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ARTICLE

Narratives of "good care" at hospitals in Turkey: occupational experiences of retired nurses

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Abstract

Recent changes in the Turkish healthcare system aim to enhance efficiency by implementing various feedback systems, performance-based wages, and new auditing mechanisms to monitor resource and time use and cycle of motions in medical settings. This paper aims to answer the following question: how do nurses respond to changes that place them in a subordinate position, where supervisors and administrators dictate control over time and the nature of labor? In the literature on labor and neoliberalization, resistance by workers to control over work is mostly concluded as part of the reproduction of workers' subordination. However, this paper challenges such a conclusion by presenting an alternative perspective. In-depth interviews with twenty-one nurses conducted in İstanbul revealed that nurses disrupt control mechanisms by refusing to conform to behaviors dictated by managerial principles, manipulating information about medication and equipment usage, and concealing beds and patients through their authoritative control over them. This study unveils new dimensions of contemporary nursing in Turkey through which covert solidarities between nurses enable efforts to maintain "good care" often shaped by gendered expectations. These efforts mostly resist the "hotelization" of hospitals and aim to remake the moral boundaries of care work.

Keywords: care work; neoliberalism; nursing; organizational control; Turkey

Introduction

In this article, I explore the occupational experiences of retired nurses in Turkey, focusing on their fragile memories, recurring anxieties, and the subtle yet powerful solidarities they forged in their workplaces. Their narratives oscillate between three interconnected dimensions: change, the (loss) of morality, and organizational control. I aim to unpack the relationship between these dimensions and demonstrate how nurses navigate and resist the pressures of a transforming healthcare system.

Central to this study is the question: how do nurses counteract the changes that put them in a subordinate position in which the control of the time and content of labor is dictated by supervisors and administrators? Drawing on Collinson's (2003) concept of resistant selves, I argue that excessive organizational control paradoxically

fosters resistance among workers. This article contributes to this perspective by revealing nurses as agents who critically engage with and resist the neoliberal and gendered ideologies embedded in Turkey's healthcare system.

The study also offers a nuanced understanding and different outlook toward workers' resistance. The article empirically demonstrates that nurses do not reproduce their subordination by complying with the austerity logic behind New Public Management (NPM) and gendered ideals for nurses, such as "self-sacrificing" and "angel of mercy." They rebel, hide, confront, and ignore any practice disturbing the enabling environment necessary for sustaining good care for the patients, perpetuating their occupational fulfillment.

Organizational control over care work renders nurses as actors who push back against the loss of autonomy in their profession as well as the loss of whole-person care. The foci of our conversations were their occupational priorities, molded by the moral nature of care work, trust, and privacy of patients, as well as the sisterhood they established over the years: the glue sustaining the subtle solidarity among nurses in the workplace. Such solidarity is crucial to understanding the collective effort and resistance to being swallowed, flattened, and muted by the practices rendering care work as drudgery.

In February 2020, right before the onset of a global pandemic, I finished conducting interviews with twenty-one nurses in İstanbul, Turkey. Sometimes narrated with a thin and shaky voice, their stories are enveloped in clouds of emotions. To make sense of what nurses refer to as change, it is critical to understand the dynamics catalyzing the alterations at hospitals in Turkey.

The Health Transformation Program

Since 2002, Turkey has undergone significant policy shifts in various domains, including education, economy, family, and, finally, health, under the government of the Justice and Development Party (Adalet ve Kalkınma Partisi; AKP). Agartan (2012) characterizes these healthcare reforms as a combination of universalism and marketization. While the reforms extended social health insurance coverage and improved access to medications and healthcare services, they also increased the role of private actors in healthcare delivery, introducing market dynamics into the sector (Yılmaz 2017). Furthermore, the state's primary focus in attracting people for medical procedures to Turkey required medical institutions to seek Joint Commission International accreditation to benefit from the state incentives for promoting medical tourism (Yılmaz and Aktas 2021). Such a drive for effectiveness alters the structure and organization of medicine, with an increasing emphasis on metrics and statistics, potentially overshadowing clinical realities, compromising care, and obscuring data that does not serve the institution's performance, thereby changing both the content of care work and its management.

Central to these reforms was the Health Transformation Program (Sağlıkta Dönüşüm Programı; SDP), which was initiated in 2003 through a coalition between the World Bank and the AKP (Yılmaz 2017). Various professional groups, such as the Turkish Medical Association (Türk Tabipleri Birliği) and the Turkish Nurses Association (Türk Hemşireler Derneği), opposed these transformations because of the program's initial aim for privatizing healthcare services, promoting competition,

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and subcontracting labor and flexible employment in public services. These changes aim to promote efficiency by implementing varied feedback systems, performance-based wages, and new auditing mechanisms to monitor resource use, tasks to be completed, time use, and cycle of motions in medical settings. The aim of "high-quality health services" has become the main motto for policy making.

New auditing systems, as part of the SDP, were introduced to reduce errors in medical treatment and maximize the quality and quantity of care in a limited time to ensure efficiency and standardization. Unavoidably, audits created a new form of control, operating from a distance over hospitals and care facilities, replacing the previous reliance on professional knowledge and decision-making with standards and metrics (Foth and Holmes 2017). Consequently, to ensure the improvement and effectiveness of the SDP in Turkey, different institutions emerged, such as the Turkish Health Care Quality and Accreditation Institute operating with the Health Services General Directorate.

As a consequence of these interventions, the work of nurses has come under intense scrutiny and surveillance. This scrutiny is implemented through various means, including performance indicators, managerial criteria, ISO 9001 standards and regulations, instant patient feedback, and government-mandated computerized filing systems. In addition, healthcare reforms affect nurse managers' and nurses' work by centering their labor around budget management, accreditation, and satisfaction of patients (Newman and Lawler 2009). As part of these reforms, data-gathering, which serves the information and data collection at the national level, intensifies the clerical work for healthcare workers since it necessitates consistent reporting of patient numbers, their anamnesis (the record of previous diseases enabling patient profiling), as well as self-reporting of nurse managers. This results in detailed documentation of various aspects of healthcare delivery. The number of conducted tests, patients examined, and daily use of medications, medical instruments, and tools such as syringes, medical kits, and sterilizers are all meticulously reported and documented.

These sweeping changes in the healthcare system raise important questions about their impact on nurses' autonomy and work experiences. In light of these changes implemented by the AKP government and the World Bank, I find it helpful to reiterate my research question here: how do nurses counteract the changes that put them in a subordinate position in which the control of the time and content of labor is dictated by supervisors and administrators? Focusing on care work as their central task at the hospital carves out the changes and losses that nurses articulate within the tension between the institutional and neoliberal organization of care work and care work as moral work. Lying between these two, gendered power relations and hierarchies become the driving force sustaining the dichotomy and superiority of the institutional demands over the content of the care work. This very tension, institutional endings that objectify and subjugate nursing skills into financial interests, make prioritizing care as moral work deeply political in the everyday care work of nurses.

Care work and NPM

NPM – the application of market principles to public services to enhance efficiency and reduce risks – has been globally adopted, with its implementation shaped by local

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socio-political conditions. This study particularly unveils the specificity of care work in Turkish hospitals under the effects of the SDP, a fractal manifestation of NPM principles in the Turkish healthcare system.

Professions are not independent of the state's controlling mechanisms across different domains (Johnson 1995). Indeed, they have been primary targets of NPM, which aims to redefine the self-governing capacities of professions (Kuhlmann et al. 2016). Clarke (2004, 116–117) describes managerialism as 'organizational glue of what has been called the dispersed state'. However, the relationship between professions and governance is inherently unstable and malleable. Consequently, similar structural changes across different healthcare systems can lead to diverse manifestations of professionalism and varying types of relationships between professionals and organizations in varying contexts.

Nursing practice has always been influenced by changes in social policy (Hoyle 2014). Notably, this relationship is not unilateral. Nurses can also shape and influence the implementation of healthcare policies (Lipsky 1980) through their practices, decision-making, and use of discretion in various organizational contexts. Lipsky argued that nurses, as street-level bureaucrats – frontline public service workers who interact directly with citizens in the course of their jobs – would unavoidably exercise their discretion and judgment (Lipsky 1980). This discretion can be determined by organizational constraints, the sense of fairness and injustice, and the peculiarity of the tasks to be completed (Taylor and Kelly 2006). Therefore, nurses are not passive agents who unquestionably implement policies, but, rather, they circumvent policies in a way that consolidates their professional values and norms (Hoyle 2014).

Recently, the literature portrayed that divergent logics dominate the ways that medical care is delivered, and NPM is seen as the primary cause of these fractions in caregiving priorities. These discussions often construct a dichotomous relationship between professionalism and managerialism (Carvalho 2014), either leading to controlled professionalism or hybrid professionalism (Noordegraaf 2015). Whereas the former refers to the pure control of professional values and identities by managerial and institutional logics, the latter understands this relationship in a more complex and contested way in which professional boundaries become blurred (Waring 2024) and combined, mixed, or blended (Pache and Santos 2013). Van Wieringen et al. (2017) also argue that nurses can comply with different logics while they can de-couple from divergent pressures and continue caregiving and support that is not allocated.

Newman and Lawler (2009) argue that the competing and contradictory demands by the very nature of the care work and auditing systems put nurse managers into vulnerable and stressful positions while they are trying to do more by less (Chiarella and Cordery 1995). The increase in the amount of clerical work diminishes the time allocated for care work and interaction with the patient and puts more stress on workers in terms of their time management. Quality-control auditing in clinics, such as measuring patient safety, clinical hygiene, compliance with dress, and communication with the patients, creates multiple gazes coupled with internalized self-discipline of the nurses. Consequently, the materialization of managerial discourse has not resulted in increasing efficiency or coordination, but, rather, it

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is coupled with bureaucratic surveillance around performance indicators (Newman and Lawler 2009).

The surveillance studies have long shed light on the intensification of data collection by nurses at medical institutions. Whereas some scholars emphasize more self-disciplinary and panoptic modes of surveillance in medical settings (Evetts 2009; Timmons 2003; Waring 2024), other scholars also advocate for a more self-responsible agency that can create their own professional intervention and contestation areas, which can undermine such technologies that gaze upon labor and care (Ferlie et al. 2012; Flynn 2002; Lundqvist and Axelsson 2007). Parallel to this argument, I describe that such control and surveillance over care work leads to the interpretation of nursing activities, roles, and responsibilities through nurses' discretionary efforts. These efforts neither expand nor narrow their professional boundaries, as the literature has suggested (Flynn 2002). Instead, they serve to protect the moral nature of nursing's professional marker: care work.

Gendered care work meets gendered NPM

The studies on nursing in Turkey have also revealed the experiences of subcontracted employees at hospitals and invisible care work conducted by nurses in the formal sector, which are overlooked dimensions in the literature (Acar 2020). The idealization of good women as devoted wives, mothers, and caregivers mostly obscures the intensive work that nurses perform in the formal organizational structures since these are considered natural duties and skills for women, which are not gained and learned but rather innate to them (Şimşek-Rathke 2011). However, care work includes different amalgams of tasks such as nutrition, cleaning, accommodating, drug and blood pressure monitoring, and lifting that necessitate divergent abilities from emotional intelligence and technical skills to physical strength as the demanding nature of nursing.

Skill is crystallized as an ideological category imposed on certain tasks, kinds of work, and jobs not independent from who performs them along gender lines (Phillips and Taylor 1980). Hospitals are home to such ideological impinging on skills; they are gendered organizations where the ideas about nursing have always been connected with femininity and women's work (Acker 1990; Witz 1990). Care work is also unavoidably bodywork, which also cements the symbolic meaning attached to it as intimacy and privacy, in turn reinforcing the patriarchal ideology (Twigg 2000). In addition, while men's positions in the medical field are assumed to signify more authoritative roles, allowing them to control the decision-making process, women are often seen as supportive actors who are distanced from decision-making and control over their labor. This article contests the notion that nurses are distanced from controlling the time and space of their labor.

NPM is not gender-neutral; it reinforces "competitive behavior as involving hard, macho, or 'cowboy' styles of working" (Davies 1995, 27). Whereas management, rationality, and performance are linked inextricably to masculinity, caring appears as "soft, private, and emotional." Several works in the literature argue that the practice of managerialism enacts masculinity in organizations (Collinson and Hearn 1994). Such dichotomization along gender lines perpetuates the illusion of "objective rationality" dominating over caring and care work (Barry et al. 2010).

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In parallel to this, Turkey has experienced a unique political shift over the last two decades. As Acar and Altunok (2013, 14) describe, "two political rationalities ... [neoliberalism and neo-conservatism] have come to play important roles in the shaping or regulation of public and private domains, and the relations within these domains." This "happy marriage" of neoliberalism with neoconservatism has not only altered women's roles in the private domain but also reinforced an idea in the formal sector that working women should be patient, undemanding, and silent, aligning with the ideal image of Muslim women. The gendered nature of NPM has inevitably led to gendered responses from nurses in the form of "backing up the care work" for the claims of professionalization, which is empirically demonstrated in the Findings section. These responses reflect the complex interplay between management practices, economic policies, and deeply ingrained gender norms, further highlighting the non-neutral impact of NPM on different genders in the workplace.

Methodology

To reiterate, this study explores the occupational experiences of retired nurses in Turkey under the effects of the SDP, examining changes in care-work values, strategies, and gendered power dynamics. The research focuses on discretionary work effort, strategies around maintaining professional boundaries, and interpersonal relationships in medical settings.

A descriptive case-study approach was used to explore the experiences of retired nurses in the occupation over the past three decades. Through semi-structured interviews with twenty-one nurses and participant observation methods in an informal meeting for five hours, the study allowed nurses to share their experiences organically, resulting in detailed narratives. Our conversations covered why they chose nursing, their work trajectories, relationships with patients, and interactions with hospital management, with each session lasting one to two hours. Participants primarily were women with at least twenty years of experience, which enabled me to understand the process of organizational changes over time. The wards (such as oncology, pediatrics, maternity, surgery, and emergency services) that nurses had worked varied throughout their working years. However, this is hardly a disadvantage for the analysis. Indeed, it enriches the data to see commonalities across different areas of care work.

It is important to note that all my interviewees were women. However, such a result was more than a consequence rather than an intention. In Turkey, until 2007, men were not legally permitted to work as nurses but only permitted to work as health personnel. Since my interviews were with retired nurses in 2020, the years do not correlate with the years that men have been entitled to be nurses. Additionally, the age range of this cohort (forty-five to sixty years old by 2020) is essential in terms of their educational background. Most of the nurses in my study received their education from Vocational Schools for Nursing, which gave nursing diplomas to individuals between the years 1986 and 1990. These Vocational Nursing Schools were also mostly boarding schools. Due to spending most of their time together, away from the family at an early age (fifteen years old), yet being under the surveillance and control of the school administration all the time, sowed the seeds of solidarity among nurses. Therefore, the solidarity mentioned in our conversations often traces back to

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their educational years rather than originating from their workplace dynamics and struggles.

Data analysis involved a three-stage coding process: open coding; axial coding; and selective coding (Neuman 2014). In the first stage, open coding, I identified and categorized key elements such as critical dates, changes in hospital regulations, patient–nurse relationships, and the introduction of new actors in the medical field. During the axial coding phase, I examined the identified themes and explored their connections within the data. Finally, in the selective coding stage, I focussed on selecting data that supports and refines my analytical categories, thereby enhancing my conceptual framework. Finally, transcriptions were completed by the researcher, all the listed participants were kept confidential, and pseudo-names were used.

Findings

Nurses' experiences of institutional change

Nurses' discretionary efforts and everyday resistance are shaped by the prioritization of care work and the control over decision-making processes surrounding it. Therefore, this section highlights the motivations behind unique and everyday resistance among nurses to maintain control over their professional domain. This resistance is often linked to the morality and ethics of care work, as discussed in the interviews. It also explores the elements of moral aspects of caregiving that configure the nurses' choices and discretionary efforts.

Hospitals are unique in terms of containing different varieties of reasoning between calculative regimes and bureaucratic structures tied to broad socio-economic transformations. The micro-foundations of global neoliberal capitalism introduce particular ways of seeing, evaluating, and determining the quality of medical treatment and care, which is calculable and comparable (Reilley and Scheytt 2019). Hospital management collects information and sorts the data tied to financial interests, which consider failure an economic rather than a moral event (Reilley and Scheytt 2019). On the contrary, this research reveals that nurses' definition of quality of care and the failure to deliver it is a moral event rather than an economic one. This imposed dichotomy between moral and economic failure is pregnant with possibilities for nurses to develop new ways to underline the artificial nature of purely economic evaluations and success in healthcare.

In healthcare settings, nurses employ a range of divergent practices in response to mandated changes that affect their professional priorities, the timing of care work, and administrative control. These changes, which nurses describe as the "hotel-ization" or "hotelizing" of hospitals, reflect their experiences of a shifting healthcare landscape. The term captures the transformation of their relationship with patients – now framed by management as "customers" – as well as the increased pace of their labor and the growing privatization of healthcare institutions. For nurses, "hotel-ization" signifies a departure from the traditional ethos of care, where the focus on patient well-being is increasingly overshadowed by market-driven efficiency and consumer-oriented practices.

This study reveals that nurses do not directly contest powerful actors or institutions; rather, they contest the practices that are imposed by these actors – such as quantification of quality, collection of data, and management of workers'

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performance – through creative efforts and exercise of discretion. These activities have one common motive: sustaining the care work as moral work. Our conversations revealed a significant interrelationship between the moral aspect of care work and its tangible component – the body. For instance, one of the nurses mentioned that:

> I always make sure to care for my patients without hurting them and by respecting their privacy and concerns about their illness. My way of communicating with them has always been about that. It is about ethics and morality (Nurse Çağla, twenty-eight years of nursing experience).

Here, it is explicit that not hurting the patient and reassurance of bodily maintenance in peace and privacy are integral constituents of the ethical facet of caregiving. Moral consciousness (*vicdan* in Turkish, meaning the inner force to make a judgment) becomes a recurring theme that nurses directly relate to the ethics of providing care. For instance, one of the nurses described that:

> When you go to bed after doing this job and put your head on the pillow, you know . . . you evaluate that day. And I always asked myself, "Can you sleep at ease?" (Nurse Aslı, thirty years of experience in nursing).

According to the nurses I interviewed, moral consciousness forms an integral part of their professional socialization process, learned through education in schools and training at hospitals. This moral consciousness informs their approach to care, embodying crucial components like privacy protection, trust building, dialogue, attention, competence, integrity, and empathy. Rather than viewing these elements as prescriptive metrics for quantifying the quality of care, they serve to foster a deeper patient–nurse relationship, one that extends beyond mere diagnosis and treatment.

In our conversations, the nurses pointed out that the core aspect of their work (caring), with its moral component, is at risk of being overshadowed because of the pressure to prioritize administrative tasks. Therefore, it has become their primary battleground in which nurses reflect their occupational priorities by limiting the sway of managerial urgencies. That is, nurses do not simply comply with the new rules and ideologies; there has always been resistance and non-compliance. Although managerial efficiency and coordination in care work are assumed to improve the quality of care, for most nurses, these mechanisms, as a matter of fact, increase the quantity of care rather than its quality.

Quality of care becomes one of the spheres to scrutinize and sustain the surveillance of tasks completed by nurses rather than a primary goal. One of the nurses described the futility of such transformation in the Turkish healthcare system as:

> We used to spend more time with the patient in the past. The time we spent with patients diminished after this . . . what they call "quality control." This policy started to be implemented in 2006. I realized that *we were already doing what they requested us to do now* [emphasis added], but we were not recording them. However, now, all we do is record and file. Instead of doing clerical work,

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> I prefer to visit patients ten times more (Nurse Belgin, thirty-four years of experience in nursing).

One of the participants also described the transformation in their experience in terms of increasing text-mediated standardization (Limoges 2007) and quality-control mechanisms in the following manner:

> We work with people; we are not robots, and they (patients) are not either. They are alive, not commodities, and neither patients nor nurses have standards for their bodies. For instance, think about appendicitis surgery or eye surgery; each surgery is different, each patient is different, and their needs, psychological, and physical conditions are various. They are human beings; we cannot set rigid standards for providing care to them. In the past, we used to ask whether they had any concerns or questions; now, what hospital management cares about is *how fast we complete the treatment* [emphasis added] (Nurse Canan, thirty-four years of experience in nursing).

This passage exemplifies how auditing mechanisms tend to reduce quality to mere quantity, measurable only by metrics that hold political efficacy while eliding critical realities. Indeed, another essential dimension of care work has been emphasized, which is often ignored in the literature: care work is an embodied experience for nurses as well. Therefore, it is not only how these metrics can standardize the patients' bodily needs but also how nurses interact with them. Parallel to that, the auditing mechanisms do not only control the data collected, use of technologies, or quantity of patients examined; they also impose a particular set of behaviors between caregivers and patients, encoding the patient as a customer purchasing a standard service across different contexts (Martin et al. 2013). One of the participants in the study described her frustration in terms of "coded behaviors" this way:

> The management insists that we greet every patient with a "Good morning, welcome" each time we interact with them. This applies even when we are dealing with the same patient multiple times within a short period. Let's say a patient approaches the information desk; as a nurse, I am expected to welcome them. Now, if the same patient steps away to collect their blood results from the laboratory and then returns to my desk, I am supposed to greet them with a "welcome" again, as per the directives from our chief physicians. Honestly, this seems redundant to me, and I find it very frustrating. I have reached a point where I cannot tolerate it anymore. This situation always leads to frequent disagreements with the doctors. Can a patient be a customer in the eyes of doctors and nurses? (Nurse Buse, twenty-six years of experience in nursing).

Such policing of the behaviors, not only over the care process, body, number of medications, and time, is one of the micro areas and small mutations (Rabinow and Rose 2006). As in the example, nurses refuse to deploy such coded behaviors, as they consider these gestures degrading to their professional autonomy. This refusal of managerialism discourse in the relationship between care worker and patient,

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coupled with priority over moral consciousness in the caring process, constitutes the primary empirical markers for their professional status (Limoges 2007).

As is evident, nurses feel anger and resentment towards such encrypted relationships with patients as if these relationships take place in a hotel, in which nurses need to serve their customers without contesting any wish that patients have. This resentment and denial stem from their strong attachment to their professional duties and the moral values associated with their responsibilities. Therefore, similar to the studies on nursing and NPM in the literature, it is evident that nurses de-couple themselves from practices damaging their relationships with the patients, which they consider humiliating for the nursing profession.

Changes imposed on hospitals do not primarily value moral aspects of caregiving in which nurses consolidate their professional identity, satisfaction, and commitment to their labor. That is, the moral order around care work is rendered irrelevant and insignificant to curing and can be sacrificed without a doubt for the sake of time efficiency and standardization. However, nurses not only de-couple themselves from such priorities but also resist them in the form of reinventing time, manipulating the provided space through covert solidarities between each other, which is explored in the next section.

Hidden spaces: vulnerable bodies and emptied beds

As empirically voiced, the nurses I interviewed were highly critical of the changes in the delivery of healthcare services in Turkey. They avoid and refuse to adapt coded behaviors dictated institutionally because they want to sustain their professional autonomy and control over their work. This often means that the implementation of the policies is compromised or even not fully adhered to. Indeed, they were selective of practices they would like to engage with, while prioritizing the moral components of the care work over management values. To accomplish this motive, in my study, nurses re-interpret the spatio-temporal organization of managed care.

In this part of the article, I unveil collective yet covert resistance strategies of nurses to mitigate the effects of the SDP in their workplace and, more importantly, in their care work. Nurses' motivation primarily derives from being disobedient to the social structure, which subjugates nursing skills as invisible and invaluable. The SDP renders the moral aspect of care work contradictory to efficiency, betterment, calculability, and predictability through divergent actors (such as auditing agencies and hospital management) while perpetuating the former's inferiority to the latter along gender lines. Therefore, nurses' gendered responses and insistence on sustaining care work centered around the vulnerability of the body, rather than considering it solely a calculated and governed corpus, becomes an important dimension.

Interestingly, novel organizations of time and space have little voice in care work and nursing studies, although they are crucial dimensions for understanding care work as both moral work and bodywork. Therefore, this chapter reveals novel spatial organizations around care work in the form of discretionary effort, the recognition of bodily vulnerability, and how a patient's bed becomes a space of contention, as bluntly expressed by nurses.

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One of the recurring themes in my conversations with the nurses is protecting the patient's privacy in a public space as a core aspect of good care. However, this task has become unachievable in public hospitals with a high number and circulation of patients. Thus, what constitutes a patient's personal space can change over time, across wards, based on the care and operation that the patient needs to receive. Here, there are important nuances regarding how nurses create such private space for patients by securing their consent first. One of the nurses described that:

> Before starting the procedure, a nurse needs to communicate the reasons behind procedures, such as urethral catheterization, detailing its benefits like maintaining hygiene, aesthetics, and health, that they will be clean, smell good, and look good. Thus, before any procedure, securing their consent is vital. This not only safeguards their rights but also fosters trust, which in turn facilitates and eases the caregiving process (Nurse Derya, thirty-one years of experience in nursing).

Hygiene (bodily and, most importantly, genital hygiene) is one of the crucial aspects of nursing when a patient cannot provide it themselves. Hence, nurses must wipe patients in comparatively public places: shared patients' rooms. In such a situation, nurses mention that they use their bodies to face the other patients in the room to provide comfort for an already uncomfortable situation for patients who need assistance. For instance, as two nurses described:

> We care about the patient's privacy to avoid causing them discomfort or offense. Consider the vulnerability someone might feel if exposed without clothes to others in the room. If one part of the body is exposed, the other should be covered to maintain the patient's dignity in the presence of others (Nurse Başak, thirty-one years of experience in nursing).

> In our efforts to respect the patient's privacy, we keep parts of the body that are not being worked on covered. With our bodies and warning other patients in the room, we put our best effort into providing patients in need of personal care with a more comfortable space (Nurse Şeyma, thirty years of experience in nursing).

Nurses in my study frequently mentioned that trust and privacy are two main components of good care; they create the climate for vulnerable bodies to feel safer and more secure. This aspect of the caring process appears as a strategy to extend both nurses' spaces for control over their labor and patients' personal space. It limits the operation of disciplinary and managerial mechanisms that prioritize the amount of diagnosis over the quality of care; surveillance of patients' bodies as quantified and measured explicitly, rather than their privacy. On the one hand, it enlarges the nurses' spaces by creating another gaze over the other patients in the room and extends their control over the labor process by controlling not only the space but also the time of care work. Control over prioritizing particular tasks over others and taking their time to consolidate their relationships with patients make nurses feel more fulfilled about the care work they are providing. Concurrent control over time

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and space accelerates their medical autonomy not only for the patient's survival but also for mutual trust and privacy, which are undervalued by the time schedules and charts that diminish the time for care.

The patient's bed also becomes a space for non-ill bodies, such as the patient's children, families, or relatives, for informal care providers. Hospitals with high numbers of patients, particularly public hospitals in Turkey, cannot frequently provide space for family and relatives for overnight visits. Nurses have deployed two strategies to open such space for patients' companions. First, they, on purpose, inform their supervisors that the ward is full, although it is not. Second, they also coordinate with patients by suggesting to them to say that the other beds in their room are full (although they are not) if someone shows up and asks them whether there are other patients in the room. A nurse says, "We sometimes make them say that the other patient is in the toilet or another place." Nurses use their authority to rearrange the limited space in patient rooms, creating more room for movement while preserving patient privacy and accommodating family members. The patient's bed becomes a space of contention between nurses, patients, patients' families, and the hospital management. Through the relations in which such contention is being stretched out, hiding, misinforming, and shifting the activities to unsurveilled space become counterpoints not only to the management but to power relations in which these management apparatuses are being realized by controlling spatio-temporal organization of care work.

Nurses' responsibilities related to computerization and filing have also dramatically increased. Indeed, they describe that while they are filing, sitting in front of the computer, nurses are open to being questioned by the patients in terms of "Why does it take longer for the doctor to arrive?" "Why are you looking at the computer instead of paying attention to me?" Thus, nurses' bodily motion and motionlessness (sitting) are highly surveilled.

Studies describe that nurses' planning of care used to take place in/near patients' beds throughout the patient's stay at hospital (Timmons 2003). Now, care plans are created in nursing desks in the middle of the clinical ward, at a distance from the patient's bed, outside the room, with a computer. Therefore, nurses' bodily acts to provide privacy for patients also reclaim the space of the patient's bed as their work realm as opposed to dissociation from care work and the patient's side. Conversely, this approach extends patients' boundaries beyond their beds by prioritizing bodily privacy rather than surveillance, creating connections between patients and nursing staff. It hides the body that is vulnerable and open to intervention.

Discussion

The article contributes to the literature on work and organizations and NPM by offering a nuanced perspective on how nurses navigate and resist the implementation of the SDP in healthcare settings in Turkey. Rather than directly confronting powerful actors, such as doctors, chief physicians, or managers, nurses employ subtle forms of resistance against specific practices imposed by these actors, such as quantification, data collection, and worker performance management. Moreover, nurses derive greater fulfillment from their work when they can triage their tasks, allocate time to build rapport with patients, and respect patients' confidentiality and privacy. This

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control over spatio-temporal organizations of their work fosters their relationship with patients, allowing them to conduct "good care," frequently undervalued by rigid time schedules and emerging new responsibilities such as filing and documentation. The insistence on caring about care underlines the moral implications of giving care rather than its naked completion (Tronto 2020).

The research unveils the complex processes of bargaining and resistance by nurses in response to managerial interventions at hospitals through their constant interpretation of institutional change. Among the nurses I interviewed, there is a strong sense of identity, which pinpoints that whilst nurses are not free from the repercussions of restructuring the Turkish healthcare system, they are also not passive recipients of the alterations. The nurses in my study exercise their power over the patients to reinterpret and challenge the dominant restructuring discourses through their subtle yet collective solidarity. Their discretionary work, mostly gendered efforts, is crystallized as an endeavor to regain their control over the time and motion of their labor.

The nurses in the study, regardless of their years of experience, workplace, and management roles, suggest that organizational restructuring at hospitals is ignorant of "real" nursing and care work, which can jeopardize the patients' lives and well-being. Therefore, their working identity is constantly hammered through key values such as respect for confidentiality and privacy of the vulnerable body requiring medical attention. The prioritization of longer communication with patients, cleaning them meticulously, and relieving the patient's physical pain when needed cannot be realized without an enabling environment. Such an environment is also cultivated by nurses' discretionary efforts: through their control over timing and the motion of labor; covert solidarity with each other; and exercising power over patients and patients' families. That is, the nurses actively enact their traditional nursing identities by exercising power and resistance simultaneously. They exercise power over patients and their families to resist control mechanisms that deprioritize care work and dissociate them from the patients.

The nurses' narratives of good care perpetuate the dichotomy between managerialism and caregiving; that is, their responses to the SDP are also gendered. However, the patriarchal gender roles in formal care settings are also discomforted. Nurses do their gender by being kind to patients but cruel and aggressive to the management. They are emotionally engaged with their patients, but they articulate that they are also rational whilst prioritizing the empirical markers of their profession: care work. They are accommodating towards the patients but confrontational with those causing disruption in their working environment.

This evidence concludes two important dimensions of nursing in Turkey. First, gendered relationships are articulated in every interaction between nurses–patients and hospital management; however, they are neither stable nor fixed. Second, nurses bargain with the SDP through ways that weaken its effects on care work. They, in a way, triage their responsibilities fed by the motivations and attachment to their work. This demonstrates that resistance is possible even in spaces that are articulated by neoliberalism and heteronormative patriarchy.

The studies on nursing and NPM have argued that the exercise of discretion by nurses has become limited since the work is now more regulated and controlled by quality-control measures (Kinnie et al. 2005). A significant point of discussion, and

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indeed tension, within the literature pertains to the fluctuation in nurses' professional autonomy within medical settings (Glasdam et al. 2015). Several studies have indicated that auditing systems in hospitals can diminish the motivation and commitment of nurses to their profession (Newman and Lawler 2009). This is mainly because these systems often channel the results of nurses' labor toward budget management, accreditation, and patient satisfaction, thereby potentially reducing their sense of professional autonomy, personal fulfillment, and any forms of collective resistance (Mulholland 2004).

Contrary to this conclusion, the study demonstrates that nurses' discretionary efforts have not become limited; instead, they have become a collective practice. Indeed, such covert and individual everyday resistance can be effective in undermining power relations, as described in the literature (Scott 2016; Yücesan-Özdemir 2003). As street-level bureaucrats, nurses effectively exercise their discretion both individually and collectively. However, such collective action does not take place overtly. It is covert, subtle, yet collective and effective to undermine the regulations that impose goals for nurses conflicting with their professional norms and professional ethics.

Nurses' insistence on control over their labor needs to be read as directly (but not solely) related to their job satisfaction. Indeed, when I asked nurses how they feel satisfied with their occupation, most of them mentioned patients' well-being, patients saying "thank you," or "God bless you." Therefore, patients' comfort, the way they feel secure and peaceful, and the recognition of vulnerable bodies in a hospital environment are essential factors in nurses' occupational attachment and fulfillment. Thus, the actions providing trust and privacy, moral care work, and bodily well-being are sustained collectively but in a subtle way among nurses. For instance, attending to a patient's bedside typically requires the teamwork of two or three nurses working together: one nurse provides direct physical care to the patient while another maintains the patient's privacy by managing the presence of other patients or visitors in the room.

Similarly, misinforming hospital management, supervisors, and doctors about the ward's occupancy cannot take place without cooperation among nurses and, indeed, without the cooperation of patients with them. The study demonstrates that discretionary work effort, non-compliance, and resistance occur collectively among nurses, but in a subtle way. This subtle nature inhibits managers from directly counteracting these actions and prevents them from scapegoating individual workers. I also argue that this control over care work influences how nurses interpret their roles and responsibilities through discretionary efforts. Contrary to some literature, these efforts neither expand nor constrict professional boundaries; instead, they protect the moral nature of care work.

Conclusion

This study shows that care work has both moral and corporeal aspects. This paper has shed light on areas of contestation and decoupling in which nurses carve out spaces to carry out care work, prioritizing the needs and outcomes of patients' physical healing and improvement rather than a sole diagnosis and treatment – as well as their sense of self-fulfillment. The latter is intricately linked to the successful completion of the former, creating a mutually reinforcing dynamic between patient care and nurses' professional satisfaction.

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Care work is not only a professional domain over which nurses insist on sustaining their control but also a moral justification for the importance of their occupation. Such control is maintained through the manipulation of auditing systems surveilling nursing care work. In addition to that, nurses see the vulnerability of patients and know firsthand the consequences of their neglect. However, their advocacy for patients is not only a professional claim or defense of turf but also a pushback against bureaucratic surveillance over their labor and the patient's body. That is, nurses are indeed in the position of non-compliance and disagreeing with policies.

The subtle solidarity and sisterhood between nurses, with roots in their school years, are maintained in the nurses' occupational years at hospitals. The collective actions of nurses take on a political tone because they do not merely stem from individual motivations but are a united response against governmental efforts to monitor, regulate, and reduce the time and space allocated for care work. It signifies that nurses' attachment to their occupation is crystallized as actions manipulating, changing, and modifying spatio-temporality around managed care work. Patients' bodies become a crucial contention area in which nurses control the organization of time and space around their labor while maintaining the moral aspect of care work.

These counteractions narrated here stem from the frustration due to transformations that nurses experience at hospitals. Attempts to privatize the healthcare system in Turkey do not only devalue care work as irrelevant to curing; the care work also sustains itself seamlessly through the nurses' alterations to such managerial priorities. However, such work should not be directly called "extra work." Empirical evidence suggests a nuanced understanding of nurses' actions: rather than simply giving up, many nurses deliberately choose not to engage in tasks they perceive as "hotelizing" the hospital environment. They often do not feel compelled to fulfill or even prioritize every responsibility assigned to them. This avoidance and disobedience stem from the augmented expectations that are unrealistic and unattainable. It is not merely a matter of relinquishing duties; it is a conscious decision to disengage from tasks deemed essential by everyone except the nurses themselves. What is at stake here is that nurses do not hesitate to sacrifice the tasks that auditing systems prioritize, to replace them with the "empirical markers of professional status," namely, care work.

The emphasis on agency and everyday resistance has important implications and insights for rethinking the workplace in which state apparatuses surveil workers. Attention to how resistance is built, and solidarity is maintained and hammered through social meanings attached to working identities and their core values, might help us unveil the daily exercise of opposition to managerialism in the healthcare.

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