauses are nothing but a specific way of pondering the care of strangers; they pave the way for a moral thinking which is very rooted in family imaginaries. Yet this is not unidirectional: the family emerges in the care of strangers but also the care of strangers re-shapes family relations in specific ways. Selma, living with her parents, fear that their parents become sick; she says that she does “her best to keep

them healthy" as both a daughter and nurse. Naile, in her forties, lives with her mother who is dependent on her and takes care of her. She sees continuity between her profession and her life at home. She says that she is really exhausted and stressed; she manages her anger towards her mother and when she gets angry at the work place at an older patient, she says she thinks of her mother: managing her anger is a moral issue rather than a professional requirement. Male nurses, however, say more easily that they see a clear-cut boundary between their profession and their life at home; the slippery "as if" clauses do not exist in their accounts.

Ethics of care as narrative and textual practice

Sevenhuijsen invites us to think of the ethics of care not only as practice but also as narrative and textual practice. According to her argument, "[the] social practices of moral deliberation can be interpreted as forms of "story-telling", in which signification, evaluation and judgment are intertwined" (1998, p.38). It is an important point both to understand the ethics of care in a new light, not necessarily through dichotomies; and to elaborate the opportunities and relevance of research in specific care-giving environments. During interviews or through my observations, nurses' eagerness to narrativize their professional and also personal experiences was obvious.

Narratives of "gift"

Nurses' narratives following my semi structured questions incorporated a tension: they started by positing certain principles of nursing, but smoothly switched to

"stories" about their (personal or collective) experiences of nursing. However, their desire to come back to the first, much more official, narrative was fraught with inconsistencies, ambiguities and dilemmas. One of these that I attempted to describe has been about emotional involvement and detachment. Another common point of tension was their attitude towards dying patients and death. Here, it is worth highlighting another aspect of nursing, which is in relation to materializing emotional relationship, but also very much linked to the ethics of care: I will call these "narratives of "gift."

Narratives of gift are a particular *genre* that I noticed especially among female nurses. Male nurses are reluctant to give emotionally loaded, personally developed narratives. Under professionalization according to rational and decontextualized criteria, subordination to medical authority, and further bureaucratization, narratives of gift challenge work place realities. It is important to hark back to the Maussian model of the gift to understand this challenge. According to Mauss, gifts are inalienable; they are objects or services which are transacted as part of social relations. Therefore, gifts refer rather to the nature of relationship (Carrier, 1991; Douglas, 1992; Tyler&Taylor, 1998,). Carrier (1991) says: "For Mauss, a gift is any object or service, utilitarian or superfluous, transacted as part of social" (p.122). In this respect, these narratives invoke another type of relationship which is different from formal, contractual, bureaucratic relations of exchange.

These narratives emerge when nurses do not feel comfortable in their accounts of not being able to cope, when they do not recognize themselves in their own narratives of detachment, when they talk about their irresponsiveness and failure to accomplish their ideals. Therefore, narratives of gift emerge in epic and romantic

tones. Kevser, a nurse in her early thirties, after meticulously evoking patients' disrespectful attitudes, and her anger towards them, continues with a narrative of gift:

> We experienced another story with my colleague Nur. Food is being served in the wards, but an old man does not eat, [we learnt] that he wants pasta. Pasta is not an expensive food, it is really simple, but at this period, it is not served in hospital. [Imitating the patient] "My daughter, I would like to eat pasta." Nur does not hesitate, goes, buys some pasta, cooks it in the office [she laughs], puts it in a dish, and serves him.[63]

This "pasta" story is an illustration of what can be given as gift in the wards. This is not dictated by the professional principles. Nurses invent a way to provide a meaningful gift for the patient. They know the importance of being served to eat. Also, it underlines the characteristic of care relationship. They respond to a wish of a patient because they know what she or he wants to eat. The gender of gift is significant in this story: it is not haphazard that pasta is thought to be a gift by female nurses.

Narratives of gift record also the imaginative efforts to create gifts in response to the relationship between nurses and patients, and this is different from the benevolence of patients' relatives. It is constructed within the context of care relationship and also evidently no equivalent of such creativity exists in the principles of nursing. Kevser tells a story of "writing letter" in a focus group session:

> [There was a patient whose] diagnosis was sudden, and his situation was deteriorating. His psychology was not good either, [he was a teacher in a primary school] he was thinking his students, his school…he was saying that he was waiting for a letter from the Ministry of Education. He said: "the letter is here but you didn't give it to me, I have to go back to school." There was a colleague of mine, we wrote a letter on the behalf of The Ministry, about his vocation. We gave it to him, [we said] you have a letter from the Ministry, in fact there was no letter, we wrote it, just in order to make him

[63] Bir tanesini de gene Nurcan'la yaşadık, yemek dağıtılıyor, amca yemek yemiyor, canı makarna istiyormuş. Makarna da hani öyle lüks bir şey değil, basit bir şey. O dönemde çıkmamış hastanede. (Taklit ederek)"Kızım canım şöyle sıcak sıcak bir makarna istedi". Nurcan sen git, hiç erinmeden makarna al, ofiste pişir, bir güzel haşla (gülüyor), koy kaba, getir hastanın önüne.

> happy, he believed and he was very happy. We can do this kind of things. Maybe it is not real but in order to make him happy.[64]

Writing a letter could come about only thanks to certain closeness with the patient and the knowledge of his priorities. As nurses knowing that the patient is in a critical situation, they dare to create a "letter" which does not exist in the reality. This gift stems from an ethical decision that is based on a belief to make the dying happy "here and now".

Nevertheless, it is important to note here that gifts in care relationship with the dying patients are not obligatory. This does not contradict Mauss' understanding of gift. As Carrier (1991) underlines, "some [gifts] are [free], particularly when people are *creating a new relationship or modifying an old one* (my *emphasis,* p.123) and therefore gifts are depicted to show the creation of a new relationship that is different from familial ones. Nursing care is imaginative and does not march in the linear way of relationality that is predetermined by universal principles.

Narratives of shaken ideals

Nurses tend to have an 'ideal of care' even though this ideal is continuously frustrated. Long hours of work, large numbers of patients, and a hierarchical division of labor along with the demands of particular patients challenge their "ideal" of care. Their personal and professional ethical principles are challenged by local actualities.

[64] Bir anda teşhis koyuldu ve bir anda kötüleşti, giderek kötüleşiyor. Psikolojisi de bozuldu, okulu, öğrencilerini...onlarla yaşıyor ve unutmuyor, sürekli sayıklıyor. Milli Eğitim Bakanlığından bana dilekçe gelecek, mektup gelecek, dilekçe geldi siz bana vermediniz, benim okula dönmem lazım falan. Nöbetçi arkadaşım vardı, biz oturduk bir güzel dilekçe yazdık bakanlık adına hastaya. Göreviyle ilgili şöyle şöyle falan. Neyse götürdük sonra, bakanlıktan dilekçe geldi, aslında öyle bir şey yok, sırf onu mutlu etmek amaçlı, o ona inandı, o kadar mutlu oldu ki, o kadar sevindi ki...Yani böyle şeyler de yapabiliyoruz. Belki gerçek değil ama sırf onu mutlu etmek adına.

The excess of emotional investment, that Tyler and Taylor call 'gift' according to Mauss' definition (1998) or indifference are two faces of the same phenomenon[65]: the deviation from an "ideal" of care. How to be compassionate, to share the experience of suffering while confronting work place actualities determined by an overload of patients, material shortages, organizational problems, a thoroughly gendered division of labor? To develop an ethical autonomy may have institutional and personal costs. From a methodological point of view, interviews record an ideal of care, an ideal of ethics, whereas observations and in-depth interviews and group conversations note the impossibility of these very ideals.

Looking at the ethics of care as narrative and textual practice illuminates three important aspects among others. Firstly as Bruner underlines, "the function of the narrative is to find an intentional state that mitigates, or at least makes comprehensible, a deviation from a canonical cultural pattern" (1990). Once narrativized, the ideal of the ethics of care appears as the canon of care-work: how a nurse must encounter a patient, how a nurse takes care of a patient in both physical and emotional terms and so forth. Deviations from this ideal appear to be the main breaches in their narratives which attempt to deal with the gender division of labor and 'the relative importance of different cultures, life experience, training, status, and the familiarity of these involved' (James, 1992). Deviations are also significant in that they show an ability to work when reality does not match this ideal of care; they reveal personal and group intelligence, deployment of specific strategies, practical answers to difficult ethical questions. However, these deviations can only be captured if the ethics of care is considered as narrative practice because the endeavor to present THE ideal of care silences the polyphony that reappears only in narratives.

[65] Nevertheless, there is a difference between them: although the former is welcome, women are expected to commodify their gender, their reluctance to do so is condemned by essentializing and overlooking material and organizational problems.

Secondly, the ethical rules of the nursing profession are not problematic only because they are decontextualized and detemporalized; they also lack actors. It is possible to say that these rules, in Foucauldian terms, attempt to produce certain kind of subjects (Nurse versus Patient), however the very effect of this discourse is neither always, nor completely successful in encounters; let's say that it produces a Nurse and a Patient, but that it never exhaustively reigns in the area of intersubjectivity. A Nurse may go beyond some ethical rules dictated to her, if she feels intimate with a Patient or indifferent with another Patient. The ethics of care as narrative allows us to note this intersubjectivity, since it often releases what happened to her, to the patient, to care, to ethics in this particular encounter.

Thirdly, following de Certeau (1984), narratives are produced (concocted), sold (circulated) and consumed (listened to). They create a personal and professional memory, they help to re-think their ideal of care, to make decisions whenever they face ethical difficulties and dilemmas, to continue to 'work' with a specific vade-mecum written in their every day activities. Therefore, narratives are not about work but they are the work. Boje (1991) points out that "people engage in a dynamic process of incremental *refinement* of their stories of new events as well as on going interpretations of culturally sacred story lines" (*my emphasis,* p.106). This refinement is necessary in order to transform ethical rules governing people sharing the practice of a similar divison of labor and the same every day actualities and problems, into a vade-mecum, and to be elliptic in order to aesthetize very difficult experiences and to create a collective memory (collective memory can be organized by its omissions as well as its representations) and to be accountable. However, every refinement tends to create a norm, which is, in its turn, negated owing to the particularity of encounters.

Narratives as templates

Nevertheless, this is not to say that narrative production is a free representation of practice. Narrative production is structured and discursive, and "rather than viewing these narratives as processes that 'illuminate' the world of practice, they produce a palatable and highly desirable discourse about practice"(Nelson&MacGillion, 2004). Thus, it is both a methodological and a theoretical challenge to turn to narrative production in nursing; the ethics of care as narrative practice paves the way for an elaborated critique of the ideal(s) of doing care work, of rhetorical tropes to understand social, cultural, moral and sexual patterns; nevertheless, they can not be examined without the audience of these narratives. A researcher attempting to understand these narratives must consider the locality of these narratives as a text(ure) and study the circulation of multiple narratives with different genres and tropes. How, to whom, and by whom, under the influence of which other texts (school books, media, policy documents, stories of other people working in the same place) these narratives are concocted and circulated constitute important landmarks.

Reinserting family and gender into nursing

To illustrate this circulation, I would like to go over a discussion that I witnessed during my fieldwork with nurses. Because of the bureaucratic problems that I faced in my field, I noted spontaneous incidents of storytelling during my prolonged field research as skillfully as I could, since I did not have 'official permission' to do it with a tape recorder. It was an afternoon, when nurses were not as busy as in the

morning. In a courtyard where nurses like to rest, smoke and have a conversation, I was with my key informant, Naile, an experienced female nurse and a friendly care assistant[66]. Following my question "as a nurse, which difficulties do you experience/have you experienced in the department?" a brief conversation took place:

> Naile: Do you know the most difficult task? Night duty...Before, there were many people...in fact, nothing has really changed in the department recently...Can you imagine, two nurses for fifty patients, this is hard, you do the treatment if necessary, sometimes you don't even see the patient a second time in the course of your rounds. If I had two patients, I also would like to take care of everything, to feed him/her, to take care of him/her, but it does not happen, you can not find enough time...Furthermore, someone is on child leave, the number of nurses diminishes, when you are here for more than one night, not at home, it becomes really hard...
> I: Can you tell some interesting event that happened during night duty?
> Care-assistant: Is it possible for it not to have happened? A new story every night, let her tell you.
> Nurse: In fact, it is calm in general, if patients are in a bad situation, they do not make a lot of noise, however relatives are much more stressed. Once there was a man accompanied by his son, the wards were crowded. My colleague visited them, seeing the man suffering, she made a palliative, after several hours, his son came to see me, and said that the man was still suffering and moaning in his sleep. My colleague was busy, and I had to change the serum of another patient, as you know, it is necessary to change it before it finishes. I told him that I would come to see him soon, he went, and then he came back and started to yell out: "you don't take care of us, what kind of a nurse are you?" I went there, the patient was sleeping, only a little voice could be heard, it can happen, it was the son who was suffering, I tried to calm him, then he became like a child, nearly crying, he became calm. It is not a big event, but many nurses take care of relatives in a way. The patient is already suffering, s/he wants it to be calm, relatives want it to be very quick, to finish rapidly, when it does not happen, they think that it is because of us.
> I: Are they talking to physicians as well?
> Nurse: I would say, in general to us, they see the doctor from one visit to another anyway.[67]

[66] I name 'care assistants' a specific group in health care team. They are called "*hizmetli, personel, hasta bakıcı*, *görevli*". They are especially male and wear blue uniforms. They are not formally educated for care but they take care of patients, of environment and many procedures like putting an order to queues. Some even practice medical treatment in daily encounters. One of them, for instance, makes an injection to take edema from patients' bodies, even though this treatment is very risky and allowed only to medical team (doctors and nurses) with formal training. It is a significant issue to elaborate and an important area for research, but for the focus on nurses in my study, I highlight only that they are very respectful to nurses and they work in collaboration with them.

[67] *Naile: En zoru ne biliyor musun?Nöbetler...Eskiden daha kalabalıktı, çok hasta vardı...gerçi şimdi de pek bir şey değişmedi bölümde...Düşünebiliyor musun, elli kişiye iki hemşire, o zaman zor işte,*

In this account of an experienced nurse, she emphasizes an ideal of care which can not be realized under the specific conditions she describes. In her ideal, nurses may and must invest physically and emotionally with patients. The "organization" of care (with reference to James' definition; care = organization + physical labor +emotional labor, 1992) does not allow them to be able to invest too much. Grammatical analysis of these statements shows this helplessness ("IT –ideal care-does not happen, YOU (a nurse) cannot find enough time). The difficulty of night shifts is explained in two ways: it is 'difficult' for two nurses to take care of fifty patients and to be at the workplace several times in a week. This narrative is elliptic in the sense that it does not seek to confront the organization of their work (Who decides for whom? How to handle the shortage of nurses?) but it also elides the 'difficulty' of not being able to be at home. With regard to the former, she is not eager to discuss the bureaucratic rules organizing shifts[68], at least with me; for the latter, she might consider the role of

tedavisi varsa yapıyorsun, bazen bir daha göremiyorsun bile. İki hastam olsa ben de her şeyiyle ilgilenmek isterim, yemeğini yediririm, bakarım, ama olmuyor, yetişemiyorsun...Bir de mesela birinin çocuk izni oluyor, haydi, nöbete kalacak hemşire sayısı azalıyor, hafta da bilmem kaç kez evde olmayınca zor...
I: Nöbet sırasında başına gelen ilginç bir olay oldu mu?
Care-assistant: Olmaz mı? her gece başka bir hikaye, anlatsın da dinle
Naile: Aslında sakin geçer, hastalar zaten ağır durumdaysa pek bir sesleri çıkmaz ama refakatçiler daha gergin olur. Bir keresinde ağır hasta bir amca vardı, yanında da oğlu, koğuş da kalabalık, arkadaşım dolaşmış, ağrısı olduğunu görünce, bir ağrı kesici yapmış, birkaç saat sonra refakatçi beni buldu, hastanın ağrısı geçmemiş, uykusunda inliyormuş, arkadaşım başka işi vardı, ben de serum değiştirecektim, biliyorsun serumları bitmeden değiştirmek lazım, geleceğim dedim, gönderdim, az sonra yine geldi, bağırıp çağırmaya başladı, "ilgilenmiyorsunuz da, nasıl hemşiresiniz de!". Gittim, hasta uyuyor, yalnız hırıltı var, o da olur, asıl acı çeken refakatçi, onu sakinleştirmeye çalıştım, sonra koskoca adam çocuk gibi oldu, ağlamaklı oldu, sakinleşti. Yani öyle büyük bir olay değil, çoğu hemşire refakatçilere de bakıyor bir anlamda. Hastanın zaten canı acıyor, sakin olsun istiyor, refakatçilerse hemen geçsin bitsin istiyor, geçmezse de bizden biliyor.
I: Doktorlarla da konuşuyorlar mı?
Naile: Yani, genelde bize, doktorları muayeneden muayeneye görüyorlar zaten.

[68] However, it is worth noting that although shifts are organized from on high, nurses can re-arrange their night shifts thanks to their group communication. It is an important subject of negotiation, which is common in many organizations working with several shifts. These negotiations are possible only through knowing outside duties of others. Nurses know who has a baby, who has an old mother, who takes care of her family. I am told also that it may be problematic since "all have families" (*hepimizin ailesi var*), but that they manage it rather successfully despite sporadic disagreements.

"double carer" as taken for granted[69]. Her gendered experience is haunting its narrative.

In her little story, she narrativizes the conditions in which she has to work. Nursing education provides nurses at least theoretically with techniques to face and help patients' relatives who accompany them in the wards. While these techniques do not challenge the patient-doctor-nurse triangle which excludes relatives, her narrative does. The existence of family members in the service of patients is a specific care imaginary in Turkey. The *refakatçi* system is under the control of the medical institution[70], and emphasizes family's role in the care of the ill, elderly and children: family members- predominantly women- take care of their patients in all wards of the hospital except the wards they can not enter (like intensive care units where all care is given by nurses and health care assistants). This is welcome by nurses in terms of providing hands-on care and dirty work. However, two basic challenges appear: firstly, nurses say that they take care of the relatives as well, like in Naile's account. Secondly, they feel themselves unable to care for patients in the way that they are educated and obliged to rethink nursing care in a creative mode, neither in familial terms, nor in cold bureaucratic and totally distancing ways.

In addition, gender, in this brief story, is not a detail but a significant layer. The young man's inability to bear suffering, his de-virilization (the metaphor of the child, the emphasis on the weeping of young man are representations of this particular encounter and of a violation of a cultural pattern; "men don't cry"), and his need of consolation are the surprising part of the story. She underlines a relationship

[69] In the very beginning of our conversation, she talked about her mother who is old now and that she was taking care of her.

[70] Relatives who take care of patients in the wards are given cards for free exit and entrance into the wards, they are served food during their stay.

between nurse and patient by referring to gender roles. As Sevenhuijsen (1998) points it out:

> The construing of moral identities is thus, in this sense, inherently a social practice, something which we do and make within human relations and within specific social and political contexts, and the narrative conventions [are] reflected in these. In this sense, the relation between gender and morality is relevant, because both the attributing, as well as the experiencing and disputing, of sexual identities takes place in social practices, gender cannot thus be simply erased from these (p. 56).

Nonetheless, her story ends with a new challenge, still relevant in terms of organization and the unequal division of labor. She underlines a fact (nurses take care of relatives of a patient), she puts it as practically and ethically performable. She stipulates that nurses can and have to carry out care with great responsibility. However, they do it with responsibility, but with limited power and possibilities. Helplessness reappears to end her story.

This short narrative shows how a consideration of the ethics of care as narrative practice can be useful to problematize inadequacies, inequalities and problems in a different way. Accusing nurses of indifference or exaltation of their work are two ways to hide what really happens in care work.

Concluding remark

In this chapter, following Sevenhuijsen's argument, the ethics of care as a narrative practice is discussed by paying particular attention to care work performed by nurses, and a brief narrative from fieldwork is analyzed in the light of these discussions. The ethics of care is about opening to the other; this opening can be neither pre-determined, nor fixed. Many discourses, ideals and experiences get together in the reality of care and care-work, and thus a rich repertoire of ethical considerations

becomes available. Nurses, in an interpersonal profession, are taught ethical principles but they listen to other nurses' stories selectively, remember fragmentarily and re-count in a way that suits their purposes. Deviations from an ideal of care are pondered over; ethical and practical answers are given. How these find an audience, how they produce subjectivities are important questions. The first step of a research about care and care-work must be to reveal this repertoire of ethical considerations.

In this way, care-work, becoming more and more in demand, can be understood better and care-workers, predominantly women can be liberated from a universal/male language of institutions by re-valuing their experience and knowledge. Clement's (1996) point is, therefore very indicative:

> In paid care work, autonomous care would require, among other things, giving caregivers credit for the knowledge they gain through their close interaction with clients, and recognizing that the bureaucratic rules that typically govern caregiving institutions cannot do so adequately. This would challenge the traditional idea that the public sphere can and should be governed exclusively by universal rules. Applying these rules with a sensitivity to particulars requires valuing the particularistic ethic of care in public institutions where it is usually thought inappropriate. (p.65)

CHAPTER SIX

Accompanying the dying

All men are mortal: but for every man his death is an accident and, even if he knows and accepts it, it is an unearthly violence. Simone de Beauvoir [71]

Introduction

Death is omnipresent in an oncology unit, yet it is a morbid and gloomy subject. Patients do not talk to each other; Blue Angels mention ways to combat disease but do not talk about death; death is implicit in their speeches. Nurses, however, do not hesitate to talk about death: death is a topic for them, sometimes scary, sometimes depressing, but it is always there.

It is worth remembering the three major philosophical approaches which contributed radically to the thought of death in philosophy. According to Plato, philosophy is to learn to die since the duality between body and soul ends in the world of Ideas (c.1975), whereas Spinoza sees mentioning death as an impossibility; the philosopher's wisdom is not to think death but life (c.1994). Both, however, endeavor to go beyond time, and to ponder an eternal substance which is not condemned to time. In Spinoza's conception, death can only be the preoccupation of the ignorant who can not think life in its plenitude. For Heidegger, forgetting death is ignorance, and human reality is temporality, and therefore death can not be excluded from human thought (c.1996). Temporality therefore is quite related to human quest to give meaning to its life.

[71] Tous les hommes sont mortels: mais pour chaque homme sa mort est un accident et, même s'il la connaît et y consent, une violence indue. Simone de Beauvoir (my translation, 1964, p. 163)

It is of special importance to ponder death in a technical and ethical context since both techniques and ethics are socially imagined, thought and applied. The death of the human being is not solely a natural, physical, technical phenomenon. For instance, brain death is an important area where many medical anthropologists do not stop to ask further questions (Lock, 2000) and this is not without relevance. There emerge significant points to emphasize in Lock's article: firstly, she highlights that biotechnologies neither emerge, nor start to be applied in a cultural vacuum; they are in dialogue with other changes and broader social understandings. Secondly, she highlights how Death is difficult to elaborate on, especially for Western assumptions emphasizing boundaries between culture and nature, mind/person and body, individual and social. Thirdly, Lock's emphasis on changing meanings attributed to death is crucial to unthink taken for granted boundaries and is prophetic of possible outcomes of any unquestioned determination criterion of death. Also it is possible to argue that although the determination of death is crucial for the efficiency of medical technologies, biomedicine's rationality increases the emphasis on death as a biological and foreseeable phenomenon but undermines the sociality of death and caring for the dying. Dying is a unique and temporal phenomenon which has repercussions in the social, rather than a fixed category which is bound only to scientificity. It is possible to argue that an individual is lonely in death, however, as Lock shows in a Japanese context, this is to forget that body is embedded in a social fabric; to tear away the "autonomous individual" means to destroy all possible meaning processes and to accelerate the commodification of not only the body, but also of life.

There are different layers of recognizing death. How human beings recognize death and what they do with death are questions in need of being

addressed in order to underline the socially constructed nature of giving meaning to this very phenomenon that tends to be ungraspable.

In this chapter, I will discuss death in relation to nurses' experience. Death is a widespread topic in an oncology unit, especially among female nurses for whom referring to death is part of their work life. In previous sections, I mentioned specific relationships between death and detachment, death and gift and so forth. In this section, which may sound rather speculative given the scope of my ethnography, I attempt to highlight particular ways of seeing and talking about death and dying among female nurses. My objective is to modestly show how talking about death has to do with gender and gendered work experiences.

Encountering Death

Death is not an event in life: Death is not lived through. Wittgenstein

Death is inescapable for living bodies; the mystery of death remains enigmatic. Although death is universal for the living, every death is unique and singular. It is possible to embody the suffering and emotions of the other to a certain degree. I insist on embodiment rather than empathy, following Maeve's argument (1998). Nurses are bodily present in their encounter with patients; this is not imaginative as the term empathy implicates. Therefore, as death is unique for every single person, the embodiment of death is impossible.

In the fourth chapter, I referred to Jankélévitch's conception to elaborate detachment. Harking back to his first category of death as "one dies" is significant here for another purpose. The recognition of death paves the way for the creation of institutions, rituals and practices through which societies introduce a natural

phenomenon into the social world. Religion, funeral rituals and mourning give meaning to the unknowable in different ways. However, the modern medical approach attempted to destroy these meanings by turning death into a biological phenomenon. For a medical approach, death is predominantly death as "one dies"; "you die" and "I will die" which are open to the experience of emotions and the creation of social bonds and meanings are excluded. Foucault (1973) puts it remarkably:

> The medical gaze pivots on itself and demands of death an account of life and disease, of its definitive immobility of their time and movements. Was it not necessary that medicine should circumvent its oldest care in order to read, in what provided evidence of its failure, that which must found its truth. (p.146)

I argue that nursing, however, has another attitude towards death: "you die" becomes inevitably their mode of encountering death which is fraught with emotions and ethical considerations.

Death and Repugnance

Phillippe Ariès was interested especially in how mentalities change over time, as a historian he has much to teach sociologists to question new areas, such as death. His brilliant essays show how the reception, the experience and understanding of death have changed over time in the Western world (1975). To reiterate his main argument, death, which used to be familiar and familial, has become something repugnant, shameful and scary; therefore it has been erased from modern everyday life. As Geoffrey Gorer (1965) puts it, death has replaced sexuality as the taboo of modern life. Similarly, death has been confined to hospitals and become a source of horror

and repugnance to be avoided in daily life. Mourning has lost its social significance and became isolated and commodified.

Ariès puts his arguments in a Western context. His examples are European. Referring rapidly to a Turkish context may obliterate some rather important nuances. In Turkey the *refakatçi* system means that patients are not alone in hospitals. All my informants, although appreciating family members' contribution to dirty work and to the emotional demands of the patient, have specific problems with these *refakatçi* people. However, we can analytically induce that death is a source of horror, sorrow and repugnance in an oncology unit in Turkey. Nurses tend to work in such an environment where relatives are afraid and sad while taking care of their patients. Nurses have to face both patients' and their relatives' fear while searching for a professional attitude. As discussed before, detachment may be a response to this repeated feeling of horror and repugnance. They have to re-arrange encounters between other co-habitants of the unit. As patients in a critical situation and other patients in a less critical situation cohabit in the same unit, confrontation between the dying patients and the suffering patients is pervasive. Patients' bodies talk to each other: changing shape (*erimek, bitmek*), losing weight and hair are specific signs in each patient. Therefore, the dying patient, following Ariès' terms, is a source of fear and repugnance, rather than compassion. It also serves as a projection for newly arrived cancer patients, and it is related to their conception of time: "very soon, I will be like her-a dying patient". Nurses feel themselves bounded to re-arrange these encounters. A chemotherapy nurse puts it clearly:

> Some patients are really worn out; we see that s/he may die very soon. We got used to this situation but newly arrived patients are afraid of seeing them, therefore we try not to get them together.[72]

[72] Bazı hastalar eriyip bitmiş oluyor, yani az sonra ex olacak. Biz alıştık neyse de yeni gelen hasta haliyle korkuyor, üzülüyor. Onları karşılaştırmamaya çalışıyoruz.

As I quoted before, some gifts are given in a similar situation. Nurses say that they endeavor to treat them separately in order to avoid confrontations between patients in terminal phase and those in less critical situations. In a focus group session, the emphasis was on young patients, Gül told her tactic after highlighting her sorrow for young cancer patients:

> We are sad of course, there are not only old patients…There are also very young people…We get them [into the ward] before others, and make their chemotherapy in a corner [of the ward] so that they do not see others, and become depressed.[73]

Nurses see the traces of death and pretend to know the process of dying, yet they know also that death is on the horizon and the dying bodies are sources of fear and repugnance for others. They develop tactics in daily practice. The oncology department is an environment which influences experiences of care in specific ways. As Edvardsson *et al.* delineate, one is that this department conveys messages of death and dying (2006). Cancer is imagined as an invading enemy resisting all defense strategies (Sontag, c.2003). They work by keeping in mind that death is a daily possibility in the oncology department. One chemotherapy nurse says:

> It is a difficult disease; the first thing people think is death. They should not be so afraid if they are in the first phase, but in general they have in their mind: "Will I die?" Yes we will all die. (She laughs)[74]

[73] Üzülüyoruz tabii, bir tek yaşlılar gelmiyor ki…Öyle genç hastalar var ki…Onları bazen önce alıyoruz, köşede veriyoruz ilacı, diğerlerini, görmesin, morali bozulmasın diye.

[74] Zor bir hastalık bu, insanların aklına hemen ölecekleri geliyor. Ama o kadar da korkmamak lazım ilk safhalarsa ama insanlarda genelde ölecek miyim? Sorusu oluyor. Hepimiz öleceğiz halbuki.(gülüyor)

Talking about Death and Silence

Ariès (1975) says that talking about death is not a daily subject; it has become an exceptional, exorbitant and always dramatic situation (p. 174). In nurses' accounts, it is not an exceptional topic. Nurses pretend to be talkative about death; they say that whenever they have time, they are eager to talk with patients about their situation and death. If they do not have the time to do it, they pretend to "be there". Their narratives are marked by deaths of patients with whom they had developed special relationships.

At this point, the difference between female and male nurses' ways of talking about death is clear. Male nurses say that they do not feel comfortable in mentioning death; they do not think that it is quite professional. Mehmet and Hakan emphasize "boosting the morale" of patients and their relatives without directly confronting the situation. Umut says he makes "some jokes if the situation is suitable". Following my question about what they were doing when they are asked questions or supposed to deepen the conversation, they underline professional distancing, not getting involved or avoiding direct questions. They do not want to share their experiences. They briefly state that it is not easy to care for a dying patient, but do not add any memory or story. I have to stress here that male nurses were more humorous and sarcastic about cancer and death than their female colleagues. After the interview, Umut made a joke that might sound harsh to an outsider. He said that there is nothing to do even if he falls asleep during his night duty, because "they will all certainly die".

In contrast, the female nurses that I interviewed talked about their personal or collective stories while taking care of patients in critical situations. They started

by relating professional attitudes, the 'musts' of nursing that they were taught, but did not stop there. All remembered at least one event that had an impact on them. Three major attitudes were important to note here:

Death as source of meaning for life

Heureux qui, comme Ulysse, a fait un bon voyage[75]. Du Bellay

The nurses that I interviewed say that they have particular and sometimes very personal ways of insinuating the arrival of death to patients and their relatives. They admit that they can not foresee the exact time of death, but they know the process of dying due to their past experience. During encounters with dying patients, they say that they feel very weak since they are not expected by doctors to talk about a death of which they have certain knowledge. As Mystakidou *et al.* (2003) discuss it in Greek context, Greek nurses feel helpless in their communication with the dying patient in the terminal phase of the disease. Similarly, my informants say that they feel helpless and that they avoid grief because the tacit workplace organization does not leave room for the expression of intense emotions. The demanded demeanor is neither to participate in mourning rituals existing in society, nor to create alternative ways of facing the death. Detachment may appear as a tactic against being overwhelmed by several deaths, yet it is not always feasible when death is there. However they grieve over the loss of special relations in personal and collective ways: Esra remembers all details of her special patients with their gifts and words. Nur says that she prays to God for them. But all experience their vulnerability and

[75] Happy, like Ulysse who enjoyed his journey.

mortality. “Death is always here” says an experienced nurse with calm and wise voice: even though it is not always possible to react in meaningful ways, living with dying patients inform them both professionally and personally. In Maeve’s terms, they engage in “weaving a fabric of moral meaning” (1998). Here it is worth remembering Selma’s account, according to which, *having lived long and beautifully* becomes a moral answer to face death and to cope with negative feelings about death. Many nurses claim that they learn from theses encounters with dying patients and talking to them inform them in their private lives as well:

> When one sees here people who are combating death, she thinks twice, we are mortal and we don’t know what will happen to us.[76]

Nurses are not reluctant to chat with some patients on death and pretend to give them consolation. In their narratives this phase of consolation is the short initial stage of a long deliberation. As I discussed before, sharing time and being in a particular relationship with the patient prevent them from being insincere or rational: they come to talk about life and death. For instance, Aliye says:

> I don’t want to lie. They ask questions of course. Doctors do not answer, and then they ask us. I don’t say anything; I say neither positive, nor negative things. Even if you have seen this situation many times, you can not say. I tell them to think about themselves, to talk with their visitors. I tell them to think about beautiful things in their life.[77]

[76] Burada canıyla uğraşanları görünce insan bir daha bir düşünüyor ölümlü dünya, ne olacağımız belli değil diye.

[77] Yalan söylemek istemiyorum. Soruyorlar tabii sormazlar mı? Doktorlar birşey demiyor. Bize soruyorlar. Ben birşey söylemem, ne olumlu ne olumsuz. Sen bin defa da görmüş olsan ne olacağını, söyleyemezsin. O yüzden kendilerini düşünmelerini söylüyorum, geleni gideni varsa onlarla konuşun diyorum. Hayatınızdaki güzel şeyleri düşünün diyorum.

Listening to the dying patients

Although nurses have many tasks to accomplish and many patients to take care of, they say that they listen to them more than doctors do. They share time in the same place; despite the work load, nurses start to know patients and their relatives who accompany them in the wards. Nurses say that they feel helpless when they are asked questions about disease, but they open up discussions about daily concerns. These discussions refer implicitly to patients' well-being, suffering and therapy.

However, nurses prefer to be at a distance from the wards during their rest time, they say that staying in the wards means continuing to work. Listening to the dying is not an easy position; they do not want to lie, they are not supposed to give additional information, but they can not radically detach themselves from patients. Daily discussions are therefore quite at the heart of nurse-patient communication. The taste of the food which is served, the effects of medicaments, the redundancy of similar topics are not meaningless, unimportant and useless. Emel says:

> E: Sometimes they [patients] look at my face to make me talk. I ask "how are you today? Do you have pain?" I say that her/his relatives care well for her/ him. Sometimes they want us to stay with them. It is not easy; I have many patients to take care of. Also we know that she/he will be exed [dead] soon, what I say does not really matter. But in general, I don't leave the ward quickly if she/he has something to say. Because, it is God's decision but, maybe she /he won't be alive in the morning, then you have a bad conscience. For instance, there was a patient, he demanded a pain killer, I made him an injection, and he said "my daughter" and started to talk. Fortunately it was not a busy night so we could chat a little.
> Q: What did you talk about?
> E: About every thing, about his disease, his destiny…
> Q: What did you tell him?
> E: In fact I didn't really talk, *rather I listened to him*. Then he died [in few days]. Were I rude to him, then I would be really sad.[78]

[78] E: Bazen bakıyorlar suratıma, bir şey söyleyeyim diye. Ben de işte bugün nasılsın? Ağrın var mı ? diye soruyorum. Bak ne güzel bakıyor refakatçin falan diyorum. Bazen de istiyorlar ki oturalım dinleyelim saatlerce. O kadar kolay değil, bir sürü hasta var bakmam gereken. Bir de tabii biz biliyoruz ex olacağını, ne desem boş oluyor. Ama yine de hemen çıkmamaya çalışıyorum söyleyeceği varsa. Çünkü Allah bilir ama sabaha çıkmayabilir, o zaman vicdan azabı oluyor. Bir hasta vardı

Emel's account illustrates how nurses may be invited by patients to "be there", to listen to them. They feel helpless when asked questions, but listening is another task, it appears to be passive yet it is not. They are not professionally allowed to answer questions, listening to them is an ethical position which escapes workplace rules. Although this account does not reflect all nurses' attitudes, listening to the dying appears to be a moral duty; if it is not accomplished, it may cause both personal and professional failure.

Costello's (2006) analysis is helpful to understand how good death and bad death are experienced by nurses. The ideology of 'good death' involves a modern rational ideal over the unknowable end of human life: control over death, high degree of predictability, appropriate time following Costello's categorizations whereas 'bad death' is sudden, unprepared, and traumatic or happening at inappropriate time. Timing of death is important. Even though they know that the patient does not have time, they want to arrange her passing away. Timing appears to be the last control over death, if they fail to prepare an acceptable time of dying, they feel themselves useless. Beril says:

> Sometimes I ask myself what I am doing here. You care for a patient, she dies, you care for another, and she dies also. It is really vain. You think that she [the patient] will be better, and then she dies, so I really feel terrible. I say that she passed away without suffering too much but what's the use?[79]

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mesela, ağrı kesici istedi, yaptım, « kızım dedi, başladı anlatmaya. O gece yoğun değildi Allahtan da biraz sohbet etmiştik.
Q : Ne konuştunuz ?
E: Aslında havadan sudan. Hastalığından, kaderinden..
Q: Sen neler söylemiştin?
E: Vallahi ben bir şey söylemedim, dinledim daha çok. Sonra kaybettik hastayı. Vallahi o gece ters bir tarafıma gelseydi, tersleseydim, sonra çok üzülürdüm.

[79] Bazen ben ne yapıyorum diyorum kendime. Baktığın ölüyor, baktığın ölüyor. Boşuna gibi. Tam biraz iyi olacak diyorsun, hasta ex oluyor, o zaman gerçekten kötü hissediyorum. En azından çok acı çekmeden öldü diyorum ama yani neye yarar?

Religion

Religion with its principles, rituals and beliefs that it provides is an important institution for apprehending death. Death escapes disenchanted explanations of modernity. Religion, in many cases, is thought to be an important reference for nurses who are expected to answer the questions of dying patients. Quite strikingly, very few nurses in my field work referred to religion as a guide. Needless to say, many nurses invoked the name of God, destiny and fatality in their accounts, but this is also part of a daily mode of conversing in Turkey. In contrast to some Iranian field works (Iranmanesh *et al.,* 2009); during my ethnography in secularized Turkey I did not hear nurses talking about religious knowledge in working with dying patients. Nur's account, however, was specifically about Islam's understanding of death to which she did not hesitate to refer. In her view in Islam, death is not an end, but a necessary transition from one life to another; therefore nursing practice in critical situations has to make the dying as comfortable as possible (*rahat ettirmek*). Death is neither an end nor something to be scared of or to be sad about. Islam's attitude towards death in this regard contributes to her nursing as a guard against sorrow. I have to add that Nur seems to be the most comfortable nurse even with the suffering, the angry and demanding relatives; she relates her calmness to her religiosity, in which she can find patience, tranquility and self-esteem. Nur's religiosity is the only example I could see; the other nurses, although referring implicitly to religious considerations, did not directly mention it. However, I could argue that in the particularity of the nurse-patient relationship, the ability and will to be

knowledgeable and responsive in religious ways of encountering death may be an important facilitator.

Nur emphasized the fact that all human beings are mortal and doomed to face it in one way or another. Following this argument she highlighted that dying patients have time to demand an absolution from God and this seems quite consoling to her.

Here it is important to note that even though people like Nur who believe in monotheist religions have the hope of immortality and of survival; this is not to say that they deny death. To affirm immortality is also to accept death. That's why Morin (1951) says "the same awareness denies and recognizes death: it denies it as destruction and recognizes it as event" (my translation, p.15).

The aftermath of death

When patients die, their relatives feel frustrated. They think that hospitals are to heal and that the health care team has not done their best. Selma says that nurses are in danger and that she was even physically attacked and that relatives damage violently the wards and attack nurses. Here I will not argue that everything is perfect in hospitals and that the patients and their relatives are over reacting; needless to say, there are many observations about inequalities in accessing the treatment, malpractice and insufficiency of hospitals in Turkey. Rather I would like to articulate three points: Firstly, while hospitals are constructed as places where treatment is available, the very relationship between hospitals and death in the clinic is always implicit. There remains a strong desire that medicine will combat death one day,

medicine is imagined and experienced as soteriological. Therefore, death in the clinic comes with its frustrations.

Secondly, hospitals are not really isolated from the rest of social practices; objections to inequalities, tragedy and suffering do not differentiate them from other social practices. Physical violence to female nurses, damaging the place/wards, insulting reflect major attitudes circulating in the society. Also, the modern hospital is not organized to incorporate mourning rituals, the expression of intense emotions, and to let death come in; the very premises of modernity do not leave room for them. Therefore, practices that reshape collectivities- like mourning are replaced by other practices-like physical violence- which do not seek to create bonds but to destroy them.

Finally, the aftermath of death is structurally left to female nurses. Putting psychology with its pathologizing perspective and terminology, or women into the places where the language of suffering and communicating death is eliminated by empirico-scientific male authorities, is political. Fassin (2004) calls these places *lieux d'écoute* (listening places), where either violence or expertise reign. Positioning women in these places paves the way for implicit articulations to patriarchal ideology: female nurses are disempowered and placed on the face of emotions that have lost their language. Doctors have an advantageous position in this structure; they are expected neither to face the outburst of patients' relatives, nor to listen to the experiences which are already isolated from the social.

Words we lost.

In this chapter, my purpose was not to praise death as something splendid which is par excellence superior to life in any case. Rather I attempted very speculatively to look at another way of encountering death unlike modernity which has rendered death fearful, repugnant and meaningless. In a society where death has been positioned at a distance from life, from daily life, where in Aries' terms, it has been isolated in hospitals, nurses are called to experiences to which they are supposed to remain distant in daily life. Evidently, I do not argue that hospitals are to be excluded from biomedicine's endeavor to provide health; I admit that it has to deal with many factors against illness and death. Yet I do not think that destroying the possible languages of talking about death is to be a part of this project. We have to take into account the very fact that women nurses fill the voids that are caused by systematic and historical silencing of certain glossia by the biomedical ambition of longer life, or always life. However, it is not easy to fill these voids. What escapes the rational ideals of the modern hospital subordinates women into more disempowered positions in the hierarchy than before. The knowledge and experience of women care givers are crucial for us to acquire the words and spaces that we have lost.

CHAPTER SEVEN

CONCLUSION

In this thesis, I attempted to highlight problems and voids in the nursing profession by paying specific attention to my field work in an oncology department. After describing my research in the first chapter, I moved to describe how I started my field work and how nurses are subordinated in a specific gender-defined position in the hospital hierarchy. I argued that their voices were silenced under the ruling relations of the organization. I attempted to show how nurses are "feminized" by the bureaucratic, male and medical authorities who denigrate nursing knowledge and think that it is not a significant field for research.

In the third chapter, by elaborating on the feminist conceptualization of "doing gender", I discussed how nursing is a both gendered and gendering profession. Doing gender is an important analytical tool to see the traces of the gendering process in the daily performance of care tasks, but it also contributes to a possibility of transforming these relations and categories. The employment of men in the nursing profession is welcome and leads to a change of the image of nursing. However, the daily reproduction of inequalities shows that the patriarchal ideology continues to reshape certain bodies and imaginaries in order to perpetuate itself in tacit forms. Nursing stills ranks low as an acknowledged profession in the estimation of predominantly male doctors, patients and their relatives.

In the fourth chapter, I concentrated on emotions by challenging the technical and instrumental use of detachment in the nursing area. In my analysis, detachment is neither a lack of emotions nor a strictly professional mask. I call

detachment a particular experience at the intersection of several layers: firstly, it appears as a particular way of working in an environment which is fraught with emotions and where the expression of these emotions is problematic in terms of the professionalization of care, the rational organization of hospital, and the emphasis on physical care. Secondly, nurses' efforts to create equilibrium between being emotionally over-involved and indifferent lead to an endless self-reflexivity. Detachment therefore becomes a professional habitus, embodied in time, in practice and locally. By locally, I refer to the lived experience of a particular nurse in relation to her colleagues, previous encounters and emotional deadlocks. Thirdly, following this argument, detachment is related to gender roles and gendering practices as well. Many female nurses underline the continuity of care in their lives, detachment appears here with its aspect of accumulation of 'bad' emotions, in the sense that the load of emotional responsibilities lead to a will for emotional illiteracy. I think that conceptualizing detachment in these ways has two important contributions to theories of emotions and emotional labor: firstly, this enlarges the understanding of the experience of emotions and highlights that there is no monolithic emotion. The rational dictum of distancing in care work is constantly under the influence of managing various emotions such as grief, indifference, anxiety, compassion and fear. Secondly, putting detachment as a particular way of working on/with/through emotions can be analyzed and apprehended through narratives. Contradictions, challenges, efforts reappear in narratives and the examination of metaphors, genres and breaches show the common repertoire of care workers which is reconstructed in time. This repertoire comprehends sediments of norms, practices and personal and collective intelligence for encounters where emotions escape the rationale of the hospital system.

In the following chapter, I adressed the universality of morality by showing how the ethics of care can contribute to a contextual and relational understanding of the reality of care. Here, putting the ethics of care as narrative and textual practice, I analyzed how nurses found an ethical repertoire through their lived and gendered experience and narratives. Narratives are not fixed and they show how temporality works in the work place; previous encounters and moral problems are articulated in narrative form. Specific genres like narratives of gift or particular formulations like as if clauses challenge the taken for granted ethical rules of nursing and create a more dynamic and multilayered deontology for nurses. The shaken ideals of the nurses are reshaped in narrative form, and inevitably this is in direct dialogue with the gendered and gendering positions of the nurses as mother, daughter, and wife. Looking at the ethics of care as narrative practice exposes biased and gendered distinctions such as rational/emotional, private/ public, professional/ personal, to examine what is excluded from the universal dicta of the professionalization, to attend to make sense of singularities and encounters, to interpret metaphors when it is difficult to give meaning to certain practices.

In the final chapter, I tried to understand how nurses talk to and take care of dying patients in an environment where death is seen as a technical issue by medical authorities. Nurses' attitudes towards death and dying differ from medical knowledge. The organization of hospitals does not leave room for death. Nurses, however, are structurally reinforced to listen to dying patients and exposed to the reactions of patients' relatives when death is on the horizon.

Power relations, gendered division of labor, and ways of knowing in the professional care are open to investigation. In this thesis, I analyzed the gendered and gendering experiences, encounters and knowledge of nurses in an oncology

department. I put emphasis on the contextuality of the care work that resists the rational, male-biased, scientific and universal organization of a formal institution. Emotions form a way of knowing and practicing, and their subordination to the rationality and devalorization are historical and political. Examining emotions pave the way for re-thinking universal moral rules, and ethics of care as narrative practice delineates how time and different layers of knowing and working are concocted and circulated among care-givers. I argue that nurses open up a creative space between professional care and familial care. The very presence of family members in the wards and the professional ideals they are given during their education lead to a creative space where nurses oscillate between professional, institutional care and familial, personal care. This creative space modestly articulates once more that in terms of employment of women, the rigid distinction of public from private is paradoxical in terms of practices, positions and work, but it goes beyond this argument. It is not monolithic and unchanging continuity, but the creation of different ways of care as both action and disposition. Nurses embroider their experience as both women and professional care workers. When they manage at appropriate these two attitudes, their narratives portray an equilibrium and the timeframe of their narratives is cyclical, in the sense that they can place their emotions, experience and actions with reference to their place in the social settings to which they belong. These narratives show both the work load on women as care givers and the significance of their knowledge transmuted from their personal lives. Nonetheless, when they fail to manage their emotions and personal ethics in the work place, the timeframe tends to be kairotic, meaning that their narratives are punctuated by important events, special encounters and patients, where this creative space is constructed. Paying attention to narratives contributes both to see the traces of the

continuity of care work and to notice the new ideals and practice in a specific work environment.

Moreover, the fact that death and suffering have become less visible and more repugnant than before, is a weakness for societies, and leads to the loss of words, practices and rituals that form and reform the collectivity, and a way of facing the mystery and tragedy of death, they must remain political, in the sense that they can find voice and space in the *polis*. Therefore, it is more than necessary to listen to women who develop new words and moral attitudes in subordinated places where they are supposed to act. But as a first step, it is crucial to combat gender inequalities, disempowerment of women in daily practice, in the hierarchy of the hospital organization and in the imaginary of people, and to engage in further research in all "taken-for-granted" areas. The relationship between nursing and gender is commonsense knowledge, but what and how this relationship is reproduced in the quotidian, and which challenges, problems and contributions stem from this are crucial to understand "care" in all its complexity.

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