

---

## 'You Can't Take It Personally': Emotion Management as Part of the Professional Nurse's Role\*

OLGA ŠMÍDOVÁ MATOUŠOVÁ and BLANKA TOLLAROVÁ\*\*

Charles University, Prague

**Abstract:** This study looks into the culture of nursing professionals in the present-day Czech health-care system at a time of personal, generational, and educational transitions (reforms), which have driven a change of organisational-cultural means in the relationship between two key professions: doctors and nurses. The article presents the results of a biographical study of nurses, paying detailed attention to their emotional labour in cooperation with doctors in accident and emergency ward settings. The study draws on the concept of organisational culture in practice/action, on a Goffmanian and Garfinkelian ethnomethodology of scripts of interaction (rules, norms) in order to reconstruct the feeling rules that govern a nurse's emotional display and her role in cooperating with doctors. The article stresses the importance of emotion management as a substantial part of the gendered professional identities of health-care workers and discusses the situations when nurses' subordinate status requires a kind of stressful emotion management to keep the doctor-nurse professional relationship intact, which is not required from doctors. The study also presents a variety of coping strategies or practices normalising these morally questionable feeling rules and norms, which guide action as an integral part of the ordinary practices of the social organisation of the nurse's occupation in hospital settings.

**Keywords:** emotion management, organisational culture, ethnomethodology, organisational norms in practice, nursing, professional roles

*Sociologický časopis/Czech Sociological Review*, 2014, Vol. 50, No. 6: 839–873

DOI: <http://dx.doi.org/10.13060/00380288.2014.50.6.146>

---

\* We would like to thank the anonymous reviewers for their exceptional helpfulness during the peer review procedure.

\*\* Direct all correspondence to: Olga Šmídová, Department of Historical Sociology, Faculty of Humanities, Charles University, U Kříže 8, Prague 5, Czech Republic, e-mail: smidovao@seznam.cz; Blanka Tollarová, Department of Management of Supervision, Faculty of Humanities, Charles University, Máchova 7, Prague 2, Czech Republic, e-mail: blanka.tollarova@fhs.cuni.cz.

## Introduction

The nurse's role is strictly defined by applicable laws and other formal norms governing the entire field of health care (codes of ethics, job descriptions, internal regulations).<sup>1</sup> At the same time, it is shaped by the tradition of an occupation firmly embedded in the health-care system, its practices and everyday operations, in the system of education of all its actors, and last but not least, in its financial framework. This tradition also comprises a number of informal norms and expectations related to the performance of the nurse's role that are shared by nurses and that are as important for the management of their professional performance as the above-mentioned formal norms.

The role of Czech nurses is currently undergoing a dramatic transformation driven by post-1989 changes to the social order: the funding of health care through universal public insurance, the large-scale privatisation of medical establishments, and the commercialisation and commodification of health [Kapr and Koukola 1998; Read 2007; Heitlingerová and Trnková 1998]. The above trends, and especially the country's accession to the European Union, are also linked to changes in nursing education, in particular the shift from secondary-level study programmes to general and specialised bachelor's and master's degree programmes in nursing. Czech nurses can, and some do, work abroad in order to obtain more experience, which can include the experience of the different status accorded to nurses in health-care teams.

All this has brought about personal, generational, and educational changes in the nursing occupation. Nurses who possess college degrees or have worked abroad expect to work in a different way than the past generations of nurses and doctors trained in the paternalistic, highly gendered, and strictly biomedical model that was in place under the old regime and remained in place for some time after the revolution in 1989. In that model, the doctor and his<sup>2</sup> expertise possessed unquestionable authority over both nurses and patients. However, the nurse's position in the system is changing rather slowly. Her job has become more demanding in terms of professional education and training; nursing has come to form an autonomous field of expertise; in recent years, hospitals have begun to set up multidisciplinary teams of doctors and paramedical health-care profession-

---

<sup>1</sup> This article was prepared with the support of the Ministry of Education, Youth and Sports—Institutional Support for the Long-term Development of Research Organisations—Charles University, Faculty of Humanities (2014).

<sup>2</sup> Both of the professions that this study is concerned with are gendered professions: in order to critically highlight the stereotype we use the corresponding pronouns: *he, him, his* for doctors and *she, her* for nurses. The stereotype of a male doctor and a female nurse is perpetuated through language, including the language of health-care statistics. The number of female doctors has been rising steadily [ÚZIS 2003, 2013]; however, when referring to the number of doctors, statistics persistently use only the masculine form of the noun (Czech has different suffixes for a male and a female doctor), while only the feminine noun 'sestra' (meaning both 'sister' and 'nurse') is used to refer to nurses.

als; and there is an increasing awareness of the Western European trend where nurses enjoy an autonomy and status equal to other professionals in health-care teams. At the same time, the position of nurses and, in particular, both their and doctors' expectations of their work are apparently still very much in line with the traditional model inherited from the old regime and promoted by the persistent gender order, which tends to reinforce the hierarchy of health-care professions by adding to it the hierarchy of traditional gender roles and expectations. Therefore, nurses are still assumed to be, and counted on as, the subordinates of doctors. As we shall demonstrate using a typical example of doctor-nurse interaction during emergency cases in the organisational life of a hospital, the asymmetry and hierarchy of the nurse-doctor relationship in the Czech health-care system are only beginning to change.

This article looks into the contemporary occupational culture of Czech nurses, especially those working in acute care (operating rooms, outpatient clinics) in the context of the Czech health-care system today. As a case study, we present selected results of a study on the occupational careers of health-care professionals as a part of their life course. We focus on the rather extreme case of the central norm that defines a good nurse, 'the nurse obeys the doctor', and reconstruct the ways in which nurses themselves understand and typically practice this norm.

The central focus of the article is to describe the rules and norms of a local and situational, yet typical script of nurse-doctor interaction, which we metaphorically refer to as 'the nurse as the doctor's lightning rod' [Šmídová and Tollarová 2013].

Our research strategy and its theoretical-methodological framework combined the cultural approach to organisation as a project and product of cooperating participants (here nurses and doctors), referred to as 'organisational culture studies' [Alvesson 2002, 2004]. In the spirit of dramaturgy and ethnomethodology [Goffman 1999; Garfinkel 2002], we focused on rules, norms, and values as the local cultural sources that order nurse-doctor interactions and that are used by nurses to construct the meaning and order of the organisation and their occupational role in its life.

At the same time, the gendered dimensions of doctor-nurse relationships must be taken into account. Therefore, we refer to Harding's concept that treats gender as a social category [Harding 1986] and/or frame [Wodak 1997] operating at multiple, interconnected levels. The term 'gendered institution', used to describe nursing as 'institutionalised as a gendered profession', refers to the same idea [Acker 2006]. Work organisations often outwardly pursue equal opportunity policies, declaring occupations to be gender-neutral, unencumbered by emotions and sexuality. But Acker points to the existence of 'inequality regimes' that are embedded within organisational practices and processes and reflect gender patterns linked to culture as a whole [Acker 1990]. Our data sources consist primarily of biographical interviews with nurses, mostly but not exclusively those from the oldest generation, who better reflect how the occupational role and status of nurses has changed in the course of their careers and in the context of the

socio-historical changes that have taken place in the health-care system and in society as a whole.

The article is structured into three parts. In the first part, we outline the (social) history of nursing in the Czech Republic. In the second, we present our theoretical framework and the concepts applied in our analysis and interpretation of the nurses' narratives of their career and life course. In our study of the occupational culture of nursing, we focus on organisational practices, guided by two key concepts: 'organisational/occupational culture in practice' [Hester and Eglin 1997; Driskill and Brenton 2005; Heritage and Clayman 2010; Šmídová 2011]. We use Goffman's dramaturgical perspective on organisation as a theatre or stage performance [Goffman 1999; Driskill and Brenton 2005]. The situational organisation of nurses' experiences relies on a set of organisational rules and norms of ordering actors' interactions and self-presentations. An integral part of this lies in the 'feeling rules' or social rules that govern the expression, experience, and reflection of one's feelings resulting from the performance of 'emotional labour' [Hochschild 1975, 1979, 1983, 1998]. In the third, empirical part, we use a multiple-case study to present the findings of our ethnomethodologically and dramaturgically informed interpretation of the nurses' biographies. Our goals are to establish the theoretical relevance of our findings and shed light on the implicit rules and norms of acting, thinking, and especially feeling that lie behind the patterns and scripts recurring in certain types of situations. Finally, we construct and present a Goffmanian working typology of 'coping strategies' used [Goffman 1961, 2003].

### **The occupational culture of Czech nursing: the ongoing transition from a doctor's assistant to an autonomous profession?**

Changes to the system of nursing education and the concept of nursing are taking place in a health-care environment that is traditionally hierarchical in structure, favours a biomedical approach to illness and recovery, and respects a hierarchy of medical occupations, with doctors at the top. The authority of doctors derives from their high expertise; until recently, this was unquestioned owing to the long-term dominance of biomedical discourse, medicalisation, and curative care [Slepičková, Šlesingerová and Šmídová 2012; Křížová 2006]. Health-care systems in Western Europe or other developed countries also went through this stage. The Czech context is characterised by the specific legacy of socialist health care, with its strong emphasis on the authority of doctors and the subordination of nurses.

The socialist health-care system was centrally planned. It was the government that determined the population's health needs and how to meet them [Read 2007; Heitlingerová and Trnková 1998]. Socialist ideology not only affected the organisation of health care but also supported a scientific model of health care that emphasised the physical and biological aspects of health [Read 2007; Staňk-

ová 1996]. Excluded from public discourse were alternative concepts and perspectives on health, patients' needs, or health-care methods. While elsewhere in the world the 1950s ushered in greater autonomy and differentiation in nursing, in Czechoslovakia the opposite trend occurred. Nurses worked in collective establishments and had a uniform occupational status; independent professional positions with responsibility for holistic nursing (e.g. outreach or community nurses) were not preferred [Bártlová, Chloubová and Trešlová 2010]. The process of differentiation between professional and auxiliary nurses that in Western and international nursing began after the Second World War only reached the Czech Republic in the 1990s.

Gender is a key social category which defines the significance and normative order of the two professions both within this organisational context and within the wider social order and/or culture in which the local organisational culture is embedded. Nursing, as seen through the prism of this culture, is a prototypical 'female occupation', based on the idea that care-giving and nursing are somehow inherent to the 'female nature'. The 'male nature', meanwhile, is assumed to be associated with different attributes and activities that characterise the actors 'as men'.

The nurse's status in the socialist health-care system was gendered in this highly stereotypical way; moreover, it relied on the specific role of a socialist woman with a legal obligation to work. According to Heitlingerová and Trnková, a woman's role was predominantly that of a working mother whose ambition was not to excel or lead others in her occupation, but to reconcile the dual workloads of employment and the household [Heitlingerová and Trnková 1998: 25]; and women were proud of their dual workload, of being able to do so much. Czech nurses had low occupational status, autonomy, and prestige, and their salaries were below the national average [ibid.: 22]. At the same time, the job description of a 'general nurse' in the understaffed hospitals of that time included a wide range of activities, from highly professional tasks to handling medical supplies to cleaning [Marková and Bártlová 2013]. The oldest generation of our respondents, who underwent occupational and gender socialisation in the socialist era, showed a similar pride. In their narratives, they were strongly appreciative of the heavy demands of their nursing jobs, their high job performance, and their ability to solve all kinds of problems under extremely stressful working conditions. Despite their relatively low salaries and the lack of symbolic rewards from their employers, they were committed to a high job performance.

### *Nursing education*

As Staňková [1996] and other authors argue, the fact that today's nurses find themselves in a dependent position and have to fight for recognition and autonomy can be traced back to the socialist system of nursing education as an important vehicle of occupational socialisation. After the communist coup of 1948, the

political orientation of the country changed and its system of nursing education underwent reforms modelled on the Soviet Union [Staňková 1996]. Czech nursing education no longer followed the same trends as other European countries or the United States. Nursing education and training were moved from the post-secondary to the secondary level: the graduates, who were just around the age of majority, thus often lacked the required level of maturity and responsibility. The poor quality of schooling was also due to the simplified, mostly biology-oriented curriculum, with very few hours of practical training [Staňková 1996: 21]. The education system emphasised technical skills and the mechanics of individual tasks; independent thinking and holistic nursing were not encouraged. The dependent status of nurses was further reinforced by the fact that they began their studies, and subsequently their professional careers, at a very young age, had little practical experience, and could not perform certain procedures before reaching the age of majority. The aim was 'to train a qualified doctor's assistant who fully accepts the doctor's decisions and does not make independent decisions herself' [Kutnohorská 2010: 115].

Nursing students were also subjected to the kind of traditional disciplinary practices often found in the culture of Goffmanian total institutions [Goffman (1974) 1986]. Living in multiple occupancy rooms in dormitories with a strict daily regimen, regular clean-up, and a shared daily schedule taught future nurses to 'sacrifice self-interest in the interests of others' [Rozsypalová, Svobodová and Zvoníčková 2006: 16]. The curriculum and organisation of nursing education systematically taught the students to accept their subordinate status and fully comply with a strict social order.

### *Occupational culture*

The norm of sacrificing self-interest to the collective interest of the occupation is another important part of the nurse's traditional subordinate role. The occupational culture established around the turn of the 20th century embraced an effort to make nurses autonomous and give them specialised post-secondary education. However, it was strongly influenced by the health-care realities of that time where most nurses only underwent practical on-the-job training in hospitals, college degrees in nursing were rare, and nun nurses occupied an important position in nursing practice. The new professional lay nurses did mostly the same jobs as nun nurses: all nurses were required to be strictly disciplined, obedient, and self-controlled, to work flawlessly, and to accept unfavourable working conditions (low salaries, practically unlimited hours, or even celibacy in some hospitals [Kutnohorská 2010]). The norms of service, devotion, and sacrificing personal needs to one's occupational life became part of the layperson's notion of nursing and were reinforced by the occupational practices of nursing as a kind of hidden curriculum.

The influence of nun nurses and their traditions is preserved in the historical narratives of Czech nurses, collective memory studies [e.g. Rozsypalová, Svobodová and Zvoníčková 2006], and textbooks on occupational history. While the emergence of the lay nurse's occupation is greeted as a part of modernisation, the image of the nurse's job and her devotion to it remains: nursing is still a 'higher calling' and, much like the nun nurses earlier, it is her 'vocation' to devote her life to it. 'What should a nurse be like? ... She should always be there for other people; First think of others, and only then of yourself; You mustn't betray your feelings; Leave your cares at the door.' [Venglářová et al. 2011: 13]

Our informants-nurses remembered nun nurses, who were still present in Czech hospitals for some time after the regime change, and the informants showed us how their notions of nursing had been influenced by the presence of nun nurses: the nurse is a silent white angel, respects a strict social order, loves and fully devotes herself to her patients and hospital service, and does not have a personal life. The persistent use of the nun as the model for nursing professionals is a very effective disciplining tool: comprising just those elements of a woman's gender role that have been cherry-picked to suit the organisation, it perpetuates the traditional image of a devoted, service-focused sister and suppresses other modes and possibilities of femininity (the passionate woman, etc.).

### *The nurse-doctor relationship*

Definitions of the occupational role of nurses often emphasise the fact that the nurse complements the doctor. In the context of the Czech health-care system, she complements him but is not equal to him, and the two cooperating occupations are not equally important. The nurse's role is by definition subordinate. Her subordination is incorporated into the system and organisational hierarchy/structure, affecting the ways she understands her role and performs every aspect of it [Bártlová, Chloubová and Trešlová 2010].

Perhaps every health-care system is characterised by inequality between doctors and nurses or by a social distance between them. In recent decades, scholars have presented different models and concepts describing the position of these occupations in relation to each other. The classic 'doctor-nurse game', based on gender stereotypes, is characterised by covert, informal, strongly ritualised patterns of interaction that enable the nurse to take part in treatment decisions by consulting the doctor, even when overt, direct ways of participation would not be permitted [Stein, Watts and Howell 1990]. Described in the 1960s, the game refers to the doctor's untouchable superiority of competence and, at the same time, to the untenable status quo where the nurse plays an important role in the treatment process without being openly invited to making decisions about it. Porter [1991] formulated four models of doctor-nurse interaction based on the distribution of power and authority between the actors: absolute subordination; the

doctor-nurse game; nurses influencing doctors in open but informal ways; and explicit regard for the nursing process in all formal decision-making. Aroskar [(1985) 2002] distinguishes four options, namely non-existent, master-servant, adversarial, and collegial doctor-nurse relationships, decrying a low appreciation for nursing work at that time (in the 1980s). The above models illustrate three trends that have shaped nursing in many developed democratic countries over the past couple of decades: the growing autonomy of nursing as a discipline, the decreasing inequality between nurses and doctors, and the growing recognition of nursing work by doctors.

In order to grasp the inequality between doctors and nurses as occupations, scholars have applied other concepts such as symbolic boundaries (and the ways they are understood and constructed), intergroup hostility (and its growth as a function of group identities) [e.g. Burford 2012; Weller 2012], or the metaphors of civil war and revolt [Weaver 2013]. Many studies have demonstrated that the traditional inequality between doctors and nurses is decreasing as more and more nurses obtain college degrees; as hospitals in many countries take measures to facilitate or symmetrise communication; as a result of organisational changes to encourage collegiality [Weller, Barrow and Gasquoine 2011; Svensson 1996]; or based on inter- and intra-occupational training. Interestingly, Czech scholarship also presents these inequalities as currently relevant or even pressing issues, but its recommendations thus far have been rather cautious compared to international literature. Instead looking at the forms and causes of lasting inequalities, Czech scholars have focused on their negative effects on health-care professionals (stress, burn-out, conflicts) and their negative structural effects on medical establishments (employees do not feel valued, high staff turnover, sub-optimal quality of care and patient satisfaction, and the risk of adverse events) [Bártlová 2006; Bártlová, Chloubová and Trešlová 2010]. It seems that an open debate on the inequality between doctors and nurses or on the recognition of nursing is just beginning.

### *Nursing as a gender-role and 'semi-profession'?*

Historically, the term profession was reserved for a select number of male-dominated occupations, such as medicine, law, and clergy.<sup>3</sup> Health-care professions are gendered. Occupational gender segregation is particularly evident in nursing

---

<sup>3</sup> In the past decade, women have made up more than three-quarters of the workforce in the Czech health-care system. In the various branches of medicine, too, female students and graduates now outnumber men by 10 to 12%. It is therefore particularly striking how strongly gender segregation manifests itself across these various branches and how few women are found in managerial positions (only 11% of hospital directors are women). The very field we are focusing on—i.e. emergency medicine, all surgical disciplines, traumatology, orthopaedics—is characterised by the strong prevalence of male doctors (about 90% of doctors in these fields are men) [ÚZIS 2003].

and is projected into the hierarchical, two-tier system of health-care professions. While medicine continues to be perceived (as well as institutionalised) as a 'full-fledged' profession, nursing typically ranks as a semi-profession [e.g. Etzioni 1969; Hrešanová 2008; Bártlová 2007] or aspiring profession [Bolton and Muzio 2008]. Despite the feminist critique of the concept of profession, these gender-biased concepts are still used as seemingly neutral classifications.

This distinction has been reinforced and institutionalised in the public discourse, and especially in the scholarly discourse, by the 'big history' of Czech nursing that has often been told as a fight for recognition of nursing as an autonomous, competent, and essential occupation [Staňková 1996; Kutnohorská 2010]. Nursing historiography clearly seeks recognition both by the general public and especially by the exclusive 'full-fledged' profession of doctors [Bártlová 2007].

According to Freidson [1988; Dingwall, Rafferty and Webster 1988], medicine as 'the prototype of the expert profession' enjoys full functional autonomy, is recognised by others, and relies on expertise; members of the profession are highly respected, form professional associations, and have control over their field (through a monopoly on certain procedures or functions). The medical profession is associated with highly valued characteristics such as objectiveness, emotional neutrality, impersonal contact with patients, independence, a high level of autonomy and freedom from external control by organisations, responsibility for their actions, and commitment to their own ethical standards.

In contrast, since a semi-profession does not fulfil the above characteristics, it is categorised as deficient, below the standard that defines professionalism. Its members have a lower social status [Elston 2004], complementing or assisting the work of full-fledged professions. From this perspective, doctors are able to attain their status precisely by relying on, and distinguishing themselves from, the complementary work of the semi-professionals in nursing. Such work includes emotional tasks (expressing or concealing one's emotions appropriately by using a rich repertoire of emotion management strategies) and a range of tasks requiring physical contact with the patient (not only purely professional tasks, but also bathing, cleaning, and bedmaking). The nurse supports the doctors' freedom by accepting their instructions and being 'available' to them.

The doctor's work is seen as 'productive', i.e. masculine, the nurse's as 're-productive', i.e. feminine, and therefore of lesser value. Cure is given symbolic precedence over care, and this bias translates into an unequal relationship between the members of the two gendered professions. In large, formal organisations such as hospitals, which are shaped by masculine cultural norms and values—rationality, emphasis on performance, leadership, competitiveness—there is a marked tendency to exclude and devalue those aspects that do not conform to such gender-biased norms of organisational culture [Acker 2006].

As the Czech health-care system is transforming and its organisational culture changing, the role of nurses in this process is co-determined by changes in their notions of professionalism and, in turn, in the inequality between doctors

and nurses and in the social recognition of the nursing occupation. Our empirical findings tend to suggest an acceptance of the subordinate or auxiliary character of the nurse's role. At the same time, the analysis has demonstrated some initial changes occurring in the doctor-nurse relationship, particularly among junior members of the medical profession (the nurses often mentioned the existence of intergenerational differences in perspectives on professionalism in nursing and on the nurse-doctor relationship). The medical profession seems to be slowly losing its monopoly: with a growing emphasis on expertise and specialisation, there is pressure to transfer some responsibilities to college-educated nursing specialists. Insofar as a monopoly over certain responsibilities is a source of power, the tendency to transfer some agendas from doctors to nurses may contribute to tensions between the two occupations.

As stressed in feminist studies of professionalisation, the way in which occupations are categorised and the distinctions between professions and semi-professions are determined by the very questions that are asked and answered. The value of a job is measured by the standards of the patriarchal order and the traditional gendered division of labour. For example, Davies [as cited in Bártlová 2007] recommends a new model of nursing professionalism based on partnership and mutual recognition with other occupational groups.

In line with the feminist critique of the concept of a semi-profession, we shall maintain a critical distance when applying the concept to characterise nurses' occupational roles. We intend to treat the concept as an object of inquiry to avoid reproducing and legitimising the lower status of nursing. These days, the boundaries between health-care occupations are shifting or becoming blurred, nursing fulfils many structural characteristics of a full-fledged profession, and the modern nursing process is defined in holistic terms, with nurses responsible for a wide range of biological, psychological, and social aspects of recovery. That said, there is no reason for nurses to view theirs as a subordinate occupation.

### **Organisational culture and norms in practice and the normalisation of the abnormal**

In the study of nurses' occupational culture, we focus on organisational practices and frames, guided by two key concepts we have mobilised, 'organisational/occupational culture in practice' [Alvesson 2004; Alvesson and Deetz 2000; Šmídová 2011]. We use Erving Goffman's dramaturgical perspective on organisation as theatre or stage performance and its subsequent applications in organisational culture studies [Goffman 1999; Driskill and Brenton 2005]. In addition to a number of dramaturgical concepts such as setting, engagement, on- and off-stage, team, co-operation, role, actor, dramatic realisation, performance, etc., we make use of Goffman's perspective on organisations as 'total institutions', which not only format the lives of their inmates but also colonise the lives of their staff [Goffman 1961], where 'people become what they do', as Casey [1995: 81] char-

acterised the effects of organisational culture. An important aspect of the culture of total institutions we should recall that reflects organisational processes along with their social effects on the transformation of organisational identities is the concept of stigma (or discrediting and exclusion) and the different strategies of stigma management applied by stigmatised individuals (especially the normalisation strategy) [Goffman 2003].

Besides dramaturgy, our work is also informed by the ethnomethodological approach to organisational culture studies which investigates occupational norms, our central object of interest, as 'norms in action/in practice' as the core of 'organisational culture in action/in practice' [Driskill and Brenton 2005]. In line with a number of other authors, we understand that neither informal rules nor formal norms can be taken as given, as simple prescriptions, because their functions and meanings are ultimately shaped by the ways actors interpret them and typically use them in practice.

From the perspective of ethnomethodology or ethnomethodologically informed organisational ethnography, there are in fact no formal norms [Bittner 1973; Kučera 1992]. One can only study cultural 'norms in action' [Hester and Eglin 1997]—as specifically formalised and specifically interpreted by someone, specifically used in specific situations by members of a given organisational culture; specifically functioning and functional, specifically effective. Thus, the focus of our interest is 'norms in action' or interaction, that is, such norms that are activated by our communication partners, nurses, when they narrate their lives in and with the nurse's occupation. We grasp the norms and rules of action evoked by the nurses, typically implicitly, as normative assumptions underlying their accounts and as norms performed through their speech act as well as negotiated with the investigators during the interview. We study the evident assumptions, the common expectations, and the demands relating to emotional behaviour, thought, and experience that these nurses retrospectively reflect as relevant cultural means of re-ordering and practically explaining (accounting for) their occupational experience, thus also as relevant aspects shaping their social identity of a nurse.

Our analysis of interactions and representations is also inspired by the concepts of 'doing gender' [West and Zimmerman 2008] and 'gender display' [Goffman 1976]. We study the various available cultural means whereby gender roles are situationally co-produced, focusing especially on normative expectations that regulate nurses' behaviour. When studying the situated co-production of the relations and a/symmetry between gender roles, it is imperative to examine not only those moments when nurses act purely 'as women' and are clearly seen as such by others (e.g. when a doctor and a nurse flirt with each other 'as man and woman'). In a whole range of cases, the behavioural display is demonstrably both professional and feminine (or gender-neutral or even masculine), since masculinity and femininity are not inherent human characteristics: gender performance, or 'doing gender', depends on context, while simultaneously shaping—'doing'

or gendering—that context. The context we are concerned with is the response to an emergency situation in a hospital establishment.

Social norms—the claims and expectations surrounding a situated action—are represented, among other things, by participants' mutual claims, obligations, and rights, which are taken for granted as ordinary, 'normal', and therefore 'moral' [Garfinkel 2002; Goffman 1981, (1974) 1986, 2003; Ogien and Quéré 2005]. Norms do not take the form of a set of instructions for use that can be followed step by step [*cf.* Ogien and Quéré 2005]. Norms of civility and politeness are integrated within the cultural practices of a given society, organisation, or reference (here an occupational) culture. Nurses master 'members' knowledge' as members of that occupational culture and as a result of their occupational socialisation and sedimented occupational experience [*cf.* ten Have 2003; Garfinkel 2002]. They share the starting points and means of practical thinking, reasoning, and action that are tacitly prescribed to members by the organisational culture as shared knowledge of how to behave in different situations, of how to act in order to be accepted normally, i.e. as members of the given, in this case occupational (professional, hospital), culture.

Here, we understand normalisation as an instrumental concept, moving slightly away from Goffman's definition. By 'normalisation' or 'normification', Goffman [2003: 41–43] meant the strategy of preventing, upholding, or reconstructing a taken-for-granted order of interaction that has been breached. Actors treat such a breach 'as if' there had been no breach, and treat the stigmatised 'as if' he/she had not violated the order, i.e. as if he/she were a 'normal' person. Participants 'correct' the breaching interaction and make it acceptable by redefining it through their action and talk, 'as if' it had taken a normal course and the rules had not been violated, as if the norms of what is socially un/acceptable had been complied with. Actors normalise the situation of breach by reframing it 'as if' it were in line with the norm.

We have taken the liberty of re-defining Goffman's concept of normalisation and normification for situations when the local ritual and moral order of situated hospital interactions, with their rules and norms, radically differs, in the negative sense (deviates), from a more general cultural order. It differs from the order of everyday rules of interaction and norms of civility and respect that are, of course, shared by the nurses not only as members of the organisational culture of health care, but also as members of the general culture. Harold Garfinkel uses the term 'degradation ceremony' to describe the typical setting of such interaction scripts, with their norms of participants' engagement and with their rules and their social effects [Garfinkel 1956], i.e. similarly to Goffman's discrediting and stigmatisation [Goffman 2003]. Both congenial classics refer to the ways of re-constructing the script (frame) of a disrupted interaction with denouncing effects on participants that are available in the broader culture. As we shall demonstrate, a local organisational culture that is embedded in the broader culture provides insiders with means of normalising and normifying such otherwise disruptive and stigmatising ceremonies. Such corrective procedures also give credit to the

discredited, making their spoiled identities once again valuable. Egon Bittner, one of the pioneers of organisational culture studies, was the first to bring attention to such rationalisation/normalisation practices (as types of interpretation practices), which are enacted by members to legitimise otherwise problematic or socially unacceptable behaviour [Bittner 1973].

We refer to normalisation as an act of redefining (reframing) a breaching interaction with discrediting effects as an ordinary, normal communication situation in which the interaction rules of deference and demeanour have not been violated.

In this paper, the term normalisation will refer to strategies of coping with the potential deviation of the rules and norms of interaction in the health-care culture from conventional interaction rituals. We use the concept of normalisation to describe the ways in which nurses manage the effects of interactions that in a normal communication context would be negative and stigmatising by reassessing them as normal, ordinary, or even positive effects that are not harmful to them and are perhaps even helpful.

### **Emotion management**

Emotional labour is considered an integral part of the nursing occupation [Hochschild 1983; Mark 2005; Read 2007; Gabe 2013]. In contrast to the vast body of literature focusing on emotion management in communication with patients and their families, we shall develop another focus, namely on emotion management and emotional discipline as part of the nurse's occupational role, and the adaptation to and more generally professionalisation of that role. For nurses, emotion management is an individual matter: each professional has to deal with her own emotions, keep them under control, and be able to justify them individually. At the same time, emotional labour is clearly an integral part of everyday social action and interaction in the workplace. Emotion management both shapes and is shaped by health care professionals' teamwork, inter- and intra-occupational communication [Brunton 2005; Waldron 2000].

The concept of emotional labour and the related concepts of feeling rules (used by actors in guiding and controlling their emotional displays) and emotion management originate in the work of Arlie Hochschild [1983, 1998].

According to Hochschild, emotional labour 'requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others' [Hochschild 1983: 7]. It 'has an exchange value, since it is paid wages for' and 'behaves like a commodity' [ibid.], especially in the service sector. Emotional labour represents also an effort to overcome a discrepancy between one's feelings and the prescribed situational script, with its feeling rules and emotional display rules.

Social settings are ordered by feeling rules which prescribe what one ought

or ought not to feel when performing a given role. As a result, actors perform emotional labour in order to comply with a cultural norm and produce the emotions that are due under given circumstances. In other words, emotions are socially constructed, cultural artefacts. 'In managing feeling, we partly create it.' [Hochschild 1998: 11] The author refers to the permanent social control of emotions through cultural frames/scripts as specific rules and social norms applicable to different organisational roles, job positions, and thus also actors' identities. These cultural means are what routinely guide people's actions, thoughts, and feelings, resulting in seamless co-operation. Following the Goffmanian concept of frames/scripts [Goffman (1974) 1986], we propose that even the affective aspects of our practical experience are organised and shaped by such scripts/frames of organisational games. The scripts/frames that are occasionally mobilised by members of a culture guide both emotional display and the ways it is interpreted and evaluated through culturally available means [Shott 1979]. In this sense, there are 'cultures of emotion' with their specific emotional 'vocabularies', practices, or strategies [Hochschild 1998; Harré and Gillet 2001].

We understand the emotional labour of sisters as 'the process of regulating both feelings and expression for organisational goals' [Grandey 2000: 97]. With regard to occupational culture, we are interested in nurses' assumptions about and expectations of how to perform their role, about the appropriate feeling rules—when, what, how (and sometimes also why) to feel and display emotion in compliance with the cultural norms they had internalised in the process of occupational socialisation or organisational enculturation.

For nursing as a gendered caring (semi-)profession, people are the object of care, and their welfare and well-being are its product. Thus, emotional labour is considered an integral part of the nurse's role, albeit textbooks typically reduce it to the requirement of empathising with the patient's situation and emotional state and pursuing the human relations necessary for cooperation.

The formal organisation, ideology, and bureaucracy of the hospital continue to rely on the principles of rationality and instrumentality, while emotionality represents an alien or inferior element of organisational life. The same modernist concept of organisation (along with the existing gender order) is responsible for the occupational stratification of health care. The medical profession is seen as rational, independent, instrumental and masculine [Mumby and Putnam 1992; Freidson 1988], while the nursing semi-profession is symbolically associated with emotionality, femininity, servility, and dependence. From this organisational perspective, emotionality and emotional labour are assigned a lower status because they are not seen and recognised as a contribution. Both formal and informal norms have traditionally designated emotional labour as part of the nurse's job description, but only as an 'extra' activity in addition to the core of her occupational competence or specialisation. However, here and now, emotionality and emotional labour as important aspects of care could hardly be accepted as the dominant part of a nurse's occupational identity by Czech nurses themselves be-

cause that would discredit their skills and professionalism (an equal conclusion was reached by Read [2007] in her study of the Czech hospital environment).

Like other cultures in practice, the feeling rules and emotional display rules scripted for different roles influence and constrain actors' emotions without determining them directly. They work as a means of discipline and social control, mostly in the form of self-surveillance, self-control, and self-discipline [*cf.* Foucault (1977) 2000]. Emotion management typically influences self-control unconsciously.

Therefore, organisational culture provides or even prescribes an 'emotional vocabulary' [Harré and Gillet 2001] and a repertoire of 'feeling rules' for role performance. It provides a range of scripts of organisational games along with the rules of emotional display in different types of social situations. However, it also commits actors performing different roles in different positions to different sets of 'feeling rules' and norms of behaviour, even in the context of a single episode of the organisational game. All in all, we believe we are facing genuine sociological issues when it comes to power relations and inequalities in experiencing and displaying emotions between actors in different, albeit complementary roles, and when it comes to seeing and recognising one's hard emotional labour and coping with emotional stress [Shott 1979].

As Hochschild [1975, 1983, 1998], Freund [1998], Newton [1995], and others argue, few studies look at these feeling rules in workers exposed to emotional stress from the perspective of power relations and social inequalities, i.e. the micro-politics of power in the organisation. When fulfilling tasks in a number of organisational situations, actors in subordinate positions tend to be exposed to stressful emotional labour more often and with higher intensity; they are more 'vulnerable'. In this symbolic space, some positions/roles or identities provide the actors performing them with a 'shell' that protects them from emotional stress and its effects [Freund 1998; Davies 2008; Potter 2000]. From this perspective, the dual occupational roles of professional doctors and semi-professional nurses, with their institutionalised positions in the organisation and in the symbolic spaces of medicine and health care, are a source of power in itself. In relation to doctors, nurses are still a kind of 'universal subordinate', in that they can be disciplined at any time by any doctor and not just by the attending physician. Therefore, Freund and others speak of nurses' 'positional vulnerability'. As Freund and Newton argue, workers in some subordinate and inferior positions/roles, with little autonomy and subject to intensive surveillance and control by the organisation are especially vulnerable or, in Goffman's [2003] terms, stigmatisable. The nurses reflected this position by referring to themselves as 'drudges' and citing the catchphrases 'everything is the nurse's fault' and 'she always gets chewed out'.

The hazards of exposure to emotional stress are clear: damage to personal identity and tangible effects on health or social-psychological well-being such as burn-out or depression. However, organisational discourse individualises and

psychologises these risks as a matter of personal adaptability or 'resilience', even though they are produced systemically, by a given organisational culture and structure, as well as by the wider culture. Following Goffman's dynamic concept of role, Davies and Harré use the concept of positioning to grasp the power of the symbolic practices people use to position themselves and (in turn) others when interacting in the symbolic social space [Davies 2008; Davies and Harré 1990]. They do so in line with the local cultural, discursive sources and rules for categorising people, in this case the doctor-nurse distinction. By inspiring assumptions, social categorisations culturally prescribe the behaviour, thinking, and affectivity of people positioned by other people or institutions or positioning themselves in a given social category—for example, that of a head physician or a general nurse. Actors usually understand their social position/role as a moral commitment to certain ways of feeling and expressing themselves in different situations, and they make an intuitive or conscious effort to comply with that commitment.

In our narratives of nurses' work throughout their occupational careers, a great many episodes dealt with hard emotional labour and emotional stress. Most of these situations were evoked by the nurses themselves. Like in real life, there was a tendency for the episodes to be recounted in a highly excited manner and with dramatic momentum. This suggests the great significance of these episodes and their message for defining the nature of the nurse-doctor relationship and the nurses' occupational identity. Indeed, doctors were apparently and generally the most relevant 'others' used by the nurses in defining their occupational identity in the hospital world, while patients were not as important for their self-identification.

### **Rules of normalisation and norms of interaction in Czech hospitals: an ethnomethodologically inspired organisational ethnography**

In presenting our findings,<sup>4</sup> we focus on eliciting selected aspects of the patterns that from the nurses' perspective structure their interaction and cooperation with doctors as members of the key complementary occupation. We also attempt to

---

<sup>4</sup> For the purpose of this study we conducted twelve narrative autobiographical interviews with nurses and held one focus group. Responses were transcribed in detail and analysed using thematic analysis and an ethnomethodologically informed analysis of positioning, categorisation, and narrative framing. Most narrators in our sample were at pre-retirement age or had recently retired. Therefore, they possess long and rich occupational experience and have spent most of their occupational careers in the hospital environment, mostly in Prague. The narrators represent nurses who obtained both their education and the major part of their occupational experience during the socialist era. Our study on social and health-care workers' occupational careers as part of their life courses is designed as a long-term effort in order to cover the process of organisational changes and capture the changes in the occupational culture of nurses that we expect to happen.

roughly reconstruct and describe the normalisation strategies associated with a frequently mentioned norm, which we provisionally refer to as 'the nurse obeys (the doctor)' (hereinafter, categories formulated in natural terms are italicised). In turn, this norm implies others: the nurse does not talk back, the nurse does not question an order, the nurse may have a different opinion but fulfils the task, the nurse does not complain. Furthermore, we attempt to roughly reconstruct and describe the strategies of emotion management and coping with emotional stress referred to as Goffmanian 'normalisation strategies'. These are used by nurses to view their occupation and the practical forms of its situated performance as normal or correct, to identify with them, and to view themselves as 'good nurses'. The source of these coping strategies lies primarily in the shared cultural organisational knowledge (ethnomethods) that tacitly instructs the culture's members on how to define normative claims (in this case, the requirement to refrain from emotions or to express them in prescribed ways) and to comply with them in line with the logic of the organisation—coping with those claims and adapting to those organisational cultural means.

We shall look at situations where nurses are socialised into these norms and use normalisation strategies to actively cope with them and shall point to the specific situations and circumstances in which the norms of obedience function and which typically emerge in the stories as shaping certain distinctive attributes of the nurses' occupational and social identity. We shall then show the normalisation (coping) strategies applied to those normative expectations as ways of understanding, enacting, practically explaining, and justifying (rationalising) the actions of their own and other actors, in particular the doctors in their teams.

### *The nurse obeys the doctor*

Our analysis focuses on those norms and rules of the nurse-doctor relationship that, in the nurses' accounts, 'typically' and 'normally' guide relations and co-operation between people in the two key complementary roles that manage the organisational agenda. However, what this involves is a complex configuration, or even a system, of norms, rules and procedures that typically facilitate the ordering and making sense of the actions, thoughts, and experiences of the organisation's members and the shaping of their social, and in particular occupational, identities.

This complex of regulations underpinning the doctor-nurse relationship that we are going to shed light on is best characterised by the main assertion articulated by the nurses in different forms: 'the nurse obeys the doctor'. The nurses provided us with a range of metaphors and explanations to show all the different things they normally understand such obedience to mean.

In the nurses' words, to obey the doctor means that the nurse is to fulfil the doctor's orders, to 'shut up and get to work', or, in the words of Nurse Dana, to

obey 'without talking back'. She knows she is expected to 'always figure out a way' to do just about anything—even things she would not be able to do by normal standards; things she would not be allowed to do under formal rules; things that are not in her job description:

Dana: Yeah, like when a doc told us: do something, do this. So we went and did it without talking back.

The nurse's role, as a set of expectations (oftentimes not only from doctors, because 'just about everyone helloses' the nurse) and demands, includes serving as a 'drudge'. As a result, 'everything is the nurse's fault' and the nurse is held responsible for everything. According to the nurses, she is always the first to blame when something goes wrong, she tends to be 'accused' upfront, and she has to fight back against accusations of not only making mistakes but also not fulfilling the doctor's silent expectations. The nurse is blamed for everything and 'everybody yells at her', 'she always gets chewed out'. However, the right to yell 'for nothing' is probably accepted from doctors, but not from other colleagues; for example, as one of the nurses argued, when she got chewed out by a laboratory technician that was unjustified because 'she wasn't even a doctor'.

Dana: ... and I started the night shift alone. There were thirty beds, no orderly. When we wanted something, like to take someone for an X-ray or to deliver blood samples, then we had to call the Surgical Unit and they said something like: I am on my way to the OR, my operation is about to begin, I can't, I'll be available in, like, two hours. But then we got chewed out by the doctors, of course, for not having it ready. So sometimes we just had to grab the wheelchair [laughing] and run the patient to the X-ray ourselves, asking the girl across the hall to watch because, you know, there was just one of us in each unit.

Katka: I also once got yelled at for not ordering blood for the OR. Like, without a doctor's decision. I said, wait a minute, this is not in my job description; you know that I can't order blood, this is your job. So, that's how far they tried to go in blaming the nurses for everything. ... And they called me and told me to come immediately, yelling at me awfully that I'd screwed up the patient's poultice because they cut into the wrong leg. Now we were used to strict obedience, so I rush to the OR and the doctor yells at me but I'm like, hello, this is the bed, there is a splint on the bed, there is a horseshoe with a weight on it, so don't tell me I'm that stupid to actually poultice the other leg ... Well, they did not apologise.

There are three typical moments in these examples: besides the dictate that a doctor's order must be fulfilled, another important assumption repeatedly emerges throughout the nurses' careers, which is that, not only is resistance impossible or pointless, but there is also no point trying to explain why something cannot be done or to defend oneself. A nurse cannot ask why the doctor wants something,

why the nurse is supposed to do it, or why it has to be done in a particular way. At the most, the nurse 'may of course have a different opinion', but 'she always follows the doctor's instructions'. It is clear from the contexts of the stories that the nurses typically follow that rule not only in their interaction with higher-ranking doctors but with practically all the doctors in the hospital. An order (from a doctor) is simply unquestionable.

Dana: He would come and reach under the blanket and I could only hope that the patient wasn't wet; he didn't care if you explained that you had been there five minutes before and the patient had been dry. He didn't care. I'd just look down and stay quiet.

### *The nurse as the doctor's lightning rod*

One of the nurses we interviewed metaphorically described a nurse as a doctor's 'lightning rod' to refer to one of the member organisational norms or rules guiding the nurse-doctor interaction that are part of the 'nurse obeys the doctor' complex that our nurses obviously shared and used to organise and make sense of their experience, thus shaping that aspect of their professional identities or roles.

In the spirit of ethnomethodology, we focused on natural 'moments of breach' [ten Have 2003] as reflected in the different episodes from the stories about problematic situations in doctor-nurse collaboration, expressed with the words 'yelling at', 'scolding', 'reprimanding' the nurse, and similar terms. At the same time, we observed breaches in the very context of the research interaction when the communication partners collided with and negotiated the meanings of what had been said. In short, we focused on morally questionable moments in the situation of doctors giving orders to nurses and the latter fulfilling them, both in the narrators' accounts and during the storytelling in the context of the research interview as situated interaction.

According to some of the nurses, the effects of these situations are morally questionable, potentially discrediting, and stigmatising for the nurse who gets 'scolded' as an incompetent nurse who has not (properly) done her job. The different normalisation strategies they use to cope with this 'humiliation', as some of them called it, become apparent in the study of emergencies and highly demanding situations, which, given the narrative genre, stand out as rather dramatic.

Typical episodes of this kind, in which the narrator positions and presents the characters of herself and other nurses as 'lightning rods', appeared in the informants' accounts of emergency situations: these were surgical operations and emergency procedures during which the nurses assisted the doctors. Apparently, in this type of situation, compared to ordinary interactions, very unusual strategies are employed to cope with being in the otherwise (in ordinary everyday in-

teraction) demeaning position of serving as a 'lightning rod'. The ways in which a nurse is supposed to conceive of her role, act, think, and feel are governed by a set of norms and rules that normalise the abnormal situation of a nurse being attacked, humiliated, and scolded, and by which they accept this as normal and therefore morally acceptable [Garfinkel 2002]; or in Goffmanian terminology [Goffman (1974) 1986, 2003], that reframe and normalise what would normally be an unacceptable type of interaction situation, with social consequences, and allow the nurse to save face and protect herself and retain her self-respect without offending the doctors; that enable her to help maintain the moral order of this kind of organisational interaction without questioning the function of the rule that governs cooperation when handling an urgent organisational agenda with a view to fulfilling the institution's goals and values, namely, to protecting patients' health and saving their lives.

In an urgent situation, a doctor is supposed to be entitled to vent at a nurse, the justification being that he is responsible for the patient's life and health. Besides the 'higher interest' in the patient's health, the nurses explained this generally questionable claim by saying that 'some people' (implicitly, doctors) are simply like that (impulsive) by nature. This practical explanation was based on the specificity of people's individual characters and the weight of responsibility borne by the doctor due to his engagement in the situation. If the doctor is 'the yelling type', then 'that's the way it is'.

Another way the members practically explained such actions as doctors throwing instruments at nurses in the operating room, calling them insulting names like 'idiot' or, most often, yelling at them, was to argue that the doctors 'did not mean it', that it was nothing personal against the nurse. In order to comply with the norm, it was pointless for the nurse to take such acts as hostile or disrespectful. They were supposed to (had to ...) 'not take them personally', keep their emotions on a leash, and, above all, refrain from any immediate reaction. The accounts of psychological stress during the initial adaptation to the requirement to not experience emotion and to maintain a poker face make it clear that abiding by this feeling rule and norm of professionalism is emotionally demanding and often devastating. Although the norm of emotional neutrality and the feeling rule are adequate to regulate the generally quite specific and extraordinary interactions in emergency situations, such situations are common in the hospital environment.

The unwritten norm organising the course of participants' actions, thoughts and, above all, emotions in 'scolding' situations commits nurses to controlling their emotions. According to the 'lightning rod' norm, in certain circumstances nurses are 'expected' to maintain a poker face and are 'forbidden' from applying the otherwise normal right to negative emotions and defences. It restricts their 'emotional vocabulary' and range of expressions in a situation where they feel intimidated, offended, morally threatened, discredited, and devalued [Geertz 1959; Harré and Gillett 2001]. Thus, this norm blocks any normal social response to

expressions of hostility, aggression, and humiliation; it is justified by the accepted argument that were a nurse to respond to an attack from a doctor that would only escalate tensions and make the already stressful situation even worse. In contrast, it is the nurse's role to mitigate tension and manifestations of that tension, in this case the doctor's yelling.

Negative emotions, insults, and acts of overt aggression are taken as a sign of 'letting off steam' or 'the ashes catching fire',<sup>5</sup> something that simply helps to 'clear the air', as some nurses referred to it. By this organisational logic, the rules of action can be understood as fully functional and impersonal, especially under stressful circumstances. Under such pressure, the nurse is supposed to act as the doctor's lightning rod, conducting the emotional charge away, earthing it safely. She represents a mere 'target of displacement'. Although generally understood as aggression or hostility, the act does not pertain to the individual nurse-object; it is not 'about her'. The affected nurse was a mere bystander, someone who 'was at hand in stressful crisis situations when emotions simply came out'.

Soňa: About the fact that sometimes there was calling in the OR during surgery? Everybody was called at. It didn't matter who was standing there at the moment. You can't take it personally. Operating surgeons are sometimes nervous, so there was various calling in the OR.

Interviewer: Would someone else say that they were yelling? [smile]

Soňa: Sure, someone might say they were <yelling>. So what.

The nurse serves as a neutraliser, earthing emotions, while she herself is not entitled to emotional expressions or outbursts under demanding circumstances. In such a situation, she suspends her subjectivity, her self-experience, and her emotions. This is the only way she can play the important role of mitigating tension, thus facilitating the common goal of saving others.

Whether she likes it or not, a woman-nurse is still a human being with human sensitivity. Therefore, it is in her interest to learn how to completely separate herself from potentially disturbing emotional effects, deny them, get over them, 'not worry about them' or, in the worst case, suffer through them without showing it. Above all, as most nurses with this kind of experience recall, she has to 'get used to it'.

Soňa, for instance, has had to learn how to draw a line between her personal and occupational identities. When she is able to manage her emotions and expressions as a nurse, then she does not feel humiliated or offended and does not raise any moral claim to retribution. She can be, and usually is, rightfully

---

<sup>5</sup> A Czech idiom meaning that even when a fire is built in a fireplace in the correct and standard way, sometimes the ashes ignite and create a mess around the fireplace, an unpleasant but not dangerous situation.

proud of the impressive ways she directs herself in such a demanding role and masters it with extreme virtuosity (professionalism).

Normative expectations dictate that a nurse is not supposed to respond angrily to a doctor's aggressive affective expressions, which are merely displaced on her. According to these rules, she is not even morally entitled to demand a rational justification or an apology (not even *ex post*). In her position, she is not allowed any reaction at all—such are the expectations of the situated performance of her role, at least in this situational script (frame). She is simply supposed to let go of her feelings as they emerge, to feel no anger, regret or injustice, and especially to keep any perceptions of disrespect to herself. That summarises, from the organisational perspective, the model of an optimally adapted nurse.

The above-described neutralisation practices (among others) work as organisational practices of ordering such interactions and making sense of events. Such practices recode the ordinary meaning of conduct that is otherwise unacceptable in normal life as cooperation between a nurse and doctor as partners on a common mission: an insult is no longer an insult, a swearword is no longer a swearword, and the throwing of a two-kilo surgical hammer at the nurse is merely the tossing of an object into space. Yelling is just loud speech or even just 'calling', as the act was euphemistically normalised by one of the nurses, now in a managing position, not 'scolding'. In this script, which would otherwise be a social situation of aggression, conflict, and insult, the doctor can praise the nurse for her performance but cannot apologise for his behaviour; the nurse is not supposed to expect or even demand an apology. An apology would bring the script of the emergency episode of organisational life in the hospital too close to the ordinary script of aggression and conflict in everyday life, which is governed by a different moral order no matter how similar it is in terms of behaviour.

Some nurses' occasional attempts to change the moral interpretation of this doctor-nurse interaction by emphasising its detrimental (stigmatising) effects tend to be overlooked or downplayed by other nurses. Moreover, the occasional subversive interpretation and condemnation of the doctors' behaviour as offensive tends to be regarded and ruled out as inappropriate, and those making such attempts are implicitly labelled as bad nurses who are exaggerating the situation and blowing it out of proportion. This may be a sign of their not being on top of the situation and undermining the organisational order.

This is due to the 'latent logic' of this organisational norm. In the light of this organisational logic, it is the nurse's personal responsibility to play the role of 'lightning rod', which is highly functional in a situation defined as an emergency. Her failure is due either to the character deficiency of a nurse who 'just doesn't have what it takes' or to her incomplete, inadequate professional adaptation. The failure to control one's emotions under such circumstances is only normal and acceptable among beginners, who have yet to go through occupational socialisation and learn from older, more experienced nurses how to endure and to cry their way through the tough beginnings.

More experienced, senior nurses instruct novices empathically on how to cope with the unusual demands of managing negative emotions in response to doctors' outbursts and draw on their own bitter experiences in doing so. A nurse has to contain herself, suppress her emotions, have a good cry afterwards, preferably alone, and, above all, 'get used to it' unless she wants to quit the job.

Martina: The girls told me: when we came here we cried for, like, eight or nine months. You just have to get used to crying, too.

In the logic of some experienced nurses, yelling, swearing, insulting, or scolding a nurse is allegedly a signal that can and should be utilised by the nurse who is, in this view, merely a target for the displacement of the doctor's tension or anger. It should be utilised as feedback on whether she did her best to prepare for the role of the doctor's assistant, predicted everything she could, and saw to all her duties. This, however, does not mean that she should examine the reasons for the doctor's yelling and swearing in terms of his being entitled to do so or it being justified—this is not a relevant model of a response for a nurse. If she is one hundred per cent sure that she took care of everything, then she can let it go and 'not worry about it'. Otherwise, the scolding should serve her as feedback for self-improvement.

Eliška: But when I felt inside that everything had been taken care of, that I had done a good job preparing everything, so he had no reason for accusing me, then I felt okay. When I felt I had neglected or forgotten about something then I blamed myself, not him. People are different. Every surgeon is a different person, but the OR nurse must learn to get along with everyone and simply must not show her emotions during the operation, I mean she shouldn't, she must not, she shouldn't show ...

Some of the nurses combat feelings of injustice and moral damage through self-control and ritualised self-discipline. They strive to see to all their duties and even predict the doctors' potential needs and demands. If the nurse is sure she has taken care of everything, has it all under control, has neglected nothing, and has predicted every eventuality, when her 'conscience is clear', then a scolding or insult should not and cannot get to her, not in her occupational role or as a person. And it does not get to her—it is not about her.

From the opposite perspective, the implicit right of nurses to experience feelings of being offended or discredited in an interaction situation of this kind is implicitly rejected as an unjustified claim for better treatment. Anything else would raise the suspicion that she probably deserved such treatment, had not 'prepared for everything', and did not have a clear conscience. This kind of complainer is certainly not a good nurse because, above all, a nurse 'never complains' and controls her emotions, she 'endures it', which tends to be the source of her professional self-image. Speaking from a senior position, Soňa shows us how to

look at a hypothetical nurse who refuses to fully submit to existing practices: she is viewed as morally weak because she is intolerant of 'the environment'. Or her demands are delegitimised as 'playing around', i.e. obstructing or demanding unreasonable advantages. And this is how order in the hospital becomes normalised: the other nurses are all right, only the complainer is making illegitimate demands. Their inadequacy and breaching character is highlighted in the context of the organisation's main goal, namely, to heal the patient; nurses' demands for fair treatment might compromise that goal. In the light of organisational discourse, the act of non-conformity and non-compliance with the norm becomes individualised, framed as a lack of occupational competence, as a sign of insufficient professionalism.

Soňa: Of course, some people may see it differently. For instance, someone hated the intensive care environment precisely because of situations like this, when the 'ashes catch fire', that's true, but this was part of the job from time to time. Yeah, this was part of the job and there was no time for playing around, like whether to put it like this or like that. Simply, an instruction was given and sometimes the way it sounded could have been, like, less acceptable to some people, like it was not a polite enough request, but that was often impossible because something bad would have happened in the meantime, you know?

Charge nurses and nurse managers teach this to their fellow nurses based on their accumulated experience of coping with these emotional states. They teach what was once instilled in their minds as good nurse behaviour, what they have found useful in practice, and what they have found to be indispensable for the job. While they recall having had problems with emotion management when faced with doctors' orders early into their careers, they find it very important for newcomers to learn this part of the 'hidden curriculum' and master the right ways of dealing with doctors, especially in stressful situations.

Eliška: On the other hand, she taught us not only the job but also the doctor-nurse relationship. She always told me when there was something I didn't like, whether during or after the operation, she always told me: keep in mind that the doctor is responsible for the patient's life. And he has the right to demand what he needs and to act according to his emotions at the moment. And you have to endure it. You can say what you want afterwards, but arguing during an operation is never a good idea. I have always taught this to my girls because I realised that not every doctor can stand ... I mean, is able to stay calm under stress. Some people manage without showing that something's going on, but others just yell or become infuriated, that's the way they are.

Such practices of re-normalising both the doctors' emotional expressions and the nurses' reactions or ways of coping share one common assumption: they refer to the 'precedence of the higher instance', a norm that prescribes a clear hierarchy of roles and a strong asymmetry of mutual entitlements and commitments be-

tween two key complementary roles. While embedded in the formalised norms of the organisation of health care, higher norms of this kind are rooted in the broader organisational culture and its underlying assumptions, including the system of norms, values, rules, other ethnomethods, and members' organisational knowledge. They rely on the habitual assumptions and implicit expectations about mutual rights and obligations in the doctor-nurse relationship that routinely shape the ways they act, relate to one another, cooperate, and enact scripts. These cultural organisational norms and values seem to be strongly shared by nurses in different positions, with different specialties, and socialised in different nursing schools and different medical establishments throughout the Czech Republic. From an analytical perspective, they represent the 'cultural resources' or ethnomethods of forming one's occupational identity that are shared and arise from practical experience.

The nurse usually becomes a lightning rod in emergency situations, typically in the course of surgery, that are normalised by all participants through undisputed reference to higher common interests and the shared mission of saving the lives and health of patients as well as to the emergency nature of the situation. Implied is the assumption that any instances of venting negative emotions and displacing them onto the nurse as a live lightning rod are functional and contribute to the higher goals, therefore they help fulfil the shared mission of both occupations and of the institution as a whole. They forward the fundamental cultural values of the organisation and the society, and they typically fall under what defines the occupation as a calling: the demand of personal sacrifice. The doctor's sacrifice consists of taking responsibility for solving any difficulties and especially for the outcome of surgery—this is assumed to be primarily his responsibility, although formal rules foresee a somewhat different distribution of responsibilities. The hospital's goal defined in medical terms is tied more closely to the doctor's profession and position than to the nurse's semi-profession. The nurse merely takes care of sick people and facilitates their physical, mental, and social well-being. She simply follows the doctor's instructions and prescriptions, and her autonomy lies in the fact that she follows them in a proper, flexible, and self-reliant fashion.

Also implied is the assumption that the way doctors vent their emotions then and there is not only functional but also undisputed, that they can only channel them in this particular way, namely, through public and immediate displacement onto the nurse. The norm and the rules that guide action in conformity with it are based on the latent assumption that this is the only solution, that there is no other way for the doctors to vent their stress. In this script, the nurse is not entitled to express her emotions under stress in the same way that doctors are allowed to. There is no alternative to this social way of managing nurses' and doctors' emotions, although this way often works at the expense of the nurses' psychological and social well-being. However, as long as this organisational discourse does not allow for alternative ways of managing emotions, then it is—in the actors' logic—pointless to search for such alternatives.

Although some nurses consider this regulation in the doctor-nurse relationship as unacceptable and devaluing in the light of the standards of general civility, they typically accept it in the context of the medical establishment as natural, normal, determined by the (emergency) nature of the work and the organisational environment (situations with unpredictable outcomes), and oftentimes the only option—the only conceivable option. It is just ‘part of the job’ in health care, in the hospital—it belongs to the occupation.

This is just the way it is in health care, our narrators sometimes said. The Goffmanian script or ‘frame’ is rewritten: for instance, Soňa’s depersonalising or downplaying metaphor of merely ‘soot catching fire’ defines the situations of emotional outbursts and aggression in operating rooms and stages this explosive regime of interaction and cooperation as normal, not immoral. In another environment, the ordinary ritual and moral order of everyday interaction, with its rules of respect and civility, guides one to protect one’s and the other’s face; through the act of normalisation, this is rejected, deformed, and transformed along with (and thanks to) its rules of ‘interaction rituals’.

As demonstrated by Erving Goffman in some classic examples [(1974) 1986], even in the course of everyday ordinary interpersonal interaction and cooperation, actors have recourse to the rules of extraordinary, urgent situations: they can use contextualisation ‘keys’ (codes) to fundamentally reframe a normal, ordinary situation as an abnormal, urgent (emergency) situation. The actors in the drama themselves ‘rewrite the script’ in the course of enacting it, by shifting it from an ordinary to an extraordinary situation [Goffman 2003: 120–122]. Sometimes this transforms the course or account of the social event, including the actors’ positions, roles, and relations, in fundamental ways. What is normally unacceptable for the actors in complementary roles is reverted into something proper or acceptable.

Particularly in the hospital’s organisational culture, the extraordinary is a constitutive feature of the ‘normal’ order (the order of the extraordinary): it is something that happens and that the professionals ‘must take into account’. It becomes an ‘accountable’ [Garfinkel 2002] means or rule and element of organisational culture. Thanks to these practices and the logics behind them, the norm becomes a commonplace, ‘normal’ part of the organisational (occupational) culture—it regulates the relations between both occupations in certain (stressful) organisational contexts or situations and provides a cultural instrument for creating professional identities.

### **The nurses’ coping strategies**

The fact that the nurses share cultural instruments (norms) for interpreting and organising action does not mean, as suggested above, that these instruments guide their behaviour, thinking, and affectivity in uniform ways. The different

nurses took different positions on this tacit 'description and prescription' of their role. They had different notions of their role and tacit scripts for enacting it. As for the role of an obedient executor of the doctor's orders and a silent lightning rod for his emotions, they held an entire range of attitudes on the role, from literally accepting and fully identifying with it to rejecting and distancing themselves from it.

Some nurses and doctors have already somewhat questioned these traditional norms and applied other, more symmetrical and collegial forms of communication, even in urgent situations; as a typical example, the nurses and doctors call one another by their first names and the nurses refuse to obey all instructions all the time. However, many nurses whose accounts were apologetic of the traditional organisational culture were rather irritated by this change of communication regime as a condition and manifestation of equality in the relationship.

Olga: But recently, I've had such a feeling, and I've been unable to teach them, even though I've been trying, but with little success; I must be old [laughter] because I've been unable to guide them to simply not talk to them like that during an operation, like when the operating surgeon wants something and she's like, you've got to work with what you have. That was unimaginable in our day. And they [the doctors] tolerate this. In order to be cool or something. Of course, there are exceptions. They wouldn't dare to treat a professor like that. But they push it much further with the boys they call by their first names, with those they are friends with; that was absolutely unimaginable in our day.

Using Goffman's [1961] ideal types, we find that the variety of coping strategies and the formation of the nurses' moral careers ranges from full conformity or conversion (when the nurse adopts the institution's perspective on her and her colleagues fully and unexceptionally, for example Soňa or Olga) to passive adaptation and dullness, to exit (to an outpatient clinic, maternity leave, or another occupation), to rebellion against these norms and an effort to innovate the rules.

The latter two ways of dealing with role norms (rebellion and innovation) are characterised by acts of criticising, questioning, and delegitimising this normative view of the nurse as an obedient executor, or even by acts of active resistance against the norm. Open 'denormalisation' of the existing (form of the) norm, 'to obey the doctor' manifests itself as acts of questioning selected aspects of its contents and effects on moral grounds, rather than acts of absolute rejection of the norm of the nurse's subordination and the doctor's superiority.

Do these critical and resistant nurses, however exceptional their stance, refute the above-described norms as no longer valid or commonplace? Paradoxically, the opposite is the case, and the exception proves the rule (here the organisational logic). Indeed, sociology teaches us that deviation from rules and norms does not just undermine but also sustains them.

As a reformist and innovator, Katka speaks from the position of an experienced and educated charge nurse and advises her fellow nurses not to conform to everything doctors say all the time. One is supposed to obey 'when the doctor's right', i.e. to think critically about his instructions, negotiate their meaning or reject them, which itself is a certain attempt to violate the norm of nurses never questioning a doctor's order.

However, her revolt against the norm is not consistent: on the one hand, Katka questions the norms (or contributes to redefining them), and on the other hand, she balances her reform effort by criticising some nurses and, actually, not always fully insisting on the nurse's right to reject the doctor's order.

Katka: We are, as I said multiple times, when the doctor tells you, for instance, that you have to do this and that, even if he is mistaken, then you are going, if he gives you an order then you are going to do it. You don't have to do it. And there have been girls who were, like, intimidated or enslaved by those doctors. And it was like ... the patients sensed it and some of them didn't treat us nicely. Sometimes the nurse deserved it; I have to look at our work critically, too, and sometimes I wouldn't have been polite to her either.

Martina is even more of a rebel and innovator. As a seasoned, highly educated nurse with a wealth of international experience, she opposes these norms and rules publicly and openly, refuses to obey them as wrong, unjust, discrediting, and mentally detrimental to the nurse. They do not sustain but instead destroy the kind of moral order that should, in her opinion, exist in the organisation. They deform the doctor-nurse relationship, humiliate nurses, and undermine their professional dignity.

Martina: At the same time, to be honest, I wasn't happy when they found it normal for a doctor to call them names and throw hammers<sup>6</sup> at them. Or when they unpack their snack and a doctor takes it and eats it. So, as for me, I said to myself, this is not okay. And they said: you've got to get used to it. I said: but I shouldn't have to get used to it, you can't be serious, do you really consider it okay when a doctor eats your food? And they're like, that's the way it is around here. At the same time, though, from what I saw, they feel lucky when the doctor picks them personally and eats just their food. ... So they said, for example, they say, like: we're in trouble because some nurses are spoiled. And I'm like, what do you mean by spoiled? And they're like: that's when a nurse tells a doctor she won't prepare his tea. ... And now I say: okay, but why should a nurse make tea? And they're like: um, it's always been that way, as simple as that.

---

<sup>6</sup> Martina, at another place in her account, described a situation when an angry surgeon threw a four-pound orthopaedic hammer, which broke a window and could have injured the other staff present at the operation.

At the same time, Martina (like Katka) reflects the fact that it is almost pointless to try to change the way of thinking of nurses who have been, as one put it, 'eaten up and reprocessed by the system'. Her colleagues are not very sympathetic with her effort to lead the resistance by example and to motivate other nurses in the ward to simply refuse to serve as the doctors' lightning rod and to wait on them. In contrast, Martina notes that her advice to fellow nurses to just say no to this has been taken as 'offensive'. They feel judged by Martina for submitting to these oppressive norms and not resisting them, for their sheepishness. Instead of finding the critical reflection offered by Martina helpful, they feel stigmatised by her.

However, Martina also came to feel devalued and discredited in the eyes of her colleagues after her attempts to rebel and to change the rules resulted, as she found out, in making her fellow nurses feel humiliated. She finds herself in the position of a maverick, a kind of deviant in the organisation, although all she was trying to accomplish was, at most, positive deviation. She wanted to correct morally questionable norms of organisational behaviour and raise awareness, but from the perspective of the institution and in her own eyes this only turned her into a deviant. She feels as though she represents a negative deviation from the norm in the given organisational culture; in her own words, she feels 'weird'. She is now doubtful about the significance of her effort to motivate resistance among the nurses. Looking back, she fell short of her personal goal even in the sense that her attempt to help nurses to raise their prestige and occupational dignity has had harmful consequences. She cannot and does not want to adapt and is quitting her job at a prestigious hospital. For now, she does not see any other way to change the organisational norms, values, and rules, the entire organisational culture. But she continues to look for a way, which means she is (implicitly) convinced—along with us—that such a change in the position of nurses is generally possible.

Martina: I have a big wish for nurses, like if it was to come true, that they, I just believe this exists in some places, that ... above all, that they had the kind of status where they feel that they don't have to be, like, ashamed of their occupation. Or that they can be proud of being a nurse. And that will, I believe, give them a completely new pair of wings.

## **Conclusion**

Emotion management is regarded as part of the nurse's professional performance. In the analysis presented above, we demonstrated the specific situated form of emotion management that exists in the nurse-doctor relationship. By working under immense pressure, nurses learn to control their emotional display or, in some situations, to experience no emotions at all. They learn to accept the normality of the fact that others (doctors, patients) are entitled to display emotion, while nurses are not. The requirements of emotion management are a

part of their occupational culture, and perfect compliance with emotional (non-) display rules is part of a standard professional performance. This performance is expected by all the actors, including the nurses themselves. It is a part of this occupation. Also a part of the occupation is that the nurse is fully subordinated to the professional doctor, 'obeys' without 'talking back', and 'assists' him. She does not have full command of the highly-valued knowledge of medicine that hospital culture rests in symbolic and economic terms (medical services are reimbursed in the fee-for-service model).

In the context of the doctors' and nurses' occupations, rational management of one's emotions is regarded as an attribute and measure of professionalism. The nurse's role is defined, among other things, by the requirement to submit her emotionality to rational control [Farkašová et al. 2009]. This requirement applies *a fortiori* to the 'full-fledged' profession of doctors.

In the script we re-constructed under the label 'nurse as a doctor's lightning rod', the nurse is subject to much higher standards of emotional labour than the doctor. She must cope with potential stigmatisation (when offended), normalise the relationship, de-escalate the situation and, at the same time, keep focusing on her work. She bears the costs of emotional labour even though she is not acknowledged as a 'full-fledged' professional like the doctor. The situation appears paradoxical: the nursing 'semi-professional' deals professionally with the non-professional failure of the professional doctor. But it is also paradoxical from the gender viewpoint, since the sources of the hospital's organisational culture—feeling rules and the norms of 'good nurse' behaviour—turn on its head the usual cultural coding according to which nursing is 'female work': here, it is the doctors, i.e. representatives of a profession culturally coded as masculine and supposedly endowed with 'typical masculine' attributes—rational behaviour, self-control, and emotional neutrality—who exhibit the lack of emotional or affective self-control. If we compare the relative amounts of emotional labour expended by doctors and nurses on de-escalating crisis situations that occur during their teamwork on emergency tasks, it is clearly the nurses—i.e. representatives of a 'feminine' profession—who are primarily responsible for maintaining cooperation and whose emotional labour sustains the working consensus in a mixed team.

However, the 'lightning rod' interaction episode makes sense from the actors' viewpoint, through the lens of 'organisational culture in practice'. According to Garfinkel [1956], successful performance of the script of a 'degradation ceremony' requires actors' social (here, occupational), not personal identities to be at stake. The doctor's outburst of emotion is not ascribed to his occupational role (but rather to his personality type), while the nurse's response to the outburst is ascribed to her role as a 'good/bad nurse', i.e. as a (semi-)professional. Actions that would humiliate the subject, as a woman, under ordinary circumstances unrelated to work are not degrading for a professional nurse because she copes with them professionally. Such actions are not considered degrading by the actors performing the nurse's and doctor's roles in the lightning rod script.

In the re-constructed organisational script, the ascribed motives of nurses' and doctors' engagement are categorised in similar ways. While the doctor strives to protect health and save lives, the nurse is led by him and assists him in his effort. In this script, by managing her emotions and de-escalating the situation, she stands by the doctor and helps him attain the organisational goal of protecting the health of the patient.

According to Bittner [1973], the cultural concept of organisation shows members of staff the ways of making sense and purpose of any practical actions that might otherwise seem senseless, immoral, or harmful. In short, cultural organisational resources guide them in normalising the abnormal and immoral, in making sense of the senseless or paradoxical.

Insofar as the organisational logic of the hospital prescribes certain feeling rules and norms of obedience for nurses, it often produces social effects such as tension, stress, burn-out, and depression, which are, in that same logic, defined as a lack of professionalism on the individual's part [e.g. Venglářová et al. 2011]. Contemporary health-care practice fails to acknowledge these effects as matters of organisational culture and organisational structure. The resulting injuries are individualised and psychologised as personal matters of the actor performing her role, as signs of insufficient 'professional resilience' of someone who is unable to rise to the required degree of professionalism.

Our analysis pays particular attention to factors preserving the existing constellation of power. In the narrative accounts collected by us, preservation and reproduction of the hierarchical order in place were often presented as central themes of the nurse's job experience. At the same time, the relations between different health-care occupations have become a sensitive issue, especially in the accounts of younger and better educated nurses. It seems that existing rules and norms with regard to hierarchy and doctors' superiority are gradually losing their axiomatic nature, people are starting to re-think or even question them, whether this means criticising or defending them.

Change is possibly driven by these initial signs of testing the symbolic boundaries—for example, when nurses refuse an order, talk back, or insist on their job description. Changes to established relational asymmetries and cultural practices are further driven by the reforms to the system in progress, such as the establishment of nursing as an academic discipline. The current implementation of major structural reforms may be accompanied by fundamental occupational and organisational cultural changes in medical establishments. These changes provide opportunities to study the very process of cultural change or transformation in vivo and in process.

*Translated by Jan Morávek and Zuzana Šťastná*

OLGA ŠMÍDOVÁ MATOUŠOVÁ is researcher and teacher. She focuses on the discursive construction of identity, the politics of memory, organisational culture and institutional ethnography and qualitative methods.

BLANKA TOLLAROVÁ is a lecturer in qualitative methods at the Faculty of Humanities, Charles University in Prague. She specialises in the sociology of medicine and organisational studies.

## References

- Acker, J. 1990. 'Hierarchies, Jobs, Bodies: A Theory of Gendered Organizations.' *Gender & Society* 4 (2): 139–158, <http://dx.doi.org/10.1177/089124390004002002>.
- Acker, J. 2006. 'Inequality Regimes. Gender, Class, and Race in Organizations.' *Gender & Society* 20 (4): 441–464, <http://dx.doi.org/10.1177/0891243206289499>.
- Alvesson, M. and S. Deetz. 2000. *Doing Critical Management Research*. London: Sage.
- Alvesson, M. 2002. *Understanding Organizational Culture*. London: Sage, <http://dx.doi.org/10.4135/9781446280072>.
- Alvesson, M. 2004. 'Organizational Culture and Discourse.' Pp. 317–336 in *Handbook of Organizational Discourse*, edited by D. Grant, C. Hardy, C. Oswick and L. L. Putnam. London: Sage, <http://dx.doi.org/10.4135/9781848608122.n15>.
- Aroskar, M. A. [1985] 2002. 'Ethical Relationships between Nurses and Physicians: Goals and Realities—A Nursing Perspective.' Pp 44–61 in *Caring, Curing, Coping: Nurse, Physician and Patient Relationships*, edited by R. Badger, L. Clayton and A. Bishop. Tuscaloosa, AL: University of Alabama Press.
- Bártlová, S. 2006. 'Vliv pracovních vztahů mezi lékaři a sestrami na péči o pacienta.' (The Effect of Working Relations between Doctors and Nurses on Patient Care) *Kontakt* 7 (1): 31–35.
- Bártlová, S. 2007. 'Profese sestry, profesionalizace a elitářství ze sociologického pohledu.' (The Nursing Profession, Professionalisation and Elitism from a Sociological Perspective) *Kontakt* 8 (2): 254–259.
- Bártlová, S., I. Chloubová and M. Trešlová. 2010. *Vztah sestra-lékař* (The Nurse-Doctor Relationship) Brno: Národní centrum ošetřovatelství a nelékařských zdravotnických oborů.
- Bittner, E. 1973. 'The Concept of Organization.' Pp. 264–276 in *People and Organisations*, edited by G. Salman and K. Thompson. London: Longman.
- Bolton, S. and D. Muzio. 2008. 'The Paradoxical Processes of Feminization in the Professions: The Case of Established, Aspiring and Semi-professions.' *Work, Employment & Society* 22 (2): 281–299, <http://dx.doi.org/10.1177/0950017008089105>.
- Brunton, M. 2005. 'Emotion in Health Care: The Cost of Caring.' *Journal of Health Organization and Management* 19 (4/5): 340–354, <http://dx.doi.org/10.1108/14777260510615387>.
- Burford, B. 2012. 'Group Processes in Medical Education: Learning from Social Identity Theory.' *Medical Education* 46 (2): 143–152, <http://dx.doi.org/10.1111/j.1365-2923.2011.04099.x>.
- Casey, C. 1995. *Work, Self and Society: After Industrialism*. Abingdon and New York: Routledge.
- Davies, B. 2008. 'Jak znovu-promyslet "chování" v pojmech umístování a etiky odpovědnosti.' (Rethinking 'Behaviour' in Concepts of Situatedness and the Ethics

- of Responsibility) *Biograf* 47: 40. Retrieved 15 September 2013 (<http://www.biograf.org/clanek.php?clanek=4701>).
- Davies, B. and R. Harré. 1990. 'Positioning: The Discursive Production of Selves.' *Journal for the Theory and Social Behaviour* 20 (1): 43–63, <http://dx.doi.org/10.1111/j.1468-5914.1990.tb00174.x>.
- Dingwall, R., A. M. Rafferty and C. Webster. 1988. *Introduction to the Social History of Nursing*. London: Routledge.
- Driskill, G. W. and A. L. Brenton. 2005. *Organizational Culture in Action. A Cultural Analysis Workbook*. London: Sage.
- Elston, M. A. 2004. 'Professions and Professionalization.' Pp. 163–168 in *Key Concepts in Medical Sociology*, edited by J. Gabe, M. Bury and M. A. Elston. London: Sage Publications Ltd.
- Etzioni, A. 1969. *The Semi-professions and Their Organization*. New York: Free Press.
- Farkašová, D. et al. 2009. *Ošetrovatelstvo—teória*. (Nursing—Theory) 3rd edition. Martin: Osveta.
- Foucault, M. (1977) 2000. *Dohlížet a trestat. Kniha o zrodu vězení*. (Discipline and Punish) Prague: Dauphin.
- Freidson, E. 1988. *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. Chicago, IL: University of Chicago Press.
- Freund, P. E. S. 1998. 'Social Performances and Their Discontents: The Biopsychosocial Aspects of Dramaturgical Stress.' Pp. 268–294 in *Emotions in Social Life. Critical Themes and Contemporary Issues*, edited by G. Bendelow and S. Williams. London and New York: Routledge.
- Gabe, J. 2013. *Key Concepts in Medical Sociology*. London: Sage Publications Ltd.
- Garfinkel, H. 1956. 'Conditions of Successful Degradation Ceremonies.' *American Journal of Sociology* 61 (5): 420–424, <http://dx.doi.org/10.1086/221800>.
- Garfinkel, H. 2002. *Ethnomethodology's Program: Working Out Durkheim's Aphorism*. New York: Rowman and Littlefield Publishers.
- Geertz, H. 1959. 'The Vocabulary of Emotion: A Study of Javanese Socialization Processes.' *Psychiatry: Journal for the Study of Interpersonal Processes* 22: 225–237.
- Goffman, E. 1961. *Asylums*. New York: Doubleday Anchor.
- Goffman, E. (1974) 1986. *Frame Analysis: An Essay on the Organization of Experience*. New York: Harper & Row.
- Goffman, E. 1976. *Gender Advertisements*. Cambridge, MA: Harvard University Press.
- Goffman, E. 1981. *Forms of Talk*. Philadelphia, PA: University of Pennsylvania Press.
- Goffman, E. 1999. *Všichni hrajeme divadlo* (The Presentation of Self in Everyday Life) Prague: Nakladatelství Studia Ypsilon.
- Goffman, E. 2003. *Stigma*. Prague: Sociologické nakladatelství (SLON).
- Grandey, A. A. 2000. 'Emotional Regulation in the Workplace: A New Way to Conceptualize Emotional Labor.' *Journal of Occupational Health Psychology*. 5 (1): 95–110, <http://dx.doi.org/10.1037/1076-8998.5.1.95>.
- Harding, S. 1986. *The Science Question in Feminism*. New York: Cornell University Press.
- Harré, R. and G. R. Gillet. 2001. *Diskurz a myseľ: Úvod do diskurzívnej psychológie*. (Discourse and Mind: An Introduction to Discursive Psychology) Bratislava: IRIS.
- Heitlingerová, A. and Z. Trnková. 1998. *Životy mladých pražských žen*. (The Lives of Young Prague Women) Prague: Sociologické nakladatelství (SLON).
- Heritage, J. and S. Clayman. 2010. *Talk in Action: Interactions, Identities, and Institutions*. Oxford: Wiley Blackwell, <http://dx.doi.org/10.1002/9781444318135>.
- Hester, S. and P. Eglin. 1997. *Culture in Action: Studies in Membership Categorization Analysis*. Washington, DC: International Institute for Ethnomethodology and Conversation Analysis and University Press of America.

- Hochschild, A. R. 1975. 'The Sociology of Feeling and Emotion.' Pp. 280–307 in *Another Voice*, edited by M. Millman and R. M. Kanter. Garden City, NY: Doubleday Anchor.
- Hochschild, A. R. 1979. 'Emotion Work, Feeling Rules and Social Structure.' *American Journal of Sociology* 85 (3): 551–575, <http://dx.doi.org/10.1086/227049>.
- Hochschild, A. R. 1983. *The Managed Heart: Commercialization of Human Feeling*. Berkeley, CA: University of California.
- Hochschild, A. R. 1998. 'The Sociology of Emotion as a Way of Seeing.' Pp. 3–15 in *Emotions in Social Life. Critical Themes and Contemporary Issues*, edited by G. Bendelow and S. Williams. London and New York: Routledge.
- Hřešanová, E. 2008. *Kultury dvou porodnic: etnografická studie*. (The Cultures of Two Maternity Hospitals: An Ethnographic Study) Pilsen: Vydavatelství ZČU v Plzni.
- Kapr, J. and B. Koukola. 1998. *Pacient: Revoluce v poskytování péče*. (The Patient: A Revolution in Care Provision) Prague: Sociologické nakladatelství.
- Křížová, E. 2006. *Proměny lékařské profese z pohledu sociologie*. (The Changing Medical Profession in a Sociological Perspective) Prague: Sociologické nakladatelství.
- Kučera, M. 1992. *Školní etnografie: Přehled problematiky*. (Educational Ethnography: An Overview) Prague: PedF UK.
- Kutnohorská, J. 2010. *Historie ošetřovatelství*. (A History of Nursing) Prague: Grada Publishing.
- Mark, A. 2005. 'Organizing Emotions in Health Care.' *Journal of Health Organization and Management* 19 (4/5): 277–289, <http://dx.doi.org/10.1108/14777260510615332>.
- Marková, E. and S. Bártlová. 2013. 'Historical Development of the Ward Nurse Position in the Czech Republic.' *Journal of Nursing, Social Studies, Public Health and Rehabilitation* 4 (1–2): 37–46.
- Newton, T. 1995. *Managing Stress: Emotion and Power at Work*. London: Sage.
- Ogien, A. and L. Quéré. 2005. *Le vocabulaire de la sociologie de l'action*. Paris: Ellipses.
- Porter, S. 1991. 'A Participant Observation Study of Power Relations between Nurses and Doctors in a General Hospital.' *Journal of Advanced Nursing* 16 (6): 728–735, <http://dx.doi.org/10.1111/j.1365-2648.1991.tb01731.x>.
- Potter, J. 2000. *Representing Reality. Discourse, Rhetoric and Social Construction*. London: Sage.
- Read, R. 2007. 'Labour and Love: Competing Constructions of "Care" in a Czech Nursing Home.' *Critique of Anthropology* 27 (2): 203–222, <http://dx.doi.org/10.1177/0308275X07076798>.
- Rozsypalová, M., H. Svobodová and Marie Zvoníčková. 2006. *Sestry vzpomínají. Příspěvek k historii ošetřovatelství*. (Nurses' Memories: A Contribution to the History of Nursing) Prague: Grada Publishing.
- Shott, S. 1979. 'Emotion and Social Life: A Symbolic Interactionist Analysis.' *The American Journal of Sociology* 84 (6): 1317–1334, <http://dx.doi.org/10.1086/226936>.
- Slepičková, L., E. Šlesingerová and I. Šmídová. 2012. 'Biomoc a reprodukční biomedicína: konceptuální inspirace pro český kontext.' (Biopower and Reproductive Biomedicine: A Conceptual Inspiration for Czech Sociology of Medicine) *Sociologický časopis/Czech Sociological Review* 48 (1): 85–106.
- Šmídová, O. 2011. 'Kulturní přístup k organizacím a metodologické aspekty výzkumu.' (The Cultural Approach to Organisations and Methodological Aspects of Research) Pp. 34–173 in *Organizační kultura v sociálních službách jako předmět výzkumu*, edited by Z. Havrdová, O. Šmídová, J. Šafr, I. Štegmánová et al. Prague: Fakulta humanitních věd, Karlova Univerzita.
- Šmídová, O. and B. Tollarová. 2013. "'Taková normální profese"—Strategie normalizace povolání v biografických vyprávěních zdravotních sester.' (An Ordinary Profession—Strategies of Occupational Normalisation in the Biographical Narratives of Nurses)

- Pp. 101–109 in *Kvalitativní přístup a metody ve vědách o člověku 'Hranice normality'*. Olomouc: Vydavatelství University Palackého.
- Staňková, M. 1996. *Základy teorie ošetrovatelství*. (Basic Nursing Theory) Prague: Karolinum.
- Stein, L. I., D. T. Watts and T. Howell. 1990. 'Sounding Board: The Doctor-Nurse Game Revisited.' *The New England Journal of Medicine* 322 (8): 546–549, <http://dx.doi.org/10.1056/NEJM199002223220810>.
- Svensson, R. 1996. 'The Interplay between Doctors and Nurses—A Negotiated Order Perspective.' *Sociology of Health & Illness* 18 (3): 379–398, <http://dx.doi.org/10.1111/1467-9566.ep10934735>.
- ten Have, P. 2003. 'Predstava člena je jadrom věci. O úlohe členského vedenia v etnometodologickom výzkume.' (The Member's Notion Is the Heart of the Matter: On the Role of Member Knowledge in Ethnomethodological Research) *Biograf* 32: 3–29.
- ÚZIS (Ústav zdravotnických informací a statistiky České republiky). 2003. *Ženy a muži v číslech zdravotnické statistiky/Women and Men in the Figures of Health Statistics*. Prague: ÚZIS. Retrieved 20 November 2014 (<http://www.uzis.cz/katalog/mimoradne-publikace/zeny-muzi-cislech-zdravotnicke-statistiky>).
- ÚZIS (Ústav zdravotnických informací a statistiky České republiky). 2013. *Zdravotnická ročenka České republiky 2012/Czech Health Statistics Yearbook 2012*. Prague: ÚZIS. Retrieved 20 November 2014 (<http://www.uzis.cz/publikace/zdravotnicka-rocenka-ceske-republiky-2012>).
- Venglářová, M., L. Myšáková, G. Mahrová and M. Laštovica. 2011. *Sestry v nouzi. Syndrom vyhoření, mobbing, bossing*. (Sisters in Crisis: Burn-out, Mobbing, Bossing) Prague: Grada Publishing.
- Waldron, V. R. 2000. 'Relational Experiences and Emotion at Work.' Pp. 64–82 in *Emotion in Organizations*, edited by S. Fineman. 2nd edition. London: SAGE Publications Ltd., <http://dx.doi.org/10.4135/9781446219850.n4>.
- Weaver, R. 2013. 'Games, Civil War and Mutiny: Metaphors of Conflict for the Nurse–Doctor Relationship in Medical Television Programmes.' *Nursing Inquiry* 20 (4): 280–292, <http://dx.doi.org/10.1111/nin.12023>.
- Weller, J. 2012. 'Shedding New Light on Tribalism in Health Care.' *Medical Education* 46 (2): 134–136, <http://dx.doi.org/10.1111/j.1365-2923.2011.04178.x>.
- Weller, J. M., M. Barrow and S. Gasquoin. 2011. 'Interprofessional Collaboration among Junior Doctors and Nurses in the Hospital Setting.' *Medical Education* 45 (5): 478–487, <http://dx.doi.org/10.1111/j.1365-2923.2010.03919.x>.
- West, C. and D. H. Zimmerman. 2008. 'Dělat gender.' (Doing Gender) *Sociální studia* 5 (1): 99–120.
- Wodak, R. (ed.) 1997. *Gender and Discourse*. London: Sage Publications.