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Narrative Meaning Productions of Compassionate Healthcare: An Examination of Cultural Codes, Organizational Practices, and Everyday Realities

by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of
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DEDICATION

For Rob and Violet

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ABSTRACT

This dissertation examines the social complexities of emotion in healthcare; employing a multi-level narrative approach that explores the cultural, organizational, and interactional aspects of “compassionate care.” The central question I ask is: How do cultural beliefs and values surrounding compassionate healthcare inform organizational practices and the lived experiences of individuals providing such care? This project highlights the largely overlooked cultural, structural aspects of emotion, demonstrating how pervasive collective values and beliefs become institutionalized, and how such standards inform everyday experiences of healthcare providers.

CHAPTER ONE:

INTRODUCTION

Healthcare work is extremely demanding. Providers face a variety of challenges in providing care, including a lack of resources, ever-changing policy implementation, and innovations in protocols and technologies. A large body of literature has examined the psychological impacts of healthcare work, particularly in regard to “burnout” (Maslach 1982), a state of physical, emotional, and mental exhaustion often related to stressful work environments. Researchers have estimated burnout among physicians to be as high as 70% globally (Lamothe et al. 2014), which is directly related to quality of care (Poghosyan et al. 2010), as well as a contributing factor to turnover (Potter et al. 2010).

Emotional exhaustion is a factor that can contribute to burnout (Maslach 1982), and more specifically, “compassion fatigue,” which Figley (2002) described as a “cost of caring” for others who have experienced trauma. As healthcare work is foundationally a caring profession, it makes sense that researchers have focused on the ongoing problem of burnout and how emotional aspects of the work can negatively impact worker satisfaction and quality of work life (e.g. Ferrans 1996). Further, researchers have demonstrated how compassion fatigue can result in decreased productivity and higher turnover (Pfifferling and Gilley 2000), and there are ongoing efforts to ameliorate this persistent problem, primarily through mental health interventions such as the Accelerated Recovery Program (ARP) (Gentry and Baranowsky 1998).

While frontline healthcare workers in general, and nurses specifically (Joinson 1992), have been found to be vulnerable to compassion fatigue and burnout due to the nature of their work, there is an ongoing public discussion about the need for *more* compassion in healthcare (Shea, Wynyard, and Lionis 2014). Such concerns have resulted in various organized efforts to address this problem, including changes to medical education (Patel et al. 2019) and the development of academic outlets such as the *Journal of Compassionate Health Care,* (founded in 2014). It is clear that compassion is no longer simply an implied expectation of good providers but has been explicitly written into codes of medical ethics (American Medical Association 2016; Wang 2016). This project is centered within the context of the seemingly contradictory social problems of (1) burnout and compassion fatigue among health care workers, and (2) a lack of compassion in healthcare.

The issue of compassion in healthcare has been examined mostly from a psychologically-rooted conceptualization of compassion; treating compassion as something about individuals, experienced privately, with consequences for people in terms of emotional affect and personal perceptions. For example, in a meta-review of compassionate care in health literatures, Sinclair et al. (2016) found six primary themes, each of which are focused on perceptions: the nature of compassion, development of compassion, interpersonal factors that relate to compassion, action and practical compassion, barriers and enablers of compassion, and outcomes of compassion. The tendency of health researchers concerned with compassion to examine the perspectives of individuals, through mostly survey methodology, results in a limited understanding of this important topic. There has been less attention to the ways compassion is related to social structure. Particularly relevant to this research is Brown and Flores' (2011) article that examines "how compassion and hope can spur the creation of and become embedded within institutions which, in turn, impact upon the diffusion of these emotions across society" (2011: 62). Brown and Flores (2011) call for continued empirical attention to the ways compassion is enacted within institutions. My dissertation takes up this invitation and highlights interconnected narrative meaning productions as related to compassionate healthcare.

In this dissertation, I tend to the complex, largely taken for granted social aspects of emotion in institutional worlds; employing a macro-meso-micro approach that explores the cultural, organizational, and interactional complexities of compassionate care. The central question I ask is: How do cultural beliefs and values surrounding "compassionate healthcare" inform organizational practices and the lived experiences of individuals providing such care?

This dissertation contributes to existing scholarship in two main ways. First, this research contributes a multi-level perspective of emotion and narrative in healthcare. More specifically, I demonstrate the need to move beyond attention to individual experiences of emotion and examine cultural and organizational aspects of meaning construction. Second, this project contributes a qualitative approach to examining compassion in healthcare, which is largely absent from multidisciplinary scholarship. In addition to theoretical and empirical contributions, this project speaks to practical concerns of policy-makers, institutional actors, and administrators regarding healthcare delivery and outcomes by moving beyond positivist research design, which must be done in order to explore the layered, subjective complexities of emotion at various, entwined levels of healthcare.

EXTENDING THE SOCIOLOGY OF EMOTION: SOCIAL PRODUCTIONS OF COMPASSION

While sociologists have long recognized the importance of altruistic emotions in social order and behaviors, there is a lack of explicit attention to compassion. Theoretically, this is important, as within the sociology of emotions there is "conceptual untidiness" (Loseke and Kusenbach 2008: 512) in regards to empathy, sympathy, and compassion. For example, Cooley's (1992:132) definition of sympathy, "entering into and sharing the minds of other persons" is understood by contemporary scholars as *empathy* (Jacobs 2006; Ruiz Junco 2017), whereas Clark (1997) suggests that empathy is a prerequisite to sympathetic concern. Nussbaum (2001) describes how sympathy, empathy, and pity "appear in texts and in common usage, usually without clear distinction" from one another, and often reflect what others refer to as "compassion." Thus, it is clear that feelings related to helping behaviors are similar and often related, but there is a need for distinction. Empirically, attention to compassion in sociology is limited and is primarily concerned with feelings and behaviors of individuals, as seen in research on charity shop volunteers (Flores 2014), breast cancer and antirape activists (Blackstone 2009), mental health care practitioners (Brown et al. 2014), and displays of compassion in childbirth (Walsh 2010).

The focus on individuals is predominant in the sociology of emotions, in part due to Hochschild's (1983) influential framework that relies upon a Marxist and Freudian scaffolding. Research in this tradition is primarily concerned with the exploitation and alienation that come as a result of emotional demands, particularly of employment. This framework has inspired a tremendous breath of empirical work in a variety of professions (Meanwell et al. 2008).

Despite Hochschild's (1979) assertion that social life is organized by framing rules, feeling rules, and expression rules which inform individual experiences of emotional labor and management, this framework largely takes for granted the social processes that construct such standards of emotion. I approach "compassion" as an emotion code (Loseke 2009) created through discourse; a set of cultural guidelines that communicates emotional standards and expectations for social actors. What is particularly important is how emotion codes are created and become embedded within institutions which informs practical consequences for individual actors. This approach considers the "*social* nature, origins, and consequences of emotion" (Kusenbach and Loseke 2012: 35, emphasis in original) by answering Bericat's (2016: 505) call for "a greater degree of integration between theory and empirical research, structural and cultural approaches, and micro- and macro- perspectives" (Bericat 2016: 505) within the sociology of emotions.

EXTENDING NARRATIVE SOCIOLOGY: MULTI-LEVEL PRODUCTIONS OF COMPASSION

As with the sociology of emotions, narrative research has been primarily focused on experiences of individuals, or "self-stories." In contrast, this project shifts attention from personal stories to cultural and organizational narratives. I am primarily concerned with the ways cultural narrative resources inform organizational practices, as well as everyday experiences of workers in healthcare settings. Through this perspective, I illuminate consequences of storytelling beyond those for individuals.

Our social world is saturated with stories; they create meaning at every level and in every realm of social life. Narratives are tools to make sense of the self, others, and experiences, as well as emotions – categories that are often difficult to define. Cultural narratives are those recognizable stories of that reflect unspoken widely shared values and beliefs (Quinn 2005), such as the "American Dream" (Loseke 2018); a formula story (Berger 1996) that reflects collective ways of thinking and feeling about the United States and what it means to be a "good American." Cultural narratives offer meaning-making resources for organizations, groups, and individuals –

who choose how to employ cultural resources to make sense of social worlds and experiences (Gubrium and Holstein 1997; Quinn 2005).

Cultural meanings are largely taken for granted social codes of collective thinking, feeling, and morality, and they become powerful as they are institutionalized (Alexander and Smith 1993). Narratives told by institutions and organizations construct various "institutional selves" (Gubrium and Holstein 2001), such as "substance using clients" (Selseng 2017) or "Alcoholics Anonymous members" (Pollner and Stein 1996). These narrative processes organize how types of services are provided (Allahyari 2000), for which types of people, and influence interactions within organizational worlds (Geiss 2019). As such, narratives are not merely consequential symbolically, but quite practically.

In moving beyond a focus on individual storytelling, researchers can explore multi-level complexities and paradoxes that are inherently sociological, rather than limit the importance of stories to psychological concerns.

EXTENDING MEDICAL SOCIOLOGY: PROMOTING AND PROVIDING COMPASSIONATE CARE

This dissertation contributes to medical sociology in two main ways. The first contribution is my analysis of shifting professional expectations of emotion for healthcare workers. Previous attention to this topic has focused on the ways the medical profession has historically prioritized a code of "affective neutrality" (Parsons 1951) and "detached concern" toward patients (Fox and Lief 1963) in order to maintain a position of professional authority and expertise. Other research has demonstrated that physicians are encouraged to maintain an emotional state of "indifference," and attachment to a particular case or patient is understood as a problem (Daniels 1960). Similarly, Smith and Kleinman (1989) found that discussions of personal feelings in medical school was considered taboo, and the avoidance of faculty to address emotional aspects of medicine maintained a standard of “emotional neutrality,” informing how students developed strategies in managing their own emotions. My project continues this line of research, examining how organizations assist in shifting emotional expectations and standards toward empathy and compassion.

The second main contribution to medical sociology is through my use of narrative; examining stories of health organizations and healthcare providers. Narrative research in medical sociology has been primarily concerned with experiences of illness (Frank 1995; Kleinman 1988) and has shed light on the various challenges experienced by patients. However, there is a tendency to treat patient stories as insights into “hyperauthentic version of actors’ experiences or selves” (Atkinson 1997: 343). This emphasis detracts attention from the important cultural, institutional, and contextual aspects of narrative that inform such individual accounts. Further, the focus on illness narratives has left stories of providers largely ignored and undertheorized.

POSITIONALITY AND METHODOLOGICAL CONSIDERATIONS

Part of my initial interest in this research topic comes from my personal exposure to healthcare work through family members. Like all types of workers, they often share stories about various challenges; managing dying patients, administrative changes in protocols and charting systems, disagreements with co-workers, and an overall lack of resources. While they often talk about the technical aspects of their work, they less commonly discuss the emotional aspects of the job. I can relate to their stories on some level as a curious healthcare researcher, however I realize my comprehension will always be limited by my position as a distanced spectator. I will never know what it feels like to have a parent counting on me to successfully remove their child’s cancer, watch a patient die on the operating table, feel ribs crack below my hands from doing CPR, or push life-saving drugs into a patient's veins. I have a personal commitment to more comprehensively understand the experiences of frontline healthcare workers, who are often depicted as simply uncaring and callous in social science scholarship and in the social world more broadly. Most importantly, I believe that understanding the experiences and perspectives of workers can inform more equitable, improved models of healthcare.

Aside from informing my practice of reflexivity throughout the research process, my personal relationship to healthcare workers was practically helpful in snowball sampling to recruit nurses for interviews. Through this technique, there was a greater level of initial trust from participants. Further, my personal ties to healthcare work helped in developing rapport with interview participants. At times during interviews, I shared about my connections to family members in the medical field and related their experiences to help participants feel comfortable sharing aspects of their work that are "unspeakable" to most outsiders. This conversational approach to interviews resulted in incredibly rich data, as demonstrated in chapter four of this project.

CHAPTER DESCRIPTIONS

To examine how cultural beliefs and values surrounding "compassionate healthcare" inform organizational practices and the lived experiences of individuals providing such care, I employ a multi-level approach to examine macro, meso, and micro levels of narrative meaning production.

Chapter 2: Cultural Conventions of Compassionate Healthcare

In this chapter, I ask two main research questions: (1) What are the cultural meanings associated with compassionate care? (2) How is compassionate care informed by institutional structure? To explore these questions, I use narrative analysis to examine symbolic and emotion codes in publicly circulating stories promoted by The Schwartz Center for Compassionate Healthcare (SCCH), an American nonprofit leading global efforts in prioritizing compassion in healthcare. My analysis for this paper is based on 34 profiles of healthcare providers nominated for The SCCH's National Compassionate Caregiver of the Year Award, curated patient stories of compassion promoted on the organization's YouTube channel, and the organization's Twitter posts related to stories and benefits of compassionate care. Through analyzing stories featured on the organization's web presence, I demonstrate how The SCCH constructs a formula story of the "compassion-worthy patient," which centers a blameless victim patient, a plot of empathetic connection between patients and providers, and moral lessons that communicate psychological, clinical, and institutional benefits of compassionate care. While seemingly innocuous, this cultural code establishes *institutional* and *interactional* guidelines of compassionate care in terms of deservingness, morality, and emotionality. Further, I demonstrate how "compassionate care" is informed by and reinforces existing institutional structuring of medicine.

Chapter 3: Organizational Mediation of the Compassionate Caregiver

This chapter shifts attention from cultural meanings to organizational practices and is guided by two main questions: (1) How do organizations promote a shifting emotion culture of compassion in healthcare? (2) How do shifts in emotion culture inform collective professional identity work? The data for this chapter's analysis come from publicly accessible resources on the SCCH's website that tend specifically to the organization's signature program, Schwartz Rounds; meetings designed for healthcare workers to make sense of emotional aspects of their work. My sample is composed of six webinars, three white papers, two news articles, and one featured story titled, "Supporting Caregivers on the Front Lines of Care." Using narrative analysis, I examine the organizationally supported production of "compassionate caregivers," and collective emotion management practices. I demonstrate how Schwartz Rounds assist providers in collaborative meaning-making to reconcile grief, doubt, guilt, and frustration; emotions incongruent with the moral identity code of the compassionate caregiver. These sessions also assist workers in transforming negative emotions into feelings of pride, closure, and resilience to make sense of a moral professional self.

Chapter 4: Managing Everyday Troubles of Compassionate Care

This chapter continues to explore compassionate healthcare by centering on the experiences of providers tasked with providing such care. I focus my attention on the perspectives of nurses, as nursing is the profession in medicine most historically and culturally linked to "caring" and "compassion." In this chapter I ask two main questions: (1) How do cultural ways of thinking and feeling inform the everyday experiences of doing "compassionate care?" (2) How do nurses reconcile a moral sense of self when lived experiences conflict with cultural values and beliefs? To examine these questions, I use in-depth interviews with a diverse sample of eleven hospital nurses working in a variety of departments, including the general floor, post-anesthesia care, transplant, operating room, neonatal intensive care unit, wound care, and Hospice. Through narrative interviewing (Gubrium and Holstein 2009), I explore the relationships between personal experience, institutional order, and cultural resources, and demonstrate how cultural codes of "doing good" inform everyday troubles, moral identity production (Kleinman 1996), and the development of emotion management (Hochschild 1983) tactics to reconcile meaning disjunctures.

Chapter 5: Discussion and Conclusion

In the final chapter of this dissertation, I discuss the theoretical, methodological, and practical contributions of this project and suggestions for future research.

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CHAPTER TWO:

CULTURAL CONVENTIONS OF COMPASSIONATE HEALTHCARE

ABSTRACT

This paper extends attention to compassionate healthcare by moving beyond analyses of individuals; guided by two main research questions: What is the cultural meaning of compassionate healthcare? How is compassionate healthcare organizationally promoted? My virtual narrative analysis of the Schwartz Center of Compassionate Healthcare demonstrates the construction of a formula story that that operates through (1) characterizations of the "compassion-worthy patient," (2) plots of empathetic connection and compassionate action between patients and providers, (3) morals that communicate the personal, clinical, and institutional benefits of compassion in healthcare, (4) with specific appeals to administrative audiences. I argue that as this formula story becomes a cultural code, it serves as an organizational model that establishes expectations and yardsticks of deservingness, morality, emotionality, and efficiency in healthcare. This paper demonstrates the need to move beyond examinations of emotion as individual-level phenomena and the need for continued empirical attention to the construction of cultural meanings in conjunction with organizational structuring and interaction.

INTRODUCTION

The healthcare system in the United States faces multiple problems; one of which is described as a lack of compassion and dehumanization (Shea, Wynyard, and Lionis 2014). The persistent discourse on the failings of healthcare due to a lack of compassion has resulted in efforts to write "compassionate care" into the ethical code of conduct for healthcare professionals (Wang 2016). While some scholars and medical professionals support these efforts as a way to improve patient outcomes (e.g. Lown et al. 2011), others are concerned that doing so is futile, overlooks potential pitfalls, leads to increased emotional labor (Hochschild 1983) and burnout of medical providers, and results in a "culture of perfunctoriness and cynicism" (Wang 2016: 7).

The issue of compassion in healthcare has been examined mostly from a psychologically-rooted conceptualization of compassion; treating compassion as something felt and enacted by *individuals*, experienced privately, with consequences for people primarily in terms of emotional affect. For example, in a meta-review of compassionate care in health literatures, Sinclair et al. (2016) found six primary themes; each of which are focused on perceptions: the nature of compassion, development of compassion, interpersonal factors that relate to compassion, action and practical compassion, barriers and enablers of compassion, and outcomes of compassion. Sociological attention that centers the topic of compassionate healthcare has been minimal. Previous research includes attention to compassion in childbirth (Walsh 2010), compassionate health policy and practices (Singleton and Mee 2017), and the practical compassionate work of mental health practitioners (Brown et al. 2014).

Particularly relevant to this article is Brown and Flores' (2011) research that examines the public discourse of the British National Health Service and hospice movement;

demonstrating “how compassion and hope can spur the creation of and become embedded within institutions which, in turn, impact upon the diffusion of these emotions across society” (2011: 62). Brown and Flores (2011) call for continued empirical attention to the ways compassion is enacted within institutions. My paper takes up this invitation; furthering this line of research by examining “compassionate healthcare” as *cultural* phenomena constructed through discourse, which informs the organizational structuring of healthcare. Specifically, this paper is guided by two main research questions: What is the cultural meaning of compassionate healthcare? How is compassionate healthcare organizationally promoted? To examine these questions, I employ an original method of virtual narrative analysis – an approach that tends to the complexities and fluidity of narrative productions of meaning in virtual social contexts.

This paper begins with a discussion of narrative as a way to examine the cultural and organizational meaning production of compassionate healthcare. I then outline my use of narrative analysis and methodological choices. Next, the first part of my findings section demonstrates how the Schwartz Center of Compassionate Healthcare promotes a formula story that relies on: (1) characterizations of the “compassion-worthy patient,” (2) plots of empathetic connection and compassionate action between patients and providers, and (3) narrative morals that communicate the personal, clinical, and institutional benefits of compassion in healthcare. The second part of my findings section examines how the SCCH employs Twitter as an organizational tool that persuades target audiences to enact institutional change in the name of compassionate care; couching narratives of compassion in administrative, capitalist logic. I conclude this paper with a discussion of furthering this line of research and stress the theoretical and practical value of examining the ways cultural meanings are constructed in relation to structure, process, and interaction.

EXAMINING CULTURAL ASPECTS OF EMOTION THROUGH NARRATIVE

The social world is inundated with stories; they are pervasive in all aspects of social life, in all cultures, and in all historical moments. Simply stated, humans are skilled "storytelling animals" (MacIntyre 1984) and stories, or narratives, are tools of meaning-making. Stories typically contain settings, plots, and characters that communicate lessons (morals) to audiences. For example, a story about a person who loses their job for being late to work coveys the morality of punctuality. As such, stories do not merely construct meaning for authors (self-stores); stories encourage audiences to think and feel in particular ways. Narratives are embedded with unspoken cultural meanings (Quinn 2005) and they provide a way to uncover hidden aspects of social life (Polkinghorn 1988).

This paper focuses attention to formula stories (Berger 1997), or those stories that are composed of familiar and predictable characters, plots, and morals. They operate through use of symbolic codes (Alexander 1992) and emotion codes (Loseke 2009) that serve as cognitive models, communicating boundaries of meanings to audiences. Symbolic codes are cultural ways of thinking, or systems of ideas about how the world works (logical appeals) or should work (moral appeals) that inform "what audiences think they know, what they value, what they regard as appropriate and promising" (Davis 2002:17-18). Emotion codes operate similarly through discourse (Abu-Lughod and Lutz 1990) and serve as models of feeling rules, framing rules, and display rules (Hochschild 1979) that "organize and structure the ways we express our emotional states and respond to others" (Tudor 2003: 241). Symbolic and emotion codes encourage audience evaluations about story characters, plots, settings, and morals. For example, a pervasive system of meaning in stories of help commonly feature the character of a victim (symbolic code) that is evaluated as worthy of sympathy (emotion code) and help (Clark 1997).

Formula stories are pervasive as they are composed of deeply embraced social codes. For example, in the United States *the* cultural narrative is the American Dream, a pervasive, widely circulating story about a specific type of person, the “good American,” who is characterized by a particular type of motivation and behavior to work hard in order to achieve success. Within this story widely shared cultural codes of individualism, capitalism, and family operating together, this story as a cultural code itself, or a model of how people *should* act and how the world *should* work (Loseke 2019: 27). This formula serves as a cultural code (Alexander and Smith 1993), which is so pervasive that “individual instances of [the American Dream] can be recognized even when audiences are *not explicitly told* that a particular story is an instance of this type of story” (Loseke 2019: 26, emphasis added). In other words, formula stories are largely taken for granted social codes of collective thinking, feeling, and morality that are built into various aspects of social life and inform personal, organizational, and institutional storytelling. My specific concern is how such codes inform standards of healthcare.

Cultural Meanings in Organizational Worlds

Cultural systems of meaning become powerful as they become institutionalized (Alexander and Smith 1993), organizing not simply the collective conscious (Durkheim 1961), but *standards* and *behaviors* within social structure. Narratives at the meso-level construct various “institutional selves” (Gubrium and Holstein 2001) that justify and structure the organization of services provided (Allahyari 2000). For example, categorizations of people such as “substance using clients” (Selseng 2017) or “Alcoholics Anonymous members” (Pollner and Stein 1996) designate who is served by a particular organization (and who is not) and in what ways. “Target populations” (Schneider and Ingram 1993) are diverse; with some types of services for people culturally evaluated as moral, worthy of sympathy and help, while others as immoral, worthy of punitive responses such as condemnation or punishment. These categories provide members' resource (Garfinkel 1967) for interactions within organizational worlds.

As organizational structuring is informed by cultural meaning systems, so are interactions within them. Cultural meanings are part of a "tool kit" (Swidler 1986) of resources and practical actors do everyday work to uphold, challenge, or adapt such pervasive systems of meaning to make sense of their social worlds and experiences (Gubrium and Holstein 1997; Quinn 2005). For example, in my previous research (Geiss 2019), I demonstrate how social service workers manage culturally pervasive notions of "help," that are reflected and reinforced through public storytelling. Case managers at a child mentoring organization described that while glamorized images are effective in generating public support (absolutely necessary for non-profit organizations), these images added to the difficulties of their everyday work in managing the expectations of unpaid volunteer mentors. For example, volunteer mentors would question how they were making a difference if their child mentee was not easily recognized as a victim in need of help. Workers described performing emotional labor techniques of "drama dilution" to meet organizational goals of keeping mentors and mentees together. As such, narratives are not merely consequentially symbolically, but quite practically.

Attention to narratives in sociology of health (and sociology more broadly), has been largely concerned with self-stories and individual sensemaking. There is a rich tradition that takes a narrative approach to understanding illness experiences (Frank 1995; Kleinman 1988); that while useful in understanding the lived experiences of illness, has a tendency to treat patient stories as insights into "hyperauthentic version of actors' experiences or selves" (Atkinson 1997: 343). This emphasis relegates the importance of narrative to the psychological logic; largely ignoring the cultural and institutional contexts that inform such individual accounts. It is particularly important for health researchers to tend to the ways that narratives are "*simultaneously* about the personal, the social, and the cultural" as well as "private life as well as about public social processes, social forces, and social institutions" (Loseke 2019: 85, emphasis in original). This paper illuminates how organizationally promoted narratives are informed by cultural ways of thinking and feeling; which ultimately inform structural and interactional guidelines.

METHODS

To explore how cultural systems of meaning inform institutional structuring of compassion, this project employs a developing method of virtual narrative analysis that combines elements of virtual ethnography (Hine 2000), narrative ethnography (Gubrium and Holstein 2008), and formula story analysis (Loseke 2012). The primary goal of this method is to embrace the unbound, fluid, multi-directional nature of narrative doings in virtual spaces; emphasizing story content, context, and consequences. This developing approach answers Loseke's call for "more concerted attention to developing methodological techniques for examining how [formula] stories work and the work these stories do" (2012: 265). Virtual narrative analysis is particularly useful for the study of organizations, as digital organizational worlds do not exist separately from physical spaces but are continuously *entangled* and influence one another in meaningful ways (Geiss 2019, emphasis in original).

While virtual ethnography (Hine 2002) informs my method of data collection (as I discuss in more detail below), virtual narrative ethnography does have some distinct differences. Virtual ethnography (as well as traditional ethnography) is particularly concerned with *people's* doings. However, narratives cannot (and should not) be confined to something of people, as this would be an oversimplification and limit understandings of the work narratives do in social life.

As narrative transcends analytical levels and social spaces, this requires methodological innovation that blurs the distinction between levels of analysis, as well as virtual and in-person social worlds.

Narrative ethnography (Gubrium and Holstein 2008) informs my approach, however, is conceptualized as best suited for in-person immersion. I draw from the tenants of this approach, emphasizing "the interplay between experience, storying practices, descriptive resources, purposes at hand, audiences, and the environments that condition storytelling" (Gubrium and Holstein 2008: 250). Scholars have recently begun employing virtual ethnography to explore narratives in the digital world (e.g. Busby and Laviolette 2006; Egner 2019; Underberg and Zorn 2013; Webb 2001), demonstrating a need for innovative methodology.

Site

The Schwartz Center for Compassionate Healthcare (SCCH) is an American nonprofit founded by Kenneth Schwartz, who was diagnosed with advanced lung cancer and near the end of his life became passionate about creating an organization that promotes compassion in healthcare. The center produces and distributes educational webinars, hosts an annual Compassion in Action Healthcare Conference, and recognizes exemplary compassionate healthcare professionals through the National Compassionate Caregiver of the Year (NCCY) Award. The SCCH also supports Schwartz Rounds, which are sessions designed for healthcare providers to discuss the social and emotional issues they face in their work. These events are held at over 600 healthcare organizations in the United States, Canada, United Kingdom, Ireland, Australia, and New Zealand.

Data

My entry point for data collection was through the SCCH website, where I followed linkages to connected virtual fields, such as the organization's public YouTube and Twitter accounts. My analysis for this paper is based on all 34 finalist profiles of healthcare professionals nominated for the 2013-2018 NCCY awards, curated patient stories of compassion promoted on the organizational YouTube account, and the organization's Twitter posts from Oct 2017- Oct 2019 that promote stories of and benefits to compassionate healthcare. Other health research has analyzed YouTube data (see Kousha, Thelwall, and Abdoli 2012 for a review), including examinations of HPV vaccine coverage (Briones et al. 2011), obesity framing (Yoo and Kim 2011), and direct-to-consumer genetic testing utilizing narrative analysis (Harris et al. 2014) and is particularly relevant in examining cultural elements in publicly promoted narratives of compassionate healthcare.

I managed data by lumping and splitting data into various themes and subthemes; and tracing the connections between them. I began my analysis by closely reading all textual data and watching all of the videos in my sample, gaining a general understanding of the narrative context. I then uploaded text and audio transcriptions into N Vivo software program to analyze "culture in talk" (Quinn 2005). While conducting the initial stage of analysis in N Vivo, I watched the videos again, adding themes based on what is shown rather than merely stated. During these observations, I paid close attention to emotion performance, supplemental imagery, and story production.

I thematically and manually categorized data in N Vivo utilizing Loseke's (2012) approach to analyzing formula stories. I began by focusing on characters, plots, morals, settings, and potential audience interpretations, looking for patterns across stories. I asked questions such as: What are the qualities of a patient receiving compassion? What are the characteristics of a compassionate provider? The next step of my analysis focused on uncovering symbolic and emotion codes; questioning assumptions, beliefs, and values communicated within stories. Last, I asked questions about the consequences of these stories: What is the work of these organizationally promoted narrative? How might these stories inform institutional structuring, guidelines, and everyday interactions?

CULTURAL ASPECTS OF COMPASSIONATE HEALTHCARE

My analysis examines: What is the cultural meaning of compassionate healthcare? How is compassionate healthcare organizationally promoted? I focus on how cultural ways of thinking and feeling about compassionate healthcare inform a publicly promoted formula story that serves as a tool of persuasion, as well as a meaning-making resource for health professionals, patients, policy makers, and the general public. My analysis consists of two main sections: (1) story contents, including characters, plots, and morals, and (2) how such a story persuades structuring compassionate care through administrative, capitalist logic.

The Formula Story of Compassionate Healthcare: Characters, Plots, and Morals

The Compassion-Worthy Patient

Aristotle (1926) asserted that compassion is informed by three key judgements: that the suffering of another is *serious*; the suffering is *undeserved*; and that one's *own* possibilities are similar to those who are suffering (see also Nussbaum 2001, emphasis added). The formula story of compassionate healthcare exemplifies these understandings; reliant upon a medical recognition of suffering and a moral evaluation of deservingness informed by western values and belief systems.

All of the patients featured in the public organizational stories of compassionate care can be culturally understood as victims in some way; and the vast majority of patients can be easily evaluated as “pure victims,” or individuals who have been unjustly harmed through no fault of their own (Best 1997; Holstein and Miller 1990; Loseke 2007). The symbolic code of victim organizes a variety of “helping” human services, social problems groups and advocacy, and the promotion of this categorical, simplistic, image is an effective tool in persuading audiences that a problem exists, and those affected are in need of and deserving of concern and help (Clark 1997; Dunn 2004, 2008); in this case, compassionate care.

The SCCH stories commonly featured characters such as “the good parent,” “the innocent child,” and “the good American;” all types of people that are culturally recognized as respectable, moral people, whose lives were interrupted by accident or illness. Jessica’s story featured on the organizational YouTube account provides an example:

> When I first found out that I had breast cancer I had a three month old baby. I thought the whole world was perfect and had gotten to just the place I wanted to be in life. And I found a lump accidentally in the shower and thought my whole world was ending; that it was all crashing in and I was going to be leaving this beautiful little daughter behind.

Jessica’s life prior to her diagnosis was, in her words, “perfect.” She had just quit her job to stay home with her new baby, an admirable decision when evaluated through American cultural beliefs of motherhood. She is clearly not only responsible, but loving, dedicated, and fulfilled by her family. Jessica exemplifies the “caring mother.” Later in her story, a nurse described when she first saw Jessica: “I went around the corner and there was this lovely [*not ugly*] young [*not old*] woman with a baby stroller and I remember all of us just, ‘oh please don’t let that be the patient,'" portraying an expected sentiment toward this type of patient. The majority of patients featured in stories can be categorized as "the good patient" character: brave fighters with supportive families and friends, a hopeful attitude, courageous, and life goals despite diagnosis and treatment. Part of Jessica's story features her doctor recalling their first meeting:

> Jessica was very quick to mention that she had just had a baby and she was thinking about another child as well. And so those types of cues gave me the sense that Jessica was already looking at her life not just a cancer diagnosis but her life in terms of being able to do what she had to do the conquer cancer…That really gave me the confidence and security that Jessica was going to be somebody who would be able to conquer the diagnosis and really have a fulfilling life as a cancer survivor.

Despite her cancer diagnosis, Jessica tells the doctor about her dedication to achieving her life goals; including not only being a good mother to her newborn child, but also in having a second. As such, Jessica's doctor describes her as having the potential to be a cancer "survivor." Such patients were often described as "inspirations" or "heroes."

While the vast majority of patients were portrayed as pure victims, there were some stories that featured the character of the "homeless person," a more contested image that does not as easily call up cultural evaluations of deservingness. For example, one story from a NCCY award profile highlights a homeless patient who was diagnosed with terminal cancer:

> Michael [MD] first met Charles [patient] in a soup kitchen. Earlier in his life, he had been a successful man with a family until his world collapsed when his daughter died in a car accident. Charles became homeless and slept under a

> bridge, where he was everyone's protector, helping them find resources, which he denied himself.

This excerpt highlights Charles, a "successful man" who became homeless, not because of his own lack of motivation (which would result in negative audience evaluations based on the cultural code of individualism), but because he lost his daughter tragically in a car accident, which affected him to where he was unable to continue his everyday life. These indicators encourage feelings of sympathy, rather than pity or disgust. Charles is not described as a "vagrant" (a portrayal that would result in a negative audience evaluations), but as a selfless helper who puts others before himself. *All* of these traits are culturally admirable and construct a person worthy of sympathy and assistance.

However, some patients featured in the NCCY award profiles could be evaluated as not so exemplary, more deviant, such as "the drug user," who might be commonly understood as having caused their own problems or as villains for putting others at risk. This type of negative image lends more to an emotional and behavioral evaluation of fear and control, rather than sympathy and compassion. When such contested types of patients were featured, their deviance was medicalized (Conrad and Schneider 2010), as demonstrated by an excerpt from Rosie's NCCY profile about working with patients who are drug users:

> She finds herself troubled especially when she knows a patient is lying to her but recognizes this is part of the disease. "They're protecting their best friend," she says…. Says another (co-worker), "Rosie understands that addiction is a complex disease. For those who struggle, who slip, who fail, Rosie is always there – never abandoning them, always welcoming them, always trying to find ways to keep them alive."

In emphasizing that troubling, immoral behaviors such as lying are direct consequences of disease, blame is removed from the individual which encourages the emotion of sympathy. In this example, medicalization serves as a tool of victimization; doing important moral character work that is congruent with sympathy. This story not only constructs drug user patients as worthy of sympathy and compassion, but the *provider* as moral. Within this characterization, Rosie is a superbly compassionate provider, as she is able to provide compassion to even *deviant* patients when deservingness is questionable.

Across stories, patients were largely diagnosed with cancer, or were involved in an accident of some kind. *None* of the patients featured could be evaluated as having *caused* their illness (for instance, founder of the SCCH Ken Schwartz who was diagnosed with and died of lung cancer was explicitly identified as a "non-smoker"), communicating blamelessness, an important qualifier of "victim." As patients are cast as victims, they are culturally understood as deserving of sympathy; a precursor to empathy and compassion, which is constructed through plot elements.

Plots of Empathetic Connection and Compassionate Action

As sympathy can further distance the sympathizer and the recipient (Clark 1997), empathy is a necessary next step of compassionate care in these stories; linking the observer (in this case, health providers) to the person suffering (patients). In the formula story of compassionate healthcare, empathy is constructed through plot development of deep connections between patients, families, and providers. Through this plot, compassion is reaffirmed in terms of Aristotle's third qualifier: the observer can come to understand the suffering of another as a possibility in their own life.

It was very common distinctions of “patient” and “provider” to be blurred throughout stories; many featured providers who have been patients and a persistent theme that providers could find themselves in the “Johnny” (hospital gown) at any time. For example, the most widely circulated SCCH YouTube video (with over 30,000 views) titled “An Accidental Doctor,” features a physician who was electrocuted and thrown over 20 feet, resulting in multiple amputations. The accident inspired him to become a doctor and informs his empathetic approach to patients:

> Medicine would be a place I could use these experiences. You use your own humanity, that's your source; that's your wellspring. That you sort of look at your own life and see your own suffering that's the platform for empathy that's the platform for connection… [My patients] take one look at me and they know I've been in the hospital bed. I don't have to explain it. I don't have to say anything. You know, it's not doctor here [*holds hand up as a measure*], patient here [*lowers hand*]; all of a sudden, it's human to human.

There is a persistent emphasis on recognizing the “inherent” human connection between patients and providers throughout stories; empathy was commonly described as a key element of humanity generally and compassionate care specifically. The SCCH stories highlight deep relationships forming between patients and providers, often times as a friendship or family-like bond. Many of the organization’s YouTube videos were produced in a sequence that after introducing patients, a story descriptor appeared on the screen: “a relationship begins” or “a special relationship.” For example, the story of Todd, a patient with vascular disease and diabetes, and his doctor described the “rewarding relationship they developed over the course of [his] lengthy treatment.” Todd reflects on how he views their relationship:

> We've grown together and when we first met, we were both young professionals and setting out on our way and then all these we've had children the same age. It's been a great relationship for both of us… in a word it is longevity, because we've developed a trust and a friendship…It's the difference between, you know, friendship and acquaintances. I'm acquaintances to most of my doctors, but Bill is truly a friend of mine.

Throughout the SCCH stories, providers were portrayed as extremely close to patients and their families; building relationships in and outside of medical settings. Providers were regularly depicted interacting with patients outside of healthcare settings; they attended patient funerals and were invited to birthday parties; one was asked to be the maid of honor in a patient's wedding. It was common for providers to be referred to as "part of the family," which is exemplified by the story of Katherine and her nurse Lisa, as narrated by Katherine's sibling and mother:

> The week before she died, she had a seizure and actually Lisa was there for the last three days that Katherine was alive. She had a place in our family just as much as any one of our siblings and my parents did because she had been so important to Katherine that it seemed only natural that she should be there at the moment… At one point Lisa tried to leave the room and the kids wanted her right back, "No, please stay in here with us;" because we knew she was going to die.

Not only was the relationship portrayed as highly valued by the family, but also by the provider. Lisa described: "They're my link to Katherine, but I'm their link to Katherine because I related to her on a different level. And I think that's how we hold on to her; we hold on to her together."

This type of connection is portrayed as a fundamental component of compassionate care and is emphasized throughout the SCCH stories. One nurse provided her perspective on compassionate care and advice to other caregivers: "If I could summarize compassionate care in just one word, I would use, 'love'… If you could put yourself in a position where you're thinking of the patient as your own family member, your own spouse whom you love, and treat them the way you would expect your person to be treated – with love, kindness and competency." This quote demonstrates Sprecher and Fehr's (2005) concept of compassionate love, a type of compassion that includes tenderness, caring, and self-sacrificing; all of which are values aligned with the cultural code of "family."

Another plot element that follows an empathetic connection is compassionate *action* for patients and families. Berlant (2004) describes compassion as most clearly an "emotion in operation" (p. 4). Compassion is not merely a feeling; it is tied to behaviors. While most of the promoted stories feature deep connections and friendships between patients and providers guiding compassionate action (such as attending funerals, birthday parties, and so forth) there is also potential for compassion in brief, seemingly banal occasions. Compassion is performed throughout the stories in a variety of ways; ranging from "small acts of kindness" such as a soft touch on the shoulder, a warm smile, or asking about a patient's personal interests; emphasizing how compassion can be built into action during mundane, everyday interactions and that *anyone* at *any time* can be compassionate- from surgeons to parking attendants, and that doing so takes little time and effort.

Narrative Morals of Compassionate Healthcare

Stories communicate moral lessons; something to be learned by audiences. The morals promoted by the stories of the SCCH support the organizational mission: compassion is a vital component of effective healthcare and therefore medicine must be restructured to reflect this. Benefits of compassionate healthcare are portrayed as threefold: improved clinical outcomes and satisfaction of patients, greater personal fulfillment and job satisfaction for providers, and ultimately improved systems of care.

Throughout the stories promoted by the SCCH, there is an emphasis on the clinical importance of compassion. It was extremely common for compassion to be portrayed as an integral aspect of quality health care; just as important, if not more than, medical knowledge and expertise. One NCCY care team profile describes that “technically complex care will never replace the healing power of a simple act of kindness.” Compassionate care is portrayed as something that can relieve symptoms and plays a critical role in clinical outcomes. For example, one NCCY profile features a story of such success:

> “A patient who had been in a vegetative state during his treatment came back to visit Pallavi [MD], having returned to full health. He told her he remembered every word she had spoken to him and that her compassion had meaningfully contributed to his recovery,” says a colleague.

This story validates the organization’s call for compassionate care; appealing not only to shared notions of morality and emotion, but to medical logic that upholds the familiar and pervasive restitution narrative. This example portrays that compassionate care is medically impactful and can assist in the ultimate medical goal of cure and further communicates that even when patients cannot express gratitude or verify the benefits of compassionate care received during treatment, that compassion has a long-lasting impact. This type of story instills the belief in “seed theory” (Geiss 2019); that even though results may not be immediate or observed during care, they will come potentially long after care is provided.

Stories also communicate the benefits for healthcare professionals in providing compassionate care. Throughout stories, it was common for providers to be described as attracted to working in medicine to help other people; some NCCY stories featured providers who left other professions to make a positive difference through providing medical care. In connecting on a personal level with patients (practicing compassion oriented care), providers are portrayed as more personally fulfilled by their work. The NCCY profile of nursing assistant Jeffrey demonstrates this clearly:

> "I feel like I didn't choose oncology, oncology chose me," says Jeffrey, who believes that every encounter with a person is a chance to make a positive difference in that person's life. "If you're doing it right, you're going to get just as much out of caring for that person as that person is going to get from you."

It was common for stories to feature providers who work in healthcare to attain a moral identity (Kleinman 1996); demonstrating that health care is a moral, helping profession that requires a professional standard of compassion. There is a logic that in standardizing compassion in healthcare, there are greater opportunities for providers to align their work with personal and professional identity, which ultimately lowers feelings of "burnout."

The SCCH emphasizes that while providers are drawn to health care to "do good," there are persistent challenges to doing so, including the fast-paced and sometimes traumatic nature of the job that requires institutional support for healthcare workers. Throughout the promoted stories, particularly in the NCCY award profiles, there was an emphasis on the need to provide compassion to providers; and a logic that when this is done, a *culture* of compassion ensues. One NCCY story provides an example of the success that comes from such initiatives that support providers:

> "These initiatives continue to change the culture at Lakeside Community Health and have led to increased social connections, healthy coping and resiliency, and the improved overall happiness and satisfaction of the ICU team," colleagues report. "There is ongoing support of the team members in developing resiliency and meeting the emotional challenges inherent in delivering care…" Hannah also created a day-long program for caregivers to learn how to emphasize compassion in all care interactions…These programs have helped reduce burnout and stress.

Throughout award profiles, it was extremely common for nominees to have developed or taken part in programs designed to support healthcare colleagues. A number of these nominees were directly involved with Schwartz Rounds, the SCCH's program that serves as an interdisciplinary forum to address the emotional challenges of healthcare work. As such, these stories construct the notion that successes related to compassionate care is partially dependent upon services provided by organizations like the SCCH. Put simply, this narrative moral validates the organization itself.

Appeals to Administrative Audiences

Stories are told for a variety of reasons. For organizations, public storytelling serves organizational goals; persuading audiences to subscribe to particular claims and offered services. As my main concern in this paper is on the ways cultural meanings inform institutional structure, this portion of my analysis focuses on how such stories are packaged to appeal to healthcare leadership and administrators; audiences with power to initiate and support institutional change in the name of compassion. In this portion of my analysis, I treat the SCCH Twitter account as a narrative supplement, guiding audiences on how stories of compassionate care should be read and understood as important to improving healthcare systems.

As demonstrated in the above analysis section, it was common throughout stories to convey the importance of helping providers avoid burnout by implementing self-care programs and initiatives such as Schwartz Rounds to support an effective model of compassionate healthcare. The SCCH employs Twitter to further situate the importance of such support through administrative appeals that rely on bureaucratic, capitalist measures of institutional success. For example, the SCCH explicitly reminds audiences of the financial costs associated with burnout, arguing:

> Did you know that doctors in the U.S. experience symptoms of burnout at almost twice the rate of other workers? According to a new study published in the Annals of Internal Medicine, this very human problem also has major financial implications.

Throughout stories and Twitter posts, compassionate care is constructed as a way to prevent burnout and turnover. Providers are portrayed as more fulfilled and more passionate about their work when connecting to patients and more likely to support one another, resulting in lower instances of burnout and the financial troubles that come as a result.

In addition to financial savings in reducing burnout, the SCCH also describes how models of compassion and support for providers can result in other measurable benefits such as a reduced rate of medical errors and higher measures of safety. For example, one Tweet states: "Fearless healthcare organizations create psychological safety. Better teams are more willing and able to reveal errors, which then enables improvement #compassionmatters." As such, the SCCH promotes that in institutionalizing compassion, institutions can observe measurable improvements such as higher quality assurance and safety, which translates to lower rates of insurance claims and financial loss.

The SCCH also provides administrative justification for compassion by mediating the practical concern of time (and therefore, money) lost in order to provide such care. In addition to the plot of the above formula story that demonstrates how compassion can be built into small actions, the organization's Twitter account further alleviates such concerns by sending posts such as, "40 seconds of compassion can change everything for a patient." Another tweet from the organization shared an article titled, "Does Taking Time For Compassion Make Doctors Better At Their Jobs?;" furthering this point through medical research:

> [Researchers have] found that compassion doesn't just benefit its recipients, but it also makes caregivers feel as if they have more time. For doctors, this point is crucial – because 56% feel they don't have time to be empathetic.
>
> #compassionmatters

This tweet from the SCCH not only alleviates concerns of providers having less time when compassionate care is implemented; it suggests that providers will feel as though they have *more* time. As such, administrative logic might follow that in institutionalizing models of compassionate care, there may be an expected *increase* in the number of patients seen along with a diminished rate of provider stress. This is of particular concern for healthcare administrators who are tasked with ensuring "efficiency" and managing budgetary restrictions.

In addition to a solution for problems related to providers, the SCCH constructs compassionate healthcare as important for patient outcomes and measurable institutional improvements. As demonstrated in the above formula story, compassionate care often relies on a plot of restitution, with predictable morals of improved patient outcomes. The SCCH's twitter account provides further evidence specifically regarding the clinical importance of compassion;

it was very common for compassion to be constructed as not only a supplement of "good care," but as a medical treatment in itself. For example, one tweet states:

> Studies show that compassionate healthcare environments were found to be more effective than aspirin in preventing heart attacks or stopping smoking habits. #compassionmatters

Other research is promoted in the SCCH's twitter posts, including work that describes how compassion can help cure the common cold and how conversations between patients and providers can be "as potent an analgesic as many treatments we prescribe." One NCCY award nominee is featured in a tweet stating, "Science has now proven that compassion is not a luxury but an imperative for survival." As compassion is medicalized as a fundamental clinical treatment, it becomes imperative to provide in quality healthcare.

Not only is compassion constructed as a medical necessity, and therefore vital to quality clinical outcomes; it is promoted by the SCCH as a way to improve other healthcare metrics. For example, one tweet communicates how compassionate care can increase rates of patient compliance:

> If a patient thinks his physician cares for him or is concerned about him, he's more likely to trust her. And a patient that trusts his physician is more likely to follow her advice and plans for treatment. #compassionmatters

The SCCH promotes that compassion is a way for hospitals and care facilities to not only improve patient satisfaction scores, as patients feel like they are cared for. The above tweet also communicates that compassionate care translates to higher rates of patient adherence.

Such claims are artfully composed by the SCCH and are targeted to those institutional actors with positions of power and the ability to approve institutional changes. The SCCH does not merely emphasize the importance of compassion for individuals, but also for healthcare *systems* more broadly. There is a clear and practical administrative logic: compassionate care can reduce provider burnout and medical errors, as well as improve clinical outcomes, patient compliance, and satisfaction ratings. Perhaps most important for administrators and leadership, compassionate care is a lucrative investment. *All* of these claims can be translated into quantifiable indicators used to evaluate the performance of healthcare institutions. As such, in institutionalizing compassion, there are *measurable* quality improvements that go well beyond personal feelings and moral standards of "doing good."

DISCUSSION AND CONCLUSION

With the persistent concern of a lack of compassion in the United States' healthcare system (Shea et al. 2014), organizations such as the SCCH have begun to address how compassionate healthcare can be achieved. While there is growing empirical attention to compassion in healthcare (see Sinclair et al. 2016 for a review), there is an overemphasis on the ways individuals experience and understand compassion; employing a psychological understanding of compassion. Within sociology, there is minimal attention to the topic (Brown and Flores 2011; Brown et al. 2014; Singleton and Mee 2017; Walsh 2010) and largely overlooks the ways cultural meanings are attributed to "compassionate healthcare" and how they inform healthcare structuring.

This paper focuses on the cultural meanings of compassion and how such meanings are promoted organizationally. As the success of the SCCH depends on the ability to appeal to very diverse audiences, including patients, families, healthcare professionals, health administrators, policy makers, and donors; public organizational storytelling *must* resonate culturally in order to operate as a successful non-profit. My analysis shows that through skillful deployment of cultural codes, the SCCH promotes a formula story that features (1) characterizations of the "compassion-worthy patient," (2) plots of empathetic connection and compassionate action between patients and providers, and (3) morals that communicate the personal, clinical, and institutional benefits of compassion in healthcare, that (4) appeal to administrative audiences. As such, storytelling serves as an organizational tool that appeals to logic, emotion, and morality; persuading audiences of need to structure compassionate healthcare.

Such organizational stories may seem benign; however, I argue that as this formula story becomes a cultural code in its own right, it serves as a model of healthcare that establishes expectations and yardsticks of deservingness, morality, and emotionality. This formula story communicates the *types* of patients who are deserving of compassionate care (and those who are not), with plots that convey *how* empathy and compassion should be enacted, received, and perceived, and moral lessons that promote expected *outcomes* of providing compassionate healthcare. These cultural meanings are powerful as they inform healthcare structure, becoming embedded in rules, policies, and protocols. As cultural codes serve as implicit social contracts, there are implications for practical actors when such idealized standards fail to capture the complexities of daily life. Unique individuals are tasked with the everyday work of negotiating cultural and institutional boundaries of meaning; adhering to, challenging, or modifying such typifications.

The formula story of compassionate healthcare relies on the symbolic code of victim. While a strategic characterization in that "victim" is tied to evaluations of sympathy and help (Dunn 2004, 2008), this typified image is troubling as it communicates that in order to be a recipient of compassionate care, patients must more or less conform to the image of the "good patient," which reaffirms existing power dynamics. The victim image excludes a *tremendous* breadth of patients who are not easily evaluated as “blameless;” for instance, patients who have cancer from smoking, those who contracted a disease from sharing needles, or those who visit the emergency room with “foreign objects” in their rectum are most obviously absent from organizational storytelling; such images muddy the formula of compassion and put the success of public storytelling in jeopardy. The formula story analyzed in this paper most clearly communicates that those patients who deviate from “victim,” are culturally unworthy of compassionate care. As other research on legal systems (Dunn 2002) and social services (Geiss 2019; Kolb 2014) have shown, the category of victim informs institutional order and action; how services are provided, for whom, and in what ways. Adherence to or distancing from “victim” informs day-to-day interactions in organized social worlds (Geiss 2019), and importantly, the life chances for those served.

In addition to the consequences for those individuals navigating healthcare, this narrative production is also concerning in terms of reliance on bureaucratic, capitalist justification of compassion. As demonstrated in the fourth section of my analysis, compassionate care is portrayed as not merely a way to provide good care, but that it is *effective*; a way to improve measurable healthcare outcomes and generate higher profits. While this image is likely effective in persuading administrators to support such initiatives, when outcomes do not align with these images, it would be expected that such initiatives would lose support. As such, there are consequences not only for individuals, but also in terms of structure.

This paper demonstrates the need to empirically tend to how cultural meanings *come to be* and operate in organizational worlds. Rather than treating culture as merely a social force “out there” operating in the background, largely taken for granted, there is a need to understand the reflexive relationships of meaning production. There is additional research to tend to the ways are “*simultaneously* about the personal, the social, and the cultural” as well as “private life as well as about public social processes, social forces, and social institutions” (Loseke 2019: 85, emphasis in original). To extend this line of research, questions that should be considered include: How is compassionate care institutionally enacted through institutional texts, policies, and protocols? How does the notion of compassionate healthcare inform change in organization and practice? What types of practical consequences are associated with such promotion? How is compassionate care understood by workers charged with putting ideals into daily practice? How do patients negotiate conventions of compassionate care and what does this mean for treatment? How might cultural systems of meaning influence life chances for patients?

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CHAPTER THREE:

ORGANIZATIONAL MEDIATION OF THE COMPASSIONATE CAREGIVER

ABSTRACT

This paper examines how cultural systems of meaning inform organizational practices of promoting compassionate healthcare. My document analysis of the Schwartz Center for Compassionate Healthcare's (SCCH) signature "Schwartz Rounds" demonstrates the ways organizations mediate the moral identity of the "compassionate caregiver" in ways that create an emotion culture shift in medicine. My analysis demonstrates how the SCCH assists in the emotion management of healthcare providers through (1) making sense of "difficult" patients and families, (2) managing personal feelings of grief, doubt, and guilt, and (3) finding pride, closure, and resilience. This article emphasizes the need to examine relationships between culture, structure, and interaction to more fully understand multi-level aspects of compassion in healthcare specifically, and emotion in social worlds more generally.

INTRODUCTION

There are many problems in healthcare systems in the United States and across the globe, one of which is described as a lack of compassion and dehumanization (Shea, Wynyard, and Lionis 2014). The persistent discourse on the failings of healthcare due to a lack of compassion has led to institutional shifts. For example, in 1980 the American Medical Association added a new clause at the top of the Principles of Medical Ethics: "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights" (American Medical Association 2016). Such ideological shifts have informed organizational strategies to promote compassion in healthcare, which is the focus of this paper. Specifically, I focus on the work of the Schwartz Center of Compassionate Healthcare (SCCH), an organization leading the charge for promoting compassion in medicine.

My interests are specifically with the organizational techniques of emotion management and collective identity work for healthcare providers. Hochschild's (1983) concept of emotion management refers to individuals' efforts of aligning one's own emotions with those required by broader (cultural or organizational, etc.) feeling rules. While previous research has largely conceptualized emotion management as a practice of individuals, I apply this concept to practices of organizations to understand how collective emotion management tactics inform alignment with a professional culture of compassion and institutional change. Further, through employing a narrative perspective of emotion, I focus on the ways organizational practices inform and are informed by broader cultural meaning systems.

Further, I apply the concept of moral mediators (Geiss 2019) to the organizational work examined in this paper. I demonstrate how organizations model qualities of compassionate caregiving and promote techniques to "strategically monitor, maintain, and manage moral identity of others" (p. 539). These organizational practices support emotional shifts in healthcare professions by constructing an ideal type of compassionate caregiver, as well as mediate everyday troubles that fail to align with an identity code of compassionate caregiver.

I begin with a brief discussion of the historical shifts in the medical profession and situate contemporary shifts toward compassion as a meta-virtue in healthcare. Next, I provide an overview of the ways professional emotion cultures inform identity work and emotion management. I then outline my methods, data, and analysis, followed by a brief overview of the Schwartz Center (SCCH) and Schwartz Rounds. My findings section is composed of three parts that explore emotion management strategies to promote compassionate caregivers, including (1) making sense of "difficult" patients and families, (2) managing personal feelings of grief, doubt, and guilt, and (3) finding pride, closure, and resilience. I conclude with discussing the value of examining emotion in terms of organizational meaning-making, as well as the value of exploring how cultural meanings of morality and emotion inform institutional standards and practices.

SHIFTING EMOTION CULTURES AND EMOTIONAL SELVES IN MEDICINE

Professions have a wide variety of emotion cultures (Loseke and Kusenbach 2008: 516) that "include emotion vocabularies (words) and emotion discourse (the structure of talk), as well as complexes of expectations, standards, and ideals surrounding emotion." Such guidelines, what Hochschild (1979;1983) calls feeling and display rules, communicate what emotions should be expressed, toward whom, to what extent, and in what circumstances. Workers are trained (explicitly and implicitly) into local emotion cultures in order to acquire "emotional competence" (Lutz and White 1986: 424) required by professional standards and employers.

Researchers have demonstrated that emotion cultures within the medical profession have historically prioritized a code of "affective neutrality" (Parsons 1951) and "detached concern" (Fox and Lief 1963) toward patients in order to maintain a position of professional authority and expertise. Other research has demonstrated that physicians are encouraged to maintain an emotional state of "indifference," and attachment to a particular case or patient is understood as a problem (Daniels 1960). Similarly, Smith and Kleinman (1989) found that discussions of personal feelings in medical school was considered taboo, and the avoidance of faculty to address emotional aspects of medicine maintained a standard of “emotional neutrality,” informing how students developed strategies in managing their own emotions.

Such standards of emotionality more or less reflect the old paternalistic model of “doctor knows best,” in which patients are understood as largely passive and dependent upon physicians’ professional authority (see Parsons 1951). However, more contemporary models are those that emphasize shared-decision making (Charles et al. 1997) or patient-centered care (Barry and Edgman-Levitan 2012), where patients are collaborators in their own clinical decisions. Such models that aim to balance power and promote better care are not congruent with professional emotion cultures that prize detachment or indifference, but rather prioritize feelings of empathy and compassion.

While compassion is commonly understood as a trait of good healthcare providers and understood by some as a fundamental principle of medical oaths and a prerequisite to the profession (Hamilton et al. 2016), there is an apparent and relatively recent call to “restore humanity” and compassion in medicine (Shea, Wynyard, and Lionis 2014). Compassion is not an emotional requirement *explicitly* found in the traditional Hippocratic Oath (Miles 2004); only until recently have there been efforts to write compassion into standards of care. In 1980 the American Medical Association (2016:1) added a new clause, listed at the top of the Principles of Medical Ethics: “A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.” With the definition of compassion as an ethical standard, there have been a variety of efforts to encourage this type of care, including changes to medical education (Patel et al. 2019) and the development of academic outlets such as the *Journal of Compassionate Health Care,* (founded in 2014). While there are debates on whether or not compassion should be written into medical codes of ethics (Wang 2016), the movement of compassionate healthcare has clearly begun.

ORGANIZATIONAL MORAL IDENTITY AND EMOTION MANAGEMENT

With institutional shifts that prioritize compassion in healthcare, come shifts in expectations for those individuals working in health professions. A professional emotion culture of compassion most clearly relies upon cultural notions of morality and humanity, which requires a particular type of provider; the “compassionate caregiver.” In this paper, I treat “compassionate caregiver” as a type of moral identity; a social role (such as mother or social worker) that “testifies to a person’s good character” (Kleinman 1996:5). I demonstrate how organizations promote emotional expectations and standards of this particular moral identity code, as well as the organizational techniques of moral mediation.

One method of constructing identity is through narrative meaning-making – which takes place at every level of social life. At the meso level, stories construct institutional and organizational identities which justify and structure services and offer meaning-making resources for unique actors. Such stories produce categorical images of people served, such as “substance using clients” (Selseng 2017), “at-risk youth” (Geiss 2019), or “successful slimmers” (O’Toole 2018). Organizational narratives communicate standards and expectations for workers as well as clients. For example, public organizational narratives of sex work for disabled clients construct an image of a type of sex worker who is morally superior, compassionate, and a skilled medical practitioner (Geiss and Egner forthcoming). Put plainly, organizational narratives offer resources to make sense of the self.

Previous research has demonstrated the influence of organizations in narrative identity processes, predominantly through attention to self-help groups that transform types of people with particular emotional troubles, such as “Codependents Anonymous” (Irvine 1999), “Alcoholics Anonymous” (Pollner and Stein 1996), and families with “domestic disorder” (Gubrium 1992). For example, Zajdow’s (2002) research of the organization Al-Anon, a group for people who have alcoholic family members, demonstrated how the organization serves as an emotional community (Denzin 1989) where individuals can make sense of their emotions through storytelling. In this research, Al-Anon is described as an “emotion manager” for members, assisting in the development of new emotion rules.

In this paper, I examine how organizations narratively construct the “compassionate caregiver,” a particular type of healthcare provider that aligns with shifting emotion cultures in medicine. I am most interested in the ways organizations ascribe meaning to this identity category and the efforts in maintaining this type of professional moral self. I extend the concept of “moral mediators” (Geiss 2019); “organizational actors who work to strategically monitor, maintain, and manage the moral identity of others,” by shifting focus from individuals to organizations. In what follows, I demonstrate how organizations such as the SCCH assist in moral identity construction through narrative meaning-making and collective emotion management strategies.

SITE OVERVIEW AND METHODS

To study how “compassionate caregiver” is organizationally accomplished, I did a document analysis of the Schwartz Center for Compassionate Healthcare (SCCH), a leading organization promoting compassion in healthcare. This American nonprofit was founded in 1995 by Kenneth Schwartz, who was diagnosed with advanced lung cancer and near the end of his life became passionate about creating an organization that promotes the level of compassionate care he received as a patient. The mission of the SCCH is “to put compassion at the heart of healthcare through programs, education, and advocacy" (The Schwartz Center, "Who We Are"). The SCCH partners with other foundations and health organizations such as the American Diabetes Association, the American Heart and American Stroke Associations, the American Hospital Association, and the Arnold P. Gold Foundation.

Hundreds of healthcare organizations are members of the SCCH, including hospitals, hospice, and long-term care facilities in the United States, Canada, United Kingdom, Ireland, Australia, and New Zealand. Membership comes with benefits in the form of educational training, access to resources, and the rights to conduct "Schwartz Rounds," which is the SCCH's flagship program that attracts over 300,000 attendees annually. Schwartz Rounds (which I will also refer to simply as "Rounds") are designed for *all* types of people working in medical environments – physicians, nurses, social workers, administrators, bus drivers, and so forth; anyone who comes in contact with patients and families are welcome. These multidisciplinary events are designed for providers to regularly take time during their workday to discuss emotional issues they face when dealing with patients. The premise of these rounds is that "caregivers are better able to make personal connections with patients and colleagues when they have greater insights into their own responses and feelings" (Schwartz Center, "Schwartz Rounds and Membership"). In encouraging a professional emotion culture of compassion, there is a logic that providers will be more personally invested and fulfilled by their work, as a culture of compassion is conducive to a moral sense of self.

The SCCH is particularly concerned with burnout, high rates of suicide among physicians, and emotional detachment from work in general and patients specifically. Rounds are an attempt to mediate such troubles and "care for the caregivers," so they can continue caring for others.

Data

The data for this analysis come from publicly accessible resources on the SCCH website that specifically tend to Schwartz Rounds. After exploring the organizational website generally, I searched "Schwartz Rounds" with the website's search function which provided 160 results. To narrow my sample, I selected results to include based on the following criteria: (1) linked to an active, accessible page, (2) provided insights into the practices of Schwartz Rounds, (3) included narrative elements. This resulted in six webinars that were an hour in length each, four videos totaling approximately 25 minutes, three white papers, two news articles, and one featured story titled, "Supporting Caregivers on the Front Lines of Care."

I began my analysis by closely reading all textual data and watching all of the videos in my sample, gaining a general understanding of the narrative context of compassion in healthcare. Next, I did multiple close readings of the data to gain familiarity, focusing on characters, plots, and morals (lessons to be learned). The next step of my analysis involved categorizing descriptions and qualities of characters, particularly patients and families featured in storytelling. Following this, I examined symbolic and emotion codes by questioning underlying assumptions, beliefs, and values embedded within the data; "building blocks" of storytelling that reflect broader ways of thinking and feeling. Lumping and splitting the data into wide and narrow themes multiple times, while utilizing D'Andrade's (2005) discovery techniques, assisted in uncovering cultural and organizational systems of meaning. Lastly, I considered questions particularly relevant to understanding the consequences of such storytelling: How does organizational storytelling uphold or challenge cultural values and belief systems? What does this mean for everyday work of healthcare providers?

ORGANIZATIONAL CONSTRUCTION OF THE COMPASSIONATE CAREGIVER

In the following sections, I will demonstrate how Schwartz Rounds serve as a collaborative narrative forum to make sense of the everyday emotional complexities of compassionate caregiving. More specifically, these events assist healthcare providers make sense of experiences that do not align with cultural standards and beliefs about doing good in the form of compassionate care. This organizational emotion management is conducted in three main ways: (1) making sense of "difficult" patients and families, (2) managing personal feelings of grief, doubt, and guilt, and (3) finding pride, closure, and resilience. In doing so, the moral identity of "compassionate caregiver" is organizationally mediated to promote a shift in professional emotion culture in healthcare.

Making Sense of Difficult Patients and Families

Widely circulating stories of helping reflect and perpetuate taken-for-granted cultural ways of thinking and feeling. The cultural code of help, often promoted by social problems groups, advocates, and organizations, features a simplistic formula that reflects and reinforces cultural standards: pure victims – those individuals evaluated as good people who have been unjustly harmed for no good reason and through no fault of their own (Best 1997; Holstein and Miller 1990; Loseke 2007) – are deserving of sympathy and should be helped (Clark 1997; Dunn 2004, 2008). Indeed, as I have shown in the previous chapter, the SCCH tells a similar public narrative of the "compassion-worthy patient" who is most clearly a blameless victim and "ideal patient," easily evaluated as deserving of help in the form of compassionate care. While such a story can be successful tactic in bringing attention to various social problems, these codes simultaneously provide narrow resources of sense-making for practical actors seeking to construct a moral identity.

Schwartz Rounds serve as a forum to make sense of everyday troubles related to working with “difficult” patients; those patients who are not so easily evaluated as victims deserving of sympathy and help according to cultural ways of thinking and feeling. Put simply, the SCCH offers opportunities to make sense of providing compassionate care to patients not typically understood as deserving or blameless. For example, the SCCH focuses attention to the opioid epidemic, as the “drug addict” is historically associated with a moral evaluation of being at fault for their own troubles, due to making poor life choices. To assist providers in finding compassion for this type of patient, the SCCH has dedicated attention to the “opioid epidemic,” as demonstrated by a wide-reaching, multi-site, shared Rounds topic of “What Happens to Compassion During an Opioid Epidemic?” These sessions were described by the SCCH in a white paper (Lown 2017) as a way to:

> foster reflection about the impact of this epidemic, to share perspectives and examine assumptions…the Center hoped that participants would emerge with renewed motivation to offer understanding and support to each other and self-compassion when empathy wanes, so that healthcare professionals may offer the full depth of compassion to those who are suffering in the wake of this epidemic.

Through these specific Rounds sessions, providers were described as having gained a “new or deepened understanding of SUD (substance use disorder) as a chronic illness rather than as a moral failing,” and should “remember that lying and manipulation can be a symptom of addition and not to take these things personally” (p. 8). Thus, in medicalizing addiction, blame is removed from SUD patients, constructing them as a victim worthy of sympathy and help. Further, “bad behaviors” of this type of patient, such as lying and manipulation, are transformed into symptoms of a medical condition rather than traits of a bad person. As quoted by one participant on the issue of “frequent flyers[1]:” “I like the idea of using the term, ‘comfort-seeking’ rather than ‘drug-seeking,” reframing this type of patient as one who can be empathized with, as we all know the desire to be comfortable.

Providing help of any kind is culturally understood as deserving of appreciation from the recipient. Indeed, showing appreciation is a key characteristic of the “ideal patient,” and patients receiving compassionate care. However, providers routinely care for patients who are far from this depiction, including those who can be most clearly characterized as villains – patients who are violent, abusive, intimidating, threatening, and hateful. Despite cultural meaning systems that promote a response toward villains as people in need of control and punishment, providers are expected to provide compassionate care, adhering to institutional and professional expectations. Rounds offer a way to make sense of this disjuncture. For example, one meeting was described in an article shared on the SCCH’s website (Purtil 2019) as focusing on a “pervasive but rarely acknowledged problem: acts of discrimination by patients against hospital staff.” During this featured session, a nurse shared a story about his experience with a verbally abusive, homophobic patient who assumed (accurately) that he was gay, shouting, “Go away…You’re filthy. You’re disgusting,” pushing him away during a critical emergency. The nurse continued: “My compassion shouldn’t change because of other people’s view of me, but that takes practice,” exemplifying the challenge of maintaining an identity of a compassionate caregiver during such interactions. Typical of Rounds design, other providers in the session shared similar experiences with abusive patients, as described in the article:

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[1] Frequent flyer is a term that refers to a type of patient who frequents the emergency room for care. This label is commonly associated with patients seeking drugs.

> The grotesquely racist patient who hurled bedpans at any caregiver of color who entered his room. The man saved from the brink of death by the hospital's experienced and diverse staff, who insisted on having only white male doctors as soon as he was well enough to speak. Another doctor shared that after she was groped by a patient, she found that only people outside the medical profession were truly sympathetic. Her fellow doctors had rationalized away so many similar experiences that they weren't able to empathize with her own. Later, another woman rose and shared, with a note of surprise in her voice, a sexually abusive thing a patient had done to her. She had never told anyone, she said. There was never a time she felt she could.

Health providers are expected to provide compassionate care to all people, some of whom in other social spaces would be most clearly deemed worthy of punishment or harm. For example, a terrorist or child abuser in the hospital receives compassionate care, while in the justice system receives a death sentence. Rounds offer a collective sense-making forum to openly discuss and reflect on "feelings that it doesn't feel ok to have," such as feeling that some patients do not deserve compassion. Rather than dwell on feelings of anger and frustration toward abusive patients and dismissive co-workers, Rounds conversations are viewed as forums of "self-care," and a way to unload negative feelings and connect with co-workers. Indeed, sharing difficult experiences and challenges serve a way to receive empathy and concern from other care providers and provide a restored state of compassion. This shift in focus away from troubles toward a sense of community is one of the goals of Schwartz Rounds; that providers will feel less isolated with their troubles and can help providers "walk away feeling grateful."

Rounds also included stories not only about types of "difficult" patients, but also the challenges that can come from family members who can be controlling, angry, irrational, unappreciative, have disagreements on end of life decisions, or interfere with the care plan. For instance, one video titled, "Understanding Schwartz Rounds" (Maben, Leamy, and Shuldham 2018) featured a story about a dying pediatric patient, Paul[2], and his angry father. The oncologist on the panel spoke about how "his dad's anger and frustration was causing disruption and the nurses felt unable to care for them both. As Paul's pain got worse, we all felt increasingly anxious. Eventually his dad had lost all faith in our ability to care for him, so the adult team took over Paul's care." The consultant described the case as one of the "three most difficult cases of my consultant career," continuing:

> I didn't gel with Paul's dad; all my usual tactics didn't work. A few days before Paul died, I wasn't feeling very well. If I could've stayed at home I would've, but by the time I got in it was clear he was dying. I was talking to a colleague and said, "People feel unsafe around Paul's dad." I didn't realize he was standing behind me. He asked me why I'd said that. It was awful. I would have never wanted him to hear that, but realistically that's how people felt. They felt scared of him. I was scared of him. I could barely speak. I've never felt so awful about anything. I don't remember how I drove home. When my colleague telephoned to say Paul had died, I collapsed. I couldn't work that day. I had to go home, I felt sick. I couldn't eat, sleep. It was a horrible mistake. I'd tried my hardest to help that family.

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[2] pseudonym

Despite panelists' attempts to do everything they could to help not only the child, but the family more broadly (which "should" result in displays of appreciation and respect), they were met with anger and disappointment. The panelists described a sense of hopelessness with this case; not only were they unable to save a child from cancer (the purest of innocent victims), they were unable to successfully manage the father's anger and maintain a moral sense of self. After the three panelists discussed their experiences, an audience member responded, "Thanks for sharing that. I think one of the things about grief is anger. Paul's dad was angry, and this was his way of grieving and it wasn't you that was doing badly, it was a combination of things. It was a very aggressive disease and a father grieving." This audience member's comments assist in preserving a moral identity by transforming the father's anger into grief, relieving blame from the care team and perceived failure. This type of audience incorporation is an important aspect of story transformation orchestrated by the SCCH, providing narrative resources to make sense of various troubles.

Transforming Feelings of Grief, Doubt, and Guilt

"Compassionate caregiver" is a moral role that comes with an ability to do good for others in need. This role comes with opportunities to earn what Kolb (2014) calls "moral wages," or a "sense of satisfaction… (of) living up to the demands of their moral identity code, and the positive feelings that come with it." Most commonly, Rounds topics addressed negative self-feelings such as grief, guilt, doubt, and helplessness, as related to perceived clinical failures. Through collaborative narrative sense-making, Rounds offer tactics for making sense of these emotions and moral identity dilemmas.

A significant amount of organizational planning goes into the storytelling processes of Rounds. For example, in an office hours webinar (Yuan and Scopin 2019) titled, "Case or Topic?

What to Discuss at Schwartz Rounds and How to Decide," included a variety of suggestions for Round storytelling including: "caring for a colleague, my first code, it's okay to cry, and when everything you've got isn't enough." One "universal" Rounds topic, "The Patient You Never Forget," was featured in a YouTube video of the same name. In this example, stories featured cases where providers were unable to receive moral wages, as they were not able to save a patient or provide a good outcome. For example, one doctor told a story about a time she was unable to save a child:

> I remember being confused and I knew, I just knew we were going to get her back. So, I said, "Let me take the chest," and I went up and started to do compressions because I thought maybe we weren't circulating the medicines around. And I knew we're gonna get her back. So, I started compressions and I don't know how long I was doing compressions…I looked again, and it was flatline. And then I felt some gentle but firm pressure on my hand at some point and I looked over my shoulder and it was her father, the paramedic who himself had done many resuscitations, and he was watching the scene and knew his child had died. And he was watching me be desperate to get her back. And when I reflect on it…I had lost my role. I couldn't fail because I was supposed to get this child back and he stopped my hand. So, he like, had this incredible compassion for me at this amazing time to say, "It's done, stop." And I hadn't been able to do that at all.

This patient story is most clearly a tragedy; despite the doctor's confidence and determination, they were unable to be the hero for an innocent child taken too soon. While the doctor described viewing themselves as a failure based on their role expectations, they were able to find some type of peace through the father's acknowledgement that nothing more could be done to save his child. This story communicates a clear narrative moral to other providers with similar experiences: if a parent can forgive you for not being able to save their child, then you can forgive yourself. This story offers a meaning-making resource for other providers to manage negative emotions associated with clinical failures and preserve a moral identity.

Rounds also tended to everyday ethical dilemmas, conflicted feelings over a patient's outcome, self-doubt, and fear of whether or not providers did "the right thing." For example, one session featured in a YouTube video titled, "Voices of Caregivers, Schwartz Rounds," (The Schwartz Center for Compassionate Healthcare 2013) included conversations about delicate life and death clinical decisions. The panel recalled a difficult case; a stat C-section for a mother with a full placental abruption which led to the birth of a "limp, blue baby with Apgar's of zero, who did not respond to pain and made no respiratory efforts." The panel discussed different emotional aspects of this case:

> *Nurse*: We really thought there was no hope here…we were going to call the code at 15 and we did our best, and at 14 minutes, I felt for the heart rate and there it was. And all of a sudden it's a whole different story and you get really frightened, well, you're excited that the heart rate's there and you've got a baby, but then you worried about, you know, how much damage has been done and what's happened and what's going on and what did *we* do. You know, was this the right choice to have done what we did?
>
> *Doctor*: The role we played in that is something that I think none of us feel comfortable; that 30 seconds ago we were going to call this baby dead and now

> we are calling him alive and he has a name…because we gave him one more dose of that epinephrine.

The panelists above described the emotional rollercoaster of clinical decision making, navigating feelings from hope, to fear and doubt in this high intensity scenario with an emergency childbirth. The doctor described the struggle of being in a position where everything can change based on one clinical decision, and the uncertainty of the life and death consequences associated with those choices. After sharing details about the case, audience members assisted in emotion management by offering examples of similar stories. One audience member shared a story about "an identical case and the baby *didn't* die:"

> It was about ten years ago and I just happened to be visiting someone in the hospital and got dragged into a case with the patient bleeding, saying, "Please do something, the last time this happened to me the baby died." It's been ten years. The baby does really nothing but drool. He's totally incapacitated but the family thinks that the doctors and the hospital were wonderful because we listened to them, did what they wanted us to do and they do have a baby. And I guess I had to feel good that I fulfilled their wishes, but I don't feel good that I gave them such a devastating situation.

This story provides a way to make sense of feelings related to a perceived clinical failure, by providing a meaning of "success" that is distinct from a medical definition of a good outcome. In this example, the physician describes how although the child is "incapacitated," he finds a moral payoff knowing the family is happy with the outcome and appreciative of the care they received.

In addition to managing feelings of uncertainty and disappointment, there was a common theme of managing provider feelings of guilt. For instance, in a SCCH white paper titled, "Using

Schwartz Center Rounds to Help a Community Recover After Tragedy" (The Schwartz Center for Compassionate Healthcare 2013), the SCCH described how guilt was the most common feeling providers experienced during the Boston Marathon bombings, which they discussed during Rounds: "guilt that they hadn't done enough at the scene, that they had been prevented from helping, that they weren't trained in how to care for patients in a trauma situation, or that they had left before the bombs exploded and opted not to return to the scene." The report goes on to cover how Rounds conversations offered techniques in transforming guilt into fuel for compassion. For example, a cardiologist framed guilt as something that can be "transformative:"

> Guilt is an indication you're a good person and if you give it a chance to work through your system, it will empower you to bring your best to your professional situation…It helps us to become better, more compassionate people and face, rather than turn away from situations. Guilt is good. It will run its course and be a source of power moving forward.

In transforming guilt from a negative, emotional hinderance to a positive, moral attribute, providers are able to view themselves as a good people with the ability to become more compassionate moving forward from this experience. The SCCH is concerned with caregivers' experiences with trauma, working during mass casualty events like the Boston Marathon bombing and mass shootings. These events are challenging for providers, as it is described that there are often feelings of guilt, as well as inadequacy related to the limited ability to help in these situations. One surgeon during the Boston Marathon Rounds managed this feeling of inadequacy by focusing on the success stories of patients: "We all did a very good job, and it's important to keep that in mind. Not that people aren't traumatized, but the majority are moving on, walking again, running again, dancing again" (p.3). Indeed, focusing on "the good" is a tactic I will describe in further detail below.

Pride, Closure, and Resilience: Moving Forward

The SCCH emphasizes the importance of organizing more positive, celebratory Rounds in addition to sessions addressing emotional troubles. These Rounds, such as "The Good Stuff: What Keeps Us Going" (Yuan and McDonnell 2016), focus on uplifting and inspiring stories; those that reflect widely shared systems of meaning regarding "doing good" broadly, and compassionate care more specifically. One example of how this is accomplished is through Rounds that include patients and families in Schwartz Rounds as panelists. On the SCCH webpage, "Giving Thanks to the Caregivers" as part of the "Inside Schwartz Rounds" series, there is a story that features how one Rounds session invited three families to share their experiences and say, "thank you."

> One family member praised an RN in the ICU who had performed Reiki on her mother. As the daughter described the touch and comfort her mother experienced, a peaceful feeling came over the room. Her story made everyone proud to be part of an organization that provides this kind of care and compassion to a grieving family.

This example shows how "compassionate care" can be provided in a variety of ways and that success in providing such care is not merely defined by saving a patient's life. Although the daughter's mother died, by expressing gratitude for compassionate care, the daughter and other families included in the panel "provided an invaluable gift to the staff members in the room that day" and "caregivers left feeling proud of what they do on a daily basis, but also re-energized to keep providing compassionate care to other families in need." This story communicates to providers that when compassionate care is provided, families and patients notice and appreciate such care. Indeed, throughout stories, there were no cases that featured a lack of appreciation for compassionate care. In sharing these stories, organizations assist compassionate caregivers in earning moral wages and fulfilling a moral sense of self.

The code of "compassionate care" encourages providers to build relationships and emotional connections with patients (as demonstrated in the previous chapter). However, due to the structuring of healthcare, it is common for healthcare providers to often be left unaware of how their efforts informed the life chances or outcomes of patients once patients leave the hospital or care facility. Through Rounds' inclusion of patient stories, there is an opportunity to find "closure" and reaffirm the importance of providing compassionate care. For example, one news story shared on the SCCH website (Burling 2011), featured a story about the transformation of a former patient:

> A young man who had walked into the hospital earlier this year on heroin and bleeding from a stab wound in his stomach – sat before her looking unrecognizably good. He'd been to rehab, put on weight, and gotten a job. He had come back to thank the staff for saving his life.

This patient story is successful in inspiring audiences, as it reflects cultural values. It features a young (not old) man who hit rock bottom due to drugs, who completely turned his life around through hard work, and has a second chance at life. This patient's story features a character transformation of the "drug addict" to a "recovered addict," who is on track to become a "Good American," all because of the compassionate care he received. In sharing this story, the SCCH assists providers in earning a moral payoff, as demonstrated by one audience participant who worked with this patient:

> It was just so moving to actually see him in person and see how well he was doing…I don't get to see the follow-up of how [patients] are doing afterward, unfortunately, unless they're not doing well and then they come back…It's refreshing to go back to the core of why I went into psychiatry and health care in general, that we are all there for the same purposes…It sounds somewhat corny to say we're here to help people, but we are…It reinspires us to go back to work and take a fresh look and stay connected with patients.

Through these organizational efforts, providers have opportunities to realize their contribution to a success story, which reaffirms a sense of "doing good." As stated in the above quotation, these types of stories "reinspire" providers to continue wanting to provide compassionate care for patients. Indeed, survivor stories are described as a source of healing for caregivers, with Rounds attendees describing how these stories "reminded me and others why we went into healthcare in the first place." As such, the SCCH curated storytelling assists providers earn moral wages by promoting particular stories that align with cultural standards and expectations of helping others.

DISCUSSION AND CONCLUSION

Compassion has shifted from an implicit expectation of good healthcare providers to a professional, institutional standard. As compassionate healthcare is written into codes of ethics (American Medical Associations 2016; Wang 2016), there have been explicit organizational efforts to promote a culture of compassion in medicine. This paper examines how the SCCH promotes a shift in emotion culture and moral identity of healthcare providers. Specifically, I demonstrate how organizational events, Schwartz Rounds, offer strategies of emotion management (Hochschild 1983) through structured and collaborative storytelling. In doing so, the SCCH serves as a moral mediation (Geiss 2019) organization that assists in managing the moral identity of "compassionate caregivers."

Previous research on the emotion culture of medicine has been largely concerned with the persistence of "affective neutrality" (Parsons 1951), "detached concern" (Fox and Lief 1963), and "emotional neutrality" toward patients (Smith and Kleinman 1989), particularly in relation to power dynamics between patients and providers. While some research has discussed the work of individuals in healthcare roles to provide "compassionate care" and affirm a moral sense of self (e.g. Doane 2002; Peter et al. 2016), there is a lack of attention to the ways organizations promote shifts in professional emotion culture and moral identity.

Hochschild's (1979;1983) framework emphasizes the influence of cultural "feeling rules," yet researchers have largely ignored *how* such rules come to be. As the construction of cultural standards of emotion is taken for granted, attention has remained primarily centered on the influence of feeling rules on individual practices of emotion management, limiting theoretical and empirical attention. As I demonstrate in this paper, there is a need to move beyond a "top-down" understanding of the relationships between cultures and emotion management to more comprehensively understand the social processes and consequences of emotion.

To further understand the relationships between culture, structure, and interaction, I employ a narrative perspective. Cultural images of doing good, which are widely valued and publicly promoted, tend to follow a predictable story: a pure, deserving victim receives a particular service, that results in an improved social location. This story is a familiar cultural code; the "service-worthy client" (Geiss 2019; Marvasti 2002; Spencer 1994), that informs organizational design and the ways social actors navigate services. While such pervasive images are largely taken for granted meaning-making resources, they provide yardsticks to evaluate deservingness, morality, and emotionality, which inform organizational practices. For example, in cultural stories of "compassionate care," patients who are constructed as deserving are those who conform to an image of the "ideal patient." When patients fail to meet idealized images of deservingness, or when experiences of helping others diverges from how compassionate care "should" look, organizations such as the SCCH assist in mediating provider experiences and a moral sense of self.

While this paper focuses on the ways cultural systems of meaning inform organizational emotion management of providers, future research might examine how compassion is institutionally supported through local policies and protocols, how the everyday work of practical actors is informed by cultural shifts in various healthcare professions, how standards of emotion inform interactions between providers and providers, as well as patient care.

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CHAPTER FOUR:

MANAGING EVERYDAY TROUBLES OF COMPASSIONATE CARE

ABSTRACT

This paper examines how cultural meanings of "doing good" inform the everyday emotional complexities of nursing. Specifically, I examine how such cultural codes become embedded institutionally and influence the moral identity work and emotion management of nurses. Through eleven in-depth, semi-structured interviews with hospital nurses analyzed through a narrative perspective, I explore (1) how experiences that reflect "good stories" reaffirm a moral sense of self, (2) how common "unspeakable" experiences create moral identity dilemmas, and (3) the emotion management tactics developed by nurses to make sense of such disjunctures and everyday troubles. This paper emphasizes the need to examine the often overlooked lived experiences and perspectives of providers to more comprehensively theorize emotion in medicine, as well as tend to practical issues of institutional order and policy-making.

INTRODUCTION

Public stories of nursing tend to reflect "what we all know" (Adorjan et al. 2012) about the profession – nurses are endlessly selfless and caring and fulfilled by helping patients in need. Widely circulating stories of nursing depict happy, or at least, hopeful endings: patients recover or die peacefully, families are appreciative and supportive, and nurses feel good about making a difference, knowing they did all they could. Such "good stories" are evaluated as such in that they are culturally salient; reflecting and reinforcing collective ways of thinking and feeling about the world.

Less visible stories are those that fail to align with such ideals, what I will refer to as "untellable stories" (Stein 2009); stories that do not align with cultural values and beliefs. This type of story is not merely difficult to recall, but perhaps more difficult to find an audience to listen. One example of such a story stood out to me when interviewing nurses about their work; Melissa, a nurse of 32 years, broke down crying when recalling caring for a young woman who was in a terrible car crash on her way back to college:

> I was hysterical crying. I said, "I'm hurting your kid. And it hurts me to do this to her because I know what I'm doing is not gonna save her life"…I spent eight weeks torturing that child, I can't do anymore. Chest tubes, ventilators, medications, watching her have seizures because her fevers got so high…I just told [the mother], "I'm exhausted. I can't do this anymore. And if I have to punch on your daughter's chest one more time and feel another rib break, I said, I am causing more damage to her. I'm hurting her and it's not gonna make a change."

I was unable to hold back tears listening to Melissa's telling of a gut-wrenching story. To me, this was an unimaginable experience, but to Melissa, this was an everyday reality of nursing. *How can someone live through such trauma and wake up the next day ready to do it all over again? How can anyone feel good about their work when their daily experience is, or could be, an absolute tragedy?*

In this paper, I examine how cultural meanings inform the everyday complexities of doing "compassionate care" by centering perspectives of nurses. Nursing – at its core – can be understood as a profession easily aligned with compassion; a moral virtue that most simply aims to alleviate the suffering of others. As such, the profession provides an opportunity for workers to construct a moral identity (Kleinman 1996: 5). However, as I demonstrate in this paper, there is a tremendous amount of emotion management (Hochschild 1983) required to do so, as the cultural standards of compassion and "doing good" are often times incongruent with lived experiences.

My paper begins with a discussion of narrative meaning-making, followed by an overview of emotion management and moral identity work in helping professions. I then discuss my methodological approach to interviews with nurses and use of narrative analysis. Next, my findings section contains three main parts. First, I demonstrate how nurses reaffirm a moral sense of self through "good stories" of compassionate care. Second, I examine "unspeakable stories" to examine the everyday, complex troubles of "doing good" in nursing. Last, I document everyday emotion management tactics, demonstrating how nurses make sense of meaning disjunctures of "compassionate care" and reconcile moral identity.

This paper contributes both theoretically and practically. First, I draw attention to the largely overlooked stories of nurses to demonstrate the multi-level emotional complexities of compassionate caregiving, connecting cultural meanings to everyday practices of care. Additionally, this research offers useful insights to organizations and policy-makers aiming to improve health services by writing compassion into healthcare ethics (Wang 2016).

NARRATIVE MEANING-MAKING AND EMOTIONS

Our social world is saturated with stories; they create meaning at every level and in every realm of social life. Narratives are tools to make sense of the self, others, and experiences, as well as emotions – categories of feeling that are often difficult to define. In this section, I will briefly outline how narratives operate at macro, meso, and micro levels of social life, and emphasize the value of examining the connections across these levels.

Cultural narratives are those that feature disembodied characters, with recognizable plots and predictable moral lessons that reflect and reinforce widely shared values and beliefs (Davis 2002). Such stories are widely circulating and understood by broad, diverse audiences as believable and important; they are evaluated as "good stories," as they deploy symbolic and emotion codes. Symbolic codes (Alexander 1992) are categories of meaning (i.e. "citizen" or "enemy") that appeal to shared ideas about how the world works (appeals to logic) and the way it *should* work (appeals to morality) (Loseke 2019). Symbolic codes, that appeal to collective thought, are tied to emotion codes, that appeal to collective feeling (Loseke 2009); models that communicate social standards of feeling and display rules (Hochschild 1979). Thus, cultural narratives serve as "cultural codes" (Alexander and Smith 1993), or widely-shared systems of meaning about our social world. For example, a cultural code of "help" is commonly reflected in publicly circulated stories of "doing good:" a pure victim (symbolic code that communicates a type of person who is harmed through no fault of their own) is evaluated as deserving of sympathy (emotion code of how this type of person should felt about), which is tied to expectations about helping behaviors (Clark 1997).

Cultural ways of thinking and feeling also inform organizational and institutional storytelling. At the meso-level, stories inform how various types of social services are structured, for whom, and in what ways. Some "target populations" (Schneider and Ingram 1993) are portrayed and evaluated as moral types of people worthy of sympathy and help, while others are evaluated as immoral, deserving of condemnation or punishment. Such stories produce images of institutional selves (Gubrium and Holstein 2001) and designate the "conditions of possibility"

(Foucault 1979) of how they should be processed. Organizational stories construct collective identities such as “substance using clients” (Selseng 2017), “at-risk youth” (Geiss 2019), or “disabled artists” (Maconi 2019), that inform order and everyday practice.

Cultural, institutional, and organizational narratives are not deterministic, rather, they provide a members’ resource (Garfinkel 1967) for making sense of lived experiences and the self. While practical actors have agency in the stories we tell, we are limited by available narrative resources. Loseke (2019) describes how individuals “scan the environment for stories that might make sense of personal experiences,” to make sense of troubling experiences such as illness (Frank 1995), relationships (Irvine 1999), or rape (Wood and Rennie 1994). While cultural and organizational narratives offer resources to make sense of everyday troubles, the simplistic categories of stock characters, plot elements, and clear morals do not neatly translate to everyday life. Indeed, practical actors modify and challenge aspects of circulating narratives to author self-stories that account for complexities of everyday experiences.

Medical sociologists have employed narrative perspectives, with a primary focus on patient storytelling (Frank 1995; Kleinman 1988). While this tradition of research has been useful in understanding the lived experiences of illness, there is a tendency to treat patient stories as insights into “hyperauthentic version of actors’ experiences or selves” (Atkinson 1997: 343), relegating the importance of narrative to the psychological; which detracts attention from the important complexities of narrative that inform individual experiences, organization of services, and cultural evaluations. Further, in addition to centering the perspectives of patients, there is a theoretical and practical need to understand the experiences of providers – whose stories have been largely overlooked. In this paper, I demonstrate how nurses employ narratives to make sense of the emotional complexities of their day-to-day work. Through a narrative approach to sense-making, I demonstrate the reflexive nature of how stories are *simultaneously* about the social, cultural, and personal, and *simultaneously* about private life, public processes, social forces, and institutions (Loseke 2019).

HELPING PROFESSIONS, EMOTION MANAGEMENT, AND MORAL SELVES

Front line social service work is a fruitful area for exploring how people navigate emotional complexities, stemming from Hochschild’s (1983) groundbreaking research on airline attendants. Hochschild’s concept of emotional labor has been particularly salient; a type of paid work that “requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others” (1983: 7). Researchers have examined the emotional labor requirements and processes of a wide variety of workers, including people working in fast food restaurants (Leidner 1991; 1993), nail salons (Kang 2010), and plus size clothing stores (Gruys 2012). There has been wide multidisciplinary empirical attention to emotional labor associated within nursing (see Badolamenti et al. 2017 for a review; see Hayward and Tuckey 2011 and Theodosius 2008 for empirical examples). As Hochschild’s theory relies upon a Marxist, Freudian scaffolding, research in this tradition has primarily focused on aspects of worker estrangement, alienation, and “burnout.”

Other researchers have focused on how workers manage emotions not merely due to the demand of employers, but as an interactional accomplishment of identity (Blumer 1969), where confirmation depends upon adherence to conventions of one’s identity code (Schwalbe and Mason-Schrock 1996). This has been demonstrated through empirical attention to workers in various “helping” professions, which can attract people seeking to construct a moral identity (Kleinman 1996). Moral roles, such as mother, social worker, or activist, for example, are informed by cultural notions of morality and contributing to the “greater good” (Deeb-Sossa 2013; Kleinman 1996; Kolb 2014).

In fulfilling such social roles, individuals can receive what Kolb (2014:22) refers to as “moral wages,” or a “sense of satisfaction… (of) living up to the demands of their moral identity code, and the positive feelings that come with it.” However, moral wages often do not come easily, and individuals have to make sense of moral identity dilemmas they experience in their day-to-day work. For example, Wolkomir and Powers (2007) demonstrated that abortion clinic staff are attracted to the job because of a sympathetic position toward patients, however, commonly encountered “difficult” patients who challenged their ability to feel like “good helpers.” Workers developed unscripted emotional investment and detachment tactics to preserve self-commitments.

While researchers have begun to explore the moral identity work of nurses (e.g. Doane 2002; Peter et al. 2016), there is a lack of attention to the ways such identity processes are informed by broader cultural meanings. In this paper, I demonstrate how cultural notions of “compassion” inform nurses’ understandings of their work, and describe the techniques employed by nurses to make sense of everyday troubles and complexities.

METHODS

To understand the everyday complexities of emotion and identity in nursing, I conducted eleven in-depth, semi-structured interviews with nurses working in a metropolitan area in the Southeastern United States. Interviews were completed in-person and ranged in length from one to two hours each. I used an interview guide of general questions such as, “What are the things about your job that are emotionally rewarding?” as well as questions designed to elicit specific storytelling, such as, “Can you tell me about a past patient that you still think about?” Following interviews, participants completed a short demographic survey about education and work history. Participants included eight females and three males; seven were white, two were African American, and two were Hispanic.

Interview participants came from a variety of nursing subfields and departments, including the general floor, post-anesthesia care unit, transplant, operating room, neonatal intensive care unit, wound care, and Hospice. Experience in nursing ranged from three years to over thirty. To protect respondents' identities, I assigned pseudonyms to all participants as well as other individuals (patients, family members, and co-workers) mentioned during interviews, which are used throughout this paper. All aspects of data collection were approved by the University of South Florida Institutional Review Board.

My approach to interviewing is informed by Gubrium and Holstein's (2009) framework that conceptualizes the interview process as an active form of narrative practice, in that interviews are always interactional, social accomplishments informed by narrative environments. Rather than assuming personal narratives are insights into individuals' "hyperauthentic version of actors' experiences or selves" (Atkinson 1997: 343), I assume that narratives feature personal agency, as well as institutional patterns (Gubrium and Holstein 2009) and cultural meaning systems. Hence, those stories told by individuals, nurses in this case, are informed by broader institutional and cultural resources.

My conversations with nurses were rich sites of emotional expression. While participants talked about their work, I observed an array of apparent feelings such as contentment, pride, happiness, fulfillment, frustration, exhaustion, sadness, and sorrow. Conversations typically began with matter-of-fact discussions of responsibilities and day-to-day tasks. However, as conversations progressed respondents shared intimate stories about patients, families, and care, the emotional aspects were overwhelming and complex. I recall one participant, Lucia, who initially appeared rather “buttoned up,” as she focused on caseloads, time management, and findings in existing literature. About half-way into our conversation, I asked, “Can you think of a time that you had a patient who really stands out in your mind? It could be good or bad, but as a patient story, who do you really remember?” She began telling me a story about a patient she thought would not make it, despite doing all she and the others on the care team could. While she told me that a colleague sent her a video of the patient now “being totally normal,” her voice shivered as tears rolled down her cheeks. My goal in sharing the perspectives of nurses is to “stay true to their stories” (Green 2015).

NAVIGATING EMOTIONAL COMPLEXITIES AND EVERYDAY TROUBLES OF COMPASSIONATE CARE

My analysis examines the questions: *How do cultural ways of thinking and feeling inform the everyday experiences of doing “compassionate care?” How do nurses reconcile a moral sense of self when lived experiences conflict with cultural values and beliefs?* First, I demonstrate how nurses reaffirm a moral sense of self through “good stories” of compassionate care. Second, I examine “unspeakable stories” to highlight the everyday, complex troubles of doing good in nursing. Third, I document emotion management tactics, demonstrating how nurses make sense of meaning disjunctures of “compassionate care” and reconcile moral identity.

Doing Compassionate Care and Earning Moral Wages

Throughout interviews, nurses emphasized what brought them to the profession: a desire to help others. Lucia’s comments demonstrate a common sentiment:

> Everybody who goes into the healthcare field will tell you they went into the healthcare field because they want to take care of people. So I was like, yeah, I

> would love to take care of people. I thought that the greatest thing you could do with your life was to help somebody with theirs. So I went back to school. I got my nursing degree. And then I started working as a nurse and I loved it. I loved it, even though it was crazy, even though you didn't get, you know, to drink or eat or anything like that. Just taking care of my patients was so rewarding; to help somebody who couldn't help themselves. You're there when patients are at their absolute worst, and you're there when they're at their absolute best, when they're feeling better.

Participants described choosing a career in nursing to feel like they could “make a difference” and positively influence the lives of patients, family members, and caregivers. Nursing is historically and culturally understood as most clearly a caring, helping profession, thus, an opportunity for workers to construct a moral sense of self.

Throughout interviews, nurses emphasized that compassion is a requirement of the profession, as well as a trait of their own moral identity code. As put by Melissa, “On the back of my badge, it says compassion, respect, knowledge, you know, they give you their keywords for [the hospital]. That's how I live my life. You don't have to tell me to be accountable, compassionate, respectful.” Another nurse, Kelly, described, “If you don't have it in you, you don't last long as a nurse…So there is a level of compassion I think that is ingrained in most nurses… it's kind of like a part of them.”

Nurses described the “moral wages” (Kolb 2014) that can come from their work, those payoffs that make them feel like good helpers. They told stories about moments where they felt like they helped someone or made a difference, reaffirming a moral sense of self. For example, when I asked Melanie what they most rewarding part of nursing is, she responded:

> Just seeing a patient come in at like their absolute worst, and just watching them progressively get better and eventually heal; are eventually better, and they walk out of here and they're just smiling and they're happy and they're thankful. That is so rewarding… When I was in the LTEC, long term acute care, so they are…not sick enough to be in acute care, but they're not healthy enough to go to like a long term rehab or something. So they go to like another hospital, which is like middle ground…I have a story of a gentleman that when he came to us at LTEC and he was in ICU on a vent, and he progressed, to where he ended up with a trache, started working on physical therapy, was downgraded and he just, he walked out of the LTEC. That was amazing.

Melanie's story reaffirms what we all know – culturally – about helping others; how it "should" look in an ideal world: a person in need of medical care, who is appreciative and cheerful, receives care, progresses, and leaves better for it. Most commonly, nurses' stories of receiving moral wages focused on patient recovery, which is similar to Peter et al.'s (2016) research that found nurses' moral identities were realized when there was visible improvement in the health of patients. Other nurses described the emotional rewards associated with watching sick babies leaving the NICU to go home with their families, staying in touch with patients after their discharge to see them thrive, or being able to make a positive difference in someone's day (however small). As put by Anastasia, "At the end of the day, it's how rewarding it is; it's that feeling that you help somebody, made a difference. That makes it all worth it." These are "good stories;" those that reflect broader cultural meaning systems of doing good.

Nurses earn moral wages quite easily in such cases. However, they also told stories that were much more complex, and incongruent with idealized notions of compassion and doing good. These “untellable” stories (Stein 2009) that do not align with cultural expectations of help, shed light on some of the everyday troubles nurses experience when attempting to do good.

Unspeakable Stories: Everyday Troubles of Compassionate Care

At the core of every definition of compassion is recognizing suffering of another person and feeling a need to take action to alleviate it. While nurses often do have opportunities to provide such care, participants repeatedly described one of the hardest parts of the job was fulfilling orders that contribute to, what they understand as, patient suffering and pain. One nurse, Anastasia, described there is “so much…patients suffering…that doesn't need to happen. I guess it's just, you know, the advances in technology. That's the downside of it. Because now people expect doctors can do miracles with all the technology that we have.” Another nurse, Jasmine, talked about the struggles of “torturing” babies in the NICU, fulfilling the family’s wishes and treatment orders:

> You don’t see what I see. There have been many days I go into work and I’m like, I'm torturing this kid. All 12 hours. I’m torturing this kid, based on what the family wants, based on what the orders say, based on what I have to do. I'm like, “I'm so sorry.” Sometimes I will go in and I'm withholding tears because I was like, this is torture. The minute I touched the kid, and you can see, they can't do anything, but you see the whole face shrivel up like, owww [*grimacing*]. Yeah, this is torture….if you are a baby, and you've been doing really bad, and we've had to do surgery on you and your guts are still hanging out. And we keep doing surgery after surgery. And it just becomes a routine thing where we just continue doing this stuff, where we know they're not going to qualify for any transplant or any sort like, you know, bowel transplant or whatnot. And we just keep going and

> going and going and the kid is clearly trying to die. You know what I mean? In terms of their presentation, the monitor, you're like, this kid is trying to see Jesus. Why won't we let him? And it sounds so cruel people will be like, "Are you crazy?" I'm like, no, I'm not crazy. But you are torturing this human being like, I really feel like it's torture. If you have a drain in your brain and you have brain matter in the bag, and I see your brain floating in the bag. This is torture. Make it stop. You know what I mean? But I see it from both sides. The parents, they want everything done. I feel them. I understand. And that's the hardest part of the job.

Jasmine provides an example of the complexities of "doing good" in nursing: the use of available, clinical tools of help (i.e. surgeries and drains) can result in feeling like baby torturer – perhaps the furthest thing imaginable from what we understand as moral. While nurses recognized that sometimes painful, torturous treatments can result in "miracles," they emphasized that those are not common. More commonly, they described how it is most difficult when they recognize that a patient's death is inevitable. For example, Kelly described an experience with a patient she was taking care of for months after their stroke; disagreeing with treatment plans and wanting to advocate for her patient, but lacking the power to change the course of care to what she felt was compassionate care:

> She was so sick, and I felt like she wanted to be like a DNR [*do not recessitate*], she just wanted comfort measures. But we had to do everything we can because her son wasn't here and he was next of kin, and he was saying do everything. Never laid eyes on her, wasn't seeing like what condition she was in…I remember turning her, me and this nurse turning her and like, blood was coming out like, like she would poop, but it was also blood… And I looked at her and we both just

> started crying. And I felt like this was wrong. What we're doing is wrong. I feel like, I knew like this woman would not want this. Finally the son came into town and he saw her, and he did make her DNR. She died the next day. But they had the ethics committee, like, can we do anything? Like, nothing is working, you know, can we make her comfort measures? And they're like, "Nope, the son says do everything. We have to do everything we can."…And that's why neuro to me was so emotional, because you saw a lot of that stuff play out, like next of kin, because these patients stay on for long because they were, waiting for placement for like, rehab or something. And they stay long, and you saw like more family issues because people couldn't decide. One family wants this, the other family didn't want, nothing was written. So now the families are like battling out what they want to do and what they don't want to do. It feels like, sometimes it feels sickening. Like, this isn't right, what we're doing isn't right I would never want this for me like, why are we doing this to somebody that can't even make this decision? But ultimately, they never got like their affairs in order, they never said this was what they want. So we have to do whatever that its saying, you know.

Participants frequently described the challenges associated with of end-of-life care determined by next of kin; family members often disagree on treatment plans, are not ready to say goodbye to their loved one, or have "unfinished business." The default plan, "do everything," reflects broader western beliefs and values: family members must do (and should be able to do) everything possible to save our loved ones in *any* circumstance, hope *cannot* be lost, and patients *must* continue fighting. As these beliefs are put into practice and reinforced through institutional structuring (in this case, the ethics committee relegates decision making to family members), nurses carry out protocols that they understand as “wrong” and “sickening.” Thus, while family members may feel at peace knowing they did all they could, nurses’ experience pain and moral identity dilemmas associated with managing dying bodies.

In addition to troubles associated with tools and protocols of body management, participants also talked of the emotional challenges associated with being unable to give patients better outcomes and life chances, despite their best efforts. One nurse, Jessica, described how she and her co-workers went above and beyond to help a patient, but she was still left feeling hopeless that a poor outcome was inevitable:

> I'm doing all this work for you. And I'm trying to make this situation better, but nothing I can do is going to fix that, you know? Like, we had one patient with this massive fistula on his abdomen. He came in, he's like in his late 20s. And his wife was nine months pregnant when he came in. He ended up being in the hospital for seven months. So he almost had a one year old by the time he was discharged from the hospital and was still discharged with this huge open wound on his stomach with a fistula, so his stool was draining out his abdomen. And no insurance; didn't speak English. It's like, we gave him everything we could, but I just knew I was sending him out into the world with this horrible scenario. And it's like, there's nothing I can do about it, like I can't change how the government's going to help him, not going to change how his life is outside of here, that he's never going to be able to work the same way, maybe in 10 years or so. But like, what am I supposed to do? I’m supposed to be able to help people, but I can't.

Nurses often described feeling powerless; having a desire to help but also understanding that they are limited in their ability to do so due to a variety of external factors. Jessica’s story features a patient evaluated as deserving of help – a young (not old), married (not single) father (not “deadbeat dad”), with frustration related to an inability to help a person in need. Participants described how helping in a clinical sense (getting them discharged) could likely result in a new set of troubles; in the above case, being unable to work or take care of their family. Nurses described feeling sadness and frustration when they could not provide a “good outcome,” or knowing that things would likely become much worse for patients when they left the hospital. For example, Jasmine described the complex feelings of helping a baby born with an addiction (the purest of pure victims) to send them home with a family “that sucks:”

> And sometimes you really do bond with these babies. And you just give it your all and you’re like, this sucks. Your life sucks. You know, the baby, right? Your life sucks. You were born and you were born in pain immediately. You don't even know what it is to be born comfortably. You were literally in pain from the minute you took your first breath, because you were withdrawing… they are born in pain. I'm like, your life sucks. You know, you don't want to say, but in your mind, you’re like, and your parents suck. That sucks, you know? And sometimes it takes everything in you to not want to take the kid home. So now that neonatal abstinence syndrome is a thing and that it's been researched more, we have all these studies on it…So now they're looking at the long term outcomes of these kids. It alters the brain; the drugs alter the brain when they come out like that. So these studies are now starting to come out with kids, like in elementary school; major behavioral issues, because it alters their brain…They can't behave. So then they're labeled as soon as they go to school. They’re the bad kids, you know what I mean? And then where do they usually end up? In the system.

Finding an Audience, Managing Emotions, and Moral Identity

To make sense of untellable stories, participants emphasized the need for collaborative sense-making with other nurses and healthcare workers; describing that people outside of health care cannot understand, and do not care to understand, this aspect of their lives. Participants described that simply hearing about the management of bodies and bodily fluids, pain, death, and other "unpleasant" topics make outsiders uncomfortable and these stories should be largely be left undiscussed. As one participant said, they did not want to make their family "depressed." Thus, sense-making and emotion management between co-workers or other nurses was understood as essential. Robert described how "you create a bond by passing through the crucible… it's rough. But if you have people there to lean on, you just, you kind of share the burden. So it's easier to lift."

One nurse, Jessica, shared a story about the importance of having nurse friends to make sense of everyday experiences. She told me a story about being a new nurse called to help with a patient who was "finger painting," (which turned out to be code for a patient with dementia smearing their feces on the wall). She continued:

> That's why nurse friends are the best friends. It's just like a different type of relationship. Because you see just bizarre things together [*laughing*]. I mean, sometimes you just laugh as a coping mechanism. You just have to laugh at it, or just be like, "Oh my god, I just need to vent about this ridiculous situation"… It really sounds so bad sometimes, but, it's the only way to get through it though honestly. There's just, when you see these patients like just, just make the weirdest decisions and do the strangest things and expect to get a different result. It's like, I mean, you can't fix it. You just kind of have to laugh at it to get

> through. I mean, that kind of situation is why people in nursing become, like, closer than regular friends. Because you can't really explain that to anybody else. It's like being in the trenches. Like if you go through that with somebody else, you're friends forever, it doesn't matter what happens. There's just nothing else you can do about it. That's just how you're bonded. You're family; that's it. There's just stuff that you can't un-see [*laughing*]. I mean it, I think that's the biggest takeaway, like you have to have support. You have to have people that you can get along with. It's just crazy. And it's crazy, no matter where you go.

Humor between co-workers was often described as a useful emotion management technique, as demonstrated by Jessica's story. Nurses described that "sometimes all you can do is laugh," however, they emphasized that this emotion management tactic is most successfully employed with people working in healthcare. As put by Robert, if humor is deployed with the wrong audience, particularly in making sense of trauma, "you just look like a psychopath."

Nurses developed a variety of tactics to manage negative emotions and reconcile a moral sense of self through their work. One approach described by participants was to focus on "the good;" telling stories that "make it all worth it," such as watching a patient recover and thrive, making someone's day with the "little things" like a close shave, or helping someone and their family experience a "good death." Lucia told a story that demonstrates how good stories, or those that reflect cultural notions of doing good, help her get through the hard times:

> I *beg* my surgeons when they're in clinic, *please* send us a picture of this person when they're in clinic, please send us an update of how they're doing. I remember one of our surgeons sent us a video of a patient that was there for a long time that I had been taking care of for a few months, and he left the hospital super

> confused; young kid. I had no idea if he was ever going to recover. And they sent me a video of him in clinic and he's like, totally normal. Totally, like totally fine. I was like bawling. I was like, oh my god! You know, it's those kinds of things that like, get you through. You're like, okay, I can do this for another year. I can do this for another two years, because you burn out really quickly. All it takes is that one really bad shift or those few bad shifts in a row where it's like really long hours and you didn't do anything; you didn’t sleep, pee, or drink water. And you want to *quit* after those, you know, but then it just takes one of those moments. And you see the results of your hard work, when you see a patient doing well, and then you're like, okay, I can do this for another year.

Lucia’s story demonstrates how patient success stories inform moral identity construction and emphasizes the value of collaborative storytelling. Further, Lucia’s remarks demonstrate the importance of narrative closure; how it is difficult to make sense of a moral self when there is no confirmation of doing good. Thus, good stories can make up for those times that are difficult, frustrating or even horrifying. Similarly, Mark, who is a nurse of 22 years, described the importance of focusing on “the good stuff” and distancing from the negative things you “can’t control:”

> I mean, I can’t take this kid away from that parent. You know, I can’t make this family let somebody die in peace. So I guess, focus more on the good things. You know, the guy [*who attempted to kill himself*] I saved, try to remember those things more than the person that, you know, had Munchausen [by proxy] syndrome. We had a woman that, she was intentionally making her kids sick over and over and over and over and over. And they didn't figure it out for a while

> either because she seemed so normal and so right, and it didn't seem like she was seeking that attention…You know, they're making the child sick so they can be the savior and take care of them… So trying to not remember those things as much or think about those things. Yeah, kind of compartmentalize that stuff.

Mark's comments further demonstrate the importance of lived experiences that reflect "good stories" in maintaining a moral sense of self as a nurse, and the work done to compartmentalize those experiences and feelings (guilt, sadness, disgust, hopelessness) that deviate from how compassionate care should look and feel. Also reflected in Mark's comments, nurses discussed the practical importance of maintaining emotional boundaries in order to continue providing quality, compassionate care. Mark emphasized how nursing requires you to be empathetic, but "you can be *too* empathetic because then every death or every, thing, would just weigh on you forever," suggesting this pushes some people out of direct patient care. Indeed, nurses commonly described the need to practice a type of distanced empathy and the practical need to maintain a level of distance to deal with challenging experiences. For example, Fran, a hospice nurse of over 20 years, strongly emphasized how important it is to maintain "professional boundaries" and not get "too deep, in the name of compassion:"

> You have to have that professional boundary going into a home because if you don't, you just, even with good boundaries, you absorb their energies. Not to be weird, you absorb their energies. You can't be around that much grief, anticipatory bereavement, that much sadness, that much illness, without it affecting you, or me. I can speak for myself, without it affecting me.

Nurses described the importance of maintaining an emotional distance to combat being overwhelmed by everyday troubles, artfully toting a line between compassion and too much empathy. Nurses stressed that not only will overly “feeling with” take its toll emotionally but can lead to an inability to focus on other clinically important aspects of patient care. For example, Lucia described the importance of “staying strong” in order to provide care to all of her patients:

> We have patients sometimes that have liver cancer. And sometimes we have to be the one to tell them I'm sorry, but we can't offer you anything. Your cancer is so advanced, we can’t even cut it out and be done with it. And those are, you don’t even know those patients really, I mean, you kind of know them because you've been on their team for like a week or whatever. But with their families there, it's *so* hard and then they just, they just, sometimes just like, breaking down. Or their family breaks down. And, to see the patient break down, you're just like, you're trying not to cry. And there are a lot of times where I have to turn around in the room. I just turn around or leave the room because I can't, because…you can't sit there and cry. You're supposed to be the provider, you're supposed to be, sort of the rock, you know, and if you're crying the patient's thinking, “Oh shit,” you know, like, there's no hope there's no, you know, whatever, you can't. And not only can you not be that way for the patient, not only do you have to be strong for the patient, but for yourself too, you know. You can't let it get to you because then otherwise you're never going to get through the day. You've got a ton of other stuff to do. As soon as you leave that patient's room, you gotta go see 20, and you gotta focus on those patients when you go in the room and that individual patient.

Participants described how direct patient care can be an emotional rollercoaster from day to day, and room to room. For instance, when I asked NICU nurse Jasmine how she continues her day after feeling sick from doing what she experienced as “torturing” a baby, she quickly responded:

> Snap out of it. You go into one baby's room and they're like sobbing because their baby is on their deathbed, and you go *this* person's room and they're like, "Oh my gosh! We're going home!" And you like, go over smiling, but then you go back, and you're like, oh my gosh. You just have to do it, you know it's just, something that I don't have to think about because like after a while it becomes normal and if you can't do that, you can't do this job. You can't leave one room crying and go into to the next room crying, right? You know what I mean? It's just part of the, requirement of the job.

Thus, nurses' emotion management tactics are not only important in managing a moral sense of self and performing job tasks but are clearly informed by cultural feeling rules that a person going home with their newborn requires a performance of excitement and happiness that influence how others perceive "compassionate caregiver."

DISCUSSION AND CONCLUSION

This paper examines how cultural ways of thinking and feeling inform everyday meaning-making processes of nurses. More specifically, I demonstrate how nurses' "moral wages" (Kolb 2014) are received when experiences reflect cultural values about "doing good," as well as the ways nurses develop emotion management techniques to make sense of experiences that do not align with the cultural code of compassionate care and a moral sense of self.

Particularly relevant to this paper is Peter et al.'s (2016) research that examined publicly circulating narratives titled, "In the End…What Nursing Means to Me..." In this article, authors highlighted how stories constructed moral identity of nurses when health of patients and communities improved, when nurses could maintain patient identity despite illness and hospitalization, and when patients expressed gratitude. This is similar to other research that demonstrates how moral identity is reaffirmed through earning “moral wages” (Kolb 2014), in a variety of roles such as welfare-to-work managers (Taylor, Turgeon, and Gross 2018), homeless shelter workers and volunteers (Rogers 2017), and victim advocates and counselors (Kolb 2011; 2014). However, when lived experiences make it difficult to feel like “good helpers” (Wolkomir and Powers 2007), workers develop emotion management strategies to make sense of moral identity dilemmas, as seen in research on abortion clinic employees (Joffe 1978; Wolkomir and Powers 2007), domestic violence and sexual assault advocates and counselors (Kolb 2011, 2014), and welfare-to-work managers (Taylor et al. 2018). In my previous research (Geiss 2019), I have demonstrated how cultural meaning systems reflected and reinforced through widely circulating narratives inform everyday sense-making of organizational actors.

In this paper, I continue this line of research by considering the ways stories operate as “culture in action” (Swidler 1986). In treating narratives as multi-level, reflexive meaning-making tools, I demonstrate the ways cultural meanings inform narrative identity processes and emotion management, and shed light on how such processes are related to institutional structure. As such, this paper contributes insights into the ways social scientists can move away from a tendency to treat narratives as a “hyperauthentic version[s] of actors’ experiences or selves” (Atkinson 1997: 343) that relegates the importance of stories to the psychological state of individuals, and rather, emphasize the sociological importance of understanding narrative meaning production.

Examining patient narratives has become an important area of research, both theoretically and practically (e.g. Frank 1995; Kleinman 1988). However, because researchers have focused primarily on patient perspectives, providers’ stories and experiences have been largely overlooked. By centering stories of nurses, we can begin to understand “insider” experiences that are largely incomprehensible to those outside of these emotionally complex, institutional worlds. Further, we can begin to understand how provider experiences (as well as patient experiences) are informed by cultural systems of meaning. For example, widely circulating narratives of patients as “fighters” and “survivors” reflect the cultural expectation to overcome illness, continuing treatment until the bitter end. Scholars have troubled such images, particularly as they tend to communicate notions of “the ideal patient,” which relinquishes power to medical authority and oversimplifies the complexities of illness (e.g. Dubriwny 2009), stigmatizing particular conditions and people (e.g. Gilman 1988; Sontag 1978). In this paper, I demonstrate how such images and widely held beliefs not only inform illness experiences, but also everyday experiences of providers.

In addition to contributing theoretically, this paper is of practical importance, particularly as “lack of compassion” and “compassion fatigue” are understood as ongoing problems in health care. These concerns have led to various efforts to treat individuals (nurses and other providers) understood as experiencing psychological troubles, such as emotional exhaustion and burnout. However, as I have demonstrated in this paper, nurses are most clearly fulfilled by providing quality, compassionate care. Their troubles, as they describe them, come from an inability to meet cultural standards of “doing good” in their role, particularly as patients regularly die regardless of the painful medical procedures they administer. Thus, my goal is to introduce multi-level intricacies to these conversations and trouble the tendency to characterize providers as individuals simply lacking compassion or emotionally detached. The everyday experiences of nurses provide valuable insights that are necessary in gaining a broader understanding of compassion in health care.

Interviews with nurses revealed many complexities of the emotional aspects in healthcare practice that are ripe for investigation. To extend this line of research, questions that should be considered include: How do other workers in other health care roles understand and practice compassionate care? How is compassion institutionally supported, and limited, in terms of policy and protocol? How do patients negotiate conventions of compassionate care and what does this mean for treatment?

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CHAPTER FIVE:

DISCUSSION AND CONCLUSION

Compassion is more than a feeling; it is a state of virtuous existence that most simply relies upon an ability to recognize the suffering of others and a desire to take action to alleviate it (Nussbaum 2001). This basic idea seems easily congruent with healthcare – patients are assumed to be suffering from clinical disease, and healthcare providers are well positioned to relieve patient pain and suffering with medical interventions and overall care. However, there is a current widespread dialogue about a lack of compassion and humanity in healthcare (Shea, Wynyard, and Lionis 2014). Such concerns have resulted in various organized efforts to address this problem, particularly as compassion is no longer simply an implied expectation of good providers but recently has been explicitly written into codes of ethics (American Medical Association 2016; also see Wang 2016). In this dissertation, I explored the idea of "compassionate care" from three perspectives: publicly promoted stories, organizational practices, and lived experiences as understood by frontline providers.

In chapter two, I examined stories of "compassionate care" promoted by the Schwartz Center of Compassionate Healthcare (SCCH). Publicly promoted organizational narratives are artfully constructed and do work of practical importance: Persuading wide audiences of the need for services. For such storytelling to be successful, stories must reflect cultural values and beliefs systems, appealing to collective logic, emotion, and morality. The public storytelling of the

SCCH is familiar and predictable, as it employs the pervasive narrative form of "the service-worthy client" (Geiss 2019); a cultural code that features a type of deserving client (the "ideal patient"), who receives an organizational service ("compassionate care"), that results in a changed social location or condition (in this case, improved physical, mental, and emotional state of patients and families). This formula story (Berger 1997) is typical of "helping" organizations of all varieties, and can be observed consistently across time and place, in a variety of organized services such as battered women's shelters (Loseke 1992), homeless shelters (Marvasti 2002; Spencer 1994), mentoring services for "at-risk youth" (Geiss 2019), and sex work for disabled clients (Geiss and Egner forthcoming). Thus, public stories of "compassionate care" are influenced by and uphold a cultural system of meaning about the types of people who are morally evaluated as deserving of help and beliefs about doing good for others.

This cultural code can be observed through publicly promoted organizational stories most often referred to as "success stories" – those that portray examples of the effectiveness of an organizational initiative or service (such as "compassionate care") that appeal to collective values and beliefs. These stories are commonly promoted and largely taken for granted, as their work goes unnoticed by organizational actors and audiences. However, such stories in effect set standards of "compassionate care" specifically, and helping others more generally, informing beliefs regarding the types of people who are deserving of which types of services, and in what ways. Thus, as such stories become part of the collective conscious (Durkheim 1961), they inform standards of thinking, feeling, and most importantly, behaviors.

In chapter three, I focused on the organizational tactics in promoting emotion culture shifts in healthcare, specifically through the SCCH's organizational practices of Schwartz Rounds. These events are designed to assist healthcare providers in making sense of emotional aspects of their work through collective narrative sense-making and emotion management. Primarily, Rounds offer a way to make sense of emotional troubles incongruent with the professional moral identity (Kleinman 1996) of the “compassionate caregiver,” similarly to other types of support groups for troubled emotional selves, such as “Codependents Anonymous” (Irvine 1999), “Alcoholics Anonymous” (Pollner and Stein 1996), and families with “domestic disorder” (Gubrium 1992). Through these “moral mediation” (Geiss 2019) sessions, healthcare providers share narrative tool-kits to make sense of “difficult patients” (those who do not align with a culturally ideal recipient of compassionate care) and manage personal feelings of grief, doubt, and guilt (emotions incongruent with cultural expectations of fulfillment from doing good). In addition to making sense of emotional troubles, Rounds also reaffirm idealized representations of “doing good” through sharing “uplifting” stories to “reinspire” and assist compassionate caregivers earn “moral wages” (Kolb 2014). Thus, these sessions reflect and reinforce cultural assumptions of “doing good,” which can ironically lead to everyday troubles of providers, as I demonstrate in chapter four.

Cultural values are embedded within institutions and inform everyday interactions among social actors. In chapter four, I focused on the lived experiences of nurses – those workers who are most clearly tasked with providing compassionate care to patients. This chapter continues to examine “culture in action” (Swidler 1986), demonstrating how nurses’ moral wages (Kolb 2014) are received when experiences reflect cultural codes of “doing good.” Nurses also emphasized the everyday troubles they experience when they are unable to fulfill cultural obligations of the “compassionate caregiver” when caring for patients, often due to institutional protocols, available clinical tools, and biological processes of death. Thus, it is paradoxical that cultural systems of meaning about help and compassion provide moral wages, yet simultaneously lead to everyday troubles of frontline healthcare workers.

EXTENDING SOCIAL RESEARCH ON EMOTION

While sociologists have long recognized the importance of altruistic emotions in social order and behaviors, there is "conceptual untidiness" (Loseke and Kusenbach 2008) in regards to compassion, sympathy, and empathy. For example, Cooley's (1992:132) definition of sympathy, "entering into and sharing the minds of other persons" is understood by contemporary scholars as empathy (Jacobs 2006; Ruiz Junco 2017), whereas Clark (1997) suggests that empathy is a prerequisite to sympathetic concern. Nussbaum (2001) describes how sympathy, empathy, and pity are often used interchangeably, and often reflect what others refer to as "compassion." While definitions of these emotions remain murky, there is a consistent thread that emphasizes altruistic emotions are those of individuals. Indeed, previous research has examined compassion of charity shop volunteers (Flores 2014), breast cancer and antirape activists (Blackstone 2009), mental health care practitioners (Brown et al. 2014), and displays of compassion in childbirth (Walsh 2010).

Researchers in the sociology of emotions more broadly have been primarily concerned with emotion as a lived experience. This is in part due to Hochschild's (1983) widely influential framework that relies upon a Freudian scaffolding; introducing concepts of emotional labor and emotion management – the work individuals do to manage their own emotions and those of others when their "inner feelings" do not align with cultural and professional feeling rules. While this framework acknowledges that cultural expectations of feeling inform the understandings and practices of individuals, there is insufficient attention to how such cultural standards and expectations come to be, shift over time, and inform social structuring.

My dissertation shifts focus away from individuals; examining how organizations construct "compassion" as an emotion code (Loseke 2009) through discourse that communicates emotional standards and expectations for social actors. Through this approach, I demonstrate how the SCCH packages "compassionate care" not merely in terms of collective morality, but specific administrative logic that is necessary in appealing to powerful audiences with the ability to implement change. As I demonstrate in chapter two, the SCCH communicates compassion as not merely something that will make providers "better people," but rather best *practice* that once implemented, can *reduce* provider burnout and medical errors, as well as *improve* clinical outcomes, patient compliance, and satisfaction ratings. *All* of these claims can be translated into quantifiable indicators used to evaluate the performance of healthcare institutions, which are directly related to funding. As such, "compassion" at the meso level can operate as an institutional tool that is defined by and upholds existing social structures, informing organizational and individual practices which I explore in chapters three and four.

EXTENDING NARRATIVE RESEARCH IN MEDICAL SOCIOLOGY

Just as research on emotions has focused on emotion as experienced by individuals, narrative research has also been primarily concerned with individuals. Narrative approaches in medical sociology have been mainly concerned with individuals' experiences of illness (Frank 1995; Kleinman 1988). This dominant tradition has a tendency to treat patient stories as insights into "hyperauthentic version of actors' experiences or selves" (Atkinson 1997: 343). This approach is troublesome for various reasons, largely ignoring stories told at macro and meso levels, as well as the connections of narrative meaning production across levels of social life. First, this type of logic leads to fruitless debates regarding "truth" of stories. Rather than focusing on a positivist goal of truth-seeking, it is perhaps more valuable to tend to consequences of stories. This is particularly relevant in our current postmodern, “post-fact” world in which “alternative facts” are accepted by some as merely truth. Further, in assuming stories provide insights into one’s “true” psychological state, the importance of narrative is relegated to the psychology of individuals. As my dissertation has shown, stories are most certainly of sociological importance, as they are informed by and inform the collective ways of thinking and feeling, becoming embedded within organizational structure and practice, and influence lived experiences of institutional actors.

This project further contributes to narrative scholarship by demonstrating the need for multi-level analysis. Through tracing meaning-making across macro, meso, and micro levels of analysis, there are opportunities to gain insights into the complexities of narrative meaning-making processes. What I have shown in this project is that meanings of “compassionate care” vary depending on the level of analysis. At the macro level, the concept of “compassionate care” is remarkably similar to other types of help and reflects pervasive cultural beliefs of recipient deservingness and doing good for others in need. At the meso level, “compassionate care” is employed as an institutional tool for maximizing productivity within existing social structure. At the micro level, too much compassion can be a problem for frontline workers.

What is noteworthy are the contradictions across levels, and the consequences of meaning-making. Culturally prevailing “formula stories” (Berger 1997) are oversimplified versions of social life, and are commonly employed by organizations to garner necessary support for a variety of services. Indeed, the SCCH employs “success stories” that reflect cultural beliefs and values that can effectively garner necessary support from diverse audiences. While such collective representations (Durkheim 1961) can persuade audiences of the need for “compassionate care,” they are consequential in providing an oversimplified blueprint that is not compatible with the complexities of social life. As demonstrated in chapters three and four, such codes are often contradictory to lived experiences, which requires collective and individual sense-making, particularly from healthcare providers as examined in this project.

PRACTICAL CONTRIBUTIONS

In addition to theoretical and empirical contributions, this dissertation is of practical value, particularly in regard to institutionalizing compassion in healthcare and building emotional requirements into healthcare ethics (American Medical Association 2016). My concerns are organized as related to (1) patients and (2) providers.

Those advocating for institutionalizing compassionate care often cite research that has shown how receiving more compassionate care results in improved outcomes for patients (Lown 2011). Narrative medicine (Charon 2006) is one approach often promoted by advocates, including the SCCH, that most centrally suggests sharing patient stories can promote empathy and compassion between patients and providers. Thus, it is not surprising that organizations promote the sharing of patient stories, and technologies are being developed to integrate patient stories into medical charts. However, this approach largely ignores the ways cultural meanings inform in the evaluation of stories; which *can* be told, *should* be told, in what circumstances, and with what consequences.

To suggest that knowing patient stories generates empathy, compassion, and improved outcomes is overly simplistic. Cultural ways of thinking and feeling inform how we interpret stories about individuals; with only *some* types of people commonly evaluated as “deserving” of empathy and compassion. For example, a patient diagnosed with cancer due to 30 years of smoking is culturally understood as partially (if not completely) to blame for their diagnosis. Conversely, interpretation is much different if a story of lung cancer highlights a person who was diagnosed with lung cancer, despite living a healthy lifestyle and never smoked. Indeed, this is the story of Kenneth Schwartz, the founder of the SCCH, and echoed in the stories promoted by the SCCH analyzed in chapter two. There are hierarchies of morality that inform emotional and cognitive interpretation, and associated behaviors. As narratives are always situated within broader cultures, concern with improving healthcare should be cautious of narrative as a solution embedded within clinical protocols, as storytelling often reinforces existing power dynamics and institutional orders that unequally inform the life chances of patients.

In addition to consequences for patients, shifting emotional expectations are most clearly consequential for healthcare providers. As nurses in chapter four described, being too emotionally involved with patients can be a problem in carrying out technical aspects of their work. Thus, as the demand and institutional standard of providing a more emotionally invested type of care for patients, there are important practical question to consider: If providers are required to become more emotionally in tune with patients, how will this impact technical aspects of clinical care? Further, how will these emotional standards inform persistent issues of compassion fatigue (Figley 2002) and burnout (Maslach 1982)?

The demand for providers to provide more “compassionate care” to patients compliments shifts toward “patient-centered” care, as well as the capitalist design of healthcare in the United States, with patients as “consumers” of healthcare services (Conrad 2005). Nurses spoke about this throughout interviews, and commonly problematized HCHAPS, Hospital Consumer Assessment of Healthcare Providers Surveys. These patient satisfaction surveys are directly tied to Medicare and Medicaid funding and ask patients about their care experiences, which are in part used to evaluate provider performance. One nurse described them as “Yelp reviews,” and emphasized how wanting to get higher scores can result in providers “cav[ing] to what the patient wants, instead of actually providing the type of care they need. So you end up catering." Similarly, nurses described that sometimes quality nursing requires "tough love," or making patients do things they do not necessarily want to do, such as getting out of bed when they are in pain, so they are able to promote circulation and recovery. Thus, it is possible that compassion, or patient satisfaction, can come with life or death consequences.

As compassion continues to be viewed as a trait of good providers, the lack of compassion in healthcare predictably points blame at individual healthcare workers, suggesting that healthcare as a system can be improved if providers *care* more about patients. However, attention to individual providers obscures the broader social structuring of healthcare in the United States, that is glaringly incongruent with notions of compassion. Most obvious is the reliance on capitalist logic and design of healthcare delivery that is most concerned with increasing profits. Indeed, this system directly results in long-term, ongoing suffering of patients who are unable to pay their medical bills and receive necessary preventative and continued care. It is particularly concerning that calls for compassionate care rely on capitalist logic, as demonstrated in chapter two, which promotes the idea that compassionate care should produce a return on investment. Healthcare policy attempting to address a lack of compassion in healthcare cannot ignore the influence of capitalism on patient suffering and persistent inequality.

Healthcare work is extremely difficult, as highlighted and exacerbated by the ongoing COVID-19 pandemic. Despite the symbolic, "moral wages" (Kolb 2014) paid to healthcare workers during this time, who are commonly referred to as "heath care heroes" in public discourse, there remains a lack of personal protective equipment (PPE), furloughs, and inadequate clinical support. Healthcare providers require more than moral wages to provide quality, "compassionate" care; providers must be given *resources* and institutional support to do so. To suggest that healthcare can be improved by making providers more emotional is not only dangerously oversimplified, it further burdens providers by suggesting that structural problems and affiliated everyday troubles can be alleviated by “self-care” and “resilience.”

FUTURE DIRECTIONS

Cultural meanings associated with compassion are informing the values, policies, and practices within Western healthcare. In this project, I have been most interested in the ways cultural codes are reflected and reinforced through storytelling, and the associated consequences for frontline healthcare workers. Future work should examine the various institutional changes to policies and protocols associated with promoting compassionate healthcare. For example, during data collection, I learned about one hospital’s efforts to promote compassion by modifying the course of treatment for babies born with drug addictions. To provide more comfort to newborn babies during withdrawal, mothers were integrated into the care team. Described as a “common sense” approach, mothers care for and comfort their children, shifting some of the burden from nursing staff, while empowering mothers to become the “hero of the story.” Through the implementation of this model, it is reported that babies spend significantly less time in the NICU and receive lower dosages of methadone. The justification of such policy implementation reflects pervasive cultural values and beliefs: addicted mothers *should* feel guilt and remorse, good mothers *should* want to do everything they can to help their child, there is *nothing* stronger than a bond between a mother and child. However, what happens when these codes fails to align with lived experiences? Under what circumstances do mothers reject the role of the “good mother?” How do those choices affect interactions with healthcare providers? How might this inform treatment, outcomes, and life chances for patients? There is a practical need to examine how policy justification makes invisible its consequences to healthcare providers and patients alike.

In addition to examining the ways cultural codes inform changes to treatment plans, there should also be research tending to the development and use of technologies in promoting compassionate care. While technologies are commonly understood as *the* tools of "progress," they can often reinforce existing inequalities. In addition to innovations mentioned above to "enhance" patient records with curated stories, there should also be attention to emotional training technologies, such as patient "simulations" geared at enhancing empathy of providers toward patients. Which patient experiences are worthy of simulation, and which are not? How do these technologies inform moral evaluations of patients? What cultural codes are embedded within innovations? How are moral hierarchies communicated through such approaches? How do these standards and expectations inform everyday interactions?

Additionally, further research might well consider the ways cultural codes associated with identity categories can conflict interactionally. I became interested in this topic when speaking with nurses about the difficult experiences related to "next of kin" decision making. Nurses often described how emotionally difficult it is to continue painful medical interventions for patients who are unable to direct their own course of treatment, particularly when nurses view the treatment as providing little to no benefit. When family members begin to make medical decisions for the patient, nurses' clinical perspectives are trumped by institutional design of ethics. This design presents a moral identity dilemma, requiring nurses to continue procedures they view as "torture" because family members want to "do everything." As I briefly discuss in chapter four, the directive, "do everything," is part of a cultural code – an expectation of family members to have so much love for a patient, they cannot give up or bear to say goodbye. Family decision-makers likely feel good knowing they did everything they could to try and save their family member. However, adherence to this cultural expectation simultaneously creates troubles for providers and obstacles for providing "compassionate care," as understood by nurses.

While I focused attention on hospital nurses in an urban area, future research should consider other types of nursing, and focus attention on nursing in rural areas, religious-sponsored organizations, VA clinics, and cancer centers. In addition to examining experiences and perspectives of nurses, future research should tend to other provider roles. It is particularly interesting to consider "compassionate caregiving" from the perspectives of those in fields not necessarily historically or culturally understood as compassionate, such as surgeons or anesthesia providers.

In tracing meaning making across levels of social life, there are opportunities to more comprehensively understand complex issues related to healthcare policy, practice, and outcomes.

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APPENDIX A:

INTERVIEW QUESTIONS

1. Can you tell me about your job? *What are your duties?*
2. Where did you go to nursing/medical school? *When did you attend/graduate? How did this prepare you for your career?*
3. Can you tell me about how you decided on a career in health care? *What/who influenced your decision? What was appealing to you about this work? Is there anything that surprised you about the job once you were out of school?*
4. Is there anything in particular you like about this job? *What else?*
5. Is there anything you dislike about this job? *What else?*
6. Is there anything about your job you feel is generally misunderstood?
7. What are the things about your job that are emotionally rewarding? *What else?*
8. What do you find emotionally challenging about this work? *How were you prepared/trained for these emotional challenges? How do you deal with this emotional demand? Do you talk about these emotional challenges with co-workers? Do you have an idea how other co-workers feel about these emotional demands?*
9. Can you tell me about a patient you really enjoy(ed) caring for?
10. Can you tell me about a patient you didn't enjoy caring for?
11. Can you tell me about a patient that needed extra attention? *How did you care for them? Thinking back, do you feel that you made the right choice?*
12. Can you tell me about past patient that you still think about? *What was unique about that particular case? What was the patient like? What is it about that case that stuck with you? What did you think about it at the time? How do you think about it now? Did you learn any lessons from this experience?*
13. Do you have any other patient stories that stick with you? (Repeat other follow up questions.)
14. Can you describe a time when you had to emotionally support a patient and/or family? *In what ways did you support them? In retrospect, would you do anything differently?*
15. What things do you do to cope with such emotionally demanding work? *What do you and your co-workers do to balance your work life and personal life?*
16. Have you ever heard of Schwartz Rounds events at work? (If *yes*- have you ever attended? What was your experience like? How was this experience useful or not? If *no*- describe Schwartz Rounds and ask if they have experienced anything like that before, in school, previous work, etc. Is it something you would be interested in attending? In what ways might these emotionally engaging panels be helpful or not?)
17. Where do you see yourself in five years?

18. Is there something that you might not have thought about before that occurred to you during this interview?
19. Is there anything else I should know to understand your work better?
20. Is there anything you would like to ask *me*?

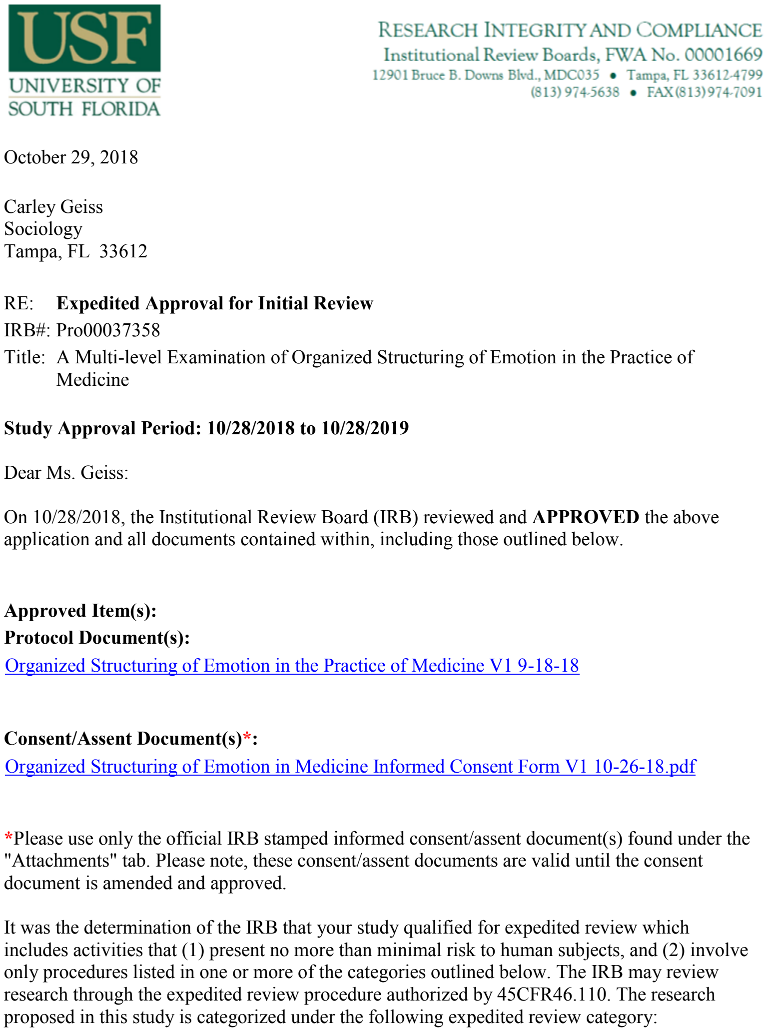
APPENDIX B:

POST INTERVIEW SURVEY

1. What is your current job title?
2. What is your work background?
3. Number of years worked in this position?
4. What is your gender?
5. What is your race/ethnicity?
6. What year were you born?
7. Have you attended Schwartz Rounds? *If so, how many? Where did you attend?*

APPENDIX C:

IRB APPROVAL



RESEARCH INTEGRITY AND COMPLIANCE
Institutional Review Boards, FWA No. 00001669
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October 29, 2018

Carley Geiss
Sociology
Tampa, FL 33612

RE: **Expedited Approval for Initial Review**
IRB#: Pro00037358
Title: A Multi-level Examination of Organized Structuring of Emotion in the Practice of Medicine

Study Approval Period: 10/28/2018 to 10/28/2019

Dear Ms. Geiss:

On 10/28/2018, the Institutional Review Board (IRB) reviewed and **APPROVED** the above application and all documents contained within, including those outlined below.

Approved Item(s):
Protocol Document(s):
Organized Structuring of Emotion in the Practice of Medicine V1 9-18-18

Consent/Assent Document(s)*:
Organized Structuring of Emotion in Medicine Informed Consent Form V1 10-26-18.pdf

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent documents are valid until the consent document is amended and approved.

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110. The research proposed in this study is categorized under the following expedited review category: