BURDEN OF BEING A NURSE: A CASE STUDY ON RETIRED NURSES' OCCUPATIONAL EXPERIENCES IN TURKEY

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ABSTRACT

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In this thesis, the main objective is to understand the changing occupational experiences of retired nurses throughout their working years between 1988 and 2020 within three periods (1988-1998, 1999-2009, 2010-2020) that corresponds to major changes in distribution of healthcare service in Turkey within neoliberal policies. The rationalization attempts in medical settings, aim for standardization in care work, and process and flexibilization in the responsibilities to increase multi-functionality will be important to understand the process of professional building of nurses in Turkey. In addition to that, gender as a control mechanism in the medical field is reflected on their occupational experience within the restructuring in the healthcare system. Therefore, this thesis is constructed through trajectories of participants while locating them in a historical transformation regarding Turkish health system. I argue that effects of neoliberal policies on Turkish healthcare system put nurses into a vulnerable position in terms of their profession, and they

become distant from their main jurisdictional areas and lost their domination areas. Nurses' occupational boundaries and responsibilities become stretched and flexible; the working environment become insecure and their labor become invisible in medical field. By also focusing on the resistance and adaptation strategies to these alterations, I draw a framework for de-passivized agency in this process, rather than describing them as victims of the changes. They resisted through emphasizing care process by upgrading its importance despite of increasing work burden over peripheral activities to reconstruct themselves as a crucial agency in the medical field over the years.

Keywords: nursing practice, new health paradigm, care work experience, de-professionalization, skill

ÖZ

HEMŞİRE OLMANIN YÜKÜ: TÜRKİYE'DE EMEKLİ HEMŞİRELERİN MESLEKİ DENEYİMLERİ ÜZERİNE BİR VAKA ÇALIŞMASI

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Bu tez, Türkiye'de emekli hemşirelerin mesleki deneyimlerinde yaşanan değişimleri 1988-2020 yılları arasında üç ana dönem üzerinden incelemektedir. Bu üç dönemde, (1988-1998, 1999-2009, 2010-2020), sağlık hizmetlerinin dağıtımında ve işleyişinde büyük değişiklikler yaşanmıştır. Neo-liberal politikalar ekseninde yaşanan bu değişimler, sağlık hizmetleri alanında rasyonelleştirme girişimlerini, bakım işlerinde standardizasyonu ve işlevselliği arttırma girişimlerini kapsamaktadır. Bu doğrultuda araştırmanın temel amacını; bu süreçlerin hemşirelik mesleği üzerindeki etkisini, başta hasta-hemşire arasındaki ilişki dinamiklerinde yaşanan değişimi ve hemşirelerin profesyonelleşme deneyimlerinin dönüşümünü anlamak oluşturmaktadır. Buna ek olarak, toplumsal cinsiyet, medikal alanda kontrol ve şekillendirici mekanizma olarak küresel yapılanmanın etkilerini de dönüştürmüştür. Bu nedenle hemşirelerin bakım deneyimleri ve ilişkisel mesleki özerk alanlarının değişimi ve karmaşıklığı sosyolojik bir kaygı taşımaktadır. Tez,

Türkiye'deki sağlık sistemi ile ilgili tarihsel bir dönüşüme katılımcıların deneyimlerini yerleştirerek inşa edilmiştir. Tezde bu değişikliklere karşı hemşireler tarafından gösterilen direnç ve uyum stratejilerine odaklanılmış, bu süreçte hemşireler, etkisiz birer aktör ve değişikliklerin kurbanı olarak tanımlanmak yerine, sosyal organizasyonu şekillendiren aktörler olarak tanımlanmıştır. Hemşireler, tıbbi alanda önemli bir aktör olarak kendilerini yeniden inşa etmek amacıyla iş yüklerinin artmasına rağmen bakım sürecine vurgu yaparak direnmişlerdir. Yapılan araştırmada, bu direnişe rağmen, neo-liberal politikaların Türkiye'deki sağlık sistemi üzerindeki etkilerinin hemşireleri kendi meslekleri açısından savunmasız bir konuma getirdiği, hemşirelerin mesleki kontrol alanlarından uzaklaşmaya başladıkları ve tahakküm alanlarını kaybettikleri sonucuna ulaşılmıştır. Buna ek olarak, süreç içinde, hemşirelerin mesleki sınırları daha esnek, çalışma ortamları ise güvensiz bir hal alırken, bakım emekleri görünmez kalmaya devam etmiştir.

Anahtar Kelimeler: hemşirelik, yeni sağlık paradigması, bakım emeği deneyimi, meslekleşmeden uzaklaşma, beceri

To people who risk their lives to save others'

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It is unbelievable that in which context I am able to complete this thesis. Witnessing the circumstances that health care providers confront make me more conscious about the inequalities, health disparities and worker's rights in Turkey in such an extreme condition. In a crisis that world faces with now, COVID-19, it is revealed that how much we need to appreciate to the health service providers. In those days, in which the other things become insignificant but the health, it was hard for me to focus on writing the thesis and isolate myself from the news about the pandemic. To witness every stage of the pandemic, the reaction of states, and market economy makes me rethink about what I have learned in my sociology education. What I confront in this process is the concentrated form of the brutality in this system.

I wish to thank all the people whose assistance was a milestone in the completion of this study. As a gratefulness, first and foremost, I want to thank my supervisor Prof. Dr. Ayşe Gündüz Hoşgör, for her patience, supports and encouragements during this stressful process. Whenever I feel like I am captured by all the responsibilities, she made me feel more comfort about the process, and reminded me that I am able to complete my study when the road got though. I also wish to my deepest gratitude to Çağatay Topal for his guidance during my sociology education at Middle East Technical University. His deep knowledge enlightened me in my academic path and his calmness guided me to change my perspective towards the world around me.

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I am grateful to all my friends who always listen to me even I talk non-sense and made me enjoy this stressful process. Especially, I want to thank Ceren Başer and Okşan Tüylüoğlu for their academic insights and contributions to my study while also emotionally supporting me when I am fed up with all uncertainty which diffuses our lives in this time.

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EU	European Union
HTP	Health Transformation Program
IMF	International Monetary Fund
LTC Facilities	Long-term Care Facilities
MoH	Ministry of Health
NHP	New Health Paradigm
NPM	New Public Management
SEI	Self-Employed Institution
SII	Social Insurance Institution
SSI	Social Security Institution
WB	World Bank

CHAPTER 1

INTRODUCTION

My wish to study nursing as a profession is derived from my mother's experience in the medical field. My first memories of my childhood are about the hospitals, patients, and night shifts of my mother back then, the beginnings of 2000s. Since I could not see my mother all the time, I remember that I asked my dad to visit my mother at hospitals during her night shifts. Sometimes, I spent the night there, in nurses' rooms on a couch, and came back home with my mother. As a child, I was not aware of what my mother passed through in those days as both a nurse and a mother. What we experienced personally becomes an intuition for a sociological investigation over the medical field in my academic career.

Nursing has been the focus of sociological inquiry for many years. Scholars have studied nursing for its being a feminized occupation within the framework of skill discussion, as a segregated market and as an inferior occupation compared to other medical professions. Women are concentrated on the care service due to their attributed "natural" skills, which are accepted as innate. That is why, nursing has been considered as the most attractive and appropriate job for the women because of similarities between childcaring and caring of the patients. Caring, in that sense, is regarded as a significant part of the nursing. Indeed, it is an umbrella concept, including physical, emotional, material caring. However, there is no consensus among nursing literature about what care is and how to define it precisely. Indeed, defining care according to the needs of patients put an essential part of the

occupation into an open intervention which is directly related with the professional building process of nurses.

In Turkey, there is a massive transformation of the provision of services since it is also a part of the global transformation. “During the 1980s and 1990s, the neoliberal transformation of the welfare state intersected with the “international management revolution” that called for radical changes in the public sector with the aim to reduce costs, implement pseudo-market mechanisms, and improve services” (Montin, 2012, p.2 as cited in Selberg, 2013, p. 10). In Turkey, especially, the neo-liberal policies started to become effective after the 1980s as in line with the transformation of the welfare state. Within the decisions and interventions of IMF and World Bank, and also EU process, the relationship between state and economic actors have changed, and the role of the state is redefined as an actor contributing to the competition in the labor market. It decreased the intervention area in the labor market for the state. These are crucial instances for me to understand the turning points in the nurses’ changing occupational experiences while locating these experiences in time intervals. Changes in the health sector in Turkey for the last 30 years in terms of its distribution and delivery and attempts to standardize the care-work process, protecting the patients' and workers' rights, as well as controlling the workload is an essential part of this thesis. These changes are shaped around the introduction of Health Transformation Program, and its instances to increase efficiency such as a “feedback system”, performance-based system and Quality Control and Accreditation System. As mentioned previously, ongoing alterations need to be evaluated through the standardization in care-work and process, attempts to rationalize the medical settings and flexibilization of responsibilities and time arrangements needs further evaluation in Turkish health care system. Timmermans and Almeling argue that,

> The changing engines of health imply a different research agenda for the study of objectification, commodification, and standardization. The call for a more descriptive approach to the study of these three processes is based on the recognition that neither actors nor consequences can be assumed a priori, but

> must be empirically established in all their intended, contradictory, and unintended consequences. We need a much more detailed examination of the diversity of actions that ravel under the banner of objectification, commodification, and standardization (Timmermans & Almeling, 2009, p. 26).

Therefore, in this thesis, the main objective is to understand the complexity of the relations within the actors, their relationality and bargaining strategies with the system, their adaptation, and resistance with the changing healthcare system. It is crucial to be able to demonstrate that the case for Turkey in terms of nurses' experiences do not coincide with the professional building as Weber discussed as parallel to modernization, rationalization and standardization process which will be discussed later in Chapter 2, but rather they started to experience a de-professionalization process by losing their main jurisdiction areas. Therefore, while understanding the proximity of nurses in Turkey to the de-professionalization process, this thesis is constructed through the critique of Weberian understanding in terms of its definition over professionalism and its relationship with modernization. However, it should be noted that de-professionalization is a macro level phenomenon. Therefore, by de-professionalization, I will refer to the sample that I interviewed with. In addition to that, within this discussion, a gender dimension will be important to understand nurses' de-professionalization process in Turkey. Their core activity, care, cannot be constructed as a distinctive and autonomous area since it necessitates a degree of relationship. Therefore, I will address another critical point while understanding nursing as a profession by adding the relationality notion. There are many reasons for de-professionalization of nurses which this thesis draws attention. The cultural codes behind the construction of skill notion in the nursing occupation, the gendered relations at medical settings, and double hierarchy constructed through both gender and bureaucracy are described as the main drawbacks for nurses in Turkey to build their profession as separate and unique one. They are mostly shadowed by the other occupations in the medical settings and manipulated through both state mechanisms and patriarchal mechanisms. Rather than constructing the relationality as a drawback for them to construct a distinct profession, I will describe that how loss of relationality ends up with loss of core

activity of nurses which is care activity. That is one of the important aspects that the thesis emphasizes. This thesis argues that, in Turkey, concerning the healthcare service regarding nurses' changing occupational experiences for the lastapproximately 30 years, there has been an insecure working environment, ambiguous occupational boundaries, and increase in the work burden, un-paid extended work hours. These have affected the experiences of the medical staff at hospitals in terms of their motivation and work satisfaction. The invisibility of care labor, in this sense, not only in the informal sector or in the domestic sphere, but also in the formal sector, as in the case of nurses, is a social fact that we confront. Their emotional labor experiences which prioritize exchange of the feelings in the labor process, how they experience their labor under these circumstances, their evaluation of their own labor signifies importance. The insecure environment, changing the logic in the healthcare system, increasing work burden can be important means to understand this transformation which Turkey faces in the healthcare system.

1.1 Background & Context

Within the structural adjustment policies in EU process, Turkey's fragmented healthcare delivery was defined as a problem, and there were attempts to diminish this problem. Yılmaz described the health care system in those years as,

> Turkey's healthcare system before the introduction of the HTP relied upon public provision of healthcare services. The public sector was divided into different institution types, most of which were owned by the MoH, the SSK and public universities, respectively. The number of private sector hospitals, including hospitals funded by foreign or minority foundations, constituted only a negligible portion of healthcare provision in the country (The Ministry of Health 2004, p. 7–8 as mentioned in Yılmaz, 2017, p.75).

Aziz Küçük describes the effects of global restructuring as,

> In Turkey, reform practices related to public hospitals emerged as a sectoral reflection of the structural adjustment programs of the International Monetary Fund, and the World Bank. In those years, the basic

> components of the policy reforms conforming to neoliberal ideology were shaped in the healthcare field in line with decentralization, deregulation, and privatization (Küçük, 2018, p. 972).

Aim for increasing profit opens new intervention areas for the private sector. Since there is a lack of regulating mechanisms, the private sector becomes the main actor controlling the market in the following years. Public services became open to the private sector and started to gain an exchange value in the market, which can be exemplified as education, healthcare, transportation. In addition to that, commodification and commercialization of health cannot be taken for granted by ignoring their complexity since as part of the health system, care process includes relationality between the patient, the complexity of their relationships, contradictions and interdependency cannot be de-valued by taking it for granted. Therefore, it necessitates a further systematic evaluation within a social context and setting, and this thesis aims to do that.

In this thesis, the main concern is to explore the retired nurses' occupational experiences in their work fields, at hospitals. This thesis aims to describe the occupational and care work experiences in the contemporary conditions of capitalism in Turkey. Turkey has been experiencing a neoliberal transformation in every instance of the economic and political sphere since the 1980s. This situation affected many sectors and pushed them into a conversion. One of the most affected areas is the health sector, which can be grouped under the public service sector. Therefore, it is inevitable that new mechanisms reshape the conditions in which provided services take place. Thus, the main objective is to understand the care and occupational experiences of nurses through the changing health system. “Because care is labor-intensive and dependent on interpersonal relationships, it is less responsive to the supply and demand mechanism of the market, leading to shortages in both the quality and quantity of care provided by paid workers” (Stacey, Duffy, & Armenia, 2015, p. 4). Therefore, it is necessary to understand the contradictions, complexities of actions and unintended consequences, resistance, and adaptation ways to the new system.

To have a detailed examination, it is necessary to indicate the turning points in the health system in Turkey. The information below is taken from OECD Reviews of Health System in Turkey published in 2009. Many studies have different approaches to dividing the history of the healthcare system in Turkey. I aim to demonstrate important turning points that are visible to actors throughout the transformation regarding the healthcare system in Turkey. Besides this, in the literature, one of the critical indicators for alterations in the health system is the changes in the provision of healthcare services. Therefore, analyzing these turning points in terms of changing regulation and changing logic will be crucial. For the scope of this thesis, I will include three different time intervals which will be examined in a detailed way in the following chapters. It should be noted that, the critic years in this transformation process started with the EU process. Therefore, as a starting point, the 1980s is critical. In the OECD Report, it has been mentioned that,

> 1980-2002: During the period 1980-2002, Turkish citizens were granted critical constitutional rights with regards to access to social security and health services. According to the 1982 Constitution, all citizens have the right to social security, and the state shall take the necessary steps to provide social security to all its citizens. The Constitution also includes articles that strengthen the role of the state in regulating health services and providers for the implementation of Universal Health Insurance. Between 1986-1989, the government adopted the Basic Law of Health Services (1987) and the law on Launching Health Insurance through Bağ-Kur (the Social Insurance Agency for Merchants, Artisans, and Self-Employed). During 1983-93, the MoH and the State Planning Organization (SPO) carried out a major health reform study to understand needs and identify directions for reforms. The National Health Policy formally adopted by the government in 1990 and included, among other things, the introduction of Universal Health Insurance and family medicine in Turkey (OECD, 2008, p. 41).

Health System in Turkey has undergone a massive change in terms of its provision and implementation. Before 2003, the health system in Turkey was arranged through

different channels and had segregated coverage. These channels are SII[1], Self-Employed Institution (Bağ-Kur)[2], Pension Chest (Emekli Sandığı)[3] and Green Card (Yeşil Kart)[4]. These institutions differed in terms of their health coverage while differentiating people in terms of their employment. For instance, Green Card was covering poor and vulnerable people; while SII, which has the largest health insurance scheme, was provided to blue-collars and white collars in public and private sectors. As Aysıt Tansel stated that,

> The second-largest insurance scheme, Bağ-Kur, covered artisans and the self-employed (22.3 percent of the population). Bağ-Kur dates to the 1970s, but it started providing health services in 1985. Bağ-Kur insures could use inpatient and outpatient services at the Ministry of Health hospitals, university hospitals, and private hospitals (Tansel, 2012, p. 392).

Retirement Chest is one of the channels that provide healthcare for retired people. It is also known as the retirement fund or pension fund. It covered the people who worked for the government at that time. Tansel indicated that,

> Healthcare expenses of active civil servants were financed directly from the state budget. *Emekli Sandığı* and the state budget covered 15.4 percent of the population. It had a better benefits package than

[1] "The Social Insurance Institution (Sosyal Sigortalar Kurumu, or SSK), formerly known as the Workers' Insurances Institution, was founded in 1946 as Turkey's first social insurance institution.

[2] The social insurance for the self-employed people.

[3] "Shortly after the SSK was created, the Retirement Fund for Civil Servants (Emekli Sandığı, or ES) was established in 1954 (The Republic of Turkey 1949). Only in 1971 did Turkey's social security system begin to provide insurance coverage for the self-employed, including farmers, with the establishment of the Pension Fund for the Self Employed (Esnaf, Sanatkarlar ve Diğer Bağımsız Çalışanlar Sigorta Kurumu, or BAĞ-KUR) (The Republic of Turkey 1971)" (Yılmaz, 2017, pp. 54-55).

[4] "The Green Card scheme was a tax-funded social assistance program that granted the poor without social security coverage access to inpatient healthcare services. The introduction of the Green Card scheme was the only reform that aimed at facilitating access to healthcare services for the uninsured poor" (Yılmaz, 2017, p. 66).

> the other insurance schemes, and enrollees had access to all types of public facilities (Tansel, 2012, p. 392).

In 1992, the Green card program was introduced for poor and vulnerable people to provide them the healthcare service. In those years, the healthcare system in Turkey was considered weak since it was unable to cover most of the population. It had limited coverage, and this situation ends up with many vulnerable people in Turkey. Yılmaz concludes this situation as,

> The failure of Turkey's healthcare system to provide universal coverage and the organizational problems of the system were visible to all actors in the 1990s, but this did not lead to any significant policy response with the exception of incremental changes towards passive privatization in healthcare delivery and introduction of the Green Card scheme for the uninsured poor (Yılmaz, 2017, p. 78).

In summary, it can be said that the governance arrangements of the pre-2003 system were fragmented and segmented in terms of duplicative financing and running of the hospitals as well as its delivery and distribution. Turkey was aware of a need to expand health coverage across the country and address the regional and rural-urban disparities in access to health services. "Allocative efficiency was less than the ideal" (Tansel, 2012, p. 393). Especially since 2003, there are major and intense health reforms in Turkey through the Health Transformation Program. For instance, the fragmented health coverage means were gathered under one type of health coverage, which is called General Health Insurance in 2008 which will be discussed later.

In his article, Aziz Küçük evaluates the health transformation program, and one of its instances, which is the Public Hospital Union. "In Turkey, liberalization and decentralization reforms in the hospital system, which began after the mid-1980s, evolved to a "public hospital union" policy with the Decree Law No. 663, published in November 2011" (Küçük, 2018, p. 972). This model took place in the years between 2012 and 2017 and consequently failed in terms of its promises. However, its implications and aims are vital for us to understand a period in healthcare delivery in Turkey. Furthermore, he mentions that there are changes in the percentage of

public hospitals in Turkey in terms of delivering healthcare services. "Public hospitals, which have an important role in delivering healthcare services, are the backbone of the Turkish healthcare system. In the mid-1980s, public hospitals accounted for 78% of all hospitals and 75% of the total number of beds. Currently, due to neoliberal reforms, public hospitals accounted constitute 58% of all hospitals and 61% of all beds. In addition, 64% of the health care professionals is employed in public hospitals" (Küçük, 2018, p. 972). To provide a piece of more up-to-date information, the Figure 1 taken from OECD, Health at A Glance 2019 Report demonstrates the distribution of health expenditure by the provider in Turkey compared to the other OECD counties.

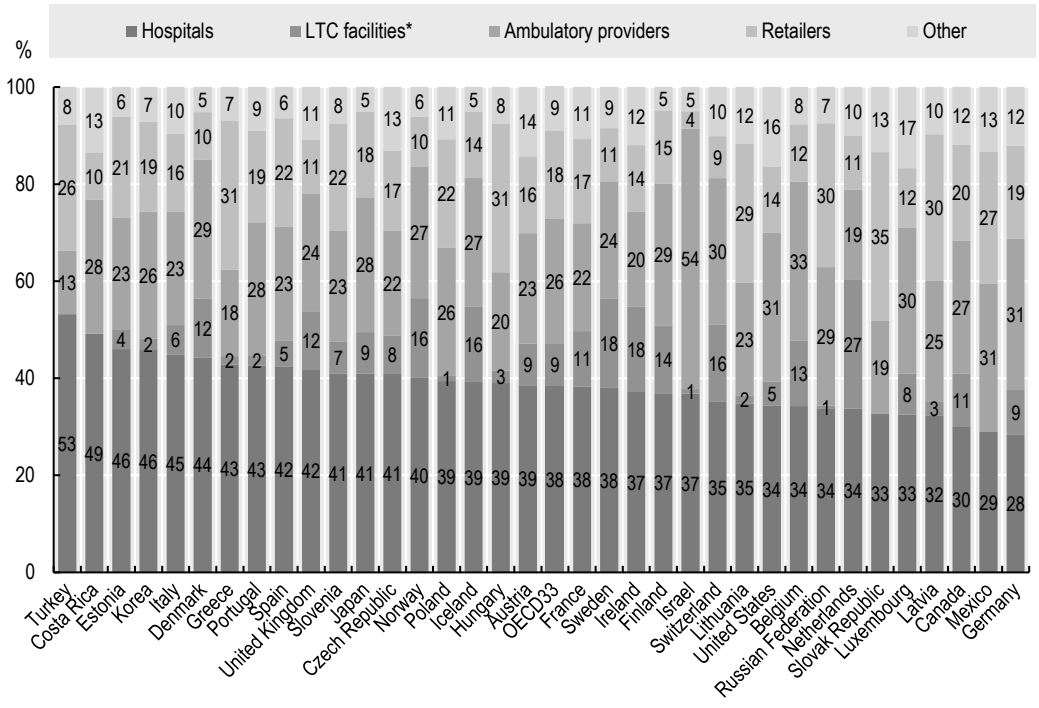

Figure 1: *The health expenditure by the provider.* Reprinted from OECD (2019), Health at a Glance 2019 (163): OECD Indicators, OECD Publishing, Paris, https://doi.org/10.1787/4dd50c09-en.

From the table, it can be summarized that healthcare services in Turkey are mostly provided by the hospitals. Hospitals are followed by LTC facilities, which means long-term care facilities. The examples of LTC facilities are rehabilitation facilities and care facilities for long term chronic diseases. In addition to that, within the

country, one of the least numbers at this distribution belongs to the ambulatory providers, which can be categorized as primary health services by the year 2017. Therefore, the fluctuations in the number of primary health care services, or secondary health care services are crucial for understanding the fulfillment of health-related needs in the society.

While this was the situation in which the Turkish healthcare system, nurses' numbers in the labor market in Turkey differentiate according to previous years. To have a coherent picture of the situation, it should be better to have following graphic from OECD Health at a Glance 2019 Report (OECD Indicators, 2019). Turkey is among the lowest countries for the number of practicing nurses per 1 000 population, 2000 and 2017 (or nearest year), as it is shown in Figure 2.

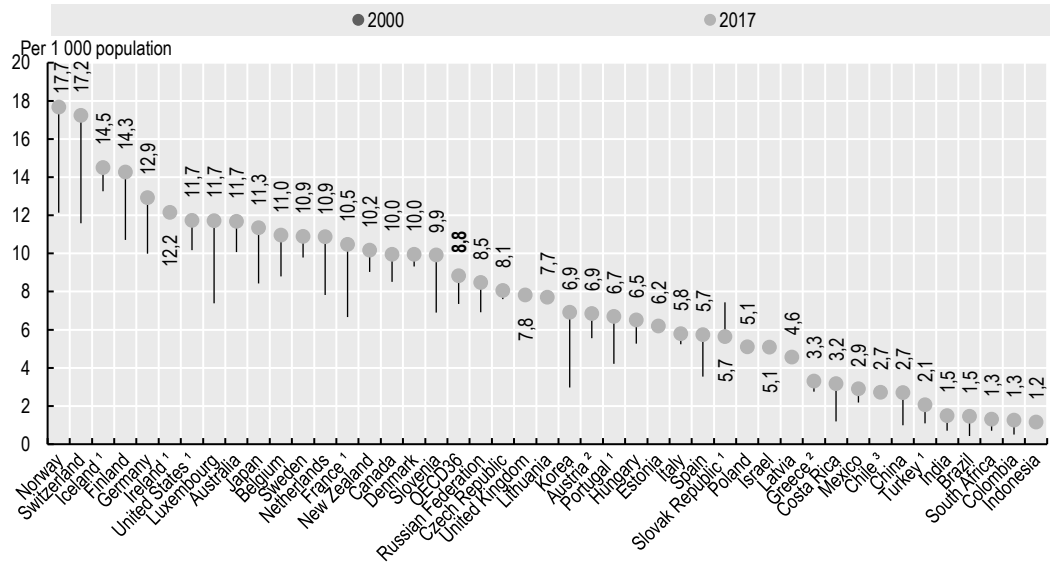

Figure 2*: The number of practicing nurses per 1 000 population, 2000 and 2017 (or nearest year)*. Reprinted from OECD (2019), Health at a Glance 2019 (179): OECD Indicators, OECD Publishing, Paris, https://doi.org/10.1787/4dd50c09-en.

As it is demonstrated in the graphics, Turkey, between these 17 years, have a slight increase in the number of nurses for 1 0000 population. However, as it is shown, the number is approximately 2.1 for 1 000 population. This means that, for every 1 000 people, in Turkey, there are only two nurses who can provide service for them accurately. The OECD countries' average for the 1 000 population is closed to the

nine nurses. The variation between the standard of the OECD countries and Turkey is indisputably considerable. How this lack can be evaluated, and what kind of consequences it brings are mainly discussed in this thesis.

Within the following years, there occurred an increase in the number of private hospitals in Turkey as part of the increasing pseudo-market dynamics in public service. For instance, the primary health care institutions are transformed into family medicine centers, and doctors at these institutions become autonomous in terms of their workplace, running of the institutions, and for choosing the personnel that they will be working with. In addition to that, in Turkey, the number of nurses working is 198, 465 by 2020, and the majority of the health sector consists of nurses. In this thesis, nurses will be the major actors since they constitute an essential part of the health sector. They can be considered and defined as the mediatory actors between the patients and the doctors most of the time. They are responsible for an immense number of things related to the patients, such as their physical care, after a surgery in the pop-up process, proper physical and emotional care. They are responsible for patient's care, the diet, their bodily cleanliness; if necessary, they are even responsible for the cleanliness of the patient's room. Therefore, hearing about their one day at hospitals, responsibilities, and describing it will be valuable in terms of the scope of this thesis.

1.2 Research Question

New Health Paradigm aims that healthcare needs to be effective, rationalized, and standardized within all the means it included. The performance-based system, quality control, assurance, and accreditation in the health system, registration of every stage in the curing and caring process are the instances of this transformation process. Therefore, in that sense, it is necessary to understand how privatization in the health sector and standardization alter the experience of nurses in terms of their work environment, responsibilities, and dynamics in the medical field. How nurses handle the changes, compromise with, or resist them will be necessary while understanding the relationship between structure and agency relationship. Furthermore, it is essential to investigate whether their burden is doubled, their

workload increases or decreases due to changing health system, and if health care provision affects their experience with the patients and with their co-workers or not. How care workers define themselves, describe and make sense of their labor can be reshaped through changes in the system. An in-depth exploration of the cultural meanings of paid care work and the subjective experiences of care workers is, therefore, crucial to achieving an understanding of the care sector in terms of nursing experience.

Within this environment, I think the service providers in the health sector need to be elaborated within changing experiences in their work field. Notably, the researches focusing on nurses mostly have a gendered aspect and focuses on the "femininization of the occupation." Many studies, primarily, focus on the "care" aspect of the nurses and tries to elaborate on the intersectionality between domestic labor and the profession as care. While we are in an age in which the service sector has risen up, the occupations also have been reshaped by this new industry. Especially in the health sector, for example, the introduction of a performance-based salary system as a feedback, pushes the doctors to cure many patients in a short period, and due to that, the time shared with one patient has decreased. It does not only affect the relationship between doctor and patient, but also it increases the competition between health service providers and may double the work burden for other medical staff at hospitals. Therefore, the trajectorial analysis of health care providers and their changing relationship patients and structure is important. Research topic covers, in that sense, the relationship between occupational experience as a concept and the New Health Paradigm introduced by neoliberal policies. I aim to focus more on the structure and agency relationship. Retired nurses' past experiences, trajectories, and stories will be helpful for me to understand the turning points in history regarding the health system in Turkey in the years between 1988 and 2020, and their changing occupational experience. The research question can be summed up as, “How retired nurses experienced their occupation within changes introduced by neo-liberal policies to the Turkish healthcare system after 1980?" In this case, the care providers are considered as the nurses, and their experiences will be elaborated within the framework of subjective care work

experience, occupational closure strategies, relational autonomy, interactions, material conditions of their work, power, and hierarchical relations.

In addition to that, how they manage the changes within the organizational structure, how intrapersonal relations as well as, interpersonal relations contribute to the transformation of change, and how they resist or adapt to these changes will be scrutinized. While I am doing this, I will analyze the relationship between professionalization and the modernization as Max Weber draws in case of nurses in Turkey by pointing out the uniqueness of care work and its being gendered notion. In addition to that, I will emphasize the professional building process for nurses in Turkey by discussing its core activity, care, and occupational closure strategies. I will describe, how nursing as a profession in Turkey struggles with de-professionalization process through instances of introduced structural adjustment regulations in healthcare system, since the instances of this transformation have major effects on their core activities, and responsibilities at medical settings.

In my opinion, to provide a more analytical approach towards the question, it is important to mention the related sub-questions under this topic. These are,

- What are the changes in the Turkish health system after 1980s?
- How have provisions of services changed during Health Transformation Program?
- What are the implications of this transformation for the nurses?
- What are the challenges of nursing as a profession faces in Turkey?
- How did nurses perceive these changes?
- How did they react to these changes?
- What is the adaptation or resistance strategies of nurses to these changes?
- How does it change the relations at hospitals with patients, with other working groups?
- How does the standardization aim of the New Health Paradigm has shaped the occupational boundaries of nursing?

1.3 Outline of Literature Review

In the literature review, first of all, it is necessary to develop a description of for what profession means from a Weberian, mostly, neo-Weberian theoretical framework by emphasizing the closure strategies of a profession. In addition to that, I argue that Weberian understanding of profession is lack for understanding the case of nurses in Turkey. Therefore, I will conceptualize professional autonomy of nurses as relational and mention the occupational closure strategies within a direct relationship with the notion of relationality. Then, the care process will be discussed as a core activity of nursing practice. Skill is a crucial dimension to be able to understand the nurse as an occupation, and its relationship with defined closure strategies to construct itself as a profession. Finally, New Health Paradigm will be conceptualized within the scope of this thesis. Second of all, the interpretative methodology will guide the theoretical framework of this thesis in the analysis part. In the literature, internationally, nursing has been studied from many different perspectives. Emotional labor, care, relationality, skill discussion are major discussed topics in the literature. Then, I will continue with the discussions over the care and medical care. Care is a well-discussed topic in the literature globally since the increasing need for care in the medical field ends up with the diversified theoretical discussions. Thus, it is necessary to have a deeper understanding of the care notion. In this part of the thesis, with the care notion, it is important to discuss the relationality aspect of medical care. Relationality and relational autonomy are notions which define the difference between the medical care sector, and the other service sectors. It is the non-distinguished part of the medical care which nurses are responsible for. To have a deeper understanding of the changes in the health sector, the subsequent chapters will be shaped through the discussions of the New Health Paradigm, its premises, and impacts on the labor market for nursing in Turkey will be evaluated with social closure notion. These chapters will be shaped around the accreditation on quality of health care, standardization of care, performance-based system, privatization, and logic of effectiveness and rationalization. Therefore, it is crucial for the literature review to provide us a theoretical framework to be able to

understand the sharp changes in the health care system in Turkey for the last approximately thirty years.

1.4 Significance of the Study

In the sociology literature, this topic relating to nursing, their profession, occupational boundaries, and experiences are mostly studied within the quantitative methods. The studies are mostly shaped through the literature of work stress, work burden, their well-being, and high turnover rates. In this study, I plan to understand the experience and handling and negotiation strategies of nurses within the changes in the system regarding their professionalization process. Rather than only focusing the changes, or changes in occupation and health system, in this study, it is important to understand the relationship between structure and agency. Therefore, as well as the consequences of the transformation in the health care system, it will be important to understand the changes in the experiences of the nurses in the medical field. In addition to that, while doing that, the demographic information of nurses may matter for further research. Socio-economic status, as well as gender, may have an impact on their perception of occupation and their experiences. How they experience their occupational boundaries, whether they consider themselves as a profession, how they perceive the changes in the system, and what kinds of action they take to handle the changes, resistance to it, or compromise with it are important questions throughout this thesis.

1.5 Structure of the Thesis

This thesis is constructed within five chapters. In the Introduction chapter, I gave a background for the scope of the issue and how the social phenomenon is placed within a context. Then, in the second chapter, Literature Review and Theoretical Background, I will have a glance over the related sociology literature and try to conceptualize what I mean by nursing and caring as an occupation as mentioned thoroughly in the Outline of Literature Review part. In addition to that, in order to understand the changes in the healthcare system in Turkey, a systematic conceptualization is necessary to have a concrete understanding for these changes. Therefore, I also try to conceptualize these changes through the paradigm shift in the healthcare system, which is derived from the basic premises of neo-liberalism

and summed up under the headings of rationalization, flexibilization, and standardization embedded in the New Health Paradigm within New Public Management Chapter. In the following chapters, I will analyze the data through three different time periods according to the sayings of participants as well as major turning points in the healthcare system in Turkey. In my research, I try to figure out the changes that are visible to nurses and how they perceive these changes. In chapter 4, I will divide the analysis part into four. I will construct these chapters similar to each other. In every part of the chapter, I will describe the social context for healthcare services specific to that period, through new regulations and legislations. Then, I will give a place to stories of the interviewees regarding that period by framing the narratives with the theoretical discussion.

The first part of the Chapter 4 will scrutinize the reasons for becoming a nurse, how they were educated, the tasks they were responsible for. The reason for describing the early years of their occupation is to understand the transformation of their experiences throughout the years. Since the changes in the healthcare system are reflected in the experience many years later, the reflections of changes in the following years will be easier to trace. The second part of this chapter will describe both changes they mentioned before, and how these changes reshape the social organization of the nursing profession, the medical field, and relations. Besides these, to what degree there is a change in the work-burden of nurses, how they handle time and space restrictions at the hospitals, and in other medical institutions. In the third part of Chapter 4, first, I will go through the sharp changes that Turkish Health system has undergone, and I will discuss what the consequences are, and to what degree care can be standardized. In last part of Chapter 4, I will give a short description of how nurses experience retirement. This is not one of the purposes of this thesis; however, as I conduct interviews, I realize that they develop strategies for economic vulnerability after retirement.

Therefore, I think that it will be essential for situating nursing as an occupation within the socio-economic sphere also after the retirement.

CHAPTER 2

THEORETICAL BACKGROUND & LITERATURE REVIEW

This thesis uses the term occupation for nurses since it does not directly claim that nursing is a full profession within the context of Turkey, or lose its professional status completely; but rather tries to show that, how an occupation resists to de-professionalization process in a degree and the complexity of the resisting strategies within a sample included in this study. While doing that, neo-Weberian closure theory, and the discussion over the gendered professions will be crucial. In the case of nurses in Turkey, as Weber discussed, we do not witness a professionalization within the rationalization and modernization process. Their specific relationships with the adjacent occupations as well as dominant professions in the medical field will be analyzed through the medical dominance with gender relationships, and hierarchical relationships at the medical settings. While analyzing them, I will draw attention to the care-work unpredictability, nurses' domain areas, the ways in which they construct their occupational autonomy and boundary. That is why, I will draw a framework for nursing as a profession, then I will theorize paid care activity as their main jurisdiction and domain area and discuss the skill notion within this specific occupation. The theoretical construction of skill will be important to be able to understand the relationship between their skills and de-professionalization process and its complexity. I will not aim to carry the discussion towards a neo-Marxist discussion with the deskilling and upskilling notions, but rather in this thesis, these notions will be constructed through the closure theory inter and intra-occupations as shrinking or extension of control areas. In addition to that, in this thesis, I will not construct a sharp distinction between profession and occupation as a term, but rather describe the discussions in the literature whether they are

differentiated or have common characteristics. That is why, they are interchangeable as notions throughout thesis.

2.1 Nursing as a "Profession"?

There are many approaches towards professions, professionalization and professionalism in the sociology literature. The main approaches can be exemplified as Trait approach, neo-Weberian approach, Marxist approach, Functionalist approach, Neo-institutionalist approach, Symbolic Interactionist approach and so on. In this part of the chapter, I will more focus on the Weberian and neo-Weberian construction of profession and try to locate nursing within these discussions. In some parts, to be able to understand the inside dynamics of nursing, varied theoretical approaches will be demonstrated.

To begin with, to understand what de-professionalization means, it is crucial to understand what profession signifies in the sociology of professions and what the main discussions are. However, it is crucial to note that, professionalization and de-professionalization process can be understood through a macro-level analysis. That is why, within my sample, it would be wrong to say that and generalize the data for all the nurses as they become de-professionalized within thirty years through state mechanisms. I will rather try to locate their experience specific to sample and trace the pattern within the group and understand these patterns within the proximity to the de-professionalization process discussed in the literature and determine the handling and resistance strategies of agency. In that sense, a reflexive agency, nurses, in that process will be important to understand their experience of resistance and adaptation within the process.

Nursing, historically and socially one of the intriguing fields of study for sociologists since its inside dynamics are keys for understanding both segregations in the labor market and within the medical field. That is why many studies focus on nursing and care in hospital environments. Sociology literature tries to locate nursing as a profession and analyzes its inside dynamics. In this chapter, I will try to focus on the existing studies which concern nursing and its professional building, domain, jurisdiction areas and care. While doing that, I will try to locate my research

question in terms of its position. Indeed, the profession as a notion is described in many ways in sociology literature. Then, what is a profession within the scope of this thesis?

Abbott and Meerabeau give a description of the literature on professions and point out the key elements such as requiring intellectual training, a body of expert knowledge, a degree of self-regulation by a professional body, and a royal charter or charter or establishment by statute (Abbott & Meerabeau, 2003). Rather than defining what profession is, idealizing its core elements was the dominant discussion in the sociology of work and organizations in those times. One of the definitions done by Goode suggested that a profession needs to be based on a body of knowledge, requires skills, and necessitates application of this knowledge while at the same time conducted through code of ethics (Goode, 1960). These elements are considered essential for establishing a jurisdiction area through a scientific language, and body of knowledge and within a degree of education.

Carr-Saunders, as cited in Abbott and Meerabeau (1955), writing in this tradition, suggested that there were four types of professions which are, established profession, the new professions, the semi-professions and would be professions (Carr-Saunders, 1955 as cited in Abbott & Meerabeau, 2003). Carr-Saunders categorized nursing in the semi-professions, which are based on the acquisition of technical skills rather than a high level of education or training. By describing this phenomenon in the literature, Adams stated that, "In the mid-20th century, these jobs were labeled as "semi-professions" because as women's professions, they did not possess the autonomy, authority, status or length of training of traditional men's professions" (Adams, 2010, p. 454). There are defined differences between occupation and profession. What the elements are, how the lines are drawn are controversial topics. In their book, Abbott and Meerabeau discuss how a profession can be defined. They argue that,

> Key elements in any claim to professional status seem to be autonomy or control overwork, a clearly defined monopoly over an area of work, and a knowledge base. It is in these areas that both social work and

> nursing have attempted to demonstrate that they are professions, and in which they have also been challenged (Abbott & Meerabeau, 2003, p. 9).

However, as I mentioned before, rather than draw a sharp line between occupations and professions, it is more crucial to understand their commonalities, and inside dynamics.

By Ritzer, through the discussion of Weber for a priest, there are some specialties for an occupation to be a profession. These are mentioned as, "power, doctrine or general systematic knowledge, rational training, vocational qualifications, specialization, a full-time occupation, the existence of a clientele, salaries, promotions, professional duties, a distinctive way of life (professional culture)" as similar to the previous definitions discussed above (Ritzer, 1975). Max Weber argues that specialization; professionalization, rationalization and bureaucratization processes are all intertwined into each other, and cannot be analyzed distinctly. Specialization is defined in his definition for core elements of priest as, “The crucial feature of the priesthood [is] the specialization of a particular group of persons in the operation of a cultic enterprise" (Weber, 1968, p. 426). In his analysis, George Ritzer traces Weber's definition of professionalism and professionalization. Although this was not the prevailing thought in sociology in those days, Weber tries to construct what professionalism is as a part of the rationalization process in society. In addition to that, Ritzer argues that, "Professionals contributed to the rationalization of these institutions and, conversely, the rationalizing institutions contributed to the development of the profession" (Ritzer, 1975, p. 628). The picture draw by both Weber and Ritzer is important in terms of the scope of this thesis since their close relationship will be evaluated in the context of Turkish healthcare system and professionalization process of nurses in Turkey. Specialization will be important part of the analysis chapter and it will be discussed through the closure strategies in the following chapters.

A Norwegian study focusing on nursing as a profession tries to understand a devaluation and de-professionalization phenomenon for the nursing occupation is very related to this research's aim. In this article, they try to describe the nurses in

the Norwegian context faces a de-professionalization process and there is no resistance to this process by nurses. Therese Marie Andrews and Kari Wærness, say that,

> […] Norwegian public health nurses, after a long period of professionalization, have recently undergone a process of de-professionalization. Public health nurses' jurisdiction has become heavily circumscribed. They have lost duties linked with power and respect in the local community, and they have lost the monopoly on duties originally ascribed to the profession (Andrews & Wærness, 2011, p. 42).

They try to examine nursing occupation by neo-Weberian framework which claims that "Professional organizations are understood as guards of self-interest, they claim a monopoly on duties, strive to expand their area of jurisdiction and protect their domains" (Andrews & Wærness, 2011, p. 42). They also use the emphasis of closure strategies, and Weberian understanding of a profession by drawing attention to the monopoly over duties, jurisdiction areas and domains. They try to elaborate on the nursing occupation and conclude that, with the Norwegian context, this occupation started to be de-professionalized since it is not able to protect its occupational domain. For instance, in the case of nursing, the tasks that nurses fulfill became easy to complete and completed by unrelated actors, as mentioned by Andrews & Wærness (Andrews & Wærness, 2011). Neo-Weberian perspective is curial for this thesis as well as this study. This perspective allows researcher to analyze professions within different levels including dominance, hierarchy, jurisdiction areas as well as different power relations while locating professions within socio-economic context and institutions. Saks argued that,

> In this sense, neo-Weberian work variously includes analyses of collective social mobility through professionalization (Parry and Parry 1976), the interplay between different occupational jurisdictions in the system of professions (Abbott 1988) and inter-professional working (Barrett, Sellman, and Thomas 2005 as cited in Saks, 2016, p. 177).

To understand a reverse process, which is de-professionalization, in the same article, Mike Saks gives a short description of literature for de-professionalization with neo-Weberian understanding as,

> Contributors like Calnan and Gabe (2009), Carvalho and Santiago (2015), and Sommerlad, Young, Vaughan, and Harris-Short (2015) also acknowledge that, on the other side of the coin, the de-professionalization and internal re-stratification of professions can occur through processes such as growing corporatization, marketization, and shifts in state positioning (Saks, 2016, p. 177).

That is why, this study is essential since while trying to construct nursing as a profession from a neo-Weberian perspective, it also demonstrates that this perspective is gender blind. While examining a profession in terms of its jurisdiction and control area, its dominance over the tasks, and its occupational autonomy and boundary, which are directly related to masculinity, we attribute the profession a masculine trait. In the article, this explains as, "Autonomy, Davies underscores, still stands at the very heart of the concept of the profession, and of cultural concepts of masculinity, whereas connectedness, which culturally has been dissociated with femininity, is a less prestigious feature of professional work" (Andrews & Wærness, 2011, p. 44). In this thesis, it is evident that, through the theoretical framework of conceptualization, occupational boundary and autonomy are also considered as crucial parts of a profession. These are also essential tools for us to investigate and locate the nursing while criticizing the lack of gender dimension in neo-Weberian theory in terms of its definition of a profession. It is important to note that, rather than the attribution, the significance and critique of this perspective lie behind the order of these attributive traits. I mean, rather than relating autonomy with masculinity and connectedness with femininity, it is crucial to understand why these two have an ordered hierarchy within each other. Furthermore, while demonstrating the relationship between rationalization and professionalization processes and how they are integrated into each other needs to be questioned, my main aim is to show that why this theory is insufficient to understand the case of nurses in Turkey.

Within all the restructuring processes that the healthcare sector has undergone by emphasizing rationalization, flexibilization, and standardization; how nurses become more vulnerable and de-valued within the labor market. That is why a gender perspective signifies importance while trying to understand the inside dynamics within nursing occupation. In addition to that, the article is an example for this thesis in terms of searching for resistance and handling strategies parallel to the aim of this thesis by de-passivizing the agency, which is nurses in that sense. In the previous study, Andrew and Wærness (2011) further try to understand why this de-professionalization process comes without resistance by nurses. In that sense, the importance of this study for this thesis is that its theoretical construction of profession and the emphasis over the closure and jurisdiction areas of a profession. Indeed, their emphasis over the de-professionalization process for PHNs in Norway after 1980s is the inspiration for this study. The differentiating point with this study and this thesis is more about the emphasis over the neo-liberal reconstitution of the social and economic spheres in Turkey, rather than only emphasizing the changing political agenda in terms of occupations. Although neo-Weberian approach also focuses on the means for achieving a professional status through exclusionary closure in labor market, I will analyze the notion of closure within the profession itself in addition to labor market, since it will be more suitable to understand the re-stratification in the medical field.

One of the critical studies intersecting with the thesis's subject is written by Rebecca Selberg. The article aims to show how nurses respond to the neoliberal transformations in the Swedish health sector and how it intensified the labor process of nurses. In the article, she also adds the discussion of emotional labor and its contradictory effects of increased demands. In the end, she argues that,

> Work intensification is a result of austerity ideology linked to the neoliberal transformation of the welfare state and public sector depletion. Secondly, work intensification is a result of explicit care rationalities impelled by aspirations of the nursing profession to establish, render visible, and expand the nursing field both in relation to the medical profession and in

> relation to so-called unskilled care work performed by assistant nurses and auxiliaries (Selberg, 2013, p. 29).

She also mentions the ambiguous position of nursing in the healthcare sector. She adds that nursing duties are barely identified, and they are given so many responsibilities at hospitals. The ambiguously defined tasks put nursing into a disadvantaged position as an occupation (Selberg, 2013). Therefore, the ambiguous definition of working tasks needs to be evaluated through their control areas and specialization areas.

Through these specialties, nursing tries to construct itself as a profession; however, as it is mentioned, it is challenged by many actors. The medical field is considered as a white male field, and it creates a control and domination area differentiated by race, ethnicity, gender, and class within the literature. In addition to that, it is necessary to state that within the consumerism, state-oriented problems, lack of regulations, and policies regarding the healthcare system are also additional factors for nurses not to be able to construct themselves as a profession. Furthermore, in the case of nursing, Davies well-describes the location of the nursing in the medical field by emphasizing the patriarchal relationships,

> […] There is a sense in which nursing is not a profession but an adjunct to a gendered concept of the profession. Nursing is the activity; in other words, that enables medicine to present itself as masculine/ rational and to gain the power and the privilege of so doing. It has clearly not had the first bite of the cherry in defining its work, and…we get closer to the…matter in recognizing that it is trying to put a conceptual framework around just those aspects of the work of health and healing that are 'leftover' after the medicine has imposed an essentially masculine vision (Davies, 1995, p. 61).

This description is vital in terms of understanding the hierarchical relationships in the medical field between nurses and doctors. Here, the concept of "medical dominance" gain an importance.

> The term "medical dominance" refers to the power and influence of physicians within the healthcare

> systems. It encompasses medicine's attempts to control the conditions of its own work, and also the conditions of supporting and competing occupations. (Freidson, 1988: Wolinsky, 1993) While physicians have dominated the medical division of labor, they also have been able to control the power relations and influence the professional activities of other healthcare occupations (Zimmerman & Hill, 2006, p. 486).

The notion of medical dominance becomes a theoretical framework, a tool for us to conceptualize the relationships in a medical field. The definition of the medical field is related with the dominant definition of an organization. Acker, while trying to conceptualize organizations as gendering, argues that,

> The organization itself is often described, defined through metaphors of masculinity of a certain sort. Today, organizations are lean, mean, aggressive, goal-oriented, efficient and competitive but rarely empathetic, supportive, kind and caring (Acker, 2016, p. 422).

This description of organization is important since medical field refers to a type of organization in this thesis. Furthermore, locating nursing within a neo-Weberian theoretical framework necessitates a gendered organization analysis since its construction of organization is mainly through masculinity as described above. In addition to that, considering the thought of close relation between the tasks of nursing and the invisible labor at home creates the biggest drawback for nursing to construct itself as a profession within this "masculinity". It is important to note that nursing as an occupation had attempted to claim and area of expertise by upgrading their educational level and training. Abbott and Meerabeau describe this situation as,

> During the course of the twentieth-century teaching, social work and nursing, for example, have all raised the entry qualifications for training, developed first-level training courses at the university level and argued for in-service training and continuing professional development (Abbott & Meerabeau, 2003, p. 9).

Abbott and Wallace have described the nursing within the medical field through the professionalism discussion as,

> […] Thus, as male doctors acquire the status of a profession, they not only exclude female healers from practicing but also gain control over female workers, who take on a subordinate role in the medical division of labor. Part of the process of gaining control lies in the ability to claim scientific superiority for the knowledge that underpins intervention. Medical science became dominant, and nurses were seen as working to support doctors—to carry out orders. Nurses were to have responsibility for the day-to-day surveillance of patients but were exercising power only on behalf of doctors. They conformed and were to ensure that patients conformed to the instructions of doctors (Abbott & Wallace, 2003, p. 40).

Here, the emphasis over the "behalf of the doctors" signifies a critical perspective for understanding the nurses' position in the medical field. Rather than having an autonomous work of the field, they are considered as the "helper of the doctors." And this saying leads to dependent work tasks to doctors, or their orders. That is why, while explaining professionalization and de-professionalization process for nursing in Turkey, there will be also a gender dimension of the issue in addition to the discussion of closure and jurisdiction over the main tasks, and this gender perspective will be diffused to thesis by highlighting the background of nursing in Turkey as well as understanding the inside dynamics at hospitals through medical dominance. In addition to that, drawing a Weberian framework for nursing necessitates a gender perspective as mentioned previously. Rather than speaking only sake for nurses, it is important to note that to understand a profession and its social relations; we need to take these relations as historically constructed. The existing schema for a profession is not built in one day; they are constructed through a set of relations in a social context. This is best summed up as by Walby et al.,

> The nature of the historical context at that formative moment, in terms of its forms class, and gender relations, is crucial to understanding how the division of labor between different groups of health workers, including doctors and nurses, was created (Abel-Smith,

> 1960; Stacey, 1988; Witz, 1992). The development of gender-specific occupations is not an even historical process but proceeds in sections, with periods of stability and continuity intersected by periods of change and restructuring (Massey, 1984; Walby, 1985, 1986 as cited in Walby, Greenwell, Mackay, & Soothill, 1994, p. 65).

Therefore, in its professionalization and de-professionalization process, nursing needs to be located through the socio-historical context. This perspective is important since, as the scope of this thesis, the relationships in the process of transformation is more exposed to different mechanisms. Therefore, while trying to understand social relations, their continuity, and discontinuity, we need to consider gender as crosscutting between categories in the restructuring process.

The education, the scientific body of knowledge is also an important dimension for a profession and its profession building process. In many kinds of research scrutinizing nursing and care, care education becomes an intriguing topic for scholars, as the notion of care signifies a crucial part of the nursing. Therefore, the way it is taught is also critique in terms of its application. In her article, Ester Carolina Apesoa-Varano argues that “Attempts to scientize caring must be understood as an occupational response to upgrade nursing in light of the dominance of the medical model and the widespread perception that neither knowledge nor skills are necessary to perform caring” (Apesoa-Varano, 2007, p. 258). The required skills for nursing are always considered as intrinsic and natural. Therefore, as a profession, it always tries to justify its dominance over tasks and to define its boundaries. By saying that caring "is always there" and that "people have it," educators assumed it is intrinsic to individuals, particularly women given pervasive stereotypes of them as mothers, nurturers, and caretakers. This presupposes that women do not need to be educated to care for others, and that is why they make "good nurses." Therefore, its indecisive lines are also fed by the lack of consensus over the education of caring. In her study among the nurses, Apesoa-Varano argues that within the results of interviews, one of the biggest motivations for becoming a nurse is the "narrative of caring as an art or craft" (Apesoa-Varano, 2007).

It is a craft which becomes perfect during the field, in the workplace within the experience. Therefore, in the article, the conclusion drawn indicates that professionalization and caring cannot be separated. Therefore, the caring notion will be discussed in the following chapter as a major domain of nursing practice. The separation is an analytical one since they coexist in the field. Similar to that, Chambliss finds that "When nurses say they "care," this is more than an empirical description of duty; it is a defense of their own importance… it [caring] is used as weapons in nurses' conflicts with physicians to distinguish what nurses do and to assert their moral superiority" (Chambliss, 1996, p. 68).

Another sociological study analyzing nursing experience also includes the nurse burnout, their satisfaction with their work environment, and their changing experiences with changing structural background, which shapes their occupational practices. These kinds of researches are also crucial in terms of investigating the working arrangements, conditions, and even the outcomes of existing adjustments. Bégat, Ellefsen, and Severinsson try to describe nurses' satisfaction with their work environment and the outcomes of clinical nursing supervision on nurses' experiences of well-being (Bégat, Ellefsen, & Severinsson, 2004). This study needs to be mentioned since the research will make it easier to understand the environment and the structure in which these working conditions are explicitly shaped to social context. In this article, they aim to have a descriptive-correlational study that exhibits the psycho-social environment and the stress level that nurses have. Indeed, it is a quantitative study; therefore, it describes a broader framework for the working conditions of nurses. While researching the nurses' burnout experience, I confronted many studies. One of the important points about these studies is that both are based on quantitative methods. It can be said that, rather than the experience itself, these studies mostly focus on the level of stress by using inferential and descriptive statistics. They identify six factors affecting the nurses' satisfaction which are, 'job stress and anxiety, relationship with colleagues, collaboration and good communication, job motivation, work demands, professional development. They end up with the result showing that ethical conflicts are the main reasons for the increasing level of getting stressed of nurses (Bégat, Ellefsen, & Severinsson, 2004).

In my opinion, these six factors are worth investigating and can contribute to my research while trying to understand the personal experiences.

Lately, the studies about nursing started to focus on a new rising phenomenon, which is a home care service. It is crucial since home care services are also important for the analysis of emotional labor. A home care aide will probably know her/ his patient for weeks and possibly months or years. A nurse can become familiar with intimate details about her client's life and experiences, family gatherings, and this situation may make them feel like they are a member of the family. This signifies importance since it blurs the distinction between the home and the working field. In addition to that, whether if stretches the working boundaries of nurses or not is an integral part of the issue in terms of professional building. That is why, this can be an inspiration for following studies.

2.2 Care as an Occupational Instance

I firmly believe that a general glance at the literature of care and emotional labor briefly would be important to make the definitions to the point. Since care has been considered as a significant part of nursing throughout the literature, in this thesis, main practice of nursing will be conceptualized as care giving. By defining care activity as an occupational mean, I will try to describe its core elements to be able to understand how these elements are reshaped, re-constructed or eliminated within a transformation process. Indeed, what caring is, how medical care should be, and what holistic care is discussed throughout the literature and includes various theoretical discussions. Therefore, it is necessary to draw a framework for the philosophy of care. To begin with, Clare Stacey, Mignon Duffy and Amy Armenia in their book called *Caring on the Clock: The Complexities and Contradictions of Paid Work* try to give a comprehensive framework for both changing relationship within the labor market dynamics and therefore changing dynamics within the paid care work environment and relations. Furthermore, they aim to have a better understanding of the challenges which these workers are facing and to show difficulties working in this sector. They define care as,

> First, the activity [of the industry] contributes to physical, mental, social, and/or emotional well-being; Second, the primary labor process [in the industry] involves a face-to-face relationship with those cared for. Third, those receiving care are members of groups that by normal social standards cannot provide for all of their care because of age, illness, or disability; and fourth, care work builds and maintains the human infrastructure that cannot be adequately produced through unpaid work or unsubsidized markets, necessitating public investment (Stacey, Duffy, & Armenia, 2015, p. 4-5).

This definition emphasizes the market dynamics and its relationship with the care, the fluidity of the care according to the patients, and also core specialties such as face to face relationships and providing mental, social, physical, and emotional well-being. They also focus on the emotional labor workers to understand the blurred distinction between family and work. Care, in that sense, needs to be operationalized as both occupational mean and as a gendered activity which women responsible for at home. They argue that it is important to understand their uniqueness. In their work, one of the main concerns is the notion of relationality. Relationality can be defined as the relationship between the one who cares and who is cared for. It is important since their relationship is not shaped through their relativeness, intimacy, or familial tie; rather it is formed in a medical field without interdependency with each other. Thus, professionalized care needs to be re-evaluated within this context. Smith, in her article, called Caring and the Discipline of Nursing by emphasizing the importance of care activity in nurse experience, (2013) mentioned that,

> Caring has been at the heart of nursing's identity before its recognition as a profession or discipline. The root of the word "nursing" means nurturance or care. Nursing, as a set of nurturing activities focused on caring for the sick, was assigned or ascribed as a role in all societies to healers, members of religious orders or women in their homes before the role became formalized. In these myriad variations, the role of the one performing these activities has been imbued with qualities of protection, nurturance, and altruism (Smith, 2013, p. 17).

Therefore, it can be said that caring as part of nursing is important historically. She mentions that "It is the nature of the nurse-patient relationship that unites the practice of nursing as it occurs in myriad settings throughout the world at every moment of everyday" (Smith, 2013, p. 18). Therefore, the caring activity cannot be conceptualized without considering the relationship between patient and nurse. Care as a concept is essential to understand its scope in terms of discussion. Francesca Cancian and Stacey Oliker define the concept in this way: "feelings of affection and responsibility combined with actions that provide responsibly for an individual's personal needs or well-being, in a face to face relationship" (Cancian and Oliker as cited in Duffy, 2011, p. 9).

For this thesis, there is an important dimension for caring process. As it is mentioned, it includes a proximate relationship with the human bodies, therefore, it also needs to be conceptualized as a bodily work through this relationship. Cohen describes this situation as,

> Possible responses include work on conscious bodies, work on live bodies, work on intact bodies, work on body parts, and work on bodily excretions. These responses are nested: work on conscious bodies necessarily encompasses all that follows – work on live, intact bodies, body parts, and usually some excretions – but the reverse is not true; bodily excretions can be examined without encountering any live, intact bodies, or even body parts (Cohen, 2011, p. 191).

Therefore, it is the body, and its limits and de-limits determine the predictability and unpredictability of the care work. The care work is complex and chaotic most of the time. It may necessitate one or two workers for one body, and for the workers, it is impossible to accomplish all tasks in a day with multi-tasking in terms of care-work. As Cohen discusses, multi-tasking is not something that care workers can take advantage of it for three reasons. She mentions that,

> First: rigidity in the ratio of workers to bodies-worked-upon limits the potential to increase capital-labor ratios or cut labor. Secondly: the requirement for co-presence and temporal unpredictability in

> demand for bodywork diminish the spatial and temporal malleability of the labor process. Thirdly: the nature of bodies as a material of production – complex, unitary, and responsive – makes it difficult to standardize, reorganize or rationalize work (Cohen, 2011, p. 189).

That means, if the need for care work increases, the need for care labor also increases. Therefore, very nature of the human body determines the care process, the need for specific care processes and therefore, the relationship between nurses and patients. In addition to that, the degree of surveillance and control over the bodies is also regulated with the direct relations in which body the action takes place.

Nurses try to justify their difference from curing by emphasizing caring since they are always in a struggle for their occupational field. Curing and caring cannot be separated distinctively; in the process, they are all-inclusive to each other. However, they are different in their means. Curing means has been innovated in past decades but caring has insisted on its means. Therefore, while having such an analysis, it is important to analyze them within their instances and their implications. One of the important questions related to this issue is that why they need such a defense. It may be a handling strategy for protecting their occupational domain and boundaries. Why they need this necessitates further investigation throughout this thesis.

As mentioned in the Chapter of Nursing as a Profession, the reasons for individual burnout may be helpful for understanding nurse experience. However, naming them as individual burnout would be misleading since the reasons for burnout are rooted in structural implications in the healthcare system. In line with this sentence, it is important to highlight that in the medical setting, emotional labor and experiences are mostly framed by the structural implications such as policies conducted in public health or health policies directly. For instance, the study conducted in Romania is an example of that. The authors indicate that there is a direct relationship between the conditions that nurses, or medical staff work, and the burnout level. While describing the context, they say that,

> The Romanian medical system is currently characterized by poor financing, inadequate equipment, and medical facilities, lack of decent income for the medical staff; all these lead to work disruptions and implicitly to consequences affecting the medical care (Băiaș & Grama, 2018, p. 16).

Another important dimension regarding nursing practice is its education and how nurses are educated to care. One of the studies focuses on this issue written by Young, Godbold, and Wood (2018) is called "*How do student nurses learn to care? An analysis of pre-registration adult nursing practice assessment documents*" (Young, Godbold, & Wood, 2017). Since it is an article published in a nursing department, their design of research and methodology differs from the sociological analysis. However, the results that they end up with signify a sociological concern. They revealed that, in the education of caring, there is some emphasis on specific points. They argue that one of them is the approach of holistic care. As the evaluation of this holistic care, they identify some categories such as adaptive, flexible care, seeing and doing in practice, being watchful, harm avoidances, management of learning (Young, Godbold, & Wood, 2017). These elements of holistic care are also significant because they signify a professional domain for nursing activity and therefore will consist the important part of the analysis while locating the nursing in Turkey as a profession.

2.3 Occupational Closure & Relational Autonomy

It is necessary to conceptualize the occupational closures and autonomy of nurses within their relations with the other actors taking place in a hospital environment. The occupational boundaries of a profession are well-discussed topics in the sociology of work and organizations, especially constitute a major part of neo-Weberian framework for professions. Crompton compares the neo-Marxist and neo-Weberian framework in terms of closure as,

> With considerable over simplification, neo-Weberian accounts of the occupational structure may be described as laying more stress on the processes of "closure" in shaping it, whereas neo-Marxist accounts would stress the external economic logic of capitalist development (Crompton, 1987, p. 414).

Therefore, understanding the specific relations in terms of constructing occupational closure and closure strategies is crucial for process of profession building. In this part of this thesis, I would like to focus on how to define their occupational boundaries and how they change within interactions and organizational structure of the hospital as well as labor market relations which will be more visible in the analysis part. It is important to note that occupational closure and boundary as concepts are replaceable within the scope of this thesis. In addition to that, the autonomy of nurses at medical setting is drawn as relational by the very nature of the caring activity as described in the previous chapter and this discussion will be important in terms of professional domain of nurses. Allen's notion of boundary-blurring distinctions will dominate this part of the thesis since it is an analytical tool for us to understand changing occupational closure of nurses and its relationship with the relational autonomy concept. However, before that, it is important to understand what closure means within the sociology of professions literature. In the literature, there are many types of closure which are mainly discussed. Indeed, closure strategies are mainly discussed in the sociology of professions literature. In here, I will mention two of them, which are directly related with the topic. Here, the main closure strategies are exclusionary and demarcationary closure strategies. In their article, Andrews and Wærness argue that,

> Writers distinguish between different strategies: exclusionary closure is used in intra-occupational relationships often when an occupational group is trying to achieve upward mobility in a professional hierarchical setting. Demarcationary closure aims for inter-occupational control over the affairs of related or adjacent occupations (Andrews & Wærness , 2011, p. 43).

Therefore, to be able to understand nurses' strategies to occupy broader jurisdiction area in the medical setting, their relationship with the adjacent occupations as well as dominant occupations need an analysis through inter-occupational relationships. Their intention to extend their area and make their labor visible in the medical field will be analyzed through types of closure strategies.

Witz's discussion of dual closure is another dimension for the closure strategies in the labor market. She adds a gender dimension to the issue, since she values the gender-specific strategies within a professional project, or professional building process. Anne Witz describes dual closure strategy as,

> They entail the upwards countervailing exercise of power in the form of resistance on the part of subordinate occupational groups to the demarcationary strategies of dominant groups, but who also in their turn seek to consolidate their own position within a division of labor by employing exclusionary strategies (Witz, 1990, p. 679).

However, it should be noted that this categorization of the strategies and actions are not in purified form. They need to be elaborated through the social context and specific to changes within this context. In parallel with this argument, in a study which aims to understand the diversified form of strategies and consequences for social workers in a neoliberal transformation through NPM by applying risk management regimes, it is mentioned that,

> The researchers found a range of responses, some positive, some critical and some mixed, and they conclude that human service professionals in community care 'maintain a strong sense of agency, a professional ethos and a focus on clients' needs. Indeed, respondents who had a 'positive risk rationality' had integrated the framework of risk management into their professional identity and believed it to have improved their practice (Connell, Fawcett, & Meagher, 2009, pp. 335-336).

Thus, with parallel to this study, I will try to understand the relationship between structure and agency, as mentioned before. While having such an analysis, I will not take agency as granted, which is acted upon, but rather I will show how these agencies are part of the reconstruction of the social organization of the work.

Skill and specializations are important elements for an understanding of a profession. That is why, in the analysis part, the skill, specialization and their relations with the closure strategies and professional autonomy of nurses will be

discussed through the changes they had been faced with. In addition to that, these strategies are important to understand in terms of protecting the professional domain, jurisdictional areas and expanding or narrowing the jurisdictional area in the process of professionalization and de-professionalization. However, while drawing nurse's professional domain it is important to add the dimension of relationality, and its outcomes for the notion of occupational closure. Their relationality with the other actors including professions and non-professions actors leads a complexity in terms of their experience of their profession. Allen describes this situation as occupational boundary-blurring and identifies five categories which discussed below.

As mentioned before, in the analysis of Weber, the closure of a profession signifies an importance since it distincts the main jurisdiction area from others within institutions as well as in labor market. Especially, neo-Weberian approach defines social closures as regulating market conditions for its benefits, rather than subjecting to a competition within the labor market (Saks, 2016). Saks further argues that,

> The state is also critical in neo-Weberian analyses as it underwrites the legal boundaries of professions, typically leading to higher income, status, and power in such groups as compared with most other occupations in the marketplace (Saks, 2016, p. 176).

It determines the professional duties and boundaries as well as differentiate one from the other. As indicated before, it is important to understand the occupational boundaries within the other actors taking place within an institution. The other actors in a hospital environment can be concluded as patients, doctors, nurses, the other working groups, and patient's relatives. Therefore, while trying to conceptualize the occupational boundary, it is necessary to define the relationship between nurses-doctors or nurses and the other actors at the hospital. Therefore, this situation brings an ambiguous definition for occupational closure of nurses in their professional working areas. To begin with, as Allen mentions in the article called *The Nursing-Medical Boundary: a negotiated order?* (Allen, 1997) that there is a blurring boundary between nursing and medical, and it should be analyzed through the changing division of labor in medical service. Allen has a typology for blurring

boundaries between which is distinguished within the five categories, which are, continuity-oriented boundary-blurring, articulation-oriented boundary-blurring, judgmental boundary-blurring, rule-oriented boundary-blurring, and layout boundary-blurring (Allen, 1997). She identifies the reasons for the boundary-blurring of nurses. She argues that the reasons for continuity-oriented boundary-blurring are derived from ensuring the co-ordination of the care work and also restrain the discontinuity within the order of services. For the articulation-oriented boundary-blurring, she exemplifies pre-blood tests done by nurses for saving time and also conduction of rest of the tests on time. She further argues that the judgmental-oriented boundary-blurring is conducted by requesting blood tests with the nurses' own judgment about a patient but without the order of the doctors. Fourthly, for the rule-oriented boundary-blurring, she emphasizes that even if it means breaking the rules, they keep on working with the framework of work ethics such as giving medication before it is prescribed in case of emergency (Allen, 1997). Lastly, she argues that "Nurses justified this lay-oriented boundary-blurring on the basis of the action the patient would have taken, had they been at home" (Allen, 1997, p. 511).

It is important to understand why this blurring occurs, and sometimes nurses have to do the doctor's and the other's job to fulfill the tasks and make the things go on well. Allen divides these reasons into three parts by analyzing the working environment of a hospital. She says that, first of all, temporal-spatial organization between medical and nursing work is a reason for blurring the duties. This is also directly related with the care process which is conceptualized before as unpredictable and depend on the body acted. Since nurses and physicians work in different spatial and temporal periods, it is an important factor to determine their priorities during the work.

Sometimes, a call from a nurse called emergency may not seem to a doctor as such. Therefore, it creates vacancies in the flow of distribution of medical and nurses, and coordination becomes complex and hard to have. Thus, nurses take responsibility for continuity of the tasks, and sometimes they need to act intrinsically since it is

hard to reach the doctor. She also mentions the organizational hierarchies as a second reason for the boundary-blurring (Allen, 1997). The third reason for her is the workplace turbulence and gender ideologies (Allen, 1997). In my opinion, the second and third reasons cannot be separated and need an evaluation together. It is defined in the article that hospitals have a turbulent environment since they are complex, hierarchical, segmented, and serve 7/24 for 365 days (Allen, 1997). She mentions that "Arguably, the expectation that nurses will be flexible workers in part reflects the legacy of nursing's occupational history, and underlines the point made by Davies (1995) that gender is embedded in the design and functioning of organizations" (Allen, 1997, p. 227). Gender differences, a turbulent environment, and the hierarchical structure of the hospital make nurses blur their occupational boundaries in order to continue the tasks without disparities. However, an interesting outcome of this study, as Allen mentions in her article, is that they do it with a little negotiation and less conflict than expected (Allen, 1997). "Negotiations occur when rules and policies are not inclusive, when there are disagreements, when there is uncertainty, and when changes are introduced" (Maines and Charlton, 1985 as cited in Allen, 1997, p. 278). Therefore, nursing tasks, circulations within the hospitals, managing the patient process, order of priority, blurring the boundaries of the working task to complete the responsibility on time need to be considered while having an analysis of occupational experiences on them. Moreover, in Turkey context, in what degree the nurses negotiate and whether there are conflicts or not will be discussed throughout the thesis.

In his article, Chris MacDonald discusses that nurse's occupational autonomy needs to be defined through its relationality. He defines the professional autonomy of a medical profession, the nurses in this sense, as,

> When we speak of the professional autonomy of an individual nurse, what we are really considering is the right – indeed, the responsibility – of a member of the nursing profession to act according to the shared standards of that profession (MacDonald, 2002, p. 196).

He argues that nurses' professional autonomy is in direct relation with the institution in which they work. The organizational structure is an important factor shaping this autonomy. Therefore, while considering the occupational boundary of nurses, it should be noticed that it will be operationalized as relational, within the work environment and also structural and hierarchical relationships. There is another dimension for understanding the autonomy of nurses as relational. Chris MacDonald emphasizes the notion of relational autonomy of nurses in the medical field and puts an emphasis on the relationality notion in terms of professions in the sociology literature. The notion of relational autonomy also can be seen as the critique of traditional and liberal definitions of autonomy by feminist theories. MacDonald argues that "A relational understanding of autonomy means a shift away from older views focused on individuals achieving independence; towards a view that seeks meaningful self-direction within a context of interdependency" (MacDonald, 2002, p. 194). In this model of autonomy, the emphasis is on personal relationships and their interdependence with each other. In the article, MacDonald discusses that the patient's autonomy in terms of their health care process is widely focused in the literature and the notion of relational autonomy over their body with the healthcare providers through differentiating means such as informed consent forms, confidentiality and privacy and so on. While trying to understand the professional autonomy of nurses, as the other side of the coin, MacDonald touches upon a critical point. He argues that "Even when nurses are carrying out physicians' orders, they typically retain a sphere of autonomous judgment regarding how those orders are fulfilled. Nurses receive formal training and gain experience in activities about which physicians typically know less" (MacDonald, 2002, p. 197). That is one of the sources of autonomy for nurses in the medical field. As the importance of the new definition of the autonomy, MacDonald, for the concept of relational autonomy, argued that "In such a view, individual autonomy is socially constructed; that is, the capacity and opportunity for autonomous action is dependent upon our particular social relationships and the power structures in which we are embedded" (MacDonald, 2002, p. 197). Then why did I prefer to conceptualize professional autonomy as relational in this thesis? The answer to this question is quite related

with the very inside dynamics of caring process, which includes a face to face relationship with the patient, shared intimate moments and common making decision process towards the same body within multiple actors. I realize that, Weberian understanding of professional autonomy is lack for understanding the experience of nurses in the medical field. Therefore, while investigating the nurses' professional autonomy, we need to conceptualize it as a relational autonomy in relation to the institution, structures, and particular social relationships. This will be the dominating view for the rest of the thesis to understand nurses' experiences within their occupational boundaries as well as the autonomy of them in the work domain.

2.4 What is Skill in Nursing?

The discussion of skill is a hot topic in the sociology of work literature as well. Therefore, reviewing theoretical discussions will be helpful for us to understand the literature broadly and the ways in which they question the subject. I divided this part into two parts. First of all, I will try to demonstrate how skill is located in neo-Weberian understanding shortly and I will introduce gender dimension as essential for discussion of skill in terms of nursing as an occupation. Secondly, I will analyze care notion within the skill discussion as a major part of the nursing occupation. Although this thesis is not constructed through feminist methodology, this discussion is important in terms of understanding skill notion in nursing.

Although I want to include neo-Weberian discussion of skill in terms of professions and labor market, I think that this perspective is lack for us to have a better understanding for nursing in Turkey. However, I want to include that perspective, since the closure term that I discussed in previous chapter is directly related with the notion of skill for neo-Weberian understanding. For this approach, social closure is important for an occupation since it determines the hierarchical relationship between other occupations within the labor market. In that way, by strengthening the place in the labor market, it approves that it is an occupation which requires specific skills and labor to be learnt. “The most direct method of enhancing an occupation’s power

is to remove itself (or its members) from market competition, a process that Weber and his followers called “social closure” (Attewell, 1990, p. 435).

The social closure term is ability to for one occupation differentiate itself from the competition in the labor market. In that way, this specific occupation becomes more prestigious and powerful. This approach is important since while understanding the nursing within the labor market, what kinds of external constraints they are exposed to, and how these constraints affect the ways in which they experience their labor will be the important part of the analysis.

> Requiring lengthy periods of apprenticeship or training and slowing (or discouraging) the entry of new practitioners help build a public perception that the work requires exceptional knowledge and preparation (Attewell, 1990, p. 435).

In that manner, public image of an occupation is important to protect this occupation from lower prestige, salary and respect. In addition to that, if occupations do not restrict the newcomers, and more intervention of them; it is argued that it will devalue the importance of their skills within the occupation as well as labor market. That jeopardizes their domination in the labor market. Task complexity, on the other hand, is another dimension to the discussion of skill in the sociology literature. It is argued that within the neo-Weberian approach, even in the absence of task complexity, some occupations are regarded as high-skilled, whereas the others are categorized as lower-skilled. This dimension opens another discussion that skill is social constructed. In that manner, skill cannot be only determined by labor market relations and social closure dimension, or task complexity within the labor process. That is why, in addition to that discussion, I also want to a gender dimension to the discussion of skill in the literature. Within the case of nursing in Turkey, it will be important to discuss this occupation from a gender dimension as well as its location within the labor market. It will be important for us to understand how the hierarchy between nursing and other medical professions are constructed not only through social closure as neo-Weberian understanding draws but also a gendered hierarchy.

Nursing as an occupation is mainly discussed through the feminist perspective also. Why feminist perspective matters are directly related with the nursing activity and its construction as a female occupation in the labor market. In addition to that, locating the nursing within the labor market in the context of Turkey is important while discussing major theoretical dimensions towards that issue. To begin with, one of the important aspects of feminist studies about nursing are the feminization of the work and how women are concentrated in this sector within the labor market. Indeed, what nursing necessitates are mostly considered as similar to what women have to do at home or their " intimate skills." Here, the discourse of intimate skills includes many dimensions. Considering the skills gained by women in their occupational field as intimate leads to a degradation of value in terms of their labor. By saying that, these skills are intimate; it is emphasized that there is not time, labor, training, or education is needed to obtain those skills. In the labor market, therefore, they are treated as invaluable and invisible. Nursing, which is categorized and considered as a "feminine occupation," is one of the occupations that hold the incomes and consequences of patriarchal relations in the labor market. Evans explains this situation as,

> The devalued status of women and women's work in the context of patriarchal society is reflected in the female-dominated occupation of nursing. Here stereotypical feminine traits of nurturing, caring, dependence, and submission exist in stark contrast to masculine characteristics such as strength, aggression, dominance, self-control and feminine image of nursing itself (Evans, 1997, p. 226).

The crucial point is here that the traits are considered as feminine are de-valued within the system. It is important to question why these specialties considered feminine and why they are hierarchically ordered in a subordinated position. Furthermore, feminist scholars have critiqued the literature on professions for emphasizing principles of objectivity and rationality based on scientific norms, rather than equally exploring the significance of affective, expressive, relational aspects of professional work. I will especially try to examine this part of nursing by pointing out relationality and relational autonomy notion.

Then, what is skill? Skill needs to be conceptualized as socially constructed through different power relationships. That is why sociologists and feminist scholars insist on digging it. As Yıldız Ecevit mentions in her article in which she examines women workers working in a factory in Bursa,

> The allocation of the sexes to different jobs is usually carried out according to characteristics which are attributed to the jobs and the workers. It is believed that passivity, patience, dexterity', and accuracy are typical female attributes so that women are better suited to sedentary, monotonous, 'fiddly,' and repetitive jobs. On the other hand, typical male attributes include a high level of activity, physical strength, and technical ability, which are said to make men suitable for jobs requiring mobility, strength and, technical knowledge (Ecevit, 1991, p. 62).

In the passage, it is indicated that the notion of skill is along with gender, and it is shaped by gendered attributions. There is gender-based segregation in the labor market, and the reason for it is based upon the socially constructed skill attributions. The attribution of close relationship with nursing and the work that women are responsible at home is leads a devaluation since they are seen as an "easy" task within the patriarchal and capitalist society. Hartmann, while explaining the gender segregation in the labor market, mentions the patriarchy and capitalism in a relationship to oppress women and make them distanced from the public sphere and segregated nature of the labor market (Hartmann, 1976). Women are segregated both horizontally and vertically through their "lower" skills in the capitalist system, and in that way, they become cheap labor in the labor market. While they are mostly and consequently, concentrated on the precarious works in the labor market, they also become double marginalized by occupying the lower positions in the sector. We confront a vicious circle here. Women's skills are considered as invaluable since the time and labor spent for them are ignored; they are regarded as inner capacities and thought that they are given by birth. They became marginalized in the labor market and segregated to the lower sectors and lower positions. Because there is a circumscribed arena in the labor market for women, and the ideologically defined 'proper' jobs, there occurs a surplus of labor and end up with a reserve army of labor.

This situation is also valid for trivializing the value of women's labor. They are mostly employed in the informal sector, in precarious jobs that lack social insurance, social security, and other benefits. Skill is very complementary to the position that a person occupies in the labor market. However, skill attribution should be re-thought. Being a nurse also has a gendered aspect as one of the reasons for its de-valuation in the formal market by the reproduction of gendered division of labor in the medical field. The gendered division of labor in the medical field is a crucial point in terms of the scope of the thesis. In her article *Gender and Feminization in Healthcare Professions*, Tracey Adams defined the gendered division of labor in the medical field as, "Among health professions, there has traditionally been a clear gender division of labor. The most prominent and authoritative professions like medicine and dentistry were strongly male dominated" (Adams, 2010, p. 454). While she defines the women's labor in medical field as "Women's healthcare labor was often concentrated in jobs, like nursing, and dental assisting, that were seen support men's professions" (Adams, 2010, p. 454). Through this division, it can be concluded that, while men's position in the medical field signifies a more authoritative place and they are able to control the decision-making process, women are seen as a supportive actors in the medical field who are distanced to decision making and controlling over their own labor. She continues to describe the situation of different attribution to men and women as, "Professional men, like middle class men, were expected to be distinguished, rational, unemotional, authoritative, physically robust, committed to their jobs, highly educated and broad minded and especially later in the 19th and early 20th centuries, scientific" (Adams, 2010, p. 455). She adds that, this definition marginalizes the women which are considered as obedient, emotional and dependent, and somehow less committed to the work (Adams, 2010). Although this situation is changed since many women started to enter the professions which were mainly male-dominated, dynamics and set of social relations created through gender division of labor remain visible at medical setting. That is why, this notion is important to understand the existing social relationships at medical settings, too.

The skills defined above in the passages, such as patience, emotional, caring, sensitiveness is included in the nursing occupation. It is also ideologically considered as the proper job for a woman as being a teacher, secretary, or midwifery. It is seen as the extension of the domestic duties that women need to accomplish. I also emphasized the labor market relationships in terms of skill discussion since this perspective will be critical in terms of positioning the nurses and their labor in the capitalist market. In their article, Phillips and Taylor says that,

> […] The classification of women's jobs as unskilled and men's jobs as skilled frequently bears little relation to the actual amount of training of ability required for them. Skill definitions are saturated with sexual bias. The work of women is often deemed inferior simply because women who do it. Women workers carry into the workplace their status as subordinate individuals, and this status comes to define the value of the work they do. Far from being an objective economic fact, skill is often an ideological category imposed on certain types of work by virtue of the sex and power of the workers who perform it (Phillips & Taylor, 1980, p. 79).

The passage shortly argues that the value of the labor in the market is not related to education or time of the education, but rather related to the people by whom the tasks are completed. Therefore, it is not an economic fact, but a socially imposed category. The difficulty of the tasks, or how much training it necessitates are overlooked since it is the women performing this profession mostly. Therefore, this perspective is important to understand the reproduction of gendered relations in a hospital environment. The medical field is obviously a gendered and hierarchical field as conceptualized before. Hence, its power dynamics may be reflected in the construction of the relations between patients, or between nurses and doctors, or with other working groups. The occupational experience should not be limited to the care-experience of the nurses throughout their professional history. Thus, the organizational structure, its implementation, and reflecting points on the individual and subjective experience is an important dimension. Within the scope of this thesis, therefore, how they perceive their skills in the medical field, how they gain these skills, and how these skills are challenged by other actors will be important in terms

of their professional building process. Crompton tries to describe the notion of skill within an organization.

> However, professional skills may have been sex-typed and thus differentially ranked. Where the skill is either applied within an organizational context, or dependent on an organizational context as in management, then women will find themselves confronted by gender exclusion at the organizational level (Crompton, 1987, p. 421).

As mentioned, the issue is more related with the hierarchical order of these traits and how these are contextualized through gendered organizations.

Lastly, nursing tasks that need to be fulfilled within occupation signify feminine traits through their similarity with the domestic labor, as mentioned before, and therefore, men feel like they need to create their area of action within this occupation to get rid of fulfilling these feminine tasks. That is why there is an increasing number of studies that focus on "men in nursing." The topic seemed interesting to the researchers because of the lower number of men nurses in the sector compared to women's numbers. One of the studies focusing on this issue is about how men nurses are becoming distanced from the women nurses, and how they are positioned in the high level of nursing, such as administrative roles. Evans says that "Male nurses do this by employing strategies that allow them to distance themselves from female colleagues and the quintessential feminine image of nursing itself, as a prerequisite to elevating their prestige and power" (Evans, 1997, p. 226). Here, the vital point is to understand that men try to create their work domain within the same occupation and try to get rid of the feminized work stigma for their own. This is the concrete example of how men and women perceive their labor within the same occupation, in this case, nursing.

Care, by definition, provides dependency, an intimate relationship, nurturance, emotions as conceptualized before. These traits are considered as "easy" in a private environment through their attachments to traditionally ascribed roles for women. However, occupations whose duties are directly related to accomplishing the need for care bring the burden for the caregivers as an occupation. It can be considered

easy to care for the one you loved, your sister, mother, or friend; however, caring for a person who you have never met before is your duty within these professions. In this situation, the case became interesting. The teacher, whether a woman or a man, needs to care for the children that they teach; the nurses are the ones who are in a mediatory situation between doctors and the patient. These people spend most of the time with the people that they need to look after. Without a previous emotional relationship, there is a mutual dependency on each other. Here, the relationship between the nurse and the patient is vital since they develop a relationship through a need for patients. Care as an occupation includes an obligation, a necessity. It requires a defined environment such as school, hospital, or another home. It has its working hours, and as a caregiver, you are under the control of supervisors, which indicates a surveillance mechanism in the workplace. In medical settings, care includes a portion of the control, surveillance, and investment over the patient's body. The medical settings provide expert knowledge, authority, and negotiation between the patient and the medical authority as discussed before in the previous chapters. We cannot deny the patient's role and cannot describe a picture in which the patient takes a passive role. It is a reflexive process between nurses and patients. It includes a degree of intimacy and proximity. They wash patient's bodies, help them to take their medicines, share their emotions and concerns; these necessitate some degree of skill, patience, and dedication to the care activity.

Throughout this part of the thesis, I tried to draw a picture of studies regarding skill discussion within gender discussion and care as the core activity of nursing which gain importance in the discussion of medical dominance as well in the Analysis Part. Now, it is important to conceptualize the changing process in which nurses experience their occupations, which is New Health Paradigm and its outcomes in Turkey context.

Therefore, while I am discussing the changes in the healthcare system in Turkey at the beginning of every analysis chapter, I will refer to these theoretical discussions and changes mentioned below.

2.5 New Health Paradigm within New Public Management

New Health Paradigm necessitates an understanding within a more prominent framework. Therefore, in this part of the paper, first, I will try to neo-liberalization and its outcomes, and then by mentioning its three instances, which are rationalization, flexibilization, and standardization.

I will try to relate these instances with the health care changes taking place in Turkey. Brenner, Peck, and Theodore (2010) try to conceptualize neo-liberalization and pursue aiming of meta-theoretical construction. They argue that,

> On the most general level, we conceptualize neo-liberalization as one among several tendencies of regulatory change that have been unleashed across the global capitalist system since the 1970s: it prioritizes market-based, market-oriented, or market-disciplinary responses to regulatory problems; it strives to intensify commodification in all realms of social life; and it often mobilizes speculative financial instruments to open up new arenas for capitalist profit-making (Brenner, Peck, & Nik, 2010, p. 329-330).

In addition to that, it should be noted that neo-liberalization is not a pure and unique form. Within the increase in mobility and transection over the world, and in the time of liquid modernity (Bauman, 2000), the neo-liberalization process needs to be analyzed within the changing social context, and its diversified means and outcomes. It shapes itself according to the socio-political context, and in that way, it creates its own intervention areas, handling, and resistance strategies. Thus, we need to operationalize the neo-liberalization as diversified across the countries, cultures, and socio-political contexts, and always in the process of being. In their article, Brenner, Peck, and Theodore (2010) conceptualize neo-liberalization within the three analytical dimensions, which are systems of inter-jurisdictional policy transfer, transnational rule-regimes, and regulatory experiments. (Brenner, Peck, & Nik, 2010) One of the important dimensions relating to healthcare transformation in Turkey can be studied within the transnational rule regimes. They argue that,

> Large-scale institutional arrangements, regulatory frameworks, legal systems, and policy relays that impose determinate ‘rules of the game’ on contextually specific forms of policy experimentation and regulatory reorganization, thereby enframing the activities of actors and institutions within specific politico-institutional parameters (Brenner, Peck, & Nik, 2010, p. 335).

This aspect is crucial since they do not try to have a pure definition of neo-liberalization, but rather define it as something within the specific politico-institutional parameters. Thus, we cannot expect that the neo-liberal transformation will lead to a unilateral outcome for all countries in which it diffuses. They concluded that in their article,

> In our conceptualization, neo-liberalization is not an all-encompassing global totality, but an evenly developed pattern of restructuring that has been produced through a succession of path-dependent collisions between emergent, market disciplinary, regulatory projects and inherited institutional landscapes across places, territories, and scales (Brenner, Peck, & Nik, 2010, p. 342).

New Public Management (NPM) is one of the neoliberal policies' instances for reconstructing the means of public resources, and its distribution. Notably, New Health Paradigm needs to be considered as a part of the NPM. In their article, Newman and Lawler mentioned that "The impact of NPM (known in this sector as 'health care reform') on nurses and nursing as an occupation has also received substantial attention in the nursing research literature" (Newman & Lawler, 2009, p. 420). They added that the well-discussed topics could be mentioned as the impacts of NPM on nursing and physicians (Newman & Lawler, 2009). New Health Paradigm within the NPM has many consequences over the social services and public sector. Beach concludes this situation as,

> Processes of commercialization of previously socialized services characterize the most recent global structural changes noted in the organization of teaching and nursing and the recruitment, competence, authority, and positions of the professional groups of teachers and nurses

> respectively, in both extreme and regulated forms of the neoliberal state (Beach, 2010, p. 563).

New Public Management has a more focused on hierarchy, bureaucracy, and efficiency of the public sector. "With the 'New Public Management,' schemes of organization and control are imported from business to public institutions" (Connell, Fawcett, & Meagher, 2009, p. 334). Connell, Fawcett, and Meagher explain the core elements and the consequences of the NPM for the public sector as,

> […] But more fundamental is the shift to what might be called fractal organizational logics, such that each part of an organization is a microcosm of the larger unit in which it is embedded. In particular, each part of an organization functions like a profit-making firm, with its managers held accountable for the income/expenditure balance. Under neoliberalism, this principle holds down to the lowest level. Individual workers are treated as firms, expected to follow a profit-making logic, and are held accountable to the organization in these terms, through 'performance management' schemes. Both organizations and individuals are required to make themselves accountable in terms of competition (Connell, Fawcett, & Meagher, 2009, p. 334).

The described situation is one of the examples of de-centralization login in neo-liberalism. In every division of an institution, there are maximized and achievement goals, and this leads to an independent functioning division within the same institutions. Decentralization includes the elimination of authoritative power, state power in the market, and make the market more flexible and open to intervention. McGregor states that,

> In principle, decentralization is supposed to: (a) bring about a more rational and unified health service that caters to local preferences; (b) improve implementation of health programs; (c) decrease duplication of services; (d) reduce inequalities between different target audiences; (e) contain costs as a result of streamlining;(f) increase community involvement in healthcare; (g) improve integration of health care activities between public and private agencies; and (h)

> improve coordination of health care services (McGregor, 2001, p. 86).

Allen also describes this situation as control over small parts. She argues that "Changes in management arrangements involved combining tighter accountability and monitoring with an increase in devolved freedoms. Units of management became smaller and under tighter local control" (Allen, 2003, p. 212). Therefore, as concerning the fractal organizational unit, de-centralization is also aimed at having more efficient conduct of the organization by dividing it into pieces. In healthcare institutions, this process can be seen as the separation of finance and service. This implementation may have many consequences since every separated division will aim to maximize their executions. While finance tries to maximize the profit, the services given will be considered as qualified or not. Therefore, within the institution itself, it is inevitable to have conflicts of interest. Therefore, it is essential to have such a dimension while trying to picture the experience itself within the altering social condition of work. These dimensions mentioned above will be our tool to conceptualize and typology the nurses' experiences throughout their working years.

One of the interesting studies about the medical profession and its relationship with the paradigm shift in the health system is written by Timmermans, and Oh (2010) focus on the transformation of the medical profession. In the article, the attempt is to demonstrate the relationship between consumerism, health policy, and the medical profession. Timmermans and Oh examine the recent challenges to the medical profession, which demonstrates the tension between self-interest and collective altruism: 1) the rise of patient consumerism, 2) the advent of evidence-based medicine, 3) the increasing power of pharmaceutical industry (Timmermans & Oh, 2010). They try to give a conceptualization of the medical profession while considering stress between altruism and self-interest. This study is important since they try to provide a conceptual relationship between physicians and changing market dynamics, in which this thesis conceptualizes this relationship through nurses and market dynamics and changing policy logic regarding the health system. They concluded that four main points at the end of the article. First of all, they argue that "It is easy to underestimate the role of the medical profession" (Timmermans &

Oh, 2010, p. 101). It necessitates a deeper analysis of direct or in-direct and longer- or short-term consequences. "Second of all, it is similarly easy to overestimate the role of the medical profession" (Timmermans & Oh, 2010, p. 101). This point is based upon the over-visibility of the physicians in the process of curing and caring. This point is vital since nurses are considered as invisible in this process, and therefore, the consequences and experiences may differ in that sense. One of the most important points mentioned in the article is that "Reforming health care can have unintended professional consequences" (Timmermans & Oh, 2010, p. 102). Therefore, in this thesis, the main concern will be investigating the unintended consequences of this transformation for nurses.

In her article, Rebecca Selberg mentions that standardization is desired in the healthcare sector through new public management. “Because it enables the predictable allocation of resources” (Cohen, 2011, p. 198). Predictable allocation of resources is also directly related to the rationalization process. Intending to increase efficiency, calculability, and predictability, there emerge new mechanisms to control the labor process. Technology, new actors in the labor process, cheap labor are examples of it. Cohen, in the article, conceptualizes care wok as bodywork and focuses its unpredictability by discussing its borders through standardization. In that sense, Cohen argues that standardization is essential for predictability of the body and care-work and gives examples through a cesarean birth, and its malleability. The body here becomes the material of production. And by transforming the labor process, and bodily predictability, the standardization is realized through selection, and transformation of body (Cohen, 2011). However, while doing that, Cohen argues that the complexity of the experience is important and how care work within the unpredictability and individualistic nature of it, can be standardized is discussed (Cohen, 2011).

In the analysis part, with parallel to what Cohen discusses, I will try to investigate how care work can be standardized, to what degree it is possible to standardize care work, through what means it is standardized in this process, how nursing experience

is changed, or it resists to this change. I will try to understand nurses' professional subjectivity and commitment to their occupations.

One of the important implications of the rationalization in the care-work is the risk management process. Risk management is seen as a crucial part of predictability and efficiency. Risk management, in the process of standardization and rationalization, becomes important since it lessens the level of the risky labor process. Therefore, its management and eliminating tools are important for the system to conduct and work well. In their article, Sawyer et al. try to describe the nurses' experience in the process of risk management, and rather than a taken for a granted conclusion, they try to show us the complexity of the experience (Sawyer, Green, Moran, & Brett, 2009). They argue that "The term 'rationality' was used to encapsulate the complex, active and sophisticated reasoning processes that workers engaged in when analyzing and identifying risks and making professional judgments about clients' situations" (Sawyer, Green, Moran, & Brett, 2009, p. 365). Therefore, rather than passivizing the actors, they try to show us their professional engagement in this process. At a hospital, the patient's needs, their situations, and possible risks need to be controlled and managed to have a more predictable, efficient, and rationalized process. These may include new means such as technology emerging in healthcare, registration for protecting workers and patients, and control of every stage and phase.

Ritzer furthered this discussion and called this process as McDonaldization. He argues that this process has some core elements, such as efficiency, calculability, followed by predictability, control, and irrationality of rationality (Ritzer, 1996). With parallel to the discussion of rationalization by Weber, Ritzer argued that this rationalization process is diffused to every instance of life, such as birth and death. In addition to time, the place is also another dimension of this diffusion and effect. Ritzer argues that "The fast-food restaurant has combined the principles of the bureaucracy with those of other rationalized precursors (for example, assembly line, scientific management) to create a particularly powerful organization of the rationalization process" (Ritzer, 1996, p. 292). He gave some examples within the

health, such as decreasing needs for midwifery due to increasing birth numbers at hospitals. While discussing McDonaldization spatially, he also adds a dimension for temporality by discussing birth and death. He argues that "Hospitals and medical profession developed standard, routinized (McDonaldized) procedures of handling child-birth" (Ritzer, 1996, p. 301). In every step, he argues the childbirth is calculated and rationalized through intervening the process by considering it as a pathologic process. Ritzer's McDonaldization thesis is an important analysis for us to understand the rationalization process that society confronts with and its relationship with the professionalism.

All in all, in the health sector, with the increasing population, there are rising costs for the governments. To cut spending and expenditures, and for using the resources more efficiently, it is argued that the private sector needs more area to control. State intervention has lessened but not stopped. Specifically, in the health sector, there occurs the joint of both government and private sectors. As parallel to that, McGregor specifies some aspects of the free market via privatization and deregulation mechanisms for the public and public services.

> Deregulation involves (a) removing pieces of law that previously enabled the government to deliver a service to the public or (b) reworking laws so that more power is given to the private sector. In the eyes of neoliberalists, markets are far superior to government in the allocation of scarce resources (the underlying principle of economics) (McGregor, 2001, p. 85).

Step by step, social services such as health, telecommunications, transportations, social security are sold to private companies and become open areas for competition. The privatization, adapting the means and techniques of the private sector to the health sector has many consequences. One of the aims of the free market is to expand itself to diffusing the new areas. As Connell, Fawcett, and Meagher mentioned in their article, the expansion of pseudo-market dynamics to public services become a norm, and companies started to meet public needs (Connell, Fawcett, & Meagher, 2009).

As one of the public services, the health care sector begun to be dominated by the free market dynamics and its extensive mechanisms such as public policy partnership in healthcare, increasing privatized education for healthcare professions, an increasing number in private hospitals and care services centers. It also brings the logic of free markets such as making more profit in a shorter time of period, a customer relationship, and competition between health caregivers and institutions through different means. "At the same time, an emphasis on labor market 'flexibility' has produced a growing workforce of part-time and casual and contract labor at the bottom of the organizations" (Connell, Fawcett, & Meagher, 2009, p. 332). As they mentioned in the article, neo-liberalism is rhetorically gender neutral. However, flexibility in the market and flexibilization over time and place constraints of work have mostly affected the sectors in which women dominate. These occupations can be exemplified as nurses, teachers, and social workers (Connell, Fawcett, & Meagher, 2009).

Thus, within the framework of the health transformation in Turkey, it should be recognized that the actors and institutions are unique for the socio-political context, and their outcomes cannot be predicted in a taken for granted way. While McGregor explains how neo-liberalism restructures, he defines its instances as,

> Language and metaphors reflecting this philosophy prevail in all public, private and civil dialogue, especially in healthcare policy: spending cuts, dismantling, de-indexing, deficit-cutting, haves and have-nots, competitiveness, downsizing, the declining welfare state, inefficiencies, inevitability, closures, chopping services, de-insured, user-pay fees, two-tier health care, for-profit health care, escalating costs, free markets, erosion of health care, being forced to make difficult policy choices, unfortunate necessities and justifiable sacrifices (McGregor, 2001, p. 83).

Cutting expenses, having a narrower financial plan for public services, the increasing need for healthcare become altogether a part of the dialogue between state, public services, and private market. Hence, it is important to consider that, the principles drawn in this chapter will be our tool while having an understanding of

nurses' subjective experiences of their occupation, their handling strategies to construct nursing as profession, and how skill notion in nursing is re-constructed and its relation with the occupational experience.

CHAPTER 3

METHODOLOGY OF THE THESIS

3.1 Background of the Methodology

As I mentioned, what pushed me to study nurses' experiences in Turkey is rooted from my own experience with my mother. She was a nurse working in a hospital, and also a mother who was responsible for taking care of two children. She had to work at nights, and most of the time, she had to sleep during the days after nightshifts at the hospital. As a child, I was not aware of the things that my mother had to pass through in her working life. As I grow up, I understand that she got tired, become anxious and nervous after working at nights. She had to care for two children at home, and as well as patients that she had never met before. Sometimes, when I miss my mother while she was working, we visited her at hospitals, and I remember myself as willing to spend the night at hospitals to see her. In my sociology career, the fact that how a medical field can be tiring hits me hard for a woman who is also charged for taking care of her own children at home. That is how I take an eager interest in studying care labor in the medical field. As a nurse, within their occupation, what kind of things makes them vulnerable in terms of their working life through different mechanisms and how they try to handle them are essential in my thesis. I want to understand how agency is shaped towards this process, as well as how they shape the process itself.

In this thesis, my main concern is to understand the handling and resistance strategies of nurses with the changing healthcare system in Turkey. Methodologically speaking, the goal is to understand the relationship between structure and agency through the survival strategies. While trying to understand how these two notions are interrelated, diffused or in a dialectical relationship, tracing

the changes that structure has undergone become another complex part of the thesis. That is why, while having an analysis, I prefer to conduct a methodology which enables me to understand both spatial and temporal trajectories, and its direct relation with the agency. Therefore, in the analysis part, I will be more focusing on the changes in the institutional level while locating strategic action of nurses.

Before starting, I want to describe how this thesis is stratified in terms of understanding the relationship between actors. As I described throughout the Theoretical Background and Literature Review, healthcare system, hospitals and nurses are main actors while understanding nurses' social action within the changing process. In the Introduction part, I gave a more macro-level background to make meaningful the changes in which healthcare system in Turkey has undergone. In addition to that, I need to say that, my main concern is rather than constructing a direct relationship between retired nurses' experience and global neo-liberal structuring, to understand how its effects on institutional level have affected the retired nurses' experience within the specific space and time.

As described within the aim of this study, methodologically speaking, tracing the change of occupational experience is a complex process since their short-term and long-term effects may not be presented in the investigation time. To note that, in this thesis, as a researcher, I aim to conceptualize the changes in the occupational experience of nurses mainly through their occupational closures and closure strategies. In addition to that, to be able to understand the adaptation and resistance strategies to these changes, I argue that their relationship with structure, in that sense, institutions, matters. That is why, while understanding their resistance and adaptation strategies, it is important to locate their action within a social context as well as within "professional project". That is how, it will be possible to argue that whether they have undergone a de-professionalization process although they resist through sort of actions called closure strategies. As it is mentioned in Witz's article, "This raise the issue of relation between strategic action and structural constraints, an issue which is highlighted as a particularly problematic aspect of the use of concept of strategy in sociology generally by Crow (1989)" (Crow, 1989 as

mentioned in Witz, 1990, p. 676). It is therefore essential to keep in view the interplay between strategy and structure, between actions and resources for action.

> […]In regarding actors as reflexive, strategically calculating subjects oriented to the structural-conjunctural complexities of action contexts, the strategic-relational approach implies that they reflect on their identities and interests, are able to learn from experience, and by acting in contexts which involve strategically selective constraints and opportunities can and do transform structures (Jessop, 1996, p. 125).

Therefore, while conceptualizing the nurses' actions, it will be important to understand the relationship between structure and agency. In that sense, rather than defining the structure and agency as separate and independent from each other, it is crucial to operationalize them as in relation with themselves and shaping each other through the process. As it is mentioned that "Structures are irredeemably concrete, temporalized and spatialized; and they have no meaning outside the context of specific agents pursuing specific strategies" (Jessop, 2008, p. 1990). Therefore, while understanding the action of nurses within a socio-historical context, their action needs to be located temporalized and spatialized. As a methodological tool, I will use strategic-relational approach, which emphasizes the dialectic relationship between structure and agency by locating structures spatially and temporally and locating the action specific to conjectures. In that way, it will be more revealing to describe their strategies within the social organization of work.

> In short, structures do not exist outside of specific spatial and temporal horizons of action pursued by specific actors acting alone or together and in the face of opposition from others. Likewise, actors always act in specific action contexts which depend on the coupling between specific institutional materialities and interaction of other social actors (Jessop, 1996, p. 126).

In that manner, this approach includes an important dimension to understand the social phenomenon within a specific time and space. Furthermore, the institutional analysis and the relationships between the social actors within the institutions may

be well understood through this perspective. This approach also provides to understand the actors through the time and conjunctural changes. In addition to that,

> It examines structures in relation to action, action in relation to structure, rather than bracketing one of them. Structures are thereby treated analytically as strategically selective in their form, content, and operation; and actions are likewise treated as structurally constrained more or less context-specific and structuring. To treat structures as strategically selective involves examining how a given structure may privilege some actors, some identities, some spatial and temporal horizons, some actions over others (Jessop & Sum, 2013, p. 49).

Therefore, rather than imposed, and routinized activities which forced through the structure itself, in this approach, unintended consequences of social action, and therefore, its reflexivity within the structure gains an importance. That is, structures are not rigid and unchanging systems, but rather they are in relation with the actors within a specific time and space. In that sense, they may privilege some actors, actions or the actors or the actions they favor can change over the time. That is how, nurses as actor within the institutions, and power dynamics, become a reflexive agency within the scope of this thesis. In addition to that, this approach treats structures as specific to time and spaces and reflect on the agency by extending and changing the social action. On the other hand, social action and agency are conceptualized within this approach as reflexive. It is argued by Jessop that, while understanding institutions through strategic-relational approach,

> First, all structures (and, a fortiori, all institutions) have a definite spatiotemporal extension. They emerge in specific places and at specific times, operate on one or more particular scales and with specific temporal horizons of action, have their own specific ways of articulating and interweaving their various spatial and temporal horizons of action, develop their own specific capacities to stretch social relations and to compress events in space and time, in consequence, they have their own specific spatial and temporal rhythms (Jessop, 2001, p. 1227).

The importance of this methodological approach lies under its emphasis over institutions and their formation within specific action context. Within this methodological approach, the structures, that is, the institutions are attributed some specialties such as institutions exist within the action contexts. Second of all, actors within the institutions are able to act upon it, perform it or do it. Third of all, institutions have micro-level formations as well as macro level contexts. Furthermore, strategic relational approach emphasized the reflexivity of agency within such institutions by addressing agent's capacity to engage in learning and to reflect on institutional context. Within the institutions, while some strategies, such as adaption strategies are privileged in order to keep alive the structure itself; some other strategies become disadvantaged. It should be noted that, institutions, structures, do not determine the unity of the social action; that is, course of action is not directly affected and dominated by the institutions itself. "Institutions cannot be meaningfully or productively analyzed without locating actors, identities, interests, strategies or tactics in a wider strategic-relational context" (Jessop, 2001, p. 1230). That is why, while attributing institutional contextuality to the social action, it should be noted that institutions do not directly determine the social action itself, but they create opportunity and source for some kinds of action by privileging them.

In addition to that, understanding a profession is multi-faceted. It has many actors, social relations, and these social relations are not well-captured with snapshots, but rather they need to be evaluated as social-historical phenomena. That is why, as institutions, the medicine needs evaluation within the actors taking place in a specific time and space. This situation is best described as,

> Professions and occupations cannot be understood simply in terms of the current balance of social relations but have structures and practices which are rooted in past sets of social relations. The organizational structures of professions have been formed over long periods of time, and there are usually several critical moments at which institutions were formed in a professions' past which affect its current operation (Walby, Greenwell, Mackay, & Soothill, 1994, p. 67).

Within the methodology, I want to come to conclusion that, nurses, as I proposed previously, nurses had been in the process of restructuring their occupation within Turkey context over the last 30 years. As occupation, they are in relation to institutional mechanisms and control mechanisms, and the other medical actors within the institutions. That is why, for the last 30 years, although thy may lose their occupational visibility within the medical field, in the long run, this process can be a part of a broader period of change. That is how, I want to locate their experience within the period of change.

3.2 Methodology and Method of the Study

In this thesis, the main concern is to understand the experience and its meaning within a specific social context. Therefore, rather than having a semi-structured interview, I prefer to conduct oral history and let them direct the conversation most of the time. In that way, the social relationships in a medical field, past experiences of the retired nurses, and relationality notion can be explained and revealed in a specific social context and time by referring to the significant turning points regarding transformation in healthcare service in Turkey. As a tool, oral history method provides me to learn their subjective experience from primary sources within their understandings. The changes that they are subjected to within their medical field need to be elaborated within their differentiating lived experience. These lived experiences can be grouped as their care work experience, medical field experience, occupational experience with other specific working groups at hospitals. Locating the experience itself within the specific transformation in Turkey, by emphasizing turning points through a primary source. That is why, subjective experience, complexity, and contradictions can be seen more concretely by having an oral history analysis by mentioning the importance of the events took place in medical environment. While I was conducting the field, I decided that the case study as a research design will be helpful for both scrutinizing social context and social action within that context. Neuman, in his book, states that "Case-study research intensively investigates one or a small set of cases, focusing on many details within each case and the context. In short, it examines both details of each case's internal features as well as the surrounding situation" (Neuman, 2013, p. 42).

Capturing memories and experienced particular turning points will be a landmark in terms of the analysis part of this thesis. In addition to that, in my opinion, it will be better to divide the investigation into parts according to the changes they had to pass through in the medical field. In addition to that, the occupational experience is an umbrella term that includes many aspects of one profession. In my study, I plan to understand this experience through inter-occupational and intra-occupational relations. In addition to that, changes they confront within these relations, such as changes in meanings attributed to the care work, changes in values, inner-goods, strategies, or as intrapersonal relations, changes in structures, power relations will be means to understand the occupational experience and turns within this experience. French et al. (1999) describe subtopics to describe the occupational experiences within a medical field which are conflict with physicians, problems with peers, problems with supervisors, discrimination, workload, dealing with death and dying patients, dealing with patients and with their families (French, Lenton, Walters, & Eyles, 1999).

Understanding the experiences and changes in occupational experience may sound complicated at first glance. In this thesis, the occupational experiences are defined through the inter-occupational and intra-occupational relations through their strategies on closure and jurisdiction areas. Furthermore, interpersonal relations in the medical field include the care work and relations with co-workers, doctors, and other actors in the medical field. In this thesis, care work consists of relations with patients, relationships, and conflicts with the family of patients, dealing with death and dying patients, shared-care experience, trust, and privacy (French et al. 1999). Trust as a term will be important to understand the relationality notion and its importance with the relational autonomy of nurses with the patients. In the article called "*Trust and Professionalism: Challenges and Occupational Changes*, Evetts mentioned that,

> […] Greenwood (1957) and Wilensky (1964) argued that professional work required a long and expensive education and training in order to acquire the necessary knowledge and expertise; professionals were autonomous and performed to a public service;

> were guided in their decision making by a professional ethic or code of conduct: they were in special relations of trust with clients as well as with their managers/employers and were altruistic and motivated by universalistic values (Evetts, 2006, p. 519).

In addition to that, interpersonal relations also include relations in the medical field, which can be relations with the physicians, other nurses, and supervisors, problems with peers, discrimination. Furthermore, it should be noted that hierarchy is a crucial factor to the medical field and diffused to the everyday relations. Therefore, hierarchy constructed through professions, gender, age will be part of the analysis in both interpersonal relationships and intrapersonal relationships. The reason for analyzing hierarchical relations in the intrapersonal relations as well as interpersonal relations is that hierarchy should be identified both something constructed and imposed through definitions.

In this thesis, as mentioned before, the main concern is to explore the occupational experiences of nurses in the neo-liberal era, which dominates the health sector in Turkey as well as other socio-economic spheres. In the field, nurses are encouraged to talk about their changing occupational experiences throughout their working years in the medical field which corresponds the neo-liberal transformation in healthcare in Turkey. The oral history technique was used to gather the data. Rather than conducting a semi-structured interview with the participants, I choose this technique since I want to indicate the changes in the healthcare system, which are visible and sensible to them. This point is important since the changes were not asked directly to the participants, but rather, the stories they told me include some clues about the changes they confront in their working life. In that sense, the oral history technique helped me to protect the flow of the conversations and allow me to catch the details. This technique makes the participants more comfortable with sharing the intimate touches of their nursing story. As mentioned, the questions are shaped through the flow. However, it should be noted that before going to the field, some sub-topics covered by questions were identified to have a meaningful flow. Firstly, to begin the conversation, I decided to ask why they become a nurse. Indeed,

it is a critical question in terms of understanding the historical link between middle-class women and nursing and locating them within the labor market in Turkey as well as skill discussion framed earlier. Then, I shortly ask them to narrate their working history to identify the fracture points regarding experiencing their occupation in terms of care work experience and social organization of the care work, hierarchical relations at the hospital, and how they negotiate with the changing conditions of work. One of my sub-topics was about how nurses stretch their occupational boundaries to fulfill all the tasks in a working day. Therefore, in our conversations, their narratives regarding the tasks they are responsible for and are not accountable become important. To be able to understand how they stretch their occupational boundaries, the question of "What are the responsibilities that you have at the hospital in a day?" was a tool for me to capture the situation. In addition to that, some of my participants were working senior centers and institutions for the care of orphans. These social settings may not signify a medical field; however, they include care labor and nursing. Indeed, the cases for these institutions' may be helpful to understand how care is specific to social context, and how they are shaped through the actors in the process of care. A relationship between nurses and the children, the patients, the elder may differ in terms of nurses' care experiences. Furthermore, there was another sub-topic that I want to scrutinize, which is the care of the patient. The notion of care in the sociology literature has been defined widely from different perspectives. Through this topic, I want to investigate what the prior elements of caring for nurses are. That is why I ask what care means for them. And also, I want to investigate how these prior elements resist or change throughout their nursing career. This is essential since it may reveal the resistance and handling strategies towards the changes in the healthcare system in Turkey.

While selecting participants, I aim to contact with nurses who have thirty years' experience in the medical field and then become retired. The reasons for this selection can be understood in two instances. Firstly, change as a notion cannot be identified within a snapshot. Therefore, I need participants who can provide me this alteration process. I follow the changes as specific to the participants. I mean, I do

not compare two parts of groups such as who has just started nursing and who have been retired already.

Secondly, I want to observe and indicate the changes through the experience and identify how the meanings attached to experience have been altered within a subject. This is an important part of the thesis to indicate that this thesis does not aim to have a comparison between subjects, but the time. To continue with, I follow the sub-topics as relations at the medical field, relations with patients, and the difficulties which they confront in their working life regarding both institutional relations and also the subjective meaning of care work and what kind of changes they experienced within the occupation. Within these subtopics, I want to explain the particular changes, experiences within the whole transformation in the healthcare system in Turkey. In my opinion, in order not to direct the participant, it is important not to intervene during the respondent during the interview. Hence, the questions need to be clear, short, and precise. That is why I divided up my questions into sub-topics to make the analysis more ordered and consistent.

3.3 The Rationale of the Choosing Social Group

In terms of my sample, I decided to interview retired nurses who are between 50-65 years old mainly since the time that they started to work in the field intersects with the beginning of the transformation period of the Turkish health system. Their experiences throughout their career will be analyzed in terms of turning points in the health system. To make the sample more precise, I decide to conduct my interviews with those who live in Istanbul. Although I conduct my interviews in İstanbul since all of the participants' current living location is İstanbul, throughout their working years, the nurses had been working in different locations in Turkey. My mother's social environment provided me to gain access to the possible interviewees and made me gain trust in an easier way for the rest of the participants. It should be acknowledged that unfamiliarity of the social environment is a crucial dimension while conducting such a research. Although for some of the participants my mother became a gatekeeper for me, as sample grows, through snow-ball technique, the nurses I met also helped me to have new contacts. Since my selection

of participants is restricted due to the reasons mentioned above, my analysis is limited to the people in the same cohort therefore, within the specific gender.

This situation signifies many commonalities due to their background, education level, and age and gender. This selection is on purpose since I want to understand the diversities within a group, rather than between the groups. However, as it can be seen in the table, there are some participants not suitable for the study in terms of their age or their years of experience. One of the reasons for this situation is that some of the participants got retired at an early age since they were not exposed to arrangements in retirement age. In addition to that, although some participants were younger than the others, I include them as part of the research since they have similar turning points with the rest of the sample.

3.4 Fieldwork Experience and Research Process

This thesis's main inspiration comes from the fieldwork that I conducted to have a picture of registered nurses' experiences at hospitals in the Qualitative Research course. The results I have come up with at the end of the fieldwork shaped my research question for my thesis. The experiences I had during the fieldwork made me gain a deeper understanding of the medical setting and its investigation. In that fieldwork, I conducted interviews with nurses from different backgrounds in terms of their education, their experiences in this profession, their socio-economic status. I realized that these are the main factors affecting the motivations behind for becoming a nurse, and therefore, affecting their experiences. Then, I come up with the conclusion that it would be better to limit the sample within their ages. Thus, I restricted my sample with the nurses who are between fifty and sixty-five years old or with their years of experience in the medical field for this thesis. In that way, it will be better to reveal the patterns within the same age group. Their experiences in the medical field, the years they spent for working, their age are the main indicators for selecting participants in the field.

In my fieldwork experience, the gatekeeper was my mother. She was a nurse who worked for many years in İstanbul; therefore, I had to conduct my interviews in İstanbul. By the time I arrived at İstanbul, I had made a list of retired nurses to whom

I can reach through my mother's social environment. Due to the nature of nursing in Turkey, nurses can work in different services at the hospitals. Since my mother was a nurse too, she has many friends who worked in different services within the same cohort. My mother's age group falls into the category of the people with whom I want to conduct interviews. As an initial step, I reached out to those nurses that my mother knows personally, and I made an interview plan for these nurses. Then, as I did the interviews, I ask the nurses whether they know other nurses who can be helpful for my study. All in all, I had interviews with twenty-one nurses who are retired. These nurses had work experience at hospitals for thirty years and more. In addition to that, all my participants were women. It is important since it was not aimed for the thesis; however, the nurses who are retired by 2020 are mostly women. This was not planned, and it can be seen as one of the outcomes of the thesis. That is why the question of reasons for becoming nurses is crucial.

One of my questions asks whether they can tell me experience at the hospital, which they never forget. This question opens up new exploration areas for me while doing interviews. Mostly, the participants express their feelings about a patient that they never forget how they were devastated with a dying patient and tried to handle it. Sometimes, they got emotional, and I had difficulties for holding the conversation. Furthermore, I witnessed that they always emphasized the solidarity and unity between the nurses. Most of the participants said that they wanted to meet with me since I am the daughter of a nurse and also need help from them. As nurses, they said that they need to support each other and help each other when it is necessary. Therefore, my identity as a daughter of a nurse, and as a student who needs help are two primary motivations for them to be part of my research. I need to mention that, sometimes my mother’s relationship with the specific participants are reflected in the interview process. This situation sometimes opened up new areas to talk and go deeper to the question itself, but sometimes it closed. That is my, my identity in the field process is changed participant to participant and sometimes enabled me to identify myself with a so-called experience in the medical field through my mother. Such a proximity, as I sensed that, constructed a trust relationship with the participant and make me an insider.

On the other side, most of the time I took the role of stranger, since the things seem to ordinary to the nurses can reveal some inside points regarding their experience and working areas. That is how, my identity and social role as a researcher was a dynamic one in the field. Besides these, although they are retired, many of the participants work in non-medical fields to earn money. That is why I had the hardship of having a proper schedule, which is suitable for everyone. All of my respondents allowed me to have a voice-record, and they are asked to sign a paper informing them about content of my study. That means, they are well-informed about the content of the research, and how they will contribute to the research through informed consent forms.

This allowed me to have a proper conversation with them without losing eye contact and interest over the topic. I also take notes during the conversation, which helped me to remember specific cases. I let the participants choose the place of the interviews to make them more comfortable with the environment. Therefore, some of the interviews are conducted at their home with a quiet and uninterrupted environment. Approximately, interviews last 1.5- 2 hours for each participant. Afterward, all transcriptions were completed by me, and all the listed participants are kept confidential, and pseudo-names are used.

In the following table, there is a list of participants that I interviewed with. I want to make some clarification about the table such as level of education. In Turkey, as mentioned before, the educational means for becoming nurse had changed over the years, and some of the nurses who were already graduated from vocational health schools were given a chance to complete their bachelor's, university-level degrees at universities after a couple of years. In the table, some of them complete their education, but some of them do not. Therefore, some of the participants indicated as "Undergraduate" actually are the ones who also experience an education in the vocational school of health. I want to emphasize this part of the issue since I want to acknowledge that although it does not seem like that, most of the nurses have similar experiences in terms of their education. In addition to that, in the table, pseudo-names are used to not harm the participants as well as to assure their

anonymity and privacy. As mentioned before, all participants are women. Their fields at hospitals vary time to time as well as participants to participants. That is why, there is no consistency within their working areas at hospitals. However, this situation became, rather than a drawback, an advantage. This provides me rich information about different care process conducted in different services at hospitals. In that way, it enriches the data. Some of the nurses worked mainly at primary-care services, rather than working at hospitals. That is how, those nurses helped me to understand the transformation in primary-care services within their experience. Therefore, differentiating institutions regarding nurses' working place became a tool for me to understand their experience within a wider range.

Figure 3: List of Participants

	NAME	**AGE**	**YEARS OF EXPERIENCE**	**LEVEL OF EDUCATION**
1	Belgin Hemşire	53	34	Two-year Degree
2	Açelya Hemşire	50	32	Two-year Degree
3	Başak Hemşire	52	31	Undergraduate
4	Arzu Hemşire	55	32	Vocational School
5	Aslı Hemşire	53	30	Two-year Degree
6	Ceren Hemşire	49	30	Two-year Degree
7	Tuba Hemşire	57	20	Two-year Degree
8	Ezgi Hemşire	50	28	Two-year Degree
9	Melike Hemşire	56	38	Two-year Degree
10	Buse Hemşire	54	26	Two-year Degree
11	Leyla Hemşire	51	26	Two-year Degree
12	Şeyma Hemşire	50	30	Two-year Degree
13	Canan Hemşire	52	34	Undergraduate
14	Sibel Hemşire	50	27	Undergraduate
15	Derya Hemşire	51	31	Undergraduate
16	Çağla Hemşire	50	28	Undergraduate
17	Necla Hemşire	48	30	Undergraduate
18	Ayça Hemşire	49	23	Undergraduate
19	Deniz Hemşire	51	32	Two-Year Degree
20	Aylin Hemşire	75	40	Undergraduate
21	Bahar Hemşire	52	33	Two-Year Degree

Data analysis is another part of the methodology since it is a tool for researcher to handle the data in hand. Tracing changes within the experience itself throughout the

30 years became a struggle for me to locate effects on the experience itself since they may refer to a change within a longer time, as well as short time intervals. My data consists of voice records as well as my observational notes in the field. While trying to catch the patterns within the data itself, the ways in which the data is analyzed become crucial. To conceptualize the data, coding is a way to categorize and re-think the data in an abstract level. To code my data with each other and organize the codes, I use open-coding, axial coding and selective coding (Neuman, 2013). In the first step for data analysis, I categorized the data through coloring with a fresh look and in this step, I try to discover the data through critical dates, critical actors taking place such as changes in regulations for hospitals, specific patient-nurse relationships as well as incoming new actors in the medical field. In the second step in data analysis, in the axial coding, rather than the data itself, I started to more focus on the things I have determined in the first phase, and their similarities within the data itself. In the selective coding, once I have constructed the categories, I select the data to support my analytic categories and emphasize my previous conceptualization.

3.5 Limitations of the Study

First of all, it is important to note that this study is not based on the registered nurses, but rather focusing on the retired nurses' experiences who are the age of between 50 and 65 years old. This means that, since they are older compared to their co-workers, they experienced a different education model for nursing. In Turkey, those are the years in which there is gender segregation for nursing. The men were not allowed to perform this job. Therefore, even though I do not intend to restrict myself within a gender, the outcome is what I expected. Since it is a qualitative study, the results and outcomes of this research cannot be generalizable to all the retired nurses. In addition to that, observing the medical field would give me important clues about the organizational setting and gain the study of an ethnographic approach. However, since my social group consists of retired nurses, I did not have a chance to observe a hospital environment and observe them in the medical field. In addition to that, there were some participants who wished to have an appointment in their working places which are not medical field or a hospital. Therefore, it created a time pressure

both for me and the participant. These working places were not hospitals, but rather they were non-medical fields in which they work after their retirement, such as schools. In addition to that, although I include work stress, dissatisfaction, and job motivation, and anxiety levels of nurses for nurses in the medical field, I only try to describe the possible reasons for it through their sayings. Since I do not have big data or quantitative data for stress level, or anxiety for nurses, this dimension of the study is restricted to the interview data.

3.6 Documents Reviewed

Within the scope of this thesis, I had to have a glance over many documents regarding nursing occupation and policy changes in the health care system in Turkey. That is why I want them to include as part of the method part of the thesis.

- OECD Health at a Glance Report, 2019
- Aile Hekimliği Uygulama Yönetmeliği, 2004
- OECD Global Health Report, 2008
- Aile Hekimliği Yönetmeliği, 2004
- Hemşirelik Yönetmeliği, 2011
- Hemşirelik Kanunu, 1954
- Hemşirelik Kanununda Değişiklik Yapılmasına Dair Kanun, 2007
- İstatistiklerle Türkiye, 2018
- Sağlık Hizmetlerine Erişimde Toplumsal Cinsiyet Eşitliği, 2018
- Aile Hekimliği Kanunu, 2005
- Sözleşmeli Personel Çalıştırılmasına Dair Esaslar
- Hasta HaklarıYönetmeliğinde Değişiklik Yapılmasına Dair Yönetmelik, 2014
- World Medical Association of Lisbon on The Rights of the Patient, 1981
- Yataklı Tedavi Kurumları İşletme Yönetmeliği
- Sağlık Bakanlığı ve Bağlı Kuruluşlarının Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname
- Kamu Hastane Birlikleri Pilot Uygulaması Hakkında Kanun Tasarısı
- Sağlıkta Kalite Standartları-Hastane
- İş Sağlığı ve Güvenliği Hizmetleri Yönetmeliği

CHAPTER 4

BATTLE OF CLOSURES: TRACING CHANGES IN THE OCCUPATIONAL EXPERIENCE ITSELF

This chapter is allocated through the answers of the respondents to my short questions under a wide range of sub-topics. My results show that it is better to analyze the thirty years change in experience through three phases, which are 1988-1998, 1999-2009, and 2010-2020. These years and their division are on purpose since they indicate specific changes in the healthcare system and how they affect nursing as an occupation. Each year interval has different sub-topics in terms of the changes they are exposed in this time interval. Therefore, rather than comparing the same dimensions regarding nursing professions in every part, I decided to shape the parts in terms of highlighting changes of concerning period. Through the stories they told me and trajectories, I will describe the paradigm shifts in the distribution of healthcare services in Turkey and how they respond to the changes or compromise with them. In addition to that, I will try to discuss how nursing battles throughout the years to testify itself as a profession. Therefore, in this part of the thesis, we will witness how nursing strives with ups and downs in the healthcare system while trying to construct itself as a profession and protect its occupational domain, occupational boundary, and how skill notion is re-constructed through these transformations.

Furthermore, in this part of the thesis, I will try to demonstrate the transformation of nurses' occupational experiences for the last approximately thirty years. This period is divided into three and follows specific changes in the healthcare system in Turkey through rationalization, standardization, and flexibilization as

conceptualized before. The first chapter will be shaped around their initial years in the profession. Therefore, in this part, rather than the changing experience itself, it should be better to understand how the social organization of work was structured at hospitals. This period of time may lack in terms of demonstrating a transformation in their experience of occupation; however, it is crucial for an understanding of the older healthcare system in the country. In the second chapter, I will be more focused on the alterations and their influences. This time period is vital since it signifies immense alterations in the healthcare system, which is Common Health Insurance, GSS, and its initial attempts. This unification of healthcare services has some outcomes for the medical workers, especially nurses, in my case. The third chapter is structured through the accelerating effect of standardization and rationalization logic by increasing effect of Quality Assurance and Accreditation in Health System. In this thesis, my main aim is to demonstrate that, within the discourse of rationalization, standardization, flexibilization in the healthcare system, how nurses become more vulnerable in terms of their profession, how they become de-professionalized, and how their work boundaries become more flexible, rather than standardized throughout the years as well as describing the resistance strategies. Therefore, constructing the analysis part within the actors take place in this process will be better to comprehend.

4.1 Years between 1988-1998: Time for Skilled Care

Throughout the years, nursing education becomes one of the most changed parts of the occupation. Although most of my participants are graduated from Vocational Schools of Health, we can observe that they latterly completed their two-year degrees at universities. Indeed, some of them completed their Bachelor of Nursing for four years at universities. Therefore, while analyzing the data, this criterion is essential in terms of why and how they are obliged to complete their further education.

Scientific knowledge, as Weber discussed, is an integral part of a profession. Therefore, means to constitute the scientific body of knowledge, the education in that sense, is an integral part of the professional building as Max Weber draws. This

dimension is also important for an occupation to differentiate itself from the others in the labor market. There are some turning points in enhancing nursing education in Turkey. The nursing history in Turkey started with the efforts of Florence Nightingale in the wars by relieving and curing the soldiers. Women were educated with the basic tasks, and the initial programs began to function in the 1920s. The nature of training and the level of education has many alterations during the past years. In Turkey, nursing education has many clusters. Red Crescent Nursing School started teaching in 1925 as the first Turkish nursing school. As mentioned in Bahçecik and Alpar, "Modern nursing education started in Turkey with this school, and nursing occupation gained professional identity" (Birol, 1975; Krum, 1972 as cited in Bahçecik & Ecevit Alpar, 2009, p. 700). By the time, the number of nurses increased gradually, and they necessitated other educational means. Health Colleges were founded in 1952, and the education years have risen to the four-years in addition to the health colleges. These colleges were transformed into Vocational Schools in 1976. Then, the university level education for nurses had been provided in 1992. And these enhances were followed by associate degree programs and also the introduction of post-graduate programs throughout the years. It seems that there is an upgrading towards the nursing education throughout the years. The training years for becoming a nurse gradually increased, and it provided a more qualified training in terms of their scientific knowledge at the medical field. Its outcomes for the nurses in Turkey in the process of profession building is important since it can be supposed that this upgrading in the educational means for nurses accelerated their professional status at the medical field. However, while describing this process, the gendered division of labor, and its dynamics in the medical field will be important for the rest of the thesis. “[…] The classification of women’s jobs as unskilled and men’s jobs as skilled frequently bears little relation to the actual amount of training of ability required for them” (Phillips & Taylor, 1980, p. 79). Furthermore, there occurred many regulations due to nursing education, and it ended up with the diversified graduates in terms of education level. Bahçecik and Alpar explained this situation as,

> By 1996, vocational health schools and associate degree programs stopped enrolling nursing students; however, since 2001, legal regulations have permitted readmission to such institutions. Consequently, nurses with different educational levels, competencies, professional identity perceptions and values now provide care (Bahçecik & Ecevit Alpar, 2009).

This situation, in the following years, will be reflected as new occurring actors in medical staff, such as nurses' aid, and auxiliary personnel whose effects end up with re-stratification will be discussed later.

It is necessary to indicate that, the nurses who I interviewed with mostly completed their education at Vocational School of Health. In addition to that, in this part of the analysis, I will describe how they spend one day at a hospital and how they perceive their relationships with the patient and the other actors at hospitals, doctors, and other nurses. It is necessary to indicate that I will not mention the changes in this period compared to the previous years. Therefore, this time will give a snapshot of the existing situation at that time (1988-1998), medical organizations, and their scope at that time. In this way, the following years will be understood within this snapshot of that period. This may provide me to have a clearer analysis by making the subject more to the point. Again, it is beneficial to mention that I will first start the analysis by demonstrating the reasons for becoming a nurse. This is an important part since it will tell us about the background of the participants that I interviewed with and also understand their motivations for becoming a nurse and how these motivations may or may not affect their perception of their occupation. I also want to ask this question since it will give me a deeper understanding of their occupational experiences in that time and their expectations from their occupations, and how these expectations are reshaped throughout the years. Then I will continue with a description of a working day at hospitals and at other medical institutions to understand their duties and responsibilities at that time. In addition to that, in that part, I will try to portray the relationships and how these relationships are shaped parallel to kinship relations within nurses as well as other actors in the medical field.

4.1.1 Becoming a Nurse as a Survival Strategy

My first question is about how they decided to become a nurse. In my participants, most of them replied to this question as, to have a job as soon as possible. One of the most important factors is that they knew they had to have a profession to make money, and they needed to do that without demanding money from their parents. In those times, at the beginning of the 1980s, the education of nursing was provided by some health schools, which students can be registered after the secondary school, and also by the vocational schools of health, to which students can register after completing the eight years of compulsory education in elementary school. That is why they did not have to complete a university-level degree, and in that way, they were able to start to work at an early age. In addition to that, the vocational schools of health were among the public boarding schools, and that is why nursing education became a mean for them to free them from their parents financially. Most of the participants indicated that they had no other chance but being a nurse for its free of charge education. However, as an aftereffect, this will be one of the examples of dual education structure for nursing and a segregated occupation since both types of graduates (vocational schools and universities) were assigned as nurses. One of the crucial factors of education in nursing at those years, as mentioned before, was provided by the public boarding school. When I ask, why they wanted to become a nurse, the replies were shaped through an obligation rather than a personal choice. Some of them indicated that it is their personal choice and then added that there was no other option. The families were the main actors to direct them to become a nurse because the education was costless since schools were supported by the state financially. One of my participants said, "I had to become a nurse since my father did not want to send me to a high school." I mainly confront this answer as a reason for becoming a nurse since it was the wishes of their parents. Some of the participants said that it was totally a coincidence for them to be a nurse. I realized that the school managers, teachers at elementary schools are one of the major actors for this decision. Some of the participants even mention that they were not aware that they took the test for nursing. It was all the decision of the teachers. Sometimes,

from the classes, they picked good students and made them enter these kinds of exams. Furthermore, Leyla mentioned that,

> I did not start voluntarily to become a nurse because I did not necessarily want to be a nurse. I was born in Erzurum; I am from Erzurum. There is a saying, you know, geography is the fate of humanity. Here is a mandatory chosen profession since I was grown up in East. There were primary and secondary schools, but no high school in the place where I lived. My father said, "I can't send the girl to the city high school and wait for her to return at dusk." Because our weather gets dark early there. "It will take 6-7 p.m. for you to come home." My father did not like it and said that I would not go to school for sure. Geography had been my destiny. Then I cried a lot, insisted a lot. My father said if it would be a boarding school, I might register. By chance, I heard the nurse school exams. And it is a great coincidence that I heard it on the last day. I registered. I took the exam and became a nurse because I had no other choice. I had to be a nurse (Leyla, 26 years in nursing).

This quotation sums up most of the participants' reasons for being a nurse. It was rare in my participants saying that they were willing to become a nurse, help people, wearing the white uniforms or just because they were interested in medical education. This quotation is important since it is the concrete example of how patriarchal system and state mechanism push women to locate in terms of their own wishes within the labor market. That means, nursing as an occupation has always been under the influence of these mechanisms in the labor market, which means that social closure of this occupation is highly determined by external factors. This situation lasts in the following years, and in some point, within the competition in the labor market, they are not able to differentiate themselves from this competition, which is one of the crucial things for an occupation within neo-Weberian discussion. This point will be highlighted throughout the thesis.

As I conceptualized in the Literature Review and Theoretical Background part, the skill as a notion plays a determining factor for both encapsulating women into specific sectors, while also de-valorizing these sectors within the labor market. That

is why, the factors behind becoming a nurse is more dominated by the state's apparatus by freeing the nursing education specifically but not for another occupation. Patriarchal relationships which favors the family as a controlling mechanism for young girls is also an inevitable reason for "choosing" to be a nurse as a survival strategy. That is why firstly, I wanted to describe the triggering factors for them to become a nurse. In addition to that, it should be noted that these schools were providing education to only girls. These schools were also seen as a controlling mechanism for the daughters of the families. They considered the ages of this time as "dangerous ages," and it was hard to control them. One of my participants said, "I had two options, being a teacher or being a nurse." These two occupations are considered as the most appropriate professions for women to become. This is important since the skills required for these occupations are considered parallel and integrated with each other. As noted in the *What is skill in nursing?* Part in this thesis, the skill is socially constructed, and the hierarchical order between skills by prioritizing the masculine traits and subordinating the feminine traits make de-valorized specific occupations within the labor market. In addition to that, social closure in the labor market is directly related with the skill debate for neo-Weberian perspective. A long term education is a necessity for public image of an occupation since it refers to a complexity, exceptional preparation (Attewell, 1990). In here, the crucial point is that, for nurses in Turkey, the notion of social closure, and their relations with the labor market is not free from gendered relationships within the labor market. That is why, the aspect of free education for girls to become nurses signifies an importance. Furthermore, in those years, men were not allowed to study nursing which was determined by Nursing Law. That is another factor for making nurse occupation as a "feminized" occupation. Furthermore, the close relationship between care at domestic sphere, and the medical settings is one of the main reasons for pushing women into this specific occupation. The socio-economic status of women that I interviewed with, and patriarchal power dynamics within family as well as state's apparatus constitute many reasons for them to become nurse, as a survival strategy. In addition to that, most of the participants said that the age they decided to attend the vocational school of health was a young age and they indicated

that it was too early to have such a decision about their careers. That situation shows that the decision is mostly made by families, or their teachers. Until this time. I try to describe the main factors for my participants to become a nurse. I named this part as "Becoming a Nurse as a Survival Strategy" since I want to show how these women had to bargain with the patriarchy to have an education and survive in the capitalist system. Most of them indicate that their families were willing to send them these schools only because they are free of charge. It is crucial to mention that the nursing schools at that time, since they were public boarding schools, were strict in their education as well as social control of its students, too. Students were controlled through their teacher, not only about their education but also about their social life, too. The authority became the school, rather than the family itself, there was a shift of autonomy suppressing the women in that age. That is one of the main motivations, why families had no problem with sending their daughter away for vocational schools of health, but no to another high school. This situation is not limited to the schools, but also diffuses their working field, too. That is why it is important to understand hierarchical and gendered relationships at hospitals, and this situation shows that the following chapter will be an essential part of the analysis.

4.1.2 A Qualified Training: Vocational School of Health

As I mentioned before, nurses I interviewed were sent to different places to complete their compulsory duty. I wonder how they get used to a strange place, people, and also the responsibilities that they had to take at this age since the answers to this question would be crucial for theoretical discussion of their professional building process throughout their working years. I received some similar answers. These answers can be headed under one topic, which is the quality of the education they received at the schools. They all said that, at those times, the education they had at the vocational school of health was different than now. Most of the participants acknowledge that their pre-medical and theoretical education included a compulsory internship at the hospitals. They described that; they completed their internships with a close supervision of their teacher at the schools through detailed examinations of their work with the patients. Throughout their internships, they were tasked with different services such as emergency service, eye clinic, surgery clinic,

otorhinolaryngology clinic, and so on. They said that this situation provided them a wide range of experience. Indeed, they argued that the medical field is unpredictable, and therefore this unpredictability can only be met by gaining experiences at different services as much as they can. In addition to that, one of the participants said that,

> Throughout our education, our teachers said that we need to be creative since we cannot predict the situation that we will confront in our nursing career (Belgin, 34 years in nursing).

Behind this discourse of creativity, it should be noted that there is an emphasis on perfect nursing. That is why they are educated as to be able to comply with every unexpected situation, and act, create a solution for this unclarity at any time, to be multi-functional. This emphasis over perfect nursing needs to be read through emphasis over the care process as kind, empathetic, flexible as conceptualized in Chapter 2. Its outcomes will be further analyzed in the following chapters through their closure strategies, by expanding their jurisdiction areas or narrowing it. In addition to that, during their education, one of my participants emphasized that their practice at the internships was a major contribution to their development of skills. All the nurses emphasize that in nursing, the practice is a key component to trust themselves as a nurse, to have self-reliance, and to make the patient feel that they are safe. This notion of trust is important since for nursing, it constitutes a professional jurisdiction area with the patients which will be discussed further. The education they received in those times is more practice-focused and care-oriented. However, some of the participants said that this practice-focused, care-oriented, and a wide-range education in different services and their internships were also insufficient to comprehend all the cases and risks they can confront. They argue that they got professionalized in the medical field, as they witnessed different circumstances, illnesses, and varying types of patients throughout the years.

As summarized within the data, this group of nurses gives their priority the practice of nursing in the field rather than theoretical knowledge. Indeed, the education provided to these nurses at that time demonstrates that it also prioritized the practice

over the theory. Therefore, in the constitution of scientific body of knowledge, the practice dominates the theoretical knowledge at that time. Their internships started in 3rd grade and continued in 4th grade until the graduation. There is a specific case which a nurse mentioned during our conversations which also demonstrates how these internships are critical for their knowledge of medical field. She said that since teachers thought that, after the two years of internship at the hospitals, they were still insufficient for confronting a patient alone, that is why, they were sent to different hospitals in the summertime to have the essential training and experience before starting as a nurse at hospitals. This example shows how practice was a necessary part of the nursing education as well as its conduct in the medical field. In addition to that, some of the nurses were critical about nursing education that they did receive, since the training tried to make them perfect in terms of their caregiving role, but not to teach for protecting their rights and domains but just to obey. One of the participants said, "We were taught to obey, apply to whatever is said to us." This is also crucial for deeper understanding the medical dominance over nurses. It does not start once they enter the medical field as workers, but it is something taught through the educational means. As conceptualized before, the medical dominance which characterize sets of relationships in the medical field through ranking different traits such as skill, gender, and education; it creates power relations within the organizations. For the scope of this thesis, how nurses handle with this situation and how they try to occupy their professional closures within this set of relations will be important.

While they were internships at the hospitals, some of the participants said that they work so hard, but in the end, this situation became something beneficial for them, as Çağla mentioned. She said that,

> Our sisters gave us self-confidence with their harsh behavior, like "Go, do this, go, do it." Maybe it was offensive at that time, but then we had a lot of its benefits on the field. Because we were able to do things on our own, we had self-confidence. When I started a new duty like that, I did not get too confused with it. I think our sisters, fortunately, did in that way by pushing us. In other words, I believe that our

> internships in that period were productive, and they made us work well, they directed us with orders. And we earned our self-confidence. When I was in the field, I did not have any difficulties. So, we already knew what to do. Because when we were trainees, we worked very hard on our own, there was a sense of self-confidence (Çağla, 28 years in nursing).

This is one of the common answers among the nurses I interviewed with. They thought that practice, and having experience in the field, were main and prior things for nursing education. In that way, they got experienced and provided the trust to the patient, although they were comparatively younger. One of the participants, Açelya, mentioned a different side of the issue as,

> There was only one thing they did not teach us that is nursing is so disrespectful. I think that is the biggest thing that nurse associations must do, but for years, it has been 30 years, it is still the same. We were considered as the assistant medical staff. It is not, nursing is a profession. Lately, friends, new graduates started to oppose this situation. I hope it will be more in the future. In other words, if a doctor is a doctor; If the doctor gives the order, we have the authority to do it or not. But you are guilty when you do it so. I think they must teach it at school. You are not a pawn that does everything you are said (Açelya, 32 years in nursing).

This is important since this quotation gives important clues about how nurses are educated to oblige to some of the orders, and they do not know how to protect their occupational rights and accustomed to doing everything that are said to them since they have the education to do so. Otherwise, it will be disrespectful for the doctors, to the authority. In addition to that, this quotation signifies how nurses tried to constitute an occupational domain for themselves within medical settings in those years also. Their strategies towards close their professional domain will remain in the following years and will be important for tracing their professionalization process in Turkey between years of 1988 and 2020.

One of the critical aspects of nursing education, midwives, and nurses were educated together at some of the schools. In accordance with the need of the state, they were

graduated as midwives or nurses in the graduation year. This signifies a critical point since it demonstrates that how state is able to construct a labor market according to its needs and wishes. As I mentioned earlier, this is an instance for us to understand how the social closure notion needs to be understood within nursing in Turkey. That is why some of the nurses said that they are nurses and midwives at the same time. I wanted to include nursing education as a part since it was one of the altered dimensions of nursing education and led a re-stratification within the same occupation in addition to different educational level. Their educational means, market relationship is mostly affected through state mechanisms and become a drawback for them to differentiate themselves from the competition in the labor market. Therefore, what kinds of implications that it brought are important for having such an analysis of nursing since education is a mean for constructing professional knowledge as well as a professional domain.

4.1.3 Social Organization of the Care-Work: A Day at a Hospital

In this part of the Findings and Analysis Chapter, it would be necessary to indicate what kind of responsibilities that nurses take during a day in a medical field in the early years of neoliberal transformation which indicates the early stages of 1990s. In addition to that, the services that hospitals provide to the patients, primary care organizations, and the other medical institutions take place at that time will be mean for us to trace the changes in the healthcare system. The existing, continuing, and non-existing organizations will picture the changes in the following years. In addition to that, in a medical field, it is necessary to understand the social relations, hierarchical relations within the actors to be able to understand the changing and reshaping dynamics. Through the sayings of the participants, I try to order the responsibilities they have at the hospitals. It should be noted that, according to the service at hospitals in which nurses are assigned, these responsibilities can differ and vary. That is why I want to sum up the common responsibilities they have, how they engage in it, how they define care and the relationship with the patients in order to construct a framework for their occupational jurisdiction. Thus, I gather the common points and have a short description of a day at hospitals. In addition to that, the period I described also have some additional responsibilities for nurses outside

the hospitals. These can be exemplified as vaccination in elementary schools, home visits, monitoring the patients in a periodic way. After a brief description, I will move onto the social relationships and how these relationships are shaped through gendered hierarchies.

First of all, it is necessary to mention that the number of nurses who worked at hospitals at the beginning of their career is comparatively few in number. The reason for that since they are educated at schools that were supported by the state, they had to complete four years of bounden duty, which the Ministry of Health or Sanitary Board assigned. Therefore, most of the participants, while talking about their beginning years in the medical field, they mentioned rural areas, small towns, villages, indeed, hamlets *(mezra).* When I want them to tell me about their experience in these places, and what the duties are, they mainly mentioned that it was so hard to get used to a new place, a profession, duties they need to complete and new people at that earlier age. They were approximately eighteen when they completed their education and went to the field. One of my participants said that their gender and age were some of the major drawbacks for them to impress the people they have to work with in that time as well as constructing a control area over patients and in the organizations. In addition to that, they said that trust is one of the major components of giving care, therefore, at that age, the patients sometimes do not trust them, and this situation makes everything harder in terms of communication with the patients and caring process. Therefore, it should be noted that these people are sent to places that they had never been before at an earlier age to save lives. That is why, at the first time, they mentioned that they are hesitant and scared. These assignments were not through a centralized system, but rather, it was determined by chance. The places were determined by the Ministry of Health; however, the students were randomly assigned to these places. Therefore, it will be more coherent first, talk about the primary care institutions, and their responsibilities at these institutions. Then, I want to move to hospitals as a secondary care institution. These two phases of care institutions have different means and aims in terms of protecting the health and its therapeutic methods which end up with different outcomes in terms of transformation in the healthcare systems through

market dynamics in the following years. They will later, necessitate different mechanisms within the different level of healthcare institutions.

In health care systems, primary care institutions can be exemplified as community health centers, tuberculosis control dispensaries, health centers, mother and childcare, and family planning centers. On the other hand, secondary care institutions consist of public hospitals, SSK (SSI) hospitals at that time, and institutional hospitals. In addition to that, university (training and research) hospitals were categorized as tertiary care institutions, since they provide a wider range of treatment and care. The main logic behind this categorization aimed at lessening the volume of patients in each phase and constitute a balance between healthcare institutions in terms of volume of patients, and circulation of bed.

First of all, in the primary care organizations, nurses had diversified tasks. In their initial years at work, they were mostly assigned to the villages. One of my participants described these villages as places without electricity, water, communication, and transportation facilities. She said that at these circumstances, they had to work, provide hygiene to the patients, and complete their treatment and care. It can be said that, at that time, the lack of some facilities and infrastructures were major drawbacks for nurses and doctors to provide a comprehensive curing and caring process. Besides, to provide ambulatory care, they had to check the households if they need vaccination to their children, or they needed to supervise to pregnant women, and educate women about both contraception and childcare. They had to plan the vaccination dates of newborns and children and visit dates of the households for routine control. Most of the participants indicate that, sometimes, there was not a doctor to lead them since doctors were mostly at the center of the village rather than the hamlets, *mezra* with nurses. Therefore, they felt under pressure for risky situation they could confront at that age without a co-worker. One of the participants, Canan, said that,

> I did not know the language they were talking; that is why it was hard to communicate with them and provide them a proper care and treatment. Then, I decided to learn their languages for at least, to

> understand their medical history, anamnesis. Men did know Turkish, but women did not know, and since I am a midwife, I need to be alone with the woman during the delivery (Canan, 24 years in nursing).

As understood, communication between nurse and the patients has a priority in terms of a qualified care. Some of the nurses, as mentioned before, graduated as midwives from the nursing schools, and they were both titled as nurses and midwives. One of these nurses said that,

> I was the only nurse and midwife there, in the middle of the night, they were coming to pick me for delivery of a baby. I did know the pregnant women; I had their patient chart. However, there were some houses that I could not reach, and I did not know whether there was a pregnant woman or not. I did not know to where they were taking me. Sometimes, I was scared all alone (Buse, 26 years in nursing).

It can be said that nurses' duties were transcendent to medical organizations in those years. They were sometimes the only responsible person for the health of people in a village as well as birth and monitoring the household. In that time, state's protective health mechanisms were more focused, and the vaccination operations were made for protecting the health of a household. The education of 15-49 age interval and their medical monitoring were conducted by nurses most of the time. Besides the fieldwork, they were also responsible for the registration of the patients' information that they were responsible for. The registration of the household information and collection of the data were also assigned to the nurses as a peripheral activity of the occupation.

Second of all, at secondary care institutions, nurses are assigned to different tasks than a primary care organization. Firstly, as soon as they arrived to the hospital, they have to visit the patients with doctors and get to know their past, family, past diseases, and write them down as notes in the paper of anamnesis, medical history. Most of the time, the doctor decides the curative techniques and treatment which they need to follow for a patient. Before that, sometimes it is necessary to receive the patient from the nurse on call since, at nights, there might occur some unexpected

symptoms, and the nurses working during the day had to be informed about the changing condition of the patient. Then, doctor and nurse visits are finished, and the necessary treatments, medicines are determined. During the day, nurses are responsible for the care of the patient, the needs of the patient, the control of the condition of the patient. In addition to that, nurses were also responsible for some file completing tasks related to the patients' medical story, the medication they received and checking whether defined tasks by the doctor are completed or not. It should be noted that, when I ask the question of what you do at one day at the hospital, they first answer the question as "It depends." That is why it should be emphasized that it is a dynamic situation what nurses' tasks are. However, there are some common points that they mentioned as core elements of medical care for nurses. These are privacy, cleanliness, communication with the patient, not to harm, and inform them. These factors will be important while understanding their shifting experiences regarding patients and how these instances resist or are changed and reshaped.

Third of all, the medical field needs to be considered as a gendered organization. As Davies (1995) mentioned before, the organizations are constructed through the gendered functioning and design, the hierarchical relationship. Acker suggests in her article,

> Ressner argues that bureaucracy has its own dynamic, and gender enters through patriarchy, a more or less autonomous structure that exists alongside the bureaucratic structure. The analysis of two hierarchies facilitates and clarifies the discussion of women's experiences of discrimination, exclusion, segregation, and low wages (Ressner 1987 as cited in Acker, 1990, s. 143-144).

Hospitals are hierarchical organizations due to differing functioning of occupations in the medical field. However, here, it is important to be able to realize how these hierarchical relations overlap with the gendered relations and how they compromise with the dominant power relations and shape their occupational autonomy. Therefore, while analyzing "perfect nursing," flexible responsibilities to complete

the tasks, we need to look at the situation from a gendered perspective, too. The control over the work and its domains, professional knowledge, and self-regulation of nurses will be analyzed through the literature of the sociology of work and organizations. However, the gender dimension is also internal to this discussion.

Many of the participants, when I asked, "What changes in your working environment?", they mostly answer as it was more peaceful and we were like a family, but now it has changed. They defined their relationships as “family” through their relations with the “sisters” who are more experienced compared to them in their initial years at work. When they entered the work field, they mostly mention that they worked hard. Sometimes, they need to compensate for lack of nurses; they help other working groups at hospitals when necessary; most of them defined their manner of work as devoted, self-sacrificing, unselfish. The environment at work at those times is characterized by a nurse as friendly, supportive, and like a "family." This type of relations and ties they constructed through their close shape the working environment and dynamics between nurses. As an example, for that, a participant said that,

> Since we were younger nurses, we were willing to be on duty at nights, instead of the married nurses. We used to send them to their home to take care of their children and spending time with their families.
>
> We were helping each other, and our big sisters (nurses who have more experience in the field) trusted us and protected us (Melike, 38 years in nursing).

In addition to that sisterhood notion between nurses, there is another dimension which MacDonald describes as,

> During the early years of professionalization, nurses were often told to think of the physician–nurse-patient triad as a family, with the physician as the head of the family and the nurse playing a watchful supportive role (MacDonald, 2002, p. 196).

Here, considering the nurses as in a supportive role is rooted from their “lack of skills”, “lower level of education” and “their subordinate role to the medicine”, to the authority. For these women, the controlling mechanisms has reshaped throughout their lives.

For the nurses, it was first the family, then become the school itself, and then medicine become an apparatus for patriarchal control. In addition to that, in those times, at the hospitals, we can observe that the relationships are shaped through trust and apprenticeship. A nurse indicated that, if a nurse started to work even for two hours ago before she started, that nurse become her big sister at hospitals. Their trust relationships were reciprocal. They say that, at the beginning of their career, sometimes they had some mistakes while completing the tasks, related or unrelated to the patients. At those times, their big sisters help to make up for the mistake. That is one of the elements demonstrating their relations with the co-workers at that time. On the contrary, when they began their work-life at an earlier age, one of the participants said that it was easy to be controlled by the other medical professions at the hospitals. This dimension is important since it exemplifies how nurses are controlled through gendered and hierarchical power relations, and due to their younger age, how they are manipulated in terms of their responsibilities and non-responsibilities. That is why they needed to be “protected” by their big sisters at work. Also, one of the participants adds that they were exploited through different mechanisms. One of the participants, Şeyma, argues that "They make us suffer in the field while we were young, to be able to be professionalized in the field" (Şeyma, 30 years in nursing).

One of the resisting situations regarding the nursing occupation is their struggles for defining the working tasks. In the following chapters, I will try to describe how austerity logic and gendered nature of medical organizations double the burden over the nurses and how they respond to this situation while extending their jurisdiction area as both survival strategy and adaptation strategy.

4.2 Years between 1999-2009: Time for Being Faster and Smarter

I have to mention that the changes took place in previous years as well as the following years are difficult to trace in terms of their effects since, they are all interdependent to each other. There is a considerable change in the healthcare system regarding that period, which will be scrutinized in a detailed way later, which is the Health Transformation Program. However, the outcomes of this program are more visible to the nurses in the following period (2010-2020). Thus, I will include some of the dimensions of the HTP in this part, such as the establishment of Social Security Institution, integration of SSI Hospitals to MoH, and changes in the conduction of primary care services. In addition to that, HTP includes many other aspects such as a performance-based system, quality assurance and control, and also emphasis on patient's rights. However, as I realized, these changes, rather than being instant in this period, they are more realized in the following years.

At those times, in Turkey, the healthcare system was divided into different means. The hospitals were categorized as belonging to SII (SSK), Bağkur (Self-Employed Institution), or Emekli Sandığı (Retirement Chest). These are different health coverage means for the citizens. Therefore, their coverage differs, and the institutions they employed also varied. There was a hierarchy between these health coverages since the people covered, their social status, and the service received both in differed in quality and quantity. Şeyma describes that the hospital in which she was working at those times belonged to SII. The number of patients was comparatively lower to the other hospitals since the coverage of this health insurance was available to the small portion of the population. Thus, this major change was rooted in economic concerns, but in the long term, it had many consequences. Küçük explains this economic concern as,

> As achieving autonomization of public hospitals is one of the main issues in HTP, all of the public hospitals, especially the hospitals of SSI, were integrated in 2005. The purpose of this reform was to align the management and payment mechanisms among all the public hospitals and to cause the autonomization of those hospitals (Küçük, 2018, p. 973).

The major reasons for the unification of the social insurance systems and also hospitals are indeed rooted in economic concerns, rather than social concerns. There was a bare debit in terms of healthcare expenditures and, to gather the money in one pool, they decided to unite the different healthcare insurances and also their differentiating hospitals. In addition to that, making unionized public hospitals was the initial step for decentralization in the healthcare system. After collecting the delivery of services at one type of social insurance and hospitals, which are public hospitals, the flow of the money became much easier to lessen the fiscal deficit.

Within the introduction of HTP in 2003, there are determined goals by the Ministry of Health. In the objectives and targets, the MoH defines them as "To organize, to provide financing and or to deliver the health services in an effective, productive and equal way" (MoH, 2003) as well as, the main principles are defined as human centrism, sustainability, continuous quality improvement, participation, reconcile-ment, volunteerism, division of power, decentralization, competition in service. The Ministry of Health, through that program, aimed to sustain quality improvement through feedback systems. One of the feedback systems is the performance-based salary system implemented to doctors. As it is emphasized in the proposal of MoH, the health system is designed to be based on performance management by abolishing the nominated stationary management. Also, the emphasis on the patient's rights in the following terms also becomes a part of a feedback system. In addition to that, decentralization, and division of power, as I emphasized in Chapter 2, become a major shift. Through this, they aimed at dividing the finance of health services and delivery and receiving part of these services. They also attribute the competition in services as a way to quality improvement and management. It is important to see these as the premises of the neo-liberalism, and HTP in Turkey. Whether they are actualized or not, is one of the dimensions that this thesis questions.

In the light of these developments, in this part of the analysis, I will divide the data into three main topics, and at the same time will give a snapshot of the changes in this time of period, and what kinds of changes they experienced until the year of 2009. The process of curing has been shaped throughout the years since there

occurred new technologies at health and medicine. This situation made easier some curative and medication treatments for doctors as well as patients. However, caring insisted its means, since there is a differentiating part of caring than curing in terms of its focus in a treatment process. In addition to that, caring and curing as a process are hard to separate, and they are all integrated with each other. Therefore, while trying to understand the changes in the occupational experiences of nurses, this point needs to be highlighted and also necessitates a changing context in healthcare.

4.2.1 Beyond Nursing

In this part of the thesis, I would like to draw attention to the relationship between nurses and patients in the medical field. Indeed, I will try to describe how this relationship is transcendent to the medical field and how affection becomes an important dimension in the caring process for nurses for this period. My intention is to discuss how as a notion the relational autonomy of nurses is important for nurses to construct themselves as a profession in the medical field.

As a critique for professional autonomy, which Weber tries to define, feminists, as theorized before, conceptualize the relational autonomy. Relational autonomy, as mentioned previously, refers to the autonomy of a person in the occupational field within an interdependence. However, the emphasis over standardization, rationalization, and its interdependent relationship with professionalization as described by Weber is a gender-biased definition, and that is why nurses, need further investigation in the process of professional building. Therefore, besides arguing relational autonomy as a drawback, I would rather prefer to describe how within this system, it is the core elements of the caring process, and how it is challenged and how it resists to protect their main jurisdiction area. In this case, nurses are directly interdependent to their patients, which vary in need, socio-economic status, and in gender, age. In addition to that, I will define the nurses' extended role in terms of their relationship with the patients as part of the relational autonomy.

In the regulation for inpatient treatment institutions, the nurses' responsibilities and duties are defined within the 132nd matter. As it is mentioned, "The main duties of

nurses are to treat patients well, listen to their problems, comfort them and make relief those who need comfort and those who are nervous about the upcoming surgery, and provide information about the process" (Yataklı Tedavi Kurumları İşletme Yönetmeliği, 1983). While in this regulation nurses are attributed as assistant healthcare staff who are educated in the vocational school of health; in the Law No 5634 which was changed in 2007, it is emphasized that they are professionals graduated from universities and master's degree. (Nursing Law, 2007)In addition to that, in the Law No 5634, nurses are treated as people who are "applying the treatments given by the physician in a written form other than emergency situations, determining the health-related needs that can be met with the nursing interventions of the individual, family, and society in every environment and planning, implementing, controlling and evaluating the nursing care within the framework of the needs determined within the scope of the nursing diagnosis process" (Nursing Law 5634/ 3, 2007). However, defining the nurses' duties and responsibilities limited with the order of the doctors and ordered medication would be a narrower perspective since they are also included in many dimensions of the patients' care period. Thus, one of my sub-topics in the interviews was focusing on understanding the relationships between nurses and patients, whether it differs from the relationship between doctors and patients, or what kinds of dynamics it has. Many of the participants indicated that the relationship between them and the patients defines one of the core elements of the care process, which is communication. Talking with the patients and comforting them lead to more open communication, help them to construct a trust relationship, and, therefore, a healthier care process. When I ask how they treat the patients, they mostly answer as it depends on the patients and on the specific treatment that the patients receive. In addition to that, nurses' role in the relationship with the patients, the ways in which they define themselves also depends on the patient's identity, and the caring process. For instance, nurses working at pediatric service try to communicate with children through their toys. They become their "big sisters" and a person that they can trust besides their families. Or, in elderly care, nurses define themselves as their "daughter." Within the medical field, as they emphasized, nurses act as one of the

family, rather than medical staff. They soften their language for patients to make it more understandable, when in case of emergency, sometimes, they take the role of calming the family and relaxing them, or when in time of death, even they cry together with the family of the patient. That is why, rather than considering and defining them as rigid medical staff, it is important to describe their relationships as liquid and reshaping according to the patients' age, gender, identity, or their needs. They mostly refer to the psychological care of the patients in the interviews. It is important for us to understand how they provide psychological care and how they build these relationships, which brings the trust notion together. One of the nurses describes this process as,

> Of course, as I said, we considered the patients as part of the family. We used to have a conversation with the patient, such as "Good morning, how are you, my dear?" as if we knew each other for 40 years. I would say, "Here I will do these things to you today, I will change the bed first." I mean, we were explaining, whatever we were going to do, we were actively informing them (Buse, 26 years in nursing)

As understood, explaining, sharing every step of the treatment or caring process, and also acknowledging the patients are already part of their duty for comforting the patients and gain their trust through a level of affection through their relationality. Thus, their professional autonomy cannot be thoroughly separated as a unique autonomy but should be constructed as relational.

Most of the nurses say that they witness the intimate moment of families. In that situation, they cannot separate themselves or define themselves as medical staff, but rather they become a friend, big sister, or a daughter of them. Through a relative affinity, they are defined within the family. A nurse who is responsible for home-visits said that,

> For example, we visit houses in public health. In a house, the woman was a mother with some mental problems. I saw that her child peed everywhere. That is why everything and all kinds of services are important for this family. In other words, it is important to inform the mother, to explain the hygiene

> to the mother, to explain the childcare. We went to that house many times until it became better. We explain how the toilet's slippers should be, it should not come here (in the middle of the house), or how she should tie your child's diaper (Çağla, 28 years in nursing).

Therefore, it should be noted that "relieving and caring the patient" comes with other dimensions. They extend their roles as sisters, daughters, or friends. It is a way to gain trust and a way to provide a better caring process since the notion of trust extends their intervention areas over the patient in that process. One of the nurses, during the interview, emphasized how they deeply connected with the patients, and how they are committed to these values. Therefore, this aspect of nursing needs to be considered as their occupational values and morals. After I describe how they extend their role in the medical field, it is better to understand how the nursing role is transcendent to the medical field.

One of my interviewees told of memory during her early years in nursing while in the duty of household visits to fulfilling the form by information received. She told that,

> I went to a house; I asked the woman, I said, how many children you have? She said that she has no children. Well, I said how many years you were married? Then she said she was married for 18 years; I asked whether she went to a doctor. She said she went many times, but her husband did not want to go. I said to the woman, whenever your husband is at home, I will come and talk, she said okay, and added "I do not think he will accept it." Anyway, I talked to the woman, and then I went there at the time when her husband was at home, I sat down, I talked to the man. I said that you have no children, do you want children? Well, why you are not being treated, I said, he did not say anything. I said that there is no shame in health. Maybe there is something simple, no major problem. I said you would not know before you left. Anyway, I had the name of the obstetrician, and I gave her a doctor's card. Anyway, I convinced the man accepted. Then the woman got pregnant after 18 years…" (Başak, 31 years in nursing).

Here, it is important to understand that nursing, within its intervention areas, does not refer to a total repetitious job, it has occupational areas which cannot be standardized, and cannot be narrowed to the basic duties such as injection, medication and file processing. Therefore, as discussed in the Literature Review and Theoretical Background Chapter, the care process as a core activity of nursing practice is unpredictable, and to be able to provide a holistic care to the patients, nurses need to be flexible, adaptive to the changing circumstances and conditions of the patient as Young, Gold and Wood (2017) described. Therefore, their professional domain is directly and mostly related with the other actors, in this case, patients. It cannot be directly suggested that, as they got professionalized, their professional domain will be more autonomous and independent. But rather, through their sayings, it is important to note that, they got professionalized as long as they understand the patients well and construct a strong and reliable relationships with them. That is why, the discussion of relational autonomy signifies an importance while understanding the occupational closure of nurses at medical field. These examples are also for us to understand how nursing as an occupation signifies a subjective experience. I do not argue that all the nurses do more than they have to do within the relationships between patients. However, the interviewees, most of the time, mentioned that they are trained for "caring" the patient, rather than being a robot who completes the simple tasks repetitively. As described in this example, besides their registered or assigned duties, the nurses go beyond the borders of the medical field. In addition to that, the private sphere of the patients, such as their familial relationships, their socio-economic status also visible and are witnessed by the nurses. Some of the nurses say that, when there is a patient who is vulnerable financially, they do whatever they can to help them financially and socially. Especially, the nurses who began their professional lives in rural areas say that they witnessed many difficulties, and they felt like they need to help those people. That is why I witnessed many nurses helped the patients even though it is not a medical intervention, but rather financial support, or sometimes psychological support. Thus, nursing beyond the profession ends up with the emotional burden for nurses, stress, anxiety, and emotional burnout during the work. In addition to that, the occupational

boundary of nurses is shaped through the negotiation between the nurses and patients. That is one of the important aspects of this thesis since nursing itself, at this point, resists a standardization phenomenon.

By its emphasis over its morality and values in terms of affection, commitment, and communication with the patient, it cannot establish rigid boundaries with the patients, as well as other professions in the medical field. Thus, while analyzing nursing in the process of professional building, we need to direct overemphasis over their relational autonomy, rather than a rigid jurisdiction area. Thus, emphasis over standardization, efficiency, and rationalization logic behind HTP introduced by MoH in the healthcare services, the nurses are left to choose to abandon their commitment and values towards their relationship with the patient in the following years. In that situation, it is hard to have a conclusion as nurses become less important, or they abandon their morality or become monotonous in the medical field. Indeed, this transformation needs to be evaluated through its complexity. Although this was the situation in those years, their struggle become more visible in the following periods. In the following parts, I will describe this complexity through both uniqueness of care and through the relations in the medical field. The boundaries between the patients sometimes become visible, but there is another side of the coin, what about the boundaries between the other agencies in the medical field?

4.2.2 Increasing Number of Patients, Lessening Resources

In 2008, the Turkish Healthcare system went under a massive change in terms of its means. All different types of health coverages which were SSK, Emekli Sandığı, Bağ-Kur, and Green Card, became unified under one type of health coverage. That is called General Social Security, GSS. In Turkey, there were many types of public hospitals since these different health coverages provided patients the health care service through different types of hospitals. For instance, SSK had its own hospitals, although they were categorized as public hospitals. Therefore, it was seen as necessary to gather all types of public hospitals under one institution by the Ministry of Health. In those years, one of the biggest attempts to change the running of

healthcare services was the introduction of the Health Transformation Program. Within this program, MoH aimed a more qualified, standardized, efficient, rational care for the citizens.

Needless to say, this transformation brought many consequences in the running of the healthcare system, and therefore for the health care providers. While I was doing my interviews with nurses, one of the highlighting changes in the working life is this unification of different types hospitals under one institution. Therefore, I want to constitute this part with the framework of a unified health system and its implications for the nurses in terms of their occupation. I want to add that, while I was in the field, I learn that a transformation process is hard to trace and categorize, since its consequences may not be puzzled well even after a long time. Therefore, sometimes it confused me to locate the consequences of changes since they are all interrelated and transitional.

As I mentioned before, the hospitals were categorized according to their health insurance and coverage. Some of the nurses I interviewed with experienced this transformation in a sharp way. One of my participants said that,

> Over one night, we become a different type of hospital. We did not have sufficient sources to meet all the people's needs, did not have enough services, and sufficient number of the medical staff at the hospital. In this transformation process, we suffered a lot (Şeyma, 30 years in nursing).

The nurses working at a specific type of hospital before confronted a sudden large number of patients abruptly. They were not ready since they did not have enough resources, enough nurses and doctors, a sufficient number of beds. Therefore, the lack of personnel was met by the sub-contracted people at hospitals. These people were under the category of a civil servant, but rather they were categorized as 4B, which means they are also sub-contracted. This situation leads a fragmentation and segregation within the same occupations as well as a competition in the labor market within the same occupation. Not being able to exclude themselves from the competition is another obstacle for them to enhance itself as an occupation as

discussed through Weberian understanding by referring to social closure (Attewell, 1990). I ask how this situation affected them. One of the participants said that,

> It was hard at the beginning. We were happy since they came for us to help. We were not sufficient for a sudden increase in the number of patients. However, we realized that the sub-contracted people did not know how to work in a hospital environment. We had to teach them, we had no time for the patients, but we had to teach them in order to lessen the burden on us (Melike, 38 years in nursing).

In addition to that situation, at those times, the number of caregivers (*hastabakıcı*) became less in number since some of their assignments to the hospitals were decreased. This means that, for the nurses, the qualified personnel who help them in the caring process in number dropped. According to nurses, the caregiver is the most helpful personnel at hospitals while providing care to the patient. They were helpful since they knew the details; they were trustable and had experience in the medical institutions and accustomed to its environment. In a reverse situation, as described above, that may end up with an extended role for the other occupational groups in the medical field, such as nurses. One of the nurses explained this situation as,

> We thought that our workload would decrease since there were coming, new staff. However, they were not experienced, and we could not trust them with caring for the patient. All of a sudden, our workload increased since we had to complete the tasks that caregiver completed before (Ceren, 30 years in nursing).

This situation pushed nurses to complete more unrelated tasks that they were not responsible before. For instance, they had to clean and tidy up the patient's bed more frequently; they had to control their diet, regulate the meal that patients will have, and even sometimes they were responsible for serving the food to the patients, or fixing a medical devices. However, it is important to indicate that the situation was not once and become repetitive in terms of nurses' duties. The extended role, the role of extension of the nurses into another fields, such as caregivers' field, which is directly related with the demarcationary strategies. However, in my field, I do not

observe that it is on purpose, but rather an obligation for them to run the hospital well since the circulation at hospitals also increased in that time. As I discussed in Chapter 2, in the typology of Allen for nurses' extended role at the hospital, there are mentioned five categories as a typology which are continuity oriented, articulation oriented, judgmental boundary-blurring, rule-oriented boundary-blurring, and layout-oriented boundary-blurring. (Allen, 1997). Here, when I ask why they continue to fulfill the other's job, they mostly respond as they have to, since the work needs to be done on time, and it is the people's lives at risk. The nurses mostly focused on the continuity of the work rather than concentrating on occupying their own jurisdiction area by not rejecting the unrelated tasks to be done, although they are not charged for them. Furthermore, sometimes they have to take the initiative for additional medical tests to be able to fasten the process for both the patient and the doctor, even though they are not allowed to do so. There is another dimension relating to nurses' increasing tasks in the medical field. Many nurses indicated that when they handle with time and bodily restrictions, they blame themselves for not being able to complete all the tasks which are planned for that day. Most of the nurses mentioned that it is one of the reasons for them to be stressful at work, and have anxiety, and therefore, they become distanced to their occupation and become less satisfied with what they do in the medical field. The job motivation decreased since the work demands moved up quickly recently.

This situation was not single-sided. Since the number of patients suddenly increased at that time, the burden for doctors escalated, too. Therefore, doctors needed to arrange their time according to their priorities and assigned some kinds of additional tasks to the nurses. Here, it should be noted that hospitals are an unpredictable environment. Sometimes, in an emergency, medical staff at hospitals may need to cover the lack of another person in order to save lives. However, the tasks that will be mentioned are the tasks that nurses are not responsible for within their profession, but year by year, they are added to their workload and become their unofficial duties at hospitals. Nurses were expected to complete these tasks in order to give a complete curing and caring process. From the interviews, as I summed up, these tasks can be exemplified as suture, probing, fulfilling the documents that doctors

need to complete, sometimes prescribing according to doctor's telephone call. These tasks, at training and research hospitals, mostly are completed by intern doctors.

However, in the secondary care institutions, which consist of public hospitals, these duties are transformed into the nurses where they compensated for the lack of intern doctors and other personnel groups. This is a critical point since it demonstrates that dual closure strategies taken by nurses is a result of continuity-oriented boundary-blurring (Allen, 2017) at the medical field. The intra-occupational closure strategy, which is conceptualized as dual closure strategy which conceptualized before, is an obligation for nurses to continue to work well, rather than a purpose. While they try to control their own jurisdiction areas, as a subordinate group to the intern doctors in the medical field, they also respond them as extending their jurisdiction areas. That is why, in that sense, they extend their jurisdictional domain within the medical field as an adaptation strategy to increasing workload and insufficient medical actors in organization. In addition to that, one of the nurses said that,

> We need to receive the order of the doctors as written. However, doctors are not able to come to the service most of the time; they can be at the emergency service, or in operation. At those times, we receive orders through a telephone call, not written on the table. There is always a possibility that patients can get hurt by the treatment and can get allergic to the medicine. If it happens, there is no one to protect you, since doctors may say that it was not the order for the patient (Belgin, 34 years in nursing).

This situation describes well how nurses are left within the whole responsibility of taking risks on behalf of the doctors. Most of the nurses said that they are vulnerable in terms of protecting their rights. Formally, they have the right not to implement an order, which is directed through a telephone-call. However, when they want to use their right, they are mostly considered as "noncompliant" and "disobedient" by emphasizing obedience of nurses to medicine. This labeling pushes nurses not to protect their rights through suppression of superior as well as peers. Doctors, as nurses' superiors in the medical field, become a dominant character by eliminating any negotiations with nurses. In that period, nurses do these negotiations without

conflicts within the doctors; therefore, they face blurring occupational boundaries and uncertainty regarding their nursing tasks.

It is mentioned that it is a rather shifting process rather than negotiating. Doctor's tasks shift to the nursing tasks; therefore, they doubled burden the nursing responsibility at hospitals. This is one of the concrete examples for how medical dominance has a power over its subordinates. Nurses, in the medical field, although they are upgraded within their educational means in that period, remain visible and become distant to decision making process since this situation is derived from not only their position as a profession in the medical field, but also from their being "women" which are seen as obedient. As Acker (1990) argues that, the organizations are gendered, and the social relations are embedded through the patriarchal relationships and power dynamics become apparatus to control them.

Furthermore, in the regulations for nursing, which was published in 19.04.2011 by MoH, there is a concrete definition for what nurses should do at the field, and in which circumstances they need to continue the operation with the doctor. For instance, a suture as a duty is categorized as a need to be done with the doctors. In addition to that, the fastening urinary catheter is one of the tasks that need to be accomplished with the doctor. However, most of the nurses said that they need to complete these tasks alone since they are attributed to these additional tasks day to day without negotiations with the doctors. They are not paid for these unofficial duties since these duties are seen as part of the command of the doctors. Nurses are seen as taking actions on behalf of the doctors and seen as helpers of them. One of the reasons, as they indicated during my interviews, for not categorized as a profession in Turkey is the perception towards nurses which draws a peripheral role in the medical field. They are considered as (from their sayings) "secretary of the doctors."

Furthermore, within this context, we need to locate nursing in the formal sector within the discussion of the sociology of work and organization. In that point, in his article, Ulrich Beck tries to understand the new paradigm shift in the socio-political sphere and conceptualizes the outcomes of this paradigm shift as Brazilianization of

the West (Beck, 2000). Insecurity, as discussed before, one of the threatening outcomes of the neo-liberalization process affecting every dimension of the social, political, and economic sphere. He conceptualizes the insecurity of the political economy as acted out between the different actors. These actors are conceptualized as territorially fixed, such as governments, parliaments, trade unions and capital, finance, and commerce (Beck, 2000). Insecurity is diffused to all work spheres, undifferentiable, informal, and formal sector. Nursing, within this framework, also faces insecurity in Turkey. Their disturbed environment, unpaid working hours, and lack of side benefits, in that period, become more visible to the working nurses. Beck concludes this situation as,

> Paid employment is becoming precarious; the foundations of the social-welfare state are collapsing; normal life-stories are breaking up into fragments; old-age poverty is programmed in advance; and the growing demands on welfare protection cannot be met from the empty coffers of local authorities (Beck, 2006, p.2).

This statement can be read through the transformation which Turkey has undergone. In addition to that, an increase in the number of sub-contracted workers in the health care system accelerated the circulation of the people in this sector, and it leads to a disturbed environment at hospitals. This situation leads to a stressful work environment as well as escalates the tension between patients and doctors most of the time.

Asceticism is one of the crucial concepts for us to understand the existing situation which nurses experience in my study group. While they try to handle the increasing other non-medical working tasks in their work definition, they also complete the registration of the data and the information that hospitals need to save. However, I recognize within their sayings, there is an emphasis on perfect nursing and giving the best care no matter what. The notion of asceticism and austerity logic is directly related to the working experience of the nurses. They sometimes have to make concessions to complete the care they want to give. One of the nurses I interviewed with is a concrete example of this consciousness of the care workers. She was

responsible for all the service, for controlling medicines, workers, or the tables, and distributing the tasks between the nurses at hospitals. In our interview, she said that,

> Sometimes, I had to pay for the fuel at the community clinic not to disturb the working environment. When there was lack of syringes and other medication, I paid for them since they did not send us (Buse, 26 years in nursing).

This nurse is one of the nurses who made many sacrifices to discharge the responsibilities. Weber said that,

> This worldly asceticism as a whole favors the breeding and exaltation of the professionalism needed by capitalism and bureaucracy. Life is focused not on persons but on impersonal, rational goals (Weber, 1968:1200).

Here, for the nurses, the impersonal, rational goals are constructed through their ascetic action towards their occupation and also their education, which emphasized the perfect nursing by idealizing the ascetic and austerity ideology, and excellent and creative caregiving. Many of the nurses mentioned that sometimes they had to work without having a meal and drinking tea as a break. They had to work for 48 hours without breaks to make the best of them while working. This situation is directly related to the notion of asceticism. They are pushed through the necessities of the rationalization and bureaucratization process with the increasing demand in healthcare service by compensating the lack of labor in the market for free. In addition to that, in that process,, it should be noted that, rather than abandoning their main activity in the medical field which is caring, they try to emphasize its importance since this is directly related with their importance in the medical field. That is why, this aspect of the issue needs to be equivocally, which are adaptation and resistance strategy to what changes brought to medical field.

Here, it is important to mention the relationship between nursing and the medical field. As discussed before in the Literature Review and Theoretical Background Chapter, the neo-liberalism is rhetorically gender neutral. However, in the service sector, in which women are mostly concentrated, they become more vulnerable to this process. As a part of the service sector, the healthcare system started to be

affected through pseudo-market dynamics within structural adjustment projects such as HTP. This situation resulted in the changes in experience regarding nurses, as described above. However, I observe that, in those years, nurses were mostly concentrated on their duty of perfect nursing and prove themselves as a profession. Their duties are considered as internal and not learned through education. Since they are women, they have already known how to be “affective, enduring, and tolerant.” Their tasks are considered as easy, and not complicated because they only 'help' the doctors, rather than considered as a separate profession. In that social context, I understand that as both resistance and also adaptation strategy for the system. They both want to prove themselves, and in need for proving themselves as successful at the medical field, and in addition to that, the learned process of "being perfect, self-sacrificing and creative," rather than resistance to increasing work burden and workload, they took this process as a chance to prove themselves, and work hard. I think this dimension is important since it can be both considered as a resistance strategy with the capitalist and patriarchal system, which tries to make their labor invisible in the formal market and also an adaptation process to this ascetic worldview. They try to extend their role in the medical field, their closure areas by dual closure strategies as completing the other working group's tasks as an obligation but without resistance. However, by diffusing the work of others, and trying to control other's labor process, they also resist in terms of their professionalization process.

All in all, within the increasing number of patients in those years, by the process of unification of hospitals and transformation in the health system, there occurs an increasing expectation from nurses. Over the years, the expected duties become institutionalized at hospitals. Although the nurses I had interview worked in different hospitals and different services, they told me about a similar shift of responsibilities. That means that this institutionalized expectation does not change service to service, or hospital to hospital. It became usual and ordinary. Belgin said, "I remember I had to work for 48 hours non-stop, we were only two nurses at the service and tried to handle with 34 patients all alone." At that time, to decrease the work burden, the state decided to send additional nurses to public hospitals.

However, some of the nurses sent to the public hospitals were working on the primary-care institutions for many years. This also created a problem since although they were educated as a nurse, the practice is learned in the field, and that is how they gain their skills. As they confront with many patients, they get used to different cases, conditions, and extreme situations at hospitals. Therefore, the nurses sent to public hospitals were not sufficient to compensate for the lack of the personnel, since the care primary care institutions provide to patients differ from the care that a secondary care institution. At the primary care institutions, patients do not receive inpatient treatment. They do not have emergency services or do not provide a surgical operation to the patient. These institutions were mediatory institutions to lessen the burden of public hospitals and give treatment for risk-free patients. For this reason, the nurses who were working in the community health centers, or dispensaries, were not acquainted with secondary care institutions. This is one of the factors that they were not able to become significant helpers for the nurses working at the hospitals already. This system of rotation also made vulnerable the incoming nurses within the hospital environment. One of the nurses, who experience this rotation said that,

> I did not know where the medication's stored, did not know how to suture; it was not because we are not educated, but we lack the practice for these services. Suddenly, I found myself at emergency service without having a prior education for this specific service (Bahar, 33 years in nursing).

Most of the nurses experiencing the rotation told that they were treated as new in the discipline. The rotation was applied between the services, rather than the institutions because of the lack of workers. If there is a lack of staff in the emergency or urology service, generally, from the other departments, nurses need to be transferred from the different services. Rather than hiring new personnel, the state, MoH, tried to fulfill the lack within the existing labor force at hospitals. That is why I named this part of the topic as lessening resources since comparatively, and they were not able to meet the existing need. The circulation at hospitals has concentrated and accelerated more than ever. In addition to that, the cuts and attempts to decrease

the healthcare service resulted in the complicated work organization, doubled workload. Indeed, some of the nurses said that this is a good thing since they learn different types of treatments and witness varied curing process and medication in different services. However, some of them argue that, in the long term, this situation worked against them. This carries us into the next topic in this part of the analysis.

4.2.3 Nursing as a Buffer Profession at Medical Field: Lack of Specialization

There was a commonality between nurses whom I interviewed. They were always emphasizing the branch out and lack of specialization in nursing. Doctors, who completed a six-year education at universities, become specialized in specific fields such as otorhinolaryngology, gynecology, urology, ophthalmology, and so on. At hospitals, doctors work with nurses, who complete the caring process, after a treatment, or the healing process. However, these nurses do not have specialization over a disease or a field. This might not seem like a problem at first glance; however, as a result, they started to play a buffer role between the services at hospitals. Some of the participants indicate that it is not that hard to get used to another service since they are basically the same in terms of curing methods. You give medication, applied the doctor's order for the specific patient, injection, giving serum therapy. However, they also added that this is manipulated within the system, and they are used as a tampon profession between the services and hospitals, as previously mentioned. They attempted to overcome this situation through the individual means. In a hospital, within the institution itself, nurses are assigned into specific services, and they were working there for long years or temporarily. However, they are not educated through a specific field, and they had general education for all the nursing tasks. And that is why, by practicing over the years in same service, they become surgery nurses, urology nurses, and emergency service nurses. However, this was something initiative of the hospitals in which they work, not something institutionalized at this period of time. Therefore, it necessitates an individual resistance for not changing the service over the years, as mentioned before.

I want to discuss the skill of nursing in this part of the thesis since I want to also demonstrate how they resist to narrow their occupational boundaries in the medical

field and through what means they are subjected to completing repetitious tasks at the same time. It will be explained through their professional domain, whether they extend it or narrow it. Thus, their jurisdiction areas, and occupational closures, and their dynamic relations with the other actors will be explained through nurses' specialization and controlling their own domain. First of all, although there is increasing awareness for nurses' lack of specialization in the medical field, which is realized by nurses, neither in education nor at hospitals, there is an institutionalized branch out or specialization for nurses into the different fields. As I discussed earlier, this situation has two-sided consequences in terms of nurses. First of all, it provides nurses to gain different skills in different services at hospitals and expand their occupational control domain. However, to look at the situation from only this dimension would be lack and redundant rather than a comprehensive perspective. Second of all, the lack of institutionalized specialization puts nurses into a manipulated position since they are expected to accommodate themselves to changing responsibilities and duties of altering services and their circumstances. That is why, the skill dimension regarding nursing is equivocal. First of all, as they change the services according to the need for medical staff due to scarcity of new comings, they had to learn what to do in those services even they are not trained for the extreme demands of specific services such as emergency service or surgical service. Therefore, every time they change their service without their willingness, they need to learn the whole process all again. There is something I want to emphasize here, by specialization, I do not refer to the division of tasks or subdivision of tasks, but I refer to whole different labor processes. At different services, nurses are expected to conduct different care processes since the needs of patients vary as discussed in previous chapters besides the routinized peripheral works. Açelya describes this situation as,

> So, when you get your basic education, when I go to an ophthalmology service, you learn to serve the patients of that service there according to the patient and order. For example, you learn to meet the patient in an emergency to follow the patient. You already learn this in vocational classes, but you learn more while doing and implementing it. You get an

> education at school, what you need to know is basic, but that education is never enough. In working life, especially in the field of health, you learn according to the service you enter, that is, the patient you address. The details there are learned entirely by working in the field, to be serial, to be fast, to address patients. For example, you cannot treat the eye patient and cancer patient in the same way (Açelya, 32 years in nursing).

Therefore, learning a new process, or adaption for this process becomes a major drawback for nurses to specialize a specific field since their service change frequently. Moreover, every time they change the service, it ends up with the discrimination in the workplace since regardless of their years of experience, they are regarded as inexperienced at this specific service. As a mean for discrimination, some of the nurses were only assigned to the file tasks since they are considered as "not knowing the job well." And therefore, they are pushed to complete the repetitive works. During my interviews, most of the nurses acknowledged that they feel like they do "donkey work." There are some strategies that some of the nurses I interviewed to exclude themselves from this “label” and completing “repetitious jobs”. They try to stay in the same service for many years. In that way, they gain experience in the same field. In addition to that, in the public hospitals, except the university hospitals, there are no intern doctors to work with doctor one to one. In surgery, for example, therefore, it is the nurses who help the doctor and have to complete the tasks which an intern doctor is responsible for. In that way, nurses learn the tasks which intern doctors are actually responsible for as described previously. In addition to that, although they are not taught at nursing schools how to suture, many of the nurses indicated that they learned it through suturing on pillows by practicing at home. Therefore, the lack of actors in public hospitals resulted in a degree of extension in their professional domain in the nursing occupation for the ones who are able to stay in the same service for many years. On the other side, some of the nurses indicated that, as mentioned before, the lack of actors leads to rotation at hospitals frequently, which resulted in adaptation to service all over again.

Some of the nurses said that, in a way, this situation provided them to learn many things in a medical field, which they did not learn at schools, but it was an abrasive process. In addition to that, I want to emphasize the pressure over nurses for them to be a creative person. In their education, one of the important things taught them is to be creative, as I mentioned before. This pressure, and extended role in the medical field, and its necessities, in those years, started to become effective in terms of increasing work burden. As their burden is increased, they try to make themselves more creative and accommodating. Being creative in this process actually refers to a lack of resources in that manner. The lack of medical staff, medical technologies, medical and scientific knowledge and even beds at hospitals are compensated through pushing nurses to be more creative to do miracles with limited resources but without complaining. Therefore, this ideology lies behind the education system, emphasizes both "critical situations" at hospitals, and “unpredictability of body and care work”, and also "lack of resources" that a few numbers of nurses need to compensate. This situation described by a nurse who is responsible for the whole service,

> I knew that I am working in the lab. I did urine and blood analysis of many patients, I evaluated them, but I did not take an X-ray. Because I thought that if I enter the X-ray and learn how to use the X-ray device, they will diminish the staff. They take the lab technician; they take the x-ray technician. I am a manager, I have to manage, but I was saying that I do not have to do these things while I am managing. But I could not explain, I left it when there were many problems (Buse, 26 years in nursing).

This situation is the concrete example for compensating the lack of the medical staff, as well as decreasing the number of medical personnel by adapting nurses into those skills with at hand workers. On the other hand, extending their closure, therefore, needs to be considered as a notion in the medical field in the neo-liberal era, referring to the adaptation for compensating the lack of resources and flexibility towards the professional duties rather than as an element contributing for their professionalization.

The lack of specialization brought out many other problems, such as intervention from the other actors at the hospitals. This is one of the main reasons why nursing become vulnerable in terms of its occupational boundaries, and how they are defined as buffer profession at hospitals. In terms of need, they are sent to other hospitals, services that they have never been before. Every time they changed the service they work, they are treated as new, negligibly the year of experience at the field, as mentioned previously, and this situation leads to the intervening of other medical staff to the care process. This situation is also valid for patients. But I will further discuss this dimension in the chapter of "Patient's Rights as a Source of Conflict."

One of the premises of the health transformation in Turkey is that standardizing the care, rationalizing the process, and become effective. However, in the case of nurses, we witness an increasing informality in their working process in terms of their responsibilities and roles. Since they were not able to care for all the patients with restricted sources, they need to increase the time they spend on the work without paid for it. Since it is the position of a civil servant, it can be thought that they have a secure environment, well-defined work boundaries, and fixated working hours. Abbott and Wallace (2003) describe this situation as in Chapter 2 by arguing that in medical science, nurses are always seen as helper rather than a distinct profession. The dimension of helping the doctors is one of the main reasons for nurses to not be able to construct a specialized field for themselves besides the institutional means. Doctors and patients need every time nurses in every circumstance. Their occupational boundary is shaped through both the doctor's order and the patient's need, which is a changing and dynamic one in the curing and caring process. Therefore, their labor is needed in different services at the same time and this is also a directly related issue with the very nature of caring process as described in Chapter 2, with its bodily and time restrictions. In addition to that, as I mentioned, hospitals are turbulent environment, in such environments, workers are pushed to have multi-functionality in order to handle the unpredictability and ever-changing situations. Flexibility, in that manner, becomes a necessity to operate in an effective way.

> For example, it is argued (Kanter 1990; Casey 1995) that the boundaries between different professional

> groups are being blurred as professionals in organizations are asked to work in multi-functional teams in order to provide the "flexibility" supposedly required to operate effectively in a 'turbulent' environment (Fournier, 2000, p. 67).

The specialization in one field for nurses has many consequences for the state since it will necessitate many numbers of nurses for different domains, rather than one nurse in varied services and fields and thus will increase the expenses. And this is a consequence which clashes with the cutting expenses in the public service in the system. That is why the lack of specialization of nurses needs to be read through both a mechanism that state supports for a cheaper labor process and also a patriarchal mechanism for eliminating the challenging actors to doctors.

The lack of specialization or handling and resistance strategies to this process needs to be read through the profession building and doing nursing. A study written by Allen, focusing on professions and nursing, is called *What do you do at work? Profession building and doing nursing* (Allen, 2007). The study is parallel to what I found in the field and tries to reveal the actual content of nursing work. In the study, she discusses the challenges of the profession building. She suggests that one of the tasks that nursing includes is circulating patients. By emphasizing this notion, she focuses on patient populations rather than an individualized work structure. Mediating the occupational boundaries is another important part of this occupation since the flexibility regarding their responsibilities is an expectation from nurses. This automatically comes with another dimension, which is managing the work of others. (Allen, 2007). She concludes that,

> Field studies indicate that in modern healthcare systems, the core nursing function is to mediate different agenda, articulate the work of different care providers around individual patients, and fabricate patient identities from diverse information sources. It is nurses who reconcile the requirements of healthcare organizations with those of patients and constitute and prioritize needs in response to available resources. It is nurses who broker, interpret, translate, and communicate clinical, social, and organizational information in ways that are highly consequential for

> patient diagnoses and outcomes. It is nurses who work flexibly to blur their jurisdictional boundaries with those of others in order to ensure continuity of care. In fulfilling these roles, it is nurses who weave together the many facets of the service and create order in a fast flowing and turbulent work environment (Allen, 2004, p. 278-9).

Therefore, within this environment, since nurses are lack of institutionalized specialization, sometimes they are the cleaners of the rooms, sometimes they are in charge of caring process, and sometimes they are technical staff if it is necessary. Therefore, rather than the medical duties, the duties included by all care process is described as a nursing duty. However, as mentioned, this process also leads to decreasing work satisfaction due to completing unrelated tasks. Therefore, their extension of responsibilities is two-faced in the case of nurses in Turkey in terms of their professional building. Although they control more occupational domain and area in the medical field, they become more open to be taken advantage with assigned unrelated and repetitious tasks. However, this situation needs to be read as both a resistance strategy to create themselves as a profession by extending their intervention area and also an obligation for the increasing workload and lack of sources. By extending their working area towards the doctor's or practitioner doctor's jurisdiction, they try to prove themselves as a profession. And through other medical staff's boundaries' violation, they try to extend their field to this dimension as a dual closure strategy. At the same time, their skills started to become degraded by completing the un-related tasks and peripheral activities of the nursing most of the time, and also do not have the opportunity for specialization in the medical field, through institutional power mechanisms.

There are other dimensions and consequences of a lack of specialization for nurses. It should be noted that the specialization for nurses is not supported by an institution, however, within the market dynamics, there occurs another alternative to gain this specialization through different means outside the nursing education or hospitals in the following years.

There created courses for nurses to learn different types of technological devices used in the medical field, such as bronchoscopy, EMG (electromyography), or they are registered to these courses for becoming a surgery nurse, diabetes nurses, dialysis. However, one of the nurses said that "These courses do not function well, we first learn at the field, then go to courses to only have the certificate, to make it official." Within the system, they try to create their own intervention areas; however, the means for "helping them to specialize" are inconclusive. In addition to that, the education of nursing is upgraded in those years to the university level, it became more common, and the nurses already at field had the opportunity to complete their university level at universities. However, most of the nurses' concern was about more financial, and some of them did not prefer since it did not create an additional salary. Their up-graded education did not make them visible in the medical field, although the lengthy of their education is stretched, and more "qualified" as discussed before.

To highlight the important points of this part, it should be noted that, within the framework of Weberian profession definition, the nurses struggle with the professional building is described through their lack of specialization, and coping mechanisms by emphasizing the core activities of nursing. This process has been shaped through the increasing demands, and lack of labor, which ends up with the buffer position of nurses for many services, and lead to struggling not to lose their authority over their core tasks, and professional body of knowledge, since their knowledge is regarded as degraded and need to be upgraded through different means, which are inconclusive. Also, the resistance strategies to this process is described for understanding the notion of agency and its complexity in terms of the experience. In addition to that, the professional building is a critical concept, since as we see the scientific knowledge is defined superior to the experience by the system in the field of nurse, even nurses indicated the reverse. Gaining experience in the field is not enough, but it needs to be certified. In addition to that, as a conclusion, I want to emphasize the bare relationship between lack of specialization and the flexibilization of occupational boundaries.

I argue that, as nurses become more flexible about their responsibilities in the medical field, with spending more time with completing the peripheral activities, the core activity, which is the care of the patient, becomes a time-limited activity. Care-activity, which is dominated by nurses, and is their jurisdiction area in their work field, become a process that is open to intervention. However, rather than abandoning their core activities, they struggle for completing them despite of increasing work burden and intervention to the work process to emphasize their importance in the medical field. As conceptualized before, care activity cannot be defined without the relationship between the patient and the nurses. In the next chapter, I will try to define how this relationship is diminished. In addition to that, how nurses are dedicated care activity is also important since it will help us to understand the handling strategies in the next chapter.

4.3 Years between 2010-2020: Period of Registration

In this period, there are some highlighting changes taking place in the delivery of health care services. In addition to that, as I noticed before, I will include the ongoing effects of alterations done in the preceding one. To begin with, one of the significant changes regarding this period is the "Public Hospital Unions," which started in 2012. This reform aims to the unification of public hospitals within a general secretariat, which is responsible for managing the healthcare services. In that way, the aim is to manage the public hospitals in smaller units and, therefore, provide them a level of autonomy. Having smaller units, and de-centralized managing system are thought to be better in terms of speeding up the decision-making process. This system took place in the years between 2012 and 2017. Küçük says that,

> Eighty-nine public hospital unions were established, considering the size of the service, several cities had multiple hospital unions (six in Istanbul, three in Ankara, two in Izmir). With the reorganization in the form of the union model, it was expected that goals such as effective planning and coordination of resources, transferring control of decision-making areas from hierarchy to enterprise management. Those steps provided the opportunity for hospitals to gain legal public personality and fiscal autonomy, to employ contractual staff, to apply a performance

> system to delivering healthcare services, and to contract out some services to the private sector, such as catering and cleaning (Küçük, 2018, p. 975).

In addition to that, the HTP, which started in 2003, has some effects over this period also. The quality assurance and control, performance-based system, and the rising importance of patient's rights dominate this period. One of the reasons for that is the 2009-2013 Health Strategic Planning. This plan has an emphasis on "Quality Management and Improvement in Health." Although the performance-based system attempts started to be implemented in 2004, their impacts are seen in the long run, especially in this period. This performance-based system does affect not only the doctors and their wages but also affects the delivery of healthcare service and the process of curing and caring as well as nurses' working conditions.

After a brief contextual description, now I will describe my aim in terms of this chapter through the theoretical discussions in this thesis. In this part of the thesis, in addition to the brief debate on skill regarding nursing, I will also discuss the same topic from a different dimension since, in this period, the changes have altered some other things regarding nurses' skills. Malcolm Carey discusses the precarity in terms of de-skilling and up-skilling discussion. Within this discussion and the outcomes of my interviews, I will try to conclude my findings parallel to how Malcom Carey problematizes. Malcom Carey tries to do it through the social work and adds that the scientific management does not end the social work, but it transformed the professional identity, skills, and alteration of role and skill (Carey, White-Collar Proletariat? Braverman,the Deskilling/Upskilling of Social Work and the Paradoxical Life of the Agency Care Manage, 2007). She also cites Pithouse's ethnographic study. Pithouse, in the ethnographic research, concluded that for the care-workers, completing the bureaucratic files becomes a priority, and this situation ends up with the decreasing time for the children at children-care services (Pithouse, 2018). This is one of the outcomes I have summed up through the interviews that I did with the nurses. Although this situation dominates the previous period, in this period, it has accelerated its effects in terms of its share in the labor process. One of the nurses considered it as an unnecessary part of the job, but it becomes the most crucial thing to be completed. Belgin describes this situation as,

> In the past, there was not much file work. But recently, the system has had a lot of file work. For example, I argued in the cardiology service because of this. I can say that I officially had a fight with those who came to control. I took the patient from the operating room; the patient was on the stretcher; we were taking it. I took it to the service, signed it, and received it. But the patient was still on the stretcher and agitated. We have no wake-up service. We brought it to the service as soon as it recovered its consciousness. The man came, and said "Why was he not on the list? I said, “I did not take it to bed; the patient is on the stretcher.” After that, I should take the patient from the operating room and sign it, okay? But he wants me to do the paperwork before taking it bed, comforting the patient, measuring its blood pressure, that is what they want. I said, go away, and I will do my job. Seriously, this happened. The patient is more important to me. It is more important than paperwork, we grew up like this, but now it is more important (Belgin, 34 years of experience).

From a different dimension, they both try to protect their control area for their occupation and try to give their best care to the patient. On the other hand, they also feel like they have first to complete the documents relating to the patient. The Control and Accreditation System, as a part of Health Transformation Program, which is introduced recently makes them overwhelmed about the filing process. Documents need to be prepared for all the time, and the files needs to be completed on a daily basis to make the registered information updated. The registration process also accelerated through the family medicine centers and its function as registration of any kind of information relating to the patient, and local health. One of the assigned functions for the family medicine centers is that to have statistics for age, diseases, the characteristics of the population and store this information. This is also one of the reasons for rising file fulfilling tasks, and registration of statistics. Carey described this situation as,

> Once again, this confirms a previous study, which concluded that the ‘collection and processing of raw information has become the predominant role of [state] social work (Carey, 2003, p. 126).

There are two reasons for this situation. First of all, as many mentioned before, the distinction of primary care services into two as family medicine and community healthcare services created a hierarchy between these institutions. For instance, community healthcare services become institutions for completing peripheral activities regarding health. Most of the time, the file-processing duties are assigned to these institutions, such as the collection of data, storage of data, and also processing the data. Therefore, some of the nurses, while talking about community health services, they mention that they are not willing to be assigned to those institutions. The lower wages for the nurses working in these institutions and fulfilling the peripheral activities end up with lower work satisfaction for nurses. In addition to that, not providing care any of the patients in those institutions is also a reason for them to avoid working there. Therefore, for the primary-care institutions, the function of the collection and processing of raw information becomes the main task. It created an immense amount of work burden for the nurses working in primary-care organizations; they become estranged from the care process, which can be considered as the core of the nursing occupation. We see subordination of care work, which includes patient, tolerant, affection to the file tasking, which provides for registration of information by aiming the efficiency and standardization in the labor process in every level of medical institutions. In addition to that, many nurses indicated that the time spent for the patients critically decreased at hospitals, and their once peripheral duties become dominant responsibility on a daily basis, which leads to a loss of ability to implement their learned skills. Therefore, the dichotomic relationship between nurses and medicine insists on this dimension, too. Consequently, I will try to investigate this relationship and the means of a New Health Paradigm system in Turkey for the last ten years in this part.

Within this context, in the following part of this thesis, I will investigate the last term and period that the healthcare system in Turkey experiences over the previous ten years, and how these changes alter the dynamics within the medical staff and between the patients and medical staff. In this time, Turkey had experienced many different regulations on the health care system. To begin with, one of the most prominent alterations was that the performance-based system brought to the doctors

working at hospitals. The second biggest adjustments were about primary care institutions. The primary care institutions were changed into the family medicine centers. In addition to that, to increase efficiency in the running of hospitals, there occurred a new regulation. This regulation is called Quality and Accreditation in the Health Sector. At the same time, private schools that provide nursing education have risen up in number, and the public vocational school of health decreased in number since the education for nursing is carried to the university level. One of the outcomes of an increasing number in the private vocational school of health is that the number of graduates in nursing has increased for the last few years. Moreover, since there is also a university-level education, it created a duplicative education system in nursing and created a segregated and fragmented labor market for nursing in Turkey which also accelerate the competition within the nurses. In the last two years, the students graduating from these private vocational schools of health are attributed as a new name and new work title, nurse's aide. Therefore, I must say that this last period is the period when the transformation was felt the most.

4.3.1 To What Degree a Standardized Care: Unpredictability of Care-Work

In the health transformation, nurses are expected to become more open to flexible work boundaries, responsibilities in terms of patient care. They try to defend their occupational domain through their emphasis on the importance of caring in the medical field, although it became a time-restricted activity. The expectation from them to be adaptive and flexible in the care process becomes key for a well-functioning hospital. Therefore, the dissolution of this unpredictability and the relationship between this unpredictability and the nurses will provide a picture of conflict of standardization and not calculability. Cohen argues that care as a bodywork carries unpredictability, and it can resist the means of standardization and rationalization within the care process itself (Cohen, 2011) as mentioned in Chapter 2 before. In her article, she argues that this predictability depends on three reasons which were rigidity in the ratio of worker to number of people needs care, need for co-presence and temporal restrictions and the very nature of bodies. This argument is crucial in terms of understanding the borders of the care-work. It is vital to understand care work as bodywork also since it includes the intervention over the

body and necessitates a compromise between body and the worker. In addition to that, different bodies signify various means of controlling bodies for the caring process. Cohen describes this process as 'slip between bodies,' by emphasizing diversified care process according to different bodily experience as it is discussed in the Chapter 2. Therefore, it is the body which mostly defines the limits of the care work and care work experience for workers and patients. In the health sector, while trying to rationalize, standardize, and make it more efficient, do not end up with the efficiency savings and a predictable process directly. As it is described in the Literature Review and Theoretical Background, the care work is complex and demanding most of the time. Therefore, it is not possible to accomplish all tasks in a day with multi-tasking for several reasons.

As Cohen discusses, multi-tasking is not something that care workers can take advantage of it. That means, if the need for care work increases, the need for care labor also increases. Otherwise, Cohen ends up with this conclusion,

> To cut costs, or increase profits, either the body must receive less attention or a division of labor introduced, with parts of the labor process assigned to lower-skilled, or at least lower-paid workers" (Cohen, 2011, p. 193).

This is what is confronted in the Turkish healthcare system due to cutting expenses and expenditures. The introduction of auxiliary workers in the medical field also ends up with an interrupted care process. Nurses are pushed to share the "holistic care" process, their core activity, with the other actors who are less qualified for completing care work since their other activities have increased dramatically. This is an essential point since as care is intervened more and more; the fewer nurses can construct a trust relationship with the patients and end up with an unsatisfactory care process for nurses and lead a dissatisfaction over their core occupational activity. Firstly, through the interviews I made with the nurses, care is of secondary importance now since they need to complete the file related tasks too, and within the time restrictions, they needed to alter their priorities as changes in system re-determine. Second of all, we witness new actors entering the care process, which

Cohen describes as lower-skilled and lower-paid, in the case of Turkey, they are nurse's aides. These nurse's aides, which were graduated from Vocational School of Health, become required, since the care work and the body insist on a ratio of workers to patients. It is hard to cut the expenses of labor since the labor process necessitates human work rather than a machine work. That is how they can compensate for the labor with other actors, which costs less, which is, in this case, a nurse's aide. Due to an immense number of nursing graduates, the state had to make provision for handling with the excess amount of graduates of nurses and decided to attribute new title them as nurse's aide with lower wages and narrower domain area. In that way, the state divided the nursing graduates as nurses and nurse's aide and created a new supporting actor at hospitals. These nurse's aides do not have control and jurisdiction over the patient's body. They cannot take action over the body, but they are only eligible for cleaning, completing the file tasks, and help nurses to care for the patient in a short time period. This brings two different outcomes. First of all, it degraded the nursing skills and nursing graduates into a lower-skilled job. To represent this situation with neo-Weberian framework, shorter time period for nurse aide's education, the competition within the same occupation group, re-stratification, and not defining a social closure in the labor market, nurse's aides become a lower-skilled job. Second of all, it created an opportunity for hiring low-paid workers. In that way, instead of hiring skilled nurses for the field such as nurses with university graduates, the state decided to increase the unskilled actors which will help the nurses with a lower cost. This leads to a divided care process for the patients since the multiple actors start to have an intervention on their bodies whether they can medically intervene or not. Since as Cohen describes, cleaning is an intervention and also a bodywork since it includes the other bodies' extensions (Cohen, 2011). Therefore, prioritizing the holistic care for the nurses has been degraded since the division of tasks between health caregivers has increased. In this way, they cut the expenses and hire more people for completing the same tasks for a lower amount of money, which can be seen as part of the New Health Paradigm within the framework of neo-liberal policies.

To return to our main topic, to what degree standardized care is possible problematic remains controversial in terms of constructing nurse's care activity as steady and enclosed through neo-Weberian framework. Cohen, in her analysis, mentions the time and space restrictions that nurses and the other medical staff face during their working days (Cohen, 2011). This aspect is important since the situation here is one of the most confronted answers during my interviews in the field. Most of the nurses said that, they feel depressed, and stressful since the work that they need to complete is essentially a care work, but their increasing peripheral activities diminish the time allocated to this activity. In addition to that, they do not have opportunity for multi-tasking, they need to care every person individually, since their care process is unique to the person. When they do not have time for eating, in those times, they eat or drink and register the files for completing the work on time. In addition to that, as mentioned before, the increasing in the number of other actors such as nurse's aides make them more distant to their care activity. In that way, they could not be able to protect their professional domain from more intervention as discussed before. This situation, again, shows that care activity is complex, and its predictability and calculability varied within the actors take place. Most of the nurses said that, the Quality and Control Assurance System needs also a control over the care process, rather than only focusing on the registration, or filing process of the raw data. For the nurses that I interviewed with, the quality of care process was a priority, and in this process, lately, they stated that the quality of care they provided to the patient started to lessen because of diminishing holistic care logic, time restrictions as well as increasing peripheral activities. Julia Twigg argues that,

> It is hard to schedule work on the body: 'care tasks cannot be accumulated and dealt with efficiently in one go: you cannot save up going to the toilet for a week and then do it just once. The body has its own timings (Twigg, 2006, p. 128).

Therefore, care needs to be understood through the frontier of the controlling bodies, and its restrictions and unpredictability of body necessitate questioning of the standardization and rationalization process. Cohen sums up that,

> Body labor is not necessarily better, nor worse, than other work. It is, however, perhaps uniquely difficult to rationalise, not least because transformations of the labour process directly impact on the body-worked-upon. In this context struggles between the capital and workers over labour process (re)organisation cannot but include other actors: first, the body-worked-upon, but also the state, whether as regulator or employer of last resort (Cohen, 2011, p. 202).

That is why, it gains importance to understand the other actors such as state, as regulator through differentiating means over the care-work.

In this part of the thesis, I also want to draw attention to how nurses define care, how they prioritize some elements during the care, and have a conclusion on whether it is possible to have standardized care for every person. Within the Quality Assurance and Accreditation system, MoH aims that the more they register, the more they are standardized. One of my questions to the nurses is that what are the prior elements in a caring process for them. They listed many different things like privacy, cleanliness of the patient, emotional and psychological care, and not hurting them. However, as mentioned previously, they said that it depends on the condition of the patient, which disorder they have, and the treatment they will receive. The nurses need to negotiate with the patients in terms of intervention to their bodies and bodily activities. Nurses have control over the body of the patients, and they need to educate the patient in terms of their diseases, illnesses and about their diet, the practices they need to do, and medication. That is why shared care is one of the important aspects of the issue. Shared care can be seen as a survival strategy for nurses to keep their core activity as hand while completing the other responsibilities at medical field. Since there is an increasing number of patients in-country, lessening sources, an insufficient number of medical staff, they needed to create some handling strategies within the system.

One of them is shared care, which includes the patient's family. If it is necessary, the patient's family has to help the nurses for the well-being of the patients. Due to the mentioned reasons, nurses were no longer able to complete all the patient's care processes in a day, and that is why, they included the patient's family within the

process. This has some unintended consequences. One of them is, they unwarily open their profession area for the other group of people, who are not an occupational group in the medical field. One of the main problems that nurses are facing nowadays, the intervention to the working process by the patients and their families mostly. This situation leads to a fragmented care process and decreases the trust between nurses and patients. Trust is a key dimension for nurses as I mentioned previously. It functions as a gatekeeper role for opening the patient's body more intervention and provide nurses more flexible area for giving a holistic care routine. However, when they include the family of the patient to lessen the work burden for some practices, they open their professional areas to the intervention. Families sometimes complain about the nurses since they thought that they hurt patients and therefore intervene nurses' tasks. This is one of the main drawbacks for nurses to protect their professional domain. In addition to that, nurses need to share their knowledge about the care process to acknowledge the patient and the family to make them help in this process. However, as mentioned in the Literature Review and Theoretical Background Chapter, one of the important instances for defining a profession is its scientific body of knowledge. In this case, nurses open their scientific body of knowledge to intervention and deterioration. The profession, as it is defined in Chapter 2, is defined as with a different language, an accumulation of knowledge, application of this knowledge and practice. However, nurses, within the intervention of patients, their families, or other personnel groups, as well as doctors, become bare to any interference and degradation of their working process. This situation is supported by changing educational mechanisms. In addition to that, upward education in nursing may be accepted as a mean for making the nurses as a separate occupation and profession and define them as a new occupation rather than helpers of the doctors. However, they indicated that they were trained in a holistic way in the health vocational schools and trained as more practice-focused, and education was more decent than now. Currently, their educational means do not provide a practice-focused training since in the university level, education of nurses becomes more theory-oriented. In addition to that, increasing private schools for nurses also and decreasing quality of education in these schools are main reasons

for them. Lately, private schools direct their aim into more profit making through education and provide a more "short-cut" diploma. Attempts to standardized education for nursing both upgrading it into the university level does not end up with a more qualified education since there is increasing number of private schools. The skills they gained at vocational schools were a mechanism for them to separate themselves from other occupations. However, this also become invisible and de-valuation of the skills become inevitable within the occupation.

Abbott tries to describe the process of professionalization of nurses while describing the grey areas between nurses and another care worker as by emphasizing the educational means,

> To the extent that they do claim a monopoly of caring work and stress their role in assessing the needs of frail elderly people, nurses are emphasizing expertise over experience. This claim to specialist knowledge and skills is based on their claim to a unique training with certification and credentials. By claiming to have unique skills, nurses are able to maintain a distance between themselves and other carers—paid and unpaid—and increase their autonomy and status (Abbott, 2003, p. 206).

To conclude, the attempts to standardize care work do not end as desired since the care work has spatial and temporal deficiencies. In addition to that, handling strategies for nurses to complete the complex care process with all the increasing peripheral activities open their jurisdiction area into the intervention. Shared care with families, with other actors such as medical doctors at first, auxiliaries, and nurses' aides lead to a fragmented care process, and de-valued the notion of holistic care which is considered as the core activity of nursing. This situation is also supported by the educational means which is duplicative in that period while creating a competition between the nurse and nurses' aides in the market. Needless to say, the nurses' aides consist of mostly women, which means they are the ones who compete with each other. This situation made labor market for women more insecure and manipulable, since the nurses' aides' responsibilities are not well-defined also. This also necessitates a further research.

4.3.2 Which Performance Matters?

In Turkey, as a concrete example, we confront the increasing pseudo-market dynamics in public services. There are differentiating salary systems, an increasing number of private hospitals, and regardfulness for competition. One of the major changes in the health care system is the doctor's salary system. It does not seem as something directly affecting the nurses; however, it has more effect over nurses' work conditions than imagined. Doctors are now evaluated through the performance-based system which also provide "feedback." This system evaluates every medical doctor individually according to their number of patients, the treatment process they provide, and the medication they use. The performance-based system also aimed at maximizing health outcomes, minimizing the costs and elimination of predictable care costs. Therefore, this instrument should be seen as a piece of the standardization process in the health care system. However, as I mentioned before, these processes are intertwined with each other, and it is hard to separate them in terms of their aims. Thus, the performance-based salary system cannot only be related to the standardization of the health service process but also indicates a possible competition between the actors. Therefore, in a competitive environment, the nurses' handling strategies need to be framed.

To begin with, the performance-based system at the hospitals aimed at efficiency and rationalization as a new feedback system for doctors. However, unintendedly, it created a large work burden for the nurses. First of all, doctors are now paid for their performance, which means the number of patients they examine, and also the number of surgical operations is essential mean for deciding the performance of the doctors. This regulation can be seen as doctor's-oriented issue. However, it has so many outcomes for the nurses and other medical staff. First of all, it created a competition between doctors. As long as a doctor treats a minimum number of patients, and has the surgical operation, they are paid in terms of these numbers. Some of the participants said that,

> It really affected our working environment. We were working in a peaceful environment; however, it is all about competition now (Belgin, 34 years in nursing).

In addition to the individual performance system, this performance-based feedback system is also applied to the institutions such as hospitals. Every public hospital is now evaluated through some charts, which indicate the points interval needs to be reached by the hospital on a yearly base. Otherwise, if there is a decrease in the total point of the hospitals, and that ends up with the replacement of doctors and cuts in the salaries. Within this system, as long as doctors' process of curing becomes faster, the work burden that nurses need to carry rises up since they are intertwined. Circulation in one service increases since the beds are now arranged to have the maximum patients at the hospitals. The system aims at the maximum efficiency within the hospitals; however, there is another problem, whether qualified care can be given to the patients within increasing circulations at the hospital remains controversial. In addition to that, the number of depletions, the number of blood tests, the MR, visual scanning numbers are also valid for increasing the performance of a doctor.

An increase in the medical inspection impact all divisions of hospitals, and therefore, the rest of the medical staff. Therefore, this situation ended up with the increasing work burden over the other medical staff, too, without paid for that. One of the participants said that,

> We work harder than ever to give the doctor the desired performance. However, we are not got paid for it; it makes me frustrated and tired more than ever (Ezgi, 28 years in nursing).

To be able to complete the tasks in a day, they had to extend their working hours. Multi-tasking becomes the norm of the occupation; even it is contradictory to the care-process. To be able to meet all the needs, they need to conduct different tasks at the same time, such as while fulfilling the documents for patients, they need to have their launch since they do not have enough time to eat or drink. As I mention, care activity has restrictions since its intervention area includes the human body. The type of multi-tasking that I refer to here preferably consists of meeting the biological needs of nurses, drinking water, having lunch, or going to the toilet. They need to complete many files regarding a patient's medical history, the treatments,

and medicine that the patients received or will receive. Some of these files need to be fulfilled by the doctors. However, as I witnessed, and summed up from the sayings of the people whom I interviewed, these files are filled by nurses since doctors do not have time for file works. When this is the case for nurses, they say that the amount of time that they spend for the caring of patients decreased, since they both have to register the information, the order and the program order to the computer and also to the paper. That means, repetitively, they complete the same files twice. In addition to that, nurses started to divide the tasks in a day in order to complete them on time. For instance, a nurse become responsible for only file work for the whole day, and the other's assigned to the injection of patients. This leads to a sub-division of care process in terms of actors within the nurses also. In that way, nurses become distant from the caring process as mentioned before, and the peripheral activities become dominant in their daily responsibilities in that period.

There is another dimension for this process which dominates the primary care institutions. In 2006, there was an attempt for family medicine in Eskişehir as a prototype, and there were so many discussions about how to implement it all over the country. After that, the family medicine started to take place in the following years and completed for all institutions in 2010. One of the major changes in family medicine is that they become de-centralized and draw apart from the state's government as a public institution. These family medicine centers become autonomous in terms of their running, organization, and financial management. The medical staff's status as a civil servant was suspended, and nurses became sub-contracted workers in these institutions. This is important since it draws a line for us to understand how the healthcare system become decentralized throughout the years and what the implications it brought for the working groups.

In the beginning, since they were not so widely accessible, and there were a few numbers of them, the state decided to support them by stretching some rules that family medicine centers need to follow up. For instance, the state provided them places with the lesser rental fee, which were the primary health care center before they were closed. In addition to that, the state provided them extra financial support

for them to establish a family medicine center on the condition for demonstrating their expenses in the process of constitution. Most of the doctors, to share the expenses and other expenditures to increase the advantage of the credit taken from the state, started a common family medicine center, and it becomes wide across the country. The number of the population that they are responsible for determines the number of the medical staff, nurses at these family medicine centers. The first nurse's salary is financially supported by the state; however, the doctors need to pay for the second nurse that they hired. Therefore, in most of the family medicine, they prefer to hire one nurse if it is suitable for the amount of the population that they are responsible for. However, the nurses at the family medicine centers, are not only responsible for one doctor's patient, since some of these centers are commonly established, but they are also responsible for two or three doctor's patients. This also created an additional work burden for the nurses in those centers. Some of the participants indicated that they feel invaluable and become invisible within the medical field. That is how, nursing in the medical field is seen as subordinated to the male professions, doctors. They are seen as the support mechanism for doctors, and helper of the doctors at hospitals. On the other hand, this situation creates a struggle for them to constitute a work definition, autonomous intervention area. Their intervention areas are defined by the other actors in these institutions as discussed before. And in that case, this relationality with the doctors put them into a more vulnerable place and make them marginalized from the care activity.

As mentioned before, medical organizations can be seen as inherently hierarchical; however, this hierarchy mechanisms, for the group of nurses that I interviewed with, always works against them. Their labor is seen as invisible and treated as invaluable within the medical field. They are charged to the additional tasks without paid for it, and their skills are seen as invaluable and seen as necessitating side-responsibilities. In addition to that, they had to complete the tasks that a doctor needs to end most of the time without a negotiation. These duties are given and assigned to them since they are seen as the help providers for doctors since “helping” notion includes the other parts of the care work such as catering and cleaning. This is not a unilateral relationship. There are other medical staff and personnel at the hospitals

that nurses can ask for help. However, this hierarchical relationship cannot be seen between the nurses and the other working groups at hospitals. For instance, the nurse's aide and sub-contracted workers are responsible for cleaning and cooking; the technicians are more able to define their working boundaries. However, these workers challenge the work given them as an extra, so nurses feel obliged to complete these tasks alone since they still prioritize the continuity of work process. One of the participants said that,

> Sometimes, I ask for them to help me with the cleaning of a room or to tidy up the bed. However, all they say is that it is not my job, or I am not paid for it. I do many things that I am not responsible for, and I am not paid also (Canan, 34 years in nursing).

In addition to the performance- based salary system, there are other consequences which brought by new regulations. Since the primary health centers are diminished to family health centers because the primary health centers were more inclusive in terms of polyclinic services, the burden for the secondary primary organizations increased. The patients are transformed into secondary and tertiary care organizations directly, and this disturbed the referral chain in the healthcare system. In that context, one of the participants indicates that if you want to receive help from the other person to handle rapid circulation at the hospital, you need to get along with them. It is about a personal relationship rather than referring only to a hierarchical relationship.

Cohen differentiates care work, the bodywork from the non-body work within the increasing technologies. This aspect is important for understanding the uniqueness of the body and care work. It is mentioned that,

> In non-body work service industries, the need for co-presence has decreased with the expansion in remote or virtual interactions mediated by information and communication technologies (ICT). Similarly, attempts are being made to substitute co-present body labor for telepresence; for instance, 'telemedicine' (Dyb and Halford 2009), which involves virtual links between patient and clinician or between multiple clinicians (Cohen, 2011, p. 195).

The telemedicine is one of the most confronted strategies for family medicine centers, and for the doctors in secondary care institutions. In the family medicine care centers, rather than seeing the related patients directly and educate them in a face to face communication, nowadays, they prefer to educate them through telephone and sometimes make them examine themselves to identify the illness. In addition to that, in the secondary care institutions, for the time and space restrictions for every body's needs, doctors may not be available at that time, and this ends up directing nurses through the phones and providing the patients an online and telecare treatment process. However, it is clearly mentioned that in the previous chapters, through the law itself, nurses are assigned to the duties that doctors indicate most of the time for the medication process, through patient's tables. These orders of the medication need to be in written, without these orders, nurses cannot implement a medication or treatment to the patients. However, since I described the hospital environment before and its complexity and unpredictability, nurses sometimes have to give medication to the patients through doctor's call to not risk the patient's lives and while jeopardize their position at hospitals or medical centers.

To conclude, the performance-based system and the diminishing functions of primary care institutions put them nurses into a more vulnerable position since they are exploited through the hierarchical relationships and institutional mechanisms which is provided by the state itself. Their burden extremely increased in the primary care institutions, and also in the secondary institutions since the referral chain does not function well anymore. Direct and indirect mechanisms to compensate lack of medical staff end up with an excessive amount of responsibilities for nurses which they are not paid for. While trying to handle increase in their workload, they started to abandon their core activity, which is caring. This situation ends up with more intervention by other actors. Therefore, their jurisdiction are become invisible as well as trivial within the medical field.

4.3.3 Patient’s Rights as a Source of Conflict

In the Theoretical Background and Literature Review chapter, I had an emphasis on relationality and nurses’ professional autonomy as relational in the medical field.

One of the reasons for that, is to understand, in what degree, the relationality notion, and its connection with the professional autonomy affect the process of professional building of nurses. In this part of the thesis, I will try to describe the changing relationship between nurses and patients, and its consequences in terms of occupational experiences of nurses. I will try to explain this transformation with the framework of increasing customer logic in public services. This situation brings and defines many new responsibilities for medical staff. In addition to that, I will try to describe the patient's rights and its increasing visibility and the ways in which it is understood and implemented. Then, I will connect and construe these two different phenomena within the medical field through its outcomes.

To begin with, as mentioned in previous chapters, trust is a core element for establishing a better relationship between patients and nurses to have a more holistic care process, as participants indicated that. However, these notions started to be invisible for many reasons and affected the nature of the caring process. First of all, patient's rights, which can be considered as part of human rights, include, most importantly, the right to care. The notion, patients' rights, is not new. However, its rising visibility and re-interpretation have many reasons in recent years. The customer satisfaction logic and the surveys for measure and evaluate the patient's satisfaction have risen up recently. These surveys are done through some forms and registered to the computers by nurses. These forms become part of the feedback system, even for public hospitals, and patient satisfaction becomes the primary objective for the institutions. In addition to that, patients become hardly satisfied with the service they received. The changes in the healthcare systems, the increasing alternatives for reaching out the information about diseases, illnesses, or any kind of information regarding medicine and technology are one of these reasons. The new occurring alternatives and also simplification and popularization of medical knowledge have altered the relationship between medicine and patients, as K. Merakou et al. mentioned (2001). World Medical Association defines the patient's rights in the Lisbon Declaration under matters. These are right to the medical care of good quality, right to freedom of choice, right to self-determination, the unconscious patient, the legally incompetent patient, procedures against the patient's

will, right to information, right to confidentiality, right to health education, right to dignity, right to religious assistance. In line with this declaration, in 2014, there had been a change in the regulation for patient's rights in Turkey. In this regulation, it is emphasized the shared caring process, including acknowledgment of the patients with a clear and understandable language, consent of the patients, privacy, and registration of the whole process. Through this registration, it is aimed to protect both patient's rights and also workers', healthcare provider's rights. However, how it is implemented and interpreted varied according to social contexts. In Turkey, the patient's rights become a source of conflict and draw an antagonistic relationship with the medical setting. In Turkey, there is an over-emphasis over the patient's right in the last years according to nurses I interviewed with. To what patient's rights refer is a controversial topic within the social context. However, its misinterpretation creates a conflict between the medical staff and the patients. Nurses, with whom I interviewed, indicated that there is one more reason for changing relationships in addition to increasing emphasis on patient's rights, which is customer logic behind the regulations in new public management. Thus, we witness a customer logic in the patients since they think that it is a right to intervene the caring process rather than make it softer, painless, and more comfortable. Year by year, the care become patient-oriented and shaped through the desires of the patient, rather than the primary necessities of giving proper and holistic care. Also, the regulations put an emphasis on patient-oriented logic, which resulted in the intervention over the care process. Then, how the autonomy and occupational boundary is reshaped through this intervention will be crucial, since there is another rising autonomy in the medical field, which is the patient's autonomy. I do not say that patient was passive and only the object of the caring process. Indeed, I aim to understand how the unbalanced relationship between these two different autonomies may clash over the care process and describe the consequences. While doing that, it should be re-emphasized that care as a process necessitates a negotiation with the patient. In this relationship, a new responsibility is assigned to the nurses to assert the patient's rights through institutional means. Timmermans and Oh (2010) discuss the relationship between the trust of the patient and rising consumerism in their article.

The points that they specified in the article are important in terms of the scope of this thesis. They argue that,

> Furthermore, with the increased bureaucratization of medical care, the rise of defensive medicine and malpractice litigation, the thalidomide scandal and reports of medical experimentation, and the implementation of informed consent laws (Haug and Lavin 1983; Taylor and Merrijoy 1987), suspicion grew about physicians acting in patients' best interests (Reeder 1972 as mentioned in (Timmermans & Oh, 2010, p. 97).

In addition to that, increasing alternatives to the medical field, there occurred a competition in the sector, and this has ended up with the rising consumerism logic in the receiving sphere for healthcare services. The nurses I talked with mostly emphasize a discourse of patients, which is, "You got paid with my taxes." This is a sentence which shows that patient regards themselves as the controlling mechanisms for the medical staff. This is a situation creating over-pressure on the nurses, which needs to soften the anger of the patients towards the doctor. One of the nurses described the intervention over their autonomy in this way,

> There had always been the patient's rights. We were doing these things in the past, too, only without registering it. Yes, of course, there is a patient right, but it is reflected in the media as "The patient is always right." The patients understand that they can do or say anything to the doctor or us. It is understood that patients can talk with doctors, medical staff unproperly. Violence against health workers increases. They are also privatizing health, the doctor and the nurse started to look at the patients as customers (Açelya, 32 years in nursing).

Here, it is important to note that I do not aim to say that increasing awareness for patients leads to conflict between healthcare providers and patients. But instead, I want to emphasize that, its interpretation within the market dynamics, and reshaping logic of consumerism, and customer logic leads to an unbalanced relationship between patient and medical staff. This situation is well-described as,

> Finally, as the logics of the market is spreading its message across the professions, professionals' patients or clients are transformed into "empowered customers" who in their quest for choice and value for money are questioning the authority and mystery surrounding the professions (Fournier, 2000, p. 67).

For instance, there occurred new means for patients to report their complaints about the doctor or nurses to the related council, such as ALO 184. The patients desire cheaper, efficient, and faster service, while healthcare providers handle time restrictions and increasing expectations. Nurses indicated that they are mostly intervened by the patient or patient's family since it is seen as a right to interrupt the caring and curing process. The increasing violence against the medical staff at hospitals is one of the outcomes, as they say, of this customer logic and increasing emphasis over patient's rights, which is misinterpreted. In Turkey, the ongoing refusal of introduction of the law which protects the health care providers and medical staff becomes a non-existing mean which can be considered as one of the reasons for this accelerated tense in medical field until this time. Abbott and Meerabeau describes the situation of nurses for being stuck with customer satisfaction and managerial power and say that,

> They are also employed, usually, within state bureaucracies and subject to the constraints of managerial power. Their employer is the state (or a voluntary organization) rather than 'the client,' and they have to 'fit' the client's 'needs' to the services and resources available. Indeed, despite the current rhetoric of consumerism, problems are often defined by the state rather than the client, and workers are accountable to managers, not clients (Abbott & Meerabeau, 2003, p. 10).

The nurses indicate that they are exposed to psychological violence, physical violence, as well as verbal violence by the patients and the patient's family. A nurse said, "When a patient dies, the doctor needs to tell the family. However, they demolish this duty to us to avoid physical violence by the patient's family." Nurses are here, between the doctors and patients, take the role of clearing the air, and also calming the patients. The increasing precautions for lessening the harm of medical

staff are one of the consequences of violence in the medical field. For instance, there is a "white code," which is a button providing medical staff to report an act of violence as soon as possible. However, these precautions are not permanent solutions since the problem is rooted in the logic which is imposed through the system rather than being personal.

To conclude, nurses are stuck by the medicine and customer which is hard to satisfy within the lack of resources, while the tension between the medicine and patients has risen up since there are lack of mechanisms for protecting the healthcare providers while there is an over-emphasis on the patient's rights. They are in the role of mediating actors; they try to handle the tense relationship between patients and doctors while diminishing their boundaries.

4.4 What Happens after Retirement?

One of the important outcomes of this thesis, even though I did not aim to investigate, the participants mention their post-working life frequently. Although it was not intentional, I want to include this dimension also since it points some critical and inside aspects for nursing occupation.

Most of the nurses I interviewed must work after they got retired. They mostly mentioned their economic vulnerability and lack of financial acquisition throughout the interview. They try to handle the financial difficulties by working at schools as nurses for medical intervention when it is necessary or as nurses in private companies due to new requirements for private sectors. With regulation, the workplaces which are in the category of high risk such as shipyard, slaughterhouses, factories become obliged to keep doctors and nurses in the workplace to be able to treat the patient or transfer them to hospitals after a pre-treatment. That is how there occurs an opportunity for them to work beside the hospitals.

One of the participants mentioned that one of the reasons she has to work after she worked 28 years in the medical field is that nurses are considered as valueless, and de-valued. Their salaries are not enough while they are working. Indeed, after they

got retired, their salaries got worse. One of the nurses describes their economic vulnerability as many others as,

> Revolving funds are cut automatically when you retire. However, that is what your salary should have been. You have a constant, circulating capital, and a salary. However, when you retire, you have to live with a lesser salary. Approximately 2000 TL of our salary is lost (Buse, 26 years in nursing).

This is a common issue for nurses since almost every nurse mentioned this situation as one of the "disadvantages" of being a nurse. The regulation they desire is called "3600," which provides nurses, actually in general, civil servants, to have comparatively higher salaries when they are retired according to their degree in civil servant, which is determined by the years of experience. To lessen the effects of a sudden decrease in salary when they are retired, to compensate for the lack, they work at private hospitals, shipyards, schools. Some of the nurses were registered for courses to be able to work in companies as a nurse after retirement. This is also an opportunity for them; however, this necessitates an investigation themselves through certificates and extra online courses. Since there is a law for hazardous working environments such as shipyards signifying that they have to have a nurse and doctor for an industrial and occupational accident in the organization, it becomes an option for them to work. However, in these companies, their salaries are not good enough, even though they work without a doctor sometimes since, in these institutions, doctors are not full-time workers but rather part-time workers. That is why, most of the time, nurses have to handle critical patients alone while paid in lower wages compared to public hospitals.

One of the common working areas for nurses is the private hospitals. Some of the participants provided me to gain insight into the working environment in private hospitals. This is important since they talk about working experiences; most of the time, they compare private hospitals and public hospitals. They mentioned that, in private hospitals, it is more accurate that they are managed through economic concerns, rather than prioritizing the quality of healthcare. In that way, the medical staff who are vulnerable to additional income in those institutions are dominated

through managers and their bosses to work over-time. Although some nurses indicate that, to be able to have higher salaries after retirement, they complete their vocational schools into the university level while working at the field. However, they also mentioned that this "upgraded" education does not end up with higher salaries for them after they got retired, since their labor in the market is regarded as value-less, rooted from gendered division of labor rather than the years of education they received. The nurses have to find a way to handle their financial lack compared to other medical working groups, and after tiring years in the medical field, they feel obliged to continue work since their salaries are not good enough to survive a family. In addition to that, they mention that they got tired while they were waiting for their retirement. Some of the nurses are suffered from changing policies about retirement, and they had to wait to be old enough to be retired. It was not about the experience in the field, but rather they had to wait for their age since most of them started to work in earlier ages as described Becoming a nurse as a Survival Strategy part. Their salary, and their financial vulnerability, according to their sayings, is one of the important indicators for them to consider themselves as worthless and insignificant. The doctors' added salary through their performance is fixed in retirement, too. The nurses' one of the expectations comparatively has a fairer salary system. That is one of the reasons for them to give up working. In addition to that, as mentioned before, the lack of personal services and benefits, lack of even unpaid leave, risky environment for working, increasing violence, and the working burden is major reasons for not continuing to work. There are also other reasons for nurses not to continue their occupational life.

They mentioned that, through their occupational life, they are consumed away emotionally, physically as well as mentally. That is why they think that they deserve depreciation right, which confirms their damage throughout their working life. And also, even though nurses are categorized as a civil servant, their working time become flexible in terms of overtime at hospitals without additional payment. As retired nurses, their retirement life become also insecure. As Beck states that,

> This means, first of all, that top and bottom are no longer clearly defined poles, but overlap and fuse in

> new ways into a kind of wealth-aspect/poverty-aspect or into fixed-term wealth with its corresponding forms of existence. Consequently, insecurity prevails in nearly all positions within society (Beck, 2006, p.3).

All in all, occupation is not something restricted to working life, but it is also part of the after working life. The economic and social vulnerability of nurses, in after working life, in retirement is one of the dimensions of gendered division of labor and inequality in retirement. Their struggle for the professional building is both suppressed by the capitalist, pseudo-market dynamics, and state intervention to the health care service, as well as by the medicine itself. When I ask them what kinds of changes they experienced, they mostly answer this question as a lack of respect towards them, and insecure environment at hospitals, misusage of their flexibility in terms of their responsibilities, and doctor's oppression for completing more works in limited time.

There was another question that I asked may be related to this topic, which is, "Are you happy to be a nurse when you consider your career?" Most of the nurses answer this question as they are disappointed by their occupation. They mentioned that "It does not worth it." They mention that most of the time, they suffer from physical disorders, and care an emotional burden.

To conclude the whole analysis part, I try to describe nurses within my sample, in some points, resist the de-professionalization process and emphasize their labor in the medical field, by extending their jurisdiction areas into different fields, and other occupational groups' fields. This is rooted from two main reasons. First of all, they had to compensate the lack of labor at hospitals. Therefore, they extend their occupational closure towards to occupations located in higher places in the hierarchical setting, such as doctors, or intern doctors. Second of all, nurses had to extend their areas towards adjacent occupations in the medical field. They started to be flexible in terms of their occupational boundaries within the medical field. They become a buffer occupation in the medical field fulfilling any kind of lack in terms of labor. Moreover, with increasing bureaucratic mechanisms, they are assigned to

filing process at hospitals in addition to their current responsibilities. Increasing work burden pushed them to drop their core working area, care activity. This leads to introduction of new actors such as nurses' auxiliaries and aided for care process, and weakens the holistic care understanding in the medical field. This situation resulted in a loss of face to face relationship with the patient for nurses, and therefore, an opportunity to construct a trust with the patient which provides a holistic care process. Since their main dominance over the patient is constructed through their trust relationship, their domain over the patient, and decision making within the care process have lessened. In addition to that, rather than an approach for a distinctive autonomy, I try to show that how relational autonomy of nurses with the patient become weaker, and it resulted in a depreciation in their core activities as well. Throughout the years, they resist in some points to make themselves visible in the medical setting. They extend their skills towards other occupation's closures, and they emphasized and perfected the care process. However, they remain invisible in terms of their labor, and become distant to decision making process. In that way, they become distant to their core activities and their responsibilities started to be shaped by activities which were considered as peripheral once.

As I will propose later, this study necessitates a further feminist research on its topic. The invisibility of care labor in the medical setting needs to be further analyzed, and the gender-specific strategies need to be framed in the case of nursing in Turkey. That is why, in my conclusion, while I am summarizing the highlighting point of the thesis, I will address to feminist agenda and other related dimensions of the same topic.

CHAPTER 5

CONCLUSION

In this part of the thesis, I will try to gather the highlighting points of the thesis as a conclusion. I will first give a conclusion about the altering social context in terms of healthcare service in Turkey. Later, in the divided parts, I will sum up the crucial points in terms of the scope of the thesis.

To begin with, the philosophy of the "welfare state" replaced itself with the free-market, individualism, competition, flexibility in the market relations, and health became an objective and apparatus for competition in the market as well as increasing profit. In Turkey, there is an increasing number of private hospitals that adopt pseudo-market dynamics. Not only the private hospitals, but also public hospitals, and newly established city hospitals also adopt the pseudo-market logic, which includes increasing efficiency in curing and caring process, rationality and calculability in the expenses, flexibility in work arrangements, and therefore, more predictable treatment process. In addition to that, in that institutions, the conduct of them are divided into management, finance and de-centralized in order to adapt the private market to the public service. In the private sector, a company or an organization, as a first step, decrease the labor expenses to be able to have a place in the competition. One of the most critical costs is seen as wages. Therefore, as a first, the payments remain low to increase the profit. This situation burdens the caregiver since they are expected to be efficient, fast, to compensate the lack of labor, but at the same time, they need to care, to smile, to be affectionate, but for lower wages especially in the case of nursing in Turkey. This is the current situation

in the health sector now. Besides the public hospitals and civil servants, the increasing number in private hospitals necessitates much new staff to work at hospitals but in lower wages due to immense labor in the market for the same sector. Moreover, unified health care needs to provide a unification of the service available to people. However, within the privatization and free market, we confront a segregated health care sector in Turkey. The private sector is available for a minority of people, whereas the public sector necessitates recognition by state through formal employment. In addition to that, it is believed that for the uncontrollable demand for health services, offering choices as public and private hospitals increase the customer's satisfaction and expectation and accelerate the competition between the public and private sectors.

As Selberg puts it in a concrete way, “Becoming a “good nurse” has historically been closely linked to “being a good woman” (Selberg, 2013, p. 12). Their skills, and roles at medical setting is considered as closed to the tasks a woman has to complete in domestic sphere, which signifies a gendered division of labor. This division of labor insists in the medical setting as well, instead of their education at both schools and at the medical field. Their years of experience at hospitals, which is an indicator for their improvement of skill, then, become invisible in terms of their profession. That is how, their skills become unseen neglect of the time and labor they spent to gain those skills. That is why, in my sample, I realized that their struggle for proving and placing themselves as complete profession in the medical settings is fed by the logic of being a good mother, as well as good worker. They always try to expand their jurisdiction domain both by gaining new skills and new responsibilities. In addition to that, within the outcomes of neoliberal policies, and the capitalist system, the austerity logic has been located in the nursing occupation. These two of them made nurses' burden doubled since they feel that they are obliged to complete all the tasks without being paid for it, and without any appreciation even though they are not responsible for them.

MacDonald argued that nursing was considered as a supportive role for physicians and through education, and medical experiences, it tries to construct its professional boundaries and autonomy. He argued that,

> As nursing roles and educational experiences have become standardized, their recognition as a profession has grown. In most modern health care systems, nursing is a licensed, self-regulating profession. Today, nurses have their own professional standards, which imply a right and a wrong way of doing things; no physician order has sufficient moral weight to override those (MacDonald, 2002, p. 196).

However, this is not the case in Turkey. The education is upgraded in the nursing occupation, and it became a university-level in addition to the vocational schools of health. They are differentiated from the other healthcare staff in terms of their education. However, this upgrading does not end up with a complete profession in terms of nursing. On the other hand, they became the victim of increasing competition within the nurses with different educational backgrounds in the labor market. The thesis demonstrated that the close relation between rationalization and professionalization process which Weber emphasizes, becomes weak in terms of nurses' experiences in Turkey. As we witness, as the healthcare system started to be rationalized, standardized, and in a degree predictable, the nurses become more vulnerable in terms of their economic and social situation in the medical field since they are exploited more than ever without paid for it. In addition to that, hiring other actors for the same jobs degraded nurse's skills and made them extend their role to the other working group's boundaries. Also, the introduction of other actors to the medical field interrupted the care process, which the nurse is responsible for and degraded the holistic care philosophy in the institutions. Also, the care is considered as the core activity of nursing, and nurses in the medical field started to abandon their core activities for file processing tasks while they also try to expand their jurisdiction area as both for obligation and as a closure strategy. In addition to that, the standardization within the medical field needs to be questioned as well as efficiency in the care process.

This thesis' aim is to show that how Weberian understanding of professionalization and its relationship with the rationalization process is lack in terms of understanding nursing in Turkey. That is why the gender dimension introduced throughout the thesis is important to understand their handling, resistance strategies in terms of their occupational transformation process by emphasizing the turning points in the Turkish healthcare system. In the conclusion part, I aim to describe my conclusions in three highlighted points which covers the invisibility of care work in formal sector, perfect nursing in between customers and time, and finally, flexibilization in terms of occupational boundaries. In these parts, I will sum up the highlighting points in the thesis and try to have a final conclusion mark in terms of their agency role in this transformation process of the structure.

In this part of the thesis, I would like to draw attention to the invisibility of care work in the formal sector, which is healthcare service in this case and propose a further research within the feminist agenda. As I re-read the data at hand, I realized that these women were handling the powerful suppression strategies constructed through the state's means and patriarchal ideology behind it. Through the interviews, I realized that nurses' labor at hospitals become more and more invisible and they started to lose their occupational jurisdiction areas. They both started to work harder than ever and therefore became more vulnerable throughout the thirty years I indicate. The reasons for that can be summed up in three ways. First of all, as mentioned before, the nurses' skills are considered as easy tasks and internal to the women who are mostly completing these tasks. In addition to that, nurses' skills both extended and narrowed within the transformations in the health care system. Therefore, this situation was analyzed as equivocal. At first glance, carrying education to the university level may seem to result in upgrading nursing as a profession. However, as a part of the remarking specialties of nursing indicated, learning in the field, while working, was degraded and eliminated from the education process, and this ended up with the subordination of practice to the theoretical knowledge. Furthermore, care is considered as the core part of the nursing, become degraded to lower-skilled people such as auxilaries, which affected the trust between patients and nurses and interrupt the process of holistic care. They

are not able to distract themselves from the competition in the market, in Weberian terms, they could not construct a social closure. In that way, their skills become degraded and they lost their visibility within the labor market as well as medical field. In addition to that, they try to protect their core activity, the relationship with the patient, since their importance is highlighted in this relationship within the care process. However, within the last ten years in my sample, they started to abondon their core activity.

Their invisibility in the medical field can be understood through their unpaid labor in the medical field, their overburden, and decreasing work satisfaction as they indicated. Their professional knowledge is not respected by the others, and that is why they are intervened while working and struggling with protecting their professional domain in that sense. Sometimes, being responsible for all of the needs which patients demand make them vulnerable and open to manipulation and exploitation. One of my participants indicated that fulfilling unrelated tasks such as trying to fix a TV in a patient's room is really tiring for them. I can conclude that, within my sample, there is a vicious circle regarding their de-valued status and loss of authority over their tasks. They are first considered as de-valued within the medical field since their skills are considered as related to monotonous and repetitive working tasks. Reproduction of gendered division of labor in the medical field shapes the relations between patients and nurses, as well as doctors and nurses. Then, they are intervened by others and become open to exploitation and manipulation as they regarded as unskillful. As it continues, they start to lose their professional domain and again, de-valued within the medical field. In addition to that, they continued to become distant from the decision making process at hospitals. Their decision remain to seen as “on the behalf of the doctor”, even they are mostly know the patient well, and make decisions according to the specific conditions and patients. Here, the dominance of medical over the nurses’ decision making process shadowed the nurses’ occupational decision making area. As I noted earlier, nurses have some strategies to not lose their occupational territory, and one of the strategies is that to emphasize the caring process by perfect nursing which is the highlight of the next chapter and also extend their occupational boundaries to compensate the

lack of other medical staff at hospitals such as intern doctors which is the highlight of the 5.3 part through dual closure and demarcationary strategies. Their extension of professional domain as equivocal since firstly, they extend their boundaries for compensating the lack as both a closure strategy, as a handling strategy and also an adaptation strategy for the situation which state leads for cutting expenses in the health care service. Secondly, their skills become redundant since they started to complete more repetitious tasks at work place such as registration of data and filing. Lose of their core activity, care, leads to a de-valuation on nursing practice and made them degraded within the medical field but with a resistance as mentioned in the following conclusion part.

As I try to describe within the flow of the thesis, rather than de-prioritizing the caring, they try to do their best in the medical field. One of the reasons for that, as mentioned and discussed in Chapter 2, the emphasis over the care process is important for nurses since it also signifies the importance of the nursing and their visibility in the medical field. As the core activity of their occupation, why they insist on keeping their perfection in the medical field despite their social and economic vulnerability is an important question. As I noticed that, rather than decreasing the importance of caring within the treatment process, they try to re-emphasize over and over again by including themselves as an active actor in the process. Entrance of new actors, and transmission of some tasks to these actors, finally, degraded the nursing skills. Elimination of the importance of the care notion in a medical field leads to more degradation of nursing activities and more concentration of peripheral activities such as gathering statistics and transcribing them into both files and computers in the following years. In this process, there are two phases of registration, which are filing tasks, and also saving them to computers. This is one of the peripheral duties for nursing, which medical secretaries are supposed to be responsible for. Within all the duties, their struggle and resistance not to lose their occupational jurisdiction in terms of its medical importance, the increasing pressure due to rising expectations from medical institutions with lesser resources put nurses into a more disadvantaged position. As I try to describe in the

chapter called Patient's Rights as a Source of Conflict, the rising emphasis over patient's autonomy in the medical field, and clashes with the doctors, make nurses more vulnerable since they are the actors mediating this relationship between patients and doctors most of the time.

Sometimes, they need to soften the tension between the patient and the doctor, and in this time of period, there is much more need to accommodate this relationship to lessen the tension. Furthermore, being responsible for every need of patients and also charged for meeting this need make them stressful at the workplace. The institutionalized expectation from nurses to be more creative, adaptive, and flexible is rooted in the austerity ideology imposed through the capitalist system and also the perfectness of the nurturing process imposed by the patriarchal ideology. In addition to that, according to them, quality of care is only thing that matters, rather than the quantity of the patient, and the pace of care process. However, this logic clashed with the HTP which aims to more efficient care process in Turkey. That is why, through the system, they become "failed" in terms of their pace. When they fail, they say that, personally, they are responsible for this failure, rather than an organizational failure. Their resistance to occupy their professional domain make them more stressful throughout the years and lead to abandon some of the core tasks assigned to nurses.

In Turkey, nursing as profession faces many difficulties due to their ambiguous occupational boundaries. Not having a definite occupational boundary and not having a concrete definition for medical caring have resulted in many consequences in their experience of occupation. What care is, how care can be taught, what educated care is and how to define it are major discussions in nursing academic field. In addition to that, different educational means for being a nurse ends up with a segregated market within the nursing occupation in Turkey. In addition to horizontal segregation in the labor market through gendered division of labor, which nursing is placed compared to other occupations, there occurred a vertical segregation within the nursing occupations due to different completed education level.

Throughout the thesis, I want to emphasize the lack of specialization, the drawbacks for nurses in the process of professional building. One of these drawbacks is that their flexibilization within the occupational closures. As one of the premises of New Health Paradigm in Turkey, there needs to be standardization within the medical field in terms of completed tasks, in order to be more efficient since within the increasing demands, and the time needs to be consumed more profitable. However, despite of increasing labor, the term of efficiency brings an economic concern for the public services, and that is how, nurses become open to more duties and responsibilities. Year by year, as my interviews narrated, the technology become more dominant in the medical field, but it does not result in decrease in their work burden, but rather there occurs intensification for demand in the labor process. The unpredictability of the body does not let a multi-tasking labor process; however, it leads to a sub-division in the care process. Rather than having a holistic care approach, now hospitals demand more efficient care process through different actors in the care process by sub-dividing it. However, entrance of another actor does not help the nurses to decrease their work burden, but rather, as they want to protect the significance of the care, they also started to complete the lack elements which other actors do not complete since they are not paid for. This "perfection" as I mentioned earlier, is the result of their education, which always emphasized the creativeness and fruitfulness in the medical field, and also nurses' desire to keep existing in the medical field, rather than become invisible. That is why, this flexibilization in their occupational closures and boundaries need to be considered as both a resistance strategy and also an adaptation to increasing efficiency logic in the healthcare services. Witz's concept of dual closure is one of the tools for us to understand how nurses try to keep themselves in the medical field visible, and they do this both extending their boundaries while trying to have more dominance over the care process and also define their jurisdiction areas precisely. This situation as mentioned before two consequences which are, de-stabilization of responsibilities at medical field, and also, narrower care process. These are crucial consequences since they re-arrange the social organization of care-work at hospitals. In addition to that, while they are up-skilled by compensating the lack of intern doctors, or lack of doctors at

the medical field year by year, they tend to lose this opportunity to more extension because of increasing time and bodily constraints in the medical field. The standardization phenomenon is not something that we can confront in the care process, or in the relationship between patients and nurses, but rather in the peripheral activities such as gathering the data, processing the raw data and their registration to the system. Therefore, nursing core activity, which is defined as the care activity in this thesis, remains its complexity through the human interaction by forcing nurses to be more flexible in terms of their occupational boundaries. Their relational autonomy with the patients does not remain constant but lessened which provided them to be more dominant in the care process with the relation of the bodies, and therefore leads to lose of authority. In addition to that, their relationality with the other actors at medical field became a disadvantaged for them to protect their jurisdiction area at the end since they become a buffer occupation. The reason for that is mainly rooted from diminishing relationality with the patients through disturbing the holistic care with other actors. In addition to that, overemphasis on feedback systems such as patient's rights becomes a major tool for patients to intervene the care and treatment process, and therefore lessen their importance in terms of their skills, knowledge, and experience.

Although they extend their skills year by year, they witnessed that their care labor remains invisible within the medical field. There are two reasons for that, firstly, state does not support or recognize the formal care work in the labor market and continues to free-ride from care work in formal sector. In addition to that, although nurses become able to complete specific tasks that doctors are responsible before, they are not paid for these duties since the capitalist system continues to be free-rider over the care in the formal sector as well as a domestic sphere, in the household.

Nursing as a paid and formal employment pushed to abandon their core activities and morals, become lower-paid, and hospitals become insecure environments in terms of health care providers. Thus, in addition to the informal labor market and through flexibilization in the work sphere in terms of time, space, and work relations, there is surrounding insecurity and precarity which the formal sector also

faces. Flexibility is, as mentioned before, one of the premises of neoliberal policies in the labor market in Turkey. Increasing work burden comes up with the new strategies. However, these strategies open up the professional nursing area for a more intervened sphere. The flexibility in terms of work arrangements is something that we confronted in the formal sector, rather than only in the informal sector. It is always emphasized the insecurity of the informal sector in Turkey. However, nurses in Turkey become invisible in terms of their labor, become more flexible in terms of their responsibilities and work arrangements, and become more vulnerable socially and economically over the past thirty years throughout the transformation in health. The precarity of the nurses in the formal sector in the public sector is something that we need to pay attention to.

As discussed through in Literature Review and Theoretical Background part through Connell, Fawcett and Meagher, the flexibility is also a notion which dominates the market dynamics in addition to that professional closures in that discussion. As they noted, from the top to the bottom of organizations, the sub-contracted workers, and part-time actors in the medical field has risen in the past years, and this is another dimension needs a further evaluation.

It should be noted that, the strategies that I have mentioned throughout the thesis are more individual strategies in terms of occupying their professional domain, importance and visibility in the medical field. However, it is crucial to mention that the nursing solidarity within the medical field is concrete and needs a further investigation through their identities as well as their common backgrounds in terms of their family, education, gender and socio-economic status. That is why, while conceptualizing their informal solidarity within the medical field, what their expectation from their occupation is, as well as the transformation of inner-good in terms of nursing practice throughout the years, and change in their perception towards their occupation signify another importance. Furthermore, neo-liberalism undermines the internal good within the market dynamics, and that is why, this process became more frustrating for nurses within the medical field itself. That is why, how they got emotionally burdened over the years, and how they become

devastated both physically and emotionally and its relationship with the market dynamics which defines their labor as invisible need a further investigation. Throughout the thesis, abandonment of these values as well as transformation of these values in terms of nursing experience is demonstrated within the time periods. Especially, the first analysis part and the description of their relationship within the other nurses is a concrete example of this situation. Moreover, it should be noted that, there is another dimension for nursing to be a tool for emancipation for women and a tool for upward mobility in the lower social status families. Although in this thesis, education is also described as the another controlling mechanisms, within my sample, I realized that, the sacred values and inner goods attached to the nursing occupation within my sample is rooted from the opportunities that this occupation provides young women to emancipate themselves from families socially and economically. That is why, their sisterhood and informal solidarity within the medical field as I described in the first analysis part remains visible and lasting in the medical field. However, this topic also needs further investigation within the different cohorts, since different cohorts within the nursing education signifies different socio-economic status and therefore, different values attached to the occupation itself.

Formal solidarity, or unionized nurses are another dimension for investigating the handling and resistance strategies as well as political mechanisms for them to be part of the decision-making process in terms of their professions. Although it is not existent in the sample within this thesis, conducting such a field would enhance the dimension of the same topic. Especially within Turkey, the functionality of occupational groups, their transformations and their contribution to the political decision-making process with specific nursing occupation may signify another important dimension about the trade unions in terms of understanding their role.

As a final note, I want to mention that neo-liberalism and its means are shaped through the social context as discussed in the New Health Paradigm within New Public Management Chapter. As I mentioned before, it is rhetorically gender-neutral since it always has more effects over the labor market which women are mostly

concentrated than others. In the case of nursing in Turkey, that is why, in addition to the professionalism, profession discussion, I want to add the gender dimension to the thesis to demonstrate that how social and cultural codes are integrated to this logic. That is why, this thesis' subject also needs a further research through a feminist paradigm. The ways in which women experience this process is an important dimension to further understanding of global restructuring and its effects on women's labor and experience.

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APPENDICES

A. APPROVAL OF THE METU HUMAN SUBJECTS ETHICS COMMITTEE

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02 Ocak 2020

Konu: Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Ayşe Gündüz HOŞGÖR

Danışmanlığını yaptığınız **Seray BİRCAN'ın "Burden Of Being a Nurse: A Case Study On Retired Nurses' Occupational Experiences in Turkey"** başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülmüş ve **493 ODTU 2019** protokol numarası ile onaylanmıştır.

Saygılarımızla bilgilerinize sunarız

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B. TÜRKÇE ÖZET/ TURKISH SUMMARY

Sosyoloji literatüründe hemşirelik mesleği, mesleki sınırları ve deneyimleri çoğunlukla nicel yöntemlerle incelenmektedir. Araştırmalar çoğunlukla çalışma stresi, iş yükü ve iş yerinde ayrımcılık literatürü ile şekillenmektedir. Bu çalışmada ise, sağlık sisteminde yaşanan radikal değişikliklerle birlikte, hemşirelerin profesyonelleşme ya da profesyonellikten uzaklaşma süreçleri, bu meslek grubunun deneyimleri ve uyum ve direniş stratejilerini anlaşılmak istenmiştir. Bu çalışmada, sadece sağlık sistemindeki değişiklikleri anlamak yerine, yapı ve birey arasındaki ilişkiyi anlamak açısından da kritik bir önem taşımaktadır. Bu nedenle, sağlık sistemindeki dönüşümün sonuçları kadar, hemşirelerin bu dönüşümle birlikte deneyimlerindeki değişiklikleri de anlamak önemlidir. Bu nedenle, yapı ve aktörü ayrı ayrı konumlandırmak ve tanımlamak yerine, metodolojik olarak, bu iki yapının ayrı birer yapı olmasından ziyade, birbirinin içine geçen ve devamlı bir şekilde birbirlerini şekillendiren süreçler olduğu tartışılmıştır. Buna ek olarak belirtmek gerekir ki, hemşirelerin demografik ve sosyo-ekonomik bilgileri ileri bir araştırma için önemli olabilir. Sosyo-ekonomik durumun yanı sıra toplumsal cinsiyet de meslek algısı ve deneyimleri üzerinde olası bir etkiye sahiptir. Mesleki sınırlarını nasıl tecrübe ettikleri, kendilerini bir meslek olarak nitelendirip nitelendirmedikleri, sağlık sistemindeki değişiklikleri nasıl algıladıkları, bu değişikliklere direnmek veya uyum sağlamak için ne tür yollar izledikleri bu tez boyunca ele alınan önemli sorulardır.

Hemşirelik, yıllar boyunca sosyolojik araştırmanın odak noktalarından biri olmuştur. Akademisyenler, hemşireliği hem toplumsal cinsiyete dayalı iş birliği tartışmaları çerçevesinde, hem de kadınlara ayrılmış ve atfedilmiş bir meslek olarak tartışmaktadır. Bu tartışmaların vurguladığı, ikili bir emek pazarı oluşması ve sektörde diğer sağlık alanındaki mesleklere kıyasla hiyerarşik olarak daha düşük bir meslek olarak değerlendirilmesi, iş ve organizasyon sosyolojisi literatüründe

konunun çok fazla yönden tartışılmasına neden olmuştur. Bunlardan bazıları, hemşirelikte ve sağlık sektöründe ayrımcılık, iş yerinde eşitsizlik, kadınların hemşirelik mesleğini yürütürken karşılaştığı sorunlar hem kapitalist sistem içerisinde hem de ataerkil sistem içerisinde sorunsallaştırılmıştır. Bu tartışmalardan bu tez için önemli olan bir başka tartışma ise, hemşirelikte *beceri* tartışmasıdır. Kadınlar, doğuştan kabul edilen ve "doğal" olarak atfedilen nitelikleri nedeniyle sektörel olarak belli başlı emek piyasalarında yoğunlaşmıştır. Bunlardan biri ise bakım hizmetidir. Bu nedenle hemşirelik, tarih boyu, çocuk bakımı ile hastaların bakımı arasındaki benzerlikler nedeniyle kadınlar için en çekici ve uygun iş olarak kabul edilmiştir ve kadınlar emek piyasasında bu alanlara doğru yoğunlaştırılmıştır. Bu da emek piyasası içerisinde toplumsal cinsiyete dayalı bir ayrışmaya neden olup hiyerarşik bir market düzenini oluşturmaktadır.

Araştırmacı olarak, benim bu çalışmayı yürütmemdeki motivasyon Türkiye'nin girdiği yapısal uyum sürecinde, değişen meslek gruplarını nasıl anlamlandırabiliriz ve nasıl anlayabiliriz sorusu ile başladı. Hemşireliği bir meslek olarak inceleme isteğim ise annemin bu alanındaki deneyiminden kaynaklandı. Çocukluğuma dair ilk anılarımın çoğu, o zamanlar 2000'li yılların başlarındaki anılardan; hastaneler, hastalar ve gece vardiyalarından oluşmakta. Annemi sürekli göremediğim için, gece vardiyaları sırasında babamdan hastanede annemi ziyaret etmemizi istediğimi hatırlıyorum. Bazen geceyi orada, hemşirelerin odasında bir kanepede geçirirdim ve annemle birlikte eve dönerdim. Annemin hem hemşire hem de bir kadın olarak o günlerde neler yaşadığının beş yaşında bir çocuk olarak farkında değildim. Daha sonra sosyoloji disiplininde okuduklarım ve tecrübe ettiklerim, bu alanı araştırmam için sosyolojik bir sezi haline dönüştü. Kişisel olarak deneyimlediklerim, akademik kariyerimde bu alan üzerinde sosyolojik bir araştırma için bir ilham haline geldi. Gerek annemin yıllarca bu mesleği sürdürmüş olması, gerek mesleğine saygısı ve öz çalışması benim için sosyolojik bir ilham oldu.

Çalışmanın mesleki eğitim boyutu, gelecekteki çalışmalar için de önemli bir tartışma boyutudur. Tarihsel olarak Florence Nihtangale'den başlayarak iyi bir hemşirenin, iyi bir kadın, iyi bir anne olmakla doğrudan alakalı olduğu vurgulanmış

ve eğitim sistemini de buna göre düzenlemiştir. Türkiye'de hemşirelik eğitimi yıllar boyu çok fazla değişikliğe uğramıştır. Önceki yıllarda sağlık kolejleri ile hemşirelik eğitimi verilmiştir. Daha sonraki yıllarda, bu okulların yerine sayıca sağlık meslek liselerinde artış olmuştur. Sağlık meslek liseleri, sekiz yıllık zorunlu eğitimden sonra, öğrencilerin mezun olduktan sonra doğrudan hemşire sıfatı ile işe girmelerine olanak sağlamıştır. Yıllar içerisinde, hemşirelik için eğitim seviyesi kademeli olarak artmış, önce hemşirelik ön lisans programları açılmış; daha sonra bu programları lisans, yüksek lisans ve doktora programları izlemiştir. Bu durum, hemşireler için emek piyasasındaki rekabeti anlamak açısında büyük bir önem taşımaktadır. Aynı anda farklı dereceden mezun olan insanları aynı sıfat ile yani hemşirelik sıfatı ile işe almak, hemşirelik için emek piyasasında meslek içerisinde de bir katmanlaşmaya ve hiyerarşiye doğru sürülmüştür. Bunun yanı sıra, hemşirelik eğitiminde gözlemlenen farklı bir boyut ise, eğitimin pratik odaklı olmasından daha çok, kuram odaklı olmaya doğru evrilmesidir. Geçmiş yıllarda, öğrencilerin saha deneyimleri eğitim sürecinde başarıyı değerlendirmek için bir kriter olmuşken, üniversite seviyesine yükseltilen hemşirelik eğitimi teorik anlamda da zenginleşmeye başlamıştır.

Türkiye'de yapısal uyum süreçleriyle birlikte kârı artırmayı hedefleyen özel sektör için yeni müdahale alanları açılmıştır ve özel sektör piyasayı kontrol eden ana aktör haline gelmiştir. Kamu hizmetleri özel sektöre açık bir pazar haline gelmiş ve eğitim, sağlık, ulaşım olarak örneklenebilecek sektörlerde bir değişime yol açmış; bu sektörler de meta değeri kazanmaya başlamıştır. Buna bağlı olarak, hemşirelik mesleğinin önemli bir parçası, bakım sürecini, yani hasta ile bakımı veren kişi arasındaki ilişkiyi, ilişkilerinin karmaşıklığını ve birbirine geçişkenliği anlamaya çalışırken bu durumun etkileri de sorgulanmalıdır. Her ilişki ve aktör sosyal bağlamda değerlendirilmeli ve ilişkilerin karmaşıklığı betimlenmelidir. Bu nedenle, bakım süreci, sosyal bir bağlam ve ortam içinde daha sistematik bir değerlendirmeyi gerektirir ve bu tez bunu yapmayı amaçlamaktadır.

Bu nedenle, bu tezdeki esas amaç, aktörler arasındaki ilişkilerin karmaşıklığını, sistemle olan ilişkilerini ve pazarlık ve uyum yollarını ve değişen sağlık sistemine olan direnç yöntemlerini anlamaktır. Türkiye'de hemşirelerin meslekleşme

deneyimleri, Weber'in kurduğu gibi modernleşme, rasyonalleşme ve standartlaşma sürecine paralel olarak profesyonel yapıyı beslemediğini göstermesi açısından çok önemlidir. Bu nedenle, hemşirelerin profesyonellikten ya da meslekleşmeden uzaklaşma sürecini anlarken, bu tez, Weberyan anlayışın profesyonellik tanımı ve modernleşme ile ilişkisi açısından eleştirilmesi yoluyla inşa edilmiştir. Buna ek olarak, bu tartışma dahilinde, Türkiye'deki hemşirelerin profesyonelleşmeden uzaklaşma sürecini anlamak için bir toplumsal cinsiyet boyutu da önemli olacaktır. Hemşirelerin mesleki iktidar alanları olarak tanımlanan bakım, bakım sağlanan kişi ile ilişki kurmayı gerektirdiğinden, meslek içerisinde ayırt edici ve özerk bir alan olarak inşa edilemez. Bu nedenle, ilişkisellik kavramını hemşireliği bir meslek olarak tartışırken sorunsallaştırmak gerekir. Tezin de kendi örneklemi içerisinde değinmeye çalıştığı hemşireliğin meslekleşme sürecinde hemşirelerin karşılaştığı birçok sorun mevcuttur. Hemşirelik mesleğinde beceri kavramının inşasının arkasındaki kültürel kodlar, sağlık sektöründe özellikle hastanelerde toplumsal cinsiyete dayalı ilişkiler ve iş bölümleri ve hem cinsiyet hem de bürokrasi yoluyla inşa edilen çifte hiyerarşi, Türkiye'deki hemşirelerin mesleklerini ayrı ve özerk bir şekilde inşa edememelerinin temel sebepleri olarak sıralanabilir. Hemşireler, genellikle kendi sektörleri içerisinde diğer meslekler tarafından gölgelenir ve hem devlet mekanizmaları hem de ataerkil mekanizmalar aracılığıyla manipüle edilirler. Bunun yanı sıra tez boyunca, ilişkiselliği, farklı bir meslek ve otonom bir alan inşa etmeleri için bir dezavantaj olarak inşa etmek yerine, ilişkisellik nosyonunun kaybı, ana sorumlulukları bakım faaliyeti olan hemşirelerin bu alanı yıllar boyunca kademeli olarak kaybetmesine yol açtığını anlatmaya çalıştım. Bu tez, Türkiye'de, hemşirelerin son 30 yıldır değişen mesleki deneyimlerini anlamlandırmaya çalışırken, sağlık alanında riskli ve güvencesiz bir çalışma ortamının, belirsiz mesleki sınırların, çalışma yükünün artmasının, ödenmemiş ek çalışma saatlerinin olduğunu da savunmaktadır. Bu durum, hastanelerdeki sağlık personelinin motivasyonları ve iş doyumları açısından mesleki doyumlarını etkilemiştir. Çalışmanın bu kısmı, nicel araştırma ile desteklenmeye ihtiyaç duymaktadır. Bakım emeğinin görünmezliği, bu anlamda, sadece kayıt dışı sektörde değil, aynı zamanda formel emek piyasasında, hemşirelerde olduğu gibi, karşılaştığımız sosyal bir

gerçektir. Riskli çalışma ortamları, sağlık sistemindeki işleyişin kademeli değiştirilmesi, iş yükünün arttırılması, Türkiye'nin sağlık sisteminde karşılaştığı bu dönüşümü anlamak için önemli bir araç olmaktadır. Bu anlamda bakım, hemşireliğin önemli bir parçası ve merkez eylemi olarak kabul edilir. Gerçekten de bakım; fiziksel, duygusal ve maddi bakım da dahil olmak üzere şemsiye bir konsepttir. Bununla birlikte, hemşirelik literatüründe bakımın ne olduğu ve tam olarak nasıl tanımlanacağı konusunda bir fikir birliği yoktur. Bakımın hastaların ihtiyaçlarına göre tanımlanması, mesleğin önemli bir bölümünü doğrudan hemşirelerin meslekleşme sürecinde müdahaleye açık hale getirmektedir.

Tezin bir diğer teorik tartışmasında ise, sağlıkta dönüşümün yer aldığı sosyal konjonktür kavramsallaştırılmıştır. Dünya'da yapısal reformlarla birlikte, sosyal ve ekonomik anlamda birçok alan değişim sürecine girmiştir. Neo-liberal dönüşüm, hayatın her alanında etkilerini göstermiştir. Sağlık, eğitim, hizmet sektörleri büyük ölçüde bu dönüşümden payını almıştır. Türkiye'de özellikle neo-liberal politikalar, 1980'lerden sonra da etkili olmaya başlamıştır, bu durum tezin odaklandığı tarihsel dönem açısından önem taşımaktadır. IMF ve Dünya Bankası'nın kararları ve müdahaleleri ile AB sürecinin içinde devlet ve ekonomik aktörler arasındaki ilişki değişmiş ve devletin rolü işgücü piyasasındaki rekabete katkıda bulunan bir aktör olarak yeniden tanımlanmıştır. Bu şekilde, devletin işgücü piyasasına müdahale alanını azalmış ve rekabeti arttıran bir araç haline gelmiştir. Bunlar, hemşirelerin değişen mesleki deneyimlerindeki dönüm noktalarını anlarken bu deneyimleri belirttiğim zaman aralıklarında (1988-1998, 1999-2009, 2010-2020) bulabilmem için çok önemli değişimlerdir. Tezde, bu değişim süreci, üç ana hedef üzerinden tartışılmıştır. Üretim süreçlerinde rasyonelleşme ve standartlaşma, çalışma saatlerinde ve iş gücünde esnekleşme neo-liberal dönemin en belirgin üç özelliğidir. Türkiye'de sağlık sektöründe son 30 yıldır yapılan bu değişiklikler, sağlık sektöründe hizmetin dağılımını ve işleyişini ve bakım-emek sürecini standartlaştırma, hasta ve işçi haklarını koruma ve iş yükünü kontrol etme çabaları açısından bu tezin önemli bir parçasıdır.

Bu değişiklikler Sağlıkta Dönüşüm Programının ve bir geri bildirim sistemi olarak "Performansa Dayalı Sistem" ve Kalite Kontrol ve Akreditasyon Sistemi gibi verimliliğin artırılmasına yönelik örneklerin etrafında şekillenmektedir. Daha önce de belirtildiği gibi, devam eden değişikliklerin bakım ve süreçte standardizasyon yoluyla değerlendirilmesi, bakım hizmetlerinin rasyonelleştirilmeye çalışılması, sorumlulukların ve zaman düzenlemelerinin esnekleştirilmesi Türkiye sağlık sistemindeki radikal değişimleri daha iyi okuyabilmek adına değerlendirmeye ihtiyaç duymaktadır.

Neo-liberalizm tek boyutta ve kültürel kodlardan bağımsız bir dönüşüm olarak okunmamalıdır. Sosyal ve kültürel farklılıklar, küresel değişimler için önemli şekillendirici faktörlerdir. Yerel çapta, bu dönüşümler tekrardan anlam ve boyut kazanırlar. Bu yüzden, bu tezin bağlamında, neo-liberalizmi saf ve tek bir yapı olarak incelemektense, kültürle birlikte hareket eden ve onun bazı dinamiklerini içselleştirip şekillendiren bir yapı olarak tanımlamak gerekir. Sağlıktaki dönüşüm ise, kamu hizmeti olarak okunduğunda bu dönüşümün bazı noktalarını daha belirgin ve keskin kılmaktadır. Bu yüzden, bu noktaların incelenmesi hem dönüşümün ne şekilde yaşandığı hem de ne gibi sosyal sonuçlar doğurduğunu anlamak açısından önemli olacaktır.

Daha önce bahsedildiği üzere, bu çalışmada, teorik tartışmalar iki bağlamda yürütülmüştür. Bunlardan ilki, hemşireliği meslek literatürüne oturtmaya çalışırken yapılan tartışmaları kapsamaktadır. Diğer bölümde ise, neo-liberal politikaların sağlık sektörünü nasıl etkilediğini anlamak üzerine, bu sosyal ve ekonomik yeniden yapılandırmanın teorik tartışmalarını kapsamaktadır. İlk bölümde, hemşireliği iş ve organizasyon sosyolojisi literatüründe konumlandırmaya çalışırken, ikinci bölümde, bu mesleğin değişim geçirdiği sosyal bağlam teorik olarak tartışılmıştır. Hemşirelik meslek olarak, neo-Weberyan çerçevesinden, mesleki kapanma (*closure)* tartışmaları çerçevesinden yürütülmüştür. Weberyan düşüncenin tanımlamasına ek olarak, hemşireler için ayrı bir özerklik alanı çizmekten ziyade, bu tartışmaya ilişkisel mesleki özerklik boyutu da eklenmiştir. İlişkisellik boyutu, hemşirelerin mesleki kontrol alanlarını anlamak için önemlidir. Gerek hasta ile olan ilişkileri,

hastanedeki diğer aktörler ve meslek gruplarıyla ilişkileri, geçişken bir otonom alanı yaratmaktadır. Bu noktada, bu ilişkiselliğin hemşireler için açtığı yeni kontrol alanları da çalışma için önem taşımaktadır. Örneğin, hemşirelerin hasta ile güçlü ilişkiler kurması, hastalar üzerinde hemşireler için daha fazla müdahale noktası açmaktadır. Yani ilişkisellik bu noktada, meslekleşme sürecinde hemşireler için mesleki kontrol alanları açısından büyük önem taşımaktadır. Bunun yanı sıra, bakımın literatürde tanımlanan önemli elementleri vardır. Bu elementler başlıca yüz yüze iletişim, güven ilişkisi kurmak, sabır, gizliliğe ve mahremiyete önem vermek, hastaya zarar vermemektir. Literatürde özellikle vurgulanan bu özellikler, hemşirelerin mesleki deneyimlerinin değişimini anlarken, bakım sürecinde hangi noktalara daha çok dikkat ettiğini ve bu değerlerini ne zaman kaybetmeye başladıklarını anlamak adına önemli olacaktır.

Tartışmanın ikinci bölümünde ise, neoliberalizmin yarattığı etkilerin sosyal bağlamda incelenmesi gerektiği ve yalnızca bir yönlü sonuçlar doğurmadığı tartışılmaktadır. Bu tartışmanın, hemşirelerin meslekleşmesi açısından önemi, kültürel kodlar taşıyan bir mesleğin, diğer mesleklerle aynı şekilde etkilenmeyeceğini vurgulamasıdır. Bunun yanı sıra, neo-liberalizm tartışması standartlaşma, rasyonelleşme ve esnekleşme tartışmalarından da yürütülmüştür. Bu üç kavram, daha sonra hemşireliği tartışırken önemli olacaktır; çünkü, bakımın ne kadar standartlaşacağı, emeğin hastane ortamında hangi noktada esnekleşebileceği ve hastane sürecinin kendisinin ne noktada tahmin edilebilir ve rasyonel bir süreç olabileceği bu bağlamda tartışılmıştır. Bunun yanı sıra, daha önce de belirtildiği gibi, Max Weber'in profesyonelleşme ve modernleşme arasında doğrudan kurduğu ilişki tez boyunca eleştirilmiş ve hemşireler için bu deneyimin bu tezin aksi olacak şekilde savunulmuştur.

Bu çalışma, emekli olmuş hemşirelerle birlikte yürütülmüştür. Örneklemdeki bütün hemşireler, çalışma sırasında emekli olmuş hemşirelerdir. Neo-liberal politikaların sağlık sektörünü ve çalışanlarını nasıl etkilediğini anlamak ve daha geniş bir zaman dilimi sunabilmek adına bu nokta önemlidir. Katılımcılarla ortalama bir buçuk-iki saat süren görüşmeler yapılmıştır. Çalışmada, sözlü tarih tekniği kullanılmıştır.

Görüşmelerden önce, görüşme esnasında sorulabilecek soruların temaları belirlenmiştir. Hemşirelere, önce mesleğinin ilk yıllarını anlatmaları, daha sonra da günümüz tarihine yaklaşarak mesleki deneyimlerinden bahsetmeleri istenmiştir. Bu temalar, hastane içi değişkenleri, hemşirelerin mesleğe başlama nedenlerini, nasıl bir eğitim aldıklarını, hangi servislerde görev yaptıklarını, diğer meslek grupları ile ilişkilerini, meslek içi ilişkilerini ve hasta bakımını ve deneyimlerini içermektedir. Alınan cevaplar sistematik bir şekilde, araştırmacının kendisi tarafından deşifre edilmiş ve kodlanmıştır. Elde edilen veri, alt başlıklara ayrılmış ve bir düzen yakalanmaya çalışılmıştır. Bu çalışmada önemli olan nokta, Türkiye'deki sağlık sisteminde yapılan değişikliklerin, bireysel ve mesleksel olarak nasıl deneyimlendiğini anlamaya çalışırken, mesleki uyum ve direnç yollarını da belirlemektir. Bu yüzden, sadece yapılan sistem değişikliklerini belirlemek bu konuda yetersiz kalacaktır. Literatürde yapılan Türkiye'deki sağlık dönüşümüne ek olarak, hemşirelere yani aktörlere görünür olan değişimler de bu çalışmada vurgulanmaya çalışılmıştır. Bu tez aynı zamanda bir vaka çalışması olarak yürütülmüştür. Vaka çalışmasının seçilmesinin en önemli nedenlerinden biri, sosyal bağlamda aktörleri incelerken belli bir sürece ve gruba odaklanarak, durumun detaylıca kavranabilmesinde yarattığı esnekliktir (Neuman, 2013).

Politikaların en çok etkilerinin gözlemlendiği noktalar, 1980'lerden sonra, kamu hizmetlerinde de etkili olmaya başladığı yıllardır. Bu dönüşümü anlatırken, hemşirelerin aynı zamanda kendilerini mesleki olarak nasıl konumlandırdıkları ve mesleki sınırlarını korumaya çalışırken ne gibi zorluklarla karşılaştıklarını ne gibi noktalarda direndiklerini de anlamaya çalışmak, mesleki deneyimlerini anlamlandırmak açısından önemli olacaktır. Bu noktada, tezi daha kolay anlamlandırmak adına yaklaşık otuz yıl olan bu süreç, üç ana periyot halinde analiz edilmiştir. Birinci periyot 1988-1998 yıllarını kapsamaktadır ve daha çok hemşireliğin nasıl bir meslek olduğunu betimlemek amacı ile verilmiştir. Ayrıca bu periyot, diğer periyotlarla bir karşılaştırma yapmak açısından önem taşımaktadır. Değişimi anlatmak, değişim sürecini betimleyebilmek karmaşık bir süreçtir.

Bu noktada, değişimleri anlamaya çalışırken, değişimin getirdiği etkiler birden fazla noktada görülebilir. Bu değişim ve dönüşüm birbirine geçmiş süreçlerden ve etkilerden beslenmektedir. Bu noktada, hemşirelerin deneyimlerini periyotlara göre kategorize etmeye çalışmak sanıldığı kadar kolay olmamıştır. Bu yüzden, ilk periyottan sonraki iki periyot bazı noktalarda birbirleri ile örtüşmektedir. İkinci periyot, 1999-2009 aralığı üzerinde durmaktadır. Bu periyotta, sağlık anlamında Türkiye birçok değişime gitmiştir. Bu değişimlerden biri, Sağlıkta Dönüşüm Programının sunulmasıdır. Bu periyot daha çok hemşirelerin, değişen sisteme belli başlı noktalarda direnmeye çalıştıkları periyottur. Artan iş gücünün yanı sıra, bakım sürecini terk etmemiş ve onu mükemmelleştirmeye çalışmışlardır. Üçüncü periyotta ise hemşirelerin mesleki sınırlarını korumakta zorlandıklarını ve bazı becerilerini kaybetmeye başladıkları görülmektedir. Daha önce de bahsedildiği gibi, bu tez bağlamında, bakım hemşireliğin önemli bir aktivitesi olarak vurgulanmıştır. Özellikle, bu dönemde bakım sürecinde hasta ile olan ilişkilerinin hemşire yardımcıları gibi başka aktörler tarafından sürekli olarak kesintiye uğratılması hemşirelerin hasta ile olan güven ilişkisine zarar vermiştir. Güven ilişkisinin kesintiye uğraması, hemşirelerin mesleki olarak kontrol ettikleri bir alandan uzaklaşmalarına neden olmuştur. Aynı zamanda bu dönemde artan dosyalama işleri, sağlık sistemine getirilen Kalite ve Kontrol Sistemi, hemşireler için yeni görevler tanımlamıştır. Bu görevlerden birisi de elde edilen verilerin kaydedilmesi ve dijital ortama geçirilmesidir. Bu işlem, her ne kadar medikal sekreterler tarafından tamamlanması gerekse de gerek bütçedeki kısıtlamalar ve bunun getirisi olarak çalışan sayısındaki eksiklik, bu sorumlulukların hemşirelere bırakılması sonucunu doğurmuştur.

Sonuç olarak, analiz bölümü boyunca, hemşireleri, bazı noktalarda, profesyonelleşmeden, meslekleşmeden uzaklaşma sürecine karşı koymaya ve yargı alanlarını farklı alanlara ve diğer meslek gruplarının alanına genişleterek bu alanda emeklerini vurgulamaya çalıştıklarını gördüm. Bu durum, iki ana sebepten kaynaklanmaktadır. Her şeyden önce, hemşireler, aktör olarak hastanelerde iş gücü eksikliğini tek başlarına telafi etmek zorunda kalmaktadır.

Bu nedenle, mesleki alanlarını kapatmak, tek bir alanda uzmanlaşmak onlar için daha zor hale gelmektedir. Bunun yanı sıra kendi meslek sınırlarını, doktorlar veya stajyer doktorlar gibi hiyerarşik ortamda daha yüksek yerlerde bulunan mesleklere doğru genişletmişlerdir. Bu durum, sağlık sistemindeki değişikliklere hem bir uyum hem de aktör olarak kendilerini bu alanda göstermek için bir başa çıkma yöntemi haline gelmektedir. İkincil olarak, hemşireler alanlarını tıp alanındaki bitişik mesleklere doğru genişletmek zorunda kalmaktadır. Bu demek oluyor ki, daha önceden yapmak durumunda olmadıkları, görev tanımında olmayan işler, resmi olmayan bir şekilde kademeli olarak yıllar boyunca hemşirelere yıkılmıştır ve bakım sektöründe, özellikle hastane içerisinde emek açısından her türlü eksikliği karşılayan tampon bir meslek haline gelmişlerdir. Buna ek olarak, artan bürokratik mekanizmalar, mevcut sorumluluklarının yanı sıra hastanelerde dosyalama sürecine de hemşirelerin atanma durumunu beraberinde getirmektedir. Bu şekilde, ana faaliyetlerini, bakım süreçlerini bu ek sorumluluklarla birlikte tamamlamaya çalışırlarken, bütünsel bakım anlayışı, hemşire yardımcıları ve diğer meslek gruplarının müdahalesi ile kesintiye uğradığı için zayıflamaktadır. Bu durum, hasta ile yüz yüze ilişkide bir kayba ve bu nedenle hastada hemşire için bir güven ilişkisi kuramamaya yol açmıştır. Hemşireler, hasta üzerindeki ana hakimiyetlerini güven ilişkilerinden kurdukları için, hasta üzerindeki etki alanları ve karar verme süreçleri bu şekilde zayıflamaya başlamıştır. Bu noktada amacım, ayrı bir özerklik yaklaşımından ve onun kaybedilmesinden ziyade, hemşirelerin hastayla ilişkisel özerkliğinin nasıl zayıfladığını ve temel faaliyetlerinde buna bağlı olarak nasıl bir azalma yaşadıklarını tez boyunca vurgulamak olmuştur. Hemşireler, yıllar boyunca, emeklerini ve kendilerini görünür kılmak için bazı noktalara direnmişlerdir. Direnme stratejisi olarak bir süre, becerilerini diğer mesleklerin sınırlarına doğru genişletip bakım sürecini vurgulayıp, mükemmelleştirdiler. Bunun sonuncunda ise, emekleri açısından daha da görünmez kaldılar ve meslek içinde karar verme sürecine uzak kaldılar. Bu şekilde meslekteki merkezi kontrol alanlarından uzaklaşmaya başladılar.

Özetlemek gerekirse, hemşireler gerek iş yükünün artması gerek başka aktörlerin bakım sürecine dahil olması ile birlikte mesleki kontrol alanlarını kaybetmeye başladılar. Bunun en önemli örneği, bakım sürecinin kademe kademe başka çalışma gruplarına aktarılması ile başladı. Bütüncül bir bakım süreci felsefesini izlemeye çalışan hemşirelik, kısıtlı zaman ve artan iş yükü arasında, hemşire yardımcıları gibi aktörlerin de medikal ve tıbbi bir alana girmesi sonucunda hasta ile kesintisiz olan ilişkilerini kaybetmeye başladılar. Bunun Weber'in savunduğu şekilde, mesleki olarak özerkliklerinin kaybetmeleri aksine, hastaları ile olan ilişkiselliklerinin zayıflaması ile doğrudan ilişkili şekilde betimlenmiştir. Bunun yanı sıra, hemşirelerin hastanede artan yan sorumlulukları, merkez sorumlulukları ile yer değiştirmeye başlamaktadır. Hemşirelerin hastanedeki sorumlulukları, bakım yapmaktan başka bir alana kaymış ve daha çok dosya ve kayıt tutma olarak dönüşmüştür. Belirtmek gerekir ki, bu süreç onların emek piyasasında direkt olarak profesyonel alanlarını kaybetmeye başlamasından öte, yeniden mesleki bir çerçeve kurulmasına dair bir süreç için bir başlangıç da olabilir. Bu sürecin uzun süredeki etkileri daha uzun dönemi kapsayacak gelecek çalışmalarla daha iyi betimlenebilir.

Son bir not olarak, neo-liberalizmin ve araçlarının Yeni Kamu Yönetimi Bölümündeki Yeni Sağlık Paradigması'nda tartışıldığı gibi sosyal bağlamda şekillendiğinden ve bunun gelecek çalışmalar için öneminden bahsetmek istiyorum. Daha önce de belirttiğim gibi, neo-liberal dinamikler, kadınların çoğunlukla diğerlerine göre yoğunlaştığı işgücü piyasası üzerinde her zaman daha fazla dönüştürücü olmuştur ve bu yüzden toplumsal cinsiyet açısından tarafsızdır denemez. Türkiye'de hemşirelik durumunda, bu nedenle, meslek tartışmasına ek olarak, toplumsal ve kültürel kodların bu mantığa nasıl entegre olduğunu göstermek için teze toplumsal cinsiyet boyutunu eklemek istedim. Bu yüzden bu tezin konusu daha da derinleştirilerek, feminist paradigma yoluyla daha fazla araştırmaya ihtiyaç duyulmaktadır. Kadınların bu süreci deneyimleme biçimleri, küresel yeniden yapılanmanın ve bunun kadınların emek ve deneyimi üzerindeki etkilerinin daha iyi anlaşılması için bu önemli bir boyuttur.

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