

Title: Dispensing emotions: Norwegian community nurses' handling of diversity in a changing organizational context

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Abstract

Since the mid-1990s, public sector health care services in Norway have been restructured, in line with New Public Management ideas. This restructuring has coincided with demographic changes that have led to a more culturally diverse patient population. Both developments have created new challenges for community nurses in managing their work. This qualitative study applies the concept of “emotional labor” to examine nurses’ experiences in working with ethnic minority patients in the context of pressures arising from organizational reforms. The analysis sheds light on the nurses’ attempts to comply with system-induced efficiency considerations, while catering to the special situation of patients with language barriers and unfamiliar cultural traditions. The article demonstrates how efficiency requirements and time constraints either aggravate the nurses’ insecurity in dealing with minority patients or, in some cases, compel them to assume more work responsibilities so as to mitigate the effects of such constraints.

Key words: Norway, Community nurses, emotional labor, migration, minority patients, new public management

Introduction

With the aim of decreasing costs while increasing efficiency and accountability, labor-intensive human service organizations have undergone profound restructuring in most European countries (Le Grand, 2003). Within the health care sector, these endeavours often translate into an increased workload for frontline workers (Cooke, 2006; Hasenfeld, 2010). In Norway, New Public Management (NPM)-inspired reforms of health and social care services expanded throughout the mid-1990s (Ogar & Hovland, 2004).

While jobs within home health care services have long been some of the most demanding within the health sector (Szebehely, 2006), recent efforts at enhancing efficiency in the public sector have aggravated this situation, as staff assumed tasks previously handled at other levels in the health sector hierarchy (Vabø, 2007).

These developments coincide with profound demographic changes in Norway, as elsewhere in Europe, resulting in a more culturally diverse patient population (Government Report No. 6, 2013; Ingebretsen & Nergård, 2007), with new demands on home care nurses in terms of language barriers and cultural complexity (Debesay et al., 2014). Therefore, investigating the impact of ethnicity on emotional labor in workplaces is critical (Durr & Wingfield, 2011). This article examines how community nurses in Oslo carry out emotional labour when assisting a more diverse group of users in the context of time constraints exacerbated by NPM reforms. In addition to being the most multicultural city in Norway, Oslo is also of interest for this study because the main tenets of NPM have a relatively strong footing in the conservative city government that has governed Oslo since 1997.

Emotional labor in home health care

Hochschild (2003) points out that, in addition to providing physical and cognitive labor, workers in human service organizations operate through an emotional repertoire for

generating or suppressing feelings. Workers' management of emotions helps support a specific facial or bodily expression for triggering the desired response from the service recipient. Convincing the patient to act in a certain manner requires nurses to carefully regulate the expression of their feelings, in the form of either a surface act or a more personalized and deeply rooted act (Hochschild, 2003). While "surface acting" is a superficial way of simulating emotions that the sender does not genuinely feel, involving a suppression of true feelings, "deep acting" is a type of self-regulation, implying that the nurses are attempting to feel or experience the emotions they are expected to display. The emotions displayed in a deep act relate more closely to the nurse's sincere feelings. For example, nurses may actively work to make themselves feel joy or grief, to avoid giving the impression that their performance is only a façade: To create calm and security for a patient, nurses must be able to show patience and firmness through both voice and body language.

Across service professions are pronounced differences in the requirements that employers impose for emotional labor. While some professional groups are expected to comply with elaborate guidelines for displaying emotions in client interaction, other groups find these requirements embedded in the overall ethos of their profession. This applies particularly to health workers who generally advocate for, and are guided by, a view of humanity. Thus they are expected to be notably understanding towards clients while also serious and neutral. Their work, although relatively more autonomous, is governed by their own professional standards and their organization's policies (Fineman, 2003). As community nurses have regular contact with individual patients and their families over a long period, and in the patients' own homes, the emotional component of service delivery in their work is thus of particular importance (Nortvedt, 2001). The concept of emotional labor is therefore useful for understanding nurses' coping strategies relative to caring for a more diverse group of patients.

In contrast to psychoanalytical and cognitive perspectives on emotions as primarily individual traits, social constructivists view the expression of emotions as guided by normative rules within social and cultural contexts. These rules for expressing emotions are constantly shaped and reshaped, including through the organizational settings of peoples' work environments (Fineman, 2000, 2003). The way work is organized and the type of contact the professional has with the patient conditions the quality of emotional labor. While frequent contact with patients regarded as "difficult" may result in professionals' entering the mode of surface acts, a deeper display of emotions can be furthered through a supportive organizational framework (Chou et al., 2012). Scholars have therefore pointed to the importance of investigating the working conditions that shape emotional work (Gray & Smith, 2009).

Differences related to culture or ethnicity can present additional challenges when performing emotional labor. In cross-cultural interactions, uncertainties may arise about which emotions are adequate at which times. Professional work with a diverse client group may therefore require special training and knowledge if workers are to display emotions that are appropriate for the clients with whom they interact (Guy et al., 2010).

The concept of emotional labor has been a catalyst for research into critical conditions of a gender-divided labor market. Scholars have criticized traditional views, such as the notion that displaying and invoking emotions is a "natural," intrinsic quality of certain types of jobs. Such a notion may contribute to the downgrading of jobs involving emotional labor (Gray & Smith, 2009)—given their association with virtues belonging to the family sphere—virtues not sufficiently appreciated in the labor market (Guy et al., 2010; Hochschild, 2003; James, 1992). This lack of appreciation is particularly noteworthy, given that emotional labor is very demanding: It has been identified, in combination with high work pressure and low resources, as an important reason for nurses' becoming exhausted and leaving their jobs (Bartram et al.,

2012). Influencing an interaction partner by using an emotional repertoire is hard work. Although sympathy and benevolence can be carefully turned on and off, irritation and frustration can occasionally break through. In addition, the expectation of correct behavior can be so demanding that it leads to cynicism, and under stressful circumstances, the façade may crack (Fineman 2003). Nevertheless, Fineman (2003) is highly critical of the negative association attached to the surface act. He contends that an insistence on authenticity or a deep act at work underestimates the importance and necessity of “hypocrisy” as an integral part of organizational life. In many cases, a surface act is an act “in good faith,” and indispensable for nurses in helping the patient and carrying out a demanding job. Neither the patient nor the professional needs to rely on the sincerity of emotions at all times. The choice of emotions thus serves the function of managing diverse situational challenges (Fineman, 2003).

A changing organizational framework

In the Norwegian care sector, NPM policies have featured most strongly in the larger cities, especially those governed by more conservative political parties (Vabø, 2007). Research on the implications of the shift from traditional public administration to NPM has suggested that such change entails an increased overall workload for health care staff (Trygstad, 2009).

Indeed, the gradual policy change in the sector has affected the work of community nurses. The NPM-induced emphasis on production and efficiency has increased the turnover of hospital patients. In Norway, the average length of stay in acute care hospitals has been reduced by almost 25 percent during the 2000s (OECD, 2011). Along with processes of deinstitutionalization, this development off-loads additional care responsibilities for a group with larger needs to the home care services.

An important element in implementing NPM reforms in the home nursing care sector, as elsewhere, is the dividing of areas of responsibility between semi-independent purchaser and provider units (Ogar & Hovland, 2004; Vabø, 2001). In 2004, such an organizational split-up was required for all districts of Oslo (RO, 2004). Before this reorganization, the responsibility for daily care work and allocation of services lay with the district manager, who—in close collaboration with the nurses working in the field—determined the extent of care services. Decisions were based on professional discretion according to daily encounters with users, allowing the nurses to prioritize scarce personnel and funding resources in response to the changing needs of users.

The introduction of the purchaser-provider model in Oslo means that although the purchaser unit issues administrative decisions on the extent of help that users need, it has no responsibility for financing or personnel. Budget responsibilities lie with the head of the provider unit, who has no influence on administrative decisions other than executing them with available staff resources (Tønnessen, 2011).

NPM, as represented by the purchaser-provider model in Norway, inscribes itself in the work of community nurses in two important ways. First, it imposes a more rigid time regime, depriving the nurses degrees of professional discretion in determining how best to meet the varying needs of the user group. Second, the model necessitates a standardization of work tasks. This instrumental codification of tasks, Sikkeland (2008) argues, involves a highly technical and alienating language that depersonalizes care work, making it run counter to the realization of the important emotional component of care work.

Method

This study is based on a qualitative design with a sample comprising 19 community nurses, 17 women and two men. The research participants' ages ranged from the mid-20s to 60 years

old, with an average age of 43. Most had extensive work experience. Six participants were immigrants from Africa (4), Asia (1), and Europe (1), all of whom moved to Norway as adults. The selection of participants followed a strategy of purposeful sampling (Silverman & Marvasti, 2008; Stake, 1995), aimed at including nurses from home health care districts with a large proportion of non-Western ethnic minority patients.

We selected the four city districts of Oslo with the highest proportion of such minorities over the age of 50 as sites for recruiting home care nurses for this study. Although nurses were not always certain of the patients' origins, they nevertheless reported that most of those they met during their work came from India, Pakistan, Sri-Lanka, Somalia, Vietnam, Morocco, and Eastern Europe, in line with estimates showing that these groups are among the ethnic minorities using home health care services most frequently (Nergård, 2008).

The study was pre-approved by the Norwegian Social Science Data Services. Permissions were also obtained from the authorities in all participating city districts. The management of the home health care service gave information letters outlining the purpose, scope, content, confidentiality clauses, and logistics of the study to all potential participants. They were informed that their participation was voluntary and that they could withdraw from the study at any time. All participants signed letters of consent. This article uses pseudonyms.

Data was collected in March 2008 through semi-structured in-depth interviews, which were audiotaped and transcribed verbatim. The interviews elicited information about how nurses perceived differences or similarities in the way they provided care to ethnic minority patients, compared with ethnic Norwegians, which situations they found particularly challenging, and how they understood the situation of ethnic minority patients. Issues about what kinds of emotions arose in these encounters, the type of strategies the nurses used, and the values or attributes they considered appropriate while providing services to this type of

user were also covered. Most interviews lasted approximately one hour and took place in the participant's workplace.

The transcribed interviews were coded with NVivo for preparing them for thematic content analysis. The data was organized and analyzed in preparation for generating codes and categories by identifying interview excerpts related to similar subjects or with similar meanings (Miles & Huberman, 1994).

Efficiency considerations and diversity in home health care services

The increased time constraints imposed through NPM reforms featured strongly in the interviews. Several of the nurses reported that time pressure greatly hampered all aspects of their work, making it especially difficult for them to execute their work with patients from ethnic minority backgrounds, who often required more time and effort.

We work according to a very strict system and have work lists where it says, like: “Insulin injection: 5 minutes. Morning care assistance: 15 minutes.” It is very specific, and it may just work fine. But if you come to a home, for example, to care for an old mother from Pakistan, and the house is full of people of all ages and the whole family is there...then you can't just start doing things. One can't just go in and say: “Now I'll do my job,” because you are after all in someone else's home and have to somehow follow their life. [Jane]

Many participants described the time frame for home visits and work assignments as too limited, particularly with regard to the minority patients' care needs. The nurses reported that they were at increased risk of creating schedule delays during home visits to minority patients. If, when they arrived, a patient was preoccupied with activities that the nurses perceived as

related to culture or religion, they deemed it difficult to interrupt. Jorunn explained that two outcomes were possible in such situations. One was for her to return later, but then she would have already lost time on this “wild goose chase,” as she put it. The other option was to cancel or postpone the assignment, thereby creating a bad conscience. No procedures existed for granting additional time for home visits to particular groups of patients, so the nurses would need to remember to ask for more time for these patients when the daily work lists were set up.

According to the nurses, time for both conversation and help with daily living activities was thus too limited, and the visits left them with feelings of dissatisfaction. The following account illustrates the implications of these constraints.

You need to have sufficient time to level with these people, to reach them. It takes a long time to start the communication. It takes longer than the time allocated in the decision [for the care grant]. If I have a lot of clients on the list, then it affects the clients, who won't get the proper help I could otherwise give because I do not have time. If you work as normal, as stated in the decision, then you don't do much.

[Nichole]

The allocated time specified in the purchaser unit's grant decisions allowed little opportunity for engaging in aspects of care that the nurses deemed highly important, such as informal conversations with patients. As one said: “We do the best we can, we smile, and then off we go. It is because you have time constraints, simply because you do not always have time, and you are left struggling” (Bodil). Furthermore, the socio-psychological needs of patients from minority backgrounds could be extensive. The nurses mentioned the patients' need for social contact and, in some cases, for conversations about what the nurses called

“longing for the homeland.” The minority patients’ needs were thus felt to be more extensive than the nurses could appropriately deal with within their specified time limits.

The severe time constraints left the nurses with limited autonomy and flexibility, thereby contributing to their perception of minorities as a challenging patient group. Szebehely (2006) argues that although contact with needy groups can give helpers a feeling that their work is meaningful—and, as such, rewarding—the result is often a sense of inadequacy. Szebehely considers these work-related dilemmas to be important characteristics of work in home health care.

This imbalance between demands and resources appeared a particular challenge when nurses visited minority patients, because these visits often required more time than similar visits to ethnic Norwegian patients. Working under such conditions is often related to a lack of control and professional autonomy, something likely to make the nurses’ emotional labor even more demanding (Wharton, 1999). Time pressure and a lack of opportunity for creating changes that may affect nursing and care for minority patients may over time contribute to a lasting feeling of guilt among nurses (see, for example, Vabø, 2007; Vike et al., 2002).

Uncertainty and technical task orientation

The uncertainty the nurses felt when visiting minority patients was particularly related to not knowing how to act so as to inspire confidence and facilitate cooperation. One salient issue was insecurity about which approaches would work in minority patients’ homes: Nurses experienced a higher degree of unpredictability in these encounters, given their lack of knowledge about what would be considered “normal” within the patients’ culture. This insecurity may be an outcome of “unclear role performance”—as Goffman (1966) analysed this phenomenon in public places—particularly in interactions across cultures. When minority patients’ behavior conflicts with the nurses’ accepted norms, doubt may arise about whether

such a violation was intentional or simply an unintended consequence of the patients' lack of knowledge of Norwegian norms.

Fear of misunderstandings often left some nurses carefully regulating their behavior when they met minority patients, with self-monitoring and conscious adaptation to the specific setting being important coping strategies. As Jane said: "I'm probably more aware of how I conduct myself, how I talk, and how I present myself when I go to immigrants, as opposed to Norwegians." Jane also noted that she was more cautious, as she was afraid of being perceived negatively. By controlling her behavior in front of the patients, she aimed at avoiding upsetting or offending them. This cautious approach, necessitating a large amount of surface acting, was one response to the unpredictability and uncertainty that the nurses felt in these situations. For example, Tonje recounted her need to act more tactfully when she could not make herself understood verbally.

I'm much more careful with patients from a different background. It's all about my insecurities, right. It's all about my ignorance and uncertainty.... With people who speak Norwegian well, you can always be playful and be understood when you are kind of making a joke. Or you can say things in a certain way, and the patient understands you in the way you mean it. [Tonje]

Many nurses mentioned situations involving touching the patient as especially crucial in determining whether they were entering a more "controlled" role, because of difficulties in deciphering when they might go beyond the patients' intimacy boundaries. One nurse explained that achieving a mutual understanding on these issues was easier with ethnic Norwegian patients and that such home visits were much "smoother."

Communication problems prevented adequate feedback from patients. Nurses in such situations lacked the professional security they had when dealing with ethnic Norwegian patients and needed to invest more time and effort than in routine care, thus requiring substantially more emotional work (Richardson & Thomas, 2006). Inadequate knowledge of the patient's values and norms, in conjunction with time pressure and a lack of control, resulted in more demanding emotional work for the nurses, making entering the mode of deep acting potentially harder.

When feeling unable to become close to patients, some nurses distanced themselves from the patients. One mentioned that if they noticed that the patient was experiencing a situation as ambiguous or uncertain, the nurses themselves withdrew from the interaction. Particular situations in which the nurse and the patient were of the opposite gender led to uncertainty.

I've never touched a foreigner on the back as I do with Norwegians. One must adapt to the cultural values and not come too close to a man. One must try to stand in the corner, and not just come in, sit down, and start talking about things. [Nichole]

The coping strategy of distancing could, for example, involve refraining from touching the patient physically in specific areas. The nurses' descriptions of such encounters testified to emotionally strenuous situations, giving the impression that they coped with their work with minority patients by being more pragmatic. For situations in which the patients' relatives became more involved than the nurse thought necessary, or where men avoided contact with her, one nurse said: "I am fully aware of my role. I am a nurse with a job to be done." Another said she had "boiled with rage inside" because she felt that minority patients either did not understand her or were not cooperative. This type of frustration in dealing with minority patients was related to the overall challenges and complexity of home care work: "You can be

crushed in this work here. Well, this is not just about minorities. But remember that we have people with violent tendencies, we have schizophrenics, people with hallucinations and delusions” (Marit). This nurse said that it was through being “pragmatic,” that is, surface acting, that she was able to handle such situations.

The responses we received from ethnic minority participants were consistent with those we received from the majority participants, with the exception of ethnic minority nurses reporting minority-patient encounters in which they felt discriminated against. Betty, a black nurse from Africa, experienced not being respected by white patients with different ethnic backgrounds, due to what she believes was her skin color. Thus the emotional labor of surface acting appears to be heavier for staff when discrimination is added to the overall work challenges.

These accounts of patient encounters indicate that, given the constraints nurses face in home care services, they attempt to control their behavior when they have feelings of uncertainty, frustration, and anger, so as to perform care work for minority patients. They create a restrained façade to achieve the desired results with the patients. Morris and Feldman (1996) suggest that the extraordinary effort entailed in undertaking such emotional labor is primarily a result of the conflict between what the workers are expected to feel and what they “really” feel. The more they need to guard their appearance and abide by what they perceive as acceptable behavior, the more exhausting the emotional work can be. A consequence of this emotional dissonance between inner feelings and self-representation can be a distancing in the form of task orientation and a surface act.

The nurses noted that time pressure allowed only the handling of medical procedures and other “technical” duties in caring for minority patients. Lillian said that although she acted differently when she was in minority patients’ homes, she still conducted the practical tasks as usual: “If I’m there for a catheterization or for wound care, then I perform the task the same way, no matter who it is.” The nurses tended to focus on practical tasks when the conditions

for providing relational care were considered even poorer than usual. They also stressed that this technical task orientation was, as Bodil put it, “a survival strategy in a hectic day.”

A study by Lopez (2006) shows how the staff of a U.S. nursing home used distancing as a self-protective strategy when the emotional work was not recognized or accommodated by organizational measures. Staff refrained from entering into deeper conversations with patients, making it easier for them to leave without feeling any guilt. A more instrumentalist approach to work can thus be a form of remedy, as Aldridge (1994) noted; the employees can still feel mastery by performing practical tasks well enough, although the relational parts of the work are not optimal (Aldridge, 1994).

The focus of some of the nurses on technical tasks appeared to allow them an opportunity for rationalizing their distancing behavior. In particular, they emphasized that, despite the challenges, they felt they were able to perform technical procedures in the same way, no matter what the patients’ cultural preferences. Yet our study also finds that such an orientation was ultimately unsatisfactory. Keeping the critical *relational* part of nursing and care work to a satisfactory level is difficult when nurses experience uncertainty and increased time pressure while visiting minority patients. The uncertainty and frustrations that the nurses feel about insufficient cultural competence and time constraints may therefore lead to continuous surface acting and, ultimately, to low work satisfaction. Nurses as a group may be particularly vulnerable, given their professional ethos, which reflects the strong identification they often have between themselves and their work. As emotional work is tightly connected with professional identities, their emotional display of deep acting may therefore fail (Fineman, 2003).

Our discussion thus far does not preclude the likelihood that the staff’s uncertainty in encountering patients from ethnic minorities may also have to do with biased attitudes. Negative media coverage on immigration issues shapes the socio-political discourse in

Norway (Gullestad, 2006), and this discourse may surface in the working environment of home health care. General prejudices, aggravated by communication barriers, may thus lead to a particular way of conceptualizing ethnic minorities differently from other subgroups in society. Staff may be prone to labeling them firstly as “immigrants,” with the negative associations of the word, and only secondly as “patients,” with the full legal and social rights involved (Debesay, 2012). In a situation of increased efficiency requirements, unfavorable societal discourses of immigrants may consequently reinforce the construction of minority patients as “difficult patients.” Such perceptions of minority patients among some of the nurses may be a major contributing factor to their predominantly surface acting in their practice, which may deny them professional and meaningful relationships with these patients.

Compensating with “that little extra”

In contrast to the practice of withdrawal and surface acting as among some of the research participants, approaches that are more positive were also evident in the interviews. Many of the nurses were concerned about the disadvantaged position of elderly immigrant patients. As Jorunn noted, “One must never forget that they have lived under very different conditions of life, in a very different way than we have here.” Thus minority patients’ propensity for requesting and receiving help was considered lower than that of other patients, and the nurses often felt responsible for taking these patients’ particular situations into account during their home visits. Moreover, the nurses said that they wanted to show more responsiveness towards these patients, out of concern that they might be more “anxious” about finding themselves in unfamiliar circumstances in a new country. As Bente said, the nurses were often made aware of the patients’ circumstances during the home visit: “We sense their uncertainty and would like to make them feel safe.” Personal experiences and assumptions about the difficulties

minorities might encounter made these nurses particularly careful about how they appeared when they entered the patients' homes.

I would like, perhaps even more, to give the impression of empathy...that "you are equal to me." Maybe they've had many encounters with health care services in which they've had bad experiences, and I would not want them to see me the same way. I want them to experience that "I care about you, and I will give you the best possible care." So showing empathy and sensitivity in these situations is necessary. [Kari]

Kari explained that she did not want to be seen as yet another person who did not care about these patients and wanted to make sure not to discriminate against them. Nurses like Kari reported that, in such situations, they tried to show more friendliness and "much respect" for the patient and his or her culture. To make the patients feel at ease, they also tried to be more polite, emphasizing the importance of "radiating" security and an understanding of the patients' situation. Demonstrating that the nurses were reliable made their care work with these patients easier. As Kari said: "If I can generate security through my personality, then I might reach further."

To compensate for patients' potential bad experiences and to be perceived as safe helpers, the nurses particularly mentioned the need for adequate time for visiting patients in their home. Patients perceiving them as impatient could have a negative impact on nurses' effort at interacting: "You must not show that you are in a hurry," Nichole explained. "When you just take off your outdoor jacket and immediately start with preparing injections or something like that, then you are perceived as impatient." The nurses perceived the need for a less rushed approach, because it took them longer to communicate with minority patients and the risk of misunderstandings was higher.

To reassure the patient that she would spend the necessary time, Bente took several steps to avoid the impression that she was hurrying to get to the next patient. She added that she was careful not to answer her phone in the patients' presence, and that she always sat down to exchange a few words before, for example, giving medication. Furthermore, she told the patients that they should not think that she did not have enough time and emphasized that it was necessary that she took off her outer garments in the apartment.

Nurses also mentioned situations in which they went to great lengths to help minority patients with issues that went beyond the specified health care tasks but were vital for securing the patient's health. Such accounts appear consistent with the work of Bolton (2001), who stresses that nurses are able to break the prescribed rules of their organization and give some of their own time to patients. In these cases, they allow themselves to be more spontaneous and "honest" in showing their emotions.

However, such spontaneity and openness requires that they feel comfortable or safe in the interaction (Bolton, 2001). Our study indicates that what motivated the nurses to increase their work effort towards minority patients was their perception of minorities as having a weaker social position. By using some of their own time and giving patients "that little extra," the nurses wanted—in addition to hoping to be perceived as trustworthy and to convey confidence—to ensure that the level of care matched that for the ethnic majority patients. However, this form of behavior derived from the initiative of individual nurses, who could instead have provided only the minimum standard of care for getting the job done. This de facto voluntary extra work is most likely related to the inherent humanistic-normative orientation of nursing work. These nurses' personal experiences testifying to the often marginalized situation of ethnic minorities appear to have helped them to conceptualize ethnic minorities in the light of the nursing profession's humanistic ethos. Such constructions of minorities that correspond with nursing ideals of advocating for vulnerable patients may have

made the nurses more at ease, and less insecure, thereby allowing for deep acting nursing in transcultural contexts.

Moreover, a generally accepted assumption is that professional work can provide personal satisfaction in helping others and that it can be a reward in itself (Mazhindu, 2003). Emotional work is thus closely linked to the nature of the nursing work. The “little extra” or voluntary “gift” to patients is something the employee retains control of. Consequently, a primary characteristic of this gift is that it constitutes an act of spontaneous, sympathetic emotional effort *not* controlled by the employer. Instead, it constitutes an extra effort that nurses make for some patients because of sympathy, their individual convictions, or both (Fineman, 2003). Importantly, as this type of effort is primarily governed by private-sphere norms of gift exchange, it is thus located outside the formal, contractual obligation to provide a service. The extra effort is governed by a different logic than the market and exists in addition to what the market has to offer (see Mauss, 1995). This “gift” is more forthcoming in close, relational circumstances, possibly contributing to the establishment of relationships that particularly appeal to a moral obligation to help.

Such a tendency is described in studies of nurses working with marginalized groups. For example, Hart and Lockey (2002) demonstrate the gap that exists between management and nurses in the perception of the need for extra effort for such patients. This gap resulted in some of the nurses putting in extra work and helping patients according to their own self-fulfilment needs. According to Bolton (2000), despite time constraints and increasing demands for efficiency, such dedicated staff give of their spare time with no expectation of receiving anything in return. Although the emotional involvement can be stressful, such employees often experience personal satisfaction through helping. These dedicated nurses must work harder with their emotions to express a genuinely felt deep act: While working

within the same overall constraints as their peers, they give more of themselves as a result of their convictions (Bolton, 2000).

Emotional work such as showing empathy, dedication, and patience requires effort (Larson & Yao, 2005), and these feelings also need to be communicated to patients in an understandable fashion (Morris & Feldman, 1996). Emotional work is more challenging when nurses, in addition to dealing with an overall increased workload, must also show “correct” cultural expressions when caring for minority patients.

Conclusion

Time pressure and uncertainties when working in transcultural contexts affected the strategies that home care nurses adopted in performing their work in their interaction with minority patients. In particular, strategies such as distancing and keeping a narrow focus on technical procedures appear to be related to nurses’ working conditions; in a fast-paced work environment characterized by increased uncertainty concerning appropriate cultural norms, achieving a desired performance of emotional labor can be difficult (Hochschild, 2003). The nurses tried to hide from their patients the difficult conditions under which they worked, so as not to spoil the interaction or the quality of the service rendered. However, this effort was complicated by the greatly varying interaction rules with a more heterogeneous group of patients and the apparent neglect of the nurses’ experiences by the home care service management.

Henderson (2001) discusses similar conditions in her study of UK nurses’ work with abused women. Their job provided many emotionally charged situations that the staff felt that they had not been trained to handle. They felt that they were left to themselves, essentially neglected by their employer in the development of professional competence. They thus often sought informal support from their colleagues (Henderson, 2001). When the emotional

aspects of work are considered private dilemmas rather than collective problems, management in service organizations can easily ignore the cost or value of such work (Fineman, 2003; Vike et al., 2002).

Management can thus overlook the extra costs involved in attempting to provide care to patients with whom nurses cannot satisfactorily communicate. One explanation is that management allocates resources in a top-down manner, whereas the knowledge and orientation of care work is located among the professionals on the ground. While clearly closest to the patients, the nurses have no control over the prioritization of resources. Resource scarcity and lack of quality in relation to care work are clearly interpreted quite differently by managers and professionals (Vike et al., 2002).

In another study of home health care in Norway, Rasmussen (2000) shows that unit managers retained the budget responsibility, while nursing coordinators were responsible for the quality of care in the field. When the professional nurse coordinators asked for resources to make changes that they believed necessary for improving the quality of care, management often dismissed their requests. Yet the intrinsic motivation of these employees and their concern for patient welfare made cutting back on the amount of help difficult. The nurses' sense of professional pride and quality standards therefore contributed to an escalation of their work effort, leading Rasmussen to label home services as "greedy organizations" (Rasmussen, 2000). Decentralization of responsibility thus appears as a major factor in how home care organizations use their employees' emotional capital without having to pay what it really costs.

While such working conditions are likely traceable in different organizational contexts, this article suggests that—at least in Norway—NPM reinforces these conditions. Although countries differ widely in whether or how they have embraced NPM, findings from other countries show that implications for front-line workers are often remarkably similar. Rankin

(2009) found in a study of Canadian nurses that working conditions changed with the introduction of NPM in hospitals, with the new management logic intervening with and disrupting nursing practice. Although the nurses agreed that the changes negatively affected their work, they nevertheless could not disassociate themselves from the economic-administrative logic influencing their thought and practice. Rankin points out that the nurses' everyday discussions about changes in working conditions took place within the broader discourse of efficiency and productivity (i.e., in NPM terms).

Another Canadian study (Macdonald, 2007) found that the nurses' biggest challenge was having too little time to sufficiently familiarize themselves with patients to perform satisfactory work. The patients, for their part, felt that the nurses did not have enough time to help them. Macdonald related these problems to health organizations' rigid and quantitatively oriented work philosophy, based on performance and efficiency measurements that poorly matched the complex situations in which nurses often found themselves. Blame nevertheless fell on the employees: "Nurses who do not complete their work within a shift are often seen as disorganized when perhaps the system that is measuring the work needs redefinition" (Macdonald, 2007, 519).

The point here is not to suggest that nurses cannot provide extra efforts despite institutional and social barriers, but rather that such an involvement is often regarded primarily as an individual obligation, not a collective responsibility. The additional effort or the "little extra" that a few dedicated employees perform can thus be subject to exploitation by organizations. The staff members end up compensating for the negative impact of the management model with their own reinforced efforts, with the problems never brought to the attention of the responsible authorities (Szebehely, 2006).

The main issue is that emotional labor is demanding, whether performed through deep or surface acting. Changing situations may require one or the other. We argue that escalating

time constraints are increasing nurse workloads, thus limiting the nurses' professional autonomy and discretion. Consequently, situations that allow only surface acting run contrary to the nurses' ideal of good care and are hardly beneficial to nurses' professional wellbeing. Moreover, when the caregiver is in bad shape, so is the care. When community nurses face time pressure and uncertainty, involvement with patients requiring authenticity (in line with professional ideals) can be emotionally very challenging, making surface acting necessary. A certain amount of surface acting or emotional "hypocrisy," as Fineman (2003) calls it, thus appears occasionally necessary for nurses to carry out their work. Without time for preparing for new patient groups, and with little opportunity for performing the work appropriately, nurses' simulation of feelings may be an appropriate response for both nurse and patient. Indeed, Aldridge (1994) argues that an authenticity-guided self-presentation in relationships is not necessarily a good criterion for successful patient-nurse relationships (Aldridge, 1994).

Without adequate appreciation of these relational aspects of nursing work, the hidden costs of emotional labor are likely to persist. Under such conditions, surface acting, distancing, and a stronger focus on the technical aspects of work can become primary coping mechanisms in emotionally demanding encounters with ethnic minority patients. Moreover, there is a risk that NPM-imposed standardization and efficiency requirements may reinforce negative conceptualizations of vulnerable patient groups, and in this case lead to the construction of minority patients as troublesome. Such constructions may ultimately run counter to deep act performance and thereby reduce nurses' work satisfaction, resulting in adverse consequences for minority patients.

The main problem appears to lie in the lack of organizational changes that could support employees' interaction and confidence-building efforts (Bartram et al., 2012; Lopez, 2006), e.g. by enhancing their transcultural communication and interaction skills. Local authorities and the management of human service organizations should therefore promote less

standardization of tasks, instead fostering the quality of professionals' discretionary power by ensuring cultural competence and allowing more professional autonomy. Otherwise, NPM-related efforts at increasing efficiency in the Norwegian home care sector will make it even more difficult for community nurses to perform relational work in line with their professional ethos, with a resultant deterioration of their relationship with minority patients. Recognizing the community nurses' emotional labor through the reduction of the negative implications of efficiency requirements would be an important step towards improving equal access to quality care for diverse patient populations.

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