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# The Power of Protocol: Professional Identity Development and Governmentality in Post-socialist Health Care

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**Abstract:** The Czech Republic is experiencing a growing trend of health-care worker emigration. Although some emigrate for long periods of time, many return after a few months or years abroad and re-enter the Czech health system. The nurses' narratives in this study draw on experiences in Czech, British, and Saudi hospitals to explore the role standardised medical policies, procedures, and protocols play in the development and maintenance of a nurse's professional identity in the post-socialist context. The author suggests that performance of protocols versus informality of practice in health-care settings provides a lens through which to view professional identity in post-socialism. In fields such as health care, standards operate as measures of security that create normative rules of governmentality, regulate behaviour, and prevent harm. The nurses in this study describe the majority of Czech hospitals as lacking standard protocols for patient care. Encountering strict rules of practice in foreign hospitals leads them to evaluate the professionalism and quality of Czech health care and their own selves as nurses. Their assessment is often based on their own ability to effectively perform within the standardised system. The author's primary analysis for this presentation will concentrate on the ways that standardisation relates to ideas about professionalism and nursing autonomy and status.

**Keywords:** governmentality, health care, migration, post-socialism, Czech Republic

*Sociologický časopis/Czech Sociological Review*, 2014, Vol. 50, No. 6: 875–896

DOI: <http://dx.doi.org/10.13060/00380288.2014.50.6.145>

## Introduction

Working abroad taught Milena how to be a nurse.<sup>1</sup> Although she attended nursing secondary school in the Czech Republic, Milena did not truly develop her professional identity until she worked as a nurse in Saudi Arabia. There she found analytical tools—protocols and policies—through which she could measure her professional abilities. She argues that the dearth of such structure in Czech hospitals produces an environment in which nurses have to fight—both the hierarchy

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<sup>1</sup> To protect the identities of research participants, all names are pseudonyms.

and each other—for the chance to act professionally and develop identities based on the core concepts of the nursing profession. With an increase in nurse migration both globally and from post-socialist countries, Milena's story is becoming more common. Individuals living in the post-socialist region are still defining themselves through intersections of globalisation and post-socialism, migrants more so. This article explores what happens when these intersections occur in health care.

The Czech Republic is experiencing a growing trend of health-care worker emigration. Since the early 1990s, nurses from the Czech Republic have been traveling to work abroad, primarily targeting other European countries. Many work as underemployed care assistants or nannies, while some find full employment as licensed nurses. Although some emigrate for long periods of time, many return after a few months or years abroad and re-enter the Czech health system. This type of exposure to alternative systems of practice naturally elicits comparisons. During the course of a larger research project on Czech health-care worker migration, assessments of Czech health-care work in contrast to that experienced elsewhere became part of the ethnographic record as a form of discourse on the subject of hospital protocols, policy, and procedure. I find that nurses use narratives centred on protocol to discuss their professional abilities and identities. Migrant nurses' self-assessments are often based on their own abilities to effectively perform within the standardised system of a Western-styled health-care system.<sup>2</sup> However, it is less common to find the same type of health-care system in the Czech Republic leading return migrants to seek other measures through which to assess themselves.

Post-socialist transitions have opened up many new spaces in which identities have been challenged, maintained, and transformed [Berdahl 1999; Dunn 2004, 2005; Gal and Kligman 2000; Ghodsee 2010; Holy 1996; Phillips 2010; Waner 1998]. Health care is just one arena in which identity maintenance is a complex, transnational process. Primarily, the Czech health-care system has not transitioned in ways that lead to new forms of professional identity. Although Czech health care has been economically decentralised and now offers fee-for-service treatments and a patient-as-customer approach, nursing as a profession has not progressed much past the 'assistant role' established during socialism [Tóthová and Sedláková 2008: 34]. One notable change has been in regard to the role of caring duties as part of nursing duties and competences and ultimately professional identity [Read 2007].<sup>3</sup> This paper considers care the 'essence of nursing' and at

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<sup>2</sup> Although there are numerous cases of East European nurses migrating to other East European countries, notably Slovak and Ukrainian nurses to the Czech Republic and Poland, I am focusing on East European nurses who go to work in hospitals based on American or British systems.

<sup>3</sup> The term 'competence' has multiple meanings. As an abstract singular noun, competence is a form of embodiment that integrates the full complement of the senses with the appropriate professional knowledge and skills necessary to perform one's profession and

the core of professional identity [Leininger 1988: 154]. How individual nurses define and practice the five attributes of caring—compassion, competence, confidence, conscience, and commitment [Roach 1984]—is contextual and varying. Nursing may be a global profession but it has developed at different rates across the world and with different emphases and ideologies depending on local and national views [Baumann 2010; Sweet 2010]. Global imagination shifts ideas of what nursing could and should be through imported television serials and public narratives of experiences abroad. Migrants themselves experience a clash of nursing ideologies in which the role of caring is just one element. Migrant nurses in this study are coping with defining their professional identities in new environments abroad, as well as at home upon return. Like them, I use hospital protocols as a tool through which to understand the professional identity of nurses in a transnational, post-socialist context. Using performance of protocols versus informality of practice in health-care settings as a lens through which to view professional identity in post-socialism, I argue that technologies of governmentality, specifically hospital policies and protocols or the lack thereof, shape professional identity development in nurses.<sup>4</sup>

Although nurses hold a subordinate position in the biomedical hierarchy, most nurses strongly identify with their work, making it part of their personal identity in ways that workers in more mundane jobs often resist [Melosh 1982: 17; Öhlén and Segesten 1998: 721; Rose 2004]. Like other types of identity, professional identity is a dynamic, shared, relational, and internalised concept of self that develops out of a process of balancing personal experiences with others' expectations [Beijaard, Meijer and Verloop 2004; MacIntosh 2003; Öhlén and Segesten 1998; Roberts 2000]. Professional identity is rooted in one's personal history and built on through professional *and* personal experiences. It is discursive. What is expected by the individual and the public, in this case colleagues and patients, is paramount to understanding the role of the professional [Beijaard, Meijer and Verloop 2004; Öhlén and Segesten 1998]. Individuals perform their identities in context, relating to environmental norms and ideals, and internalise the values that drive their practice [Fagermoen 1997; Öhlén and Segesten 1998; Read 2007; Roberts 2000]. If a nurse's self-evaluation does not match the norms and ideals, she can improve or change her performance to meet expectations [Dunn 2005; Pratt, Rockmann and Kaufmann 2006].<sup>5</sup> For these reasons, Foucault's theory of

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responsibilities. Competence is also the term used for a specific nursing task or procedure in which a nurse has been trained, tested and certified to perform.

<sup>4</sup> In this case I am not discussing 'informal practices' such as *blat* or other gifts offered as 'thank-you tokens' for services [Benoit and Heitlinger 1998; Ledeneva 2006; Patino 2002], but an informality of practice, that which is not formalised through prescribed instructions.

<sup>5</sup> Although there are male nurses in the Czech Republic, the vast majority are still female. For example, in 2011, almost 92% of students enrolled in nursing studies in the Czech Republic were women [ÚZIS ČR 2011]. Consequently, I use female pronouns.

governmentality [Foucault et al. 1991] is useful for understanding professional identity.

Governmentality is about 'instilling a set of rules for the conduct of the self' [Gibbins and Taylor 2010: 35]. Who puts forth the rules determines what appropriate conduct is. Through various techniques and forms of knowledge and discipline, authorities seek to reshape a subject's conduct by reshaping her desires to conform to the norms and ideals of the hegemony. Hospital protocols and policies are examples of normalising tools. These technologies of power engender new sets of rules by which subjects begin to govern themselves. As part of professional identity, nurses must discipline themselves to meet the expectations and constraints of the current work environment.

In short, professional identity is one's perception and performance of self in the context of nursing practices; it is 'the feeling of being a nurse rather than working as a nurse' [Öhlén and Segesten 1998: 722]. A nurse's self-evaluation of competence within the work environment is a key component in professional identity and consequently self-worth [James 1890; MacIntosh 2003; Öhlén and Segesten 1998]. This article demonstrates that practices associated with self-evaluation and professional identity may come into conflict when a nurse's 'rules for conduct of the self' do not match the professional environment.

### **Methodology and ethnographic context**

This case study emerged from a larger project focusing on the ways in which female Czech health-care professionals employ migration activities to seek professional respect and belonging. The principal data collection took place during anthropological fieldwork I conducted in Prague in the Czech Republic from 2008 to 2009 with a follow-up period in 2011. From January to October 2009, I was embedded in a health-care recruitment firm in Prague, which led me to use recruitment firms not only as a physical but also a theoretical base for the primary project. In this study, my insider role as a recruiter became an important way for research participants to get to know me. While my position in the firm undoubtedly affected the research, it is difficult to establish its consequences.

I used ethnographic methods, chiefly interviews and participant observation of recruitment events, as well as electronic correspondence, to collect the majority of data. During the span of fieldwork, I met and interviewed nurses at different phases of their migration cycles. Some of those I met prior to migration have stayed in contact with me through e-mail and online chats. This served as a virtual way to observe their migration experience. I maintain communication with key informants who continue to inform my research. Most of the research was conducted in English, my native language. Although I offered to communicate in Czech, research participants chose English in order to practise or maintain fluency prior to going or upon returning from abroad, respectively. The prima-

ry project included 55 individuals who represent the range of migration roles, including first-time migrants, return migrants, repeat migrants, recruiters, and educators. The ages of first-time and repeat migrants ranged from 23 to 44; return migrants were as old as 60. I recruited participants from the recruitment firm's client base and used snowball techniques to widen the population.

As a case study, this article uses nurses' narratives drawn from experiences in Czech, British, and Saudi hospitals. Understanding the context in which these experiences took place is central to the case-study framework. Saudi Arabia has been a large draw for Czech nurses since Czech recruitment firms started negotiating with Saudi hospitals in the early to mid-2000s. Recruiters noted that standards for working in Western Europe push East European nurses out of the market and into other employment landscapes [Dunn 2005: 184; Guevarra 2010]. Despite open borders and European Union (EU) membership, post-socialist nurses who seek work in Western Europe often meet obstacles such as language inabilities, licensing problems, the high cost of living, or discrimination, which hinder their ability to find full employment; my research indicates that a large number of the Czech nurses who work in the UK are underemployed as care assistants or nannies. Instead of using the informal market of underemployment, nurses who want to work as professionals seek another destination, 'one that is more ready to consume their labor and better equipped to accommodate their financial, professional, and personal aspirations' [Guevarra 2010: 106]. Saudi Arabia has accommodated Czech nurses through licensure reciprocity and recognition.

The Saudi hospital system was created by American consultants and uses the American model of health care and nursing. English is the language of communication. Both Saudi and British systems use nursing models that rely on protocols and procedures to standardise care, creating a space for more nurse responsibility. Some but not all Czech hospitals have protocols in place.

## **Protocols**

In order to understand how the performance of protocols acts as an aid in the development of identity, we must understand how protocols fit into the multiple contexts of examination. In essence, it comes down to one's perspective on the necessity of protocols. At the foundation, the standardisation of labour leads to uniformity and discipline. Here I apply Dunn's [2005] work on standards in meat processing in Poland, which uses the notion of governmentality to understand the roles that transparency, audit, and risk play in post-socialist contexts. Standardisation is intended to create normative rules of governmentality, regulate behaviour, and prevent harm [Dunn 2005; Lampland and Star 2009]. Governments create control mechanisms for the security of risky behaviours like food security and health care: 'Normative governmentality attempts to integrate new geographic spaces and populations not by overt coercion, but by instituting a host of "harmonized"

regulations, codes, and standards.’ [Dunn 2005: 175] Consequently, standards are rote and uniform, as well as visible, governable, and self-regulating behaviours that are derived according to a script [Dunn 2005; Lampland and Star 2009].

Hospitals and health-care systems set standards by implementing policies and protocols for procedures. In medicine, protocols are detailed scripts that outline the patient’s treatment regime. They are ‘decision-support techniques’ for diagnosing, managing, and treating a specific area of health care [Berg 1997: 3] and aim to standardise care in order to alleviate risk. Protocols rationalise medical practice and ‘offer pre-defined, stepwise, optimal paths through complex or troublesome medical situations’ [Berg 1997: 4]. They should reduce risk, improving quality of care and health outcomes [Berg 1997; Machaczek et al. 2013]. For example, in a study of barriers to effective handover in the Czech Republic, over 50% of respondents stated use of non-standard abbreviations as problematic [Machaczek et al. 2013: 7].<sup>6</sup> Non-standard compliance in filling out paperwork, or lack of appropriate policies to complete paperwork, does not allow for audits and chains of responsibility for patient care [Dunn 2005].

Protocols act in direct relation to policies and procedures for carrying out a treatment regime. Policies also govern the documentation of protocol and procedure. These standards are set by the normative body and are locally inscribed, meaning that each country, hospital system, and hospital should define its own standards of care and labour. In other words, despite the global reach of biomedicine, protocols in health care still operate in specific communities of practice that reflect the local context [Lampland and Star 2009].<sup>7</sup>

Although the standardisation of health care at the beginning of the 20th century was hailed as a way to modernise the field of medicine, today, many health-care practitioners fight against it. Some complain that human expert performance cannot be achieved with formalised systems and that protocols dehumanise medicine, replacing holistic care with bureaucratic control [Berg 1997; Timmermans and Almeling 2009]. Standardisation is a political enterprise through which technologies of power are negotiated and professional identities are performed. Health-care workers complain that while they are required to follow protocols, very rarely do they have the power to shape protocols in their own workplace [Timmermans and Berg 2003: 69]. Protocols also pit different types of health-care professionals against each other. While standardising practices provides space for more nurse autonomy, doctors may feel that they are being rendered redun-

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<sup>6</sup> Handover is a routine procedure found in medical settings. It is when vital information regarding individual patients is transferred or ‘handed over’ to the next shift.

<sup>7</sup> Much research has been done on the use of standards and standardised problem-solving techniques in the post-socialist region [Dunn 2005; Rivkin-Fish 2005] as well as evidence-based medicine [Timmermans and Almeling 2009] when instituted by third parties. This article considers only local, in-house procedures. I do not address the question of evidence-based medicine and resulting protocols because the origin of the standards did not arise in the narratives.

dant [Berg 1997]. At the same time, while standardising the mundane nursing duties makes visible the 'caring' duties of nurses, it also may call into question clinical expertise. The nurses in this study have differing opinions on whether or not standards allow them more autonomy and are beneficial to raising the status of nursing which correlate to their abilities to negotiate a hospital system. While health-care workers from Western countries resist third-party protocols, some migrant nurses find protocols to be tools of empowerment within the medical hierarchy. This paper does not debate the value of standards in health care but rather the roles they can play in professional identity as normalising tools that provide discursive spaces for compliance and resistance, actions through which individuals know themselves as subjects [Doolin 2002].

Developing professional identity in various post-socialist and global contexts depends on the nurse's experiences with different types of nursing environments. Whether or not a hospital defines standard protocols and procedures for practice is part of that experience and nurses tell me that very few Czech hospitals follow this model.<sup>8</sup> The lack of protocols becomes apparent to Czech migrant nurses not only when encountering them in a foreign work environment but also upon return to the Czech Republic after work abroad. Upon return to Czech hospitals, successful migrant nurses want to continue using protocols to practise professional identity, but are often unable to, leading some to initiate change in the local environment. For migrant nurses, standard protocols come to represent a form of modernity and globality that is arguably still missing from Czech health care. Migrant nurses trained in the Czech system evaluate themselves, and create their professional identities, on their abilities to perform in global (i.e. Western) medical environments. When assessment tools like protocols are not present, return nurses may try to create the environment they need for positive self-assessment and, ultimately, empowerment [Roberts 2000: 72].

Czech nurses who have not been abroad or who have had negative experiences abroad may have a different relationship with policy. During communism, although the population had access to a comprehensive care system, the health sector was controlled by a strict bureaucratic hierarchy. Health care experienced a number of features of the classic socialist system, such as decision-making held at the highest political levels and chronic shortages [Kornai and Eggleston 2001]. The health sector was one of the lowest priorities in the command economy [Kornai and Eggleston 2001] and, two decades after the end of communism, it is still often considered underfunded, inefficient, and outdated [e.g. Zděnek 2011]. De-

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<sup>8</sup> As of publication, only four health-care facilities in the Czech Republic are JCI accredited. JCI is the international arm of the Joint Commission, an independent, not-for-profit organisation that accredits and certifies more than 19 000 health-care organisations and programmes in the USA. Joint Commission accreditation and certification is internationally recognised as a symbol of quality and performance standards [Joint Commission 2011]. Milena notes that Motol Hospital and IKEM, an experimental medical clinic, also have protocols in place, but other informants describe the lack of protocols in their workplaces.

spite changes in nursing education now requiring a tertiary degree for licensure, nursing competences do not reflect increased education. Professional advancement is based on seniority, not personal skills and knowledge. Consequently, nurses create their professional identities by demonstrating their own knowledge through 'clever' practice. Being clever means that one relies on one's own knowledge, experience, and wits, often working outside the system for success. Cleverness was often a survival strategy of the shortage economy in the socialist era [Dunn 2005: 188].

Standardisation of care plans can also 'give nurses greater scope of responsibility and legitimize care giving' [Bowker and Star 1999: 250]. Health care needs standards to govern the quality of care given to patients, and allowing nurses to base their work on prescribed protocols and actions provides space for increased autonomy and responsibility. The disciplinary power of standards does not need to be constraining or dehumanising but can create a space for legitimate action [Doolin 2002]. Timmermans and Almeling [2009: 26] suggest that instead of 'erasing personalities' standards can 'lead to the development of new identities' through the development of new skills. Dunn [2005] reiterates the connection between standards and identity by explaining how persons discipline themselves to meet standards, changing behaviours, and transforming themselves into subjects that fit the normative ideal set by governing bodies. At the same time, protocols and responsibility make nurses' work visible, leaving them open to censure and social control, which can be problematic in post-socialist environments.

During socialism, state control diminished the desire to be visible and a possible subject of denunciation. Individuals acted evasively in order not to draw attention to themselves. The shortage economy contributed to socialist personhood, making it relational. Personal connections and position in society were necessary for access to goods, and informal economies arose to supplement shortages. Subverting the state became part of existence. Dodging regulations and using 'clever' devices to acquire daily needs was valorised [Dunn 2005]. These socialist survival skills—using one's own mind and talents—are the ways that individuals learned to express themselves and develop self-worth. William James [1890] describes self-worth as a ratio between what an individual desires to achieve and what that individual has actually achieved. The individual sets the criteria against which she will be evaluated based on her desires. Institutional context plays a large role in shaping professional desires and therefore both identity and self-worth. Success and failure do not automatically determine a nurse's identity or worth [James 1890], but the manner in which she manages various situations will shape her sense of self.

Dunn [2005: 186] suggests that the legacy of the socialist shortage economy creates a need for self-reliance and cleverness as ways to negotiate daily life and obtain necessities, material, and so forth; a positive professional identity can be considered a necessity for a nurse. Standardisation is the antithesis of self-reliance offering prescribed actions and visibility '[evoking] responses developed

under socialism and impelling people to seek out ways to circumvent discipline' [Dunn 2005: 175]. This desire to 'circumvent discipline' and be 'clever' becomes problematic when return migrants who have experience in more disciplined health-care environments see informality of practice as not only contradictory to their own needs for self-assessment but also dangerous to patients.

### **Protocol as a lens into professional identity**

Attitudes of getting by and making do with what is available—being flexible and competent in unpredictable environments—play a large role in Czech health care. Shortages that leave nurses without latex gloves and force doctors to threaten strikes are the same that leave old machines ready for replacement still in use in some hospitals. Milena, a return nurse working in Prague, describes 'making do' while their unit waits for new ventilators. Of the old ones she says, '[b]ut these ventilators are okay, and the monitors. We learn how to do that, and, you know, if it's got some kind of problem we learn how to repair it. You know Czech people—they always find some way to make it work.' These 'golden Czech hands' that manage to cope with everything and make it work are part of the Czech national identity [Holy 1996]. Czechs describe themselves as having common sense, intelligence, ingenuity, and an ability to cope [Holy 1996]. The character of the Good Soldier Švejk, cherished as the Czech Everyman, is known as both intelligent and shrewd, someone who, in the guise of a fool, negotiates and manipulates the highly ordered military system, even undermining it at times [Hašek, Parrott and Lada 1974]. All this falls under the description of being 'clever' (*chytrý*) and lies within a culture of flexibility in unsure environments.

Being clever, as Dunn describes it, was a survival skill during socialism that has been carried over into post-socialist practice and attitude. There are two sides of this to consider. On one hand, being clever means being intelligent, not just educated. To be clever is to be knowledgeable and experienced, to possess some level of cultural capital. Nurses use it as a term to indicate that a person is capable, and it is often coupled with other adjectives used to describe competence, one of the five attributes of caring [Roach 1984]. Radka, who worked in Ireland and Saudi Arabia, explains how the Czech general public thinks about nurses: 'There are two kinds of people. The first think that a nurse is just doing what the doctor says: she is stupid, she has to be nice all the time and do what she is told. The second is very kind, admires nurses, thinks they work hard, that they have to be clever and well-trained. It depends on what unit you work in. Some admire and others ... [Radka makes a sound of disgust].' Demonstrating cleverness in this sense is a way to develop professional identity, especially within the medical hierarchy. Nurses prove that they can do the work competently even when working in a flawed system.

Being clever can also have a negative meaning, such as sly and cunning, more than being merely shrewd. To Milena, her Filipina co-workers in Saudi

Arabia were clever because 'they know a lot of laws and they know how to get around all these [rules and regulations] in Saudi Arabia very well, better than us. This was something I didn't like.' Žaneta, a recruiter and former nurse, says that she refuses to work with candidates who think they are 'clever' and that they know better than she does about the recruitment process.<sup>9</sup> By its second meaning, being clever is part of a negative professional identity that does not foster teamwork, which is necessary for nurse autonomy [MacIntosh 2003: 726]. In the world of global labour migration, being 'clever' is not always ideal. For example, Saudi hospitals seek workers who have the ability to adapt and be flexible, but who can also follow directions and maintain the protocols of the strict local—professional and political—environment.

A key to new forms of personhood found in post-socialist market economies, including global nurse migration, is the concept of 'flexibility'. The meaning of the term itself is flexible. Dunn [2004: 19–20] defines the post-socialist flexible worker as one who is 'self-directed, self-activating, [and] self-monitoring'. One would think that being clever—intelligent, able to make things work—would be an asset in this market. However, flexible *labour* means such labour that is grounded in rationalism, in which decision-making is centralised and workers are interchangeable and replaceable [Barndt 2008]. Rationality uses science and evidence to produce the most efficient labour product. Although few would consider socialist labour systems efficient [Verdery 1996], in the socialist era, the state provided health care as part of the planned central economy [Lawson and Nemeč 2003] through rationalised forms of planning or *techné* [Read 2007]. *Techné* refers to hegemonic forms of knowledge and practice expressed through 'rules (not rules of thumb), principles, and propositions' [Scott 1998: 319, emphasis in original]; protocols are a part of the *techné* of governmentality. On the opposite side of *techné* is *metis*, practical skills and acquired knowledge that work dynamically with the local environment, including 'cunning intelligence' [Scott 1998: 313]; cleverness would be part of *metis*. Although the set of skills and knowledge associated with *metis* may at times seem outdated or out of sync with new ideologies [Read 2007: 219], the post-socialist environment requires workers to embrace it along with *techné*. Flexibility involves assessing oneself in relation to hegemonic ideals and, when necessary, transforming oneself into a subject more compatible with the norms needed in the local environment.

For the reasons described above, we can use protocols as a way to examine professional identity. How nurses approach the use of protocols illustrates conflicts between different ideologies within the same profession. Professional identity depends on and is constrained by the governing techniques found in the environment of practice [Beijaard, Meijer and Verloop 2004; Gibbings and Taylor 2010]. In the global environment, flexible workers are those who can adapt to the

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<sup>9</sup> 'Candidates' in this case refers to candidates for migration who turn to health-care recruiters like Žaneta to help them find positions in foreign hospitals.

system that is in place but work within the confines and constraints of the system. Flexible labour bends with the needs of the system, and standards become a form of 'empowerment' [Dunn 2005]. Nurses in the global labour market who believe this can help nurses break out of their subordinate role [Bowker and Star 1999]. Under socialism, flexible workers were those clever persons who adapted when the state system failed to operate as needed, improvising in the shortage economy, internalising new forms of practice, demonstrating competence, and eventually performing professional identity. Nurses working in poorly resourced facilities must continue these practices as part of their professional identity.

Bowker and Star [1999: 293] remind us that 'one person's standard is another's confusion and mess'. Are protocols decision-support techniques or instructions for 'mindless cooks' [Berg 1997]? How a nurse answers this question reflects the institutions that have played a role in shaping her professional identity and informs us about her position in post-socialist transnational workspaces. To illustrate ways different approaches to protocol affect professional identity, I introduce you to Světlá, Milena, Věra and Barbora. Světlá was 33 and had over 10 years' experience when she went to Saudi Arabia to work as a nurse. She found the fast-paced, regimented work environment the hardest part of adaptation and did not pass her probationary period. Světlá's contract was terminated after three months because she could not fully adapt to the job. Světlá returned to her old hospital and unit in Prague, which she finds more relaxed. Milena spent six years working in Saudi Arabia as a nurse after five years working in the UK as a care assistant. Upon returning to the Czech Republic to stay, she resumed work at the Prague hospital where she had briefly worked in the past. Milena misses the well-equipped hospitals in Saudi Arabia, as well as the procedures and protocols that direct patient care and nursing competencies. Věra, also in her early 30s, spent over four years learning English in preparation to go abroad. She is very serious about her career as a nurse and describes herself as 'very ambitious'; she takes pride in her work and strives to continue her education through university and special courses. Věra worked in one of the few hospitals in Prague that has protocols and international accreditation. She adapted well to work in Saudi Arabia and is currently in her second contract there. Barbora was a 24-year-old midwife when she left for Saudi Arabia. She was 'fed up' with the lack of teamwork and low status and responsibility given to nurses and midwives in the Czech system. Barbora has successfully completed her first contract in Saudi Arabia. I met Věra and Barbora before they left for Saudi Arabia and continued to correspond with them during their time abroad. All four women relate protocols to their ability to perform as professionals but represent different perspectives of flexibility and professional identity.

Milena and Věra describe the increased quality of care that standardisation brings in comparison to the individuality and informality that Czech health care allows nurses to practise. Věra points out the risk to patients in a hospital in Ústí nad Labem:

We all have some manners, habits, experience and knowledge. And we all should show our abilities to perform our job. Here, we also work few shifts under supervision, but there is no system. The usual way is to let people do things independently and wait to see what will happen and correct some mistakes. It's not good, especially because new nurses cannot learn just by observation. They don't know any theory very often. In Saudi [Arabia], you have to go through orientation, they teach you, they show you all sources and they want you to explain and perform every single task. If you haven't met a competence yet, they give you time to learn, observe and practice. And if the nurse is not competent, for example, for epidural catheter care, she cannot care for this patient until she is competent. In Ústí nad Labem, they did not care. I refused many times to care for patients on hemodialysis because I never cared for this kind of patient and other nurses were too busy to check whether I do everything well. Thank God, I have my experience from other departments.

Despite noting individuality and the opportunity to demonstrate personal skill, Věra desires some sort of control and exerts it herself. Used to protocols, Věra governs herself by refusing to perform a particular caring duty on the basis of her lack of competence. She has internalised a set of rules that have become part of her performance of professional identity, demonstrating how technologies of power that attempt to engender norms are then internalised by nurses. Öhlén and Segesten [1998: 722] state that professional identity develops through interaction with colleagues and patients and the internalisation of 'knowledge, skills, norms, values and the culture of the nursing profession'. The internalisation of professional norms is not only an essential part of professional identity development but is also the essence of socialisation, an important process for student nurses [Bucher and Stelling 1977].

Věra indicates that not having a common core of practices not only endangers the patients but also is not conducive to socialising new nurses. She compares Czech and Saudi practices of training and socialisation, illustrating how different rules of conduct passed on to new nurses are context-dependent. This example demonstrates that, although it starts in nursing school, socialisation continues through work experiences to create the knowledge of how to behave as a professional in each environment [Roberts 2000: 78].

Milena links protocols to audits and responsibility, saying, '[h]ere [in the Czech Republic], we don't have many policies and procedures, which means that everyone is doing different things. The same procedure is done in different ways by different nurses. So that's why you cannot track it and keep a proper record.' Milena relates standardisation to quality of care because one does not have room to make mistakes. If one does make a mistake, it can be traced and the individual made to take responsibility. Hospitals in Saudi Arabia have protocols for every procedure, which must be recorded. Therefore, according to Milena, if a nurse does everything according to protocol and records it, mistakes can be traced through the paperwork.

Paperwork acts as ‘paper panopticons’, audits that allow both oneself and others to evaluate the quality of work the nurse is doing [Dunn 2005]. They are part of the normative rules of governmentality in Western-style biomedicine. Věra describes herself as ‘obedient’ when she follows procedure, such as in the example above. Obedience in this regard illustrates Věra’s desire to fit the form of a global nurse by being a governable and docile body who has become a subject of the governing system in which she was trained, even when that system is not present, like in Ústí nad Labem [Foucault 1995]. Valuing the strict rules of work, Věra has internalised the need to follow procedure and labels the paperwork system in Saudi Arabia as ‘perfect’:

I think [that the] direct care of patients is more important than documentation, but to document everything—what I did or what I am gonna do with a patient—is also important. Just for safe care. Especially in Saudi [Arabia], where [we] work [with] more than 54 different nationalities. Such strict rules and policies are necessary. I like it. I observed it and it’s much better than here, in my country. Even [my old hospital (which is JCI accredited)] could do it better.

Through a nurse’s adherence to protocol, she, herself, is visible and governable, which is in direct opposition to the communist worker, who would rather have been invisible and gone unnoticed [Dunn 2005: 185]. If the professional norm in Czech health care is based on the communist work ethic, then following protocols and procedures may be problematic for some.

Barbora compares the amount of paperwork required in the Czech Republic and Saudi Arabia, complaining about the amount that she must do as part of policy and protocol. From an e-mail a few months after arrival in Riyadh, she says:

Paperwork is much worse than in the Czech Republic. You have to document everything and mainly you have one form and you have to put the same date for that day 3 times!!! Like the birth notification, the date of birth UP in the middle and down on the form! Really stupid :-) ... And all this you have to copy about 10 times. During the admission it takes at least 10 minutes only filling out the basic dates ... Also, you have to describe the CTG record (similar to ECG record) every 30 minutes (sometimes it’s going 10 hours :-)). I don’t understand why I have to write something that I can see on the CTG record. There are [observed] contractions—how often, [how] strong ... and I have to write the same to my notes, that contractions are like this ... Sometimes I don’t have the nerve for this :-) Many things here not to be easily acceptable :-)

Unlike Věra, Barbora has a difficult time understanding the point of recording data multiple times and is not accustomed to the vigorous notation system.

During an online chat, Barbora extends her frustrations to actual medical procedures, not just paperwork:

Barbora: Sometimes I'm a little angry because of the different things done here but I'm trying to take it easy :-)

Heidi: Angry? About what?

Barbora: About something ... because here it is different leading of labor and sometimes it's difficult to understand and accept ... I'm not used to it done like here, you know ... but after that I say to myself that it's their business and I have to do it how they like it ... I'm ok :-)

Světlá compares her approach to protocols with that of her Malaysian and Filipina co-workers in Saudi Arabia. She says that they do everything according to protocol because it is required, whereas if Světlá thinks the protocol is not good, she does it a different way. Světlá argues that the absence of protocols in the Czech Republic taught her how to 'improvise' as a nurse and 'use [her] brain', an example of 'being clever'. Světlá represents the idea that too much standardisation can lead to a loss of autonomy [Bowker and Star 1999: 30]. Barbora and Světlá have not internalised the hospital's need for standards as a method of alleviating risk but rather imply that the standards are irrational tools by which the institution impedes their professional work. They do not see policies and procedures as empowering, like Věra and Milena, the latter of whom suggests that protocols actually provide nurses with autonomy. Here, Milena suggests that standardisation makes her more flexible as a worker. She believes that *because* the protocols are in place, a nurse can follow the directions and not be forced to rely on the doctor to look over her shoulder and certify every action. Protocols provide nurses with more autonomy and responsibility through the freedom to make care decisions. Despite the presence of protocols, it is still the clinician's responsibility to determine if the protocol fits the conditions [Timmermans and Almeling 2009: 25]. They not only provide nurses with the opportunity to 'use their brains', they require it. Here, we see that migrant nurses need not only to be flexible in their ability to adapt *to* the foreign workplace but *in* that workplace as well.

Barbora uses intercultural training from her recruitment firm to help her learn to be a flexible global nurse.<sup>10</sup> In the e-mail quoted above, Barbora also describes her feelings upon arrival in Saudi Arabia: She 'expected [to gain] a lot of experience and this work can give it to me. Saudi [Arabia] is a very different country and I think nobody understands their lifestyle and religion. We have only to respect them and keep to their regulations. We aren't trying to understand because it doesn't work.' Barbora recognises that Saudis and Czechs have

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<sup>10</sup> While recruitment firms play a large role in the acculturation of Czech nurses into Saudi culture, they play merely a supporting role in professional identity development. Recruiters serve as culture brokers by providing information and some forms of intercultural training—at most a one-day seminar—which focuses on cultural and social differences between the Czech Republic and Saudi Arabia. In my article in *Anthropology of East Europe Review* [Bludau 2011], I argue that recruiters help candidates develop certain forms of migration-specific social and cultural capital related to confidence and competence in the

different worldviews, but that if Czechs respect Saudis, they will be respected in return. Maintaining the paperwork, even though she does not understand why it is necessary, demonstrates Barbora's compliance with and attention to the protocols, which shows a respect for authority but not necessarily the policy and is a form of professional activity. Maintaining regulations, including protocols, is how Barbora defines and performs her professional identity in Saudi Arabia.

Milena illustrates her flexibility and professional identity through an incident when she had to apply her knowledge of different protocols to safeguard her patient. On this occasion, Milena had a patient with a low potassium level—he was at 3.9 and should have had at least 4. She had noted that his urine output was low and knew that raising his potassium levels, as one protocol stated, could have led to fatal arrhythmias. According to this assessment, she decided not to give him the replacement potassium. She noted her actions in the chart and later discussed it with her charge nurse who agreed with Milena's decision. Milena states that this form of 'law' is what she loved about working in Saudi Arabia. Policies and procedures told Milena how to behave and actions could be justified using the protocols put in place. In this example, Milena uses protocol as a decision-support technique that allowed her autonomy and responsibility; for her protocols opened up a 'discursive space for action' [Doolin 2002: 381].

Autonomy plays a central role in the level of nurses' confidence [Evans et al. 2010: 337] and hence professional identity. It is particularly salient for Czech nurses in foreign hospitals. Saudi hospitals operate on the model of autonomous nursing, where nurses have more responsibility to make decisions based on written protocols, policies, and procedures. Although not keen on protocols, Světa admits that she had more responsibility in the Saudi hospital, as well as more accountability for mistakes. Nurses complain that in the Czech Republic they must track down a doctor and ask permission before performing minor procedures they know they must perform and have done before. Žaneta describes nurse autonomy in Czech hospitals in relation to education reforms, saying that 'now despite all this higher education the nurses have no competencies that would enable them maybe to take some of the work from the doctors, right? They have to run after the doctors and "May I do this? May I do that?" It's still quite different from [the United States] where a registered nurse has many more competencies than a Czech nurse has.' These competencies are based on prescribed protocols.

In Saudi Arabia, where nurses play a relatively responsible and autonomous role, policies and procedures provide the foundation for responsible care

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work-environment language of English. The recruitment and pre-departure training period is a time during which a nurse transforms herself into someone who has both the outward and verifiable skills necessary for work in her profession and/or specialisation, as well as the personal characteristics of a global nurse. Recruitment firms manage this transformation through a variety of mechanisms, such as marketing, training, and interviewing. The recruiters' goal is to produce a candidate who meets the needs of the market. This article concerns the nurse's goals of producing a professional identity.

and nurses earn more value as team members. In Saudi Arabia, doctors check Barbora's patients during rounds and advise her if the patient has complications. Otherwise, they leave her to her work. In a description of her typical day, Barbora cheerfully describes in detail the number of duties for which she is responsible, listing when she works with colleagues from different units and when she needs to report to a doctor. This is in direct contrast to the degradation Barbora felt in the Czech system. The autonomy that Barbora now enjoys relies on the same documentation that she criticises. Autonomy in the workplace helps build professional identity and directly relates to a nurse's feelings of self-worth [Doolin 2002; Roberts 2000].

Milena describes how autonomy was empowering in Saudi Arabia:

You feel so needed as a nurse and you have competencies [responsibilities] that you don't have here. You really feel like a nurse. You don't feel left behind and just listening to the doctor and being like the doctor's staff. You have your work; you've got your own brain. You work as a part of the team with the doctors. And you've got more power. I think maybe American nurses have it. [In the USA] you go to school for two days and you get a certificate that you can do something and you go back to your working area and you can do more stuff. You can help the doctors because you do the same stuff like them and you are qualified to do so. That was the same in Saudi [Arabia]. I called the doctor only when I really needed him, like when I had a [patient with cardiac] arrest. Otherwise, I didn't [call the doctor].

She concludes by saying that having to ask a doctor for instructions on every procedure is a problem in the Czech Republic.

Feeling like a nurse, not just working as one, is intrinsic to a positive professional identity [Öhlén and Segesten 1998: 722]. It is also an outcome of having one's desires reshaped. Each hospital defines the ways that nurses should conduct themselves there. In some cases, this involves a transformation and even change in personality. When nurses find themselves in work environments in which their ideals do not conform to the local norms, they feel like deviants and professional identity suffers if they cannot change themselves.

Milena contrasts her experience in Saudi Arabia, described above, with that in the Czech system, which lacks the protocols that enable her to do her job as a professional:

We [nurses] are doing a lot of things that maybe we are not supposed to do and we are forgiving the doctors that they are not doing their job properly and we are doing it for him. You know what I mean. And maybe I'm supposed to call the doctor and wait for him but I cannot wait when my patient after [myocardial infarction] has 220 systolic pressure, you know, just waiting for a stroke. So obviously I will start the infusion and I will give the bolus because I know it's the normal procedure but also very dangerous because you are doing something that hasn't been ordered so

this is the problem that they [the doctors] are not always on the site and they are not always there when we need them. So this is the problem that needs to be changed and I feel that it needs to be done. And we need more ... I'm sure in Communist times it was like, really, the nurse was a slave for a doctor. At that time, we weren't even able to give injections or take blood or give [intravenous] injections. We could only make the bed, give them a bath and give them the oral tablets. That was it. Now we are doing more and more, we have got more competencies but it's still not done on paper properly—what we can do and what we cannot do.

When Milena says that 'it's still not done on paper properly', she equates the lack of written and standardised protocols and competencies to her being unable to do her job as a professional, referencing communist-era health-care practices as a comparison. If her hospital had protocols in place, like she had in Saudi Arabia, Milena would have formal permission and instructions to perform what she has internalised as her professional duties. Instead, she has to circumvent what little discipline is in place—the doctor's orders—in order to care for her patients, arguably acting clever.

Milena has no way to assess herself in the Czech system and now aspires to instil some level of protocol in her current unit. Milena's primary goal upon becoming shift leader in her unit is to implement a system of protocols for patient care. She believes that protocols, policies, and procedures not only increase the quality of patient care but also provide more autonomy and responsibility for nurses. She plans to create a set of policies and procedures for her department so that the entire team will work in the same way. Milena describes the confidence in colleagues' work and the quality of care that are a result of protocols: '[If we all] work the same way, I know that if I ask my colleague to change the central line dressing she will do it the same way that was written on paper, [like] in Saudi Arabia.' In Saudi Arabia, each procedure has instructions for the way it should be done, something that is widely lacking in the Czech system. Milena considers this the third grievance of nurses, after low pay and shift work. Some Czech hospitals, like Motol Hospital, one of the largest and most comprehensive hospitals in Prague, and JCI accredited institutions do have policies and procedures in place. In comparison, Milena calls her hospital 'backward' and wants to change it 'at least a little bit because [policies and procedures] work in Saudi Arabia amazingly well'.

Although Milena had to wait until she was a charge nurse to implement her plan, she started to make some changes earlier. She expects some resistance from her colleagues, who have been doing procedures their own way for some time. Despite the culture of being clever described above, Milena has found that most colleagues are receptive to her ideas, many finding that her advice makes their lives easier. They can do the job more quickly and it looks better for the patient. Many even respect her for having the 'guts' to go abroad, make and save some money, and return home: 'They see it like [this:] I went there, now I have got the experience and I can help them to change the world.' Milena continues,

saying that she feels that her colleagues are 'grateful' when she shares a new technique—one doctor even agreed that her way was better on one procedure.

Milena declares, 'I know exactly what I want to change. I have plans what I want to do and I think that's why my head nurse is keen to have me there.' Noting the support from her head nurse is an important element for Milena's narrative. Attempting to contradict the culture of informality that permeates the Czech system, Milena knows that without support from administration she would have difficulty making any changes. More importantly, Milena, the non-migrant, would not have had the confidence to suggest changes, even if she had the knowledge. Milena hopes to take her changes to the hospital level, and possibly to the national level. Stating that she knows her ideas work not only in Saudi Arabia but in other Czech hospitals, Milena is confident of her plan.

## **Conclusion**

The post-socialist health-care arena provides a rich site of inquiry into professional identity, where we find a complex mix of nursing experiences and colliding perspectives. I have grounded my argument in the theory that professional identity is based on self-assessment in the work environment [MacIntosh 2003; Öhlén and Segesten 1998] and is shaped by the rules of conduct in place for that environment, or governmentality. I have demonstrated that protocols are tools instituted by the governing body and internalised by nurses to assess their quality of work. Both Barbora and Světla found the protocols in Saudi Arabia challenging. However, while Barbora was successful at navigating the foreign environment, Světla was not. Their attitudes of acceptance and denial of protocols, respectively, reflect their professional identities. Implementation of protocols is like a ritual of verification and proof that you can be part of a system in which not being able to meet the standards leads to (global) marginalisation [Dunn 2005]. Workers who cannot or refuse to comply are pushed beyond the borders of global opportunities, as we see with Světla losing her contract and Žaneta's refusal to work with 'clever' candidates. Successful return migrants who have a sense of globality, like Milena and Věra, use protocols to demonstrate competence, self-worth, and confidence, which leads to empowerment in negotiating new workplace scenarios [Roberts 2000]. A professional identity based on positive experiences in different systems enables nurses to be flexible in changing health-care settings, as we see across the EU today.

Health care in the EU, including nursing training and ultimately practice, has recently been greatly affected by the calibration of European higher education. Known as the Bologna Process, the goal was to create a comparable framework of higher education degrees [Bologna Framework 2005], bringing about a harmonisation of curriculum and working towards convergence and common understanding rather than uniformity [Davies 2008]. Arguably, one can label the

creation of the European Higher Education Area (EHEA), the outcome of the Bologna Process, as yet another form of EU standardisation. Consequently, problems of standardisation in health care are not limited to return migrants in the Czech Republic.

Previously categorised as a vocational field requiring only a secondary education, nursing education in the Czech Republic and other East European countries has shifted to higher education in accordance with EHEA qualifications. New curriculum has been designed to reflect Czech (Act No. 96/2004) and European Commission (EC Decree No. 424/2004) laws that define the activities that nurses can perform with or without supervision: Czech nurses now need a minimum of three years of study with 4600 hours, half of which are practical hours so that nursing student can work without supervision. Starting with the class entering nursing studies in 2004, students leave Czech nursing secondary schools with certification as a nursing assistant and need additional education to become licensed nurses. Post-Bologna Process, nurses with a bachelor degree and an EU diploma in nursing should meet EHEA criteria for professional recognition in other member states.

Only ten years after implementation, it is too early to adequately measure the effect of educational changes on the larger picture, but I can put forth the following hypothesis for future debate. This paper used the case of post-socialist migrant nurses to illustrate that tools of governmentality like standards of conduct play an important role in shaping professional identity in context-dependent ways, and so too will standardisation of training in formal education programmes, yet another tool of governmentality. Much like the return migrants I discuss above, new graduates will seek to practise within a professional environment that meets the rules of conduct in which they have been educated. However, Czech hospitals tend to resist institutionalising standards of practice. Additionally, the larger research project shows that they maintain an 'anti-graduate' attitude [Davies 2008], operating as if the nursing profession were vocational and the cost of providing higher education for nurses unnecessary [Bludau 2012].

If the reality of nursing practice does not provide an environment conducive to creating a positive professional identity, new graduates will experience the same dissatisfaction we see in return migrant nurses. At best, they will accept and reiterate the current hospital culture, being reshaped by its governing tools, continually reproducing a stagnant system. At worst new nurses will depart the environment that does not serve their desires and seek either other professions or other countries leading to increased labour shortages. Yet another possibility is that new graduates will turn to return migrant colleagues to see how they negotiate rules of conduct that do not match personal desires in order to develop their own professional identities. They will find that the post-socialist professional identity can combine clever socialist and rationalised global (migrant) perspectives to develop a flexible professional who can 'make do', bringing new approaches into (post-)socialist locales.

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