

HEART WORK:  
CHALLENGES AND ADAPTATIONS OF HOSPICE WORKERS

by

Cindy L. Cain

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## DEDICATION

To Care Workers, for the visible and invisible work of caring.

In memory of Laura P. Bales.

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## ABSTRACT

This dissertation analyzes the everyday work experiences of hospice, a type of end-of-life care. The following chapters integrate micro-sociological perspectives with meso- and macro- level explanations of organizational behavior to account for workers' performances of emotional labor, care-related identities, constraints on their daily work, and ultimately hospice workers' strong commitment to their jobs and the hospice philosophy. Using a mixed methodological approach, I argue that hospice workers engage in emotional labor, but that instead of feeling dissonance or alienation, hospice workers develop a positive identity around their work. Their identities and work experiences are still constrained by institutional forces, however. Hospice workers' experiences highlight two tensions in the administration of caring labor: keeping commitment during times of organizational change and balancing the needs of the self with the needs of the care recipient. The main contributions of this work include new understandings of the relationships between identity, emotions, and work; a novel combination of theories that better explain care workers' behaviors and constraints on their action; and, a refined approach to thinking about emotional labor.

## CHAPTER I: INTRODUCTION

### Statement of the Problem

Sociological understandings of caring labor are incomplete. This is for theoretical and methodological reasons. Theoretically, social scientists have largely followed Weber ([1905] 1958) in thinking about caring work as constrained by bureaucratic entities. This is apparent in Hochschild's (1983) concept of emotional labor, and also shapes scholarship that argues that care workers are held "prisoner" to their compassion (Folbre 2001). In these approaches, care workers are thought to be controlled, exploited, and dehumanized by the organizations that employ them, but find themselves trapped because of their internal motivate to care for others. Most extant research does not currently account for the complexities of day-to-day experiences of care workers—who experience constraint on action because of bureaucratic regulations, and who sometimes feel imprisoned by their compassion—but, who also frequently feel high levels of work satisfaction and a sense of meaning coming from helping others (Abel and Nelson 1990; England 2005; Grant, Morales and Sallaz 2009).

Methodologically, understandings of caring labor have suffered because little work has integrated macro- and micro- approaches. One set of studies of caring labor has been at the macro-level, studying care organizations (Scott et al. 2000), or the care

system as a whole (Duffy 2011; Glenn 2010), using historical or quantitative data. Conversely, another set of studies remains at the most micro-levels of care workers' internal states (Stacey 2011), psychological health (Diefendorff et al. 2011), and their interactions with others (Erickson and Grove 2007), focusing mostly on experimental, psychological, or qualitative data collection strategies. This gap between levels is especially apparent in studies of emotional labor, leading to very little consensus on the actual harm involved in exchanging emotional expressions as part of work. Few studies have tied these levels together, leaving out critical analysis of the ways that organizations and meso-level entities affect micro-experiences.

This dissertation bridges these theoretical and methodological gaps by studying hospice workers, a type of end-of-life care worker, from a mixed methodological approach. I have gathered data on the daily work experiences of hospice workers through ethnographic, interview, and survey methods. Additionally, I analyze these data using both micro-interactionist theories as well as institutional theories, blending these perspectives to better account for hospice workers' experiences, and refining the concept of emotional labor.

### Summary of Related Literatures

Early studies of caring labor primarily took place in hospitals, or other large institutions. From these, scholars emphasized the controlling aspects of 'total institutions' (Goffman 1961), focusing mostly on the ways that staff treated inhabitants.

Through the total institution, patients were depersonalized and treated as something to be controlled (see Chambliss 1996 for more recent example). However, Goffman (1961) also emphasized that care workers engaged in ritualized interactions that sometimes allowed patients to have a sacred self. Most of these early studies treat care workers as absolutely constrained by the institution, offering a uni-dimensional account of care workers' motivations and decisions.

Scholars then began to think about medical care as a type of work, developing sociological perspectives on the medical profession through these studies. Freidson (1970) was among the first to theorize what it meant to call medicine a profession. He showed how professional status was socially constructed through the everyday tasks and interactions of physicians and other care providers. Abbott (1988) used medicine as one case to understand how professional boundaries are established and defended as actors vie for jurisdiction over care tasks. Additionally, scholars within the negotiated order perspective emphasized that workers within these kinds of settings were not completely controlled by organizational rules or procedures; in fact, their workplace interactions involved a good deal of negotiation over meanings within the setting (Becker 1976; Fine 1984; Strauss et al. 1963). These studies gave more agency to healthcare workers, but largely focused on physicians, ignoring other care workers, who have subsequently grown in number and are crucial for keeping the modern-day healthcare system operating.

Researchers have recently integrated the study of emotions into understandings of caring labor by showing how emotional control was learned through professional socialization. For instance, aspiring physicians learn detachment through modeling and implicit guidance during medical school (Smith and Kleinman 1989), while those in mortuary science were pushed to undergo “psychological transformation” in order to respond appropriately to dead bodies (Cahill 1999:102). These studies emphasize the returns on mastering appropriate emotional expressions, but do not attend to the liabilities of workplace control over emotions.

Another approach to understanding emotions within care work comes from the emotional labor perspective. Emotional labor includes managing one’s own emotions to keep inappropriate feelings out of the interaction, working to feel what one is expected to feel in that situation, and creating the conditions under which others will emote a particular way (Hochschild 1983). These types of emotional labor helped to keep clients happy and under control. Hochschild’s (1983) original theorizing focused on differentiating surface acting and deep acting. She defines surface acting as “disguising what we feel, of pretending to feel what we do not,” while deep acting makes surface acting unnecessary by “taking over the levers of feeling production, by pretending deeply” and thus altering the self (33). Early studies of emotional labor did not focus on caring work, but subsequent research has often emphasized that emotional labor is an important part of paid care work. It has been especially useful for understanding negative

consequences related to emotions at work, and accounting for inequality within workplaces (Erickson and Grove 2008; Pierce 1999).

This perspective brings in workers' experiences more fully, but still leaves care workers' own interpretations of their work quiet. It often falls into the trap of thinking about workers as prisoners of compassion (Folbre 2001), and ignores more authentic emotional experiences care providers may have with their charges (Foner 1994; Lopez 2006). It also often does not fully theorize the role of partial commodification of care, where workers perform the work because of actual care about patients as well as for economic security (Nelson 1999), or macro-level forces that devalue caring labor (England 2005)—thus not completely accounting for inequality related to caring work.

Recent scholarship has sought to remedy the neglect of authentic emotional experiences by looking at the conditions under which care workers may be able to have fruitful relationships with their charges. Lopez (2006) argued that when organizations provide opportunities for unscripted emotional encounters, instead of prescribing feeling rules and affective requirements, we can conceptualize the work as “organized emotional care” (134), instead of emotional labor. He treats this concept as complementary to emotional labor and shows that care settings can have both simultaneously. Empirical studies of care work settings have provided support for this idea by showing how workers experience both opportunities and constraints on their emotional expressions (Macdonald 2010; Rodriguez 2011; Stacey 2005; Stacey 2011). Grant and colleagues (2009) reorient the study of emotions at work to account for the multiple pathways by which workers

may align their emotional experiences with the dictates of the organization. They propose that the creation of a secular spirituality gives work meaning and can act as an impetus for workers to emote in ways approved by the organization. These studies have refined understanding of work processes, but scholars of emotions argue that studies need to more explicitly integrate emotion processes to fully understand how emotions and work intersect (Grandey 2000; Theodosius 2006; Turner and Stets 2005).

One theme that runs through much of the preceding research is the importance of workers' sense of self. Stacey (2011) argued that many home health aides in her study constructed a "caring self" through their work, and that this identity allowed them to remain committed to the work, even despite low wages and problematic work conditions. Erickson and colleagues have explicitly theorized the role of authentic self, for work as well as other social processes (Erickson 1995; Erickson and Grove 2007; Erickson and Wharton 1997), finding that a sense of authentic self is positively correlated with positive emotional states. Most recently, Stets (2012) outlined research that shows that positive affect can result from external confirmation of important identities. This research is consistent with what I find in the following dissertation.

However, current research would benefit from merging perspectives that emphasize authenticity, meaning, and positive emotional processes with an appreciation of the institutional and organizational dynamics that still constrain workers (Phillips and Lawrence 2012). Actors are embedded in contexts, which shape and are shaped by interactions, especially through defining boundaries (Lawrence 2004), creating meanings

(Powell and Colyvas 2008), and locating actions within organizational regulations (Hallett 2010). These contexts are a product of structural constraints as well as institutional logics. Institutional logics are cultural phenomena that influence society not just through structure, but also provide “symbolic systems, ways of ordering reality, and thereby [render the] experience of time and space meaningful” (Friedland and Alford 1991:243). Institutional logics include both material and symbolic aspects, including assumptions about the world, values, principles, beliefs, and routinized practices, which “condition actors’ choices for sense-making, the vocabulary they use to motivate action, and their sense of self and identity” (Thornton, Ocasio and Lounsbury 2012:2). These logics (as discussed in chapter V) lead to workplace inequality, power imbalances, and institutional change—all of which provide the context under which workers attempt to find meaning, establish identities, and provide quality care.

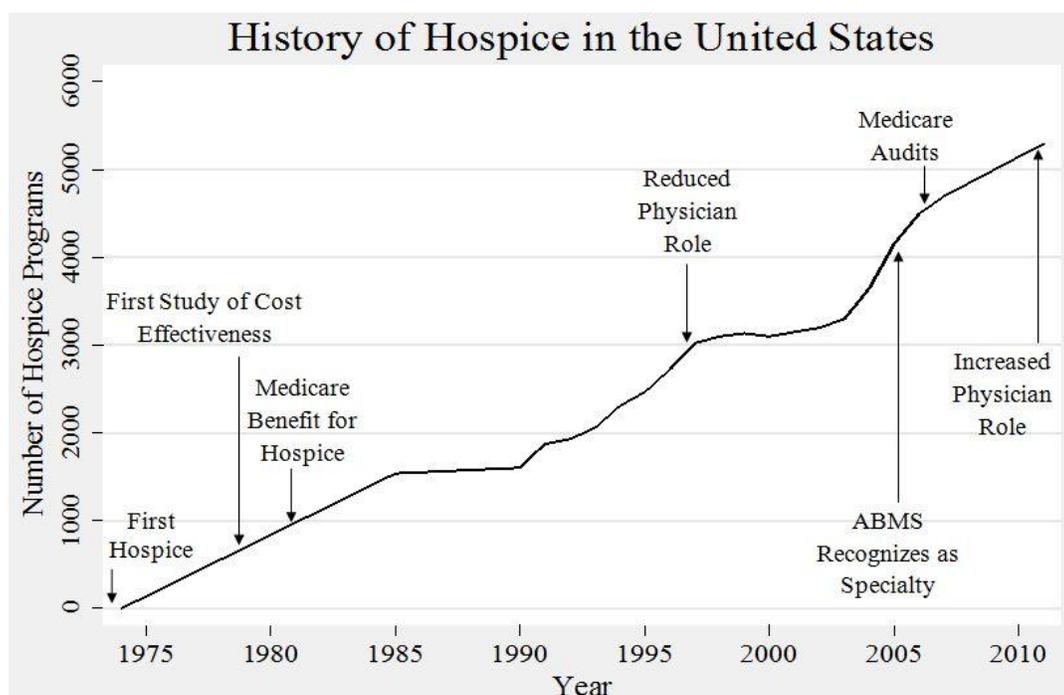
### The Case of Hospice

Hospice is an ideal case to research emotions, emotional labor, workers’ sense of self, and organizational and institutional constraints. Each chapter will outline specific features of hospice that make it appropriate for this kind of study, but the following brief history of hospice will orient the larger study.

Hospice is an end-of-life care option that emphasizes quality of life over quantity of life. It emphasizes the need for acceptance of death, treatment and assistance to the family as well as the patient, and comfort at the end stages of life. Supporters of this

philosophy seek to provide a “good death” to patients. A “good death” is one with dignity, peace, acceptance, and the control of pain (Hart, Sainsbury and Short 1998). Elisabeth Kübler-Ross, an American psychiatrist and doctor, brought the ideals of the “good death” to wide audiences with her highly influential book *On Death and Dying* (1969). Hospice, as the manifestation of this philosophy, came to the U.S. in the early 1970s. Figure 1 shows the growth of hospice since that time and identifies several key moments in the development of hospice.

Figure 1



Source: National Hospice and Palliative Care Organization (2012a), “About Hospice and Palliative Care”

Founded in 1974, the first American hospice was started by a small group of medical practitioners and one chaplain who were dissatisfied with the medicalization of death (NHPCO 2012a). Shortly after arriving in the U.S., it was discovered that hospice care was less expensive than allowing the terminally ill to decline and eventually die in hospitals. As of 1982 hospice services have been covered under Medicare for anyone that is expected, given the normal course of their disease, to die within six months and agrees to forgo curative treatment. Once Medicare allowed payment for hospice services, they quickly became the most influential force in determining the structure of hospice care. In fact, one study claims that because of Medicare's restrictions and guidelines, diversity in the ways that hospices are organized has drastically decreased over time (Paradis and Cummings 1986). Although hospice began as a critical reaction to more conventional kinds of end-of-life care, Medicare's support legitimated hospice as a type of care, bringing up hospice enrollments, but also possibly blunting the alternative approaches that were so important to the founders.

Hospices grew steadily from 1982 to 1997, each hospice organization working within the loose guidelines put forward by Medicare. In 1997, however, the Balanced Budget Act redefined the role of physicians in hospice. Whereas previous to this period there were few restrictions on what physicians could be compensated for doing, this act removed physicians from the core services of hospice and reemphasized hospices' commitment to complementary treatments. This development reinforced nurses'

authority over medical aspects of care, while also symbolically giving support to non-medical types of interventions.

Less than ten years later, however, that trend was reversed. In 2006, the American Board of Medical Specialties began recognizing hospice and palliative care as a specialty. This meant the many hospices felt a need to have a specialized physician as a medical director. Data collection for this project began just after the 2006 decision. While studies have not yet determined the long-term impact of this change, hospice workers in my study were ambivalent. On one hand, some workers thought the emphasis on physician services would improve care by making it more scientific, and that eventually it might lead to more social acceptance of hospice because it is seen as legitimate. On the other hand, many nurses were concerned about their decreased autonomy, and some were concerned that bringing physicians in would cost more money and increase financial pressures on hospice organizations.

In addition to this change, my data collection period (2007-2011) included three other important developments. First, starting in 2007, Medicare began auditing hospices suspected of enrolling patients who were not qualified for hospice services. The hospices in my study reacted to the threat of these audits by changing their enrollment and assessment process, and by removing patients from services if their health improved. Additionally, in 2011 Medicare further solidified the role of the physician by requiring that any patient enrolled in hospice for more than 180 days to see the physician before continuing care. Many hospices scrambled to find funding to pay doctors for their

increased role, some of them emphasizing marketing more to increase enrollments.

Finally, hospices continued to grow during this period, with over 5,300 hospice establishments in the U.S. in 2011. Increased need for hospice, as well as changes in the structure of hospice, provide a background to understand the structural and organizational constraints on workers within this study. Additionally, because there was a great deal of change during my study period, workers were often willing and able to explicitly articulate the challenges of their work.

The geographic location (Arizona) of the study also offers two advantages for a study of end-of-life care. First, Arizona has long been a retirement location, so the proportion of the population in need of end-of-life care is higher here than other parts of the country (Hogan and Steinnes 1998; Rogerson 1996). This is an advantage because it means that hospices are both prevalent and varied in Arizona (Connor et al. 2007). I capitalized on this through my multi-layered sampling procedure, which allowed me to document variation as well as similarities in the organization of hospice care. Second, Arizona, like many states during this time period, faced serious cutbacks on funding for social services and Medicaid (Altheide and Johnson 2011). This largely did not directly affect funding for hospice as the vast majority of hospice payments come from Medicare, which is federally funded. However, cuts to Arizona Health Care Cost Containment System (AHCCCS), which is Arizona's Medicaid program, may have increased the needs of hospice patients who were dual eligible for Medicare and Medicaid. This makes

Arizona an important site for studying the interplay between types of funding, needs of care recipients, and workers' experiences.

### Mixed Methodological Approach

Because this study combines theoretical approaches, and bridges levels of social analysis, a mixed methodological approach is most appropriate. Additionally, combining methods allowed triangulation (Flick 1992), comparison across settings (Maxwell 1998; Pearce 2002), and constant validity checks on emerging ideas. I briefly outline each method below, but more detailed descriptions are included in each chapter.

The first phase of the study included ethnographic observation at a hospice I call Rose Hospice (pseudonym). I entered Rose Hospice as a volunteer, providing a "side-in" approach to hospice, overcoming some of the access issues prevalent in medical research (Chambliss 1996). My observations included extensive training to become a volunteer; weekly meetings with the hospice interdisciplinary team, which included medical directors, nurses, social workers, counselors, chaplains, and administrators; patient care observations at an in-patient unit at Rose Hospice; and, observation in the homes of patients, while accompanying workers on their routes. Through these experiences I gained a great deal of knowledge about the daily lives of hospice workers and the kinds of things that they found valuable and difficult about their work.

From the ethnographic portion, I became interested in the ways that hospice workers' experiences did not fit Hochschild's (1983) definition of emotional labor.

Based on my observational data and my knowledge of the literature on emotional labor, I designed a semi-structured interview schedule and administered it to 41 hospice workers in the southwestern United States. Interview questions asked about workers' work history, satisfaction with hospice work, relationships with colleagues, emotional experiences at work, experiences of hiding emotions, balancing work and family life, religious beliefs, and ideas about death and dying. Interview participants came from all patient-facing positions in hospice and several hospice administrators.

From the analysis of these two forms of qualitative data, I also developed a 133-item survey of hospice workers in Arizona. The survey asked about work satisfaction, experiences with emotional labor, relationships with colleagues, and demographic questions. Many questions came from existing studies (Erickson and Ritter 2001; Harris 1989; Lazarus 1993), while others emerged during earlier stages of the research. I pretested the questions with interview respondents and one focus group, refining the instrument through their comments and questions. I administered the survey to the populations of five hospice organizations, achieving an 83% response rate through visiting team meetings. The final sample size is 165, with representation of all positions within hospice.

### Summary of Findings

Each chapter of this dissertation discusses a different aspect of hospice work. In the first chapter, I show how hospice workers' presentations of self vary between the

front and backstages of hospice. Front stage behaviors emphasize compassion, while backstage behaviors include dark humor, strategizing, and detachment. While these performances often contradict one another, hospice workers see both presentations of self as a reflection of their true, authentic hospice self. Workers constructed a hospice identity that allowed them to account for discrepancies in behavior and deal with emotional labor aspects of the job. This work challenges assumptions that fronts are only performances and that back regions are more authentic by showing how workers integrate the two into a professional sense of self.

The second chapter problematizes hospice workers' assumptions that team-based care is democratic, equalizing power across the interdisciplinary team. I show how even within a team that emphasizes interprofessional collaboration, institutional logics within the setting give medical workers more authority than social support workers. I find that conflicts in logics often produce unintended consequences: further marginalization of the most precariously situated workers (social support workers), and a reinscription of the dominance of medical institutional logics. By focusing on interaction-level consequences of conflicting institutional logics, this paper offers an alternative way to conceptualize the micro-foundations of localized social inequality and organizational isomorphism.

The final chapter tests whether emotional labor, as defined by extant literature, is influential in the work lives of hospice workers. I find that hospice includes four different types of work that might be considered emotional labor, but that only one produces the negative work outcomes predicted by Hochschild (1983). Emotional labor

with patients and their family members does not increase hospice workers' turnover intention, while experiences with hiding one's own emotions, and feeling helpless do significantly increase intention to leave. Furthermore, patient-facing workers had many authentic emotional experiences that balanced out the stress of emotional labor.

Administrative workers, because they did not have regular interactions with patients, were more susceptible than their patient-facing colleagues to the problems of emotional labor. Using these findings, I refine the emotional labor concept to explicitly account for emotion self-management, show how emotional labor is divided among workers, and link these results to hospice workers' generally high levels of work satisfaction.

Taking these chapters in conjunction, this dissertation provides evidence of two central tensions in the administration of hospice care. The first tension is between hospice workers' commitment to their work and organizational changes that make this commitment difficult to sustain. This tension is most explicitly illustrated in Chapter V where I explore some of the problems with team dynamics, especially during a time of financial constraints. Changes in the organization of hospice work—especially due to changes in Medicare requirements—threaten to reduce the amount of time hospice workers have to make meaningful emotional connections with their charges. Much to their frustration, hospice workers now spend more time than ever on administrative work, documentation, and meetings. These structural changes impose constraints that workers have, thus far, responded to in individualistic ways.

The second tension is between workers' own self-care needs and their work of tending to the needs of others. Frequently the behaviors thought to best support patients are in direct contradiction to the behaviors that workers claim are necessary for maintaining healthy distance. For instance, many hospice nurses report that even when are on vacation or otherwise not on duty, they request that their co-workers call them if the health of a patient changes. On one hand, this request assured that patients had consistent, involved care. On the other hand, many hospice staff made it clear that time away from work was essential to keeping up the emotional energy necessary for the work. Many nurses were reluctant to take that time away. The needs of the patients were held in tension with the workers' needs for breaks. This tension is illustrated Chapter IV through showing the balance between front- and backstage presentations of self.

Both of these tensions also emerge in Chapter VI where I compare emotional labor and emotional experiences (separate from emotional labor) across positions, and test their effect on turnover intention. Continued change to hospice organizations will likely increase turnover as they reduce the most worthwhile aspects of the work and impose new administrative tasks. This trend makes it difficult for workers to continue to find meaning in their work and reduces opportunities to balance their own needs with the needs of those they serve.

In addition to refining knowledge about caring work, this dissertation has practical value. The findings reported here show aspects of caring work that workers perceive as worthwhile and rewarding, as well as those that make it difficult to sustain

commitment to the work. In particular, it shows that relationships with care recipients are crucial, but that insecurity in hospice organizations challenges those relationships. By focusing on these tensions in the administrative care, this dissertation may be useful for revising organizational policy, especially during healthcare reform efforts.

## CHAPTER II: INTEGRATING DARK HUMOR AND COMPASSION

The methods, results, and conclusions of this study are presented in the paper appended to this dissertation (Appendix B). The following is a summary of the most important findings in this document. In *The Presentation of Self in Everyday Life*, Goffman (1959) drew attention to the various ways that individuals present themselves across settings. One aspect of his discussion was the division of space into front and back regions. In this paper I use data from two years of participant observation and forty-one interviews with hospice workers to examine the ways that workers identify as well as how they use those identities to account for discrepancies between front and back region behaviors. Front stage behaviors emphasize compassion, while backstage behaviors include dark humor, strategizing, and detachment. This article argues that workers create a hospice identity that emphasizes authentic emotional expression and enlightenment about death as a way to explain away discrepancies in behavior. This work challenges assumptions that fronts are only performances and that back regions are more authentic by showing how workers integrate the two into a professional sense of self.

CHAPTER III:  
CONSEQUENCES OF CONFLICTING INSTITUTIONAL LOGICS

Inequality and institutional isomorphism are each products of complex structural and cultural processes. Many studies, especially of isomorphism, come from a macro- or meso- level perspective. But how do institutional logics, as instantiated in micro-level interactions, matter for these processes? In this paper, I propose that localized social inequality and institutional isomorphism are both byproducts of conflicts between institutional logics. I use the case of hospice, a type of end-of-life care, to show how these conflicts between logics result in workplace negotiations over how to divide labor. Observing these negotiations, especially during times of organizational strain, allows analysis of how these negotiations reproduce and challenge the extant social order.

In the hospice setting, I conceptualize negotiations as a product of three conflicting institutional logics: a medical logic that prioritizes physical bodies of patients; a holistic care logic, which augments the medical logic by defining patient needs as also social, psychological, and spiritual; and a business logic that seeks to make hospice work profitable. Although these logics do not always conflict with one another, the concrete work situations in which these logics do conflict result in hospice staff members explicitly negotiating how to divide tasks. These interaction-level negotiations frequently prioritize medical concerns, thus reinforcing the dominance of the medical logic within hospice, while also reproducing precarious work situations for social support workers,

like social workers, counselors, and chaplains. Taken in the aggregate, these interaction-level consequences marginalize social support workers (localized social inequality), and push hospice organizations to act like conventional medicine (organizational isomorphism).

Using these findings, I propose an alternative way to conceptualize the role of institutional logics in both social inequality and organizational isomorphism: when institutional logics conflict and the most legitimate logic is given priority, disadvantaged actors will be further disadvantaged and organizational practices will move closer to others in the field. Bringing institutional logics into conversation with extant understandings of these complex social processes allows a more nuanced representation of actors' own experiences.

### Theory and Literature

The tendency of organizations to become more similar to one another over time has been explained using neo-institutional theories, which focus on how organizations operate within fields of competing and complementary others. Through their attempts to gain legitimacy, organizations come to adopt the practices of others like them (DiMaggio and Powell 1983; Meyer and Rowan 1977; Powell and DiMaggio 1991). These theories have been useful for advancing understanding of organizational stability and homogeneity, but have been critiqued for failing to understand individual actors within their social context (Friedland and Alford 1991; Thornton, Ocasio and Lounsbury 2012),

ignoring agency of individuals (DiMaggio 1988), empirically disregarding the micro-level (Hallett 2010), and focusing too little on change and variability in institutional practices (Greenwood and Hinings 1996). By limiting analyses to the levels of organizations or fields, we miss an opportunity to assess how micro-politics also support and/or challenge institutional change.

The institutional logics perspective (ILP) seeks to reorient the study of institutions and organizations by focusing on agency as well as structure, and by explicitly linking micro- and macro-level processes (Thornton, Ocasio and Lounsbury 2012). ILP acknowledges that institutions influence society not just through structure, but they also provide “symbolic systems, ways of ordering reality, and thereby [render the] experience of time and space meaningful” (Friedland and Alford 1991:243). Institutional logics include both material and symbolic aspects, including assumptions about the world, values, principles, beliefs, and routinized practices, which “condition actors’ choices for sense-making, the vocabulary they use to motivate action, and their sense of self and identity” (Thornton, Ocasio and Lounsbury 2012:2). While many studies of institutional logics focus on organizational leaders and the logics they use (see for example Misangyi, Weaver and Elms 2008; Reay and Hinings 2009; Thornton and Ocasio 1999), actors in subordinate positions also use logics to organize and justify their actions.

Institutional logics can be seen in actors’ daily practices, such as how they divide labor (Troyer 2004), make decisions as individuals and in groups (Ocasio 1997), classify persons and objects in their environment (DiMaggio 1997; Douglas 1986; Thornton

2004), and form attitudes about pertinent issues (Larsen 2006). Institutional logics manifest in institutional carriers like roles and relationships among participants, routines, and physical artifacts (Scott 2008). Most relevant for this study, institutional logics also give some actors authority over others as well as assign priority to some tasks over others.

Within any setting, multiple logics may exist, and social change happens primarily through the manipulation and exploitation of these multiple logics (Friedland and Alford 1991). Most empirical studies of institutional logics conclude that settings with conflicting institutional logics experience contested meaning, disputes amongst actors, and ambiguity about appropriate lines of action (Styhre 2011). Analysts often think that when multiple logics exist they will compete and one will “win” over the other (Goodrick 2002; Lounsbury 2002; Lounsbury 2007; Lounsbury and Rao 2004). Others contend that logics can and do coexist aside one another (Goodrick and Reay 2011; Marquis and Lounsbury 2007; Reay and Hinings 2009), even as they produce conflicting demands (D'Aunno, Sutton and Price 1991). Coexisting logics sometimes support one another, but other times are held in “productive tension” with one another (Murray 2010). Additionally, the level of compatibility of logics can change over time as other contextual changes take place (Greenwood et al. 2011). What these studies often leave implicit is how competing institutional logics affect micro-level processes and the lives of individual actors.

### Micro-Level Links to Institutional Logics

The above studies have helped to advance theory about how institutional logics inform macro-level practices and meanings, but as of yet, little attention has been paid to how competing institutional logics influence micro-politics within the workplace. In fact, Goodrick and Reay (2011) state, “Although most institutional scholars recognize that multiple logics coexist... they have so far given little direct attention to ongoing situations where professionals (or any other single actor) are affected by coexisting multiple logics” (373). This paper rectifies this oversight by focusing on the ways that various constellations of logics within hospice influence actors as they use medical, holistic, and business logics in negotiations over the division of labor, and how those negotiations challenge and reproduce the existing organizational order.

Actors come to interactions embedded within their occupational roles. By bringing an “inhabited” perspective to the study of institutional logics (Hallett 2010; Hallett and Ventresca 2006), I conceptualize roles as providing ‘partial autonomy’ to actors (Thornton, Ocasio and Lounsbury 2012), in that roles constrain their options, but do not determine how actors will use logics (Lawrence, Suddaby and Leca 2009). Workers use their partial autonomy to negotiate work, but workplace roles produce patterned consequences of these negotiations (Fine 1984; Strauss 1978), allowing an analysis of the cumulative effect of micro-interactions like dividing tasks. This perspective also furthers understanding of the ways that actors adopt meanings within the setting (Grant, Morales and Sallaz 2009). Whereas many of these interactions are a

taken-for-granted part of the organizational culture, some of these negotiations over the division of labor involve conflict. For instance, Abbott (1988) suggests that different groups jockey for jurisdiction and authority over types of work. Training, expertise, and credentialing are tools in these disputes over jurisdiction (Abbott 1988; Abbott 1991; Guttman and Lingard 2010), and are unequally distributed across groups of workers within a setting. These tensions within negotiations may marginalize some workers.

Workers who are already precariously situated may be especially at risk for marginalization during negotiations over the division of labor. Kalleberg (2009) outlines precarious work as “employment that is uncertain, unpredictable, and risky from the point of view of the worker” (2). Within a single workplace, the level of precarity of the work varies. Some workers experience high levels of uncertainty and unpredictability in their work, while others have relative security in their positions. This process reinforces existing inequalities within the workplace in that institutional logics are used in establishing and justifying status hierarchy amongst actors, with the most prestige going to members of groups who use common understandings to justify their position (Zhou 2005). The next section will briefly outline the history of hospice and discuss the qualities that make it useful for this type of analysis.

### The Case of Hospice

Hospice is an end-of-life care option that emphasizes the need for acceptance of death, assistance to the family as well as patients, quality of life over quantity of life, and

comfort at the end stages of life (NHPCO 2012b). Hospices try to improve end-of-life experiences by focusing on dignity, peace, and control (Hart, Sainsbury and Short 1998), and providing: “expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient’s needs and wishes” (NHPCO 2012b:3). Currently, there are approximately 5,300 hospice programs in the United States, serving 1.65 million patients in 2011, providing support during almost 45 percent of the American deaths that year (NHPCO 2012b). The number of hospice organizations has grown in recent years, and the expected need for these services will only increase over the next few decades (Stevenson 2012). An historical overview of hospice in the United States reveals several qualities that make hospice a useful case for an analysis of conflicting institutional logics.

Arriving in the United States in the 1970s, early hospices were formed as an alternative to conventional medicine, which was seen as too focused on the body, too alienating, and too cold to meet complex needs at the end of life (Paradis and Cummings 1986). These early hospice programs were entirely volunteer-based and provided the majority of care in the homes of patients. Hospice has changed a great deal since then, especially once Medicare began compensating for hospice services in 1982 (Paradis and Cummings 1986). While this change in funding contributed to the institutionalization of hospice as a type of care (e.g. bureaucratic structures, answering to regulatory agencies, and emphasizing documentation and compliance), hospice still maintains some anti-institutional characteristics, especially in its emphasis on team approaches to care

(Parker-Oliver, Bronstein and Kurzejeski 2005). In fact, given the mix of institutional and anti-institutional characteristics, hospice settings are riddled with situations wherein institutional logics conflict and actors must negotiate multiple demands.

Partly a holdover from early hospice organization, contemporary hospices typically have a flat organizational hierarchy (James and Field 1992). Most managers and administrators are trained nurses promoted from within, and the best managers are often described as giving staff a great deal of autonomy (Cain 2011), wherein all members are thought to have valuable expertise, regardless of training or credentials (NHPCO 2012b). Researching an autonomous team care setting is especially apt for developing knowledge about interaction-level consequences of conflicting institutional logics. Teams are often very close, regularly forming a unique micro social order, which shapes work practices, identities, and orientations (Lawler, Thye and Yoon 2008). While these micro social orders can be supportive to workers, other studies of interdisciplinary teams have found that role blurring and boundary maintenance activities are also common (Brown, Crawford and Darongkamas 2000), thus providing opportunity for conflict.

Additionally, team-based care requires workers to perform emotional labor with one another, as well as patients. Emotional labor includes managing one's own emotions to keep inappropriate feelings out of the interaction, working to feel what one is expected to feel in that situation, and creating the conditions under which others will emote a particular way (Hochschild 1983). Studies have highlighted that emotional labor can be

exhausting (Erickson and Grove 2008; Pugliesi 1999; Steinberg and Figart 1999), lead to worker burnout (Erickson and Ritter 2001; Masterson-Allen et al. 1985), make work/family balance difficult (Wharton 1999), and sometimes result in worker dissatisfaction (Pugliesi 1999). The use of teams, and the resulting emotional labor, makes interactions between hospice workers especially fruitful places to observe the effects of conflicting institutional logics.

The variability of end-of-life needs and commitment to working as a team often combine to produce many tasks that fall outside of the purview of organizationally defined job descriptions. In this paper I compare the work of medical workers (nurses and physicians) to the work of social support workers (social workers, counselors, chaplains).<sup>1</sup> While hospice team members are expected to work in cooperation with one another, some turf battles do occasionally take place (DeLoach 2003). Studies from other healthcare settings inform this analysis. Nurses in hospital settings deal with uncertain tasks by defending professional boundaries between their work and the work of physicians and attendants (Allen 2000). Caring laborers who work in the homes of others work within societal assumptions that they are little more than maids, attendants, or extensions of women's natural abilities for caring (Duffy 2011). Social workers in hospice frequently feel that they do not have a unique set of responsibilities, and are lacking a distinct workplace identity (MacDonald 1991). These factors combine to

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<sup>1</sup> This paper focuses on the interactions between these two dominant groups, though many of the findings could be extended to discuss the marginalization and exclusion of personal care providers as well. Future work will focus explicitly on that group.

produce work that is poorly defined, and must be negotiated at the level of workplace interactions. These negotiations draw on institutional logics to provide guidance on how to prioritize and assign care tasks.

Finally, hospice organizations have great diversity in the extent to which staff are precariously situated. Some workers experience relative security in their work and do not frequently worry about losing their job. In particular, nurses' skills and training are so much in demand that their job security is very high (BLS 2012). Meanwhile others, especially social support workers, are in a perpetual state of concern about keeping their jobs (Landsbergis 1988). In the case of hospice, the more educated workers (e.g. social support staff, all of which have M.A.-level degrees), are more precariously situated than nurses, most of whom have only completed associate degrees in nursing. Analysis of interactions between workers with high and low levels of precarity within a single workplace—especially during team negotiations over the division of labor—demonstrates how conflicts between logics can reproduce existing social inequalities.

### Medical, Holistic, and Business Logics

In this paper, I conceptualize hospice as setting informed by a mix of three institutional logics: medical, holistic care, and business logics. Although these three logics are likely present in most healthcare settings, recent reforms and concerns over profitability (Iglehart 2009) make hospice a particularly useful case for understanding the consequences of conflicting logics, as incompatibilities are more readily observable to

both participants and researchers during times of strain. This paper treats each set of institutional logics as an ideal type. Specifically, the manifestation of the logics in the setting may not be identical to the descriptions below, especially because most workers will align themselves with different logics as they suit their identities and philosophies about care. However, by treating the logics as ideal types, I can use extant studies as scaffoldings upon which to build knowledge of this case. Table 1 provides a summary of the logics.

Although hospice was formed as an alternative to conventional medicine, logics stemming from conventional medical practices still enter into the daily lives of hospice workers through the prioritization of tasks and authority given to different actors. The medical logic emphasizes scientific developments (Dunn and Jones 2010), commitment to long hours as part of a commitment to patients (Kellogg 2009), and the importance of diagnosing, explaining, and treating the physical bodies of patients (Rosenberg 2007). Specialization and emphasis on technical advancement are also important to medical logics (Bloom 1988; Scott et al. 2000).

Table 1: Summary of Logics, with Job Descriptions

	Authority	Priority	Example
Medical	Nurses and Physicians	Physical body of patients	Nurses act as case managers, who must “manage other members of the team;” “make routine supervisory visits of and with all other team members at least monthly;” and maintains “primary control and professional management of each patient and acts as primary liaison between physician, patient/family and hospice.” These responsibilities make it clear that nurses oversee patients as well as their co-workers, including social workers, chaplains, and certified nursing aides. Because nurses are given this authority, problems related to the physical bodies of patients are often given priority over non-physical problems.
Holistic	Social Workers, Counselors, and Chaplains	Social, emotional, spiritual, or family concerns	Social Workers, Counselors, and Chaplains “actively participate in the coordination of all aspects of the patient’s hospice care, in accordance with professional standards and practice, including participation in ongoing interdisciplinary comprehensive assessment, developing and evaluating the plan of care, and contributing to patient and family counseling and education.” While the job description for nurses is very specific as to tasks assigned, the responsibilities of the social support team are vague and are not differentiated by role (e.g. Social Workers vs. Counselors vs. Chaplains). In effect, the holistic logic is demonstrated by an openness to completing any task that is defined as part of the patient’s hospice care.
Business	Administrators	Cost effectiveness of care	Patients sometimes need constant monitoring, especially while in the inpatient unit. Because of this need, all Rose Hospice job descriptions included the following statement: “Performs other duties as deemed necessary by the immediate supervisor, including but not limited to providing ‘sitter’ services to wandering patients in the inpatient setting.” By including this statement in extant descriptions, hospice administrators are able to assign this task to nurses, social workers, or chaplains, instead of hiring additional staff.

As shown in Table 1, physicians and nurses in hospice are expected to keep up on advances in their specialty areas, while also overseeing the care provided by other members of the hospice team. This combination of professional knowledge and oversight gives physicians and nurses the most authority under the medical logic. Additionally, under medical logics, care is defined as tending to the physical symptoms of disease, but frequently overlooks underlying conditions and non-physical needs. It is important to note that although physicians and nurses are given authority under the medical logic, the organization of their job descriptions is open-ended (Chambliss 1996), providing ample opportunities for these staff members' responsibilities to bleed into other job descriptions, and signaling that they are subject to competing logics in the setting.

The holistic care logic, which also informs hospice practices, is often seen as an affront to science, as it focuses on understanding complex, individual patient needs and better identifying gaps in conventional medicine (Patterson 1998; Rosenberg 2007). Historically, studies have emphasized that nurses are more attuned to holistic care than physicians, who are more influenced by the conventional medical logic (Rosenberg 2007). However, as nursing has become more professionalized, the holistic aspects of their work are often relegated to the margins (D'Antonio 2010), even as caring remains an important aspect of their identities (Cain 2012b). Additionally, in hospice, nurses are the primary providers of medical care as physicians currently serve as consultants, rarely visiting patients and spending most of their hospice hours in meetings with nurses and other staff members. Consequently, holistic tasks— especially related to seeking

acceptance of death, exploring spirituality, trying alternative therapies, and treating psychosocial problems— are officially assigned to the social support team, consisting of social workers, counselors, and chaplains.<sup>2</sup> This logic prioritizes the patient (and their family) as a whole unit, with needs beyond their physical bodies, and often assigns authority and expertise to non-medical staff, who expect to take on a diversity of undefined tasks as part of this commitment, as seen in Table 1.

Finally, hospices are increasingly informed by a business success logic. Healthcare organizations, of all sorts, have become more concerned with containing costs and making money, especially with the growth of managed care (Scott et al. 2000) and corporate control of healthcare organizations (Mahar 2006). Like in hospitals, the increased emphasis on making money means that healthcare professionals are pushed to develop managerial skills in addition to their health-related training (Witman et al. 2011). Under this logic, workers are expected to follow bureaucratic procedures (Jackall 1988) and corporate rules, often coming at a sacrifice to meaningful emotional experiences with patients (Rodriquez 2011). Authority is given to administrators and managers who bureaucratically oversee costs of care by redefining work tasks to fit within fewer job descriptions. The priority of the business logic is to keep costs of care down, often meaning that staff are asked to do more, as shown in the delegation of “sitter” services described in Table 1. This kind of logic has been emphasized in prior research on

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<sup>2</sup> While nurses do sometimes also perform these non-medical tasks, these responsibilities are defined as social support tasks through the official job descriptions of Rose Hospice.

conflicting institutional logics (Reay and Hinings 2009; Thornton 2004; Thornton and Ocasio 1999), but because this research focused primarily on executives and administrators, it may have overestimated the extent to which this logic enters into subordinates' everyday work experiences.

Even though the goals of these three logics are sometimes consistent with one another, they take different paths to justifying and achieving these goals. Logics compete with one another to assign and legitimate meaning. For instance, even though both medical and business logics seem to reflect an instrumental rationality that results in patients being reduced to objects, the two logics take different paths this objectification. Medical logics prioritize the body and see agentic behaviors as barriers to care, while business logics see individual needs as inputs, profits, or losses. Sometimes the two work in conjunction to construct a modern medical system that reduces patients to objects, but other times the two compete for dominance in defining the situation. While it is important to note how the logics work together to produce outcomes like objectification of patients, the focus of this paper is on the ways that conflicting logics enter into the daily practices of hospice workers, reinforcing social inequality in the workplace, while also contributing to isomorphic shifts in the organization of hospice work.

The process by which some institutional logics win out, or are prioritized over others, reflects wider ideas about legitimacy in the setting. This paper conceptualizes legitimacy as a claim that is accepted by others (Johnson, Dowd and Ridgeway 2006; Zhou 2005). However, the pursuit of legitimacy is not without conflict: "legitimacy

processes [are] both cause and effect of institutional politics within organizations, between organizations, and between organizations and other societal actors operating in the same organizational field” (Stryker 2000:188). Competition between institutional logics can create the conditions under which differing forms of legitimacy struggle to become dominant. After becoming dominant, however, legitimacy reproduces itself, in part, through reframing the logics that are used in future interactions over task division. These struggles are implicated in the work situations of the hospice personnel I studied, especially through the prioritization of medical logics in the allocation of tasks.

#### Methods, Setting, and Sample

Because workers are frequently resistant to reporting the ways that they are disadvantaged at work, this study uses longitudinal ethnographic and semi-structured interviews to examine the actual practices of hospice care as well as the ways workers talk about their responsibilities and their working relationships with one another. Using mixed qualitative methods also allows me to bring work practices in conversation with organizational theories, refining knowledge of each (Barley and Kunda 2001).

Ultimately, I propose a model under which conflicting institutional logics produce interactions that unintentionally reproduce existing localized social inequality as well as encourage organizational isomorphism.

Ethnographic data collection for this project began in 2007 when I became a hospice volunteer at a mid-sized hospice (typically about 100 patients enrolled and

between 45 and 65 staff employed full or part time), called Rose Hospice, in the southwestern United States. Volunteer training included 35 hours of group training, an interview, and several written examinations. From my first meeting with the volunteer coordinator I was overt about my status as a researcher. In fact, the volunteer coordinator, here called Robin,<sup>3</sup> became a key informant as the study progressed. Entering as a volunteer permitted a “side-in” approach to access (Chambliss 1996), which helped alleviate some of the feasibility problems of research in medical settings. Entering the hospice in 2007 was fortuitous timing for this project as Medicare admission regulations became more strenuous starting in 2008, causing this particular hospice to change many of its practices and procedures to meet the new requirements. This period of transition offered a unique opportunity to assess how workers deal with conflicts between logics.

As a volunteer and researcher, I attended weekly meetings from February to September of 2010. These meetings were called interdisciplinary group meetings (IDG) and they included all major team members (i.e. Medical Director, Nurses, Social Workers, Chaplains, Counselors, Volunteer Coordinator, and Administrators). Nurses generally directed these meetings by giving updates on a set of patients, asking for more information from other team members, and passing around paperwork. These meetings lasted between 1 and 4 hours depending on how many patients were discussed and the seriousness of patient problems.

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<sup>3</sup> All names of workers and organizations are pseudonyms.

My observation also included time spent with workers, especially social workers and nurses in the inpatient unit (here called the IPU), and volunteer hours in the main office. The IPU is a short-term facility where most patients are either expected to die within days of entering the facility, or come to the unit to give caregivers a break from daily care. I was present, and participated when appropriate, during paperwork and patient visits, and frequently made phone calls to arrange support and check on patients. In total, I spent just over two years observing hospice work for three to ten hours per week, producing hundreds of pages of fieldnotes and over twelve hours of voice memos that synthesized emerging themes and questions.

While observing staff interactions, I took extensive notes on issues discussed, informal interaction rituals, body language, and assignment of tasks and credit. While observing staff in direct care situations, I did not take notes out of respect for the families and patients, but after each visit, the staff typically gave me a few minutes to jot down notes and ask questions, which helped me to compare the workers' categories and meaning systems to those I expected from the literature (Emerson 1987). I recorded audio notes after each meeting to document themes that emerged during the meeting, and to assess my ethnographic data in terms of existing literature related to the division of labor and inequality in the workplace.

Data from observations of the inpatient unit as well as the weekly IDG meetings were supplemented by semi-structured interviews with 41 staff members, collected in 2010-2011. I recruited interviewees first from the ethnographic site, Rose Hospice. I

invited all patient-facing care workers and their supervisors to off-site interviews. Of these, almost all of the nurses (seven out of eight), all of the social support workers (total of six), and all of the supervisors (total of three), and a small sample of certified nursing assistants (six out of approximately 18) and volunteers (three out of approximately 30) agreed to be interviewed.<sup>4</sup> I then expanded the sample of interviewees by asking each of these interviewees to pass along my recruitment information to hospice workers in other organizations. Twenty-five (61%) of the total sample worked at Rose Hospice. The other sixteen respondents (39%) came from six other hospices, and included four additional medical staffers, seven additional social support workers, three administrators, and two certified nursing aides. By interviewing Rose Hospice staff, I was able to compare my observations to their interpretations of common situations. Interviewing those working in other hospices provided a comparison point to determine if the patterns within Rose Hospice were unique. This reliability check leads me to believe that the larger social processes within Rose Hospice are present in other hospices undergoing the same types of pressures. Demographic information for interviewees appears in Table 2.

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<sup>4</sup> The recruitment of certified nursing aides and volunteers was more challenging than other workers as they were rarely present at the hospice office and did not attend team meetings. Although these groups are valuable for a comprehensive description of hospice operations, they are not the focus of this paper, so their low rate of non-response does not limit the utility of this analysis.

Table 2: Interviewee Sample Demographics, N=41

Gender	Age	Time in Hospice	Positions
71% women (29)	17% under 40 (7)	5% less than one year (2)	27% Medical Support Workers (11)
29% men (12)	22% 40-49 (9)	27% 1-5 years (11)	39% Social Support Workers (16)
	34% 50-59 (14)	36% 5-10 years (15)	20% Personal Assistance Workers (8)
	27% 60 or over (11)	32% more than 10 years (13)	14% Administrative Workers (6)
	Range: 21 to 76	Range: Less than one year to 20 years	

Note: Numbers of respondents are shown in parentheses

My sample comprises workers most frequently involved in patient care, including nurses, social workers, counselors, and chaplains. Selecting interviewees this way ensures that I have a diversity of experiences represented, while maintaining a focus on those who are most likely to be implicated in the division of care tasks. However, loosely following institutional ethnographic principles (Smith 2005), I also interviewed their managers, and supervisors, and analyzed documents (like job descriptions) produced by administrators. This allowed me to better capture both what staff do at work, but also how those in positions of power think about how staff should complete the work. Staff members left out of this analysis include marketers and off-site managers. Leaving these groups out likely shifted my data away from market concerns, making my report of the

prevalence of business logics likely an underestimate of how much profit actually mattered in this setting. However, because my focus is on the division of care tasks, the exclusion of marketers and off-site managers does not fundamentally alter my findings.

In the interviews, I asked about staff members' educational background; how they came to work in hospice; their relationships with their colleagues; and, their home and family life. Although I did not explicitly ask about the division of labor, workers frequently told stories that revealed issues in allocating the work of hospice. Interviews lasted between 38 and 87 minutes and were all audio recorded. I also took notes during the interviews about the respondents' non-verbal communications and facial expressions.

The analysis of both ethnographic and interview data was an iterative and abductive process. I identified themes as they emerged within the process of data collection, took extensive notes to document data and elaborate ideas, and refined my conceptual and theoretical ideas as I went along (Charmaz 2006). Following Burawoy's extended case method (1998), this allowed me to better grasp the issues as well as refine my approach as new questions emerged. Because I performed analysis simultaneously to collection, I could identify an issue and then return to the site the next day to further my theoretical insight. I also used an abductive logic: I entered into the setting with expectations about how work would be carried out, but as I discovered problems with my expectations, I worked backwards to explain these observations and develop new theory (Van Maanen, Sorensen and Mitchell 2007). In particular, I entered into this study assuming that the interdisciplinary team approach permitted a more democratic work

process than more hierarchical organizations. Through several poignant interactions, including one where a chaplain implied that nurses were “in charge of this place,” I found that this expectation did not accurately reflect the experiences of social support workers, most of whom did not have a great deal of power within the team. These analytical decisions allow me to offer an account that is true to my empirical data, but also focuses on refining theoretical approaches.<sup>5</sup>

### Conflicting Institutional Logics within Hospice

Throughout this section, I will draw out the consequences of conflicts between medical, holistic care, and business logics for nurses and social support workers, arguing that as actors engaged in negotiations over the division of labor, those negotiations often privileged some aspects of work (medical tasks) over others (social service tasks), which in turn perpetuated existing inequality between workers and reproduced the medical logic within the setting. Ironically, these consequences then made the hospice organizations look more like conventional medicine, leading to isomorphic institutional change (see Figure 2), and influencing logics available to workers in future interactions.

Institutional logics made themselves apparent through discussions over how tasks should be allocated, decisions made by managers and administrators, classifications of

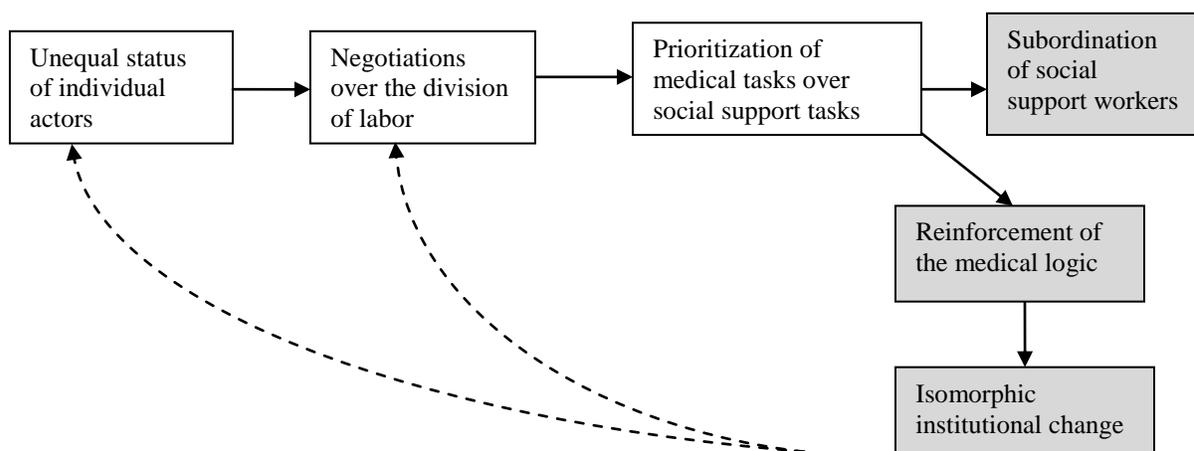
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<sup>5</sup> Although this design does not allow me to completely separate out antecedent causes of inequality among staff from the interactions that reproduce that inequality, changes in the organization of hospice over my observation time suggest that my research design can capture the reciprocal relationship between institutional logics and localized social inequality.

tasks, attitudes about work, roles of staff members, routines, and formal job descriptions. Disputes within hospice were mainly attributable to one of three types of conflicts of medical, holistic, and business success logics, described below.<sup>6</sup> It is also worth noting that while in the aggregate these negotiations produce unintended consequences for workers and the organization as a whole, at the individual level, most hospice workers in this study reported that they thought the hospice team was quite successful at establishing a democratic approach to work. By critically analyzing this claim, this article offers a less optimistic view of teams, while also linking team interactions to institutional forces.

Figure 2: Cross-Level Model of Hospice Logics

Note: Micro-level processes in white boxes; Macro-level processes in grey boxes



<sup>6</sup> Because this paper argues that hospices are informed by three major logics, it is theoretically possible for the logics to intersect in six different ways: medical vs. holistic, medical vs. business, holistic vs. business, medical vs. holistic&business, holistic vs. medical&business, and business vs. medical&holistic. This paper only focuses on three of those intersections (business vs. medical&holistic, holistic vs. medical, and holistic vs. medical&business), as these were the most common logic intersections observed in this setting.

### Money to be Made

When needs of the business conflicted with medical and holistic logics within hospice (business vs. medical/holistic), there were two main consequences. The first was that individual staff members were forced to make choices between giving the highest quality of care—even if it came at a personal financial cost—or follow new restrictions that increased workload and decreased time with patients. In many situations, hospice staff chose to continue providing quality care, even if it broke rules, interfered with their home life, or meant working additional hours without additional pay. The second consequence was that hospice staff members did not evenly absorb the consequences of the conflict between care and money. In particular, the workers who were most likely to take on additional non-patient related tasks (i.e. administrative work, compliance checks, and meetings) were disproportionately the social support staff. These non-patient tasks were described as less desirable, and often reported that they required sacrifices in the amount of time spent with patients, thus decreasing work satisfaction and quality of holistic care provided.

Hospice staff members from *all positions* were committed to high quality care, even when its administration conflicted with supervisors' attempts to save money. Hospice workers came to see this commitment as part of their professional identities (Cain 2012b), and were often quite willing to “go the extra mile” for patients: calling or stopping by during off hours to make sure patients were safe (Nurse and Social Workers),

taking patients on weekend outings (Counselor and Certified Nursing Aides), cleaning the house of a patient's former wife (Counselor and Volunteers), purchasing food and supplies for families (Social Workers, Volunteers, Nurses), and performing non-routine hygiene services, like cutting and styling hair (Nurse). Like the caregivers in Dodson and Zinbarg's study (2007), workers saw these unpaid work tasks as part of providing high quality care, the kind of care they would like their own family members to receive. In each of these situations, workers completed the tasks outside of their paid work hours. These instances are important to note as they demonstrate that working off the clock, and sometimes in unorthodox ways, was the norm within hospice workers, regardless of their position in the team.

However, social support workers, including social workers, counselors, and chaplains, were disproportionately assigned the least rewarding tasks—those not directly related to patient care. Patty, a counselor, reported that she really liked her job, except for an enduring disagreement with her supervisor over tasks that she did not feel were appropriately assigned to her. The supervisor asked Patty to complete a test of medical supplies required by Medicare, even as Patty resisted by claiming that she did not know anything about medical supplies and this clearly did not pertain to her role as a bereavement counselor. The supervisor listened, but Patty said she did not expect it would be resolved: "I think it will just ping-pong within management and might end up right back in my lap" (Patty, Counselor). When I asked her how should this have been handled, she responded, without hesitation, that this was a task that should be completed

by management, most of whom were trained nurses. In a follow-up observation at Patty's workplace, I found that Patty was no longer in charge of this task, but that it had been transferred to a group of three social workers, none of whom had medical training. Despite Patty's reluctance and protest, this non-patient related work remained with the social support team. Throughout my fieldwork, I found that nurses were infrequently asked to complete these kinds of tasks because these duties were presumed to take too much time away from patient visits. Implicit in division of tasks is the assumption that nurses' work is the real 'business' of hospice, while other workers can be reassigned to undesirable tasks without financial consequences for the organization or reductions in the quality of care.

Social support staff members were also called upon to fill gaps in administrative work unrelated to patient care. At Rose Hospice, when an office worker took time off, the counselor stepped in to field paperwork related to all new admissions. Then, because the counselor was working in the office, the volunteer coordinator then offered to help complete patient visits and organize volunteer labor to meet patient needs while the counselor was away. Volunteers, myself included, were then frequently requested to come to the office to make calls to family members of former patients to assess their needs and remind them of available bereavement services. In these moments of short staffing, the social support workers were the first to make sacrifices in their time with patients. Over my observation time, issues of short staffing became increasingly

important as layoffs and changing regulations simultaneously reoriented work toward the bottom line.

Additionally, Rose Hospice went through two transitions in management during the time I performed observation, leaving several weeks at a time with no general manager. During both of these transitions, the social support staff reported that their workloads grew as they tried to ensure that the organization continued to run without a general manager. Sean, a chaplain, responded to an interview question about feeling overwhelmed by saying:

I think--yeah, I will say that over the last month or, you know, with the changes that's happened here, with Barry [another chaplain] leaving and then with having all this paperwork and stuff and trying to sort that out, find out what I was supposed to do and then the general manager leaving. And he really, honestly was not giving me much information about what it was that was expected or how to-- or any help in terms of setting priorities, and even how many hours I was supposed to be working. It was just all very vague (Sean, Chaplain).

Even though Sean admits the former manager was not giving him much guidance, he also claims that his feelings of being overwhelmed have increased following the manager (and others) leaving and the consequent increase in paperwork.

Each new manager to Rose Hospice came in with a new plan for increasing patient enrollments, demonstrating the salience of the business logic. The most recent manager decided that social support workers, all of whom worked on salary and had no maximum limit to their work hours, would now also be responsible for 10 hours of marketing per week. Additionally, the volunteer coordinator's hours were reduced to 24 hours of coordinating volunteers and eight hours of marketing. Not only did Robin, the volunteer coordinator, have a reduction from full-time to part-time hours, but she found that she had less time to do the work she felt most passionate about, and often was not able to complete all of her work within her paid hours. Upon visiting Robin several weeks into this transition, she told me: "This week I was finally able to *only* work 35 hours... that means I only volunteered three hours of my time to the company!" (Robin, Volunteer Coordinator). Others echoed this frustration by revealing that they strongly disliked the new marketing requirements, but put up with them because they valued time with patients. However, new requirements put time with patients directly at odds with business logics.

Social support workers wanted to spend more time with patients, but were unable to make that fit with new administrative and marketing responsibilities. Sean, the chaplain quoted above, also reported an instance where the upper management held an in-service training about increasing personal care services to patients. However, when he asked how many hours he should be spending in the field as a part-time staff member, the managers reported that he should spend, at most, 20 hours per week. The manager held

to this guideline even as he expressed that not all of the patients' needs could be met with only 20 hours per week. Sean said, "They've clearly been trying to cut corners in terms of staffing, which I understand from a bureaucratic perspective, but in terms of what we're supposed to cover, it is pretty overwhelming. And, also the tension of the fact that I really feel called to being in personal relationships with people, instead of this [paperwork]" (Sean, Chaplain).

These examples show that hospice workers expected to work long hours, sometimes even without pay, if it meant providing the highest quality of care. But, when the business logic conflicted with medical and holistic logics, sacrifices to the amount of time with patients were made. Most often those sacrifices came out of the social support workers' time with patients, leading to their dissatisfaction with work. This unequal acquisition of administrative and marketing tasks also shows the prioritization of medical aspects of care over the holistic aspects. Nurses were not expected to cut down their time with patients in order to take on additional tasks, constructing the medical logic as the most legitimate logic. Meanwhile, social support tasks were treated as though they required no distinct professional knowledge, especially when they were redistributed to hospice volunteers and office staff members.

### Emotionally Unskilled

A second main cause of disputes within hospice comes from situations in which the medical logic conflicted with the holistic logic in workers' approaches to caring for

their own emotional needs (medical vs. holistic). Working in an industry where caregivers are expected to make connections with patients, but then those patients inevitably die, has the potential to be emotionally burdensome for workers. While social support workers integrated a strong commitment to holistic care of themselves (as well as patients), medical workers often did not recognize their own self-care needs until they manifested physically in illness, depression, or injury. These differences in orientation toward one's own emotional needs stemmed from different logics that ordered workers' experiences of emotions, but when they conflicted, they also reproduced the marginalization of social support workers.

Nurses and other medical workers often reported that they were not prepared for the emotional aspects of their work. Their professional training focused almost entirely on medical care, and rarely included information about self-care. Like the medical students in Smith and Kleinman (1989), nurses were informally socialized to use emotion management strategies that ignored emotional aspects of the work, thus reinforcing a medical logic of the work. Because of this, social support workers felt the need to watch over the nurses and intervene if they were on the verge of burnout. One bereavement counselor said:

Self-care, self-care, self-care, which—it's not something that comes to us naturally. We usually have to be kicked in the butt really hard before we go, 'oh, okay.' So one of the things I do is work 40 point zero hours a week. That's it. If

I start drifting into more of that, my health suffers, so I've gotten really clear about that. Those in social services tend to have a better grip on that, of self-care and the importance of it. Nurses and CNAs—it seems to be a completely foreign concept, the idea of self-care isn't even—it's a really interesting phenomenon (Patty, Counselor).

Later in the interview, Patty explains that this difference between herself and the nurses makes her feel responsible for helping her co-workers who are struggling with self-care.

In watching out for the needs of others, social support workers took responsibility for a disproportionate amount of the emotional labor that took place among staff. One nurse said, “If I'm having a really hard day, I call our counselor, because she does our counseling... just to run things by and [Michelle] will give support that I'm doing the right thing” (Bethany, Nurse) without reflecting on the fact that it is Michelle's job to listen to clients, not necessarily to counsel staff. Michelle, Ramon, and Sean, all social support workers, claim that staff frequently rely on them to work through issues, both work and non-work related. Michelle said that she has talked to staff about illnesses in their families, their own health problems, addiction, marital problems, anxiety, depression, and problems with other staff members.

The vast majority of hospice workers interviewed claimed that they turned to social support workers when they needed to discuss things that bothered them, especially, but not exclusively related to their work. Table 3 illustrates this pattern by comparing

medical workers, social support workers, and all other workers, in terms of how frequently they mentioned talking to someone from their own occupational group as opposed to someone in another group.

Table 3: Support Networks by Position, N=33

	Own Group	Other Groups	Context of Contact
Medical Support Workers N=9	44%	Social 56%: Personal 44%: Administrative 78%:	Counseling; Validation of decisions Supervisory relationship; Friendship Procedural
Social Support Workers N=14	100%	Medical 29%: Personal 14%: Administrative 29%:	Sharing information; Problem-solving Primarily in Inpatient Unit Procedural
Other Workers N=10	30%	Medical 30%: Personal 20%: Social 50%: Administrative 60%:	Supervisory relationship; Friendship Friendship Counseling; Validation of decisions Supervisory relationship; Procedural

Note: There were eight missing cases, resulting in a sample size of 33 for this question.

For instance, medical support workers listed at least one other medical support worker in 44% of the cases, while this same group mentioned a social support worker in 56% of the cases; a personal support worker in 44% of cases; and, an administrative worker in 78% of cases. It is important to note, however, that when probed about the content of those discussions, medical workers said that they spoke to social support workers to get counseling and validation, while they spoke to personal support workers as

supervisors and/or friends, and administrative workers to clear up questions about procedures. Of these contexts, it is clear that medical support workers sought out emotional labor mostly from social support workers. In juxtaposition, 100% of social support workers said that they would talk to one another about problems, and many said that they would *only* speak to another social support worker. Social support workers expected and were expected to complete a great deal of emotional labor with their colleagues.

Although social support workers frequently saw supporting staff as part of their jobs, they also suffered negative consequences because of this expectation.<sup>7</sup> First, counseling staff took time out of the typical workday. During busy times this meant that they either had to work beyond their paid hours to make up for this time counseling staff, or they felt a pressure to reduce the amount of time spent performing patient care. Second, the expectation that they would provide counseling meant that they were always expected to be available and able to listen. This created a one-sided relationship in which all staff came to social support workers for help, but social support workers claimed that they did most of their processing outside of work in order to keep clear boundaries. Social support workers frequently appeared to be the ‘natural’ choice when other staff members needed someone to talk to, pushing social support workers to perform a

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<sup>7</sup> It could also be argued that social support workers had a power advantage through having access to more information about their colleagues than their colleagues had about them. This certainly could be true in this setting, though I did not record any instances where workers used information about others to their own advantage. Additionally, even if this information could afford some advantage, the disadvantages of performing a disproportionate amount of emotional labor still exist.

disproportionate amount of emotional labor in their relationships with their colleagues. Third, the negative effects (e.g. stress, time bind, emotional burnout) of emotional labor were disproportionately taken up by the social support workers as they were expected to perform emotional labor with clients but also with their peers. Finally, by prioritizing medical care above all else, the emotional and psychological concerns of the workers were treated as outside the domain of the official organization. Consequently, if social support workers did not take on these additional counseling activities, medical workers' emotional needs were not dealt with until they manifested physically, forcing staff to take leave or discontinue hospice work altogether. By ignoring problems until they became physical, hospice organizations prioritized medical logics, even as social support workers tried to maintain holistic logics in their interactions with colleagues.

#### Excluded from the Team

While taking on a large proportion of administrative work and emotional labor can be burdensome, time-consuming, and frustrating for workers, I found that social support workers were also disadvantaged because their membership in the hospice team was incomplete. In fact, Sean, the chaplain, called the social support team the “auxiliary to medical care” (Sean, Chaplain), and others expressed that their membership in the hospice team was not taken seriously by their medically-trained peers. This exclusion reflects conflicts between holistic logics and medical/business logics (holistic vs. medical/business), such that medical and business logics were bound up with one

another, mutually reinforcing their own importance, and treating holistic logics as added benefits, but not essential, to hospice care. The following excerpt from my fieldnotes highlights how social support workers were pushed to the margins of hospice interactions:

After the meeting ended, the doctor and clinical coordinator cornered Michelle to ask about a patient's condition. Dr. James and the coordinator kept asking the same questions over and over again. Michelle first tried to answer the question, but didn't know enough about the medical procedure to give a satisfying update on the patient's condition. They asked again. Michelle then said that they should check with Cheryl, the nurse. The coordinator said she would, but then asked another question about the procedure. After at least three minutes of this, Michelle finally put her hands up and said, 'I don't know. Don't ask me, I'm not a nurse!' They both then chuckled and the coordinator said, 'Well, you should know.'

By focusing entirely on the medical aspects of care—even as they interacted with someone who admitted she was not familiar with the medical procedure—the doctor and clinical coordinator pushed the social support worker to the point of making the prioritization of medical care explicit in their interaction. Michelle was visibly upset by

this interaction, and although her work with the patient might also be relevant to the discussion of his recovery, her expertise was not part of the discussion.

In an additional example from my fieldnotes, I show how the exclusion of social support workers appeared in a discussion of a recent “success” at Rose Hospice:

The staff meeting had officially ended and a manager, Sarah, turned to me and said she wanted to tell me about their latest success story. In this story, a recent patient had had a difficult time accepting hospice care. Sarah relayed that the staff members had been working with this patient for several months and were finally able to calm her by identifying an appropriate dose of anti-anxiety medication. She referred to this story as evidence of the commitment of everyone on the team. She congratulated and thanked everyone for contributing to this success story. As she told the story, however, Robin, the Volunteer Coordinator, chimed in to say that she thought the real breakthrough came as a result of the work of a volunteer named Natalie, who worked with the patient for several months. Natalie knew of the patient’s anxiety and so she started visits by just being in the same room but not talking. Eventually they were able to touch hands, and by the end, Natalie was able to hug the patient. Sarah acknowledged that Natalie was great, but continued to talk to the physician about how finding the correct medication was pivotal for this woman.

Sarah's framing of the success story clearly shows that medical and pharmaceutical interventions were the most crucial elements of hospice care. Robin tried to speak up and remind the group of Natalie's contribution as a volunteer, but Sarah and the medical director were less interested in how Natalie's social support could have produced the changes in the patient.

In these situations, social support staff were technically part of the team, but found that their expertise was not valued as much as the medical support workers'. This devaluation of social support work especially exacerbated existing inequalities amongst workers when Rose Hospice faced financial strain. During these times, social support workers frequently experienced (or expected to experience) reductions in hours, increased workloads, or layoffs. Nurses did not report similar concerns. These exclusionary practices, and their economic consequences, show the lack of fit between the philosophy of hospice, which prioritizes the holistic care logic, and the actual hospice workplace, which is increasingly dominated by the medical logic and constrained by business concerns.

## Discussion and Conclusion

These three sets of conflicting logics show that during everyday hospice work, individual actors (with unequal access to power) come to negotiations over the division of tasks using available institutional logics (medical, holistic, and business). Especially during times of financial strain, these logics sometimes conflicted, which forced workers

to explicitly negotiate the division of tasks. In these interactions, the medical logic was frequently given priority, which privileged medical concerns and medical workers above holistic concerns and social support workers. This privileging then reinforced inequality among workers, and also reproduced the dominance of the medical logic. It became a taken-for-granted justification for the organization of hospice. Over time, these consequences change hospices to look more like conventional medicine, and less like their anti-institutional roots.

Inequality among these workers must be understood, in part, by examining the organizational context under which “interactional and experiential inequalities” exist (Stainback, Ratliff and Roscigno 2011:1179). In this case, social support workers were disadvantaged because they were overburdened with administrative, non-patient work and emotional labor with their colleagues, and because they were not given credit for their work and expertise. This effect could come, in part, from Rose Hospice’s increased emphasis on business success, which in turn, incentivized more bureaucratic control (James and Field 1992), but also contradicted the democratic ideal of the hospice team (Troyer 2004). It could also be a result of nurses drawing on more legitimate claims to scientific authority, and thus constructing their work as more important (Zhou 2005). Regardless of how this came about, however, it reproduced social support workers’ unequal status in the setting, making their work more precarious.

In addition to perpetuating workplace inequality, this particular division of labor reinforces the dominance of the medical logic, thus leading to organizational

isomorphism. Even though hospice started as a critical response to conventional medicine, the medical logic within hospice was prominent in most interactions. In the case of hospice, medical logics are powerful enough to make nurses' authority and the prioritization of medical tasks seem natural. This is consistent with Zhou's (2005) study of occupational prestige, especially as medical tasks have a strong link to science, technology, and formalized professional knowledge. In contrast, social support workers' professional knowledge is based on human relationships, and is more likely to be contested by others. While individual staff members in hospice may dispute this hierarchical ordering, workers in general accept the order because it is legitimated and taken for granted (Hannan and Carroll 1992; Johnson, Dowd and Ridgeway 2006). In this way, hospice operations have moved toward conventional medicine and away from its grassroots beginning.

Using the case of hospice, I have developed a new conceptualization of the role of institutional logics in the reproduction of inequality and isomorphic trends. Conflicts of logics enter into interactions, where one logic prevails over others in the prioritization of tasks and assignment of authority. If that logic is already legitimated, as is the case with the medical logic in hospice, those already marginalized will face further disadvantage. Additionally, organizational practices will also shift to be more isomorphic to other organizations in the field. This model came out of my observations in hospice, but may also be useful in other studies of organizational change and stability.

One alternative explanation for these findings is that hospices are only influenced by a single logic. On one hand, some may say that we should expect that the medical logic is always dominant in this setting, because it is a type of medical care. However, hospices differ quite a bit from other medical institutions, especially in their emphasis on the team approach to care. This team approach suggests that the focus is not, in theory, only on the medical care of patients, but should also include individualized, holistic care. On the other hand, some may say that the most important logic is the business logic, especially as hospices are undergoing financial strain. This argument may be true of analyses at the level of the organization or the field, but by looking at the level of interaction between workers, it is clear that workers do not prioritize profit above all else. Workers hold each of these logics in tension and navigate conflicts between them. Financial strain is the context of the findings reported here, but is not the immediate cause of the ways that workers were differentially valued.

Another set of explanations focuses on legitimacy and conflict over jurisdiction. Abbott (1988) argued that workers from different positions engaged in battles to define tasks as falling within their own professional boundaries. This reinforced their status and gave them claims to legitimacy as a professional group. In this way, it is possible to view hospice as a space where medical and social support workers vie for jurisdiction over care at the end-of-life. But this alternative explanation falls short in two ways. First, neither social support workers nor medical workers made claims that directly challenged the jurisdiction of the other; neither aimed to expand their control into the others'

territory. Second, at the same time that workers negotiated work in unequal ways, they also reported very strong commitments to the democratic ideals of hospice, which focus on team approaches to care, thus the conflict over how to divide tasks is less about professional control, and more about the underlying value assigned to different types of work.

Finally, might these findings actually be about credentialing and the valuation of training in this setting? This study offers an interesting perspective on credentialing: nurses have lower level degrees (AA, and sometimes BA, but only very rarely do they have MA level nursing degrees) than social support workers (all master's level). Nursing degrees function as a minimal signifier of competence, though most of the nurses admit that their official training was less important than their on-the-job training. Meanwhile, the higher degrees of the social support workers were treated as though they did not add any particular expertise. So, while it may be true that nurses' degrees offered something that was especially valuable at the level of the field of medical work, it is noteworthy that only looking at credentialing would miss the complex interplay between different sets of workers and the logics that made their work legitimate.

Mixed qualitative methods, especially those collected longitudinally, are ideal for speaking to the micro-level consequences of conflicting institutional logics. By watching interactions and speaking to staff about their relationships with their colleagues, I capture nuance in the ways that workers negotiate work tasks. This nuance would not be available by conventional survey methods, or either ethnography or interviews alone.

Additionally, the study of institutional logics has mostly focused on over-time, macro-level changes within a particular domain. However, by focusing on the everyday, micro-level consequences and manifestations of these logics, I better connect the macro-level changes to the lives of participants. Finally, collecting these qualitative data over time has allowed me to compare not only sets of workers, but also different time periods. This enriches the ethnographic data further by showing how workers change their behavior, given the different constraints imposed by conflicting institutional logics.

Although the mixed qualitative approach taken here is ideal, especially for linking the micro-level negotiations over the division of labor to conflicts between institutional logics, some limitations do exist. It is unwise to extrapolate these findings to all other hospices. Rose Hospice is a useful site for this study as it has many qualities that represent the majority of hospice organization in the United States: it is mid-sized, secular, and undergoing transition because of budget cuts. However, religious, smaller, very large, or non-American hospices may manifest these same logics differently. While there may be limits to the generalizability of these findings, my focus has been on using empirical data to construct a new theoretical explanation of inequality and isomorphism that can be used and tested in other settings.

Additionally, this study covers over two years observation within a single hospice, and supplements with interviews from several other hospices over the course of four years, so it can document a great deal of change over that time period. However, changes to the healthcare system continue, and hospices will likely continue to reassess

their strategies and logics in light of these changes. Importantly, Medicare is currently pushing physicians to take a more active role in hospice services, giving further evidence that the medical logic will dominate. This is an extension of changes that began with Medicare paying for hospice services (James and Field 1992), but likely will be disputed as workers continue to experience reductions in time spent with patients.

Future studies would benefit from assessing resistance to the medical logic or countervailing forces. As hospices become more like conventional medicine, the non-medical workers, like social workers, chaplains, certified nursing assistants, and volunteers are likely to continue to be asked to do more, while also being pushed out of decision-making processes. While some hospice administrators hail this as an opportunity to continue to improve the quality of care, it is likely that other hospice workers will attempt to push back on this trend, possibly drawing on new (or reinventions of the original) tenets of the hospice philosophy. Some respondents in this study are already moving in this direction as they claim “Hospice has gotten worse since I started” (Bonnie, Nurse), or “We need to get back to the beginnings” (George, Chaplain).

Other healthcare settings also offer new opportunities to advance theory, especially in terms of the multiple logics and the interaction-level processes that help give traction to some logics over others. Hospice has a very flat hierarchy in that managers and supervisors are treated more as equals than as superiors, but other healthcare settings may reveal that managers and supervisors matter a great deal for workplace inequality, especially in pay and promotion (Castilla 2011). Additionally, this

study focused mostly at the level of interaction, but individual level characteristics may matter as well: status characteristics make some actors seem to hold more competence than others (Ridgeway 2009); orientations or beliefs about work may shape how actors interpret competing logics (Grant, Morales and Sallaz 2009); and, some workers may have a greater sense of service than others (Stets and Carter 2012), thus affecting the dynamics within interactions over the division of labor. Finally, Meyerson's (2003) research emphasizes that select individuals can become leaders and activists for change in some work settings. Future studies would benefit from integrating individual level characteristics as well.

This article brings individual actors and interaction back into the study of work (Barley and Kunda 2001), thus improving extant accounts of organizational processes, like isomorphism and workplace inequality. By linking logics and practices to the reconstitution of the micro-order, this study pushes ILP to further theorize between levels of analysis and systematically analyze the ways that institutional logics condition priorities and assignment of authority, and how these then affect the workplace as a whole.

## CHAPTER IV: DIVISIONS OF EMOTIONAL LABOR

How do emotions, and social expectations about emotions, factor into the daily lives of workers within caring occupations? Much theorizing about the role of emotions in the workplace starts with the assumption that when emotions are exchanged for wages (emotional labor), workers will be negatively affected. Following Hochschild's (1983) initial work, emotional labor is defined as a part of face-to-face (or voice-to-voice) work that requires monitoring one's own emotions and/or producing particular emotional states in the self or others. Actors adjust their emotional expressions to meet the feeling rules established by the organizations that employ them. Scholars have noted that emotional labor requirements can lead to emotional dissonance (Hochschild 1983), strain on workers (Wharton 1999), burnout (Alkema, Linton and Davies 2008), and conflict between work and family life (Seery, Corrigall and Harpel 2008).

Researchers have studied emotional labor in various kinds of work: retail (Leidner 1999), teaching (Bellas 1999), management and professional occupations (Kunda and Maanen 1999), police and security work (Martin 1999), paralegals (Pierce 1999) and the family (Devault 1999). While these studies have revealed a great deal about the problems with exchanging emotional expressions as part of one's work, they leave several questions unanswered. For instance, most studies have focused on an occupational group, like nurses (Diefendorff et al. 2011; Henderson 2001), or entire

classes of workers, like service workers (Ashforth and Humphrey 1993; Durr and Wingfield 2011; Gruys 2012; Leidner 1999). What is missing from these studies is an analysis of how emotional labor is divided within a workplace that includes personnel from several different groups. How do workers from various positions divide up the labor of managing emotions? This question is crucial for health care policy as the healthcare system as a whole is shifting toward a team-based approach to care (Bodenheimer 2008).

Secondly, advancements in the emotional labor concept have refined it to include interactions with clients as well as co-workers (Wharton 2009), and to explain how status characteristics shape expectations about emotional labor (Erickson and Ritter 2001; Wingfield 2010), but might there be aspects of emotional labor previously unmeasured? Are there underlying sub-concepts within emotional labor that require elucidation?

Finally, previous research has skirted the issue of emotional experiences that could not be defined as emotional labor, treating all emotions that happen at work as a product of organizational constraints (Turner and Stets 2005). Might there be emotional experiences at work that are not managed, controlled, or hidden, and that have an effect on workers' sense of satisfaction?

This article approaches each of these questions using original survey data on hospice workers. I find that emotional labor within hospice includes four distinct kinds of experiences and that these forms of emotional labor are not evenly distributed across

work positions. Additionally, by bringing in emotional experiences that are not emotional labor, I find that workers who do the most emotional labor also have the highest reports of positive emotional experiences with patients. Finally, I find that emotional labor on the self, including hiding aspects of the self and becoming mechanical, is the most deleterious type of emotional labor. However, feelings of helplessness (regardless of levels of emotional labor) is also a strong predictor for leaving hospice. Taken in conjunction these findings help explain why patient-facing hospice workers do not greatly experience negative consequences of emotional labor, and subsequently report high levels of work satisfaction.

## Background

Emotional labor includes two distinct dimensions. Hochschild's (1983) original theorizing focused on differentiating surface acting and deep acting. She defines surface acting as "disguising what we feel, of pretending to feel what we do not," while deep acting makes surface acting unnecessary by "taking over the levers of feeling production, by pretending deeply" and thus altering the self (33). Studies have shown that surface acting is positively associated with burnout and work dissatisfaction (Brotheridge and Grandey 2002; Grandey 2000; Scott and Barnes 2011), while deep acting can sometimes improve workers' outlook (Ashforth and Humphrey 1993). Explanations of this difference frequently emphasize that surface acting requires more inauthenticity than deep acting. However, Hochschild (1983) was also wary of deep acting as she thought it

to produce emotive dissonance, meaning that workers put too much distance between their organic emotional states and those they try to take on.

In both kinds of emotional labor, regular performance has been linked to burnout, or “the numbing of the inner signals of emotional feelings, reflected in the inability to create or feel any emotion” (Wharton 1999:162), especially for those in human service occupations, who have a hard time separating themselves from their work roles and eventually lose the ability to perform the job. Burnout has also been shown to be related to feeling devoid of emotions (Alkema, Linton and Davies 2008); dissatisfaction with the work; anxiety over professional future (Vachon 1999); and eventual turnover of care workers (Dill and Cagle 2010).

Subsequent research builds on these studies by differentiating between “external” customers (clients or patients served) and “internal” customers (co-workers and supervisors), finding that the outcomes of emotional labor vary across these kinds of interactions (Erickson and Wharton 1997; Wharton 1999). On one hand, emotional labor with external customers produces more cognitive and emotional dissonance than interactions with co-workers (Tschan, Rochat and Zapf 2005). On the other hand, workers who do not have control over their work process are likely to feel inauthenticity and burnout because of emotional labor with colleagues (Erickson and Wharton 1997). Erickson and Ritter (2001) argued that agitation was most deleterious for workers because it was associated with a weakened sense of self. These studies have brought to light variation in experiences of emotional labor, but have not thoroughly conceptualized

how emotional labor, the self, and work satisfaction are related. Additionally, extant studies often contradict one another, especially in terms of the harm associated with what Hochschild (1983) called deep acting.

The performance of emotional labor also have implications for social inequality (Pierce 1995; Steinberg and Figart 1999). According to Steinberg (1999), emotional labor is an invisible aspect of work and is too often not part of the evaluation, promotion, and compensation process. This means that workers are expected to perform emotion labor, but they are not directly rewarded for meeting this expectation. In particular, expectations about emotional labor reproduce gendered relations at work, further disadvantaging women (Schwalbe et al. 2000), who perform the most emotional labor (Wharton 2009), and who are often not rewarded for it (England 2005). Additionally, race also enters into expectations about emotions at work, often limiting the range of possible acceptable emotional states for people of color (Durr and Wingfield 2011; Kang 2003; Wingfield 2010).

While the above studies have been useful for understanding the ways that emotions are constrained as part of the work process, they do not explicitly theorize emotions at work that do not fit the definition of emotional labor. Some emotions are felt and expressed, regardless of the feeling rules in the setting, and even when they are contradictory to the goals of the organization, and thus are not emotional labor. Some emotional experiences are felt to be liberating, empowering, or meaningful, instead of only constrained (Lopez 2006). Positive emotional experiences could mitigate the

relationship between emotional labor and workplace outcomes like stress and dissatisfaction. Negative emotional experiences, even if they are not technically emotional labor, may exacerbate workplace stress, or even hold addition effects on turnover intention.

It is also likely that other characteristics of work shape whether workers feel constrained by emotional dictates, or they feel liberated by organizational openness to emotions. One factor that matters a great deal for all types of work is autonomy (Hodson 2004; Rueschemeyer 1983). For home-based care workers (like most hospice workers, but also home health aides), autonomy is often a product of physical distance from supervisors and the ability to establish own hours of work (Cain Forthcoming; Meintel, Fortin and Cagnet 2006). By having autonomy, workers may be able to find time for authentic emotional encounters, even if the organization does not explicitly encourage this. Satisfaction with pay, benefits, and supervisors are also important for care workers (DeLoach 2003). While many care workers report that their desire to help others reduces the importance of high pay (Pfefferle and Weinberg 2008; Stacey 2005), others have found that all else being equal, dissatisfaction with pay and benefits increases worker turnover intention (Auerbach et al. 2010).

Studies do not yet integrate emotional labor and authentic emotions. Nor do they account for the distribution of emotional labor across work positions. For instance, within a single work setting, might some positions be expected to provide more

emotional support to internal and/or external customers than others? How does this division shape the workplace as a whole?

### Hospice as a Case

Hospice care represents an ideal case to further research on emotional labor. In order to meet the complex needs that come at the end-of-life, hospice encourages cross disciplinary communication and cooperation as well as interdependence between professional positions. Using interdisciplinary teams, consisting of physicians, nurses, certified nursing assistants, social workers, chaplains, counselors, and volunteers, hospice staff work together to meet the complex medical, social, and psychological needs of patients and their families. Weekly meetings are held with all members of the team and patients are discussed to produce plans of care. The focus on meeting the physical, emotional, and social needs of patients means that quality of care is increased, but it may also mean that workers experience increased pressures to manage their interactions with patients, families, colleagues, and professional contacts. This requires the management and production of appropriate emotions and the maintenance of others' responses.

### Structure of the Organization

Every hospice that receives payment from Medicare must include registered nurses, medical social workers, physicians, chaplains, and volunteers on staff (Miller and Mike 1995). During weekly meetings the nurse case manager, hospice physician, social

worker, and chaplain must sign off on each patient plan of care. The nurse case manager is primarily responsible for organizing services and referring patients to appropriate social support staff beyond the initial meeting in which all personnel are required to gain some familiarity with the patient and patient's family. Hospice organizations are structured this way to increase coordination across disciplines and increase quality of care through a holistic approach. This organizational form also lends itself to a comparative study of different positions.

Importantly, occupational positions within hospices have varying levels of compensation, autonomy, respect, job flexibility, training or educational requirements and skills needed. Also, hospice personnel come from a variety of different backgrounds that may shape their experiences of stress and burnout; for instance, age, gender, race, ethnicity, education, and social class background may affect how workers think about emotional expectations at work as well as produce different effects for different kinds of workers (Masterson-Allen et al. 1985). But, even given the diversity of experiences within hospice, workers are encouraged to work as a team to meet the complex needs of patients and their families. Additionally, many workers also have to coordinate care with individuals outside of the organization such as caregivers, primary care physicians in the community, and staff at adult care homes. Coordination across positions and organizations requires workers to develop skills at monitoring their own emotions and emotional expressions as well as manage the emotions of others.

### Nature of the Work

The work of caring for the ailing and dying is both physically and emotionally draining on workers. Staff at all levels of the hospice organization deal with death on a daily basis as they care for the patients and interact with grieving family members. Additionally, because the emphasis is on holistic, total care, many staff members find that they periodically feel attachments to their patients and patient families (Hawkins, Howard and Oyebode 2007). These attachments can mean that workers feel additional emotional pressures as patients' death nears.

Both dealing with challenges of death and dying and learning to cooperate across positions requires monitoring one's own feelings, adapting to the emotions and expressions of others, and learning to manage stressful situations. These kinds of skills are often ignored, rarely compensated, and very often lead to worker dissatisfaction and burnout (Pugliesi 1999). This may be especially true for the social support workers because their roles are not often well defined (Bosma et al. 2010), and they are expected to also be able to monitor medical statuses and pain during their social support assessments (Oliver et al. 2009).

### Data and Methods

The data for this article come from a multi-stage, mixed methodological study of the everyday work experiences of hospice workers. By using multiple methods I increase the scope of my contribution, gain in-depth knowledge of the case and the theoretical

import of my findings, and increase the validity of my conclusions (Flick 1992). The first stage of the study began with qualitative data collection including field observations within a single hospice company, informal field interviews, and formal interviews with hospice workers. These data collection techniques are appropriate for understanding the experiences and interpretations of workers (Denzin 2006; Singleton and Straits 2005) and also allowed me to enter the day-to-day life of hospice workers. Additionally, qualitative data allows both for assessment of deductively derived hypotheses and for the inductive formulation and refinement of new hypotheses (Corbin and Strauss 2008). The second stage used findings from the qualitative data collection to design, refine, distribute, and analyze a survey of hospice workers in Tucson and Phoenix, Arizona. This paper focuses on the survey results.

The survey ties together theoretical and empirical questions that emerged in the earlier stages of the research. Using extant studies of emotional labor, workplace stress indices (see for example: Harris 1989; Lazarus 1993; Pugliesi 1999), the General Social Survey module on emotions, and inductively derived concerns, I designed a 133 item written survey. I included questions about various kinds of emotional labor, emotional experiences that are separate from emotional labor, indicators of stress, workplace social networks, satisfaction with colleagues, satisfaction with supervisors, satisfaction with work, turnover intention, and demographic variables.

Once I compiled a complete list of possible questions (totaling approximately 200 items), I performed pre-testing in two ways. First, I distributed the survey to a sample of

15 interviewees. Interview respondents took the survey while I was there, and were advised to ask questions and identify items that they did not know how to answer. Through their feedback and a preliminary analysis of the data from these test surveys, I reduced the survey items to 150. I then held a focus group with four hospice workers from various positions (Nurse, Social Worker, Counselor, Administrator). We went through each item to clarify terminology and to ensure validity of the questions (Nassar-McMillan and Borders 2002). Respondents engaged in dialogue about questions that may be unclear or questions that I have neglected to ask. I further revised the survey to 133 items using their comments.

A random sample of hospice workers was not feasible at this stage of the project. Instead, I used a purposive sample of five hospice organizations in Arizona. Three were located in Tucson, while the other two were in Phoenix. Three were mid-to-large sized, and two were small, with fewer than 20 staff members. All but one of the organizations was secular, and all were for-profit. By stratifying by size of the organization, but controlling for profit status, I was able to capture organizational level variation that may affect how workers experience work, while also avoiding some of the feasibility problems that come from large random samples (Singleton and Straits 2005). Individual hospice workers were the unit of analysis, so I used this list of five hospice organizations to make contact with workers within these organizations. All workers within these organizations were eligible to participate in the survey, providing a population of the five organizations.

I ensured high response rates of approximately 83% (165 respondents out of 198 total staff) by attending hospice interdisciplinary team meetings and distributing the survey during these meetings. For the five organizations, I was able to attend all of their meetings, except one organization that was not able to schedule a meeting with certified nursing aides (CNAs) during the data collection period (20 CNAs were excluded because this meeting could not be scheduled). Because of this, the response rate for nurses, social workers, chaplains, counselors, physicians, and administrators is 91%, but the response rate for CNAs is 61%. While this is a limitation in the data, I still have completed surveys from 31 CNAs, so their experience is represented in the total sample. Respondents received a \$10 giftcard for completing the survey.

Surveys were then coded and entered into Stata, where I performed three types of quantitative analysis. In the first I performed a series of factor analyses to determine distinct dimensions of emotional labor. I began with 22 variables that represented three types of emotional labor: emotional labor with patients, emotional labor with co-workers, and emotional labor on the self. After conducting a separate exploratory factor analysis for each of these three types, I parsed out four different kinds of emotional labor performed by hospice workers (discussed in the Results section), using a eigenvalue cut-off of .90,<sup>8</sup> and keeping in variables that loaded at least .50 on the underlying concept (see Table 4).

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<sup>8</sup>While an eigen-value of 1.0 is typically conventional for factor analysis, theory strongly supports the divisions reported here, so I used the more liberal cut-off of .90.

Table 4: Factor Loadings for Emotional Labor Constructs

	Patients: Sad	Patients: Angry	Co- Workers	Self
Put arm around patient to comfort	.79	-	-	-
Hold hand of patient	.84	-	-	-
Talk to patients about their emotional difficulties	.51	-	-	-
Educate patients about care	.61	-	-	-
Communicate with people who are angry	-	.76	-	-
Communicate with uncooperative patients	-	.65	-	-
Talk to co-workers about their emotional difficulties	-	-	.65	-
Communicate with uncooperative co-workers	-	-	.60	-
Help co-workers with projects	-	-	.64	-
I feel like I have to become mechanical	-	-	-	.61
I don't feel I can be myself at work	-	-	-	.57
Cronbach's alpha	.87	.73	.69	.64

I used a varimax rotation of the factors in order to make the distinctions between the items clearer. While some loading scores were moderate (.50-.70), many of the variables loaded much higher, between .70 and .80, signifying coherence in the construct. I combined these questions to create indices of the four types of emotional labor.

Secondly, I identified emotional experiences that may fall outside the definition of emotional labor. These included things like laughing with patients, telling meaningful stories, and giving and receiving gratitude. Of these, I created two underlying constructs of positive emotional experiences, following the inclusion rules discussed above. These two reflect positive experiences with patients and positive experiences with co-workers, and are shown in Table 5. I also included a series of questions that asked the respondent how frequently they felt anger, ashamed, calm, excited, guilty, happy, helpless, irritated,

nervous, proud, sad, or scared in the last week. I present descriptive statistics on these emotional experiences in Table 5, and discuss their substantive meaning in the Results section. Those most predicted by extant literature to affect turnover are also included in the final analysis.

Table 5: Emotions Separate from Emotional Labor

	Mean	Standard Deviation	Positive Emotions with Patients (with loading scores)	Positive Emotions with Co-Workers (with loading scores)
How often do you... (0=Never, 5=Several Times a Day)				
Laugh with patients	4.17	1.26	.75	-
Laugh with co-workers	4.29	.89	-	-
Share stories	3.43	1.20	-	-
Get thanked by patient	3.62	1.36	.75	-
Get thanked by co-worker	3.29	1.15	-	.72
Get thanked by supervisor	2.71	1.16	-	.62
In the last week of work, did you... (0=No, 1=Yes)				
Feel happy/cheerful	.99	.08	-	-
Feel helpless	.51	.50	-	-
Feel sad/sorry	.74	.44	-	-
Feel angry	.65	.48	-	-
	Cronbach's Alpha		.80	.71

The final analysis includes the emotional labor indices and the emotional experience variables in a logistic regression to predict workers' intention to leave their current job in favor of another job with hospice. This analysis also includes standard work variables, like satisfaction with pay, benefits, and supervisors, and controls for sex and age. Table 6 provides descriptive statistics for all variables included in this final

stage. The dependent variable is coded one for worker reporting they have thought about leaving their current hospice job for another hospice job, and zero if they have not.<sup>9</sup>

Table 6: Descriptive Statistics for Independent and Dependent Variables

	Mean	Standard Deviation	Minimum	Maximum
<hr/>				
<i>Dependent Variable</i>				
<hr/>				
I have thought about looking for another hospice job in the past year (0=No, 1=Yes)	.28	.45	0	1
<hr/>				
<i>Independent Variables</i>				
<hr/>				
<i>Emotional Labor</i>				
Emotional labor with patients: Sad	3.95	1.16	0	5
Emotional labor with patients: Angry	3.17	1.07	1	5
Emotional labor with co-workers	2.47	1.10	0	5
Emotional labor with self	2.07	.88	1	5
<i>Emotions</i>				
Positive emotions with patients	3.89	1.19	0	5
Positive emotions with co-workers	2.99	1.02	0	5
Helpless	.51	.50	0	1
Sad	.74	.44	0	1
Angry	.65	.48	0	1
<i>Work-Related and Controls</i>				
Unhappy with pay	2.39	1.05	1	5
Unhappy with benefits	2.14	1.11	1	5
Unhappy with supervisor	1.57	.78	1	4
Sex (1=Female)	.86	.35	0	1
Age (Decile)	4.2	1.29	2	7
<hr/>				

<sup>9</sup> Other potential dependent variables included leaving hospice work altogether and dissatisfaction with work. I chose intention to leave current job because most hospice workers who reported dissatisfaction did not report wanting to leave hospice, but wanting to find a hospice organization that treated workers better. I assessed the robustness of these other outcomes, however, and found similar patterns, especially in terms of the effect of feelings of helplessness.

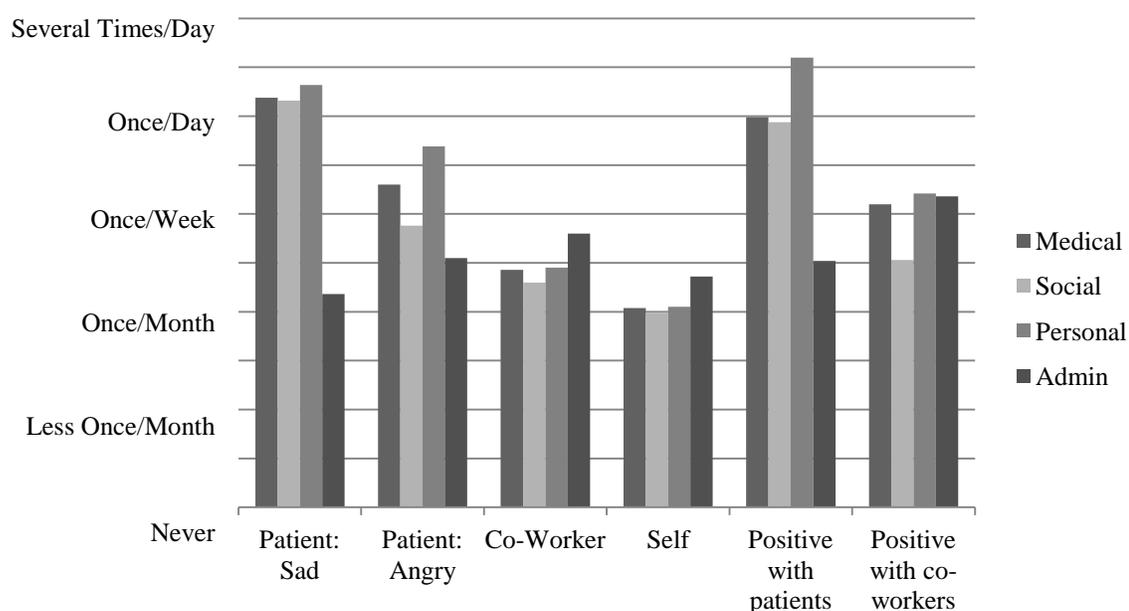
The emotional labor indices I constructed in the first stage range from zero to five, signaling a great deal of variation in amount of emotional labor performed. The same is true for the positive emotional experiences with patients and co-workers. While it does complicate interpretation, I left these indices with interval values to remain true to the variation in reports of amounts of emotional labor. I also performed a robustness check by dichotomizing all of these variables (report of once or more a week = 1; less than once a week = 0), and found the results to be identical in terms of statistical significance, direction of odds ratio, and strength of the relationship.

## Results

The first stage of the analysis concerned the refinement of the emotional labor concept. Using factor analysis, I found support for the existence of four different kinds of emotional labor in hospice work. One takes place as workers support patients and family members who are sad or grieving. They provide this support physically through putting their arms around, or holding hands, with patients. They also talk to patients about patients' emotional difficulties, and try to teach care recipients about care procedures (like treating an open wound, or properly taking medication). In these situations, workers provide a great deal of emotional support, which can be taxing, but can also be quite rewarding (Cain 2012a, Lopez 2006). As show in Figure 3, Medical, Social, and Personal Support workers provide a great deal of this kind of emotional labor (at least once a day), while Administrative workers are not in the field and do not interact

with patients as often, and subsequently do not provide emotional support to patients as often (about once a month).

Figure 3: Emotional Labor and Emotions, Distributed by Position



The second kind of emotional labor takes place when workers provide emotional support for patients or family members who are angry or uncooperative. This type of emotional labor is disproportionately taken up by Personal Support workers, most of whom are Certified Nursing Aides. Medical Support workers also perform a significant amount of this labor, reporting performing this kind of labor at least once a week, and for some as often as every day. Meanwhile, Social Support and Administrative workers

report lower levels of this kind of work. Personal and Medical Support workers deal with more patients who are angry or agitated because they are much more likely to manipulate the physical bodies of patients as they try to bathe, dress, examine, and treat patients. These physical treatments may cause pain for patients, who then become angry.

The third type of emotional labor provided by hospice workers comes from the work of supporting one's colleagues. This may be through talking to a co-worker about their emotional difficulties, dealing with uncooperative co-workers, or working together on projects. Interestingly, while the qualitative results from this study show that Social Support workers provide a disproportionate amount of emotional labor to their colleagues, workers' self-reports of emotional labor with colleagues show little variation across position. Administrative workers report the highest levels at just over once a month, which likely reflects their centralized role in the daily operations of hospice. Because Administrative workers are located in most hospice offices, they are always physically available to provide support to their colleagues.

Finally, emotional labor also includes the work one must do to ensure that her emotions are appropriate for the setting. This sometimes includes hiding aspects of the self or becoming mechanical in responses to difficult situations. Qualitative results showed that hospice workers have a sense of pride over the extent to which they are "authentic" in the setting (Cain 2012b), and consistent with this, the patient-facing workers (Medical, Social, and Personal Support workers) report low levels of self-based emotional labor. However, administrative workers report higher levels of this kind of

emotional labor. Although this type of emotional labor has the lowest reported levels of enactment, subsequent results show that it is influential to workers' intention to leave their current job.

Not all emotions at work constitute emotional labor, however. Figure 1 also shows the distribute of positive emotional experiences across hospice positions. Patient-facing staff (Medical, Social, Personal) all report positive emotional experiences of being thanked or laughing with a patient at least once a day. Personal Support workers reported the highest levels, many claiming they had these positive experiences several times a day. This is noteworthy, because this group also reports high levels of emotional labor with patients who are sad as well as angry, meaning that Personal Support workers experience a great deal of potentially harmful emotional labor as well as potentially ameliorating positive experiences. Hospice workers also report high levels of positive interactions with their co-workers, in the form of being thanked by a co-worker or a supervisor. Medical, Personal, and Administrative workers claim this happens about once a week, while Social Support workers are a bit lower. Social Support workers are likely suffering from invisibility and marginalization of their work within these interactions (Cain 2013a), and therefore do not feel as appreciated as the other groups.

Other emotional experiences that do not fit the emotional labor definition are described in Table 5 (see Data and Methods section). Specifically, hospice workers were asked if they felt a series of emotions within the last week, and almost all (99%) reported feeling happiness about something that happened at work in the last week. Just over half

(51%) reported feeling helpless in the last week. About three quarters (74%) said they felt sad or sorry in the last week, and 65% reported feeling angry in the last week. These results contradict lay assumptions that hospice work is always sad and rarely deals with happy or joyful events. They also are useful for understanding emotional experiences that are not controlled or constrained within work. Helplessness, sadness, and anger are included in the final analysis.<sup>10</sup> Happiness is excluded because of the lack of variation in reports.

I then include the emotional labor and emotions variables in a logistic regression model that predicts likelihood of leaving current hospice job (Table 7). Through this, I determine which kinds of emotional labor actually affect workers intention to leave, emotional experiences that matter separate from emotional labor, and how emotional labor compares to other more traditional predictors of turnover intention. I illustrate these effects through two models. The first includes the emotional labor variables as well as conventional variables related to work satisfaction and controls. The second includes all of the above as well as the emotional experiences separate from emotional labor. This second model is useful for determining if some emotional experiences amplify or mute the effect of emotional labor on the turnover intention outcome.

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<sup>10</sup>Reports of positive emotions are not highly correlated with one another (all correlation scores are under .10). Correlation between negative emotions is a bit higher (from .15 to .37), but are not high enough to warrant concerns of multicollinearity.

Table 7: Likelihood of Leaving Current Job

	Model 1: Emotional Labor and Controls		Model 2: Emotional Labor, Emotions, and Controls	
	OR	SE	OR	SE
EL Patients-Sad	.83	.20	1.00	.42
EL Patients-Angry	1.54	.52	1.62	.60
EL Co-Workers	1.09	.31	1.15	.39
EL Self	3.69***	1.20	3.05***	1.05
Emotions Felt				
Positive emotions: patients			.82	.35
Positive emotions: co-workers			1.00	.35
Helpless			3.28*	1.98
Angry			.79	.53
Sad			.79	.55
Work Variables				
Unhappy with pay	1.27	.33	1.32	.37
Unhappy with benefits	1.30	.30	1.37	.36
Unhappy with supervisor	1.94*	.64	1.99+	.76
Controls				
Sex (1=Female)	.41	.32	.45	.38
Age	.63*	.14	.67+	.15
Pseudo R2	.34		.36	
Sample Size	144		138	

Statistical significance denoted as (\*\*\*)=.001; (\*\*)=.01; (\*)=.05; (+)=.10

By treating emotional labor as four different types of processes, I found a great deal of variation in the effects of emotional labor. Table 7 shows that of the four types of emotional labor, only the work one does on the self is significantly related to leaving a current job. Workers who report suppressing their true selves or becoming mechanical are 3.69 times more likely to say that they do not intend to continue working in their

current job. While none of the other types of emotional labor are statistically significant, the direction of their effects is still interesting. Emotional labor with sad patients is negatively (coefficient  $<1$ ) related to intention to leave, while all other three types have a positive (coefficient  $>1$ ) relationship to turnover intention. These results should be interpreted with caution, as only emotional labor on the self is statistically significant, but they may guide research expectations for larger studies.

The second model integrates emotions separate from emotional labor. Table 7 shows that some types of emotional experiences matter—even separately from emotional labor. Specifically, I anticipated that feelings of anger, sadness and helplessness could affect workers' intention to leave, but found that only helplessness had a statistically significant relationship to turnover intention. Workers who reported feeling helpless at all during the previous week were 3.28 times more likely to say they intended to leave their jobs than those who did not feel helpless. Anger and sadness were not statistically related to turnover intention.

The second model also allows an analysis of the effect of positive emotional experiences. Neither positive emotions with patients nor positive emotions with co-workers are statistically significant. Additionally, because their coefficients are near 1.0, they do not indicate a strong direction of the relationship, making them less useful for guiding future research. However, when all these emotion variables are included, the effect of emotional labor on the self is slightly reduced to 3.05. These findings suggest

that authentic emotional experiences, good or bad, could reduce the harm that comes from emotional labor on the self, which produces a sense of inauthenticity.

Findings related to the importance of emotional labor meant to manage the self and the role of helplessness, even separate from emotional labor remain even with standard measures of work dissatisfaction, like feeling unhappy with pay, benefits, or supervisors. Reporting problems with supervisors was the only statistically significant variable from this grouping, and while the coefficients are large (1.94 for model 1; 1.99 for model 2), they are still smaller than the coefficients for either emotional labor on the self or feelings of helplessness. These emotional experiences are stronger predictors for intention to leave. Finally, these findings also hold true controlling for sex (1=female) and age. It is important to control for sex as women and men may deal with their feelings related to work differently (Cain 2013b). Age is a crucial control because it may signify a life-stage that is less willing to leave a job, especially as many hospice workers near retirement. Age is marginally significant, showing that with age, workers are less likely to leave their current job.

## Discussion and Conclusion

This article had four primary goals. The first was to understand how workers from various positions divide up the emotional labor of hospice. The second goal was to refine the concept of emotional labor to fully reflect the variety of experiences that qualify. Thirdly, I sought to integrate emotional experiences that did not fit the emotional

labor concept. And, finally, this article aimed to understand how the varying types of emotional labor and emotional experiences outside emotional labor affect workers' intention to leave their current job.

Answers to these four questions are useful for understanding why hospice workers are generally more satisfied with their work than other healthcare workers. First, I find that there are four different dimensions to emotional labor within hospice, and that emotional labor with patients is shared fairly equally across patient-facing hospice workers (Medical, Social, and Personal Support workers), while Administrative workers do little of this work. Emotionally supporting colleagues is also a type of emotional labor that self-reports show to be evenly distributed. However, by integrating positive emotional experiences, we see that patient-facing workers are also the most likely to have good experiences that make their work worthwhile. Those most likely to face angry and sad patients on a regular basis are also most likely to have positive experiences, and least likely to say they perform emotional labor on themselves to keep their own feelings in check.

Importantly, when all of these variables are included in the logistic regression, two stand out as strongly related to intention to leave a current job: emotional labor on the self and feelings of helplessness. Both of these are related to a sense of control and efficacy. But, both also have implications for workers' sense of authenticity in the setting. These findings indicate that any type of work that encourages workers to not be themselves has negative effects for the workers, and ultimately for the work organization

as these feelings increase turnover intention. These findings help refine the emotional labor concept by acknowledging underlying divisions between types of emotional labor and integrating workers' authentic emotional experiences into the analysis

Future research should continue to integrate emotional experiences alongside emotional labor. This is especially true for understanding what it means to feel 'authentic' at work and how it manifests in various settings. This article also pushes research to acknowledge the ways that emotional labor is distributed across work groups. Workplace dynamics may produce additional emotional labor for some, while providing opportunities for positive emotional experiences for others. These unequal distributions matter for workplace functioning and worker satisfaction.

## CHAPTER V: CONCLUSION

### Summary of Main Findings

Care workers actively engage their work settings, sometimes constrained by bureaucratic structure, sometimes performing emotional labor, but also frequently experiencing and expressing emotions felt to be authentic and true to their selves. Chapter IV shows that workers' sense of authenticity is important to their ability to continue doing the work of hospice. Hospice workers periodically admitted hiding, covering up, or acting while at work, but still reported that on the whole, they were true to themselves at work. One aspect of being themselves was the construction of a hospice identity. This identity explained away disparities between front- and backstage presentations of self by constructing both as "just part of hospice," something hospice workers had to do. But, in doing so, they also developed ways to deal with the emotional labor of hospice. Their identities gave meaning to the work, and allowed workers to develop strategies that helped them balance their own needs with the needs of those they served.

Another tension in hospice is between workers' strong commitment to the work and changes to hospice organizations that make that commitment hard to sustain. Chapter V shows this tension through its portrayal of institutional logics during times of financial strain within hospice. Underlying logics of hospice (Medical, Holistic,

Business) sometimes conflicted, forcing workers to explicitly negotiate how to divide up labor. Through the negotiation process I noticed that the Medical logic often dominated decision-making processes, subordinating non-medical tasks and social support workers. This was especially problematic as hospices attempted to change policies and procedures to fit the new, more restrictive, financial environment. The result was that social support workers, who report very high levels of commitment to hospice, faced changes to their work that produced fear of reduced hours, more precarious career trajectories, and less time with patients. While this change clearly presented challenges for hospice workers as they tried to balance their commitment with organizational change, it also had the more meso-level effect of making hospice look more like conventional medicine, and less like its roots.

Building on the previous chapters, Chapter VI shows how emotional labor contributes hospice workers' turnover intention. Chapter IV shows that the negative effects of emotional labor are tempered by workers' authentic emotional experiences, while Chapter V emphasizes that organization-level dynamics still produce strain, including emotional labor. How do these fit together? This final empirical chapter approaches this question by measuring four types of emotional labor: with patients who are sad, with patients who are angry, with co-workers, and on the self. Of these, only emotional labor on the self (hiding or faking emotions) was statistically related to intention to leave a current job. This relationship is strong, showing that workers who reported performing emotional labor on the self were over three times as likely to want to

leave their job as those who did not. This finding shows the importance of authenticity, while also highlighting the tension between workers' needs of the self and needs of caring for others. Chapter VI also finds that feelings of helplessness matter separate from the performance of emotional labor. This gives support for emotion scholars' critique that understandings of emotions at work would be strengthened by more explicit integration of emotion processes (and not just a focus on emotional labor). It also shows organizational change, which likely often creates increased feelings of helplessness, poses a challenge for workers who are committed to hospice, but are frustrated by the changing organization of their work.

### Limitations

There are three main limitations to this study. The first is that all the data were collected in a single geographic region, and represent a relatively small sample of hospice workers. While I tried to capture the diversity of contexts of hospice in my sampling procedures, especially for the interviews and survey, we should not assume that these findings represent the experiences of all hospices. Collecting data in Arizona offered advantages in terms of the diversity of hospice programs available and the need level of care recipients. These two things permitted a careful analysis of the various ways that emotions mattered for workers under different kinds of work contexts. While these factors make Arizona a unique care to study hospice, they also highlight how we may use the findings to better develop theory related to hospice workers' experiences.

Second, although I intentionally sought out workers from all positions, certified nursing aides (CNAs) were very difficult to recruit at all stages. In the ethnographic portion I did not encounter CNAs often as they did not attend team meetings. Additionally, they set their own schedules and avoided visiting patients the same time as other staff members. Consequently, I was able to recruit only two CNAs for observation, both of whom worked in the inpatient unit of Rose Hospice. This lack of contact with CNAs also meant that fewer accepted my invitations to participate in the interview portion of the study. I was able to recruit eight CNAs for interviews, but three of those interviews took place during their work shifts, so questions about relationships with co-workers were avoided in order to protect participants. CNAs are also underrepresented in the survey portion. Because I recruited survey participants from team meetings, CNAs were not present in the initial sample. I was able to schedule a separate training meeting with CNAs from most organizations, but for one of the five organizations, that separate meeting was never completed. Consequently, while the survey sample includes 31 CNAs, this is only a 61% response rate for this group. Findings related to CNAs as a group should be interpreted with caution and future research is needed to delineate how their experiences may differ from other hospice workers.

The third and final limitation comes from the timing of the study. In many ways, the data collection period (2007-2011) was ideal: many changes took place that made social processes more apparent; workers were sometimes frustrated and looking for an outlet; and, hospice is continuing to grow and is sometimes held up as a model for other

healthcare systems to replicate. In other ways, however, the study may have been improved by a longer view changes to hospice. Several factors discussed here will take time before their full effect is felt, and studies of turnover would be strengthened by using longitudinal data that documents who stays and who leaves hospice.

### Contributions

Despite the limitations discussed above, this study contributes to sociological knowledge through its integration of theories residing at different levels of social life, and its use of multiple methods. I focus on the ways that workers' micro-level experiences are shaped by macro- and meso-level forces like institutional logics and organizational change. This allows an analysis of how context matters for the administration of caring labor, but also how micro-level behaviors support, shape, and even change macro-level social institutions. The integration of these theories better represents the complexity of workers' experiences, allowing them agency as well as acknowledging constraints on their action.

In particular, by merging these theoretical orientations, my research reinforces care work scholars' assertions that emotions during work do not have to be exploitative, and are even useful to workers as they construct meaning about the work. Emotional processes are not always constrained by the organizations, and many hospice organizations in my study were making an effort to institute what Lopez (2006) called organized emotional care. Hospice workers responded positively to these efforts, often

demonstrating a great deal of nuance in their approaches to handling emotions at work. Additionally, workers' reports reinforced the importance of thinking about identities and sense of self when conceptualizing how actors respond to organizational dictates. Through caring labor, many hospice workers found opportunities to make meaningful connections and help others.

On the other hand, workers' experiences were not entirely positive. This dissertation contributes to knowledge about institutions by showing the ways that conflict and contradiction at the interaction-level reconstitutes meanings at the organizational level. By critically analyzing the hospice team, I was able to show that conflicts in institutional logics have unintended consequences for workers and the organization as a whole. Specifically, these conflicts marginalized social support workers and reduced the amount of time spent providing non-medical care for patients. Future research on institutional logics would benefit from continuing to bridge levels of analysis and better understand how actors are empowered and constrained within organizations.

Methodologically, by combining intensive qualitative research with more quantitative strategies, I am able to provide a full picture of hospice workplace dynamics and emotional labor. This combination allows nuance otherwise hard to observe. For instance, while the qualitative portions of the research indicate that social support workers experience strain because they perform a great deal of time-consuming and exhausting emotional labor with their co-workers, survey self-reports of emotional labor with co-workers show that hospice workers from all positions think they provide a

moderate amount of emotional labor to their colleagues. These contradictory findings point to the limits of both interview and survey methods, but they also indicate something deeper. Might it be that individuals are not particularly good at knowing how much support they give or take from others? This poses a problem for any study that seeks to understand the role of social support in any social or health outcome.

This research has several policy implications as well. First, need for end-of-life and long-term care is expected to increase over the next several decades and there are not currently enough care workers to meet this demand (Drago 2007; Stone and Dawson 2008). This means that organizations that provide care services have an incentive to consider ways to improve jobs in the caring sector in order to recruit enough workers to meet demand. This research illustrates points of intervention to improve the work, especially through its focus on workplace relationships and supports. Additionally, although this dissertation is focused on the experiences of hospice workers, the findings also link quality of work experiences to quality of care provided (Eaton 2000; Eustis and Fischer 1991). This research shows that hospice workers are more committed and concerned when they find value and meaning in their work. One way to intervene to improve care outcomes is to focus on how workers find and create meaning about their work, thus increasing workers' commitment to quality care.

Second, the Affordable Care Act (ACA) has shifted the ways that we pay for medical services. Specifically, there is an increased emphasis on paying for quality outcomes, instead of just services rendered (Miles 2012; Peterson et al. 2006). One

component of this is reducing the amount of time people spend in hospitals. Hospice care is one way to keep those at the end-of-life in the home and out of hospitals (Miles 2012), and saves money for the healthcare system (Robinson and Pham 1996). This may mean that hospitals and large-scale health providers have an increased motivation to build up hospice programs. On one hand, this may integrate hospice services more fully into the healthcare system, encouraging earlier enrollments of patients, and improving communication and cooperation across needed services. On the other hand, this dissertation shows some of the challenges of taking hospice into a more conventional healthcare setting. Specifically, some aspects of the team-approach to hospice care may be threatened, especially as hospices face financial constraint and organizational isomorphism. By focusing on the unintended effects of changes to hospice, this dissertation foreshadows struggles likely apparent all across the healthcare system as organizations shift under the ACA.

#### Future Directions

My future research will expand on the dissertation in both practical and theoretical ways. First, there are several implications from this research that may inform health policy. Future research will examine ways to increase the prevalence of care workers' positive, authentic emotional experiences with their charges and one another. If these positive experiences do allow the construction and confirmation of identities that make the work more worthwhile, they not only increase quality of care, but also may

increase retention of care providers. Relatedly, future research will further explore the role of feelings of helplessness and how they affect workers' sense of satisfaction and commitment. Are there ways to decrease helplessness? Can healthcare organizations change policies in order to better support worker self-efficacy? Additionally, my research points to some of the challenges of team approaches to care, but it is also a foundation from which to develop policy interventions that would improve team functioning.

Theoretically, I will expand future research through employing similar data collection strategies and analytical lenses to other types of care settings. In particular, I am increasingly interested in new dementia care centers and residential centers that aim to bridge the gap between declining cognitive health and death. Dementia poses a health concern as well as offers a unique opportunity for sociologists to understand interaction rituals within new types of institutions and reveals social aspects of emotional experiences.

Additionally, data from the current dissertation data collection will also be developed into several additional papers. One examines gendered definitions of emotion management strategies, focusing on the ways that men are given more credit for their emotion management skills than women. Another paper theorizes how the place of care (in the home or in an institutional setting) shapes workers experiences, finding that hospice workers report greater autonomy, closer relationships, and more flexibility in the administration of care within the home (as opposed to institutions). This has implications

for improving workers' experiences with home-based care and improving institutional care by integrating more aspects of home.

Finally, future research will examine some of the most striking contradictions and nuances between the different kinds of data collection reported here. I will assess how relationships mattered for the hospice workers, which relationships were useful for establishing and maintaining commitment to the work, and which relationships added burden onto workers. These findings will be useful for future studies of other care settings as well.

APPENDIX A: HUMAN SUBJECTS APPROVAL

**HSPP Correspondence Form**

**Investigator:** Cindy L. Cain, Graduate Student

**Department:** Sociology

**Advisor:** Don Grant, Ph.D:

**Project No./Title:** 10-0091-02 Emotional Labor within Hospice

**Expiration Date:** March 23, 2014

Submit the "FORM: Continuing Review Progress Report" no later than 45 days prior to the expiration date.

**IRB Committee Information**

**IRB2 – IRB00001751**

**Expedited Review – Continuing Review**

**FWA Number:** FWA00004218

**Documents Reviewed Concurrently**

F212 (signed 2013-01-15; revised 2013-02-07)

**Determination**

**Approved** as submitted effective as of the signature date below

**Comments**

- **Continuing Review Category Status:** Enrollment in progress or still planned

**IRB Note:** No consent forms were approved, modification approved concurrently will be approved with modified consent forms

**Regulatory Determination(s)**

- **Criteria for Approval has been met (45 CFR 46.111):** The criteria for approval listed in 45 CFR §46.111 have been met (or if previously met, have not changed).
- **Eligible for Expedite Approval (45 CFR §46.110):** Identification of the subjects or their responses (or the remaining procedures involving identification of subjects or their responses) will **NOT** reasonably place them at risk of criminal or civil liability or be damaging to the their financial standing, employability, insurability, reputation, or be stigmatizing, unless reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal.
- **Expedite Approval (45 CFR 46.110 Category 6):** Collection of data from voice, video, digital, or image recordings made for research purposes.
- **Expedite Approval (45 CFR 46.110 Category 7):** Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.
- **Waiver of Documentation of Informed Consent (45 CFR 46.117(c)(1)):** As documented in the file, the only record linking the subject and the research would be the consent document and the principal risk would be the potential harm resulting from a breach of confidentiality .

**Reminders:** No changes to a project may be made prior to IRB approval except to eliminate apparent immediate hazard to subjects.



*Thomas K Park*

2013-02-27

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Thomas K. Park, PhD  
Co-Chair, University of Arizona IRB  
TKP: ace

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Date

## APPENDIX B: PUBLISHED PAPER

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## **Integrating Dark Humor and Compassion : Identities and Presentations of Self in the Front and Back Regions of Hospice**

Cindy L. Cain

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# Integrating Dark Humor and Compassion: Identities and Presentations of Self in the Front and Back Regions of Hospice

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Cindy L. Cain<sup>1</sup>

## Abstract

In *The Presentation of Self in Everyday Life*, Goffman drew attention to the various ways that individuals present themselves across settings. One aspect of his discussion was the division of space into front and back regions. In this article, I use data from two years participant observation and forty-one interviews with hospice workers to examine the ways that workers identify as well as how they use those identities to account for discrepancies between front and back region behaviors. Front stage behaviors emphasize compassion, while backstage behaviors include dark humor, strategizing, and detachment. This article argues that workers create a hospice identity that emphasizes authentic emotional expression and enlightenment about death as a way to explain away discrepancies in behavior. This work challenges assumptions that fronts are only performances and that back regions are more authentic by showing how workers integrate the two into a professional sense of self.

## Keywords

hospice, care work, identity, presentation of self, emotions

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We cuss in the conference room and cry with the family.

—Nickie, Director of Hospice Services

Workers across various occupations and organizations are expected to manage public perceptions of their companies, professions, and work-related selves. In doing so, they engage in an array of impression management strategies, including displaying appropriate emotions for the setting (Hochschild 1983), learning and disseminating organizational meanings (Grant, Morales, and Sallaz 2009), acting like a “good soldier” (Bolino 1999), and partitioning different aspects of their work into defined areas or times (Goffman 1959; Manning 2008). Care workers feel especially pressured to use these strategies because, if they fail to convince others that they are warm as well as competent, they face the prospect of losing their jobs (Abel and Nelson 1990; England 2005; Findlay, Jeanette Findlay, and Stewar 2009).

In this article, I focus on how hospice workers partition time and space as a strategy for managing perceptions of hospice as a type of work and hospice workers as compassionate, caring professionals. My analysis draws upon Goffman’s (1959) classic writings on the front and back regions of social life. The front region (or front stage) refers to any time or location in which workers exhibit the official meaning of the setting, conforming to the expectations of their identity in this setting. The back region (or backstage) refers to any time or location in which workers are not dramaturgically “on” and, consequently, may express unofficial or even counterofficial selves or interpretations. The two regions have a symbiotic relationship in that activities in the backstage allow workers to maintain appropriate behaviors during the front stage, while front stage activities provide fodder for discussions and activities in the back region.

I use participant observation and interviews with staff members from a midsized hospice in the southwestern United States to assess the front and back region behaviors of hospice workers. Hospice is an end-of-life care option that emphasizes quality of life over quantity of life, the need for acceptance of death as a natural part of life, assistance to the family as well as the patient, and comfort at the end stages of life (NHPCO 2012). I combine ethnographic and interview methods to get a sense of how workers explain behaviors that often diverge from one another. My findings reveal that hospice workers present themselves in front regions as caring, compassionate, and serious professionals. Meanwhile, in their back regions they engage in morbid humor, strategize about how to change the conduct of patients and caregivers, and display detachment from death. Although these front- and backstage actions seem to oppose one another, hospice workers report that both sets of

behaviors are authentic expressions of self and important to their professional work. I argue that workers integrate these differing presentations of self through the creation of a hospice identity that emphasizes emotional authenticity and enlightenment about death.

The findings of my study confirm Goffman's (1959) initial theorizing about the importance of the backstage for keeping the front stage in order. My findings also challenge the assumption that front stage activities are all performances while backstage behaviors are more authentic expressions of self. Drawing on ethnographic observations and interviews, I show that *both* sets of behaviors are staged, but felt to be authentic by workers. Moreover, I highlight how hospice workers' use their hospice identities to construct front- and backstage behaviors as essential to continuing hospice work. Finally, by demonstrating how hospice workers use backstage areas to better prepare for front region performances, this article argues that different performances of self are important components of managing the stress of emotional labor.

## **The Work and Identities of Care Workers**

To better understand the experiences of hospice care workers, this project draws on two interrelated sets of concerns. First, because care workers must closely monitor their presentations of self when interacting with patients and caregivers, we can gain a more comprehensive understanding of their work-related identities by documenting both their front- and backstage behaviors. Goffman's (1959) concept of behavioral regions provides a useful theoretical orientation in this regard. Second, to make sense of how workers account for these differing presentations of self, I draw on sociological research and theory related to the creation and maintenance of social identities, with an empirical focus on the identities of care workers.

### ***Front- and Backstages***

According to Goffman (1959), front regions are defined by the maintenance of proper appearances and adherence to rules of decorum. The front contains the setting (*décor*, physical layout, props) as well as the characteristics (rank, age, gender, ethnicity) of the individuals who serve as participants. The front exists separately from the individuals who fill the roles within in it, so much so that Goffman (1959, 27) notes that each participant enters an already established front and, simply by conforming to expectations of the social situation, helps reproduce the "collective representation" of reality. The front is highly

scripted and often does not allow participants to express their personal thoughts, feelings, or desires.

In the workplace, front regions hold the official interpretations of the job at hand, the requirements for completing the job, and ideas about the worth of the job and other participants. Workers and those whom they serve do not always agree on the interpretation of the situation (Mangold and Babakus 1991), which may be especially problematic for workers who must keep up the appearance of caring (Abel and Nelson 1990). To keep the interaction on track, even as participants do not always accept the performances, these encounters often include staged behaviors for both staff members and consumers of that service (Grove and Fisk 1992). In addition, workers perform emotional labor and sometimes even exaggerate emotions for the audience in efforts to evoke a particular feeling in others (Hochschild 1983; Smith 2008).

Workplaces also typically have backstage regions that are out of view to the publics they serve. In these back regions, workers can express beliefs that are not permitted in the front stage (Hughey 2011), openly denigrate members of groups they do not like (Sallaz 2010), laugh at customers or the work situation (Tracy, Myers and Scott 2006), learn about and practice their responses to stigma related to work (O'Brien 2011), and perform tasks that would be inappropriate in sight of others (Turner 1976). According to Goffman (1959, 111), these back region behaviors must exist in order to make the front stage behaviors possible. They allow workers time and space to prepare for their roles, practice appropriate ways of being, blow off steam, and take a break from emotionally burdensome roles.

Goffman (1959) also noted that workers form teams, strategize about how to approach the work situation, and teach or critique one another on their performances in the back region. Smith (2008) notes how backstage activities with trusting coparticipants are essential for the production of effective front stage performances of emotions. Teamwork requires the establishment of consensus over rules of interaction (Futrell 1999; Manning 2008; Misztal 2001), so team practice especially helps in contexts where norms and rules of interaction are not constant, such as crisis-based situations. With enough practice, teamwork seems effortless, happening without the audience perceiving team communication or direction (Hindmarsh and Pilnick 2002).

Although workers frequently become skilled at hiding back region activities, the line between front and back regions is not always clear. Tanner and Timmons (2000) studied operating rooms and concluded that front stage regions included areas with patients, but as the patients underwent anesthesia the space transformed into a backstage area. Tardy (2000) found that the

same play area could be front stage if children with unfamiliar parents were around, but transitioned into a backstage when children were not paying attention and parents trusted one another. These variations have led some scholars to argue that we should think of regions as having a front/back continuum, rather than as distinct geographic spaces or times (MacCannell 1973). This perspective seems especially applicable to caring work because staff members turn any and all settings into front stage areas when necessary, but they can also slip into back region behaviors if they think they are not under surveillance by clients or family members.

According to Tseelon (1992), impression management research following Goffman assumed that actors strategically manipulate their public displays to hide their true selves (see Bolino et al. 2008; Durr and Wingfield 2011; Kumra and Vinnicombe 2010 for recent examples). By extension, this scholarship often concludes that the backstage is more “authentic” than the front stage (Chriss 1995). This conclusion contradicts Goffman’s original theorizing, which emphasized that all social interactions include dramaturgy and performances. And while Tseelon’s (1992) critique was published twenty years ago, studies of impression management have either (1) focused exclusively on front region presentations of self, emphasizing how particular performances work to advantage some actors while sidestepping the issue of back region behaviors (Collett 2005; Greener 2007), or (2) implied that workers exhibit their true selves in the backstage and that their front stage activities include only performance (Huppatz 2010; Kumra and Vinnicombe 2010).

Hospice workers challenge these assumptions. I found that hospice workers see both front stage and backstage behaviors as important parts of their professional identities. This conclusion is consistent with Goffman’s original observations. In fact, he noted (1959, 111) that all social situations include performances: “when one’s activity occurs in the presence of other persons, some aspects of the activity are expressively accentuated and other aspects, which might discredit the fostered impression, are suppressed.” According to Goffman, all social interactions include some aspects of impression management, but what people conceal (and highlight) shifts depending on their audience and setting. By analyzing these different modes of dramaturgical concealment and display, I document the extent to which hospice workers describe their behaviors as both authentic and staged. Although my analysis makes no judgment about the actual “authenticity” of the hospice workers’ presentations of self, it does focus on how workers construct and enact authentic selves, drawing on elements from the front stage as well as the backstage.

## *Identities of Care Workers*

Our conceptions of self emerge through our interactions with others (Cooley 1902). We form ideas about ourselves based on our interpretations of how others appraise us. However, given a particular view of ourselves, we must also constantly monitor and maintain a preferred identity (Stets and Burke 2003). In addition, we may have multiple identities at once, but characteristics of the situation help us to decide which identities matter most and how these identities will shape our actions (Ashforth, Harrison, and Corley 2008; Burke 2004).

Identities shape social action in the workplace by providing a “definition of the situation” and offering potential lines of action (Burke 2004). For instance, if a nurse provides care for someone in an official capacity, she might interact with the patient differently than she would if the person was also her mother. Ashforth, Harrison, and Corley (2008) argue that identities tie workers to organizations, making the study of identity at work especially important to understanding workers’ experiences. Identities also shift one’s orientation toward unpleasant or difficult tasks, such as dissecting a human cadaver on the way to becoming a physician (Madill and Latchford 2005) or learning how to communicate more like a physician than a student (Lingard et al. 2003).

Many studies of workers’ identities have focused on what happens when one’s identity is challenged or when a discrepancy arises between their actions and identity (Alvesson, Ashcraft and Thomas 2008; Pratt, Rockmann, and Kaufman 2006). For example, Brennan (2009) argues that discrepancies between how nurses see themselves and how they are expected to act lowers job satisfaction. In addition, Burke (2004) points out that we have numerous studies of the enactment of identity, but we need to pay more attention to the goals of identity, such as gaining legitimacy, providing meaning, or extracting more labor from others. In this article, I examine how workers negotiate identities and how they use those identities to account for discrepancies in behaviors.

While few scholars have explored the identities of hospice workers (see MacDonald 1991 for an exception), a number of researchers have documented the identities of other types of health care workers, especially nurses and physicians. After analyzing the content of introductory nursing textbooks, Goodrick and Reay (2010) concluded that nurses have shifted from serving as assistants to physicians to having identities grounded in a distinct sense of professional expertise and autonomy. Nurses in some settings defined themselves against the physicians and attendants by emphasizing

their attention to holistic care (Chambliss 1996) as well as their ability to make independent decisions (Allen 2000). To establish a distinct medical identity, nurses sometimes manage information during interactions with physicians (Riley and Manias 2009). In settings where teamwork is emphasized, such as hospice, medical support staff tend to form an identity around working well with others (Lewin and Reeves 2011). Certified nursing assistants (CNAs) often form an identity around providing high-quality care to those most in need, sometimes accepting deplorable wages and work conditions because their identity as a caring person gives the work meaning (Stacey 2011). In addition, providing medical care often involves “dirty work” (Ashforth and Kreiner 1999), pushing some care providers to form an identity that is professional and compassionate as a way to ameliorate the disgrace of performing work that involves the management of disgust (Sanders 2010).

Nurses and nursing aides provide the bulk of medical care to hospice patients, but because the hospice philosophy emphasizes caring for all aspects of patient needs at the end of life, social support workers also play a prominent role. The latter group includes not only social workers but also counselors, chaplains, and volunteers. MacDonald (1991) found that hospice social workers did not have a clear set of tasks with which to define themselves, and consequently did not have a distinct professional identity within hospice. Other social support personnel form an occupational identity that includes a sense of calling (Christopherson 1994; Dreher, Holloway, and Schoenfelder 2007) or an emphasis on performing saintly work (Solari 2006).

## **Methods and Setting**

I engaged in participant observation, informal interviews, and semistructured interviews to gather data about the identities and interactions of hospice workers. Because these methods are especially attuned to the processes by which behaviors and identities are constructed, they are ideal for assessing Goffman’s writings on the interaction order (Hillyard 2010). In fact, in a recent review of literature related to identity, Owens, Robinson, and Smith-Lovin (2010, 495) commented that “we may need new studies of naturally occurring situations to fully exploit the linkages between internalized structure and situated action.” In a related vein, Barley and Kunda (2001) argued that we need more studies of the process of work, especially ethnographic accounts like this one, to continue to build knowledge about work and workers.

Hospice serves as an ideal venue for examining workers’ presentations of self. Hospice organizations are shaped by the hospice philosophy, which seeks to provide a “good death” to patients. A “good death” is thought of as

death with dignity, peace, acceptance, and the control of pain (Hart, Sainsbury, and Short 1998). It also encourages communication and cooperation as well as interdependence between professional positions, and the use of interdisciplinary teams to conduct care. Interdisciplinary teams consist of physicians, nurses, CNAs, social workers, chaplains, counselors, and volunteers working together to meet the complex medical, social, spiritual, and psychological needs of patients and their families. The nature of hospice work makes it especially important that hospice workers carefully manage impressions of self.

The setting for this study is a midsized hospice organization in the southwestern United States, here called Rose Hospice. This location typically has approximately one hundred patients enrolled at any point in time and employs forty-five to sixty-five staff members. I use pseudonyms to refer to all staff members and organizations to ensure their anonymity. Although there is great variation in the size of hospices throughout the United States, the patient enrollment and staff size of Rose Hospice is average for this region. I entered the site as a hospice volunteer so my research includes full participation in patient services, observation of staff behavior, and partial participation in administrative responsibilities, such as paperwork and communicating with other team members. All aspects of this research were approved by my University Human Subjects Protection Program.

Much of the work of hospice takes place in the homes of patients or adult care facilities; however, this particular organization also runs an inpatient unit for those with care needs that exceed the abilities or resources of home caregivers. The inpatient unit is a short-term facility and most patients in the unit are either expected to die within days of entering the facility or come to the unit to give caregivers a break from daily care. The inpatient unit has ten rooms available at a time and is furnished to look like a comfortable hotel. Each room has a hospital bed, a few chairs or a small couch, a sink, refrigerator, and space to store belongings. Observation of staff-patient interactions took place primarily in the inpatient unit, but also included some visits to patients' homes and adult care facilities.

During patient visits, I did not take notes out of respect for the patients' families and the wishes of the hospice workers, but after each meeting I recorded my experiences in audio and written format. My observation at the inpatient unit included attending meetings in the conference room; visiting patients with nurses; visiting family members with social workers, counselors, and chaplains; and spending time in the nurses' station. The social workers and chaplains were initially more open with me about their jobs and lives outside of work than the nurses and CNAs. The nurses and CNAs were first tolerant, and then accepting, of my presence in their space. Overall, I spent

about four hours per week in the inpatient unit over the course of eight weeks from March to May of 2010.

I also conducted participant observation at weekly Interdisciplinary Team Meetings, referred to as IDG by the staff. Team members include a physician that served as the medical director, nurses, social workers, counselors, and chaplains or spiritual directors. In total, nine to twelve staff attended each meeting. I observed weekly meetings for approximately nine months from January to September of 2010, with each meeting lasting between two and four hours. I describe the content of the meetings below. Throughout 2009 and 2010, I also volunteered at the main office, performing administrative tasks, interacting with the staff, and collecting preliminary ethnographic data on the operations of hospice. I spent slightly more than two years making weekly visits to the main office, IDG meetings, the inpatient unit, and the homes of patients.

I supplemented data gathered through observations of the inpatient unit and weekly IDG meetings with semistructured interviews of thirty-four staff members as well as informal interviews of seven staff members. Participants included eight nurses, eight CNAs, five chaplains, four social workers, three volunteers, four counselors, six administrators, and three physicians. These interviewees represent the diverse experiences of workers within hospice, while still focusing attention on the staff members who perform the most patient care (i.e., nurses, nursing assistants, social workers, and chaplains). In these interviews I asked workers questions about how they did their work, how they came to hospice, how this job compares to others they have had, how they feel about the company and their coworkers, and how they fit work with their family life. The interviews ranged from 38 to 87 minutes long, with most interviews lasting at least one hour. Interestingly, I did not ask workers about their professional identities, but this theme consistently came up in my inductive coding of the ethnographic field notes and interviews, indicating that workers have a strong sense of professional identity and that it shapes both how they act and how they feel about the work they do. Also, by not explicitly asking about worker identities, I was able to get a more comprehensive view of how workers' sense of self fit within their work activities (Sveningsson and Alvesson 2003).

### *Getting Access and Building Trust*

Even though volunteers are technically part of the hospice team, I found that the hospice workers initially treated me like an outsider and did not integrate me into their backstage behaviors. However, entering the setting through the volunteer program meant that I used a "side-in" (Chambliss 1996), instead

of top-down, approach to observation. I came in as a volunteer and built up access over time, simultaneously gaining trust and information about hospice. This approach allowed me to avoid many of the access problems that typically plague research on medical institutions. For several weeks, the hospice workers did not discuss sensitive topics in my range of hearing or used vague references to keep some aspects of the work hidden. Sensitive topics included problems with other workers, elder abuse of patients, and complaints about the organization. As my research unfolded, however, workers became more open and even explained common situations to me as they happened.

I conducted all research overtly and I made an effort to integrate fully with the workers to build trust (Miller 2004). Gaining trust was especially important in that I sought to observe workers' behaviors behind the scenes and to ask them questions about sensitive topics, including feelings and behaviors that might be damaging to their professional careers. In turn, I had to monitor power dynamics between myself and the participants carefully (Hoffmann 2007; Kleinman and Copp 1993). To ensure that we had trusting relationships, I took the role of student and confidant. I also performed my own emotional labor in the following ways: I ensured participants that I did not judge them for their comments, I hid my frustration when they dodged tough questions, and I buried my delight when I was finally able to get some of the respondents to open up. I also ended the interview with an invitation to ask me anything they wanted or suggest other types of questions I should be asking. This invitation usually resulted in a few short questions about why I was interested in hospice and suggestions for additional questions or persons to interview.

### *Strategies of Data Analysis*

I analyzed the written and voice data through an iterative process that included my observations as they happened, an exploration of themes that emerged on typing and compiling notes, and rereading and coding the written notes. I transcribed all audio recorded notes, and all of the interviews were transcribed by a professional service funded by the National Science Foundation. After reading the transcribed notes and interviews, I used Atlas.ti to construct a coding scheme and a set of theoretically interesting themes. Some themes, like the identity of care workers, emerged through this process, while I derived others, especially related to emotional labor, from the literature. In both cases I carefully noted unexpected, surprising, and contradictory findings.

Guided largely by Charmaz's (2006) version of grounded theory, I performed analysis of themes and concepts as I collected ethnographic and interview data. I used memo writing to work through emerging ideas and to orient

future data collection through theoretical sampling. I evaluated and modified my conceptual approach as I collected data, which proved to be immensely helpful in sorting out how workers made sense of their contradictory behaviors. I then used memos, voice notes to myself, field notes, and interview transcripts to pull together conceptual links that were not always observable to participants in the setting.

## **The Front Stage of Hospice**

Front stage behaviors performed by hospice workers most often occurred during interactions with patients and family members. During these interactions, workers typically projected absolute professionalism, expertise, and caring. During one visit, Vonda, a social worker, allowed me to observe her conversation with the two daughters of an ailing woman. Although she had been quite busy throughout this day, Vonda took me aside to show me the case file, go over the list of topics to discuss, and come up with a strategy for discussing difficult topics. She told me that she felt “frazzled,” and then warned that she needed to talk to the family members about their funeral plans and “they might get a little teary.” When we entered the patient’s room, I was struck by how Vonda’s presentation of self changed. I recorded the following in my field notes:

She really put all of the distractions aside and was just “there with the patient.” She sat in the room, and we talked with the patient’s family again. She asked the daughters about their funeral plans for their mother and the youngest started to cry quietly. Vonda touched the shoulder of the youngest daughter twice to console her, and each time she said, “I’m sorry, I know this is really hard.” Then the daughter wiped her eyes and started asking questions about funeral preparations.

Other interactions followed the same pattern—that is, workers brought up difficult topics, family members and patients responded emotionally, and then the hospice worker assessed the needs of family members and offered support. Throughout the entire process, the staff member remained calm and compassionate.

The counselor, Michelle, frequently met with family members as their loved ones began to decline. I accompanied Michelle on a visit with a daughter of a longtime patient in her home. Michelle, the daughter, and I sat on the porch and no one said anything for the first few minutes. We sat in silence. Eventually the daughter said that she was upset that her mother was declining,

but felt relief that they had help during this difficult time. Michelle nodded and held the daughter's hand, still not saying much, but clearly offering support. After a few moments, Michelle reiterated that hospice was there to help and asked if the family needed anything. After we left, Michelle said "I like to come out here. I feel good helping her [the daughter] because they are a nice family." Even as we transitioned to a backstage area she kept the calm, supportive face that she used during the interaction with the daughter.

In another situation, I witnessed Rita, the inpatient unit nurse, greet an incoming patient. Although the patient did not seem to be responsive, Rita quietly introduced herself and welcomed the patient. Later in the afternoon this same patient started to call out, asking where she was, and if someone could help her. Rita entered the room and said, "You're in a safe place. We're going to take good care of you." She patted the patient's hand and continued to reassure her until she calmed. Rita then told me that the patient was not cognizant enough to talk about where she was or how she got there, but it helped to tell her calmly that she was safe. Rita was known throughout Rose Hospice for always treating patients in dignified and respectful ways, while also remaining calm herself.

All of these examples demonstrate the ways that hospice workers prioritize providing sensitive, compassionate, and flexible care for patients and their families. They took the time to say nothing, hold hands, and reassure patients who were not responsive. Workers took pride in meeting the needs of those who are suffering, while also accepting that their ultimate goal is not to "save" the person. The philosophy of hospice—to provide comfort, not a cure—was espoused and embodied in the front stage behaviors of staff at all levels. Nurses especially highlighted that this kind of work was a form of true nursing, and Cheryl, a hospice nurse for fifteen years commented, "Hospice is the only kind of nursing that I like." These front stage presentations of self were consistent with the workers' commitment to the hospice philosophy, and although workers admitted that they sometimes had to project feelings they did not have in these encounters, they also emphasized that their caring self-presentations felt real. As Vonda, a social worker, commented, "I don't think that we're faking it, or acting. . . . But, I suppose we do sometimes. I guess I just don't notice." However, to keep up this level of care and perform required forms of emotional labor, they needed to engage in backstage activities with their coworkers.

## **The Backstage of Hospice**

The backstage presentation of self of hospice workers differed markedly from the front stage. While workers consistently viewed and presented themselves

as caring, compassionate, and professional, they often deemphasized those characteristics when they were in a group of other hospice professionals, especially when interacting in IDG meetings.

IDG meetings began at 8 o'clock in the morning. I often arrived a few minutes early to say hello to the volunteer coordinator, Robin, who served as a key informant throughout this research. Other team members were frequently in their offices gathering paperwork, getting coffee from the communal kitchen, or sitting in the common space, discussing unresolved issues of care and compliance. The nurses entered the meeting one at a time to discuss their patients, with the official meeting beginning when the first nurse entered with the patient records. Each nurse typically supervised the care of eight to fifteen patients, and three or four nurses presented during each meeting, so the meetings often lasted two to three hours.

Although all members of the interdisciplinary team were required to attend these meetings, most of the conversation took place between the nurse and the medical director. Periodically other team members would also interject to give additional details on the state of a patient, question assumptions of the medical workers, and suggest other issues that might be unknown to these workers. The social workers were the most active of the nonmedical workers, but even they often expressed boredom and frustration with the time taken out of their workday. During interviews, social workers frequently mentioned that they were committed to high-quality care but they saw IDG meetings as being more about compliance than care, and they preferred to spend their time in the field rather than in the office. Nonmedical workers passed the time in the meeting by writing and passing notes to one another, quietly whispering about work and nonwork topics, and making lists of tasks. Joking and "messaging around" were common activities at this end of the table. Medical workers usually ignored the misbehavior of the nonmedical workers, but sometimes participated in the joking.

### *Dark Humor and Morbid Conversations*

Meetings were used not only to check in about patient care but also to address difficult aspects of the work. Hospice workers often did this with humor, teasing, and conversations that outsiders might regard as morbid. During one meeting a long-time nurse, Bonnie, reported that her patient had died unexpectedly. The medical director, Dr. Brown, asked Bonnie what the patient died from, and from the other side of the table, Ramon, a social worker replied, "She [the nurse] killed him." In another situation, a social worker noted that a patient drank approximately three to six ounces of hard alcohol each afternoon.

Dr. Brown laughed, and said, "I probably would too if I was in his situation." Several others agreed and then revealed what kinds of substances they would prefer if they faced a similarly painful dying process. These jokes were not meant to be offensive, but they often presented otherwise serious issues in a casual manner, demonstrating the extent to which the hospice workers had routinized issues surrounding death.

Workers also frequently talked about their own deaths. Proximity to death broke down social norms about the inappropriateness of these kinds of conversations, permitting workers to have morbid conversations. Before one meeting, the dietician expressed her concern that all of her children are boys and that unless she has a girl, she fears that no one will take care of her as she ages and approaches death. In another situation, Keith, a long-time hospice chaplain, explained that hospice fit with his life "because basically to me it's practice for my own dying. So that's kind of how I approach each day." He then elaborated this explanation by saying that working with people at the end of life forces him to firm up his own beliefs about death and the afterlife.

On at least two other occasions, workers confronted suicides of former colleagues. Although the hospice philosophy generally holds that with appropriate support systems and pain management, suicide would be less attractive to those facing the end of life, workers' conversations showed ambivalence about the morality of suicide. During both of these situations, workers commented on the modes of suicide used and assessed their own perception of these tactics. When one former colleague hanged himself at work, the workers at Rose Hospice expressed sadness at his death, but also commented that "I could never do that in my workplace—how horrible for his coworkers" (Robin, Administrator). In general, the workers avoided judgmental language, but they did not hide their own preferences, should they ever take their own lives. This was a somber conversation, but one that workers did not avoid. On another occasion, Barry, a chaplain in his 70s, said, "I don't believe in suicide, but with dementia I might consider it." Suicide was frequently a serious conversation among the workers, but even more frequent was conversation about preferences for disposing of their bodies after death.

One conversation about cremation became humorous to the workers as they discussed a situation in which a former patient's loved one tried to pour out his cremains, only to find big bone segments in the urn. *Cremains* is a term created by the funeral home industry, but accepted and used by staff at Rose Hospice. Robin, the key informant for this study, explained that after cremation the bones of the deceased are ground up and are the consistency of sand, not ash, so funeral directors are careful to use the word "cremains" instead.

She explained that “‘ashes’ could be misleading to loved ones.” I recorded the staff’s discussion of cremation preferences in my field notes:

[The staff] agreed that bone segments would be a horrible sight to confront while mourning, but they laughed as they discussed their own cremation preferences. Meanwhile, the meeting had ended and workers were leaving the meeting room while still discussing cremation and laughing. The volunteer coordinator turned to me and mentioned that they should keep their voices down because this conversation could be offensive to families dealing with the impending death of a loved one. Within seconds, all of the workers were quietly discussing other, more appropriate topics.

The monitoring of this conversation as the workers left the conference room signaled the move from a backstage of the staff meeting to the front stage of the public halls of the inpatient unit. Workers negotiated spaces like this throughout their workdays. In fact, one of the most common themes recorded in my field notes are moments when laughing in the nurse’s station became too loud and one of the other staffers (e.g., another nurse or the social worker) would chastise the group, reminding them to respect the visiting families. The following excerpt from my field notes illustrates this dynamic:

A patient with dementia had been trying to get out of her wheelchair all day, so the nurse brought her down to the nurses’ station to keep an eye on her. At one point the patient grabbed a bowl of sugar packets off the counter and threw it across the room. At first Rita [Nurse] seemed annoyed, but then the patient grabbed the bowl of creamers and threw it across the room as well. Belinda [CNA] then laughed and quickly moved the other items over so that the patient couldn’t reach them. Belinda, Rita, and I all looked at each other and started laughing. Yolanda [Social Worker] immediately walked in and said, “Shush, the family is visiting in 106.”

Yolanda did not think the laughter was inappropriate, but she emphasized that the family might not appreciate it. Laughing was almost universally seen as an inappropriate to front stage behavior within the inpatient unit. As Goffman (1959, 2) highlighted, managing these moments represents an attempt to keep what is “given off” in interactions consistent with intentional presentations of self.

### *Strategizing to Change Behavior*

During IDG meetings, workers also had frequent conversations about how to “educate” family members who were resistant to common hospice practices. Periodically, family members would not want their loved ones on pain medications because they feared the patient would not be aware of their surroundings, but the patient felt high levels of discomfort during bathing, transfer from wheelchair to bed, or any other kind of movement. During IDG the workers often reiterated that level of pain medication was to be decided by the medical power of attorney, but that they must make sure the family is fully aware of the level of pain. Implicit to this group discussion was an emphasis on strategies for changing the behaviors of caregivers and family members in the (presumed) interests of the patient, as demonstrated by the following interaction in IDG:

Nurse: She [Patient’s Daughter] doesn’t want any pain meds.

Medical Director: But she’s [Patient] in pain.

Nurse: I know. We need to have more discussion about her options.

Medical Director: Has she [Daughter] been there when you transfer her [Patient]?

Nurse: No, and that’s when it’s worst.

Medical Director: Next week just wait until the daughter gets there and then try to move her. That’ll get her to rethink the pain meds!

In this case the workers brought back region behaviors into a front region interaction in an attempt to persuade others. The team discussion of this strategy allowed the front stage encounters to go smoothly, even as workers tried to change the behaviors of caregivers.

Another situation where hospice workers strategized about changing the behavior of caregivers was related to hydration. Many patients at the end of life reach a point in which they can no longer swallow. Hospice, unlike hospital care, sees this as a natural process and advises caregivers not to try to give the patient food or water once they reach this stage. If the patient cannot swallow, but is given food or water, they could choke, thus hastening and making death more painful than it would be if they died from dehydration. Hospice workers frequently talked about how to educate family members about choking and how to persuade them to stop trying to feed their loved ones. During a training session for social workers, a group of ten hospice social workers discussed how to approach a son feeling guilt over not feeding his mother:

We just have to have compassion for him, but also let him know that it is natural to want to feed her and it's hard to know when she's passed that point of being able to swallow. . . . We also need to educate his siblings so that they don't blame him. (Janie, Social Worker)

These educational efforts frequently did not succeed, prompting staff to have regular backstage conversations about how to get through to family members who thought they were doing more harm by withholding food and water.

### *Detachment toward Death*

Even during backstage activities, hospice workers found it important to maintain professional, and often unemotional, presentations of self. During IDG, staff regularly discussed the death of a patient, often saying things like "they went home—the big home" or expressing relief that the patient's suffering had ended. But unless a particular staff member had grown very close to this patient, they rarely spent more than a few moments discussing him or her. During interviews, several staff said that outsiders often do not understand that hospice is not sad because they become accustomed to death and accept it as inevitable. Stephanie, a certified nursing assistant, said "It's all in how you attach yourself. You have to know when to detach, and you can't get too attached." Others expressed more ambivalent perspectives, claiming that they try to remain detached, but sometimes still need help to maintain appropriate boundaries between themselves and their patients. In the front regions, the workers emphasized their caring self, even crying about loss if it felt appropriate, but during backstage activities they often kept their sadness quiet.

These findings contradict the assumption that backstage behaviors are a more authentic expression of self than behaviors in the front region. Both sets of behaviors include elements that workers describe as genuine to their sense of self, and both sets also include behaviors that are intentionally staged. While it is often taken for granted that the front stage includes managing one's presentation of self, one CNA explicates how the backstage also includes staging: "It's hard sometimes. I don't always feel like being friendly or making jokes, but we all have to get along, so I try" (Darlene, CNA). As the opening quote, "We cuss in the conference room and cry with the family" (Nickie, Director), demonstrates, hospice workers recognized the discrepancy between their front- and backstage behaviors. They made sense of these contradictions by saying "This is part of hospice" (Nickie, Director) and "If we didn't laugh,

all we would do is cry” (Robin, Administrator). I argue, in fact, that workers used their hospice identities to account for their divergent behaviors to one another and outsiders.

## Workers’ Identities

During interviews, most hospice workers described their job with hospice as very different from any other type of work they have done. Some described it as “finding your place” (Michelle, Counselor), “fitting in with family” (Robin, Administrator), or “feeling at home” (Ramon, Social Worker). They came to see themselves not as nurses or social workers or chaplains, but as *hospice* nurses, *hospice* social workers, and *hospice* chaplains. As Anna, a new hospice social worker, said, “I’ve always wanted to work in hospice.” She explained that as soon as she learned about hospice, she knew it was the place for her. This strong dedication to hospice was integrated into a hospice identity that included authentic emotional experiences and enlightenment about death.

## Authentic Emotional Experiences

Workers’ main explanation for feeling such affinity for hospice was the ability to feel authentic emotions while going about their work. In fact, several staff members told me that they like hospice because the hospice philosophy encourages them to make real connections with their patients and their family members. Keith, a chaplain, said that he liked hospice because “This is where the juice [of life] is!” and Kate, a social worker, said, “You’re with people when . . . the bullshit is over with and there is honesty.” However, like abortion clinic workers (Wolkomir and Powers 2007), hospice workers do not form emotionally intensive relationships with all patients. In fact, they find ways to balance the needs of the job and their own self-care needs by making connections with some patients and situations, while detaching from others. When I asked which patients really touched them, most workers told stories of patients they related to because of their age, family situations, or personalities. They described their relationships with these patients as being close “like a friend or family member” (Deanna, CNA), signaling that workers bonded with patients who permitted authentic emotional connections.

Even within close relationships with patients, however, staff members were careful to distinguish between their own emotional states and those of their patients. Ramon, a social worker, explained this separation: “sometimes I will express that [sadness] clearly aloud, okay, because usually my judgment would be is that it’s noticeable by the client or family,” but he added that

he must appropriately moderate his emotional expressions. Ramon explained that he always reassures the family that he is not suffering and that their needs come first. Another social worker, Vonda, said that she often has tears when dealing with families who are emotional, but she tries not to sob or draw attention to her emotions. One nurse, Bethany, admitted that she did not cry when with family members, but noted that she felt confident that her job would not be in jeopardy if she did. In fact, Lisa, a CNA, mentioned in an informal interview that she sometimes feels like she is expected to feel sadder than she actually does. This ability to feel authentic emotions but not detract from the pain of the families is an important component of workers' identities. Like the physicians in Coombs and Powers' (1975) study, the hospice workers came to believe that the worker who "loses coolness and presence of mind . . . also loses the confidence of patients and staff" (251). Being able to feel emotions while also keeping them within "appropriate limits" was an important element of being a hospice worker.

### *Enlightenment about Death*

Joking about death has the potential to be offensive and insensitive to those suffering loss, but hospice workers described their backstage humor as "understanding that death is inevitable" (Dr. Smith, Physician) and sometimes even funny. For instance, Michelle, a counselor, was known for keeping a running list of ways that she would not like to die, which included while sitting on the toilet and while caregivers were intoxicated. These preferences came from real-life situations of patients, and hospice workers sometimes laughed at the horror of the situation, while also discussing how to meet the needs of others who might be in a similar predicament. While many medical ethnographies have focused on gallows humor as a form of distancing (Becker 1976; Wear et al. 2006) and stress release, Chambliss (1996) argues that the routinization of death and tragedy first leads to distancing, and then that distance allows participants to see humor in death and tragedy. In Rose Hospice, staff used humor not only for distancing but also to align themselves with patients, especially against poor-quality adult care homes, inadequate home caregivers, or primary care physicians who did not seem to have the patient's best interests in mind. For instance, physicians were often seen as a barrier to hospice. As Bethany, a nurse, observed:

Many physicians will not want anything to do [with patients] once they go on hospice. I've called physicians to get a medication ordered, and

they'll say, "I don't want to be any part of her death," just because they really don't understand, or maybe they don't want to understand.

Discussions of difficult physicians sometimes resulted in jokes at the expense of physicians: when one physician wanted to stop a patient's medications for seizures, Dr. Brown, the hospice medical director muttered, "Sure, we'll do what he thinks will help, but she's just as likely to end up in the psych ward as feel better." Several other staff members laughed at this comment while Dr. Brown signed the orders. Having a sense of humor in such situations enabled workers to deal with emotionally difficult times and uncooperative others while also allowing them to demonstrate their acceptance of death.

Hospice workers saw themselves as more enlightened about the inevitability of death than the average person. They emphasized the need to celebrate the ending of life in similar ways to the beginning of life. They also described time spent with the dying as a gift and reminded others that it is an honor to be present in the final moments of life. Hospice workers typically had significant experiences with death before entering hospice, as illustrated by the fact that several staff members described losses that led them to hospice and characterized the ideal hospice worker as one who had previous encounters with death and dying. However, these experiences did not necessarily make hospice workers adept at dealing with their own psychological issues. As Keith (chaplain) observed: "You'd think we'd be good at it, but most people just push it down and never really deal with their feelings."

Hospice workers formed an identity around being enlightened about death and privileging real emotional encounters over superficial forms of medical care that focus too much on the body and not enough on the person. This identity allowed them to reconcile their front stage commitment to care and compassion with their backstage expressions of morbid humor, strategizing to change others' behaviors and display detachment toward death. It did this by defining each set of behaviors as just "part of hospice" and essential to being able to continue to provide care. In fact, workers often characterized former staff who could not make it in hospice as "taking themselves too seriously" (Robin, Administrator).

## Discussion and Conclusion

Although hospice workers sometimes convey callousness in their backstage comments about death and dying, they pride themselves in offering the highest level of care and compassion to their patients and patient family members. How do we make sense of these divergent behaviors? Front stage behaviors

require distancing from others' emotions and stress while still appearing caring and compassionate, developing coping skills to deal with one's own emotions and stress, and honing the ability to communicate well with those in crisis. Meeting these complex demands is an important component of emotional labor (Hochschild 1983), but it also provokes stress, emotional burnout, and dissatisfaction with work (Wharton 1999).

In this setting, workers mitigated negative consequences of emotional labor through their interactions with one another in the back regions. Backstage activities enable them to sustain their front stage performances. Through joking, strategizing about how to change others' behavior, and detaching themselves from death, hospice workers use coping techniques that allow them to continue meeting the demands of care work in front regions. In addition, workers used scenarios and stories from their front stage interactions to share poignant, humorous, or disturbing experiences with one another while they were backstage. Through their conversations about these experiences, hospice workers not only developed strategies for dealing with difficult situations, but also built meanings that enabled them to sustain their work and identities as hospice care providers.

In addition to highlighting one factor that protects against the negative consequences of emotional labor, this study helps to extend the dramaturgical perspective. When workers conceal their backstage joking and strategizing, they are not hiding their "true" selves. Instead, they are subordinating one part of their hospice identity in order to maintain the caring and compassionate part. However, they see both parts as essential to being a hospice worker. Unlike much research that assumes that the front stage consists of contrived performances and the backstage reveals more authentic behaviors, my findings confirm Goffman's (1959) assertion that all social interactions, including front and back regions, are characterized by performances. Although workers were reluctant to admit that they ever "acted" at work, it was clear that even in backstage areas they were engaged in the process of deemphasizing some aspects of self (e.g., strong feelings of loss over particular patients) while emphasizing others (e.g., their sense of humor and acceptance of death). While workers regarded these backstage behaviors as key components of their hospice identities, it is important to recognize that their backstage presentations of self were just as performative as their front stage presentations. And hospice workers viewed both types of conduct as authentic expressions of their professional identity and their ability to handle death.

Hospice care has several qualities that may make it especially useful for exploring work-related identity formation. First, hospice work is poorly understood (Zimmermann 2004), stigmatized (Hejoaka 2009), and only used

during times of crisis. Given these qualities, workers have a strong incentive to protect the image of hospice care and themselves as moral workers (Chambliss 1996). End-of-life care may also encourage staff to form hospice identities because the fronts workers try to display may be prone to audience disbelief. Patients and patients' family members are often not accustomed to noncurative models of care, and as such may be suspicious of the displays of hospice workers. Finally, within hospice the division between front and back region presentations is not complete. Spaces used for backstage activities become front stage as patients and their family members approach the conference room or the nurse's station; the homes of patients seem to be backstage but become the center of front stage activity as workers come in to provide care and, throughout the workday, hospice workers interact with a variety of others, moving quickly from clearly defined backstage areas to front regions.

These qualities combine to produce work situations with many opportunities for hospice workers to "mess up," or fail to keep expressive control, during end-of-life care interactions. Given the challenges of controlling the definition of the situation, hospice workers are aware of how their actions will be received by patients and patients' family members. Their discussions among themselves construct both front stage expressions of caring and backstage displays of morbid humor as simply parts of being a hospice worker, signaling that their hospice identities allow them to combine the divergent behaviors as authentic and as essential aspects of their work performance. By doing so, they can account for their behavior in situations where the expressive cues they "give off" contradict those they intentionally display. Workers' awareness of these discrepancies pushed them to think about how to account (to themselves and others) for divergent behaviors, thus providing the conditions for the formation of a hospice identity.

Understanding how hospice workers' behaviors fit within their professional identities highlights several important considerations. First, research on work settings would benefit from a full analysis of both front- and backstage behaviors. This research is especially needed to understand medical and caring occupations. Interactions with patients are important, but they are made possible by interactions outside the view of patients. Ethnographic data collection techniques are particularly useful for capturing the complexities of divergent behaviors. Second, both sets of behaviors (care and compassion in the front stage and morbid joking, strategizing, and treating death with detachment in the backstage) are better understood by contextualizing them within workers' interactions and identities. Workers' identities can help to explain behaviors that seem to diverge from one another. Finally, in this case the hospice identity allowed workers to better cope with the emotional stresses of

caring for those at the end-of-life. Because hospice workers integrated both sets of behavior into their work life and sense of self, they felt able to continue to perform their work, even during times of stress. The caring aspects of the hospice identity enabled them to display continued commitment to the compassionate goals of their work, while the backstage activities helped workers to express private or troublesome feelings and bond with one another. In combination, these aspects of the hospice identity mitigated the difficulties involved in providing emotional labor within end-of-life care.

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### **References**

- Abel, Emily K., and Margaret K. Nelson. 1990. *Circles of Care: Work and Identity in Women's Lives*. Albany: State University of New York Press.
- Allen, Davina. 2000. "Doing Occupational Demarcation: The 'Boundary-Work' of Nurse Managers in a District General Hospital." *Journal of Contemporary Ethnography* 29 (3): 326–56.
- Alvesson, Mats, Karen Lee Ashcraft, and Robyn Thomas. 2008. "Identity Matters: Reflections on the Construction of Identity Scholarship in Organization Studies." *Organization* 15 (1): 5–28.
- Ashforth, Blake E., Spencer H. Harrison, and Kevin G. Corley. 2008. "Identification in Organizations: An Examination of Four Fundamental Questions." *Journal of Management* 34 (3): 325–74.
- Ashforth, Blake E., and Glen E. Kreiner. 1999. "'How Can You Do It?' Dirty Work and the Challenge of Constructing a Positive Identity." *Academy of Management Review* 24 (3): 413–34.
- Barley, Stephen R., and Gideon Kunda. 2001. "Bringing Work Back in." *Organization Science* 12 (1): 76–95.
- Becker, Howard. 1976. *Boys in White*. New York: Transaction.
- Bolino, Mark C. 1999. "Citizenship and Impression Management: Good Soldiers or Good Actors?" *Academy of Management Review* 24 (1): 82–98.

- Bolino, Mark C., K. Michele Kacmar, William H. Turnley, and J. Bruce Gilstrap. 2008. "A Multi-level Review of Impression Management Motives and Behaviors." *Journal of Management* 34 (6): 1080–1109.
- Brennan, Kathleen M. 2009. "Meaning, Discrepancy, and Satisfaction in the Nurse Role." *Sociological Spectrum* 29 (5): 551–71.
- Burke, Peter J. 2004. "Identities and Social Structure: The 2003 Cooley-Mead Award Address." *Social Psychology Quarterly* 67 (1): 5–15.
- Chambliss, Daniel F. 1996. *Beyond Caring: Hospitals, Nurses, and the Social Organization of Ethics*. Chicago: University of Chicago Press.
- Charmaz, Kathy. 2006. *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. Thousand Oaks, CA: Sage.
- Chriss, James J. 1995. "Habermas, Goffman, and Communicative Action: Implications for Professional Practice." *American Sociological Review* 60 (4): 545–65.
- Christopherson, Richard W. 1994. "Calling and Career in Christian Ministry." *Review of Religious Research* 35 (3): 219–37.
- Collett, Jessica L. 2005. "What Kind of Mother Am I? Impression Management and the Social Construction of Motherhood." *Symbolic Interaction* 28 (3): 327–47.
- Cooley, Charles Horton. 1902. *Human Nature and the Social Order*. New York: Charles Scribner's Sons.
- Coombs, Robert H., and Pauline S. Powers. 1975. "Socialization for Death: The Physician's Role." *Journal of Contemporary Ethnography* 4 (3): 250–71.
- Dreher, Diane E., Katherine A. Holloway, and Erin Schoenfelder. 2007. *Research in the Social Scientific Study of Religion*. Edited by Ralph L. Piedmont. Baltimore, MD: Loyola College.
- Durr, Marlese, and Adia M. Harvey Wingfield. 2011. "Keep Your 'n' in Check: African American Women and the Interactive Effects of Etiquette and Emotional Labor." *Critical Sociology* 37 (5): 557–71.
- England, Paula. 2005. "Emerging Theories of Care Work." *Annual Review of Sociology* 31 (1): 381–99.
- Findlay, Patricia, Jeanette Findlay, and Robert Stewart. 2009. "The Consequences of Caring: Skills, Regulation and Reward among Early Years Workers." *Work, Employment & Society* 23 (3): 422–41.
- Futrell, Robert. 1999. "Performative Governance: Impression Management, Teamwork, and Conflict Containment in City Commission Proceedings." *Journal of Contemporary Ethnography* 27 (4): 494–529.
- Goffman, Erving. 1959. *The Presentation of Self in Everyday Life*. New York: Anchor Books.
- Goodrick, Elizabeth, and Trish Reay. 2010. "Florence Nightingale Endures: Legitimizing a New Professional Role Identity." *Journal of Management Studies* 47 (1): 55–84.

- Grant, Don, Alfonso Morales, and Jeffrey J. Sallaz. 2009. "Pathways to Meaning: A New Approach to Studying Emotions at Work." *American Journal of Sociology* 115 (2): 327–64.
- Greener, Ian. 2007. "The Politics of Gender in the NHS: Impression Management and 'Getting Things Done.'" *Gender, Work and Organization* 14 (3): 281–99.
- Grove, Stephen J., and Raymond P. Fisk. 1992. "The Service Experience as Theater." *Advances in Consumer Research* 19 (1): 455–61.
- Hart, Bethne, Peter Sainsbury, and Stephanie Short. 1998. "Whose Dying? A Sociological Critique of the 'Good Death.'" *Mortality* 3 (1): 65–77.
- Hejoaka, Fabienne. 2009. "Care and Secrecy: Being a Mother of Children Living with HIV in Burkina Faso." *Social Science & Medicine* 69 (6): 869–76.
- Hillyard, Sam. 2010. "Ethnography's Capacity to Contribute to the Cumulation of Theory: A Case Study of Strong's Work on Goffman." *Journal of Contemporary Ethnography* 39 (4): 421–40.
- Hindmarsh, Jon, and Alison Pilnick. 2002. "The Tacit Order of Teamwork: Collaboration and Embodied Conduct in Anesthesia." *Sociological Quarterly* 43 (2): 139–64.
- Hochschild, Arlie Russell. 1983. *The Managed Heart: Commercialization of Human Feeling*. Berkeley: University of California Press.
- Hoffmann, Elizabeth A. 2007. "Open-Ended Interviews, Power, and Emotional Labor." *Journal of Contemporary Ethnography* 36 (3): 318–46.
- Hughey, Matthew. 2011. "Backstage Discourse and the Reproduction of White Masculinities." *The Sociological Quarterly* 52 (1): 132–53.
- Huppertz, Kate. 2010. "Respectability and the Paid Caring Occupations: An Empirical Investigation of Normality, Morality, Impression Management, Esteem in Nursing and Social Work." *Health Sociology Review* 19 (1): 73–85.
- Kleinman, Sherryll, and Martha Copp. 1993. *Emotions and Fieldwork*. Newbury Park, CA: Sage.
- Kumra, Savita, and Susan Vinnicombe. 2010. "Impressing for Success: A Gendered Analysis of a Key Social Capital Accumulation Strategy." *Gender, Work and Organization* 17 (5): 521–46.
- Lewin, Simon, and Scott Reeves. 2011. "Enacting 'Team' and 'Teamwork': Using Goffman's Theory of Impression Management to Illuminate Interprofessional Practice on Hospital Wards." *Social Science & Medicine* 72 (10): 1595–1602.
- Lingard, Lorelei, Kim Garwood, Catherine F. Schryer, and Marlee M. Spafford. 2003. "A Certain Act of Uncertainty: Case Presentation and the Development of Professional Identity." *Social Science & Medicine* 56 (3): 603–16.
- MacCannell, Dean. 1973. "Staged Authenticity: Arrangements of Social Space in Tourist Settings." *American Journal of Sociology* 79 (3): 589–603.
- MacDonald, Douglas. 1991. "Hospice Social Work: A Search for Identity." *Health and Social Work* 16 (4): 274–80.

- Madill, Anna, and Gary Latchford. 2005. "Identity Change and the Human Dissection Experience Over the First Year of Medical Training." *Social Science & Medicine* 60 (7): 1637–47.
- Mangold, W. Glynn, and Emin Babakus. 1991. "Service Quality: The Front-Stage vs. the Back-Stage Perspective." *Journal of Services Marketing* 5 (4): 59–70.
- Manning, Peter K. 2008. "Goffman on Organizations." *Organization Studies* 29 (5): 677–99.
- Miller, Kenneth E. 2004. "Beyond the Frontstage: Trust, Access, and the Relational Context in Research with Refugee Communities." *American Journal of Community Psychology* 33 (3/4): 217–27.
- Misztal, Barbara A. 2001. "Normality and Trust in Goffman's Theory of Interaction Order." *Sociological Theory* 19 (3): 312–24.
- NHPCO, National Hospice and Palliative Care Organization. "About Hospice and Palliative Care." <http://www.nhpco.org/i4a/pages/index.cfm?pageid=4648&openpage=4648> (accessed June 18, 2012).
- O'Brien, John. 2011. "Spoiled Group Identities and Backstage Work: A Theory of Stigma Management Rehearsals." *Social Psychology Quarterly* 74 (3): 291–309.
- Owens, Timothy J., Dawn T. Robinson, and Lynn Smith-Lovin. 2010. "Three Faces of Identity." *Annual Review of Sociology* 36: 477–99.
- Pratt, Michael G., Kevin W. Rockmann, and Jeffrey B. Kaufman. 2006. "Constructing Professional Identity: The Role of Work and Identity Learning Cycles in the Customization of Identity among Medical Residents." *Academy of Management Journal* 49 (2): 235–62.
- Riley, Robin, and Elizabeth Manias. 2009. "Gatekeeping Practices of Nurses in Operating Rooms." *Social Science & Medicine* 69 (2): 215–22.
- Sallaz, Jeffrey J. 2010. "Talking Race, Marketing Culture: The Racial Habitus in and out of Apartheid." *Social Problems* 57 (2): 294–314.
- Sanders, Clinton R. 2010. "Working Out Back: The Veterinary Technician and 'Dirty Work.'" *Journal of Contemporary Ethnography* 39 (3): 243–72.
- Smith, R. Tyson. 2008. "Passion Work: The Joint Production of Emotional Labor in Professional Wrestling." *Social Psychology Quarterly* 71 (2): 157–76.
- Solari, Cinzia. 2006. "Professionals and Saints: How Immigrant Careworkers Negotiate Gender Identities at Work." *Gender & Society* 20 (3): 301–31.
- Stacey, Clare L. 2011. *The Caring Self: The Work Experiences of Home Care Aides*. Ithaca, NY: Cornell University Press.
- Stets, Jan E., and Peter J. Burke. 2003. "A Sociological Approach to Self and Identity." In *Handbook of Self and Identity*, edited by Mark R. Leary and June Price Tangney, 128–52. New York: Guilford.

- Sveningsson, Stefan, and Mats Alvesson. 2003. "Managing Managerial Identities: Organizational Fragmentation, Discourse and Identity Struggle." *Human Relations* 56 (10): 1163–93.
- Tanner, Judith, and Stephen Timmons. 2000. "Backstage in the Theatre." *Journal of Advanced Nursing* 32 (4): 975–80.
- Tardy, Rebecca W. 2000. "'But I Am a Good Mom': The Social Construction of Motherhood through Health-Care Conversations." *Journal of Contemporary Ethnography* 29 (4): 433–73.
- Tracy, Sarah J., Karen K. Myers, and Clifton W. Scott. 2006. "Cracking Jokes and Crafting Selves: Sensemaking and Identity Management among Human Service Workers." *Communication Monographs* 73 (3): 283–308.
- Tseloni, Efrat. 1992. "Is the Presented Self Sincere? Goffman, Impression Management and the Postmodern Self." *Theory, Culture & Society* 9: 115–28.
- Turner, Ronny. 1976. "Death as Theater: A Dramaturgical Analysis of the American Funeral." *Sociology and Social Research* 60 (4): 377–92.
- Wear, Delese, Julie M. Aultman, Joseph D. Varley, and Joseph Zarconi. 2006. "Making Fun of Patients: Medical Students' Perceptions and Use of Derogatory and Cynical Humor in Clinical Settings." *Academic Medicine* 81 (5): 454–62.
- Wharton, Amy S. 1999. "The Psychosocial Consequences of Emotional Labor." *Annals of the American Academy of Political and Social Science* 561 (1): 158–76.
- Wolkomir, Michelle, and Jennifer Powers. 2007. "Helping Women and Protecting the Self: The Challenge of Emotional Labor in an Abortion Clinic." *Qualitative Sociology* 30 (2): 153–69.
- Zimmermann, Camilla. 2004. "Denial of Impending Death: A Discourse Analysis of the Palliative Care Literature." *Social Science & Medicine* 59 (8): 1769–80.

## Bio

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## REFERENCES

- Abbott, Andrew. 1988. *The System of Professions: An Essay on the Division of Expert Labor*. Chicago: University of Chicago Press.
- \_\_\_\_\_. 1991. "The Future of Professions: Occupation and Expertise in the Age of Organization." *Research in the Sociology of Organizations* 8(1):17-42.
- Abel, Emily K., and Margaret K. Nelson. 1990. *Circles of Care: Work and Identity in Women's Lives*. Albany, NY: State University of New York Press.
- Alkema, Karen, Jeremy M. Linton, and Randall Davies. 2008. "A Study of the Relationship Between Self-Care, Compassion Satisfaction, Compassion Fatigue, and Burnout among Hospice Professionals." *Journal of Social Work in End-of-Life and Palliative Care* 4(2):101-19.
- Allen, Davina. 2000. "Doing Occupational Demarcation: The "Boundary-Work" of Nurse Managers in a District General Hospital." *Journal of Contemporary Ethnography* 29(3):326-56.
- Altheide, David L., and John M. Johnson. 2011. "Living in Arizona: Reflections on Life in the Tumultuous Sunbelt." *Cultural Studies <=> Critical Methodologies* 11(4):346-58.
- Alvesson, Mats, Karen Lee Ashcraft, and Robyn Thomas. 2008. "Identity Matters: Reflections on the Construction of Identity Scholarship in Organization Studies." *Organization* 15(1):5-28.
- Ashforth, Blake E., Spencer H. Harrison, and Kevin G. Corley. 2008. "Identification in Organizations: An Examination of Four Fundamental Questions." *Journal of Management* 34(3):325-74.
- Ashforth, Blake E., and Glen E. Kreiner. 1999. "'How Can You Do It?' Dirty work and the Challenge of Constructing a Positive Identity." *Academy of Management Review* 24(3):413-34.
- Ashforth, Blake, and Ronald Humphrey. 1993. "Emotional Labor in Service Roles: The Influence of Identity." *Academy of Management Review* 18(1):88-115.
- Auerbach, Charles, Brenda G. McGowan, Astraea Ausberger, Jessica Strolin-Goltzman, and Wendy Schudrich. 2010. "Differential Factors Influencing Public and

- Voluntary Child Welfare Workers' Intention to Leave." *Children and Youth Services Review* 32(10):1396-402.
- Barley, Stephen R., and Gideon Kunda. 2001. "Bringing Work Back In." *Organization Science* 12(1):76-95.
- Becker, Howard. 1976. *Boys in White*. New York: Transaction.
- Bellas, Marcia L. 1999. "Emotional Labor in Academia: The Case of Professors." *Annals of the American Academy of Political and Social Science* 561:96-110.
- Bloom, Samuel W. 1988. "Structure and Ideology in Medical Education: An Analysis of Resistance to Change." *Journal of Health and Social Behavior* 29(4):294-306.
- BLS, Bureau of Labor Statistics. 2012. "Occupational Outlook Handbook, 2012-13 Edition: Registered Nurses." Washington, D.C.: United States Department of Labor.
- Bodenheimer, Thomas. 2008. "Coordinating Care-- A Perilous Journey through the Health Care System." *The New England Journal of Medicine* 358(10):1064-71.
- Bolino, Mark C. 1999. "Citizenship and Impression Management: Good Soldiers or Good Actors?" *The Academy of Management Review* 24(1):82-98.
- Bolino, Mark C., K. Michele Kacmar, William H. Turnley, and J. Bruce Gilstrap. 2008. "A Multi-Level Review of Impression Management Motives and Behaviors." *Journal of Management* 34(6):1080-109.
- Bosma, Harvey, Meaghen Johnston, Susan Cadell, Wendy Wainwright, Ngaire Abernethy, Andrew Feron, Mary Lou Kelley, and Fred Nelson. 2010. "Creating Social Work Competencies for Practice in Hospice Palliative Care." *Palliative Medicine* 24(1):79-87.
- Brennan, Kathleen M. 2009. "Meaning, Discrepancy, and Satisfaction in the Nurse Role." *Sociological Spectrum* 29(5):551-71.
- Brotheridge, Celeste M., and Alicia A. Grandey. 2002. "Emotional Labor and Burnout: Comparing Two Perspectives of "People Work"." *Journal of Vocational Behavior* 60:17-39.
- Brown, Brian, Paul Crawford, and Jurai Darongkamas. 2000. "Blurred Roles and Permeable Boundaries: The Experience of Multidisciplinary Working in

- Community Mental Health." *Health and Social Care in the Community* 8(6):425-35.
- Burawoy, Michael. 1998. "The Extended Case Method." *Sociological Theory* 16(1):4-33.
- Burke, Peter J. 2004. "Identities and Social Structure: The 2003 Cooley-Mead Award Address." *Social Psychology Quarterly* 67(1):5-15.
- Cahill, Spencer E. 1999. "Emotional Capital and Professional Socialization: The Case of Mortuary Science Students (and Me)." *Social Psychology Quarterly* 62(2):101-16.
- Cain, Cindy L. 2011. "Coming To and Staying in Hospice: The Struggle for Worker Satisfaction During Medicare Reform." Tucson: University of Arizona.
- \_\_\_\_\_. 2012a. "Emotions and the Research Interview: What Hospice Workers Can Teach Us." *Health Sociology Review* 21(4):396-405.
- \_\_\_\_\_. 2012b. "Integrating Dark Humor and Compassion: Identities and Presentations of Self in the Front and Back Regions of Hospice." *Journal of Contemporary Ethnography* 41(6):668-94.
- \_\_\_\_\_. 2013a. "Consequences of Conflicting Institutional Logics: Inequality and Isomorphism in the Hospice Division of Labor." University of Arizona.
- \_\_\_\_\_. 2013b. "Gendering Emotion Management Strategies: Friendship, Perspective, and Boundaries in Hospice Work." University of Arizona.
- \_\_\_\_\_. Forthcoming. "Orienting End-of-Life Care: The Hidden Value of Hospice Home Visits." in *Caring on the Clock: The Complexities and Contradictions of Paid Care Work*, edited by Mignon Duffy, Amy Armenia, and Clare L. Stacey. New Brunswick, NJ: Rutgers University Press.
- Castilla, Emilio J. 2011. "Bringing Managers Back In: Managerial Influences on Workplace Inequality." *American Sociological Review* 76(5):667-94.
- Chambliss, Daniel F. 1996. *Beyond Caring: Hospitals, Nurses, and the Social Organization of Ethics*. Chicago: The University of Chicago Press.
- Charmaz, Kathy. 2006. *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. Thousand Oaks, CA: Sage Publications.

- Chriss, James J. 1995. "Habermas, Goffman, and Communicative Action: Implications for Professional Practice." *American Sociological Review* 60(4):545-65.
- Christopherson, Richard W. 1994. "Calling and Career in Christian Ministry." *Review of Religious Research* 35(3):219-37.
- Collett, Jessica L. 2005. "What Kind of Mother Am I? Impression Management and the Social Construction of Motherhood." *Symbolic Interaction* 28(3):327-47.
- Connor, Stephen R., Felix Elwert, Carol Spence, and Nicholas A. Christakis. 2007. "Geographic Variation in Hospice Use in the United States in 2002." *Journal of Pain and Symptom Management* 34(3):277-85.
- Cooley, Charles Horton. 1902. *Human Nature and the Social Order*. New York: Charles Scribner's Sons.
- Coombs, Robert H., and Pauline S. Powers. 1975. "Socialization for Death: The Physician's Role." *Journal of Contemporary Ethnography* 4(3):250-71.
- Corbin, Juliet, and Anselm Strauss. 2008. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Thousand Oaks, CA: Sage.
- D'Antonio, Patricia. 2010. *American Nursing: A History of Knowledge, Authority, and the Meaning of Work*. Baltimore, MD: Johns Hopkins University Press.
- D'Aunno, Thomas, Robert I. Sutton, and Richard H. Price. 1991. "Isomorphism and External Support in Conflicting Institutional Environments: A Study of Drug Abuse Treatment Units." *Academy of Management Journal* 34(3):636-61.
- DeLoach, Roenia. 2003. "Job Satisfaction among Hospice Interdisciplinary Team Members." *Am J Hosp Palliat Care* 20(6):434-40.
- Denzin, Norman K. 2006. *Sociological Methods*. New Brunswick, NJ: Transaction Publishers.
- Devault, Margorie L. 1999. "Comfort and Struggle: Emotion Work in Family Life." *Annals of the American Academy of Political and Social Science* 561:52-63.
- Diefendorff, James M., Rebecca J. Erickson, Alicia A. Grandey, and Jason J. Dahling. 2011. "Emotional Display Rules as Work Unit Norms: A Multilevel Analysis of Emotional Labor Among Nurses." *Journal of Occupational Health Psychology* 16(2):170-86.

- Dill, Janette S., and John Cagle. 2010. "Caregiving in a Patient's Place of Residence: Turnover of Direct Care Workers in Home Care and Hospice Agencies." in *Journal of Aging Health*.
- DiMaggio, Paul J. 1988. "Interest and Agency in Institutional Theory." Pp. 3-21 in *Institutional Patterns and Organizations: Culture and Environment*, edited by Lynne G. Zucker. Cambridge, MA: Ballinger.
- \_\_\_\_\_. 1997. "Culture and Cognition." *Annual Review of Sociology* 23:263-87.
- DiMaggio, Paul, and Walter Powell. 1983. "The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields." *American Sociological Review* 48(2):147-60.
- Dodson, Lisa, and Rebekah M. Zincavage. 2007. "'It's Like a Family': Caring Labor, Exploitation, and Race in Nursing Homes." *Gender & Society* 21(6):905-28.
- Douglas, Mary. 1986. *How Institutions Think*. Syracuse, NY: Syracuse University Press.
- Drago, Robert W. 2007. *Striking a Balance : Work, Family, Life*. Boston, Mass.: Dollars & Sense.
- Dreher, Diane E., Katherine A. Holloway, and Erin Schoenfelder. 2007. "The Vocation Identity Questionnaire: Measuring a Sense of Calling." Pp. 99-120 in *Research in the Social Scientific Study of Religion*, edited by Ralph L. Piedmont.
- Duffy, Mignon. 2011. *Making Care Count: A Century of Gender, Race, and Paid Care Work*. New Brunswick, NJ: Rutgers University Press.
- Dunn, Mary B., and Candace Jones. 2010. "Institutional Logics and Institutional Pluralism: The Contestation of Care and Science Logics in Medical Education, 1967-2005." *Administrative Science Quarterly* 55(1):114-49.
- Durr, Marlese, and Adia M. Harvey Wingfield. 2011. "Keep Your 'N' in Check: African American Women and the Interactive Effects of Etiquette and Emotional Labor." *Critical Sociology* 37(5):557-71.
- Eaton, Susan C. 2000. "Beyond 'Unloving Care': Linking Human Resource Management and Patient Care Quality in Nursing Homes." *The International Journal of Human Resource Management* 11(3):591-616.

- Emerson, Robert M. 1987. "Four Ways to Improve the Craft of Fieldwork." *Journal of Contemporary Ethnography* 16(1):69-89.
- England, Paula. 2005. "Emerging Theories of Care Work." *Annual Review of Sociology* 31(1):381-99.
- Erickson, Rebecca J. 1995. "The Importance of Authenticity for Self and Society." *Symbolic Interaction* 18(2):121-44.
- Erickson, Rebecca J., and Wendy J.C. Grove. 2007. "Why Emotions Matter: Age, Agitation, and Burnout Among Registered Nurses." *Online Journal of Issues in Nursing* 13(1).
- \_\_\_\_\_. 2008. "Emotional Labor and Health Care." *Sociology Compass* 2(2):704-33.
- Erickson, Rebecca J., and Christian Ritter. 2001. "Emotional Labor, Burnout, and Inauthenticity: Does Gender Matter?" *Social Psychology Quarterly* 64(2):146-63.
- Erickson, Rebecca J., and Amy S. Wharton. 1997. "Inauthenticity and Depression: Assessing the Consequences of Interactive Service Work." *Work and Occupations* 24(2):188-213.
- Eustis, Nancy N., and Lucy Rose Fischer. 1991. "Relationships Between Home Care Clients and Their Workers: Implications for Quality of Care." *The Gerontologist* 31(4):447-56.
- Findlay, Patricia, Jeanette Findlay, and Robert Stewart. 2009. "The Consequences of Caring: Skills, Regulation and Reward among Early Years Workers." *Work, Employment & Society* 23(3):422-41.
- Fine, Gary. 1984. "Negotiated Orders and Organizational Cultures." *Annual Review of Sociology* 10:239-62.
- Flick, Uwe. 1992. "Triangulation Revisited: Strategy of Validation or Alternative?" *Journal for the Theory of Social Behaviour* 22(2):175-97.
- Folbre, Nancy. 2001. *The Invisible Heart: Economics and Family Values*. New York: The New Press.
- Foner, Nancy. 1994. *The Caregiving Dilemma: Work in an American Nursing Home*. Berkeley: University of California Press.

- Freidson, Eliot. 1970. *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. Chicago: University of Chicago Press.
- Friedland, Roger, and Robert R. Alford. 1991. "Bringing Society Back In: Symbols, Practices, and Institutional Contradictions." Pp. 232-63 in *The New Institutionalism in Organizational Analysis*, edited by Walter W. Powell and Paul J. DiMaggio. Chicago: University of Chicago Press.
- Futrell, Robert. 1999. "Performative Governance: Impression Management, Teamwork, and Conflict Containment in City Commission Proceedings." *Journal of Contemporary Ethnography* 27(4):494-529.
- Glenn, Evelyn Nakano. 2010. *Forced to Care: Coercion and Caregiving*. Cambridge, MA: Harvard University Press.
- Goffman, Erving. 1959. *The Presentation of Self in Everyday Life*. New York: Anchor Books.
- \_\_\_\_\_. 1961. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Garden City, New York: First Anchor Books.
- Goodrick, Elizabeth. 2002. "From Management as a Vocation to Management as a Scientific Activity: An Institutional Account of a Paradigm Shift " *Journal of Management* 28(5):649-69.
- Goodrick, Elizabeth, and Trish Reay. 2010. "Florence Nightingale Endures: Legitimizing a New Professional Role Identity." *Journal of Management Studies* 47(1):55-84.
- \_\_\_\_\_. 2011. "Constellations of Institutional Logics: Changes in the Professional Work of Pharmacists." *Work and Occupations* 38(3):372-416.
- Grandey, Alicia A. 2000. "Emotion Regulation in the Workplace: A New Way to Conceptualize Emotional Labor." *Journal of Occupational Health Psychology* 5(1):95-110.
- Grant, Don, Alfonso Morales, and Jeffrey J. Sallaz. 2009. "Pathways to Meaning: A New Approach to Studying Emotions at Work." *American Journal of Sociology* 115(2):327-64.
- Greener, Ian. 2007. "The Politics of Gender in the NHS: Impression Management and 'Getting Things Done'." *Gender, Work and Organization* 14(3):281-99.

- Greenwood, Royston, and C.R. Hinings. 1996. "Understanding Radical Organizational Change: Bringing Together the Old and the New Institutionalism." *Academy of Management Review* 21(4):1022-54.
- Greenwood, Royston, Mia Raynard, Farah Kodeih, Evelyn R. Micelotta, and Michael Lounsbury. 2011. "Institutional Complexity and Organizational Responses." *The Academy of Management Annals* 5(1):317-71.
- Grove, Stephen J., and Raymond P. Fisk. 1992. "The Service Experience as Theater." *Advances in Consumer Research* 19(1):455-61.
- Gruys, Kjerstin. 2012. "Does This Make Me Look Fat? Aesthetic Labor and Fat Talk as Emotional Labor in a Women's Plus-Size Clothing Store." *Social Problems* 59(4):481-500.
- Guttman, Orlee R., and Lorelei Lingard. 2010. "Credentials as Cultural Capital: The Pursuit of Higher Degrees Among Academic Medical Trainees." *Academic Medicine* 85(10):21-24.
- Hallett, Tim. 2010. "The Myth Incarnate: Recoupling Processes, Turmoil, and Inhabited Institutions in an Urban Elementary School." *American Sociological Review* 75(1):52-74.
- Hallett, Tim, and Marc Ventresca. 2006. "Inhabited Institutions: Social Interactions and Organizational Forms in Gouldner's Patterns of Industrial Bureaucracy." *Theory and Society* 35(2):213-36.
- Hannan, Michael T., and Glenn R. Carroll. 1992. *Dynamics of Organizational Populations: Density, Legitimation, and Competition*. New York: Oxford University Press.
- Harris, Philip E. 1989. "The Nurse Stress Index." *Work & Stress* 3(4):335-46.
- Hart, Bethne, Peter Sainsbury, and Stephanie Short. 1998. "Whose Dying? A Sociological Critique of the 'Good Death'." *Mortality* 3(1):65-77.
- Hawkins, Andrew C., Ruth A. Howard, and Jan R. Oyebode. 2007. "Stress and Coping in Hospice Nursing Staff: The impact of Attachment Styles." *Psychooncology* 16(6):563-72.

- Hejoaka, Fabienne. 2009. "Care and Secrecy: Being a Mother of Children Living with HIV in Burkina Faso." *Social Science and Medicine* 69(6):869-76.
- Henderson, Angela. 2001. "Emotional Labor and Nursing: An Under-Appreciated Aspect of Caring Work." *Nursing Inquiry* 8(2):130-38.
- Hillyard, Sam. 2010. "Ethnography's Capacity to Contribute to the Cumulation of Theory: A Case Study of Strong's Work on Goffman." *Journal of Contemporary Ethnography* 39(4):421-40.
- Hindmarsh, Jon, and Alison Pilnick. 2002. "The Tacit Order of Teamwork: Collaboration and Embodied Conduct in Anesthesia." *The Sociological Quarterly* 43(2):139-64.
- Hochschild, Arlie Russell. 1983. *The Managed Heart : Commercialization of Human Feeling*. Berkeley, CA: University of California Press.
- Hodson, Randy. 2004. "A Meta-Analysis of Workplace Ethnographies: Race, Gender, and Employee Attitudes and Behaviors." *Journal of Contemporary Ethnography* 33(1):4-38.
- Hoffmann, Elizabeth A. 2007. "Open-Ended Interviews, Power, and Emotional Labor." *Journal of Contemporary Ethnography* 36(3):318-46.
- Hogan, Timothy D., and Donald N. Steinnes. 1998. "A Logistic Model of the Seasonal Migration Decision for Elderly Households in Arizona and Minnesota." *The Gerontologist* 38(2):152-58.
- Hughey, Matthew. 2011. "Backstage Discourse and the Reproduction of White Masculinities." *The Sociological Quarterly* 52(1):132-53.
- Huppatz, Kate. 2010. "Respectability and the Paid Caring Occupations: An Empirical Investigation of Normality, Morality, Impression Management, Esteem in Nursing and Social Work." *Health Sociology Review* 19(1):73-85.
- Iglehart, John K. 2009. "A New Era of For-Profit Hospice Care-- The Medicare Benefit." *New England Journal of Medicine* 360(26):2701-03.
- Jackall, Robert. 1988. *Moral Mazes: The World of Corporate Managers*. New York Oxford University Press.
- James, Nicky, and David Field. 1992. "The Routinization of Hospice: Charisma and Bureaucratization." *Social Science & Medicine* 34(12):1363-75.

- Johnson, Cathryn, Timothy J. Dowd, and Cecilia L. Ridgeway. 2006. "Legitimacy as a Social Process." *Annual Review of Sociology* 32:53-78.
- Kalleberg, Arne L. 2009. "Precarious Work, Insecure Workers: Employment Relations in Transition." *American Sociological Review* 74(1):1-22.
- Kang, Miliann. 2003. "The Managed Hand: The Commercialization of Bodies and Emotions in Korean Immigrant–Owned Nail Salons." *Gender & Society* 17(6):820-39.
- Kellogg, Catherine C. 2009. "Operating Room: Relational Spaces and Microinstitutional Change in Surgery." *American Journal of Sociology* 115(3):657-711.
- Kleinman, Sherryl, and Martha Copp. 1993. *Emotions and Fieldwork*. Newbury Park, CA: Sage Publications.
- Kübler-Ross, Elisabeth. 1969. *On death and dying*. New York: Macmillan.
- Kumra, Savita, and Susan Vinnicombe. 2010. "Impressing for Success: A Gendered Analysis of a Key Social Capital Accumulation Strategy." *Gender, Work and Organization* 17(5):521-46.
- Kunda, Gideon, and John Van Maanen. 1999. "Changing Scripts at Work: Managers and Professionals." *Annals of the American Academy of Political and Social Science* 561:64-80.
- Landsbergis, Paul A. 1988. "Occupational Stress Among Health Care Workers: A Test of the Job Demands-Control Model." *Journal of Organizational Behavior* 9(3):217-39.
- Larsen, Christian Albrekt. 2006. *The Institutional Logic of Welfare Attitudes*. Burlington, VT: Ashgate Publishing Company.
- Lawler, Edward J., Shane R. Thye, and Jeongkoo Yoon. 2008. "Social Exchange and Micro Social Order." *American Sociological Review* 73(4):519-42.
- Lawrence, Thomas B. 2004. "Rituals and Resistance: Membership Dynamics in Professional Fields." *Human Relations* 57(2):115-43.

- Lawrence, Thomas B., Roy Suddaby, and Bernard Leca (Eds.). 2009. *Institutional Work: Actors and Agency in Institutional Studies of Organizations*. Cambridge: Cambridge University Press.
- Lazarus, Richard S. 1993. "Coping Theory and Research: Past, Present, and Future." *Psychosomatic Medicine* 55:234-47.
- Leidner, Robin. 1999. "Emotional Labor in Service Work." *Annals of the American Academy of Political and Social Science* 561:81-95.
- Lewin, Simon, and Scott Reeves. 2011. "Enacting 'Team' and 'Teamwork': Using Goffman's Theory of Impression Management to Illuminate Interprofessional Practice on Hospital Wards." *Social Science and Medicine* 72(10):1595-602.
- Lingard, Lorelei, Kim Garwood, Catherine F. Schryer, and Marlee M. Spafford. 2003. "A Certain Act of Uncertainty: Case Presentation and The Development of Professional Identity." *Social Science and Medicine* 56(3):603-16.
- Lopez, Steven H. 2006. "Emotional Labor and Organized Emotional Care: Conceptualizing Nursing Home Care Work." *Work and Occupations* 33(2):133-60.
- Lounsbury, Michael. 2002. "Institutional Transformation and Status Mobility: The Professionalization of the Field of Finance." *Academy of Management Journal* 45(1):255-66.
- \_\_\_\_\_. 2007. "A Tale of Two Cities: Competing Logics and Practice Variation in the Professionalizing of Mutual Funds." *Academy of Management Journal* 50(2):289-307.
- Lounsbury, Michael, and Hayagreeva Rao. 2004. "Sources of Durability and Change in Market Classifications: A Study of the Reconstitution of Product Categories in the American Mutual Fund Industry: 1944-1985." *Social Forces* 82(3):969-999.
- MacCannell, Dean. 1973. "Staged Authenticity: Arrangements of Social Space in Tourist Settings." *The American Journal of Sociology* 79(3):589-603.
- Macdonald, Cameron Lynne. 2010. *Shadow Mothers: Nannies, Au Pairs, and the Micropolitics of Mothering*. Berkeley, CA: University of California Press.

- MacDonald, Douglas. 1991. "Hospice Social Work: A Search for Identity." *Health and Social Work* 16(4):274-80.
- Madill, Anna, and Gary Latchford. 2005. "Identity Change and the Human Dissection Experience Over the First Year of Medical Training." *Social Science and Medicine* 60(7):1637-47.
- Mahar, Maggie. 2006. *Money-Driven Medicine: The Real Reason Health Care Costs So Much*. New York: HarperCollins Publishers.
- Mangold, W. Glynn, and Emin Babakus. 1991. "Service Quality: The Front-Stage vs. the Back-Stage Perspective." *The Journal of Services Marketing* 5(4):59-70.
- Manning, Peter K. 2008. "Goffman on Organizations." *Organization Studies* 29(5):677-99.
- Marquis, Christopher, and Michael Lounsbury. 2007. "Vive La Resistance: Competing Logics and the Consolidation of U.S. Community Banking." *Academy of Management Journal* 50(4):799-820.
- Martin, Susan Ehrlich. 1999. "Police Force or Police Service? Gender and Emotional Labor." *Annals of the American Academy of Political and Social Science* 561:111-26.
- Masterson-Allen, Susan, Vincent Mor, Linda Laliberte, and Lois Monteiro. 1985. "Staff Burnout in a Hospice Setting." *The Hospice Journal* 1(3):1-15.
- Maxwell, Joseph A. 1998. "Designing a Qualitative Study." Pp. 69-100 in *Handbook of Applied Social Research Methods*, edited by Leonard Bickman and Debra J. Rog. Thousand Oaks, CA: Sage.
- Meintel, Deirdre, Sylvie Fortin, and Marguerite Cognet. 2006. "On the Road and on their Own: Autonomy and Giving in Home Health Care in Quebec." *Gender, Place and Culture* 13(5):563-80.
- Meyer, John, and Brian Rowan. 1977. "Institutionalized Organizations: Formal Structure as Myth and Ceremony." *American Journal of Sociology* 83(2):340-63.
- Meyerson, Debra. 2003. *Tempered Radicals: How Everyday Leaders Inspire Change at Work*. Cambridge, MA: Harvard Business School Press.

- Miles, Toni P. 2012. *Health Care Reform and Disparities: History, Hype, and Hope*. Santa Barbara, CA: Praeger.
- Miller, Kenneth E. 2004. "Beyond the Frontstage: Trust, Access, and the Relational Context in Research with Refugee Communities." *American Journal of Community Psychology* 33(3/4):217-27.
- Miller, Pamela J., and Paula B. Mike. 1995. "The Medicare Hospice Benefit: Ten Years of Federal Policy for the Terminally Ill." *Death Studies* 19(6):531-42.
- Misangyi, Vilmos F., Gary R. Weaver, and Heather Elms. 2008. "Ending Corruption: The Interplay Among Institutional Logics, Resources, and Institutional Entrepreneurs." *Academy of Management Review* 33(3):750-70.
- Misztal, Barbara A. 2001. "Normality and Trust in Goffman's Theory of Interaction Order." *Sociological Theory* 19(3):312-24.
- Murray, Fiona. 2010. "The Oncomouse That Roared: Hybrid Exchange Strategies as a Source of Distinction at the Boundary of Overlapping Institutions." *American Journal of Sociology* 116(2):341-88.
- Nassar-McMillan, Sylvia, and L. Dianne Borders. 2002. "Use of Focus Groups in Survey Item Development." *The Qualitative Report* 7(1).
- Nelson, Julie A. 1999. "Of Markets and Martyrs: Is It OK To Pay Well For Care?" *Feminist Economics* 5(3):43-59.
- NHPCO, National Hospice and Palliative Care Organization. 2012a. "About Hospice and Palliative Care." Alexandria, VA.
- \_\_\_\_\_. 2012b. "NHPCO Facts and Figures: Hospice Care in America." Alexandria, VA.
- O'Brien, John. 2011. "Spoiled Group Identities and Backstage Work: A Theory of Stigma Management Rehearsals." *Social Psychology Quarterly* 74(3):291-309.
- Ocasio, William. 1997. "Towards an Attention-Based View of the Firm." *Strategic Management Journal* 18:187-206.
- Oliver, Debra P., Elaine Wittenberg-Lyles, Karla Washington, and Seema Sehrawat. 2009. "Social Work Role in Pain Management with Hospice Caregivers: A National Survey." *Journal of Social Work End-of-Life & Palliative Care* 5(1-2):61.

- Owens, Timothy J., Dawn T. Robinson, and Lynn Smith-Lovin. 2010. "Three Faces of Identity." *Annual Review of Sociology* 36:477-99.
- Paradis, Lenora Finn, and Scott B. Cummings. 1986. "The Evolution of Hospice in America Toward Organizational Homogeneity." *Journal of Health and Social Behavior* 27(4):370-86.
- Parker-Oliver, Debra, Laura R. Bronstein, and Lori Kurzejeski. 2005. "Examining Variables Related to Successful Collaboration on the Hospice Team." *Health and Social Work* 30(4):279-86.
- Patterson, Elissa F. 1998. "The Philosophy and Physics of Holistic Health Care: Spiritual Healing as a Workable Interpretation." *Journal of Advanced Nursing* 27(2):287-93.
- Pearce, Lisa. 2002. "Integrating Survey and Ethnographic Methods for Systematic Anomalous Case Analysis." *Sociological Methodology* 32(1):103-32.
- Peterson, Laura A., LeChauncy D. Woodward, Tracy Urech, Christina Daw, and Supicha Sookanan. 2006. "Does Pay-for Performance Improve the Quality of Health Care?" *Annals of Internal Medicine* 145(4):265-72.
- Pfefferle, Susan G., and Dana Beth Weinberg. 2008. "CNAs Making Meaning of Direct Care." *Qualitative Health Research* 18(7):952-61.
- Phillips, Nelson, and Thomas B. Lawrence. 2012. "The Turn to Work in Organization and Management Theory: Some Implications for Strategic Organization." *Strategic Organization* 10(3):223-30.
- Pierce, Jennifer L. 1995. *Gender Trials: Emotional Lives in Contemporary Law Firms*. Berkeley, CA: University of California Press.
- \_\_\_\_\_. 1999. "Emotional Labor among Paralegals." *Annals of the American Academy of Political and Social Science* 561:127-42.
- Powell, Walter, and Jeannette Colyvas. 2008. "Microfoundations of Institutional Theory." in *Handbook of Organizational Institutionalism*, edited by Royston Greenwood, Christine Oliver, Roy Suddaby, and Kerstin Sahlin-Andersson. Thousand Oaks, CA: Sage Publishers.

- Powell, Walter W., and Paul DiMaggio. 1991. *The New Institutionalism in Organizational Analysis*. Chicago, IL: University of Chicago Press.
- Pratt, Michael G., Kevin W. Rockmann, and Jeffrey B. Kaufman. 2006. "Constructing Professional Identity: The Role of work and Identity Learning Cycles in the Customization of Identity among Medical Residents." *Academy of Management Journal* 49(2):235-62.
- Pugliesi, Karen. 1999. "The Consequences of Emotional Labor: Effects on Work Stress, Job Satisfaction, and Well-Being." *Motivation and Emotion* 23(2):125-54.
- Reay, Trish, and C.R. Hinings. 2009. "Managing the Rivalry of Competing Institutional Logics." *Organization Studies* 30(6):629-52.
- Ridgeway, Cecilia L. 2009. "Framed Before We Know It: How Gender Shapes Social Relations." *Gender & Society* 23(2):145-60.
- Riley, Robin, and Elizabeth Manias. 2009. "Gatekeeping Practices of Nurses in Operating Rooms." *Social Science and Medicine* 69(2):215-22.
- Robinson, Bruce E., and Hiep Pham. 1996. "Cost-Effectiveness of Hospice Care." *Clinics in Geriatric Medicine* 12(2):417-28.
- Rodriquez, Jason. 2011. "'It's a Dignity Thing': Nursing Home Care Workers' Use of Emotions." *Sociological Forum* 26(2):265-86.
- Rogerson, Peter A. 1996. "Geographic Perspectives on Elderly Population Growth." *Growth and Change* 27(1):75-95.
- Rosenberg, Charles E. 2007. *Our Present Complaint: American Medicine, Then and Now*. Baltimore, MD: The Johns Hopkins University Press.
- Rueschemeyer, Dietrich. 1983. "Professional Autonomy and the Social Control of Expertise." Pp. 38-58 in *The Sociology of the Professions: Lawyers, Doctors, and Others*, edited by Robert Dingwall and Philip Lewis. New York: St. Martin's Press.
- Sallaz, Jeffrey J. 2010. "Talking Race, Marketing Culture: The Racial Habitus In and Out of Apartheid." *Social Problems* 57(2):294-314.

Sanders, Clinton R. 2010. "Working Out Back: The Veterinary Technician and "Dirty Work"." *Journal of Contemporary Ethnography* 39(3):243-72.

Schwalbe, Michael, Sandra Godwin, Daphne Holden, Douglas Schrock, Shealy Thompson, and Michele Wolkomir. 2000. "Generic Processes in the Reproduction of Inequality: An Interactionist Analysis." *Social Forces* 79(2):419-52.

Scott, Brent A., and Christopher M. Barnes. 2011. "A Multilevel Field Investigation of Emotional Labor, Affect, Work Withdrawal, and Gender." *Academy of Management Journal* 54(1):116-36.

Scott, W. Richard. 2008. *Institutions and Organizations: Ideas and Interests*. Los Angeles: Sage.

Scott, W. Richard, Martin Ruef, Peter J. Mendel, and Carol A. Caronna. 2000. *Institutional Change and Healthcare Organizations*. Chicago: University of Chicago Press.

Seery, Brenda L., Elizabeth A. Corrigan, and Tammy Harpel. 2008. "Job-Related Emotional Labor and Its Relationship to Work-Family Conflict and Facilitation." *Journal of Family and Economic Issues* 29(3):461-77.

Singleton, Royce A., Jr., and Bruce C. Straits. 2005. *Approaches to Social Research*. New York: Oxford University Press.

Smith, Allen C., and Sherryl Kleinman. 1989. "Managing Emotions in Medical School: Students' Contacts with the Living and the Dead." *Social Psychology Quarterly* 52(1):56-69.

Smith, Dorothy E. 2005. *Institutional Ethnography: A Sociology for People*. Lanham, MD: AltaMira Press.

Smith, R. Tyson. 2008. "Passion Work: The Joint Production of Emotional Labor in Professional Wrestling." *Social Psychology Quarterly* 71(2):157-76.

Solari, Cinzia. 2006. "Professionals and Saints: How Immigrant Careworkers Negotiate Gender Identities at Work." *Gender & Society* 20(3):301-31.

Stacey, Clare L. 2005. "Finding Dignity in Dirty Work: The Constraints and Rewards of Low-Wage Home Care Labour." *Sociology of Health & Illness* 27(6):831-54.

- \_\_\_\_\_. 2011. *The Caring Self: The Work Experiences of Home Care Aides*. Ithaca, NY: Cornell University Press.
- Stainback, Kevin, Thomas N. Ratliff, and Vincent J. Roscigno. 2011. "The Context of Workplace Sex Discrimination: Sex Composition, Workplace Culture and Relative Power." *Social Forces* 89(4):1165-88.
- Steinberg, Ronnie J. 1999. "Emotional Labor in Job Evaluation: Redesigning Compensation Practices." *Annals of the American Academy of Political and Social Science* 561:143-57.
- Steinberg, Ronnie J., and Deborah M. Figart. 1999. "Emotional Labor Since *The Managed Heart*." *Annals of the American Academy of Political and Social Science* 561:8-26.
- Stets, Jan E. 2012. "Current Emotion Research in Sociology: Advances in the Discipline." *Emotion Review* 4(3):326-34.
- Stets, Jan E., and Peter J. Burke. 2003. "A Sociological Approach to Self and Identity." Pp. 128-52 in *Handbook of Self and Identity*, edited by Mark R. Leary and June Price Tangney. New York: Guilford Press.
- Stets, Jan E., and Michael J. Carter. 2012. "A Theory of the Self for the Sociology of Morality." *American Sociological Review* 77(1):120-40.
- Stevenson, David G. 2012. "Growing Pains for the Medicare Hospice Benefit." *New England Journal of Medicine* 367(18):1683-85.
- Stone, Robyn I., and Steven L. Dawson. 2008. "The Origins of Better Jobs Better Care." *The Gerontologist* 48(1):5-13.
- Strauss, Anselm. 1978. *Negotiations*. San Francisco, CA: Jossey-Bass.
- Strauss, Anselm, Leonard Schatzman, Danuta Erlich, Rue Bucher, and Melvin Sabshin. 1963. "The Hospital and Its Negotiated Order." in *The Hospital and Modern Society*, edited by E. Freidson. New York: Free Press.
- Stryker, Robin. 2000. "Legitimacy Processes as Institutional Politics: Implications for Theory and Research in the Sociology of Organizations." *Research in the Sociology of Organizations* 17:179-223.

- Styhre, Alexander. 2011. "Competing Institutional Logics in the Biopharmaceutical Industry: The Move Away from the Small Molecules Therapies Model in the Post-Genomic Era." *Creativity and Innovation Management* 20(4):311-29.
- Sveningsson, Stefan, and Mats Alvesson. 2003. "Managing Managerial Identities: Organizational Fragmentation, Discourse and Identity Struggle." *Human Relations* 56(10):1163-93.
- Tanner, Judith, and Stephen Timmons. 2000. "Backstage in the Theatre." *Journal of Advanced Nursing* 32(4):975-80.
- Tardy, Rebecca W. 2000. "'But I Am a Good Mom': The Social Construction of Motherhood through Health-Care Conversations." *Journal of Contemporary Ethnography* 29(4):433-73.
- Theodosius, Catherine. 2006. "Recovering Emotion from Emotion Management." *Sociology* 40(5):893-910.
- Thornton, Patricia H. 2004. *Markets from Culture: Institutional Logics and Organizational Decisions in Higher Education Publishing*. Palo Alto, CA: Stanford University Press.
- Thornton, Patricia H., and William Ocasio. 1999. "Institutional Logics and the Historical Contingency of Power in Organizations: Executive Succession in the Higher Education Publishing Industry, 1958-1990." *American Journal of Sociology* 105(3):801-43.
- Thornton, Patricia H., William Ocasio, and Michael Lounsbury. 2012. *The Institutional Logics Perspective: A New Approach to Culture, Structure, and Process*. New York: Oxford University Press.
- Tracy, Sarah J., Karen K. Myers, and Clifton W. Scott. 2006. "Cracking Jokes and Crafting Selves: Sensemaking and Identity Management Among Human Service Workers." *Communication Monographs* 73(3):283-308.
- Troyer, Lisa. 2004. "Democracy in a Bureaucracy: The Legitimacy Paradox of Teamwork in Organizations." in *Legitimacy Processes in Organizations*, edited by Cathryn Johnson. Oxford: Elsevier Ltd.
- Tschan, Franziska, Sylvie Rochat, and Dieter Zapf. 2005. "It's Not Only Clients: Studying Emotion Work with Clients and Co-Workers with an Event-Sampling

- Approach." *Journal of Occupational and Organizational Psychology* 78(2):195-220.
- Tseelon, Efrat. 1992. "Is the Presented Self Sincere? Goffman, Impression Management and the Postmodern Self." *Theory, Culture & Society* 9(2):115-28.
- Turner, Jonathan H., and Jan E. Stets. 2005. *The Sociology of Emotions*. New York: Cambridge University Press.
- Turner, Ronny. 1976. "Death as Theater: A Dramaturgical Analysis of the American Funeral." *Sociology and Social Research* 60(4):377-92.
- Vachon, M. L. 1999. "Reflections on the History of Occupational Stress in Hospice/Palliative care." *Hospice Journal* 14(3-4):229-46.
- Van Maanen, John, Jesper B. Sorensen, and Terence R. Mitchell. 2007. "The Interplay Between Theory and Method." *Academy of Management Review* 32(4):1145-54.
- Wear, Delese, Julie M. Aultman, Joseph D. Varley, and Joseph Zarconi. 2006. "Making Fun of Patients: Medical Students' Perceptions and Use of Derogatory and Cynical Humor in Clinical Settings." *Academic Medicine* 81(5):454-62.
- Weber, Max. [1905] 1958. *The Protestant Ethic and the Spirit of Capitalism*. New York: Charles Scribner.
- Wharton, Amy S. 1999. "The Psychosocial Consequences of Emotional Labor." *The Annals of the American Academy of Political and Social Science* 561(1):158-76.
- \_\_\_\_\_. 2009. "The Sociology of Emotional Labor." *Annual Review of Sociology* 35:147-65.
- Wingfield, Adia Harvey. 2010. "Are Some Emotions Marked 'Whites Only'? Racialized Feeling Rules in Professional Workplaces." *Social Problems* 57(2):251-68.
- Witman, Yolande, Gerhard A.C. Smid, Pauline L. Meurs, and Dick L. Willems. 2011. "Doctor in the Lead: Balancing Between Two Worlds." *Organization* 18(4):477.
- Wolkomir, Michelle, and Jennifer Powers. 2007. "Helping Women and Protecting the Self: The Challenge of Emotional Labor in an Abortion Clinic." *Qualitative Sociology* 30(2):153-69.

- Zhou, Xueguang. 2005. "The Institutional Logic of Occupational Prestige Ranking: Reconceptualization and Reanalyses " *American Journal of Sociology* 111(1):90-140.
- Zimmermann, Camilla. 2004. "Denial of Impending Death: A Discourse Analysis of the Palliative Care Literature." *Social Science and Medicine* 59(8):1769-80.