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

Jonas Debesay [a, *], Ivan Harsløf [b], Bernd Rechel [c, d], Halvard Vike [e]

[a] Faculty of Health Sciences, Department of Nursing, Oslo and Akershus University College of Applied Sciences, P.O. Box 4, St. Olavs Plass, N-0130 Oslo, Norway
[b] Faculty of Social Sciences, Oslo and Akershus University College of Applied Sciences, P.O. Box 4, St. Olavs Plass, N-0130 Oslo, Norway
[c] European Observatory on Health Systems and Policies, United Kingdom
[d] Department of Health Services Research and Policy, London School of Hygiene & Tropical Medicine, 15-17 Tavistock Place, London WC1H 9SH, United Kingdom
[e] Faculty of Social Sciences, Department of Social Anthropology, University of Oslo, Postboks 1091, Blindern, 0317 Oslo, Norway

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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.

1. 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 endeavors 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 and 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 and 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 and Wingfield, 2011). This article examines how community nurses in Oslo carry out emotional labor 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.

1.1. 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

* Corresponding author.
E-mail addresses: Jonas.Debesay@hioa.no (J. Debesay), ivan.harslof@hioa.no (I. Harsløf), Bernd.Rechel@lshtm.ac.uk (B. Rechel), halvard.vike@sai.uio.no (H. Vike).

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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 and 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 and 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).

1.2. 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 and 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.