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# Living Stories of Care

– Exploring Discursive Clashes Through Storytelling by Nurses

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# Abstract

<b>Title</b>	Living Stories of Care: Exploring Discursive Clashes Through Storytelling by Nurses
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<b>Keywords</b>	New Public Management, Ethics of Care, Health Care Organizations, Storytelling, Discourse, Nurses, Critical Management Studies
<b>Purpose</b>	Nurses constitute a key group to focus on due to their close proximity to the core of health care, the patient. We aim to understand the care discourse in the practice of nursing within public health care organizations, and its coexistence with the current marketization discourse promoted by the New Public Management paradigm. Our intention with this approach is not only to nuance and problematize the research done to date, but to delineate and illustrate what practitioners actually draw upon in their construction of care-giving.
<b>Methodology</b>	By avoiding embarking from pre-prepared narratives and focusing on stories evoked in the moment, this study allows important discursive perspectives to naturally emerge. Analyzing the ethics in storytelling creates awareness and new room for an unheard voice, that of the nurse, and explores the nuances inherent therein. Ethics are inextricably connected to the experiences of people. Seen in the light of this, the ambivalent coexistence of care and marketization discourses calls for a need to empirically as well as methodologically nuance the way patients, and interactions with them are conceptualized. A discourse analysis of how an ethics of care is drawn upon will expand the boundaries of our understanding whether a care discourse is dominant, or is being amalgamated by customer ideals.
<b>Theoretical perspectives</b>	Implications of New Public Management in health care organizations are introduced. Further, a feminist Ethics of Care is critically discussed, from which three versions are identified: Care as an orientation, care as a practice, and care as a moral framework. A brief overview of Ethics of Care in nursing literature is provided. This provides a theoretical framework to better understand the ethics drawn upon in the storytelling by nurses
<b>Empirical foundation</b>	Empirical data is collected through six semi-structured qualitative interviews with nurses with different specializations and experiences, working at five different hospitals within Region Skåne. Further, a discourse analysis of the talks by politicians, hospital managers, and medical practitioners during a seminar held by the Ethics Council of Region Skåne is provided.
<b>Conclusions</b>	The study's knowledge contribution is directed towards the conflicting subject positions embodied in the dichotomy of 'patient' and 'customer'. The empirical results show that the conceptualization of the one cared for (patient) as a 'customer', in practice brings few benefits and rather many ponderous problems for both practitioner and said patient. The in policy much professed benefits said to be won by a union between patient and customer ideals are thus nuanced. This in the sense that the thesis has problematized their claimed complementary properties by taking the voices of nurses into account. We argue that emancipating the perspective of nurses by virtue leads to a more nuanced understanding for future research and policy-making efforts. Thus allowing them to be directed towards constructing increased concordance with the practice of care-giving and its inherent ethics.

# Sammanfattning

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<b>Nyckelord</b>	New Public Management, omsorgsetik, hälso- och sjukvårdsorganisationer, historieberättande, diskurs, sjuksköterskor, Critical Management Studies
<b>Syfte</b>	Sjuksköterskor utgör en nyckelgrupp att fokusera på pga. deras närhet till hälso- och sjukvårdens kärna, patienten. Vårt syfte är att förstå den redan existerande omsorgsdiskursen bland sjuksköterskor inom offentliga hälso- och sjukvårdsorganisationer, och dess samspel med den marknadsdiskurs som för närvarande främjas av det s.k. New Public Management-paradigmet. Utöver att nyansera och problematisera den nuvarande forskningen, ämnar vi dessutom att beskriva vad praktiker faktiskt drar på när de konstruerar omvårdnad.
<b>Metodologi</b>	Denna studie tillåter viktiga diskursiva perspektiv att växa fram naturligt, genom att undvika att ta avstamp i fördefinierade narrativ och istället fokusera på historier som framkallas i stunden. Analys av etik genom historieberättande skapar en medvetenhet och ett nytt utrymme för en tidigare ohörd röst, sjuksköterskans, vilket möjliggör att utforska dess nyanser. Människors erfarenheter är oskiljaktigt kopplat till etik. Sett i ljuset av detta, analyseras det kluvna samspelet mellan omsorgs- och marknadsdiskurser inom vården, vilket skapar ett behov av att empiriskt så väl som metodologisk nyansera sättet på vilka patienter och interaktionen med dem konceptualiseras. En diskursanalys av hur sjuksköterskor drar på en omsorgsetik kommer vidga förståelsen huruvida omsorgsdiskursen är dominerande, eller om den fusioneras av marknadsdiskursens kundideal.
<b>Teoretiska perspektiv</b>	Innebörden av New Public Management och dess konsekvenser för hälso- och sjukvården introduceras. En kritisk diskussion kring en feministisk omsorgsetik följer därefter, genom vilken tre versioner av denna etik identifieras: Omsorg som en orientering, omsorg som en praktik, och omsorg som ett moraliskt ramverk. En kort överblick av omsorgsetik inom sjuksköterskelitteraturen presenteras. Sammantaget skapar detta ett teoretiskt ramverk för att bättre förstå vad sjuksköterskor drar på i sitt historieberättande.
<b>Empiri</b>	Empirisk data samlas in genom sex stycken semistrukturerade kvalitativa intervjuer med sjuksköterskor med olika specialiseringar och erfarenheter, vilka arbetar vid fem olika sjukhus inom Region Skåne. Vidare framförs en diskursanalys av hur politiker, sjukhusledning, samt praktiker inom vården pratar om verksamheten genom ett passivt deltagande av ett seminarium arrangerat av Region Skånes Etiska råd.
<b>Slutsatser</b>	Studiens kunskapsbidrag riktar sig mot de motstridiga subjekspositioner som innesluts av dikotomin mellan 'patient' och 'kund'. Resultaten visar på att konceptualiseringen av den som omvårdas (patienten) som 'kund' i praktiken medför få fördelar, utan snarare flertalet besvärliga problem för både omvårdnadspersonal och patienten. De genom policy förespråkade fördelar som hävdas genom att komplettera patientens position med kundideal blir därigenom nyanserade, genom att uppsatsen framför sjuksköterskors perspektiv i debatten. Vi hävdar att denna frigörelse kommer leda till en mer nyanserad förståelse för framtida forskning och politiskt beslutsfattande, och därmed tillåta dessa att utvecklas i en riktning vilken kan skapa större samstämmighet med vård i praktiken och dess etik.

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# 1. Introduction

This is a thesis about care. More specifically, it is a critical inquiry in the organizing of health care that seeks to explore and understand how the notion of ‘care’ is currently being conceptualized, talked about, and experienced by analyzing the storytelling by practicing nurses. In this thesis our position is that the living stories of care, as told by nurses allows a commanding insight into what considerations ground their experiences. Despite constituting the core of any care-providing practice, the discursive nature of care does not go unchallenged in contemporary health care organizations. Thus we seek to examine how nurses relate to the discourse and concepts promoted by marketization. Viewing care as an inter-relational human activity, ethics emerges as an inextricable dimension of care-giving. Through a discourse analysis, the thesis explores this already present language of care by examining how nurses draw upon a feminist ethics of care as they construct their care-giving experiences. The thesis thereby seeks to analyze whether an ethics of care makes contact with the real issues, or is it only of aesthetic interest? This can in a sense be said to be self evidently false for if care is not an aspect of health care, the practice has surely lost all meaning.

From this perspective, it becomes crucial to analyze the discourse of nurses in order to convey a deeper understanding of care in all its intricacy. Such an understanding will lay the foundation of how their storytelling relate to an emerging counter discourse of ‘marketization’ of health care, and thereby nuance the contemporary conceptualization of patients as ‘customers’. In the midst of the New Public Management paradigm, the organizing of public health care in Sweden and throughout the Western world is heavily influenced by a marketization discourse that favors a more efficient and innovative public sector. The coexistence of these what on the surface appear as ambivalent and possibly conflicting discourses in health care, constitutes the dynamics of what the thesis seeks to understand by analyzing the way seven nurses at Region Skåne<sup>1</sup> talk about care-giving. We will set the scene of this inquiry by exemplifying what we mean by the coexistence of discourses, by providing an insightful discursive glimpse from within a recently attended seminar on “Local ethical care work” held by the Ethics Council of Region Skåne.

## 1.1 Setting the Scene

As a step in our thesis work we attended a seminar arranged by the Ethics Council of Region Skåne. The council has arranged these types of events regularly since its formation in 2007. What follows is a short depiction of the seminar, presenting and contrasting the coexistence of two primary discourses within Region Skåne; one of marketization and one of care, the first exemplified by politicians and the second by practitioners, including nurses.

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<sup>1</sup> Region Skåne is regional council and a self-governing authority of Skåne, employing 25 000 people within health and medical services, and other public services. All public health care in county is controlled by Region Skåne, either by accreditation, public procurement, or run directly by Region Skåne. About 80 per cent of primary care units and eight out of nine hospitals are operated directly by the Region. (skane.se, 2013)

The event was opened by the chairman of the Ethics Council, who set the tone for the day by explaining the ethical challenges involved in ‘administering’ patients as well as personnel within Region Skåne. Furthermore she explained that the focus for the current efforts of the Ethics Council is to “implement groups on all levels of the Region that can discuss ethical implications”. The marketization perspective was abundantly clear in the discourse of the preliminary speakers, two politicians from the Health Care Committee of Region Skåne. The initial focus was on explaining how they saw the field of ethics as one lacking clear answers, and open to a multiplicity of opinions and value foundations, with ethics described as mostly being akin to the ‘small things’. We saw a clear theme developing when it was emphasized how there was a need to approach the ‘customers’ with a common attitude based on shared values. A rhetoric furthered by the claim that ethical dilemmas were to be found throughout health care, but in the end it all lands in an ‘economic reality’.

Other remarks cherished the self-governance of Swedish municipalities, but acknowledged the difficulties associated with upholding a fair and equal ‘offer of services’. We noticed a sentiment in both politicians that further efforts should be directed to increase the patient's influence over how treatment and care should be planned and performed in order to make sure that the patient's ‘demands’ are met. Apparent New Public Management values were expressed as also guiding principles for the organization of Region Skåne. Potent examples worth mentioning include the outlining of how market forces could create a ‘competitive environment’ between the different hospitals, which subsequently would improve the ‘quality’ of their health care services. The Region should continually ‘audit’ the hospitals and “if the expected results were not reached a buck or two would be withheld”. Continued problems might make it “necessary to tinker with the compensation models”, it was also argued that the implementation of these ‘compensation models’ was the primary role of the political representatives. The models would be based on ‘key measurements’ of ‘efficiency’ which could be “hard to identify, but simplified by using models based on value creation” (value creation was hinted to mean procedures performed, patients treated etc.). ‘Value’ would be created by providing ‘freedom of choice’ of care-provider, where the ‘user’ was in a stronger position of influence. The politicians furthered this line of reasoning by stating how there is an “inherent value in the option to choose who is your care-provider”. We were informed that this translated to personnel as well, who with the option to choose a different employer than Region Skåne would generate further ‘competitive forces’ on health care employers. It was clarified that the main part of the daily ethical reflection was performed on a ‘middle managerial level’. Themes concerning ‘patient influence’ and ‘choice’ prevailed over the ethical dilemmas and considerations found in care-provision.

The portrait of Region Skåne charted by the policy makers was in our experience fundamentally contrary to that painted by the practitioners speaking during the second half. A hospital manager within Region Skåne made an insightful and informed acknowledgement that “the language and our way of speaking control how we perceive matters and how we act in the health care system”. This could also be seen as a direct response to an analogy drawn by one of the politicians who spoke of the personnel ‘on the floor’ – a comment that received further putdown by a nurse who chose to comment on it as she saw her work, caring for the patient, constituting the core of the

organization's purpose. She left the question "if we [the personnel] are on the floor, where is the patient? Under the floor?" hanging in the air. Other remarks were made but it boiled down to a sentiment that care-providers are "guests in the lives of patients" and that concepts of "utility or profitability do not have a place in Swedish health care".

The shift in focus was by now clear and the discourse was continually moving closer to the primary occupation of the health care system, caring for patients. An oncology nurse who addressed the everyday ethical issues involved in caring for cancer patients, used a revealing analogy of "juggling eggs, where none could be dropped", hinting that individuals who pass away cannot be replaced, even if the bed is soon used for another patient. She emphasized the 'relational nature' of caring; the importance in empathizing with both the 'individual's needs' and seeing the medical requirements simultaneously, adding that it is never permissible to compromise the important dialog between care-giver and patient. She explained how she in her work becomes "an anchor for the patient on a stormy sea" and that you as a nurse personify a sense of 'safeness' for both the patients and their family, "with your mooring outside-life". The 'small thing' that ethics was depicted as pertaining to by the politicians was nuanced and described as "quite significant". Several speakers followed, including chief physicians, medical doctors, and nurses. They all highlighted the supreme difficulty of providing 'sympathetic' health care under the current profound 'time constraints' levied on practitioners and the impossibility of properly 'reflecting' over the many serious ethical dilemmas involved in their work.

By the end of the seminar a telling difference in both discourse, values, and conceptualization of the patient as well as health care was exhibited. We now turn to a theoretical problematization of these observed phenomena.

## 1.2 Problematization

Care appears as a pervasive phenomenon not only, as expected, within health care but in broader contemporary organizational and societal discourse (Slote, 2007). As linguistic phenomena (Alvesson and Kärreman, 2000), individuals and organizations are increasingly expected to express a sincere attitude of care, not only for our near and dear, but also for people and causes in an almost universal sense. The notion of care thereby appears as a contemporary discursive framework through which people and organizations position themselves in a variety of contexts. Today, it seems inconceivable for organizations to solely care for (or at least articulate such a simplex care) shareholder value maximization or even a more attentive display of care for various stakeholder interests (Sundaram and Inkpen, 2004). Rather, it is becoming a widely accepted norm for organizations to express a sincere and inviolable care for employees, customers, as well as for the environment, community, and society as a whole through often-grandiose Corporate Social Responsibility statements. This ubiquitous notion of care is thus demonstrated in an amplitude of perspectives, academically as well as in practice, and a notable indication of such a 'care discourse' is the 2010 theme of the *Academy of Management* conference: "Dare to Care: Passion and Compassion in Management Practice and Research", which is the most significant gathering in the field of organization studies.

In conjunction with this development, an already present and parallel contemporary public administration discourse describes public sector organizations in terms of business-like language under the flag of what has become known as New Public Management (Diefenbach, 2009; Harrison and Calltorp, 2000). By favoring an effective public sector through a more market-oriented discourse, it deviates as the antithesis of the public administration caricature as inefficient bureaucracies. This paradigm is strongly gaining grounds, as professional care-giving is organized according to a guiding principle of achieving high quality care through increased efficiency and customer satisfaction. Work procedures, however, are organized in ways that resemble scientific management, and patients are gradually reconceptualized and displaced from passive patients to active customers (Nordgren, 2003). Styhre (1998) shows that discourses within organizations tend to be understood differently between management and workers, and that discrepancies like this can imply ambiguities in the sense making of the organization.

The parallel discussion of care corresponds to a varying degree of inclination to nurture relationships with people in a person's surrounding environment, which brings an inevitable philosophical dimension of ethics to the equation of caring. To quote Dennett (1984) from his book on free will: "The trouble with philosophy, some say, is that it isn't Science; if it were more like Science it would solve its soluble problems and dissolve or discard the rest" (p. 2). While much of health care undeniably, and rightly, fall within the sphere of science, we quite intuitively realize that there is a supererogatory element to it – care. What is interesting about the current debates described above, and what caught our interest is that one stem moves care closer to the center and one discards it as superfluous. All of us who have some experience from tours in the health care system, either from ailments of our own or of loved ones, or as professionals for that matter, have an even more vibrant picture of what it means to care for and be cared for – well. The importance of these questions being properly explored and treated with respect can in our opinion not be overstated.

Going forward, a relevant perspective is how care is currently conceptualized within nursing, as this is the context of our inquiry. Caring for one's patients is undoubtedly an integral, if not *the* integral part of the nursing profession. The International Council of Nurses is an umbrella organization that includes over 130 national nursing associations spanning the world; this equals over 13 million nurses globally (ICN, 2013a). The association has since 1953 compiled what it calls a *Code of Ethics*, this document has been periodically revised and revisited during annual meetings to accurately reflect the social and professional values of the nurses the ICN represents. The document states in the preamble of its of its current 2012 edition;

"Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering. The need for nursing is universal. Inherent in nursing is a respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status. Nurses render health services to the individual, the family and the community and coordinate their services with those of related groups." (ICN, 2012, p. 2)

While such a code of ethics in management terms can be a crucial ingredient of institutional leadership (Peters, 1987), it does not pin down in detail what is meant by ‘care’ in the context of the nursing profession. Further in the document it is stated “[t]he nurse’s primary professional responsibility is to people requiring nursing care” (ICN, 2012, p. 3). Similar statements of the responsibilities of nurses can be found in the foundational values document of the Swedish Council of Nurses. It is also here evident that the discourse of care, contextuality, and understanding of the relationships is upheld as important.

“The human being is unique and should be encountered on an individual level. He/she becomes a patient when in receipt of professional care. The extended concept of patient in nursing care includes the care providers taking the patient’s family, next of kin, environment and milieu into consideration.” (SCN, 2011, p. 6)

But what is care, what is implicitly and explicitly included in the concept? A cursory reflection over this quickly shows that there are grave implications hidden in the practice of care, some deeper and some shallower. In an institutionally structured situation of caring, such as a hospital, a nurse is daily confronted with situations in which care becomes more than simple mental heuristics but a profession. The nurses have rules to follow and more often than not the very lives of human beings are within their sphere of influence. When care is not adequately provided or does not go as planned, accountability immediately becomes the foremost issue for the parties involved.

To conclude, the emerging customer perspective in health care organizations has displaced the patient perspective, which Nordgren (2003) argues complements rather than replaces it. As a consequence, the transformational marketization discourse of health care constitutes a coexistence of subject positions with different properties. There is even research that points to this “experimentation” since the late 1990s is gaining strength and momentum anew, furthering the ideals of market reform (Harrison and Calltorp, 2000). This is a development that Nordgren (2003) states ought to be embraced, as it strengthens the position of the individual cared for; from a patient with needs and customers with demands. While the potentially ambivalent care and marketization discourses have mainly been studied from managerial and chief physicians’ perspectives within Swedish health care (e.g., Nordgren, 2003; Bringselius, 2012), no study has explored how these micro and macro discourses converge by analyzing how nurses draw upon and relate to these as they construct their care-giving practice. Through our theoretical framework, we aim to go beyond the common sense proposition that a care discourse stands in potential conflict with a marketization discourse. Rather, we seek to explore the plurality of knowledge claims about care by understanding this discrepancy by empirically analyzing how the storytelling by nurses within Region Skåne draw upon an ethics of care, and how they relate to the marketization discourse in health care.

### **1.3 Research Question**

How do nurses within Region Skåne draw upon a care discourse in their storytelling, and how do they relate to the counter discourse of marketization?

## 1.4 Purpose

We aim to understand the care discourse in the practice of nursing within public health care organizations, and its coexistence with the current marketization discourse promoted by the New Public Management paradigm.

## 1.5 Relevance

### *Public policy implications*

The arguably dangerous notion that New Public Management values can complement the actual practice of caring for patients as done in health care organizations is in this thesis nuanced and problematized. Thus it provides an argument that can help inform the decision making of political representatives, moving forward in organizing Region Skåne.

### *Knowledge contribution*

This study incorporates two increasingly highlighted fields of organization studies: The concept of care, as well as the method of storytelling. As no other studies to our knowledge have used the stories of nurses as subject for discursive inquiry of micro and macro analysis, this study provides an original perspective as to the management of public health care organizations. We argue that analyzing the storytelling by nurses will shed new light of the question of marketization in health care, as this embodies an important and previously overlooked angle in the current debate.

## 1.6 Delimitations

The ethics of care literature have since its genesis in the 1980s taken many paths and today explores a multitude of theoretical pedigrees as well as a wide range of social relations and situations. A substantial part of this work concerns political theories and international relations, for the purposes of this thesis the concepts that fall within this lineage are not of interest and therefore not discussed. Methodologically, this thesis takes an emancipatory perspective by focusing on the storytelling by nurses, and what they draw upon as they express care-giving. A complete unpacking of the implications and roots of the marketization discourse within the health care system requires broader range of empirical data from, including, but not limited to, politicians, managers, administrators, doctors, and patients. Further, due to the context of the study, the results are somewhat limited to care intensive organizations.

## 1.7 Thesis Overview

What follows is a short overview of the structure of this thesis. Having set the scene by depicting the coexistence of a care and marketization discourse in health care organizations, and theoretically motivated a line of discursive inquiry towards a defined research question, we turn next to discuss methodological research design implications. In Chapter 2, we discuss our method to collect empirical data through interviews with nurses within Region Skåne, and the analytic approach of storytelling in organizational research. We then turn to Chapter 3, where we present a theoretical framework that will inform our empirical analysis. The framework involves a brief

overview of the theoretical ideals sanctioned by the New Public Management paradigm, however the main focus of the chapter will be on providing a thorough account of an ethics of care. In doing so it will delineate how it can function in understanding nurses' construction of care-practices in action and discourse. The framework will thus guide our understanding as we subsequently turn to the empirical analysis in Chapter 4, where a selection of six authentic stories of care-giving will be presented as told by nurses. The interpretive analysis of the stories will concentrate on how they draw upon an ethics of care, as well as how they relate to marketization concepts. The concluding discussion in Chapter 5 is thereby positioned to readily revisit the research question and knowledge contributions are discussed under the themes *Taking Care Seriously* and *Nuancing the Customer Concept*. Here we conclude that conceptualizations of the patient as a customer is exhaustively estranged in the stories shared by nurses, other than in abstract discursive terms of awareness, and that nurses even actively resist constructing patients in market terms. The thesis is concluded with Chapter 6 where the phenomena of public organizations adopting a discourse stemming from business, and also the inverse, businesses increasingly talking about care are discussed. Lastly, possible implications for public policy formulation and further research endeavors are presented.

## 2. Methodology

This thesis is built around six stories as told by seven nurses at five different hospitals within Region Skåne. In this chapter, the methods to collect and analyze empirical data are discussed and argued for. By providing a transparent overview of the methods used the reader is given the opportunity to determine the trustworthiness of the results. The chapter begins with a brief discussion of the ontological considerations taken in this thesis, and the implications associated with this for the study. We proceed by arguing for the discourse analysis as a method in organizational research, and position our study in line with the Critical Management Studies tradition. Further, the data collection methods are discussed along with ethical considerations taken to ensure the integrity of the interviewees. We conclude by describing the methods deployed to analyze the stories told by the nurses.

### 2.1 Ontological Considerations

A social constructivist ontology views reality as collectively experienced and constructed by our social interactions, through which meaning is continuously created and revised as people interact (Bryman and Bell, 2005). A constructivist view of reality thus stands in contrast with a realist ontology, which sees the world as being ‘out there’ and it is up to scientific inquiry to go ‘out there’ to find out how it is comprised. The ontological assumption has a central implication in this thesis as it seeks to explore how nurses experience their practice of care-giving, which from this perspective views their experiences as co-constructions of multiple meanings that emerge in interaction and dialog among many voices (Seale, 1999). This leads us to the consideration whether ‘care’ is a socially constructed phenomenon, or if acts of physical caring should be seen as intuitions often found in human beings – thereby arguably making it an inextricable effect of biological precursors. The latter notion of care would imply a realist ontology – which goes in line with philosophical implications of the genesis of an ethics of care presented in the theoretical framework – while the *idea* of care would be seen as socially constructed, as people derive meanings with respect to variables such as particular relations, cultures, eras, spatially specific conditions, etc. The ontological conception of care would thereby have implications on how care is put into practice, as it provides a link between the socially constructed discursive conceptualization of care on the one hand, and care put in practice on another.

Implications for this study involve how we interpret care-giving in the storytelling by nurses. This approach favors a constructivist ontology of the world and thereby discards attempts to verify or falsify statements. Instead it favors an interpretive approach stemming from a postmodern school of thought to understand said statements. There is thus no predefined absolute ‘truth’ that is related to through their stories; rather, meaning is negotiated through continuous interaction and exchange (Creswell, 2007). Parton (2003) criticizes how care-giving tends to be characterized through a model of professional practice where it is viewed as an application of technical rationality through which, in the context of health care, nurses apply research-based knowledge in their profession. From such a positivist notion of care, the work of nurses is reduced to an instrument

of applying research-knowledge into caring and does not consider the intertwined social relational processes of care-giving (Gabriel, 2009). In this thesis, we explore alternative visions of morality that require an understanding of context and an ontology of relationality in caring by analyzing how nurses draw upon an ethics of care.

## **2.2 Organizational Discourse Analysis**

Several organizational theorists (cf. Styhre, 1998; Nordgren, 2003; Alvesson and Kärreman, 2000; Motion and Leitch, 2009) draw upon Foucault's notion that discourse has an important function in identity making, which applies for individuals as well as for organizations. Discourses are thus of particular relevance within Critical Management Studies, which is a community of scholars concentrated in business schools throughout the United Kingdom, and who draw upon poststructuralist perspectives and critical theory in understanding and critiquing organizations and management. Alvesson and Willmott (1992) show how seemingly natural discourses are inextricably associated with power, as linguistic categories and choice of words to label various organizational phenomena have a profound capacity to stifle alternative conceptualizations through organizational procedures and routines that appear neutral.

As there is an apparent component of power in terms of how organizational constructs are constrained by language, discourse analysis as a method provides a useful tool to critically deconstruct strategies and practices often put in place or influenced by people with the power to establish new concepts and meanings. Discourses can thereby be understood as meaning creation systems that construct objects, operations, concepts, and theoretical options, and can thereby be an effective approach to implement organizational change (Motion and Leitch, 2009). The importance of discourse has crucial implications for our study, as the object of our analysis is how an existing discourse of care converges with an emerging discourse of marketization through the storytelling by nurses. As we will see below, the storytelling analysis approach pursued fits well with the Critical Management Studies school of thought, as stories have the ability to construct symbolic spaces within organizational phenomena, and thereby offer a dimension that sidesteps organizational control by going beyond established facts, information, and technical rationality (Gabriel, 2004). As we are partly interested in how nurses draw upon an ethics of care and partly interested in how they relate to a marketization discourse, the stories will provide reflexive insights of how values and norms are expressed through events, characters, and plots.

However, as noted by Alvesson and Kärreman (2000), there is a tension between analyzing the spoken storytelling by a local discursive practice and the totality of discourses within e.g. a specific industry, as it is difficult to account for both in the same study. Nevertheless, we argue that the stories presented in this study offer diverse insights that capture the ambiguity associated with conflicting micro and macro discourses. As nursing constitutes an important and previously overlooked profession to analyze the conceptualization of care in health care organizations, we argue that this thesis is of relevance and that it can be pursued authentically and with credible results. Styhre (1998) illustrates the reciprocal relationship between micro and macro analyses very well

below, where in our case the former can be understood as the storytelling of care-giving by nurses, and the latter be seen as the marketization discursive formation in health care organizations.

“[M]icro and macro discourses are related to one another in terms of a hermeneutic circle; macro discourses can be interpreted on the basis on micro discourses, while micro discourses cannot be understood until the macro discourses have been examined”. (Styhre, 1998, p. 81)

This means that discursive formations such as marketization of health care are more fundamental to e.g. the dialog between nurse and patients. A micro analysis of stories thus focus on how individual sentences relate to the stories in the same way as the stories relate to the discursive formation in which it takes part (Styhre, 1998). Through the living stories of care presented in this thesis, a micro analysis will reveal how meaning is constructed and how an already present ethics of care is drawn upon. Furthermore, a micro analysis of the stories will also reveal how the nurses relate to and associate with the macro discourse of marketization. Thereby, we will be able to explore whether the ideals of ‘choice’, ‘customer’, ‘guarantee’, and ‘quality’ sanctioned by the New Public Management macro discourse have been internalized or related to in the storytelling by nurses.

### 2.3 Data Collection Method

Apart from the short discourse analysis presented in the opening chapter *Setting the Scene*, which was conducted through passive participation of a publicly held seminar, the empirical data that is subject for our analysis is collected through qualitative interviews with seven nurses. As recommended by Kvale and Brinkmann (2009), the interviews were thoroughly prepared by organizing the themes that were to be covered into an interview guide. From our initial literature review of New Public Management, ethics of care, and its presence in nursing literature, six themes were identified and translated into corresponding open-ended questions. The themes were: Conceptualizations of patients; experienced reflections of care; moral motivations and implications of care; contextual aspects of care-giving within the boundaries of the organization; and lastly, reflection of evidence-based care versus care as relational inter-personal dependency. The role of the interview guide was to guide the themes and did not dictate the terms of the interviews, which thus were conducted in a semi-structured fashion (Creswell, 2007). In Table 1 below, an overview of the interviews are given with corresponding information regarding the work experience of the nurses, the type of ward they worked at, length of the interviews, and their respective setting. All names are pseudonymized and the hospitals are not disclosed to ensure the anonymity of the interviewees.

Table 1: Overview of Interviewees

Interviewee	Profession	Ward	Length	Interview setting
Anna	Nurse with less than five years of experience	Ear-nose-throat center	40 minutes	Over a breakfast at a café
Sara	Nurse with less than five years of experience	Neurology ward	40 minutes	Over a beer at Sara's place
Christine	Midwife with more than 30 years of experience	Child delivery clinic, (recently changed job to a private clinic)	1 hour 30 minutes	Over a coffee at Christine's place
Astrid	Nurse with more than ten years of experience	Cardiac intensive clinic	50 minutes	During work hours at Astrid's work
Ingrid	Nurse with more than ten years of experience	Emergency room	50 minutes	During work hours at Ingrid's work
Olivia	Nurse with less than five years of experience	Emergency room	55 minutes	During work hours at Olivia's work
Alice	Nurse with more than 20 years of experience	Hematology and oncology clinic	2 hours 25 minutes	Over a coffee at a café

The respondents represent five different hospitals within Region Skåne. Three of the interviews were conducted in the homes of the interviewees after taking initial contact, one was held at a café, and three were made during work hours at a hospital. For the ones held at the hospital, contact was made with the managing nurse who scheduled time slots with the interviews. For the ones held outside of the hospitals, contact was made through mutual acquaintances. It was made explicit for each person that participation was voluntary, and with the exception of one interview held at a hospital, all were conducted candidly with no real issues of social dissonance, which enabled an atmosphere for reflexive elaborations (Alvesson, 2003).

As the objective of the interviews was to engage the interviewees in storytelling, it was crucial to create a feeling of trust in the meetings. In light of this, no notebooks were present in order to construct a context that felt more relaxed and less 'official', so that the interviews resembled more of a natural conversation. It was also made clear that there were no right or wrong answers, and that the goal of the meeting was to hear about the interviewee's experiences. By favoring long answers entailing stories, we attempted to take an as withholding position as possible by asking the respondent to elaborate, exemplify, and reflect (Kvale and Brinkmann, 2009). This was intended to encourage honest stories by going into depth in the covered themes, and thereby minimize the interviewee's inclination to follow cultural scripts or moral storytelling (Alvesson, 2003). As noted by (Myers and Newman, 2007), the social scene of the interviews did have an effect in this regard, as the ones set outside of the hospitals were not as constrained by time and were more inclined to be personal rather than professional.

## 2.4 Analyzing Stories and Storytelling

From the interviews with the seven nurses as outlined above, six separate stories were chosen that reflected the inherent diversity entailed in care-provision. We thereby deviate from the more orthodox way of analyzing interviews in organizational research, and emphasize the potential in the living stories that emerged throughout the interviews as the nurses shared their vividly memories and experiences of care-giving in the form of storytelling. On our initiative, we encouraged the nurses to share their stories in order for us to capture their emotional experiences rather than the actions themselves (Gabriel, 1997), illumining the themes of an ethics of care already present therein. As researchers, this required us to build mutual feelings of trust in each and every interview situation in order to create a setting where the interviewee felt comfortable to exemplify our semi-structured themes with self-experienced stories that came to mind. Naturally, some interviews were more successful than others in this regard, yet many generously insightful stories were told that unfolded through often intriguing plots.

Few studies focus on the link between stories and organization (Boje, 1995), although such attempts have gained recent popularity within organization studies. Critics argue that stories are just fictions, and that they offer fantasies of the storyteller rather than representations of reality. Stories constitute social and linguistic complexities, which according to Alvesson (2003) should not be seen as just sources of bias. In this thesis stories served as accounts of the experiences of the storyteller, these account problematize and nuance current theories in organization studies. In contrary to narratives, stories involve plots with characters and events that could be either real or imagined, which give stories creative ambiguities as they unravel social and organizational phenomena through experiences of the storyteller. Stories thereby provide discursive elements that enable us to make sense of actions and facts as they are related to through plots (Gabriel, 2004). In organizations, stories offer rich insights and means of interpretation in otherwise information drowned environments of numbers, lists, slideshows, priorities, rationalizations, and other generic organizational artifacts. In opposition to all these, a living story is “emotional and spontaneously expressive, and it takes place within a multiplicity of different force relations present in any situation” (Boje, 1991, p. 258). Stories can act as sense-making devices by linking causes and effects within narratives, and can thus explain social phenomena over time making actions and occurrences plausible within a given context (Gabriel, 2004). We argue that stories act as trailblazers in understanding the foundational problems of the customer concept in the inter-personal relations required by good care-provision.

As to the analysis of the presented stories; the interviews were all fully transcribed in original Swedish into a single document (for transcripts, see Appendix A), where episodes of the data were organized into clusters of meaning and common themes (Creswell, 2007). The identification of the themes was made inductively from the empirical data, as we aimed to find telling stories that captured essential, relevant, and contextual aspects of care-giving with patients. One of the main strengths of a storytelling approach in interviewing involves its capacity to highlight reflexive and serendipitous reflections of the themes addressed, as context and individual action overlap in the plots of the stories. This points to the role of theory in our analysis where the theo-

retical framework provided by the ethics of care are brought to bear as we aimed to explore how the interviewees drew upon 'care' in their stories. In doing this we lifted the concepts of 'care' through our theoretical framework, where it conclusively made contact with the underpinning values and considerations. Below, Alvesson (2003) saliently illustrates a similar position in terms of theory in interviewing.

“The interview as a complex social event calls for a theoretical understanding or, rather, a reflexive approach in which a set of various theoretical viewpoints can be considered and, when there are reasons for doing so, applied” (Alvesson, 2003, p. 14)

Being aware of the social constructive character of the nurses' storytelling, a vital objective in the analyzing of the stories was to capture episodes where the interviewees elaborated on reasons of various decisions or experiences of events, as this would provide coherence and order to events occurring (Boyce, 1996). Departing from a semiotic interpretative understanding of the stories (Czarniawska, 2008), we asked ourselves in our empirical analysis how it was possible for the texts to say what they did? We realize the difficulties in replicating this study, due to its contextual nature and trust created, but hold that this is duly compensated by the uniqueness and authenticity of the data acquired.

### 3. Theoretical Framework

The following chapter will present an overview of New Public Management and the main organizational implications sanctioned by this emerging paradigm in public administration. The remainder of the chapter will focus on the main features of an ethics of care, beginning with a short introduction to the field. After this an explanation of our division of the literature into three primary but overlapping areas will follow, them being unpacked in order in the subsequent subchapters. A chapter highlighting a collection of key caveats, or criticisms will then be presented. Lastly a short literature review of the ethics of care in the nursing journals will bridge the gap from theory to practice, and position our theoretical framework in relation to the nursing profession.

#### 3.1 Implications of New Public Management Values in Health Care

New Public Management is an important contextual perspective that needs to be introduced in this thesis. New Public Management is a term that is frequently used to describe a philosophy that challenges the existing values and forms of governance in public sector organizations. By promoting an ideal of innovativeness, entrepreneurship, and efficiency, reforms are carried out through a set of tools with managerial and market oriented logic that give prominence to cost-efficiency, performativity, and competition (Osborne and Gaebler, 1992). Pollitt and Bouckaert (2011) show how the input-output model is widely adopted, which gives a systematic overview of the organization's performance with special emphasis on output metrics. Evaluation of the performance is applied through generic business techniques such as Total Quality Management. The organizational design should be lean, flat, small, specialized, and multifunctional. Further, Pollitt and Bouckaert (2011) argue that in the case of Sweden, New Public Management has changed the administrative culture from originally being legalistic to become corporatist.

According to Motion and Leitch (2009), discourse transformations are often affected by public policy, which in turn can have significant influence on organizational legitimacy in terms of how people perceive it. Mahon and Robinson (2011) describe how the paradigm of New Public Management provided a rationale for the recent opening of private care provision in Sweden, which was actively promoted not only by neoliberal advocates but also by the unions who foresaw higher wages for their members through increased competition among care providers. This kind of macro-level theory of how discursive legitimacy is accommodated through policy provides a perspective to explain the emergence of a marketization discourse of 'choice', 'guarantee', and 'quality' in health care. The arrival of a new business-like marketization discourse can from this perspective construct organizational identities that fundamentally change the way they are perceived by stakeholders, their employees, and the way they interpret meaning through the entering macro discourse (Styhre, 1998).

In his dissertation, Nordgren (2003) empirically studies Swedish public health care, including Region Skåne, and analyzes the discursive transformation of how the language of portraying their

practice as care-providing organizations is gradually transforming in line with the influence of New Public Management in Sweden. Health care organizations have during the last 30 years in Sweden undergone a fundamental discursive transformation that, according to Nordgren (2003), trajected from an advancing quality discourse with an increased focus on customer satisfaction and lean processes. The most important conclusion drawn is that New Public Management presupposes the actively choosing customer, backed up by care guarantees, personal rights, and the right to self-determination in health care. Nordgren (2003) states that this has entailed a “displacement of the notion of the sick person from a passive patient to an active customer who makes active decisions and participates” (p. 198), and concludes that public service should embrace this complementing conceptualization as “the patient concept is [not] being replaced but rather complemented by the customer concept” (p. 198).

The restructuring and streamlining of e.g. hospitals according to the underpinnings of New Public Management is assumed to be realized through human relations, as an organization's ability to change is embedded in its employees' flexibility and mindset (Brown, 2004). In an empirical study of Region Skåne by Bringselius (2012), a quantitative approach is applied to evaluate how administrative managers as well as medical doctors of the organization perceive a recent merger of two hospitals. By analyzing responses in terms of effects on care quality, efficiency, work environment, and employee turnover, a clear discrepancy between the managers and the doctors is identified and a mutual sense of lack of communication between practitioners and decision makers is pointed out as a contributing cause.

In other studies, Ackroyd et al. (2007) report how the emphasis of professional managers within hospitals since New Public Management is favoring managerialism rather than professionalism. Skålén (2004) argues that a marketization discourse within public health care organizations creates heterogeneous and conflicting organizational identities, which can imply ambiguity for the care-providing professionals working there. Feminist critiques of New Public Management is exemplified by Sevenhuijsen (1998) below:

"Care is, after all, not simply a matter of distributing 'goods and services'; it has to do primarily with quality of life, and how we experience and interpret this. It also has to do with ways in which power processes are involved in this context." (Sevenhuijsen, 1998, p. 86)

Seen together, there appears to be a strong voice of criticism towards New Public Management and the transformational marketization discourse that precedes it within the field of organization studies. As this phenomenon has been studied mainly from management and chief physicians' perspectives in Swedish health care (cf. Bringselius, 2012; Nordgren, 2003), there appears to be a need to nuance the existing theories by researching similar phenomena among practitioners, in this thesis represented by nurses.

Having briefly covered the main implications and criticism of New Public Management in the context of health care, we now proceed by extending our theoretical framework by introducing the ethics of care.

## 3.2 Ethics of Care: Orientation, Practice, or Moral Framework

After first briefly explaining from where the ethics of care have come, and what perspectives it promotes, this chapter turns to advance a ternary partition of the ethics of care. With such a tripartition we aim to not only help the reader better understand the theory and our application of it, but more aptly use it ourselves to lift the concepts of ‘care’ in our collected stories. In this chapter our division of the ethics of care into three subdivisions will be presented and explained.

### 3.2.1 Introducing the Ethics of Care

The ethics of care says that instead of viewing a human being as a sovereign rational unit, performing calculated deliberation, we would have a better moral outlook by acknowledging that humans are constituted by a network of relations and by definition are emotional entities. Instead of suppressing such emotions of care, empathy, and connectedness; we should embrace them, and even indulge in them (Held, 2006; Noddings, 1984; Ruddick, 1980, 1989; Gilligan, 1982; Slote, 2007). Why its name is often put in plurals as the *ethics* of care instead of what might seem more intuitive, an *ethic* of care is aptly explained by Virginia Held who says “I use the term ‘ethics’ to suggest that there are multiple versions of this ethic, though they all have much in common, making it understandable that some prefer ‘the ethic of care.’ I use ‘the ethics of care’ as a collective and singular noun.” (Held, 2006, p. 169). Held’s consideration that the modern ethics of care is a broad field, with a multiplicity of ideas present within it, will be explained further in the subchapters following this one.

Care ethics have ambitions to be regarded as a suitable substitute for the dominant moral theories of our time represented by the philosophers Kant and Rawls on the one hand and Bentham, Mill, and Sidgwick on the other. These thinkers represent the ideas of Deontology (the study of duty) and Justice, contrasted with Consequentialism (the study of outcomes) and Utilitarianism, (the study of actions that create the most good). The ethics of care represent a feminist critique of these theories and accuse them of being overly focused on the autonomous person as well as being male-dominated, ignoring the experiences of women (Held, 2006). As alluded to there have since the 1980s and forward occurred a substantial expansion in what today is discussed as the ethics of care. Its distinct feminist underpinnings where context and relations of moral subjects is valued is presented as a direct contrast to mentioned Kantian or perhaps Rawlsian moral theories (Held, 2006; Gilligan, 1982; Noddings, 1984). Prevalent in the writings of most care ethicists is a use of more consequentialist and deontological ethics as a ‘dark philosophical adversary hovering in the background’ (Paley, 2002).

Health care in all forms, nursing included, are riddled with moral dilemmas and clashes between ethical considerations. The dominant (Google Scholar, 12900 citations), but not uncriticized, approach to medical ethics theory today is represented by the ‘four principles’ as originally expressed by Beauchamp and Childress in *Principles of Biomedical Ethics* (Gillon, 1994; Takala, 2001). What their proponents are crediting them with providing is “a simple, accessible, and culturally neutral approach to thinking about ethical issues in health care” (Gillon, 1994, p. 184).

The four principles are formulated in the following way; Autonomy, Beneficence, Non-Maleficence, and Justice (Beauchamp and Childress, 2001). As sound as they may seem these ideas have not gone unchallenged, but have also been widely accepted (Takala, 2001). Part of their appeal lays the principles they provide, but then, morals cannot be principles alone. In particular, Gilligan takes a clear stance against the need for, and usefulness of such, ‘universalist principles’ (Edwards, 2009. p. 233). Further, the four principles do not provide consultation to a researcher pursuing an understanding of the values grounding nursing practices. To have anything resembling a more compelling philosophical theory for such an endeavor, concepts such as moral emotions, virtues, and the ideal ‘good character’ must be acknowledged and discussed. It is here the ethics of care, which will provide the outlook for our analysis of nurses’ storytelling comes into frame. As have been discussed in the introduction the language of ‘care’ is prevalent in nursing, and our study of the underlying theories of ‘care’ will help illuminate and explain this discourse as well as allow a broader range of understanding to take place in our empirical analysis. The key notion to remember is that, as a theory the ethics of care is not one block, but diverse and multifaceted, and treating it as such facilitate much of the deeper understanding then obtainable.

As mentioned before it is our position that ethics of care is best understood by dividing it into three main formulations – Orientation, Practice, and lastly Moral Framework. These perspectives will now be discussed in turn, beginning with orientation.

### 3.2.2 Care as an Orientation

The title of this subchapter alludes to an ethics of care that operates in the background, consciously or arguably sometimes subconsciously, three writers present such an ethics of care; Carol Gilligan, Nel Noddings, and Sara Ruddick.

Beginning with Carol Gilligan; often credited for being one of the first to articulate a distinct account of care ethics in 1982 (Held, 2006. p. 27). Though Sara Ruddick is identified, at least by Held, as the original pioneer in formulating an ethics of care with Ruddick’s (1980, 1989) paper and later book named *Maternal Thinking*. The ideas Gilligan outlined in her book *In a Different Voice* came from her time working with Lawrence Kohlberg at Harvard. Kohlberg, known for his research into moral development in children caught Gilligan’s attention and suspicion when presenting his findings – apparently showing that girls came to moral maturity considerably slower than boys (Gilligan, 1982; Held, 2006). In authoring her dissertation, which was to become *In a Different Voice*, Gilligan came with two primary objections; a) The ‘Highest Stage’ of moral reasoning in Kohlberg’s framework closely mimicked the Kantian ideals of pure reason and autonomy, and b) that the work was severely gender biased, excluding the ‘different voice’ expressed by girls (Gilligan, 1982). The foundations of the ethics of care are thus formed, and are understood as that girls and women tend to reflect on and express moral problems differently than men and boys. The female thinking appear to put greater value on context and the relationships involved, over abstract principles and rules that dominate male thinking (Gilligan, 1987, p. 25).

This way of reasoning is often fundamental to nursing work, where an individual's overall situation and reciprocation have to be taken into account. Gilligan was by no means alone in taking exception to Kohlberg's findings, and criticism did not come from a feminist perspective alone. Walker in 1984, did a well cited study in which he in depth explores the gender bias in Kohlberg's work. The conclusion was that much of the work indeed was flawed and the primary conundrum became, in Walker's own words "it might be more appropriate to ask why the myth that males are more advanced in moral reasoning than females persists in light of so little evidence." (Walker, 1984, p. 688). He is worth quoting further where he concludes his paper with saying "[t]his review of the literature should make it clear that the moral reasoning of men and women is remarkably similar" (Walker, 1984, p. 688). This idea that the reasoning promoted by the ethics of care is feminist but by no means can be employed by women alone was a point of weakness in Gilligan's work that did not manage to build a solid gender-neutral case. This was later somewhat rectified by Ruddick who made a case for that a 'mothering' character and 'mothering' as work could be developed and employed by men and women alike (Ruddick, 1989). Gilligan (1982) puts forward delineation between two, arguably, conflicting ethics: 'obligation-based' ethics and 'responsibility-based' ethics. The first refer to the mentioned theories of deontology and utilitarianism, this is contrasted with 'responsibility-based' ethics, such as the ethics of care.

While Ruddick work in *Maternal Thinking* (1989) can be criticized for being a problematically sentimental (focus on moral sentiments and/or emotions) account, it is still thought provoking and noteworthy outlook to understand the parental intuitions involved in caring for others. The female essence of a term such as 'mothering' is countered by Ruddick (1980) who explains; "For me, "maternal" is a social category: Although maternal thinking arises out of actual child-caring practices, biological parenting is neither necessary nor sufficient. (p. 346). She further acknowledges that child-care is but one caring activity, but many of its foundational principles are transferable to other caring practices (Ruddick, 1989), such as nursing. A constitutive part of 'maternal thinking' is described as "Rather than separating reason from feeling, mothering makes reflective feeling one of the most difficult attainments of reason" (Ruddick, 1989, p. 70). The concept of using emotional awareness in a reflexive and intuitive way to assess the wellbeing of persons cared for is often instrumental in nursing work. Ruddick (1989) states that "[t]he work of mothering is a central instance and symbol of care" (p. 46), and later clarifies by saying "...I identify some of the specific metaphysical attitudes, cognitive capacities, and conceptions of virtue that arise from mothering" (Ruddick, 1989, p. 61).

With her 1980 article *Maternal Thinking*, Ruddick presents a case that in caring practices, traditionally performed by women there can be found a "characteristic and distinctive thinking" (Held, 2006. p. 26). From said activities, such as mothering, values and moral implications can be extracted and applied to human activity in a more general sense (Ruddick, 1989). This opens up a valid criticism, that Ruddick's work in particular is based on the mother-child relationship, which is important to be aware of. If the precepts of care ethics indeed aren't present in other contexts, such as nursing, what hope would the ethics of care have to increase our understanding of 'care' in these situations? Noddings somewhat answers this in her book *Caring, a feminine ap-*

*proach to ethics & moral education* (1984): "There can be no ethical sentiment without the initial, enabling sentiment" (p. 79). This encapsulates what is meant by a *caring orientation*, which will be shown to be almost universally present in the stories of nursing. The values and experience hidden in it has however been largely ignored in the public sphere, and it might do well to change this, bringing it back into focus (Ruddick, 1980, p. 355).

Nel Noddings who is the third writer presented here in *Caring* (1984) explores and argues for a feminine approach to ethics and moral education. She, like Gilligan, takes off from a point of seeing women's way of reasoning around morals as qualitatively different from male ways of reasoning. In her own words: "'They [women] enter the domain through a different door, so to speak" (Noddings, 1984, p. 2). The same themes as seen before in Gilligan (1982) reoccur: "Women can and do give reasons for their acts, but the reasons often point to feeling, needs, impression, and a sense of personal ideal rather than to universal principles and their application" (Noddings, 1984, p. 3) One of the more influential additions to care ethics, other than doing a more rigorous work in structuring her philosophical arguments, is Noddings' addition of categories in caring relations. Categories that will be used at times in this thesis and are constituted by the conceptual formulation of the "one-caring" and the "cared-for" (Noddings, 1984, p. 4). Their relationship is described by their terms, the 'one-caring' is the individual who cares for another and vice-versa the 'cared-for' is the one receiving care. Such a relationship is intuitively transferable to a nursing situation as relationality of human beings is foundational to ethical conduct, and "we recognize human encounter and affective response as a basic fact of human existence" (Noddings, 1984, p. 4).

There are risks inherent in caring, the 'one-caring', for our purposes the nurse, must be aware of the risks in caring for the 'cared-for', there can be infringements on the independence and autonomy of the 'cared-for' if care becomes overbearing (Noddings, 1984, p. 11). A key feature of nursing work is the relationship, however brief, often formed with the patient. Such a relationship builds trust through reciprocation of sentiments and emotions. Care is inherently reciprocal, both parties thus work to create the care in conjunction (Noddings, 1984, p. 78). For a nurse, all patients must be cared for equally, not in the sense of given the same exact attention, but a particular patient's demeanor or conduct can almost never be allowed to infringe on the care-practices. This can be understood through Noddings' who describes a difference between "I must do something" and "something must be done" (Noddings, 1984, p. 81). For the professional nurse it is uncontroversial to say that "if anything is true, it is true that nurses have responsibility for those in their care" (Edwards, 2009, p. 235).

The key takeaway is that while flaws can be found in the ethics of care, its concepts are present in nursing to a degree that make it useful to study. As stated in the beginning of this thesis our purpose is not to argue in the affirmative for a adoption of 'ethics of care' as the go-to theory in all cases, neither to salvage it from a theoretical perspective. Our intention is, hopefully self evidently, to exemplifying it where it is already found and apply its considerations where they fit, without forcing the issue.

### 3.2.3 Care as a Practice

There is a meaningful distinction to be made between having a caring orientation, and acting on that orientation. Particularly in a situation of professional caring, such as nursing, where those under your care are not family or friends but almost always strangers with whom little prior relationship exists there arises a need to use a different type of ethics to create understanding.

Joan Tronto discusses ethics of care in terms of a practice, writing: “Care is [...] best thought of as a practice [which involves] [...] both thought and action, that thought and action are interrelated, and [...] are directed to some end” (Tronto, 1993, p. 108). This is not to say that she argues for a view that to care is only this; her most known work has come through her exploration of the points where an ethic of care crosses path with feminist theory and political science at large. Again, for our purposes this part of her work will not be extensively explored, a sentiment shared by others analyzing Tronto (cf. Edwards, 2009).

What we find most useful with Tronto’s (1993) form of care ethics is that she makes a realistic effort at structuring it in such a way that it can be found interacting with a nursing context. She picks up where Gilligan abandons justice and incorporates this value in her theory, making it a very plausible and sounder formulation (Edwards, 2009). Tronto says it best herself “justice is necessary to distinguish among more and less urgent needs” (Tronto, 1993, p. 138). This can solve, to at least an extent, the problematic situation where for example one patient might provoke more urgent feelings of caring, and as a result might be unjustly prioritized over others with more pressing needs. We thus have a more practical ethics of care in front of us that cannot easily be dismissed for lacking realistic explanatory power of care-provision.

An attempt at defining care is also provided by Tronto, and even though the definition appears to be, in the words of Edwards “extraordinarily cumbersome and complicated” (Edwards, 2009, p. 234) it is well worth presenting here:

“On the most general level we suggest that caring be viewed as a species activity that includes everything we do to maintain, continue and repair our ‘world’ so that we can live in it as well as possible. That world includes our bodies, our selves and our environment, all of which we seek to interweave in a complex, life-sustaining web” (Tronto, 1993, p. 103)

As we can clearly see this way of defining care makes it almost all encompassing, and perhaps worse, almost non-excluding. Any activity performed by anyone who in at least their own mind does it out of a sense of caring is permissible, and under this definition morally praiseworthy. This is from a philosophical standpoint problematic – but it does bring something valuable to the table in understanding how nurses construct ‘care’ in their work; most, if not all, work done by a nurse can be connected to the care of patients. This is a valuable insight for any practitioner or professional, or researcher aiming to understand them. Tronto (1993) in line with that explains that when thinking from an ethics of care standpoint one has “a habit of mind to care” (p. 127).

Just as Gilligan did earlier, Tronto (1993) wants to draw a line between ‘responsibility-based’ ethics such as the ethics of care, and ‘obligation-based’. The now familiar criticisms of such theories are restated; they view humans as autonomous, reason-based units capable of rationally deliberating over moral problems. Tronto’s (and Gilligan’s) ‘responsibility-based’ approach plants its roots in the relations at hand in any given situation and count on the often innate human response to want to help when confronted with such a need. Whichever approach is chosen by an individual, we see great value in both of them. On an organizational level it seems obvious that to rely on that everyone will care about everyone in such a way that maltreatment and injustice does not become a problem is both naive and perfectionistic. On the other hand, as discussed before, to provide sympathetic care is not only to execute science and follow principles, there is a definitive place for care in understanding what one ought to do in any given situation as a nurse, and how this is expressed in remembrance.

The structure of Tronto’s caring practices is put in the form of ‘Four phases of caring’ (Tronto, 1993, p. 105) and ‘Four elements of care’ (Tronto, 1993, p. 127). This outlining of Tronto’s theory will to a large extent draw upon Edwards’ (2009) work, and for greater detail his article *Three Versions of an ethics of care* is recommended. Explaining the concepts in turn we begin with the four phases of care, which are: caring about, taking care of, care-giving and lastly care-receiving.

Tronto (1993) writes: “Caring about involves the recognition in the first place that care is necessary” (p. 106), which is something we can all relate to as most functioning human beings have a sense of empathy. For a nurse this type of cognition obviously needs to be highly attuned and directed towards the patient under one’s care. This view of an ethics of care is in line with Slotte (2007), who argues that caring about based on a notion of empathetic caring or concern for others as a general criterion of right and wrong.

‘Taking care of’ is explained as the step coming after ‘caring about’ and “involves assuming some responsibility for the identified need and determining how to respond to it” (Tronto, 1993, p. 106). For the nurse this means putting the previously explained recognition into a concept of what action could alleviate the expressed or perceived need. Attentive readers will notice a similarity to Ruddick’s (1989) concept of ‘maternal thinking’ and ‘maternal work’ which mirror the same type of considerations.

Moving on to ‘care-giving’ Tronto (1993) says “it involves physical work, and almost always requires that care-givers come in contact with the object of care” (p. 107). The nurse thus has to combine the previous two steps in to administering care. As the last step ‘care-receiving’ completes the process in that “it provides the only way to know that caring needs have actually been met” (Tronto, 1993, p. 108). This step also recognizes the problematic situations that can arise in health care; namely that needs can be misunderstood or an attempt to alleviate a need can cause additional problems. By being perceptive and using this last step to evaluate an action a nurse can solve more complex situations and provide adequate care (Tronto, 1993). This sums

up the 'four phases' of care and we move on to the 'four elements' of care. They can, according to Tronto be derived from the 'four phases', and place these in the sphere of morals.

The 'four elements' thus are; attentiveness, responsibility, competence and responsiveness. In expanding on these the 'ethical elements' of an ethics of care, Tronto does something quite creative within care ethics by putting forward a structured argument that there are moral failings to be held accountable for also within an ethics of care. 'Attentiveness' is "the recognition of a need and that there is a need that be cared about" (Tronto, 1993, p. 127). This puts 'ignorance' within the purview of moral evil. In health care this means that failing to notice that a patient is in need of care is inexcusable. In a modern care facility available technology only strengthens this in that there are few, if any, situations where the staff would be unable to notice a developing situation. Such technology includes the today almost universally used alarms patients as a rule have within arms' reach. Other means of electronically monitoring patient are also employed and include, but are not limited to, equipment overseeing pulse, blood pressure and oxygenation; alarms are then set to notify staff of unwanted fluctuations. Also the practice of routinely 'making rounds' could be categorized as a tool used to ensure the wellbeing of patients. Tronto (1993) wisely includes a discussion that there of course is a difference to be made between willfully failing to be attentive, and simply failing to be aware. It logically follows then that cultivating an ability of 'attentiveness' is morally praiseworthy; this also goes well with what it means to be a good professional care-provider.

The second element 'responsibility' is not as clear a case, but equally important. The previously mentioned "dimension of care, taking care of, makes responsibility into a central moral category" (Tronto, 1993, p. 131). What Tronto tries to achieve here is that we have a responsibility to care. To that effect she writes the following: "Ultimately, responsibility to care might rest on a number of factors; something we did or did not do has contributed to the need for care, and so we must care" (Tronto, 1993, p. 132). As mentioned, this does leave many questions hanging but again as Edwards (2009) writes when discussing Tronto's (1993) notion of a responsibility to care; "if anything is true, it is true that nurses have responsibility for those in their care" (p. 235). Just as with 'attentiveness', this does not appear unintuitive or labored, and goes hand in hand with a concept of a good nurse. The third element is 'competence' and here there is much less confusion. Arising from the third phase, 'taking care of', to do so obligates the care-giver to be competent in delivering care. Failing in doing so is just as with 'attentiveness' a moral evil resulting in 'failing to provide good care' (Tronto, 1993, p. 133). This point is worth driving home, for its implications on nursing as a profession is profound, and not just theoretically so. Quoting Edwards at length:

"In a nursing context, an analogous situation would be for administrators to allocate insufficient numbers of nursing staff to care for patient in a particular unit or ward [...] The same applies to the nurses themselves of course" (Edwards, 2009, p. 236)

An ethic of care by Tronto (1993) thus is not confined to being a perspective, but is a practice, and even provides modes of evaluation for, and of, the practitioner. Last of the 'four elements' is 'responsiveness', which pertains to "the responsiveness of the care-receiver to the care" (Tronto,

1993, p. 134). Following the same logic as above this moral implication stems from the last ‘phase’; ‘care-receiving’. This notion that a nurse or other care-giver must be very alert to the vulnerability of the care-receiver is unpacked at length by Tronto. The risk of a caring interaction becoming abusive is also acknowledged; “The moral precept of responsiveness requires that we remain alert to the possibilities for abuse that arise with vulnerability” (Tronto, 1993, p. 135). It is also rightly pointed out that it is in situations where we are not capable of fending for, or taking care of, ourselves that the idea of the moral human as autonomous and perfectly independent shows some cracks in its armor (Tronto, 1993). For the nursing context at hand for us, these are all important and valuable insights.

We part ways with Edwards (2009) when he states: “As seen, the distinctive features of it [Tronto’s ethics], when interpreted in the nursing context, do not seem to provide a distinctive approach to nursing ethics” (p. 238). For while Tronto’s (1993) case for the ethics of care has its problems it is by no means irrelevant, and refreshingly applicable compared to other versions of care ethics. After all a nurse without question need to fulfill the demands (albeit formulated in a somewhat cumbersome way) put forward by Tronto. Edwards’ (2009) sentiment that ethics of care are not perfectly sovereign as a theory, does not render it useless.

### 3.2.4 Care as a Moral Framework

Virginia Held provides an account of the ethics of care as a moral framework in her 2006 book *The Ethics of Care: Personal, Political, and Global*. So does Slote in his 2007 book *The Ethics of Care and Empathy*. Moral framework, for the purposes of this thesis means to signify that these writers argue that “caring relations should form the wider moral framework into which justice should be fitted. Care seems the most basic moral value” (Held, 2006, p. 71). Slote (2007) also puts forth a case for care as the value in which other values and principles must be fitted, he puts himself in the sentimentalist tradition (focus on moral sentiments and/or emotions) and from there argues for an “obligation to help others” (p. 21).

Held (2006) argues for a fundamental rearrangement of our moral reasoning principles, and to that effect says that for a flourishing society to be possible we need to trust our fellow man until she has proven unworthy of that trust. Such an inverse Hobbsian stand has far-reaching implications if the claim is found convincing. Continuing on this note Held (2006) says: “Those developing the ethics of care [...] focus on persons responding with sensitivity to the needs of particular others” (p. 63). Such a claim surely puts nurses within Held’s framework, since it is their job to tend to the needs of the patients, however as will be shown, the reasoning of nurses as to why they feel an obligation to help is not guided by an ethics of care, rather, the ethics of care guide them in how to do so. In line with many other care ethicists Held (2006) highlights that a caring orientation is fundamental for care-practices to happen, stating that: “Without some level of caring moral concern for all other human beings, we cannot have a satisfactory moral theory.” (p.73).

Health care in Europe, and Sweden particularly has been seen as a public function, financed through taxation of the citizens. This has created a very strict delineation between public and

private in terms of business and practices such as care. In *The Ethics of Care*, Held (2006) presents a host of criticisms against what she describes as the increased ‘marketization’ of functions such as health care, education, prisons, and the production of non-profit culture (Held 2006, p. 107). In several more places in the book a concept is put forward that the idea of public and private as domains demanding different moral considerations is unnecessary and even erroneous (Held, 2006, pp. 16-17; 69). The roots for this need for separation between matters of the family on the one hand and the society on the other are also found in the work of Tronto (1993). She writes: “A political order that presumes only independence and autonomy as the nature of human life thereby misses a great deal of human experience [...] such an order must rigidly separate public and private life” (p. 135).

As have been shown in the introduction there is an ongoing expansion of marketization in health care. In researching how nurses relate to that discourse it is relevant to theorize over whether some concordance might be said to exist with ethics of care as a moral framework. Held (2006) clarifies her position:

“With the ethics of care and an understanding of its intertwined values, such as those of sensitivity, empathy, responsiveness, and taking responsibility, we could perhaps more adequately judge where the boundaries of the market should be.” (p. 119).

Similarly, Slote (2007) as mentioned promotes an ethics of care as a full-fledged moral theory, and does not limit the intuitive feeling of care obligations to any particular perceived common roots – such as immediacy, shared living, or family connections – with potential care-receivers. Rather, admirable and good action can be morally right if it reflects or expresses caring motivation and a “fully developed empathetic concern for others” in a general sense (Slote, 2007, p. 31). However, an ethics of empathetic caring does not necessarily imply that a person is obliged to always care about others, it says, Slote (2007) argues, that acts should exhibit fully developed ‘caringness’. Although it is not made abundantly clear what is meant with such ‘caringness’, Slote’s interpretations of an ethics of care is practice-oriented in the sense that moral principles are viewed in the light of human capacity, where ‘ought’ implies ‘can’ in the actions we exhibit. Thereby, no obligations are asserted to whether a person should feel a certain way, even though a lack of caring feelings might be a display of morally deficient character. Rather, Slote (2007) advocates a theory of an ethics of care that imposes moral implications on human action viewed in a general sense.

The following chapter will turn to the application of ethics of care in the nursing literature, and what implications this has had to understand nursing practices. Worth noting before proceeding is that the ethics of care literature have not been read uncritically during the research for this thesis. Some relevant criticisms have been presented adjacent with the arguments they pertain to, but further critique will be presented in Chapter 5, where the large scope implications of ethics of care in nursing will be depicted.

### 3.3 Ethics of Care in the Nursing Literature

The purpose of this section is to bridge the gap between ethics of care as a theory on the one and its application in understanding practical nursing on the other hand. A great deal has been written on the subject of ‘ethics of care’ in the nursing literature over the last decade. Here, a number a key text will be briefly presented and broken down to exemplify the traversing from theory to practical application that has been attempted with the ethics of care in that time period. Ethics of care has had implications in nursing literature as it has gone from feminist philosophies to applied science in nursing literature; hence providing a relevant perspective to understand the living stories of care presented in the forthcoming empirical chapter.

The ethics of care quickly found a home in medicinal, bio and, nursing ethics, this is hardly surprising as these all constitute professions that are explicitly about caring. Liaschenko and Davis (1991) interestingly make the observation that the male dominated field of medicine historically has been thought to concern itself with ‘curing’ while nursing practices with ‘caring’. In a literature review of ethics in nursing literature, Goethals et al. (2009) show that the balance of medicinal-technical competence and the ability to focus on the ethical dimension of care is unbalanced in favor of the former.

A well-cited study by Cronqvist et al. (2004) uses ethics of care as a theoretical perspective to show how nurses experience moral concerns in intensive care. The study identifies two main themes – caring about and caring for – in the ethical experience by the nurses. The notion of caring about could be identified in the nurses' genuine concern about the well being, feelings, beliefs, and insights into patients' vulnerability. The notion of caring for is more task-oriented and involved moral obligations to fulfill work responsibilities and routines given by the organization. This division is compatible with the theoretical categorization of ethics of care into *care as orientation* and *care as practice* as presented above. As Cronqvist et al. (2004) apply their framework in the context of nursing they identify the following sub themes: Believing in a good death; knowing the course of events; feelings of distress; reasoning about physicians' ‘doings’; and tensions in expressing moral awareness.

In another influential study, Gastmans (1999) argues for care as a foundational normative concept in the nursing profession, implying that nurses not only derive their caring identity from caring for (medicinal-technical competence) but also from the orientation in which they commit to caring about (moral attitudes). Caring as a moral attitude is considered as “sensitive and supportive response of the nurse to the situation and circumstances of a vulnerable human being who is in need of help” adding that the searching for possible ‘solutions’ for patients’ problem requires a balance to be struck between intellectual, abstract care on the one hand and affective, concrete care on the other. Gastmans’ (1999) conceptualization of ‘care’ in the applied context of nursing is grounded with the philosophical notions of an ethics of care, both as an orientation as well as a practice. He stresses the vulnerable position adopted by nurses as they allow themselves to be emotionally involved with the patient in a real and lasting relational sense, requiring time and continuity.

Embarking from a theoretically informed ontological and epistemological foundation, we now turn to present our empirical findings in the form of six stories told by nurses.

## 4. Empirical Analysis

This chapter is focused around six stories, chosen for their representation of the dual subject matter of this thesis, represented by *How Nurses Draw Upon 'Care'* (three stories) and *How Nurses Relate to Marketization* (three stories). Each story will be introduced, presented, and then analyzed, through the theory laid out in the previous theoretical framework. Quotes and short excerpts from other parts of the interviews will be presented to correctly represent the sentiment of the storytellers.

### 4.1 How Nurses Draw Upon 'Care'

The following three stories are chosen for how they characterize how nurses draw upon 'care' when they, through stories of past events describe their experiences of care-giving. Elements of an ethics of care are discernibly present therein, which will be illustrated by drawing links to care as an orientation and care as a practice. We will also show that an ethics of care as a complete moral framework cannot be identified as the guiding principle in the reasoning of the storytellers, a finding that will be discussed at length in the following discussion, Chapter 5.

#### The Smurf

This story illuminates most of the key observations that represent returning instances in the stories by the interviewed nurses. How the success, not only in the medical sense, of their work is dependent on contextuality and inter-personal interactions. This event was pivotal in the continued hospitalization for this individual, and his family. Even though the outcome ultimately was not the desired one, a recovery, what Alice remembers and describes as most valuable for everyone involved is the relationship that formed beginning with the story.

##### *Story 1: The Smurf*

One situation took a somewhat surprising turn, because often you don't know... You don't have a clue of how to solve things, and I knew that I were to take over from a couple of younger nurses, and they were all hyped up, you know, well, there was a patient, whose family, they felt that they questioned everything all the time... "I refuse to go in there", they said, "But what is it all about?", I asked, and they said that they questioned the speed of the IV, and the times of the IV, and this and that, and thought that they [the nurses] were not given the chance to make decisions without the family questioning precisely everything, and the patient I had only heard of – he had been with us frequently but unfortunately I had never gotten to meet him, so I had never gotten the chance to form an idea of who he was – and it was during a weekend, and it was one of those days that we didn't have that much other things going on, many patients were home on leave, and during those hours in the afternoon everybody was home. Then I thought: "Well, I'll just go in there, being laid back", and it was a guy about 25 years old, the siblings were both younger and older, and I got in there, opened [the door] carefully and saw the patient lying there in the bed with the IV that everyone questioned the speed of. So I just entered you know, inspected the IV as if that was all I was there for, which it wasn't [grin], and then I just sat next to him and crouched down so that I almost appeared beneath the level of the patient, you know. Partly, this was unexpected, a nurse doesn't do that, and then I was wearing, we have some odd clothes, they look like a pajamas, so I had blue pajamas pants and a blue tunic, so I looked like a *smurf*, haha!

So I entered, nodded to the patient and said: “Hi, my name is this and I’ll be here this afternoon, so I just wanted to check on you”, and saw all of their eyes just beaming at me: “What?” and I thought: “My God! [sigh]”, and somehow I felt terrified, but also felt that I had to figure out: “What is it that causes so many problems among my younger colleagues, what is it that is so dangerous here?”, and there was a bit of tension in the room, so I just sat down and kept completely quiet, said nothing, and then there was one of the siblings who said:

- What’s so special with you?
- Eh, excuse me, why?, and I immediately felt attacked, you know
- You have the same kind of clothes as the doctor who was here earlier today.
- Ok, you mean these blue clothes?
- Mm
- Yeah, there is something special about both me and, Anna was her name right, the doctor who was here earlier?
- Yes
- No, I’m just kidding, there is nothing special with us, we get to choose these goofy clothes if we want to

And after that I felt the the ice was broken, they just wanted to be heard, and be seen, and after this episode we functioned as a great team, and this particular event laid a foundation for the whole care period, and even if this guy eventually didn’t make it, it turned out well in the sense that they saw that we were no threats to them, that we were just like anyone else who came in there, and some of us take the time to sit down and listen, and some don’t. It’s all about being able to capture... And I didn’t do anything specific, rather the opposite: I did not do anything, other than just being present, because just at that specific moment I had the time, and that changed the direction of the whole treatment after that. I think it was the day after, then I was first working with this patient and then some of the younger nurses came and were about to take over, and they said: “Oh no, him again?”, and I just said: “Well, go in and see”, and then she went in, really carefully, and just said as she got back: “What have you done?!” , haha, “I don’t know?”, “But he was making jokes and he laughed!”.

*(Alice, personal communication)*

The story begins with Alice being faced by two upset junior colleagues, who appear to describe a “difficult patient”. Alice displays her caring orientation in a mode best described as “both reflexive and reflective” (Noddings, 1984, p. 35). Reflexive, in the sense that she recognizes that there is a situation worth to investigate further, and reflective in the sense that she immediately begins contemplating what could be the problem causing this patient and his family distress and anxiety. She allows herself to be transformed into an instrument capable of handling the demands placed on her by the situation. By entering this “feeling mode”, as Noddings (1984, p. 34) calls it, she steps into “the world of relation” where we are “not attempting to transform the world, but we are allowing ourselves to be transformed” (p. 34). In her own words from another part of the interview: “You are in many ways your own instrument, and that instrument has to be kept as sharp and ready as possible” (Alice, personal communication) talking about the skill of, and courage to be emotionally and empathically present in the moment with the patient.

Alice illustrates that the ability to sympathize with the patient’s emotions is not an “add on” to being a good nurse, but a necessary (although not independently sufficient) part of it. Slote’s (2007) delineation between *empathy* (involuntarily having another’s emotions provoked in you)

and *sympathy* (on top of empathizing feeling sorry even bad, for the other) is integral in this situation. She says: “You can observe a lot about the patient by perceiving their mimicry and facial expressions”, again indicating that such interchange is necessary for caring. While time to spend on this type of emotional care (translating into better medical treatment) is not normally present in today's nursing, Alice describes how you as a nurse try to compensate: “you have to be smart with the time you have [...] do many things while at the same time doing something else, but it takes a lot more of you as a person” (Alice, personal communication). The connection between perceptions of the patient's state of mind or morale and successful treatment is highlighted by her insight that: “you feel there is something [wrong] but can't put your finger on it. Usually you should act on that gut feeling”. With experience exceeding 20 years she shares that through the lens of this type of “clinical eye” you learn to “always be on you toes, both reading and feeling [the patient]”. When asked to contemplate on the deeper meaning of *The Smurf*, she elaborates on situations with these sorts of patients, where the cause of what is wrong is not totally apparent, and points to the importance of just being cognizant and aware, to be passive yet receptive and to anticipate the situation by leaving one's emotions on the side and to see what it leads to. We also with this last part of the story clearly see the transition from caring orientation, a sort of “gut feeling”, into a distinctive practice, highly correlative with the theory presented in Chapter 3.2.3 *Care as a Practice*.

“I didn't know what it was. If I had followed my instinct that I got, which was: “Run!”, I would never have found out what it all *really* was about. And I don't think that I was more ‘excellent’ in my medicinal caring than anyone else at any given moment, but yet they told me that: “You are the best of the whole lot”, and I thought “Ok, just because I hunched down below everyone's eye level that day?” whereupon they thought: “What's she doing down there? She, the smurf”, haha! It's often things like that that change a whole situation.”

(Alice, personal communication)

To clearly show how Alice draws upon ‘care’ in practice, the ‘four phases of care’ (Tronto, 1993) will be illustrated coupled with the from them inferred ‘four elements of care’. The initial phase ‘caring about’ is difficult to decisively identify since Alice when saying “he had been with us frequently”, indicates that she was antecedently aware of the patient and his condition. Since Alice had not been taking care of him up till this point we suspect she first recognizes that care is necessary when seeing her apprehensive colleagues, since it is after this she decides: “Well, I'll just go in there, being laid back”. In this we find the coupled ‘element of caring’: attentiveness. By choosing to inform herself on the nature of the patient's and his family's problem she commits herself to not being ‘ignorant’. In this moment she simultaneously commits herself to also ‘take care of’ the young man (and his next of kin). Instead of perhaps talking to the colleagues to find out more she decides to assume responsibility for the identified need (Tronto, 1993). While it is difficult to find this ‘responsibility to care’ we can understand the obligation to act felt by Alice through Edwards, writing “if anything is true, it is true that nurses have responsibility for those in their care” (Edwards, 2009, p. 235).

When practicing actual ‘care-giving’ in this situation it involves ‘physical work’ but in a more tacit way. As will be shown in this thesis, when “care-givers come into contact with the object of care” (Tronto, 1993, p. 107), physical aspects of care often are represented by body language. In the story of *The Smurf* we can see how Alice describes herself kneeling down next to the patient, getting almost below him, in order to create a sense of safeness and take away the emotional distance between care-giver and care-receiver. Her initial inspection of the IV had, as she shares, only the function of giving her an “excuse” to go in there. The ‘element of care’ coupled with ‘care-giving’ is ‘competence’, Alice is evidently very competent in this interaction with the patient and his family. Even though she in this moment is not performing any evidence-based care, the story speaks for itself in the sense of how important the exchange was. Finally the last step ‘care-receiving’, which involves evaluating the success of administered care, is very evident, also how Alice does this with ‘responsiveness’ shines through. Well worth reiterating is that even though the patient in the story lost his battle against his disease, the event was very valuable for the family who from *The Smurf* and forward felt at ease and safe at the ward, working well as a team. The ‘responsiveness’ mentioned is best seen in how Alice navigates the emotionally loaded atmosphere and manages to turn a previously bad situation to something, under the circumstances, reasonably good and comforting.

This reflection of what is involved in practicing good nursing can be contrasted with this next excerpt. We here get to follow a hectic, but not uncommon, day at a neurology ward that brings forward a completely different perspective of what it means to care, or rather what it means not to be *able* to care. The nurse describes that in the wake of the yearly returning budget cuts, nurses are often not replaced when people call in sick, and when they are replaced it is often with an assistant nurse. This relegates the nurses working to a role of ‘pill dispensers’, as there is no time to interact with the patients. In her own words “we more or less, you know, give drugs, hand out pills, then I feel I really lose the care dimension completely” (Sara, personal communication). Compared to the story of *The Smurf*, Sara finds herself lacking every opportunity to practice care properly, and is evidently distraught by the state of affairs. She goes on to share how worried patients often have questions and a need for company, that there is no time for her to help with:

“...many are in positions where they wish to talk, about how things have been, how the night has been, and they might ask for things, if I could check this or that... But if I feel that: "Shit, I don't have the time for this right now", because there's another ten patients who need to get their medicines before eight o'clock, and then I feel... *really* stressed, and that I wish that I could do more.”

(Sara, personal communication)

From Sara we understand that she feels that if there is no dimension of care in nursing, it stops being nursing, she thus loses her identity as nurse and by not being able to act caringly the whole ‘practice of care’ topples.

## Conflicting Principles: A Vis-à-vis Situation

When sharing this story, Christine, a midwife with over 30 years of nursing experience, several times made clear how important the event had been to her, and how she thought about what it meant to be a good midwife. The story illuminates the properties of nursing that involves stepping in to a role of professional conduct, especially when faced with conflicting emotions and principles. A clear orientation of care is present, that allows for the nurse to care for the patient without them noticing the emotional dissonance. Thus the caring orientation also translates into practice. The ethics of care as a moral theory is tellingly absent, and it is by inference clear that other principles (justice, rights, law) are the ultimate deciding factors for moral and right conduct in her nursing.

### *Story 2: Conflicting Principles: A Vis-à-vis Situation*

You can end up with a feeling of “wanting to give more”, there’s a lot of ethics in my job overall, and sometimes you end up in a ‘two-faced’ situation, like I did when I was really *green* as a nurse, I worked in a gynecology ward one night, it was right in the beginning, and there was this girl who was having an abortion, late, I mean a *very* late one in week 20 or 21, and it brought up a lot of emotions in me, she did it, you know, there was no, well I’m sure she had a really valid reason for it, but there wasn’t any medical reason for it. And of course it stirred up a bunch of emotions, but I cared for her that night and she had the procedure. And then afterwards she thanked me profoundly for the help, she was really thankful, I almost had an anxiety attack, because it ended up like that... Because honestly I was against it. What I mean is that my personal feelings conflicted hugely with this, and then she thanked me for taking such good care of her, and I mean that’s what you’re supposed to do, but in this case it became really weird. [...] I mean there was an ethical collision in me, personally. Then after there was a really good nurse who came and relieved for the night, and it was one of the best things I have experienced, sometimes you don’t need professional counseling, but when we had finished up reporting and I was going home, she called me: “Hey! Before you go home lets sit down and talk 10 minutes”. She must have seen I was bothered, and I said: “Okay..?” That sort of thing wasn’t very common, you know. But I got a chance to harp on what I felt and after that it felt pretty good, and even later it felt *really* good, I mean that’s great that she was pleased, that’s what we’re supposed to be, and after that I haven’t had any problems. [...] you learn that “I can’t mix in my own feelings”, if so you can’t work with this, in that case.

*(Christine, personal communication)*

Christine is faced with a situation that is very emotionally charged for her, but cares for the young woman in such a way that she do not notice but instead feel well cared for. Even if the situation was unsettling for Christine she looks back at it, feeling both proud and happy that it turned out as it did: “that’s great that she was pleased, that’s what we’re supposed to be” and puts great value on the lesson: “I can’t mix in my own feelings” implying that you cannot work as a nurse without that realization. This sidelining of her own emotions regarding the situation is a skill mentioned in several other interviews. It is evident that this is a very honest and heartfelt opinion; even though she might not have felt good about the situation initially she is very humble to the experience had by her patient. Ruddick’s (1989) work attest to this being an integral part of an ethics of care, as humility leads to respecting the boundaries of one’s own will. Thus she objectively expresses care, as evidently experienced by the patient, while the subjective experi-

ence of emotional upheaval and anxiety was dominating her emotional state. Care can be projected in spite of conflicting emotions and principles, it seems, and it is a skill formed through experience and reflection over those experiences.

One of the most intriguing phenomena in this story is how Christine over the course of the whole story goes back and forth between different frames of reference. The recollection of the situation is rich with themes encompassed by Gilligan's (1982) 'different voice', while at the same time there is an apparent appeal to the rights involved (legal right to the abortion). And while these principles ultimately guide action, the actions are then performed from a caring orientation, reflected in the outcome. The situation is solved and demands put on her by her job carried out in a way that is "most inclusive of everyone's needs" (Gilligan, 1984, p. 38). By doing what others (the patient) count on her to do she shows how aware she is of the connectedness involved and how difficult, and dangerous it can be to judge situations like this categorically. With the 'intervention' by the more senior nurse the situation ends up not being ultimately unsettling and thus hurting Christine but the exchange, in all its simplicity and short duration, but 10 minutes, was described as "...one of the best things I have experienced". This exchange of experience and time for reflection is key to developing, and maintaining a caring attitude (Ruddick, 1989; Noddings, 1984). Earlier in the interview she mentioned "...things like ethics and respect are important and I try to convey that to my nursing students". However a theme present in *all* interviews was the pervasive lack of time, not only for patients, but for this type of exchange and learning. Another nurse described that the shortcomings in patient meetings often was an effect of having "...no time for reflection while at work" (Astrid, personal communication) adding that when something difficult happened no learning or contemplation could take place in the stressed climate she worked in. Christine appears to perform the required procedure in a way that comports with the 'four phases of care' (Tronto, 1993) and afterwards indicates that there is no other option in the context of care-giving as a nurse.

## The Surrogate

The following story provides an analogy of nursing as proximate parenthood. In the close relationship often formed with the patient, professional nurses often find themselves in the assumed position of a parent or significant other. The implications of this will provide a pertinent perspective on the role of a professional nurse, to whom emotional connection forms a way in caring for the patient. Further it will highlight the values underpinning care-giving. As will be shown and analyzed the comfort and care provided to the patient by this comes with certain risks, which are navigated by the nurse.

### *Story 3: The Surrogate*

There was a young guy here [the emergency room], who didn't have his family with him at that point, and received the diagnosis testicular cancer. In situations like that I can't just say: "Well then" and then just leave. It happens all the time that they [patients] receive negative news from us, and often they don't have anyone with them and then you have to go in and cover for that [...] You never leave anyone needing care, then you have to be there. [...] It's hard, it's easier for me to relate to people who say what they think or who are outgoing, who start crying, than it is

to relate to a closed individual who doesn't want you to touch or doesn't at all wish to be spoken to; then you first have to figure out how to approach this individual there and then. In this particular case it was an individual who was very torn up and very emotional and obviously wanted a hug and felt that closeness was okay so I approached him, and then you don't have to say a whole lot, because what is there to say? You can't say much, we're no fortunetellers, we can't say anything that soothes them, other than just being there physically. In this particular case I didn't say much, I just sat there and held his hand and tried to talk to him, talk about some other things until his mum arrived and could take over the responsibility. It all depends; sometimes you can sit still for two hours and not quite knowing what to say because they don't wish to talk. There are a lot of meetings, you meet many different individuals, it's exciting to see how you yourself choose to react because you have to adapt a lot.

*(Olivia, personal communications)*

The story above was told by a nurse in her mid twenties, with less than five years work experience. Evident in the story of the cancer diagnosed young male is the empathetic intuitions brought forward in the nurse's experience. Him being in distress after receiving a devastating and life altering diagnosis can be said to shift the nurse's perspective from medical consideration to a comforting role, resembling that of a parent. In her own words "You never leave anyone needing care, then you have to be there", the man was described as not being in any immediate physical pain, and was from a medical standpoint not in need of any ER-related treatments, but now awaiting transfer to an oncology ward. She explains how she 'diagnoses' the needs of the individual in saying "you first have to figure out how to approach this individual there and then". This way of defining "oneself in terms of the capacity to care" (Noddings, 1984, p. 42) provides an ability to rearrange the priorities of the situation. At this moment there are still other patients in the ER, but the nurse described how she immediately in such situations asked to be relieved of the medical responsibility for them to instead stay with the person in distress, thus placing "proper place-value to human love, loyalty and the relief of suffering" as expressed by Noddings (1984, p. 42). Projected into specific non-medicine related actions, which can be understood through Tronto's (1993) framework of care.

Another nurse with over 30 years in the profession draws upon her parental experience more clearly. In a situation where an extremely young expecting couple in their mid teens came to visit the antenatal clinic she worked at, she describes how she had to suppress the parent inside who was brought out, and not address them as children but as people who were about to become parents. The nurse described the separation of her personality as a mother and her professional role as a nurse in terms of "colliding conflicts".

[I]t was really difficult to handle [...] I guess it was the mother in me who was brought out, you know, I have children myself, but, this was a rather extreme situation. But then it was that core of me, the personality that came out, my own, which I had to put on the side, you know, and "put on the other glasses", it's an expecting parent couple here, with the cap backwards and chewing gum and a can of coke [...] Those things *really* can collide. [...] I hope that it's the midwife that comes out [...] It was more of an internal conflict to handle.

*(Christine, personal communication)*

An account that in even clearer terms exemplifies the parental, in this case maternal, emotions sometimes provoked in nursing, is found in Christine's story of a young couple. The experience of having children of her own made her, when talking of another situation, sigh: "Come home with me" when faced with a younger patient in a difficult life situation. A need to repress these emotions and stay in the role of a midwife arises, as maternal instincts are not allowed to take over.

## 4.2 How Nurses Relate to Marketization

Having navigated through three illuminating stories of diverse care occurrences and analyzed how nurses draw upon various aspects of an ethics of care, we are currently in a position to explore how nurses relate to the marketization discourse in health care. In nursing, the most evident aspects of this discourse is the conceptualization of the patient as a customer, and in this part of our empirical analysis we turn to another three stories that in different ways show how nurses relate to this macro discourse in different contexts.

### From Customer to Care

The following story illustrates a journey of how a nurse initially relates to the idea of the patient as a customer. As the story develops, a shift of terminology becomes evident as she progresses from discussing the customer concept on an abstract level towards more contextual and personal reflections of relational care situations.

#### *Story 4: From Customer to Care*

Now it's more like a business that should be profitable, so sure, there's a talk about money. But now I feel that I'd rather like to work in a way that makes our customers satisfied, as this is what makes us profitable [...] Patients have much higher demands today; demands in terms of what kind of care they want; how you make an appointment; availability; people have read a lot more these days. And as I work with a young clientele [she works at an antenatal clinic] they have *huge* demands, they are super well-read and up to speed, which means that I have to be updated, too, in order to be ready for all kinds of questions. So, sure, the demands have changed, as a midwife one expects more from me.

[The following part of the story is later in the interview, where the nurse reflects on the actual practice of care-giving]

Sometimes I almost feel like a mother, almost feeling like, that I almost would just like to take them home. I've had that feeling sometimes. There was a young girl who had a tough time at home and who never had anyone to be there for her, some women who come here... And that's pretty clear, I have met a couple of them, some women who have fled their countries, forced to leave their children because she was beat up by her husband, and gets placed in a local town somewhere, all by herself, and she knows no one, there is *no one*, and sooner or later they end up here [women's clinic], *every* time, that's how it is, in one errand or another... And then I feel, just to: "[sigh] come home with me". These things are extremely hard, I think. Because I feel so terribly sorry for this person.

*(Christine, personal communication)*

The initial reflections of the story are from the first couple of minutes of the interview, where Christine in her professional role elaborates on how the patient's position has evolved throughout her 30 years of experience as a nurse. She has recently moved to a private antenatal clinic after working within Region Skåne for the remainder of her career, and clearly illustrates the presence of an increased inclination to meet 'customer demands' in her work, as it is their perceived 'satisfaction' that makes the 'business' profitable. The ideals of choice and rights as promoted by the New Public Management paradigm are thus abundantly present in her preliminary storytelling. She further elaborates on how her personal motivation is praised by an increased awareness of what customers can expect and indeed are expecting from her as a nurse today, relating to the competitive forces imposed by the marketized health care system.

The second half of the story is told one hour into the interview. After covering several implications of her work the story goes from a professionally oriented narrative towards a more personal one, and the stories told are reflexively shared rather than following available vocabularies and conventions from cultural scripts and appear to be free from invoked identity work (Alvesson, 2003). As the story of the lonely women unfolds, who she genuinely feels sorry for and who in her mind always end up in the caring hands of women's clinics, the narrative of meeting 'customer demands' appears extraneous to say the least. It seems fair to interpret how she draws upon an ethics of care in the story of the lonely immigrant women as she states that she "just [would] like to take them home", corresponding to the notion of how thought and action in care as a practice are interrelated and directed to the same end (Tronto, 1993). However, even though as the situation articulately provokes parental feelings of caring, Christine does not in her story abandon a notion of justice, and eventually does not embrace the character of the story to the extent of actually taking her home, as the events are played out.

The story *From Customer to Care* demonstrates a central ambiguity of how nurses talk about care. From an ontological standpoint, this can be understood as a tugging between care-giving as a realist intuition in the meeting with the patient in need for care, and a socially constructed notion of meeting customer demands that exists only in the discursive formation of marketization. The storytelling by Christine thus powerfully deconstructs the discourse of marketization and the new concepts and meanings it attempts to establish in health care. Even as these are related to in the first part of the story, the foundational values of New Public Management are not drawn upon as she reminisces actual events of care-giving. In the second part of the story, the conceptualization of her as a business representative providing a service to demanding customers is effectively side-stepped, as she constructs symbolic spaces through the plot of the women and the caring feelings that these characters provoke inside of her. Emotional themes that unravel are her feelings of sorri-ness entailed by the vulnerable positions of the women in the story, their lack of support, the absence of someone to care for them – values not embraced by the common values of 'choice', 'guarantee', and 'quality' promoted by the New Public Management influenced political leadership of Region Skåne (cf. *Setting the Scene*).

The observed ambiguity in the story can be understood as a hermeneutic cycle (Styhre, 1998). The reflexively expressed feelings of care towards the women at the clinic clearly draw upon an

ethics of care (micro discourse), which enables us to interpret how these episodes relate to the story as whole, as well as to ideals sanctioned by marketization in general (macro discourse). Nordgren (2003, p. 157) argues that nurses part-take in the discursive formation of marketization by relating to the concept of the patient as ‘customer’. While this argument can be supported through the story as Christine initially relates to such a conceptualization, we strongly argue against the existence of such ideals in the actual practice of care-giving, which is exemplified through the latter part of the story. Although there is an awareness of a marketized conception of the customer among nurses, and that the stories indeed relate to this discursive formation, this is by no means reflected in the meeting with the women in the story and the feelings these meetings provoke. In her story, ‘customer’ can thus be said to be discursive while ‘care’ is experienced.

### The Care Factory

The following story takes place in an emergency room where we get to follow a nurse in a not uncommon scenario. We see it as a powerful analogy of a ‘care factory’, as a semiotic interpretation of the metaphors found in the story provides several correlations to a neo-Tayloristic organizing of the emergency room. With its distant management and assembly line-like work conditions, there is no spare time to interact with neither colleagues nor patients. The plot takes us through a dramatic chain of events with an unexpected ending, where the nurse concludes the story by elaborating on the abhorrent moral choices postulated by the work conditions. We round off our analysis by bringing in the voice of an additional nurse, who indicates that the nursing profession is gradually becoming more mechanistic through the use of templates. Templates that shift focus from evaluation of the person met, to arrangement into predefined categories.

#### *Story 5: The Care Factory*

I had this one patient. We have two isolation rooms where patients who have stomach flu who for example have been abroad and have suspected bacteria are. There you have to put on special equipment like mouth guard, face shield and so on. That makes it all a bit more complicated, you can’t just go in there as you wish. I had a patient there who was very sick, she’d had convulsions and such, was very distressed, it was the first time she’d had seizures and it’s very arduous then, it becomes a crucial observandum. I also had a man in a four-person room who was about 20 minutes from simply drawing his last breath. At the same time I had a woman with MS, a neurological disorder, which meant she couldn’t look after herself, she’d needed to be washed and changed on for, by then, five hours or so. Adding to that I had about twelve or thirteen more patients and at that moment I just felt; “*Pause, Stop*”. It’s not like I was the only one who was in that situation, we all are, everyone has the same workload and there is *no* time to help each other, we really do want to help one another so if you have time you do that. But it doesn’t work, at a certain point you have to say stop. This particular event had a pretty dramatic conclusion; it’s not usually like that. We wear these panic alarms, and a colleague from the ambulance came over and saw I was upset, I don’t tear up, I get angry when things don’t work, when I feel like I have to choose I become very angry instead. He gave me a hug, and must have tripped my alarm. It caused a *huge* drama, since then 25 people came running. When it’s one of our own like that everyone comes really quick, you’re afraid someone might be getting assaulted. There I was standing, having no idea that my alarm had been activated, this time the bosses showed up, and that way got to hear everyone’s version of the day. This particular event fixed itself like that, but it was

pretty dramatic. [...] I think there are things a person needs, which makes you more positive, it's a really good day when everything flows and you've had time for quality time with the patients. You haven't been forced to choose; that patient will be dying in a four-bed room with three others; one will be lying in their own feces for *six, seven, eight* hours; and another is having a heart attack. When you have to choose whom to help, that's when you constantly feel you're not enough; it becomes a very nerve-racking feeling after a while. I work well under pressure, but it can't be that you have to pick between how to treat another human being...

*(Olivia, personal communication)*

Even though the inherent stress level associated with emergency care – as it per definition encompasses patients in need for immediate treatment requiring fast coordination – the analogy of a care factory aptly concurs with the events of the story. As a colleague notices her distress and gives Olivia a comforting hug, the alarm button accidentally goes off and the factory's production suddenly halts as the otherwise distant administration rushes down to the assembly line to witness the out of control situation. While the New Public Management paradigm favors efficiency, lean processes, and quality management as leitmotifs to ensure customer satisfaction (Pollitt and Bouckaert, 2011), the evaluation by management as demonstrated in *The Care Factory* does not appear to function in line with these guiding principles. The flagrant lack of personnel and time to handle, let alone care, for the patients leads to an unsustainable situation where 'quality' cannot be upheld, as the required interaction between 'service provider' and 'customer' is not possible (Nordgren, 2003 p. 87). This would require knowledge and experience exchange between personnel, opportunities that Olivia describes as "zero". The nurse telling the story shared in a resigned tone: "[E]veryone has the same workload and there is *no* time to help each other [...] it can't be that you have to pick between how to treat another human being" (Olivia, personal communication). It is apparent that the primary concern of the nurse is the well being of the patients and her refusal to accept that a choice between people in need of care is one that has to be made.

The nurse at the emergency room describes how she has "...never experienced any reflection taking place, over ethical aspects, how we feel or how patients ought to be treated" (Olivia, personal communication). Another nurse reflects on the outcome of a recent procedural change after an intervention by the management consultant firm McKinsey, she states that: "It has become more mechanical, more like 'factory care' [...] The patient is moved around and somebody does one part, and then later somebody else does another part" (Astrid, personal communication). The imposed time constraints appear as a perpetual theme in several of the stories by the nurses, thus constituting the most apparent limitation to provide good care.

However, recently centralized routines in the emergency room also come forth as a contributing factor in making the work of the ward more mechanistic, as reflected by another nurse in the story below. Upon returning to the emergency room after spending three years in primary care, the nurse reflects on the striking difference in terms of how assessing incoming patients according to a standardized template, which she describes as a 'tool' that is used to match patients to predefined categories of priority. Much of the professional judgment is lost in this new way of working,

she feels, as all patients cannot be put in ‘boxes’. The template referred to is called METTS, Medical Emergency Triage and Treatment System, a decision support system for emergency care that Ingrid who with her over ten years of experience describes as a ‘tunnel vision’ of approaching patients.

“I’ll just go and METTS this one”, and I say: “No, you won’t *just* METTS that one”. You have to put yourself in the patient’s situation, and make your own conclusion, you know, this is how it, patients are living people who have many different symptoms, it’s not just about prioritizing, it’s not just about putting the patient in a box, it’s about knowledge [...] I feel that this is taking away focus from the interaction with the patient, the questions are getting more technical [...] What I call *care*, it’s the, well, say a scrawny old woman, she can’t lie on a hard ambulance stretcher more than perhaps a short while, and I think to myself that perhaps we need a bed in this situation; *that* is care. If the patient has been here say more than three hours and haven’t gotten anything to eat, and that she’s old and lonely, then I have to make sure she gets something to eat; *that* is care. To help someone on the toilet, to be attentive towards people in need for help, making sure that patients are comfortable, that they don’t have sweaty clothes on. Care is not just setting an IV, giving shots and medications; it’s all the other things as well. Unfortunately our ward is... there’s an incredible stress level, there’s no time to do all those things that we want to, and sometimes things fall short, they really do, but it’s due to stress, and because we don’t really *see*, it’s a bit too technically focused. [...] The oversight is not at its best all of the time; I wish that I could do more.

(Ingrid, *personal communication*)

The common themes from the stories above all relate to a ‘care’ that the nurses perceive as more mechanistic with little or ‘zero’ time for reflection, which care ethicists describe as a prerequisite for developing and maintaining a caring attitude (Ruddick, 1989; Noddings, 1984). An organizing of health care that does not foster a caring attitude appears as opposing the code of ethics as defined by the International Council of Nurses, in which caring is described as an integral part of nursing (ICN, 2012). Olivia draws a parallel to the concept of supply and demand, where the emergency room operates in a non-market situation: “...we can’t say stop and we have no doors to close, and say: ‘Stop, we can’t accept any more’. There simply needs to be more of us [personnel] in order to take charge of the situation”. Several of the nurses express distinct moral principles and a will that clearly draw upon ethics of care as an orientation (Ruddick, 1989), e.g. “[w]hen you have to choose who to help, that’s when you constantly feel you’re not enough” (Olivia), a feeling that is further articulated by Ingrid, who concludes: “I wish that I could do more”. She adds that care is “all the other things as well”, referring to the overemphasis of applying technical rationality (METTS) and not enough consideration for the inter-relational nature of care-giving. It becomes evident that the nurses in *The Care Factory* find themselves overwhelmed by the organizational shortcomings through which their agency is inevitably channeled, and are thus incapable of translating ‘ought’ into action (Slote, 2007). This is exemplified in Olivia’s concluding reflections, as she states, “it can’t be that you have to pick between how to treat another human being”.

## Choice: Between a Rock and a Hard Place

The following story offers an reflective insight how a nurse relates to the emerging marketization discourse in health care, and how the customer concept is perceived. The gist of it captures the sentiment prevalent in all interviews held; an expansion of customer ideals is seen as bearing some limited benefits, but ultimately fundamentally acrimonious and flawed in practice. Meaning it is only cursory present in discourse and non-existent in descriptions of actual experiences.

### *Story 6: Choice: Between a Rock and a Hard Place*

In one way the patients act as good customers in the way they make sure to make use of the knowledge... They're very, like, particular, they know exactly who's working today, which one of the nurses who's most experienced; which doctor is here this week? – "Okay, then he won't take any decision this week, I'll have to wait and ask that question next week, I know I'll still be at this ward", you know, some learn the system by then: "OK, I'll talk with this nurse, I know you can contact my own doctor, and the doctor I've picked out myself, you ask him to come here", I mean some figure out the system and learn to be a customer completely, all the way, they are able to choose, and be happier... But I mean, it demands *so* much more of you as a patient today, not only do you need strength to deal with your illness but also have to be able to learn an extremely complex system, and be able to *use it* in the best way, but, is it right of you to use it in the best way compared with old lady Ruth who isn't able to since she doesn't understand the system, and say: "No, I'll wait, the doctor will see me when he has time", and well, by then it might be too late, maybe something has already happened. So there's that effect as well. [...] If you're a customer, then you seek on your own initiative, and you choose the product you want, from a voluntary range and you can choose by yourself. If you were to get cancer you don't have a whole lot of choices. Freedom of choice doesn't add much. And then I mean critical disease. What you mean *customer* perspective? You don't get to choose one iota! [...] You can choose whether to get treatment or not, but that has some pretty *drastic* effects. [...] I had one young guy who said: "Oh, do I have to be hooked up [to IV] all the time?", "No", I said, "we can plan together, let's do these things now, and then you can actually be off the IV for, say, I can give you two hours. Take those two hours then, or what do you prefer? Or would you rather have everything during the afternoon?", and then he said: "No, in that case I'll take those two hours so that I can be off later", so there is something to it, you know, if you were to extend the customer concept, in other contexts, then we ought to be able to offer alternatives everywhere, but if there are no alternatives, where the alternative is *no* treatment? It easily becomes a bit of stand-up comedy you know, when you don't have a choice?

*(Alice, personal communication)*

The account above makes it thoroughly clear how foreign the conceptualization of the patient as a customer is to the nurse in question. It appears that the proverbial customer promoted by marketization ideals is an abstraction so foreign, as to being inaccessible to Alice. At no point when describing the hypothetical 'customer-patient' does she make contact with the type of choices that would be thought of as existing under such a paradigm. Instead the account remains grounded in the contextual and especially relational considerations of 'care', affirming and attesting the patients' need for support and comfort. Marketization proponents find that in the absence of customer components infused with the subject-position of 'patient', there will occur a silencing of the patient's voice, which will be relegated to a passive role of acceptance (Nordgren, 2003).

Recollecting multiple episodes to express how she feels about marketization concepts, Alice in all instances finds problematic implications with regarding the people under her care in that manner. Not from a position of not valuing their expressed opinions and preferences, but understanding that it is up to her, as the ‘one-caring’ (Noddings, 1984) to channel and then reciprocate these expressions. This is clearly reflected in her interaction with the young man under her care, who expressed a preference to if possible be free from IV treatment for a while. As seen in how she, within the restrictions set by his condition, sees to his needs by giving options of how they could solve the problem together, thereby not relegating him to the ‘passive patient’ position. Further, she puts herself in the patient’s shoes: “it demands *so* much more of you as a patient today, not only do you need strength to deal with your illness but also have to be able to learn an extremely complex system, and be able to *use it* in the best way”, and unpacks what she sees as problematic with, when sick, having the burden of being a customer imposed on oneself.

Even those acting as “good customers”, understanding the different staff working around them by being informed on their own condition and good at demanding attention are implied to having a bulging amount of responsibility and culpability placed on them. This is expressed as by inference marginalizing weaker and less capable patients (Ruth), indirectly diminishing their ability to have their voice heard and needs seen to, thereby holding them accountable for receiving the care they need. That such a patient’s interests would be served by being expected to in its fullest regard, exercise her ‘freedom of choice’, and also to build a relationship with the health care apparatus in Alice’s experience seems unlikely to transpire. Not simply to provide a demand, the patient might not ask for the correct services or be active enough to make them take form. Especially not when in competition with others more capable of navigating the system. Nordgren (2003) draws on Foucault’s notion of how subjects are constituted in varying positions as he covers patients’ right to self-determination in health care. As he applies this philosophy, he concludes that “man can form her own position in relation to health care” (p. 88), without further problematization of how this principle would apply for those with diminished autonomy? The New Public Management notion of individuals’ ‘capacity to demand’ (Nordgren, 2003, p. 69) does not appear to take into consideration elderly individuals such as Ruth, who in Alice’s story above lacks such ‘capacity’.

The idea of ‘freedom of choice’ having an inherent value is put in a different light by Alice’s account of cancer patients; “What you mean *customer* perspective? You don’t get to choose one iota! [...] You can choose whether to get treatment or not, but that has some pretty drastic effects.”. When stricken by disease where the choice is to let it have its course or fighting it with the best possible treatment, the choice is limited to how to spend a few hours when not being bedridden.

On the same theme, another nurse shares what the customer concept means to her, and states: “I would probably say it’s [customer concept] is mostly negative, I think we as care providers already focus on the ‘customer’, which I think mixes it up” (Olivia, personal communication). It appears that further focus on the patient as a customer does not add any benefits to good health care, and later she adds that: “I don’t think that focusing on having more service oriented care gives better results”. Further she says: “When it comes to the service profession, it clashes all the

time, because we can't go by 'the customer is always right', that principle doesn't work", and clarifies by adding: "it's us [care providers] who have to investigate, so it clashes all the time".

Back to Alice, who evidently goes to great lengths to as much as medically possible respect the autonomy of the patient. Long nursing experience has however made her refer to this autonomy as something different than the 'customer' conceptualized in a marketized public health care, where the responsibility to request and demand is lopsided towards patient. Such a concept of "actively using practices and techniques in order to create a position and practice self-determination" (Nordgren, 2003, p 87) is further challenged by her sharing that on a regular 10 hour shift, under the current staffing conditions, there is "15 minutes face-to-face time per patient" (Alice, personal communication). Another nurse describes how even when you have time to answer the patient's questions, these answers often, if not most times have to be repeated (Sara, personal communication). It can be seen in these accounts that the patient has little time to inform him/herself, but nurses do what they can to by drawing upon 'care'.

## 5. Discussion

Having chartered through the plots of the stories above and analyzed their empirical meaning, we have voiced alternative conceptualizations of ‘care’ in health care and thus effectively evaded the seemingly neutral marketization discourse emerging from New Public Management. We are hence in a position to ascend from a level of context and discuss the theoretical implications of our findings. We present our discussion through the use of two main themes, commencing with *Taking Care Seriously*, where previously silent voices of nurses contribute with perspectives of work formerly overlooked in the field of organization studies. In our second theme, *Nuancing the Customer Concept*, we set forth from our emancipative discussion of ‘care’ to problematize the customer concept. By drawing upon the themes pervading the stories, we revisit our ontological discussion to highlight the problems associated with conceptualizing the patient as a customer in interactions of care.

### 5.1 Taking Care Seriously

At a point in time where businesses increasingly talk about care (e.g. customer care, employee empowerment, Corporate Social Responsibility), no organizations have their core purpose as centered around caring for people as those concerned with health care. As advocated by the New Public Management paradigm the political leadership and administration of health care see the design and implementation of ‘compensation models’ as their primary role, emphasizing ‘output’ and ‘value creation’. The strategy appears to be executed without making use of the immense amount of accumulated experience of care-giving amassed among practitioners. Surely care can be conceptualized as a processes with a predefined goal, the curing of the patient, however from our finding it is evident how highly reciprocative this process is, or rather must be. When there is time for ‘the small things’ and space to do ‘a little more’ in meeting the patient, these events often translate into knowledge diffusion and organizational learning, thus creating a domino effect improving future care-practices. What we suggest with *Taking Care Seriously* is that it needs to be recognized that the relations involved not only are in themselves beneficial and necessary, but also translate into better medical treatment. The exchange taking place between care-giver and care-receiver, when given space to arise, form an integral part of health care – again, even in the medical sense.

The subject matter of this thesis is highly relevant for a contemporary debate conducted in academia but also society at large. While many studies at this point have looked at the organizing of health care through discourse analysis (cf. Doole, 2002; Nordgren, 2003), none have to our knowledge taken the storytelling by nurses as the object of their discursive inquiry. Further, no discourse analysis has to our knowledge highlighted the ethical underpinnings of care. This thesis thereby offers additional insight into a much-debated phenomenon and provides a new dimension to organization studies. The purpose of this discourse analysis was to illuminate and investigate how nurses construct care and how they draw upon a ethics of care in doing so. We have seen how nurses draw upon an ethics of care to express how they experience their practice of

nursing. We now turn to discuss the philosophical implications that have emerged during our research, as pertaining to the ethics of care.

By using ethics of care literature, we do not argue that ethics of care theory guide the caring sentiment often expressed by nurses in stories of their experiences, rather, that we can better understand and reflect on the meanings and values underlying the stories. In doing so there is an opportunity to discuss the implications on care ethics, and ethics in general, in light of our findings. While being well worth further qualitative and philosophical inquiry the ethics of care as a complete moral framework has been tellingly absent in the stories by nurses as presented in this thesis. Like any other health care profession the ethical and moral dilemmas in nursing are many and often difficult. An argument could be made that to properly guide such difficult decisions clear normative principles are necessary.

Despite, or perhaps because of, its bold claims care ethics has received substantial criticisms primarily from contemporary Kantian theoreticians. These writers accuse the care ethicists for reading Kant in a most uncharitable way, assigning him as an ominous dark enemy when in fact the ethics of care according to some easily can be assimilated by Kantian theories (Paley, 2012; Nagl-Docekal, 1997) and thereby provide said lacking principles. A stand in the objections from Kantian theorists to increase the normative or more importantly the prescriptive powers of the ethics of care, arguably confirms the critique brought forward by these writers. Two writers in particular, Paley (2002) and Munzel (1999), have made good cases for that ethics of care could and more importantly, would be better off, by being included in a Kantian framework. More contemporary scholarship in Kantian ethics has effectively rendered the use of Kant as a philosophical adversary baseless and in effect “a new basis for dialog with the ‘ethics of care’ position may be possible” (Munzel, 1999, p. 7). In reality little, or rather no reasoning in line with Held’s (2006) or Slote’s (2007) claims for ethics of care as a moral framework have been found in the stories shared. Rather it seems that other principles more in line with deontology, justice, and law theory form the foundations in most instances. Past and contemporary care ethicists almost unanimously reject the conceptual and practical need for theories that aim at being universal, and replace such notions with a contextual approach. However what seems to arise out of this is a ‘categorical imperative’ that we ought to care. By their own logic this should by definition cast doubt on the idea that “caring relations form the wider moral framework in which justice should be fitted” (Held, 2005, p. 71).

The ethics of care, as show in this thesis, is undoubtedly present in the stories by nurses as they express their experiences of care-giving. In the defense of our use of the ethics of care, Noddings (1984) clarification is worth quoting: “How are we to make judgments of right and wrong under this ethic? [...] it is important to understand that we are not primarily interested in judging but, rather, in heightening moral perception and sensitivity” (p. 90). This falls well in line with the role we have found the ethics of care playing in the accounted experiences by nurses. Caring orientations guide understanding of the context and relations present in meeting patients, and this also translates into practices guided by that orientation.

In particular Held's (2006), and arguably Slote's (2007) version of the ethics of care seem to stand and fall on whether it will succeed in providing a normative obligation that to care is something one ought to do – that viewing matters in a caring manner is not just at the mercy of the whims of the moral person deliberating over a situation or action. What does a pure ethics of care say of provide in such situations? The reality is; not much, without a clear definition of 'care' or even more broad philosophical terms such as human flourishing, not much in terms of support for analysis can be mustered, and certainly no obligation prescribed. Despite of this care-practitioners solve these types of situations on a daily basis; some accounts of such events are found in this thesis. But they do not seem to do so using the ethics of care as their moral framework, but instead draw upon an ethics of care as they construct how to conduct their care-giving. Particularly Tronto's (1993) way of structuring care ethics has in our opinion been conceptualized in such a way that gives it practical potential to be applied to both educational scenarios for care practices, but also help in resolving 'live' ethical dilemmas.

In the light of this, our thesis has shown that 'care' is a skill, and thus needs to be grounded in both knowledge and empathy. Hence, care needs the space to be co-constructed in the relational interaction between care-giver and care-receiver. Providing the capabilities and space to be receptive of signals, evaluate moods, take mark of and understand patient developments, need to be present at the outset of health care organizing. We argue that designing organizational structures solely based on managerial values of efficiency and budget control, with the naïve assumption that care will play out by itself, is a dangerous path to go in the professional practice of health care. The claim that health care organizing must be informed by a nuanced understanding of relational caring is not controversial, yet a necessary one to make. With sufficient 'space to care' present in the organization, health care organizations will not be relegated to depend on 'ambassadors of care', willing to systematically skip lunches and breaks. This will instead open possibilities for more people to capably participate in care-practices, in a caring way. The stories of *The Surrogate* and *The Smurf*, and other stories told, are prime examples of 'walking the extra mile' and working around the organizational constraints put on caring for the patient. Most of the conduct and values we associate with good health care, reflected in the stories above, are presently dependent on exceptions and atypical space to care. Such care, grounded by time, continuity, and reciprocity – does not replace the goals of efficiency, quality, and choice; but rather allows them to prosper in a meaningful way.

Concerning the knowledge contribution in *Taking Care Seriously*, storytelling as a reflexive inquiry has shown itself to be a powerful method to understand the coexistence of micro and macro discourse in organizations centered on human interaction, such as care-practices. We have by virtue of this shown how the relation between the often opposing languages of marketization and care are experienced and described as contradictory. Further the thesis provides a vivid account of the dire experienced implications of marketization in health care, and unpacks the underlying values actually drawn upon by practitioners. As mentioned, there is a lively debate on these issues but the perspectives of nurses have been systematically overlooked. The emancipatory aspects of this thesis thereby give these voices well-deserved attention and recognition, which has challenged the often taken for granted discursive conceptions of care.

## 5.2 Nuancing the Customer Concept

We now turn our discussion to problematize and nuance the conceptualization of the patient as a customer. Through this discourse analysis, we asked ourselves how the marketization discourse shapes the thoughts and behavior of nurses in the practice of care-giving. Other studies done, looking at the role and appropriateness of marketized language and values in public organization and health care have in the light of this thesis overlooked a perspective well worth bringing into focus. The stories by the nurses, representing accounts of their experiences of care-practices, problematize and cast some doubts upon previous theories. Nordgren's (2003) propositions that "the constitution of a customer position does not replace the concept of the medical patient, but rather complements it" and that "[c]ustomer and patient represent coexisting subject positions, with different properties, that can and should be embraced" (p. 192, our translation), is difficult to defend in our findings. There is no empirical support that the 'customer' concept is present in the practice of nursing as expressed, since it brings about estranged associations not comports with the inter-relational nature of caring, grounded in empathic awareness. We nuance the customer concept's existence and implications in health care, and argue that even though being subject to the boundaries prescribed by the New Public Management rationale, nurses still strive to maximize 'care' under the given circumstances. Even though conceptualizations of the patient as a customer are present on an abstract level of awareness, nursing continues to be grounded in an ethics of care (seen as a moral orientation and as practice) despite being bound under continuously increasing demands of efficiency and productivity.

Nordgren's (2003) proposed conceptualization of the patient as a customer with complementary subject position properties is a notion that clearly clashes in the accounted experiences and discourse of nurses. By showing how their constructions of care evidently draw upon an ethics of care, seen both as a moral orientation and as a practice, the properties associated with the 'customer-patient' concept stands in stark contrast with the values guiding health care practices. This is most evidently exemplified in *Choice: Between a Rock and a Hard Place*, as the nurse finds it inaccessible to conceptualize the alleged coexisting properties in light of her actual day-to-day experiences. Similar reasoning was echoed throughout all of the stories. Instead the account remains grounded in the contextual and especially relational considerations of 'care', affirming and attesting the patients' need for support and comfort. The proposed silencing of the patients' voice and influence over care-practices hence does not seem to materialize as would be suggested by New Public Management proponents (cf. Nordgren, 2003). We thereby show that this rationale, manifested through a marketization discourse, does not shape the thoughts and behavior of nurses, as they draw upon a different ethics when articulating their experiences.

Whereas Nordgren's (2003) description of how the arrival of a marketization discourse through New Public Management has "translated into routines for evaluation, delegation etc." (p. 69), we need to ask ourselves whether it has influenced health care in practice. Granting, it surely has influenced, for better or worse, the administration and management of hospitals, our results show that no such translation into the practice of care-giving has transpired. The story of *The Care Factory* presented in this thesis symbolizes this argument by showing themes of distant adminis-

trators, in the view of the practitioners having little contact with the daily implication of time constraints and personnel cuts. When presenting critical voices to the customer concept, Nordgren (2003) speaks with a nurse who in turn has interviewed two hundred colleagues, looking to ascertain what ethical principles employees considered should be followed at hospitals. He quotes her as saying:

“It’s easy to forget the moral appeal existing in expressions like the vulnerability of patients, their exposed position, patients’ dependency when they are described as customers, consumers...” (Öresland, 1999, p. 30, in Nordgren, 2003, p. 161, our translation)

He states her position as being that language used is “to such a degree forming perceptions about reality that it can be dangerous to use economic terms as it removes care-givers’ thoughts and actions from moral appeals” (Nordgren, 2003, p. 161, our translation). Further he emphasizes that Öresland several times reiterates that “the patient due to ethical reasons should not be called customer since the term customer appeals to terms like buy, choose and sell” (p. 161, our translation). It is worth noting that Öresland’s (1999) study of *two hundred* nurses boil down to conclusions clearly in line with this thesis, i.e. ethical problems with considering the patients as customers, and how estranged the customer concept is in an actual caring interaction.

Nordgren (2003) further paraphrases Alsterdal (1999) as writing that she has “never heard assistant nurses talk about the sick as customers” (p. 100, in Nordgren, 2003, pp. 161) as such language use, in her words, lacks “corporeality” (Swedish: konkretion) in health care. From the testimonies of these critical voices he concludes that they indeed are critical to the use of the customer concept in health care. However, from this he draws the conclusion that they “nevertheless as voices constitute part of the formation of the customer concept in health care” (Nordgren, 2003, p. 162). He appears to, after having asked Öresland in person for reflection over the customer concept, to take her subsequent problematization of it as her participation in the discursive formation of marketization. Further he overlooks her actual conclusions, which can be seen as consistent with those of this thesis, that ‘customer’ and market language is not only antithetical, but arguably dangerous in health care provision. We cannot determine whether this is a methodological flaw or possibly the result of a biased blind spot (Ehrlinger et al., 2004) in Nordgren’s dissertation. However this reversal of causal relationship, that nurses contribute to furthering the marketization discourse rather than seeing what stark opposition they express, is a key component in his final conclusion that “[c]ustomer and patient represent coexisting subject positions, with different properties, that can and should be embraced” (p. 192, our translation).

By suggesting a novel theoretical framework, based on ethics concurring with pre-existing discourse in care-practices, we have been able to analyze the experiences shared by nurses. In doing so we have brought forward new understanding as to how care-practitioners relate to the emerging marketization discourse in the organizations they constitute the core of. Marketized conceptualizations of care have by their accounts not gone unnoticed, but form an antipode to the values grounding their care provision.

## 6. Conclusion

Business organizations increasingly adopt a discourse that traditionally has little to do with business, e.g. a contemporary articulation of ‘care’. The same phenomenon but reversed can, as shown, be identified amongst public sector and non-governmental organizations that increasingly use business discourse to describe their activities. Through the method of storytelling, this study has problematized the implications of how care intensive organizations increasingly articulate a business-like discourse, by showing how practitioners resist such conceptualizations.

The in today’s society much promoted New Public Management paradigm has through this thesis been problematized. We set out to analyze living stories reflexively told by nurses, to thereby sidestep predefined narratives and established constructions in the organizing of health care. By emancipating these perspectives, an alternate account of what it means to care for a patient has been brought forward. The values encompassed by the emerging marketization discourse have in this light been contextualized. When contrasted with accounts of experienced care-provision those values appear to in most regards be antithetical to those guiding the practicing care-givers. This was achieved through interviews with nurses in different work settings and varying degrees of experience. Even though being aware of the emerging marketization discourse in health care in the abstract sense, the construction of the patient as customer has not shaped the thoughts or behavior of nurses. Through our theoretical framework, we showed that nurses evidently draw upon an ethics of care seen both as a moral orientation and as a practice in their work.

The study’s knowledge contribution is directed towards the above discussed conflicting subject positions, embodied in the dichotomy of ‘patient’ and ‘customer’. The empirical results show that the conceptualization of the one cared for (patient) as a ‘customer’, in practice brings few benefits and rather many ponderous problems for both practitioner and said patient. The in policy much professed benefits said to be won by a union between patient and customer ideals are thus nuanced. This in the sense that the thesis has problematized their claimed complementary properties by taking the voices of nurses into account. We argue that emancipating the perspective of nurses by virtue leads to a more nuanced understanding for future research and policy-making efforts. Thus allowing them to be directed towards constructing increased concordance with the practice of care-giving and its inherent ethics.

### *Suggestions for Future Research*

During the actualization of this study a number of ideas for further research have formed. One of these includes expanding the scope of this study’s results by involving additional perspectives. As mentioned in the *Delimitations* chapter, a study including politicians, managers, administrators, medical doctors, and patients would allow for a possibility to further research what values and considerations are fundamental for good health care. Many other perspectives have cropped up in the conducted interviews, indicative of severe structural flaws in the organizing of Swedish health care. Further research should be directed towards looking at personnel satisfaction and well being and long-term public health implications of shorter treatment times. Furthermore, the efficacy of

budget cuts and re-organizing efforts, guided by New Public Management ideals, have been put into question, and should be looked at further. On a more philosophical account, care in practice remains under-theorized and under-researched, further inquiries could be directed towards this to investigate how practitioners experience and construct their care-giving through cognition and action.

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## Appendix A: Original Swedish Transcripts

### The Smurf

Ja en situation som tog en lite överraskande vändning, för ofta så vet man inte... Ja man har ingen aning om hur man ska lösa det här, och jag vet att jag skulle ta över efter några yngre sköterskor, och de var helt hypade, liksom på att, ja det var en patient, vars alla anhöriga de kände liksom att de ifrågasatte allting och så fort... "Jag vägrar gå in där", sa dem, "Men vad är det för någonting det handlar om för någonting då?" frågade jag, och så sa dem då att de ifrågasatte hastigheten på droppen, och tidpunkterna, och det ena och det andra, och dem tyckte liksom att de inte blev lämnade i fred med sina egna beslut, alltså sjuksköterskorna, utan att de här anhöriga och patienten då ifrågasatte precis allting, och patienten hade jag bara hört talas om – han hade varit mycket hos oss men det hade blivit så olyckligt att jag hade aldrig träffat honom, så jag hade liksom inte fått tillfälle att bilda mig en egen uppfattning om honom – och det var en helg, och det var en sådan dag som vi liksom inte hade så mycket annat, många patienter var liksom hemma på permission, och just då liksom det var just de timmarna på eftermiddagen då alla är hemma. Då tänkte jag liksom: "Amen, jag går in där, så, lite laid back" och det var en kille i 25 års-åldern, och syskonen var väl både lite äldre och yngre, då då, och jag kom in där, och öppnade [dörren] försiktigt och såg patienten låg där på sängen och hade det här droppet då, som alla hade ifrågasatte hastigheten på, så jag gick bara in liksom så där, och kollade på det precis som bara det var det jag skulle göra men det var ju inte det, och sen så satte jag mig bara liksom och föll ner på huk, så jag hamnade nästan under patientens nivå liksom. Dels var det så här liksom oväntat liksom, så där gör man ju inte, kanske som sjuksköterska då, och sen så hade jag, vi har lite märkliga kläder, de ser ut liksom en pyjamas, så jag hade blåa pyjamasbyxor och blå bussarong, så jag såg ut som en smurf, haha, så jag gick ju in där, och nickade bara till patienten och sade: "Hej, jag heter det här och jag ska vara här i eftermiddag, tänkte bara kolla hur det gick", och så såg jag alla de här ögonen på mig som bara lyste "va?" och jag tänkte bara: "Guuud", och någonstans kände jag bara att jag var livrädd, men ändå tänkte jag att jag måste luska reda på: "Vad är det här för någonting som ställer till sådana problem för alla mina yngre kollegor, vad är det för något som är så farligt i det här?", och det var en viss laddning i rummet då, så satte jag bara ner, och var helt tyst, sade ingenting, och så var det en av de anhöriga som sade:

- "Är det något särskilt med dig eller?"
- "Eh, ursäkta, vadå?", och då kände jag liksom attack direkt,
- "Nej men du har samma kläder som läkaren som var här innan i dag",
- "Ok, menar du de här blåa kläderna?",
- "Mm",
- "Jo men det är något särkilt med både mig och, Agneta hette hon va, hon som var här innan?",
- "Ja",
- "Nej, jag bara skoja, det är inget särskilt med oss, vi får välja de här muppiga kläderna om vi vill",

och sen trodde jag liksom att isen var bruten, de ville ju liksom bara bli lyssnade på, och bli sedda, och sen var vi ett jättebra team sen, och då den gången så lade, alltså den situationen lade liksom grunden för hela behandlingstiden, men han klarade sig ju inte sen den här killen, men det blev bra i den bemärkelsen att de såg att vi inte är några hot, att vi är ju precis som vem som helst som kommer in där, och vissa tar sig tid att lyssna, och vissa gör inte det. Det gäller ju vara att fånga upp där, och jag gjorde ju inte något påtagligt, snarare tvärtom, gjorde inte någonting, mer än att bara vara närvarande, för just då hade jag den tiden där, och det ändrade liksom inriktningen på allting sen. Sen tror jag det var dagen efter, så jobbade jag först med den här patienten och sen kom någon av de här unga sjuksköterskorna och skulle ta över, och sa bara: "Oh nej ska jag ha honom igen?", och jag bara: "Ja, du får gå in och se", och så gick hon då för att se, skitförsiktigt, och sa bara: "Vad har du gjort?", haha, "vet inte?", "Ja, men han skämtade med mig och skrattade".

De gångerna jag känt det, det är... Som du vet har Region Skåne mycket besparingar och så, och ibland när folk [anställda] är sjuka så ersätter man inte dem, då får man helt ekelt vara den personalen man är. [...] jag vet någon gång så istället för att ha åtta patienter så hade jag 12... 14, 15 patienter, och då är det ju liksom, då kan det vara så att istället för att ta in en extra sjuksköterska så tar man in en extra undersjuksköterska istället, och då blir det så att "ni får bara ha det medicinska", så det innebär att vi bara ska i princip, alltså, ge läkemedel, dela ut tabletter, och då känner jag att man går miste om omvårdnadsbiten helt. Det blir så att man bara går in till patienten, ger tabletterna, frågar hur det är, och sen går man ut igen. Och många är ju så att de vill berätta, om hur det har varit, om hur nat-

ten har varit, och de kanske ber om det här, om jag kan kolla på det här och sånt... Men om man känner, fan, jag hinner inte det här nu, för det är typ tio andra patienter som ska ha sina mediciner klockan åtta, och då känner man sig... *sjukt* stressad och att man inte räcker till.

## The Surrogate

Det var en ung kille här, som inte hade sin familj hos sig just då och fick diagnosen testikelcancer. Då kan jag ju inte bara säga "hej och hå" och gå därifrån. Det är jätteofta man hamnar i situationer där dom [patienterna] får ett dåligt svar här hos oss, och ofta har dom inte någon här och då får man gå in och täcka upp det [...] Du lämnar ju inte en behövande person i sticket, då måste man vara där. [...] Det är svårt, jag har lättare att bemöta människor som säger vad om tycker eller är utåtagerande, börjar gråta än en sluten individ som inte vill att man tar på dom eller inte vill att man pratar med dom över huvud taget, så där får man först klura ut hur du ställer dig till den här individen och möta honom där. Just det här vad en individ som var väldigt ledsen och väldigt till sig och ville gärna ha en kram och kände att närhet var okej och då mötte jag honom där, och då behöver man inte säga så mycket, för vad ska man säga? Du kan inte säga så mycket, vi är inga spåntanter, vi kan inte säga något som lugnar dom utan man är där rent fysiskt. Just i den situationen sa jag inte så mycket utan satt där och höll honom i handen och försökte prata med honom, prata om lite annat tills hans mamma kom och hon kunde ta över ansvaret. Det beror helt på, ibland kan man sitta still i 2h och inte veta riktigt vad man ska säga för dom vill inte prata. Det är väldigt många möten, man träffar mycket olika individer, det är spännande att se hur man själv reagerar för man måste anpassa sig väldigt mycket.

## Conflicting Principles: A Vis-à-vis Situation

Sen kan man ju hamna, alltså det här: "Man vill ge mer", alltså det är ju mycket etik i mitt jobb över huvud taget, och man kan ju hamna i en sån här "tvärtomsituation" med, som jag gjorde när jag var rätt så nybliven sjuksköterska, så jobbade jag på en gynavdelning en kväll, och det var alldeles i början, och så var det en tjej som skulle göra en abort, sent, alltså en senabort väldigt sen i vecka 20-21, och det väckte mycket känslor hos mig, och hon gjorde det vara för att, alltså, det fanns inte nån, eller hon hade ju säkert nån jättebra anledning till det, men det fanns inte nån medicinsk anledning till det eller så. Och det är klart att det väckte ju jättemycket känslor, men jag tog väl hand om henne den kvällen och hon genomgick den här aborten och så. Och sen så efteråt så tackade hon mig jättemycket för hjälpen, alltså hon var jättetacksam, och det väckte nästan ångest hos mig, för det blev liksom så... För egentligen så var jag så emot detta. Alltså mina egna personliga känslor stred jättemycket emot detta, och så tackade hon mig för att jag hade tagit bra hand om henne, och det är ju det man ska göra, men just i den situationen så blev det jättekonstigt. [...] det blev ju liksom en etisk kollision hos mig, personligen. Och sen så var det en jättebra sköterska som kom löste av mig för natten, och det är med bland det bästa jag varit med om, för ibland behöver man inte så professionell handledning, men när vi hade rapporterat färdigt där och jag skulle gå hem, så: "Du" sa hon, "innan du går hem nu så sitter vi här i 10 minuter och pratar", för hon såg väl på mig att jag tyckte det var jobbigt: "Jaha", sa jag, det var inte så vanligt liksom. Och så fick man haspla ur sig vad man kände och sen kändes det ganska bra sen, och sen efter lite distans så kändes det jättebra, alltså det var väl jättebra att hon var nöjd, det är ju det vi ska, och det har ju inte varit några problem sen. [...] man har ju fått lära sig att "jag kan ju inte blanda in vad jag tycker", alltså då kan man ju inte jobba med det, i så fall.

## From Customer to Care

Nu är det lite mer ett företag som ska var lönsamt, så visst pratar man pengar. Men nu känner jag ju att man vill mer jobba på ett sätt så att man får nöjda kunder som kommer, för på så sätt så tjänar vi ju pengar [...] De har ju mycket mycket högre krav som patienter i dag; krav på vilken vård man ska ha; hur man bokar tider; tillgänglighet; man är mycket mycket mer påläst. Och jag som då jobbar med ett ungt klientel – alltså jag jobbar ju på en mödravårdscentral så jag har ju unga blivande förädrar, preventinmedelsrådgivning och så – de är ju jättehöga krav, de är jättepålästa, så det gäller ju att jag är det också, måste ju kunna bemöta alla frågor. Så visst känns det som att kraven har ändrats, jag som sjuksköterska har ju större förväntningar på mig. [...] ibland kan man ju nästan känna sig som en mamma, att man blir liksom, att man nästan skulle vilja ta med dem hem. Den känslan har man ju fått ibland. Kommit nån ung tjej som haft det taskigt hemma och som inte haft nån som stöttar upp eller, en del kvinnor som kommit hit... Och det är ju rätt tydligt, det har jag ju träffat på ett par stycken, som har flytt från sitt land, fått lämna sina barn för hon har blivit misshandlad av mannen, och så blir hon placerad i en ort här nånstans, helt själv, och hon känner ingen, det finns ingen, och förr eller senare hamnar dem hos oss, alltid, så är det, i något ärende... Och då känner man ju, att ibland liksom bara: "Puuh, kom med mig hem". Alltså, sånt är extremt jobbigt, kan jag tycka. För att man tycker så fruktansvärt synd om den här personen...

## Choice: Between a Rock and a Hard Place

På ett sätt betar sig ju patienterna sig som bra kunder på det sättet för de ser ju till att använda sig av kunskapen... De är väldigt så nogräknande, det vet precis vilka som jobbar i dag, vilka av de här sjuksköterskorna är mest erfaren, vilken doktor är här denna veckan? "Ja ok, då kommer han inte fatta något beslut den här veckan, då får jag vänta med att ställa den här frågan till nästa vecka för jag vet att jag kommer vara här då också", eller vissa kan ju liksom systemet då: "Ok, då pratar jag med den här sköterskan, och då vet jag att du kan kontakta min egen läkare, och den här läkaren som jag själv har valt ut vet jag kan komma till mig och du ber honom komma hit", så vissa lär sig ju systemet och lär sig att vara kunder liksom helt ut, och kan liksom välja, och blir mer nöjda... Men det krävs ju liksom mycket mycket mer av dig som patient i dag, du ska ju inte bara ha ork till din sjukdom utan du ska kunna lära dig ett otroligt komplicerat system, och kunna *utnyttja* det på rätt sätt, och sen, är det rätt att du utnyttjar det på rätt sätt jämfört med gamla Agda som inte kan utnyttja det för hon kan inte det systemet, och säger: "Nej, jag avvaktar, doktorn han kommer till mig när han kan", ja, men då är det kanske för sent, då kanske det har hunnit hända någonting. Om du är kund, då söker du själv, och då väljer du själv vad du vill köra för produkt, ett frivilligt utbud och du kan välja själv. Får du en cancersjukdom så har du inte så många val. Där tillför valfrihet inte så mycket. Och då menar jag akut sjukdom. Vadå kundperspektiv? Du väljer inte ett smack? [...] Du kan välja om du vill ha behandling eller inte, men det har vissa dramatiska effekter. [...] Vet någon ung kille som sade: "Oh, måste jag vara uppkopplad [i dropp] hela tiden?", "Nej, sa jag, vi kan planera tillsammans, vi gör de här sakerna nu, och sen så kan du faktiskt vara ledig från dina dropp i, ja, kan ge dig två timmar. Ta du de två timmarna då, eller hur vill du göra? Eller vill du ha allting under eftermiddagen?", och då sa han: "Nej men då tar jag de två timmarna så jag kan vara fri då", så det ligger nog mycket i att, om man ska förlänga det här kundbegreppet liksom, i andra ting, så ska vi kunna buda på alternativ överallt, men om det inte finns alternativ att bjuda på, där alternativet blir inte vård? Det blir lite standup comedy av det, när man inte har ett val?

## The Care Factory

Jag hade en patient. Vi har ju två isoleringsrum där patienter som har maginfluensa eller t.ex. har varit utomlands och har misstänkta bakterier är. Där måste man klä på sig en viss utrustning i form av munskydd, visir och dylikt. Det gör det ju lite komplicerat, man kan inte gå in och ut hur som helst. Då hade jag en patient där som var väldigt dålig, hade haft kramper och så vidare, var väldigt orolig, det var första gången hon krampade och då är det väldigt jobbigt, det blir ett viktigt observandum. Sen hade jag en man på en fyra-sal som var ungefär 20 minuter från att helt enkelt ta sitt sista andetag. Sen hade jag en annan kvinna som hade MS, en neurologisk sjukdom, så hon kan inte reda sig själv, som hade behövt bli tvättad då och bytt på då i ungefär 5 timmar. Utöver detta hade jag ca 12-13 patienter till och då kände jag bara; *PAUS, STOPP* Jag var ju inte den enda som hade det så, det har vi allihopa, alla har lika mycket att göra och det finns *ingen* tid att hjälpa varandra, vi vill ju gärna hjälpa varandra så har vi tid så gör man ju det. Men det går inte, och någonstans måste man säga stopp. Just den här händelsen fick ett rätt dramatiskt slut, det brukar inte vara så. Vi har larm på oss, och en kollega kom från ambulansen och såg att jag var upprörd, för jag blir inte ledsen, jag blir arg när det inte funkar, när man känner att man måste välja blir jag väldigt arg istället. Han gav mig en kram, varpå mitt larm utlöses. Det blev väldigt dramatiskt, för då kom ungefär 25 personer på överfallsalarm. När det gäller våra egna på det viset är ju alla väldigt snabbt på plats, man är ju rädd att någon blir misshandlad. Så där stod jag och visste inte att mitt larm hade utlösts, då kom ju cheferna på plats och fick på så sätt höra allas version av dagen. Just den händelsen roddade sig själv på det sättet, men var ganska dramatisk. [...] Jag tycker ju det finns saker som en människa behöver, då blir man ju också mer positiv, det är en jättebra dag när allting rullat på och man haft tid till bra kontakt med patienterna. Man har inte behövt välja; den patienten kommer att ligga och dö på en fyra-sal med tre andra patienter; en kommer ligga i sin egen avföring i ungefär 6, 7, 8 timmar; och den håller på att få en hjärtinfarkt. När man måste välja vem du ska hjälpa, då känner man sig väldigt otillräcklig konstant, det blir en väldigt stressande känsla till slut. Jag jobbar bra under press, men det får ju inte vara så mycket att man ska välja mellan hur man ska behandla en annan människa...

(Olivia, personal communication)

Nej det är en mall, det är pärmar som vi har att jobba efter. Och jag upplever att vissa säger att: "Nu ska jag gå och METTS:a den här patienten", men det räcker ju inte med att ta de här kontrollerna på patienten, du måste ju fråga: "Vad är det du söker för, vad är ditt problem? Var gör det ont egentligen, när för det ont, hur länge har det gjort ont? På vilket sätt?". Och det är ju mycket omkring, en patient som söker för den har ont i magen är ju inte säkert. [...] Så det räcker ju inte endast med att göra de här kontrollerna och få en prioritet enligt dem, och kontrollerna säger: "Ja men den här patienten ligger i ett väldigt bra läge och ligger på prioritet 4", det kan finnas andra saker som man har med sig i bagaget som gör att det finns andra dimensioner som gör att de ska komma i hög prioritet. [...]

Man kan glömma bort det där, och säger: "Jag ska bara gå och METTS:a den", och jag säger: "Nej, du ska inte bara gå och METTS:a den". Jag måste sätta dig in i patienten, jag måste göra en conclusion liksom, så här här det, patienter är ju en levande människa som har en massa symptom, det är inte bara att prioritera, det handlar inte bara om att vi måste sätta in patienten i ett fack, utan det handlar om kunskap. [...] Vad jag kallar omvårdnad det är det här, ja, om det är en mager, äldre kvinna, hon kan inte ligga på en hård ambulansbreds mer än kanske en liten stund, och att man kanske tänker att här får vi ha en säng, det är omvårdnad. Att nu har patienten kanske varit här i tre timmar och inte fått i sig någonting, och hon är ensam och gammal, då måste vi se till att hon får något i sig. Det är omvårdnat. Att kunna hjälpa någon på toaletten, att kunna vara lyhörd för att någon kan behöva hjälp, att man sitter skönt, att de inte har svettiga kläder på sig. Omvårdnad är inte vara att ge dropp och sprutor och mediciner, utan det är ju det andra också. Tyvärr är ju detta en avdelning som... här är ju en otrolig stress, man hinner ju inte med allt det vi vill, och ibland faller vissa delar bort, ja det gör det, men vi har det på grund av stress, och för att vi inte riktigt ser, det är lite för tekniskt fokuserat. Jag märker de yngre, nu generaliserar jag, men att de yngre kollegorna ibland är så, de är jätteduktiga tekniskt. [...] tillsynen är inte den bästa alltid, man önskar att man kunde räcka till lite mer.