On care values
Guest Editors: Jeppe Oute and Trudy Rudge

245 Guest editorial
253 Making work visible in a breast cancer support business
    Ariane B. Anderson and Jane Jorgenson
268 Logics of care in clinical education
    Sine Lehn-Christiansen and Mari Holen
279 Ethnographic reflections on access to care services
    Jeppe Oute and Bagga Bjerge
298 How “care values” as discursive practices effect the ethics of a care-setting
    Jeannine Therese Moreau and Trudy Rudge
312 The practice of selecting for values in nursing
    Michael Klaus Ronny Klingenberg and Caroline Pelletier
325 “Bring yourself to work”: rewriting the feeling rules in “personalized” social work
    Emilie Morwenna Whitaker
Tinkering with care values in public and private organizations

This special issue develops from discussions and papers presented at the Annual Ethnography Symposium in 2017 and aims to gather ethnographies on how care values intersect with service organizations, welfare policy and varying views of good professional practice in private and welfare institutions. It zooms in on the growing cross-disciplinary interest in the values of care for the ill, unwell and unhealthy or disabled in industrialized societies. The issue takes up the well-known but far from trivial debates about how bureaucrats, professionals, students, users and families often represent and face competing requirements and approaches to care in organizations informed by different values and ideologies. Yet, the ideological or value-laden underpinnings of care in organizations often remain less clear in organizational studies, nursing research and in social studies in medicine and social work. Questions of value lie at the heart of debates about the organization of current welfare systems, provision of care services and the architecture of future societies. This transpires, for example, in recent contributions to Journal of Organizational Ethnography on meaning making in acute nursing care practices (Lake et al., 2015), in studies of health care reform and patient and public involvement (PPI) (Glasmad and Oute, 2019) and in studies of volunteering and ethnographic conduct (Garthwaite, 2016).

Values are embedded in the contemporary calculus of health and social care provision in many different forms (Rose, 1999, 2007): the financial value of contracts for health or social care services; consumerist values and the commercialization of help seekers (Mol, 2008; Mol et al., 2010), ethical values located in standards and guidelines which regulate clinical practice (Huniche, 2011), and moral values, through which dilemmas and discrepancies are experienced by professionals (Mattingly, 2014, 1998). Albeit invisible and/or taken-for-granted these kinds of different orders of worth are not only deeply rooted in the political requirements that underpin care in organizations, such orders also shape reform and the very organization of welfare services. Moreover, the entanglement of different sets of values also form a background for professional-user relations, recruitment of staff, care education and professionals’ feelings and at times limit users’ access to services at street level. In response, we need ethnographic work that disentangles what care values “do” in care organizations and bring to light how they are made to work, negotiated and resisted by actors in everyday practice. The issue thus aims to elucidate such themes that are often hidden in the intersections between ethnographic, organizational and health care journals. The issue focuses on the taken-for-granted values, ideals and ideologies located in the practical realities of care giving and receiving across a range of contexts.

Organizational ethnographies on care values

This issue features six international ethnographies from comparable contexts such as the USA, UK, Canada and Denmark. The papers rely on a variety of analytical gazes such as a Foucauldian notion of discourse and knowledge (Foucault, 1992), Mol’s (2008) concept of logics of care, Latour’s (1999) Actor–Network theory (ANT), Hochschild’s (2012) work on emotional labor and Lipsky’s (2013) work on street-level bureaucracy. Empirically, the papers are based on fieldwork in a number of both private and public organizations. As featured, these varying empirical contexts include cancer support businesses, care for older persons with potential for functional decline, daily social work, mental health-, employment- and drug treatment systems, nursing recruitment at universities and clinical education in hospitals. However, one could argue that the papers consider a remarkably homogenous issue. In spite of their vast
analytical and empirical differences, they cast light on the tensions, collisions and negotiations of incommensurate care values in organizations and their social effects.

The article entitled “Making work visible in a cancer support business” (Anderson and Jorgensen, 2019) sheds light on the work that breast cancer support staff perform in the USA. Based on open-ended interviews and observation of staff-customer interaction, store activity and the physical setting, the study illuminates how individuals whose work is located in the nexus of business and medicine negotiate potential contradictions and how this positions them within professional hierarchies. Anderson and Jorgensen analyse how staff balance image enhancement with comforting care in a non-medical space. In conclusion, the authors argue that cancer support businesses represent a kind of medical-commercial organization that constitutes certain challenges for staff members and patient-customers. In this setting, the paper recommends the development of more comprehensive care for surgical patients within, as well as outside, comparable health care systems in the USA and beyond.

In the paper entitled “Logics of care in clinical education” (Lehn-Christiansen and Holen, 2019), the authors discuss how contemporary Danish health care is grounded in different values. The authors use Mol’s work on logics of care and the notion of tinkering to disentangle the fluid and value-laden practices that constitute care in the Danish health care system. They assert how nursing students, or at least their educational practices and professional identities, are shaped by different logics of care when acquiring competencies to provide care in clinical placements. The paper is based on observational- and interview data drawn from a large scale qualitative study where they follow 40 nursing students throughout all clinical elements of their study program. In the analysis, the authors identify three overall logics of care: the logic of relational care, the logic of care education and the logic of care production. Whereas the logic of production and the educational logic seem to be dominant and mutually reinforce each other, the logic of relational care remains subordinate in daily educational practice. On this backdrop, the authors argue that the struggle over the very idea of good care reflects a case of the overall struggle over care values in Danish health care systems. They argue that it forms a background for future challenges in nursing and health care more generally. In conclusion, the paper suggests that this ideological struggle and subordination of relational care in the education setting brings about an inhibition of future recruitment of nurses, make it increasingly difficult to keep nurses in the health care workforce and slowly devalue non-specialized, basic and person-centered care.

The paper entitled “Ethnographic reflections on access to care services” (Oute and Bjerge, 2019) takes its empirical point of departure in a multisited ethnographic field study of the management of citizens with complex problems in Danish welfare systems. Using Lipsky’s work on bureaucratic service regulation as an analytical lens, the authors investigate how gatekeepers’ ways of regulating the researchers’ access to knowledge in/about care services reflect the systemic and interpersonal values that inform Danish welfare systems’ daily workings. Moreover, they explore how the authors’ methodological experiences mirror or compare to the value-informed regulatory strategies that professionals and users experience in their daily encounters in the same local practices that the authors have studied. By doing so, the authors analyze how their own and informants’ experiences reflect three sets of value-informed strategies used to regulate access to care in care organization: “Gatekeepers’ sympathy and creaming,” “Queuing and delay,” and “Withdrawal of consent and ‘no resources.’” The analysis suggests that trust, shared goals and sympathy seem to be key to the process of getting access and elucidates the political-professional conditionality of access to care services. Although seeming trivial, this insight begs the question whether or how the professionals’ informal values and personal preferences can outweigh political requirements and users’ legal rights to services in care organizations.

In the article on “How care values as discursive practices effect the ethics of a care-setting”, Moreau and Rudge (2018) examine how care values permeate, legitimize and
authorize hospitalized-older-adults’ care, technologies and practices in order to put on display how values establish certain orders of worth with significant effect on the ethics of the care-setting. Drawing on a Foucauldian notion of discourse and knowledge, the authors analyze data from participant observation, interviews, chart reviews and reviewed literature to understand how values frame care situations for older-adult-patients classified with a potential for functional decline. The analysis reveals how value-laden articulations of measurement, efficiency, economics, risk and functional decline as equivalent to loss of capacity for independent living pervade care technologies and practices. The authors show how these practices subjugate older adults’ bodies to governmental techniques and how these technologies turn older patients into measurable objects of knowledge. As such, the paper reveals how dominant care values inform technologies and practices that aim to govern hospitalized older patients as a population that elide the possibility for professionals and those in need of care to engage in person-centered care.

The paper entitled “The practice of selecting for values in nursing” (Klingenberg and Pelletier, 2019) is based on observations of a selection events at three UK universities and interviews with academic staff, administrators and service users and carers. It investigates the range of methodological resources available for research on values-based selection by examining how selection processes play out in practice. In order to analyze how interactions and negotiations between the selectors, applicants and various materials deployed during the interview processes bring certain “personal values” in selection of nursing students into effect, the authors draw upon principles from ANT. In the analysis, the paper unfolds how informants talk about heroism and exclusivity and how selectors articulate applicants when talking about themselves and their relation to the socio-material backdrop of selection for values in recruitment. The presentation of the themes puts on display how care values are not static but extra-individual products of the processes of ever-changing interactions between actors in the field. This insight begs the question of recent political attempts to develop a “quick fix” to the problem of professional culture in nursing by highlighting the need to re-introduce the complexities delineated in the dominant discourse on values-based recruitment.

Based on observations, interviews and professionals’ written accounts derived from an ethnographic fieldwork at an English social work department, the paper entitled “Bring yourself to work”. Rewriting the feeling rules in “personalised’ social work” Whitaker (2019) investigates how feeling rules are constructed, experienced and contested in daily social work practice. Concentrating on the “backstage” of the organization, the author considers how the management seek to shape practitioners towards certain forms of emotional display in increasingly market-oriented conditions and on how professionals respond. In bringing Hochschild’s work on emotional labor to the analysis, the author suggests how the notion of bringing yourself to work reflects a value-laden talismanic figure for the organization which emerges through the processes of personalization as rupture, disciplining and auditing the feeling rules and frontline staff members’ responses to such a belief system. The paper displays the emergence of tensions between traditional bureaucratic function, the incursions of the market and feeling rules of relatability, commitment and creativity. With this analytical background, the paper concludes by considering how relational and interactive exchange in practice is not only commodified but that affective connections seem ready-made for audit, managerial assessment and regulation.

Taken together, the conclusions and considerations raised in this issue represent a number of interconnected themes. The papers illustrate that the study of care values is not limited to certain professional practices, such as nursing, drug treatment or social work. The papers also highlight that care values “do” something in practice despite often playing an unacknowledged role in daily care practices. It implies that values tend to shape how some actions can be seen as meaningful while also other actions
are considered less meaningful. Another theme emerging throughout the selection of papers is concerned with the overlaps, exchanges, tensions or conflicts between different and at times antagonistic value-laden care practices. The theme emerges through the papers’ illustrations of the, often, strained relationship between incommensurable sets of values. On the one hand, the papers reveal how commercial, productions-oriented, bureaucratic- and political notions of good care play a pivotal role in daily care practices. On the other, the papers show that despite the previous emphases, professionals and user or customers often, if not always, view relational and humanistic forms of care as a cornerstone in care organizations. This also touches upon a further theme reflected in the papers concerned with the dominance of practices informed by commercial-economical rather than humanistic-relational values in care organization. Finally, the papers are concerned with the effects of value-laden technologies and practices and in particular, the kinds of limitations these relations bring into effect for actors in the field. The analyses of the processes of personalization and emotional labor, responsibilization, de-legitimization of basic care and devaluation of person-centeredness in care organizations point to a similar effect. They illustrate how the technologies and practices that combine economically or politically driven care with humanistic-relational values tend to blur the lines between the state/organization and the individual/personal as well as lessening the difference between the commercial and private in favor of the state or the business.

Conceptualizing value-informed practices in care organizations

These themes point to how care values are ambiguous concepts. The very notion of value often refers to cost-effectiveness or how the idea of value is applied purposefully (Moreau and Rudge, 2018; Wegner, 2016). However, values need not be explicit or strategic. Rather they are often articulated rhetorically or discursively. They are embedded in how problems, purposes and solutions are talked about, used in practice and represented in policy (Bacchi, 2009; Oute and Bjerge, 2019). Across the different contexts and situations that have been scrutinized in this issue, values emerge through competing discourses, logics, managerial technologies, policies and regulatory strategies that structure experience and frame care practices in both private and public organizations. This implies that bureaucrats, academics, administrators, professionals, drug users and students might intentionally or un-intentionally articulate and legitimize certain ideological and value-laden practices through their talk, writing and action that have a significant impact on their possibilities to care (Mol, 2008; Laclau and Mouffe, 2014; Glasdam and Oute, 2019). Rather than care being a matter of actors’ personal choice, value-informed care is thus socially (ideologically, politically, professionally, etc.) contingent. The intentional or unintentional emphasis of specific ideologies and care values has powerful effects on the transformation or continuation of care practices in organizations in line with those conditions of care.

On a critical note, one could argue that this is hardly breaking news. The social contingency and transformative potential of values in and outside of care organizations is already well established in, for example, Mol’s (2008) work on logics of care, Foucault’s (1992) work on discourse, knowledge and subjectivity, Rose’s (1999) work on rationalities and Laclau’s and Mouffe’s (2014) work on ideology and radical democracy. This literature tends to emphasize that values and ideologies are not individual. They are extra-individual. In this overarching perspective, the different value-laden articulations of care and the value-informed care practices described in this issue suggest that care is normative per se.

However, that insight does not really add many new insights either. To name a few, political and medical anthropologists (Però et al., 2011; Shore and Wright, 1997; Mattingly, 2014; Kleinman, 1991), micro-sociologists (Goffman, 2007) and political scientists (Lipsky, 2013) have also made the observation that values and political ideology permeate care
practices, service provision at street level and caring in the everyday lives of persons and families suffering from health issues. But despite providing novel and important insights into the complex relations between material, symbolic and political underpinnings of practices embedded in care, the literature tends to downplay the particular significance of the values of care. This suggests that less is known about bureaucrats, professionals, administrators, users and family members, at times, creative ways of interrupting different requirements and their ways of tinkering with different values and concerns in care organizations. This insight echoes Vohnsen’s (2015) recent critique of conventional views of street level work as relatively coherent practices being guided by distinct sets of value-laden concerns belonging to certain professional groups. Resembling the analysis of the interplay between different sets of values throughout this issue, Vohnsen (2015) argues that the street-level workers’ planning and implementation practices in welfare organizations are informed by different vectors of concern for the citizen, for system’s ability to manage the workload and for the validity of the project. These analytical insights also bear some resemblance with recent research on the black box of service change (Bjerge and Rowe, 2017) but proceeds to elaborate this area in the literature on care organizations by casting light on what seems like a black box of the processual and shifty nature of value-informed practices in care organizations sui generis. Thus, the selection of papers featured in this issue might not offer anything epistemologically or analytically new to the field. But it provides an opportunity for the reader to deepen his or her understanding of the nature of how care values underpin, inform and bring into effect a range of matters of concern that need to be dealt with in care organizations. This issue is not an exhaustive catalogue of all value-laden vectors of concerns in care organizations and the ways actors resist political requirements of cost-effective practice, interrupt implementation of evidence-based methods, navigate ideological antagonisms in practice and handle value-conflicts between actors. Rather, this special issue considers how the value-laden underpinnings and characteristics of caring in organizations are processual, and ever-changing rather than clear cut representations and enactments of certain ethics, policies or ideologies. It does so by elaborating how care values and their often messy practical expressions and effects are available to be described empirically and analyzed in depth to show how state or organizationally derived values can be tinkered with to negotiate other ways of providing care. As well, the papers in this issue locate where the constraints of care values may reside.

The idea of value-informed care being a precarious and messy affair is well illustrated by Klingenberg and Pelletier’s (2019) use of a Latourian notion of practice as an interactional process as compared to practice being static and unchanging. The processual and messy character of caring in organizations is also illustrated in Christiansen and Holen’s (2019) paper. Echoing studies from medical anthropology, their analysis also relies on Mol’s and others’ definition of care as a processual practice (Mol, 2008). In line with the rest of this issue, they point to how caring processes are neither bound to particular contexts nor limited to certain professional practices or health care institutions. Such a view asserts the messy process of practicing care that encompasses the multiplicity of “doings” in the midst of competing political requirements, commercial concerns, professional discourses or humanistic views of what is at stake and needs to be done in any care organization. As presented by Mol and others (2010), tinkering is well-suited to capture the process of how professionals actively balance competing value-laden concerns in private and welfare organizations in order to understand the interactional characteristics of caring and the dynamics of value-informed care practices in the context of medical treatment, private care organizations, casework, nursing and social work. By relying on Vohnsen (2015), Mol’s (2008) and Mol’s et al. (2010) work, Nygaard-Christensen et al. (2018) analyze how tinkering covers a continuous and non-linear process. They point to how the process encompasses different ways of articulating good or
fitting solutions to citizens' problems through a circular process of getting an overview of all possible services, weighing up different interpretations of citizens' problems and considering how certain interpretations of the services would best help the citizen. The study of tinkering thus highlights the processual and messy character of professionals' ways of tinkering with service construction and weighing up different kinds of value-informed care. They argue that the concept can be utilized “to capture and describe a style of working that, although not a formally recognized method, might be recognizable to many caseworkers in the welfare system” (Nygaard-Christensen et al., 2018, p. 57). Given that tinkering stems from studies of care-work and seems to capture the socially contingent care practices illuminated in this issue (Mol et al., 2010; Lydahl, 2017), the analysis of casework tinkering seems to go far beyond social work. In this light, this special issue offers another and perhaps more important insight. It adds to the literature by theorizing the characteristics of care practices in organizations by paying attention to how care is characterized by different actors' ways of tinkering with what matters to them and what needs to be done in accordance with a personal, professional, organizational or governmental set of values. Taken together, the included papers suggest that social workers', students', administrators' and customers' or users' value-informed practices and their ways of balancing different values of care reflect empirically different but homogenous cases of tinkering.

**Conclusion**

As stated above, the purpose of this issue is to elucidate the taken-for-granted values, ideals and ideologies located in the practical realities of care giving and receiving across a range of contexts. The issue envelops a range of organizational ethnographies on care values suggesting that care practice is characterized by tinkering and creativity. This suggests that the daily realities of care organizations are constituted by the messy daily processes of exploring opportunities, weighing up what matters and balancing personal needs, political requirements and organizational values in order to make ends meet. However, tinkering processes need not only be a generic trait of practice in care organizations. As suggested by Vohnsen (2015) and Nygaard-Christensen et al. (2018), tinkering might also be a necessity to the maintenance of care organizations and their ability to function over time. In fact, tinkering might be key to the maintenance of social organizations in society *per se* (Graham and Thrift, 2007). This suggests that social organizations' ability to continue to provide coherent, ethical and fitting care that weigh up many different concerns would stop functioning if practitioners stop working creatively to make the organizations work, maintain them and improve their ability to provide care. From this perspective, one can only imagine what would happen in/to care organizations in real life if professionals stopped tinkering and simply stuck to strict sets of laws, regulations, ethical standards and/or managerial protocols (Graham and Thrift, 2007)? How would care organizations, and especially those facing tensions between street-level practices vs organizational/governmental protocols, do without creative maintenance and what consequences would the absence of creativity and tinkering have (Graham and Thrift, 2007)? Given that this issue was never methodologically or analytically set up to directly address questions of the effects of organizational abidance and/or organizational decay, its perhaps most important contribution lies in raising them.

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Making work visible in a breast cancer support business

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Abstract
Purpose – Breast cancer support businesses, retail stores selling mastectomy-related products, are playing an expanding role within healthcare in the USA. As commercial spaces separate from the medical settings where most cancer treatment occurs, these businesses have been largely overlooked in studies of medical care providers and their experiences. The purpose of this paper is to seek to bring to light the meanings and dimensions of the care work provided by breast cancer support staff to newly diagnosed patients.

Design/methodology/approach – This project employed an ethnographic approach centered on the workers at one breast cancer support business. The first author carried out participant observation over a 20-month period and supplemented the observations with staff member interviews.

Findings – The analysis of field notes and interviews revealed two themes or purposes as central to the employees’ understanding of their work: defining the organizational setting as a nonmedical space and balancing image enhancement with comforting care. The findings show how values of client-centered care can be enacted in a for-profit healthcare setting.

Research limitations/implications – This study is limited to one for-profit support business in the southeastern USA.

Practical implications – Mastectomy supply businesses appear to offer a kind of support that patients may not be finding elsewhere or at the particular time they need it. Thus the study holds relevance for practitioners and health policy makers who are seeking to develop more comprehensive care for surgical patients within the established healthcare system.

Originality/value – This study gives a detailed picture of breast cancer support work, including the value premises and meanings it holds for support workers.

Keywords Compassionate care, Breast cancer support, Healthcare ethnography

Paper type Research paper

Introduction
In recent years, mastectomy supply businesses have emerged in the USA to sell products including prosthetics, post-surgery wear, and wigs to breast cancer patients. Women who are facing or who have undergone surgical mastectomies commonly require some form of garment and prosthesis with which to adapt to an altered body (Lindwall and Bergbom, 2010). Within the US healthcare system, these items often require a doctor’s prescription before a patient can be fitted or make a purchase. In the past, patients relied on department stores, pharmacies or surgical supply businesses to obtain post-surgery products, but increasingly, for-profit support businesses are carving out a distinctive niche (“How Women’s Health HMEs Can Provide”, 2017; Murray, 2015; Crouch, 2007). Owned and operated largely by women, these businesses frequently describe themselves as “women’s boutiques” (Kendrick, 2008) that aim to address clients’ needs by providing both material goods and intangibles in the form of support and care for women diagnosed with breast cancer. The stores can be accessed in most metropolitan areas and seek to offer a welcoming and tranquil atmosphere where patients can feel comforted and cared for while being fitted for wigs and post-surgical garments.

In spite of their growing presence, however, women’s boutique staff and their contributions to patient support have been largely overlooked in studies of medical care providers and their experiences. One reason for this neglect can be attributed to the dominance of physical care over emotional care in studies of healthcare (Hunter, 2001). Participant roles of “staff” and “customers” do not precisely align with the categories of “patient” and “provider” found in traditional medical settings. Fitters, persons who supply
and fit the breast prosthesis, are often viewed by health professionals as “sales assistants” (Roberts et al., 2003). The fact that the work is performed by women for a female clientele also contributes to its relative invisibility within the larger medical and support network serving people with cancer. To the extent that staff members give attention to the physical and emotional needs of customers out of concern for their welfare, they are engaging in a form of caring work (Davies, 1995; England et al., 2002). Such work, even when performed on a paid basis, tends to be perceived as a “natural” expression of female workers’ gender, rather than a form of skilled practice, thus creating challenges for those workers in the valuation of their product (Davies, 1995).

In this ethnographic study we sought to shed light on the work that breast cancer support staff perform so that its visibility will be increased and so that forms of care offered in emerging health-related settings will be better understood. Our project grows out of the first author’s personal experiences as a client at one breast cancer support business. Her visits there, including encounters with the fitters and store staff, first prompted her awareness that services provided outside of formal, medical settings can be crucial sources of support. However the experience also provoked questions about how values of personalized care can be enacted in a for-profit setting. The growth of such businesses corresponds to an economic shift underway as healthcare diversifies and as for-profit businesses provide more kinds of care and social services (Davies, 1995). Some scholars have warned about the dangers of commodifying care traditionally provided by one’s family and community by outsourcing it to paid specialists (see for example Hochschild, 2003; Held, 2002). They are skeptical about whether clients can receive the quality of personalized care they require in enterprises driven by values of efficiency and profitability. Care, they argue, will inevitably become more “instrumental,” and less “expressive” (Morrison, 1992); that is, it will be increasingly scripted and focused on specific actions, rather than attuned to the needs of the individual being cared for. At the same time, an emerging literature informed by feminist theory has begun to question this assumed dichotomy, arguing that profit motivations are not necessarily antithetical to caring values (Nelson, 2006; Zelizer, 2005; see also England, 2005). Nelson, in particular, has called for further study and empirical observation of actual businesses and “real-world economic dealings” (Nelson, 2006, p. 1059) to understand how care values and profit aims can perhaps coexist.

Breast cancer boutiques respond to concerns about the commodification of care because they seek, in the words of one business owner, to “declare war on traditional sales and services” (Crouch, 2007, p. 13). Recognizing that a high quality prosthesis-fitting experience is important to patients’ well-being (see for example Roberts et al., 2003), boutiques seek to create a contrast with the impersonal interactions of traditional frontline encounters. Most boutiques offer their customers a comfortable feminine environment in which post-surgery needs can be discussed and fitting can be conducted in privacy.

As a combined commercial-medical space, the breast cancer boutique offers parallels to the community pharmacy where health promotion and retail agendas are interwoven. Recent studies have revealed the complex roles and multi-dimensional nature of care enacted by pharmacists (Banks et al., 2007; Cramer et al., 2010; Thompson and Bidwell, 2015) and by other service workers whose jobs entail attention to consumers’ welfare (Price and Arnould, 1999; Kang and Ridgeway, 1996). According to Rosenbaum et al. (2007), hair stylists, bartenders, gym attendants, and others are positioned as “natural neighbors and informal caregivers” (Cowen, 1982, p. 386). Informal caregivers are not usually trained in a professional discipline, yet are uniquely accessible to customers and willing to listen and offer advice (Cowen, 1982). This stream of research on commercial establishments as sites of support underscores the importance of moving beyond biomedical models of healthcare in order to understand the value that everyday, nonmedical, settings may hold for patients’ well-being (Milligan and Wiles, 2010).
The meanings of the care provided by wig stylists and post-surgical garment fitters are especially complex because the work takes place against a backdrop of cultural understandings of cancer as well as dominant discourses of gender and wellness. In the course of providing products and services in a nonclinical setting, staff members of mastectomy supply businesses are helping patients make sense of harsh and disturbing changes to their bodies, thus playing a potentially significant role in framing clients’ illness experience (Kendrick, 2008; Solomon, 1992). Some critics characterize the businesses as essentially a type of “image program,” comparing them to other makeover programs like the American Cancer Society’s Look Good – Feel Better program. They argue that support businesses promote a particular view of the illness identity, one that encourages women to ‘hide the physical evidence of cancer’” (Kendrick, 2008, p. 266) and focus on normalizing their appearances. Such commentaries are aimed at challenging what the authors consider the ablest and heterosexist norms underlying mainstream biomedical approaches to treatment. Their goal is to promote more inclusive treatment environments in which breast cancer patients can be open about their illnesses. However when viewed from the perspective of support business staff, these critiques suggest that the workers may face challenges in integrating bottom-line business goals with concern for clients in the midst of competing understandings of cancer recovery and women’s well-being. Exactly what meanings workers assign to their day-to-day activities as they balance these demands remains an open question. By observing activities and listening to staff perspectives in one breast cancer support business, we sought to understand how individuals whose work is located at the nexus of business and medicine negotiate these potential contradictions and how they position themselves within professional hierarchies of healthcare.

Background of the study and researcher roles
This project employed an ethnographic approach centered on the workers at one breast cancer support business in a mid-size city in the southeastern USA. The for-profit business studied here, referred to as the All For Angels Women’s Boutique or AFAWB[1], describes itself in its brochure as the area’s “first private, completely exclusive and comprehensive mastectomy boutique.” It had been in operation for 5 years at the time of the fieldwork.

As many writers have noted, researchers’ personal experiences and group memberships often draw them to certain topics as well as shaping their definitions of the research problems and study designs (Kram, 1985; Peshkin, 1985). The impetus for this co-writing project was the first author’s long-term involvement with the business, beginning when she was referred there by her physician to obtain products following breast cancer surgery. Her interest in the business as an emerging healthcare context was stimulated by her earliest impressions of the store as a home-like setting where displays of post-surgical products and “pink” breast cancer awareness merchandise were framed within a welcoming environment. As a new breast cancer patient entering the store with her prescription for a pre-surgery camisole, the first visit provoked mixed feelings. Hesitant to embrace the symbolic pink boosterism evoked by some of the merchandise, she was nevertheless struck by the store’s “living room” look and feel, with its warm decor of beige, brown, and pink, a small sofa in one corner, and a quilt hanging on the wall. The post-surgical products on display seemed to communicate the reality of the disease, while the sofa, quilts, evoked nonmedical “normalcy” and comfort. Other first impressions centered on the store personnel. The owner and other staff members were neither fashionably attired and made up as is typical in women’s retail apparel stores, nor obviously “medical,” but casually dressed in blouses and skirts. More significant to her was their approachable manner, which conveyed understanding about what happens to breast cancer patients, and an ability to meet each client’s unique needs. As she was being fitted for a surgical garment, the first author felt calmed by the fitter’s demeanor and the supportive conversation despite worries of her impending surgery.
This initial interaction and a feeling of being “in sync” with the employees and their style of service led her to make return visits and later to become a store volunteer, performing light tasks such as phoning clients when orders arrived, and eventually participating in large community fundraisers.

The first author’s long-term involvement and familiarity with the scene prompted her desire to undertake a research project to learn more about the store as an organizational space and site of care (see e.g. Pettegrew, 2017). Her personal history was not only an aid to gaining entry to the setting, but provided her with an evolving vantage point, from client to volunteer to researcher, and a perspective on the business and its workers that was both empathetic but grounded in everyday practice. The second author did not have personal experience with breast cancer support businesses but brought research experience related to working life and the everyday communication processes through which individuals negotiate their work and professional identities.

The study reported here used an ethnographic approach to bring to light the dimensions and the meanings of the care work provided by breast cancer support staff. Within the long tradition of workplace ethnographies, participant observation combined with informant interviews has been a recognized method for gaining contextualized understandings of work commonly viewed as unskilled or trivial including customer service (see e.g. Smith, 2001). In ethnographic studies of commercial customer service, for example, researchers have adopted participant roles to understand the dynamics of customer-sales worker relationships (Pettinger, 2005). Such studies reveal the complexities of work typically seen as routine even though it draws on communication-intensive skills such as active listening and “knowing when and how to speak” (Thompson et al., 2001, p. 935). Like customer service, the performance of caring work involves managing complex emotions, a largely tacit skill whose details as Miller (2007) notes, are rarely codified in employee handbooks. By explicating the implicit knowledge that informs caring work, especially care provided outside of formal healthcare systems, ethnography can aid in uncovering the discretion and social competence necessary in jobs often labeled as low-skilled, thereby broadening understanding of what medical care can involve (Savage, 2006; see also Charmaz and Olesen, 1997).

Data collection

After obtaining approval from the store owner and from the university’s human subjects board, the first author conducted a series of 14 fieldwork sessions of two to three hours each over a 20 month period, which translated into approximately 40 hours of observation. During the data collection period, she recorded what she saw and heard in field notes as she observed interactions between clients and workers at the front counter of the store, while interacting informally with the workers and performing tasks like stocking merchandise and filing.

Workplace ethnographers typically seek to maximize their first-hand involvement in to the field site by assuming participant roles. However in the current project, as in many medical settings, full participation was limited by ethical concerns (Wind, 2008; Pink and Morgan, 2013). Early in her fieldwork, the first author observed that key exchanges between store staff and clients occurred “behind the scenes” in the garment fitting room and an adjacent room where wigs were selected and styled. Despite her long history and familiarity with the staff and with store operations, she did not attempt to gain access to fitting room interactions out of concern that her presence would intrude on the delicate conversations taking place there. Instead, she supplemented direct observations of the store’s public areas with in-depth interviews with key informants. The interview participants included the following staff members.

Kelly, the fitter, is in her late 50s, and a ten-year cancer survivor herself. She initially was a volunteer and then funded her own certification as a mastectomy fitter. This certification
involved 500 hours of classes and practical experience. She chaired the county Making Strides Against Breast Cancer charity event for five years and has experience as a crisis hotline counselor.

Deborah, also in her late fifties, is a wig specialist. She has her own fitting room for clients who want to be fitted with wigs, turbans, hats or scarves. She also works from of her home (where this interview occurred) as a beautician, surrounded by hair stylist chairs, sinks, and supplies.

Meghan, the bookkeeper, is in her mid-thirties and is the owner’s adult daughter. She has a college degree in medical office management and manages all billing, accounts, insurance, and client files. She occasionally brings her infant daughter into the store while she works.

Prior to these interviews, the participants completed a consent form approved by a university human subjects board. The interviews, which were recorded and later transcribed, lasted between 45 minutes and an hour. They consisted of open-ended questions designed to guide participants’ reflections in the following areas: work history including how they came to work at AFAWB; description of the job content (a “typical day”); feelings about the organization and co-workers; feelings and motivations regarding client service; and continuing professional activities.

The value of the observational material was in providing a detailed picture of the physical setting and store activities. The observations were also an opportunity to identify things that might escape participants’ awareness including tacit, informal types of client support (e.g. explaining treatment plans). The qualitative interviews offered complementary insights especially relevant to the study of emerging organizational settings such as breast cancer support. One advantage of interviews is as a resource for accessing participants’ work meanings and motivations, or “how they understand what they do” (Barley, 1996, p. 42). The open-ended nature of the questions is particularly helpful as a prompt to storytelling, thus, giving insight into beliefs and values that may implicitly inform employee actions. As Linde (2001) explains, actors’ assumptions about the identity of an institution and the “proper” ways to fit in as a member may not lend themselves to explicit discussion. Nevertheless, participants may convey them indirectly by sharing stories and anecdotes that illustrate what kinds of behavior are expected or required in the setting. Finally, the interview accounts can be viewed as instances of occupational rhetoric in the sense that participants may attempt to display desired work identities to the researcher. As Fine (1996) concluded from his interviews with restaurant cooks, “It happens over and over that the people who practice an occupation attempt to revise the conceptions which their various publics have of the occupation and the people in it” (p. 91). By employing distinctive imagery participants are both making sense of who they are and strategically conveying the preferred meanings of their identity to others.

During the initial phase of data analysis the authors read and familiarized themselves with the field notes and interview transcripts. The first author highlighted and annotated the materials guided by several sensitizing frameworks drawn from past theory and research. These included concepts of occupational identity, emotional work as skilled work, and breast cancer survivor discourse. After completing these initial annotations, the two authors met to discuss the insights and to identify other emergent themes. We then returned to the source material to identify further instances of the categories and to specify the dominant themes that distinguished AFAWB as a site of caring work. Throughout the process, we made efforts to question and challenge our own and each other’s readings in order to arrive at interpretations that more closely reflected the empirical reality. The analysis revealed two overarching themes as central to the employees’ understanding of their work: redefining the organizational setting as a nonmedical space and balancing image enhancement with comforting care. In presenting our findings, we include descriptive details of the setting derived from observation along with interview excerpts and analysis.
Defining the organizational setting as a nonmedical space

A new client entering the All For Angels Women’s Boutique for the first time could easily be overwhelmed by the range of merchandise on display, including both medical products and retail goods bearing visible breast cancer signifiers. A large ribbon painted in hot pink, a widely recognized symbol of breast cancer, embellishes the store’s front window. Inside, breast cancer awareness products – jewelry, t-shirts and magnets and numerous items embossed with pink ribbon insignia – line the display tables alongside racks of bras, swimsuits and other mastectomy supplies. A basket full of chemo-blanket kits sits on the floor near a small sofa and a Keurig coffee machine; the kits, containing a small blanket, water bottle and cap, are offered free to customers who will be undergoing chemotherapy. With its comfortable seating and connotations of fashionable femininity, the boutique setting seems to invite comparisons to what it is not: an institutionalized medical space.

At its simplest level, the job of staff working at breast cancer support businesses is to advise patients in the purchase of bras, wigs, turbans, garments and compression wear. When clients come in to the store with a prescription for a breast form or cranial prosthesis (a wig), workers must handle medical insurance reimbursement by calling doctors’ offices and insurance companies to confirm orders or request new prescriptions or insurance coverage. One way the retail environment differs from a medical setting in the convenience and degree of access it offers. Women can visit the store at any time without having to make and wait for appointments, a feature that has previously been identified as impacting the prosthesis-fitting experience (Gallagher et al., 2010).

Beyond their specific product-related expertise, staff members at AFAWB see themselves as playing a multifaceted therapeutic role. This becomes most evident when clients enter one of two fitting rooms near the back of the store where their specific medical condition (post-surgery needs or hair loss) can be addressed. The body is a central theme in the work of both fitters and wig stylists. Kelly explained that fitting a prosthesis involves more than “picking the right size.” Selling products requires close visual inspection and hands-on assessment of a client’s physical condition. Fitters in particular must take note of the sensitivity of surgical sites and scarring as they consult with the client about the size and type of prosthesis.

Support staff members are aware that some healthcare providers of hold an image their skills and their work as trivial and they described experiences of feeling disrespected by established provider institutions. Meghan, the bookkeeper, recounted an incident involving a doctor’s office to whom she had repeatedly faxed requests to get the doctor’s signature on a prescription. When she eventually followed up with a phone call, the doctor’s employee responded impatiently that she didn’t have time to run down the faxes when their office was dealing with “real medical issues,” “not just bras.” Yet staff consider their jobs as more than promoting and selling products. Their concern with clients’ health outcomes is reflected in numerous ways, beginning with their efforts to support clients’ adjustment to their treatment plans. For example, the first author observed a client being fitted with a new compression sleeve following surgery. The fitter recommended that the client use a soft sponge to alleviate the pressure in the crook of the elbow. The client, who had been complaining about the discomfort caused by the sleeve, asked how often she needed to wear it and the fitter replied, “Everyday, all day.” The client grimaced as the fitter assured her that daily wear of the sleeve was important for healing and prevention of lymphedema in the arm.

The client’s body is a locus of attention, not only during product-related discussions, but throughout customer–employee interactions. A central aspect of the sales role is acknowledging the distress caused by the loss of breasts or breast disfigurement, weight gain, hair loss and other altered body issues. For the client who is viewing her body reflected...
in the fitting room mirror, the fitter’s sensitivity is key in setting the tone of the encounter. At these moments, staff members make special efforts to affirm the patient’s subjective embodied experience (Leder, 1990; Slatman, 2012; Timmermans and Almeling, 2009). AFAWB workers consider this ongoing attention to the client’s “lived body” (Slatman, 2012, p. 284) as distinguishing their style of care from that of mainstream providers. They imply that most healthcare professionals regard the patient’s body as an object of treatment. Staff members consider a key aspect of the sales role as acknowledging the distress caused by the loss of breasts or breast disfigurement, weight gain, hair loss and other altered body issues. They believe this particular kind of validation is missing from settings in which the practitioners are narrowly focused on medical treatment. When the first author asked staff members to describe their work, they all drew contrasts with conventional medical settings in order to emphasize that AFAWB provides emotional benefits that are not available in other, more clinical contexts. As Meghan, the bookkeeper, explains, “I think that almost more important than the service is the counseling […]. They [clients] come into the fitting room and the door closes and it’s just like you and your friend talking, it doesn’t seem like a patient.” In her comparison of fitting room conversations to friends talking she distinguishes their services from the more hierarchical encounters of institutionalized medicine. Similarly, Deborah, the hair dresser, described her interaction with clients who come in for wig fittings:

[...]they come into the wig room and I go on to explain to them what is going to happen to them. For example, “your head’s going to get cold.” So I show them caps that they can wear. A doctor isn’t going to tell you these things. Not the personal end of things. Most of all, they are men. A woman doctor can express this, though not as well as a hair dresser can. A male doctor relates better to a male patient who has prostate cancer.

Here, Deborah shows her understanding of her job as involving sensitivity to the nuances of treatment effects, in particular, the way in which a client experiences her own body. The need for a cap to warm the head is a subject that may not be considered important in a traditional healthcare setting. In defining her approach to her work in direct contrast to the presumed non-empathetic stance of (male) doctors, she indirectly aligns hair dressing with the highly regarded occupation of physician in order to assert a claim about the unique value of her work. Although brief, Deborah’s comment evokes a widely shared humanist critique of biomedical approaches as “objectifying” patients: separating the body and body parts from the “self” rather than recognizing and validating patients’ vulnerabilities (Sharp, 2000). Deborah also suggests that the common experience of being women, adds value to the products she is selling.

Both fitting and hair styling require paraprofessional certification. Yet staff members seemed initially reluctant to describe themselves as having specialized skills and qualifications for their work. When asked what her job description is, one employee, Kelly, seemed at first amused by the question, saying, “I don’t know if I have one. I’m Lorraine’s [the owner’s] assistant. Sales representative.” A few moments later, she added, “I’m a fitter.” She went on to explain the qualifications for certification, which include a class and 500 hours of practice, but she also cited her personal experience as a breast cancer survivor as motivating her decision to become a fitter. When Deborah, a professional hair and wig stylist, was asked how she acquired the skills for her job at AFAWB, she answered that it was simply something she “grew into” as a natural extension of her personality, saying “I am a compassionate person, and I want to help.”

Workers at AFAWB make efforts to demonstrate that they put the clients’ needs first over business priorities. For example sometimes clients cannot go through with the fitting and have to return another day when they feel strong enough to look at themselves in the mirror and talk about the changes they are going through. When staff members perceive...
that a client is simply unprepared to deal with the fitting process, retail functions may fade into the background. As Kelly, the fitter, explained, women may be at a point:

[...where tears come and shortness of breath and I’ll say, ‘Honey, maybe you’re just not ready. And usually at that time, we decide to just close that off and say, when you’ve had time to think about it and when you’re feeling a little bit better about making some decisions, why don’t we meet then? We never, ever insist, when somebody is anxious and upset, on closing a sale.]

Kelly’s willingness to relinquish her sales agenda seems aimed at enhancing the customer’s sense of control. Her comment illustrates Frost et al.’s (2000) point that organizations can enable or constrain the provision of compassionate care by the routines and culture they enact. Deferring the transaction is at odds with bottom-line business concerns. Yet this people-before-profit principle shows how employees work to maintain the organization’s culture around an expressed commitment to women’s well-being.

Commitment to serving client needs is reflected not only in daily customer interactions but also in numerous fundraising initiatives undertaken by the business owner. For example the boutique maintains a storeroom of donated gently used mastectomy products and it provides referral information to women who cannot afford mammograms. In addition to a fashion show and yearly calendar sales project, the store participates in Pink Promises, a charity that solicits donations for clients who cannot afford surgery products. Employees also define the task boundaries of their jobs to encompass off-site activities. The hair stylist, Deborah, told a story of meeting a client in a hospital lobby to comb her hair and talk with her about the effects of chemotherapy. Kelly also described bringing camisoles and other products to patients in the hospital so they would be prepared in the aftermath of surgery. Such regular activities help to establish a framework in which care is woven into everyday interaction (Frost et al., 2000).

In general, staff members at AFAWB define the work of breast cancer support as working with clients’ feelings as well as their bodies to provide sensitive, compassionate and flexible care. However conversations with the bookkeeper, Meghan, produced a more complicated picture. As the employee responsible for billing, insurance and web design, Meghan was ambivalent about the focus on feelings at AFAWB. Initially, she affirmed the view of others that AFAWB is unique in its concern for women’s well-being and that reassurance and “counseling” are integral to the service it provides: “We should all have degrees in counseling because more times than not you talk to somebody and you just reassure them. We’re not doctors [...] but everybody treats everybody who comes in here like a friend, [...] encouraging them if they need to cry.”

Later in her interview, as Meghan elaborated on the details of her workday and the volume of paperwork involved in billing, her tone suggested a different attitude toward “counseling”:

Because what happens is that you have all these ladies and they come in here and fit and talk and they counsel and you know, they do their job, and there’s me, and I kind of like “Well I am glad you are feeling better but here is this stuff – we have to get this done, so, it’s kind of that the pull of the compassionate side, and even though I still try to be compassionate, you gotta get done what needs to be done. You know, you have to get the actual work done. Using the word, “counsel,” in a special, emphasized way, Meghan seemed critical of the emphasis on intimate emotional connection in service delivery. She describes herself, on one hand, as someone who “tries to be compassionate” (e.g. going out of her way to help clients resolve billing problems and searching out other funding resources for those without insurance). At the same time, she frames her role as bookkeeper, in opposition to those on the “compassionate side,” and suggests that hers is the “actual work,” i.e. necessary to business operations. Meghan’s comments suggest the contradictory positioning of workers occupying different roles within an organization that defines emotional support as central to its business mission. Fitters and hair stylists, who are able to frame their sales work as
compassionate caregiving, can see their contributions as a part of clients’ healing process, whereas workers who perform traditional business tasks may feel their work does not always receive appropriate recognition.

**Balancing image enhancement with comforting care**

AFAWB workers consider sensitivity to client emotions as integral to their work. By being closely attuned to the details of a client’s appearance and demeanor, staff members can infer how a woman is coping with her illness and respond appropriately. According to Davies (1995), the calibration of response to the client’s perceived vulnerability is an important aspect of caring work but difficult to translate into discrete, identifiable tasks. A client’s degree of vulnerability cannot be predicted in advance of the initial encounter and therefore the assessment of her needs must begin when she enters the store for the first time. As Kelly described these moments, women often come through the doors directly from the doctor’s office:

> [...]and hearing the words, “You have breast cancer,” and sometimes they walk in the door and you can usually see through the body language that something’s really amiss and they may make it to the counter and put down their prescription and the mouth opens and a big sigh comes and they say, “I have [...]” and then the tears flow and the body slumps and we hope to have arms there, to say, “It’s okay, honey,” where we, the women understand, we’ve been there.

Here Kelly provides a rich description of the spontaneous comforting that occurs in response to a client in the early stages of diagnosis or treatment. Comforting can take different forms depending on specific needs. According to Deborah, it can range from “hugging” to “handing a tissue” to “just being there.” Overall, staff members emphasize the importance of taking the client’s perspective as a guide to action. Kelly’s account is noteworthy for its depiction of the intense emotional and physical aspects of client stress as well as giving a sense of her close observation of the client’s behavior. In citing details like “sighs,” “slumped posture,” and “tears,” she suggests that both noticing and feeling are part of the skillset involved in managing these highly charged interactions (Miller, 2007). Her description accords with research that conceptualizes comforting communication or compassion-giving as an embodied experience, informed by complex processes of noticing or recognizing the client’s needs and then adapting communication accordingly (Kanov et al., 2004; Miller, 2007; Way and Tracy, 2012; Wharton, 1993). Having arms out to catch the customers when they come through the door encapsulates the efforts of the worker to be poised and ready for the client who is experiencing the crushing emotions that accompany the news of the diagnosis. Yet here, too, spontaneity is important. Kelly says: “You need to have a very good sense of humor. [I say] ‘Honey, have I got some bras for you!’ We try to put some sparkle in it, we try to put some pizzazz in it [...] if I can make somebody laugh by saying that, then that’s good!” This stance stands in contrast to the scripted quality of routine sales encounters where, as Mumby and Putnam (1992) argue, the workers try to “get a jump on’ and control” customer interaction (p. 478). Kelly listens and relates to clients, not only as a woman, but as a breast cancer survivor herself. She feels that her embodied understanding “having my own scars,” helps her to understand the clients and motivates her to provide the kind of sensitive post-surgery support she would have wanted to receive as a patient herself but feels she did not.

The examples presented thus far show some of the ways that staff members prioritize sensitivity and compassion in their customer service. Employees at AFAWB derive a sense of larger purpose from helping women know they are not alone in the struggle with diagnosis and treatment. Yet this support-giving occurs within the context of aesthetic consultation and image restoration services, the cornerstones of the organizational mission. As reflected in the store’s display of stylish swimsuits, nightgowns and lingerie along with
bras and prosthetics, AFAWB products and services implicitly affirm normative standards of beauty and gender. Staff expect that their clients will experience anxiety and loss of self-confidence as a result of hair loss, mastectomy, and other appearance-related side effects. In recognition of these concerns, marketing materials address prospective clients with the salutation, “Dear beautiful woman […]” and the store’s website highlights the abilities of staff members to “fit for just the right figure and desired image.” Although workers do not consider normalizing the feminine appearance as directly reducing the side effects of the treatments, they believe their products help clients cope with treatment by mitigating the distress caused by gender-marked changes to the body. This can be summed up in the idea that if a woman feels good about how she looks, the burdens of treatment will be easier to manage, and echoes the rationale of the American Cancer Society’s Look Good – Feel Better cosmetic makeover program. Kelly explained how regaining a normal feminine appearance through the use of a prosthesis benefits clients:

We know from statistics that one in eight women will get breast cancer. A good deal of those will have a mastectomy. And other women will have lumpectomies. And those women have symmetry problems with their figure and most of them aren’t aware that there are small appliances that can create perfect symmetry for them […] their faces light up They feel like they have hit the jackpot […] [because] they can feel confident enough to wear t-shirts.

Kelly is referring to the loss of symmetry following a single mastectomy. Her comment implies that the loss of body symmetry, because it violates one cultural standard of beauty, contributes to feelings of stigma. Thus the prosthesis offers a tool for “repairing” identity and managing the presentation of self (Ogle and Ullstrop, 2006, p. 233; Goffman, 1959). In equating confidence with symmetry and wholeness, Kelly’s comment brings to the fore concerns raised by feminist critics who question the assumed necessity of breast replacement through either surgical reconstruction or a prosthesis. Women’s health advocates have argued against the notion that restoring the figure to the feminine ideal “is an essential element of cancer survivorship” (Rubin and Tanenbaum, 2011, p. 401). They suggest that widespread promotion of breast replacement amounts to a cloesting of the illness (Crompvoets, 2012; Solomon, 1992; Thorne and Murray, 2000). In contrast to these critics, Kelly upholds the view held by many mainstream health providers of the prosthesis as a simple cosmetic intervention that can help to restore clients’ sense of themselves as women. Yet a few moments later she expresses a different point of view. When she is asked what she considers the greatest need of the clients coming in to the store, she responds quickly:

Validation and understanding. It’s nice to have beautiful breasts and it’s nice to have a symmetrical figure, but what I have seen is that women who have been through breast cancer want validation that they have been through something so life changing. They want someone to say, ‘Honey, I understand’ and they just need that comfort from other women who know that they have been through the fire.

Here, she frames the service provided by AFAWB in terms of what it does to make the women feel better rather than to look better. Similar to her earlier description of meeting first-time clients with comforting arms, Kelly emphasizes the importance of addressing women’s subjective experience. Clients may enter the store out of a desire to purchase wigs, prosthetics, bras, and swimsuits, in short, to “restore” the feminine appearance. Even so, staff members project an understanding that clients’ well-being as considerably more complex than body image, as shown by the fact that consultations often include discussion of both nonmedical and medical issues. The first author observed clients confiding in staff about the break-up of their relationships, fears about the loss of employability, and financial insecurities.

By attending to the meanings that are most personally relevant to the client, support work at AFAWB implicitly challenges another assumption of mainstream medicine concerning the value of positive thinking for cancer recovery. In both scholarly and popular
literature, a recurring argument centers on the connection between patients’ health outcomes and their ability to maintain a positive attitude (Wilkinson and Kitzinger, 2000). The moral imperative to be positive in the face of breast cancer aligns with culturally prescribed role of the cancer patient as a disease warrior and “sheroe” (Sulik, 2011). For example, “Fight like a girl,” a phrase originally used to teach women self-defense, has been used in recent years by breast cancer support groups such as Making Strides Against Breast Cancer and the Susan B. Komen organization (“Fight Like a Girl!”, 2017). AFAWB carries a variety of these “pink marketing” (Sulik, 2011) products and texts embodying the disease warrior identity, including their annual calendar fundraising project. But against the backdrop of these heroic images, AFAWB is defined by highly fluid “feeling rules” (Hochschild, 1979). As the hair dresser, Deborah, explains, “When they come into my room, and there are times when I can just feel it with a person, I say, ‘Now come on, we gotta talk, you gotta let this out’ [...] And you’re allowed to be mad.” In customer encounters, staff members focus their efforts on responding to the illness experience as clients present it. In contrast to more mediatized spaces or fundraising events designed to cheer cancer patients on, staff emphasize the need for emotional attunement to what the client is going through.

Conclusions and implications
This study provides a picture of everyday care practices within the emerging healthcare setting of breast cancer boutiques. The ethnographic data give a sense of the effort and interactional skill invested by boutique employees in serving the post-surgical needs of newly diagnosed patients. Although commonly dismissed by medical professionals as “sales” personnel, staff members strive to offer a style of service grounded in the acknowledgment of patients’ unique, embodied experiences. As Wilkinson and Kitzinger (2000) observe, talking about unpleasant experiences and negative emotions such as those that accompany breast cancer treatment can be difficult for others to hear and “engage with,” (p. 805). Even so, clients in this setting are encouraged by support staff workers to let their feelings out, with the understanding that expressing anxieties and negative emotions is legitimate; as Diane says, “You’re allowed to be mad.” In offering a space for patients to express a broad range of responses to their illness, breast cancer boutiques seem to respond directly to Audre Lorde’s lament about a deficiency within mainstream healthcare. Most post-surgical spaces she writes, allow “no psychic time or space to examine what our true feelings are, to make them our own” (Lorde, 1980, p. 61).

The study gives further support to recent arguments about how seemingly contradictory pressures of commercialization and client care can be integrated in “for-profit” settings. Critics of expanding commercialization (e.g. Hochschild, 2003) argue that when care is provided as waged labor, authentic care values are undermined. However, the AFAWB workers strive for a feeling of social contribution in their working lives by prioritizing their counseling role over sales and over aesthetic goals of image restoration. Overall the ethnographic findings accord with a point made by Turco (2012) that “at the level of practice, the market and intimate relations intermingle in ways that often sustain, rather than degrade, human connection” (Turco, p. 415).

In addition to offering insights about how care values can be enacted within commercialized settings, the study illustrates the potential of ethnography to show how organizational processes can shape new understandings of women’s health. On one hand, AFAWB products and services fit within prevailing cultural discourses of breast cancer survivorship by focusing on normalizing the female appearance. Store employees do not openly question this business mission of image restoration. At the same time, employees take pride in having developed an alternative, nonbureaucratic service model, which they see as challenging the dominant practices within the standard healthcare system. Such findings, generated from within an emerging care context, show how ethnography can

Breast cancer support business
reveal practical philosophies “in flux,” (Charmaz and Olesen, 1997) and thus has the potential to capture newly emerging models of women’s health.

One additional feature of interest is the way employees’ accounts intertwine descriptions of working life with discursive constructions of their identities as compassionate care workers. When Diane recalls telling a client, “A doctor wouldn’t tell you those things [that your head will get cold],” she aligns herself with the valued occupation of doctor while positioning herself as different from, and more caring than, those providers. Identity issues also surfaced in Kelly’s interview, when she summarized the boutique mission, saying, “it’s much more than a business, this is an outreach […] a ministry, whatever you would like to call it.” Insofar as the label, “business” implies a concern with profit motives, it conflicts with the more idealistic values implied in the terms, “outreach” and “ministry” (Fine, 1996). These aspects of employee accounts suggest that concerns about identity may loom large for workers like these on the periphery of the healthcare system (see e.g. Kleinman, 1996). In the emerging field of breast cancer support, workers may feel a need to project desired identities to the researcher and thus establish the legitimacy of their work.

A possible limitation of this study stems from its focus on workers at a single organization. A larger study involving workers at multiple businesses is an important next step in order to know if these particular themes apply to other breast cancer support businesses. Further research is also needed to learn more about the client base of breast cancer boutiques and to learn about the range of reactions customers have to the store and its merchandise. Mastectomy supply businesses appear to offer a kind of support that patients may not be finding elsewhere or at the particular time they need it. Thus the insights hold relevance for practitioners and health policy makers who are seeking to develop more comprehensive care for both women and men within the established healthcare system. Based on these findings, practitioners and medical educators may be inspired to give renewed attention to physician training in which the complexity and intensity of client emotions is acknowledged as well as the supportive stances that practitioners need to take while treating the whole patient within those spaces.

Note

1. The name of the organization and the names of research participants have been changed to preserve their confidentiality.

References


**Further reading**


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Logics of care in clinical education

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Abstract
Purpose – The purpose of this paper is to explore how clinical nurse education and nursing students’ care practices are shaped by different logics of care.

Design/methodology/approach – Inspired by Mol’s work on care, the paper explores care practices connected to the clinical education of nurses. The empirical data were generated from longitudinal, multi-sited ethnographic fieldwork among nursing students in clinical practice combined with follow-up interviews with the students and their supervisors.

Findings – The paper illustrates how three logics of care shape clinical education: the logic of relational care, the logic of care education and the logic of care production. The paper demonstrates how the logics unfold and entangle in everyday clinical education. On the one hand, care of patients based on the relationship between patient and nurse is highly valued. On the other hand, this logic is not institutionalized in the same way as practices induced by the logic of care production and the logic of care education.

Originality/value – The paper may be of value to scholars and practitioners in clinical education, as well as to health educational policy makers. The findings focus on paradoxes produced by conflicting logics in practice, thus offering new reflections and alternative sensemaking of well-known problems connected to clinical education.

Keywords Institutional ethnography, Care values, Care practices, Clinical education, Undergraduate nurses

Paper type Research paper

Introduction
Public sector health care in the Nordic welfare states has undergone significant changes during the last 50 years (Dahl, 2000; Wærness, 2008). Research has explored how Scandinavian care practices are currently heavily influenced by market-based dynamics and utilitarian ethics, thus setting an ideal of care as based on humanistic values under pressure (Bakken et al., 2002; Blom et al., 2017; Hansen and Kamp, 2019; Wrede et al., 2008).

In this paper, we focus on care practices in clinical education. Through analysis of nursing students, who are in the process of acquiring competencies to provide care in clinical placements, we will argue that clinical education is shaped by different logics of care. The potential in focusing on nursing students learning to care is that the logics and values that are often implicit and therefore “invisible” in care become visible in situations of learning. They become articulated, for example, as “learning goals” or through teachers’ corrections of students who break with or fail to live up to the values and logics inherent in professional care. In other words, students learning to care are interesting study objects when looking at care values, because they are in the midst of acquiring the values of care that are prevalent in their future care practice as professionals.
The research questions that we will pursue in this paper are as follows:

**RQ1.** Which predominant logics of care pervade care education for nurses in clinical practice?

**RQ2.** How do students negotiate, adapt or reject these logics?

**RQ3.** How do the different logics of care shape patient care?

Based on our findings, we will discuss how care in contemporary Danish health care is grounded in different values – and how these can be understood as related to each other in ways that are underexplored in current research.

**Background**

Research into students’ learning of care in clinical practice is a large and very diverse field covering many aspects related to students’ accomplishment of caring competencies. Two recurrent themes are relevant to this paper.

First is the theme of empathy. Generally, the literature has as its starting point the notion that empathy is a fundamental aspect of caring related to quality and patient outcome. In a review article, Williams and Stickley (2010) point to the idea that nurse educators have a responsibility to provide an education that engenders empathic understanding in nursing students. They identify a tendency in education research to associate empathy with emotional intelligence and suggest that nursing education should promote the self-awareness that is seen as central to empathy. They hereby draw upon a concern that nursing students demonstrate a lack of empathy. Ward *et al.* (2012) find that, contrary to what might be expected, nursing students who have experienced more than the average number of encounters with patients display a lower level of empathy. McKenna *et al.* (2012) find that nursing students have an “acceptable level” of empathy, although the study points to room for improvement. Both studies draw their conclusions on the basis of statistical data, hence illustrating the inclination to approach empathy as an, inner, psychological and measurable matter (see also Mennenga *et al.*, 2016).

The second theme of relevance relates to nursing students’ experience of clinical care education. Pearcey and Draper suggest that student nurses are disillusioned with the reality of clinical nursing due to the amount of work to be done at the expense of patient contact and communication. Their research shows that a majority find nursing to be “not as caring as they expected” (Pearcey and Draper, 2008). Stress (Admi, 1997), role confusion (Cooper *et al.*, 2015), a sense of not belonging (Liljedahl *et al.*, 2016) and feelings of insecurity (Mannix *et al.*, 2006) are prevalent in research covering students’ experience of clinical placements, thus pointing toward the conclusion that clinical placement is a challenging experience. Our own research adds to the picture the finding that nursing education offers students an ambiguous socialization into the nursing profession (Lehn-Christiansen and Holen, 2019).

**Methodology**

This paper is written on the basis of a four-year study (2015–2019) of clinical nursing education named ACROSS, situated at Copenhagen University Hospital (Holen and Lehn-Christiansen, 2017; Lehn-Christiansen and Holen, 2019). The overall aim of project ACROSS is to strengthen the coherence of clinical education in nursing by providing a test class of 40 nursing students’ extracurricular activities such as supervision and training in clinical reasoning. We are connected to the project as external, university-based researchers on the project and our commission has been to produce knowledge on the project’s attempt to qualify clinical education. To do so, we have followed a class of nursing students throughout all clinical elements of their study program. We have carried out several
hundred hours of ethnographic field studies in all three health care sectors and completed
more than 50 interviews with nursing students, clinical preceptors and teachers[1].

Field observations have been conducted in all but the first two-week clinical placement.
In total, we have observed 20 students in 20 different clinical settings throughout the entire
nursing program. Each observation has been carried out over two full days. We have used a
combination of inquiry tools, such as reflexive field notes and on-site interviews with
students and their preceptors and shadowing. As pointed out by Delgado and Cruz (2014),
shadowing is a relevant tool in multi-sited ethnography because it “provides a rich context
wherein actions are produced, and it allows the researchers to be in places where they would
not usually go” (p. 47).

The study of care as a matter of practice and logics: methodological inspirations

With inspiration from Dutch researchers Annemarie Mol and colleagues, we approach the
study of care through nursing students’ care practices. We follow Mol’s understanding of
care as practices aiming at “handling life with disease” (Mol, 2008, p. 2). By working with a
loose concept of care practices, we have accepted the invitation to focus our analysis on
“actual situations and events where people, together with their artifacts and ways of
understanding the world, aim for improving or stabilizing the situation of the people or
things cared for” (Ceci et al., 2017, p. 57).

This understanding does not limit the study of care to any specific doings, to certain
professions or to specific contexts. Caring practices often imply a good deal of “tinkering,”
as Mol and colleagues Pols and Moser phrase it, to indicate the jumble of doings that
constitute care practices (Mol et al., 2010). We study care practices involving nursing
students. By taking this approach, we are enabled to think deliberately about the practices
that constitute care and thus, hopefully, understand practices on their own terms – and not,
for example, as opposed to “theory” as frequently happens within the field of nursing
education studies (Holen and Lehn-Christiansen, 2017).

Mol’s idea of “logics” has proven helpful in our exploration of the care practices of
nursing students. In line with Mol, we use the concept of “logic” to explore the patterns
of practice that make everyday practices understandable and sometimes even “natural” to
the human agents involved. A logic gives reason and appropriation to actions. Logics make
some things fit together. Using the term “logic” does not imply viewing practice as coherent
and logical (Mol, 2008, p. 9). Even if practices can be explained with reference to underlying
logics, practices are still also fluid and complex. Unexpected events that break with the
dominant logics happen all the time. We have observed nursing students doing many things
that were not prescribed by the care procedures or were not in the schedule of the day in
order to provide good care, such as working out the connection between a patient’s hearing
aids and his/her iPad to enable the patient to listen to podcasts while waiting for the test
results. Where Mol has developed her concept of the logic of care as opposed to the logic of
choice, we operate with several logics of care that permeate and become entangled in
everyday care practices in nursing education. The logic of choice has not proven to be
dominant in our material.

A focal argument for studies like ours is that the logics of care are often “invisible” or
unconscious to the actors involved; they are embedded in the institutionalized day-to-day
ways of doing and saying, the habits inherent in the professionalism, materialities and/or
the governing structures of clinical practice. The study of nursing students makes it
somewhat easier to identify these logics; students are often not familiar with the way things
are done, but they are committed to learning. Therefore, the experience of the novice makes
visible what is (often) obvious and therefore invisible to experienced nurses. As part of their
clinical education, nursing students are provided with verbal and non-verbal support and
corrections that socialize them to the institutional care practice. During this process, they are
corrected by many different professional nurses, and sometimes in contradictory ways, thus making visible the rights and wrongs of the professional care practices into which they are being socialized.

Our approach to the study of values does not start from a normative definition of care. We are not interested in exploring if or how students’ or preceptors’ care practices measure up or fall short. Instead, we follow Ceci et al. (2017) in her description of an “empirical ethics of care” (p. 82) that articulates the forms of the good that students and their professional colleagues in clinical practice value or attempt to bring into being in their practices (Ceci et al., 2017, p. 62).

Analysis
In the following, we present the results of our analysis. We identified three different logics of care in clinical education: the logic of relational care, the logic of care education and the logic of care production. As we will argue, these logics have a profound impact on the clinical education of nurses. By use of empirical examples, we seek to illustrate the workings of these logics and unfold some of their entanglements.

The logic of relational care
Let us begin by looking into student nurse Stina’s clinical placement in primary care:

Today she’s got four visits to elderly people. First visit is to an elderly man, who needs a urine catheter replaced. We meet Nurse Eva at the garden gate. Stina is not familiar with the procedure, so the plan is to observe Eva to find out how it’s done. […] After saying goodbye to Eva, we visit another male patient, who has had surgery very recently. Stina’s task is to attend to his wound. The wife answers the door; she’s very upset about the fact that her husband has already been discharged. And she had expected a specialist nurse and is therefore very unhappy about the entire situation. She also yells at her husband, angry that he is incapable of taking care of anything. The wife also yells at Stina, her yelling turns into tears and she apologizes. Stina comforts her. Afterwards she attends to the wound. She’s not sure if it is healing satisfactorily and takes a few photos with her cell phone. Then we head toward the third visit, one more wound. […] Back at the nurses’ office, Stina talks to the wound specialist, Nurse Karen, about the wound she photographed and the upset wife. She seems shocked. Karen says that the wife was just as upset the other day when she was there. On that occasion, Karen had told the wife to leave, so that she could concentrate on the wound. She also says that she’s not capable of saving the entire world, not least the bad marriages of the patients. That’s somebody else’s job. Stina starts to document the visit on the laptop. She consults Karen about the right way to describe the wound. She also adds a note saying that the wife is in a crisis. (Field notes)

The example gives a glimpse into the everyday life of clinical education. Stina is in the final clinical placement in primary care and is expected to be able work independently. The logic of relational care is rooted in the nurse–patient dyad concerned with the care practices related to the care needer and equivalent to Mol’s definition of the logic of care (Mol, 2008). Within this logic, care is the effort to support the patient in handling life with disease.

This logic can be applied to the example of Stina, who takes on the responsibility of providing the care needed by her patient and his wife in the current situation (or at least, attempting to do so). Even though the schedule defines Stina’s task as “observation of left foot wound,” she relates to the entire situation, including the angry wife.

The logic of relational care gives meaning to one of the most basic arguments underlying the idea of clinical placements as a fundamental component of care education: the need to meet and care for real patients. According to the logic of relational care, good care very much depends on the students’ ability to learn how to handle the complex care situations of
Another example of this is student nurse Vibe, who tells about her experience of caring for a patient:

In the beginning she wanted to stay in bed, she didn’t want to eat and she didn’t want to go to the toilet. But I managed to get her to join me in the dining room. We just sat there and talked. It was nice, and I could tell she enjoyed having some company. She actually ate, and I got to know more about her normal routines. She told me that she normally defecates in the evening. So we agreed that I would assist her to the bathroom at night to try to get her body back to normal. It added a lot of dignity, I think.

Vibe considers good care as connected to the establishment of a relationship to the patient and to “dignity.” Vibe’s caring practice makes perfect sense within the logic of relational care; she emphasizes the relational aspects and caring as depending on her getting to know and handle the patient as a unique human being.

A different example of the workings of the logic of relational care is student Agnete, whose final clinical placement is in an intensive psychiatric unit. Like Vibe, Agnete’s care practices can also be understood as an expression of the logic of relational care, for example, in a situation where she observes a patient who starts crying in the unit’s common room. Agnete goes to the nurses’ office and asks the nurse responsible for the patient to handle the situation. The nurse refuses, arguing “the patient cries all the time.” Professional interference is useless, she says. Agnete keeps insisting that the patient needs attentive care; she should not be left to cry by herself. At last, the nurse agrees and turns to the patient. The situation can be seen as another example of the unfolding of a student’s care practice based on the logic of relational care, implying that it is the responsibility of the professionals to attend to patients in their care. However, the example also illustrates that the logic of relational care is by no means the only logic involved in clinical practice. The professional nurse seems to be preoccupied with the question of “what works,” and a rationality that makes practices that do not seem to work meaningless. We shall return to this in the Discussion.

The logic of care education

The second logic that we identified as predominant in clinical care education is the logic of care education. This logic can be seen as an important part of the foundation of contemporary nursing education; it involves the idea that clinical education should be ruled by considerations for students’ learning and ensure a certain level of competencies among new nurses. The logic of care education makes it meaningful to formally break down the overall educational goal of becoming a nurse into a large number of single components and learning outcomes on different levels. The logic of care education is also at play in the initial example of Stina. Even though she is almost a nurse, she still needs supervision when faced with new procedures or complicated tasks, such as a difficult wound or the replacement of a urine catheter. This practice of seeking professional advice is not just a trait of formal undergraduate education; it is a profound characteristic of health care practices to seek advice when in doubt. Stina is also expected to present and discuss her doings with her preceptor at the nurses’ office, who will challenge her arguments and test her theoretical knowledge; her notes on today’s patients will be often examined with a double goal of patient safety and learning progression as she will be expected to take part in nursing conferences as a professional nurse. The logic of educational care is not solely a trait of undergraduate nurses’ everyday life; it is a characteristic of professionalized nursing care practices.

Following the visit, Stina tells us that she does not have the knowledge needed to deal with wounds like the one she encountered during this visit. We ask her why she has not studied wound care during some of the so-called “study days” reserved for reading theory
during clinical placement. She replies that she has been preoccupied with readings related to the thematic written assignments that she needs to submit during this placement. We also ask why she has not addressed her need for more knowledge of wound care in the hour-long reflection sessions with her preceptor. “But in these sessions we discuss cases and topics introduced by the preceptor,” she argues. The logic of care education has its focus on learning outcomes related to care. It is the focus on learning products, or “outcomes” as they are termed within this logic, very often in terms of skills, knowledge and competencies, which splits learning into separate components. Following the logic of care education, there is a very close connection between stimulating the learner and the expected learning outcome. When Stina is told and shown how to replace a urine catheter, she is expected to “know about” this procedure, and to be able (or at least willing) to take on the task herself the next time. In clinical practice and among students, this practice is often spoken of as “see one, do one.” It is also this rationale that makes it meaningful to student Marie to leave her patient in the middle of a conversation to go to another patient’s room to see a penicillin drip in action. To “experience things,” as another student phrases it, becomes equivalent to knowing in this logic. Consequently, and quite contrary to the logic of relational care, the logic of care education often considers care practices as independent of context. A regime of examination. Clinical placement students are commonly teamed with a nurse. In general, they are not with the same nurse on more than two or three consecutive days. We have noticed how students are very frequently asked to account for their knowledge both generally and more specifically in connection with procedures, diagnoses or nursing theory during placements. These questions are posed in all settings, at all times of the day. A way to understand these constant inquiries is that it is very difficult for the regular nurses to support the professional progression of the students without being familiar with their experience and level of knowledge. The logic of care education thus establishes a regime of examination; students are asked to account for their skills and knowledge both generally (“What can you do?”) and more specifically (“Do you know how a glucose drip works?”).

What we find remarkable is that this very dominant regime of examination seems to be only loosely connected to actual caring practices. In the case of Stina, we see that her challenges with wound care fall outside the formal teaching activities established by clinical education. In this particular case, Stina consults the wound specialist, so that the patient does not suffer from the student’s lack of competence. However, as Stina says, “It’s hard to know what you don’t know.” A more worrying example of this is student Marie, who does not take any action on a patient’s complaints about soreness around the backbone after being in bed for several days, or student Milla, who does not feel motivated to understand the complexities of the condition of the patients she cares for and therefore does not really know what to look for when caring for her patients. She explains:

Sometimes my preceptor goes through my plan, saying “you’ve done that, you’ve done that, etc.” And I just say “yes” even though I might not actually have done it by myself. I don’t know why, probably it’s because I want to please them.

This points to a care practice where instructions given to students on the one hand are systematically evaluated, but on the other hand the evaluation is disconnected from the actual care actions taken (or not) by the students. In conclusion, the logic of care education considers learning to care as controllable and measurable through tests and examinations. At the same time, the connection to the daily challenges met by the students is weakened.

Active, visible caring. Within the logic of care education, care is constituted as an assemblage of activities connected to a body of knowledge and experience of “handling Life with disease.” Learning becomes equivalent to the engagement of these activities and it is therefore worrying if students are not “active” in a visible sense during clinical placement.
An example of this is the case of student Marie. Her supervisor Gitte receives reports from the other nurses that Marie is “not active” and that she “sits around” too much. Marie is confronted with this at a formal study meeting. Being seen as a problematic student worries and confuses Marie very deeply (“It knocked me out. Completely”) and she contemplates the possibility of dropping out, but decides to carry on, trying to “show some more initiative.” Marie explains her decision as follows:

I still don’t know if what I’m doing is good enough, but […] I really feel that I […] in some way I feel that I’m competent. It comes naturally to me. I mean with the patients and so on, you know. I love to be with them. They’re the ones who keep me going, they’re the reason I haven’t quit. I really enjoy working with the patients.

The above quote indicates that Marie is not fully capable of meeting the demands following the logic of care education in order to be recognized as a competent student. Even though her preoccupation with patients and with establishing patient relationships makes perfect sense within the logic of relational care, it is not sufficient within the logic of care education.

The logic of care production

The idea of active students providing care by carrying out activities that are visible also makes sense within the logic of care production. Contrary to the logic of care, the logic of care production operates with an idea of care resources and care practices as somewhat more fixed. The logic of care production places care practices within the realm of a (public) institution, which is why this logic considers care as a service embedded in professional as well as market and organizational concerns; patients’ care needs are met according to standards and with the aim of achieving “value for money.” Within the logic of care production, it therefore makes very good sense to delegate a wound specialist to this particular kind of care work to ensure that the task at hand is solved by the use of the right competencies. Seen from the viewpoint of the logic of educational care, it also makes very good sense to allocate specialized competencies to a complex case. This is also the reason that it is perfectly legitimate when the wound specialist from Stina’s clinical placement states that it is not her job to deal with patients’ bad marriages when Stina turns to her for advice on how to deal with the crisis of her patient’s wife. The logic of care production seeks to disentangle the jumble of care practices: one specialist for the wound, another for the psychological crisis.

The logic of care production can be observed in all health care sectors in the form of various efforts to provide care in cost-effective and standardized ways. An example is when student Eric explains why “his” patient has been handed over to another care team in the unit to ensure a fair distribution of “care load” based on patients’ care score. The scoring and distribution procedure is carried out in the office every morning to ensure that the workload is equally distributed among the professionals on duty. The ward office is a key location in relation to the logic of care production; it is here that the clinical care activities are planned, distributed, evaluated and documented. The working day of the nursing students begins and ends here, and during the day several hours are spent here. It could be said that the logic of care production transforms patients into texts and tasks, and nurses into clerks.

Low-skilled workers. The logic of care production is supported by hierarchical structures in health care organizations that support a distribution of professional responsibilities, duties and lines of command. What we see is that this logic transforms new nursing students into low-skilled workers instead of learners. In order to ensure not only the quality but also the quantity of care, the hospital’s care planners try to spend the resources available in the best (which in this case means “most effective”) way possible. Just like the logic of care education, the production logic divides care into “simple” and “advanced” care. New students are given simple care tasks while the advanced tasks go to the experienced professionals.
What we see is that students are handed tasks involving patient hygiene and the collection of basic information (temperature, blood pressure, pulse and blood saturation). As student Tina explains, “I got sick of them [the nurses in the unit] saying, ‘You can start by doing the morning wash’. Then they could do something else, because morning wash isn’t very exciting.” This does not happen because the logic is ill-willed, it is simply out of concern for the production. Paradoxically, the tasks categorized as “simple” by the logic of care production are the ones valued the most by the logic of care. In other words, professional complexity becomes invisible when the logic of production categorizes the task as “simple.” It is the logic of care production that causes students, who prioritize spending their time with patients, to be seen as less productive (and maybe even “problematic,” as in the case of Marie). The logic of care production makes it meaningful to “punish” students who do not engage in the business of making the unit run smoothly and in accordance with an often busy schedule. In other words, the logic of care production renders care practices that cannot be ticked off in a system of documentation less valuable care.

*Quid pro quo*. One might think that practices rooted in the logic of care production would seem worrying to the nursing preceptors, but as already indicated, the logic of production often goes hand in hand with the logic of care education:

> I usually say to them [the students] that the more they help, in quotation marks that is, the more time the daily supervisor has for guidance and for explaining things to them. Or time for them to try to do things by themselves, while the supervisor is observing. Because it usually takes a little longer for students to do things. That’s why they should try to be part of the ward. And I do think that most of them learn to adapt quite quickly, they settle in and feel they belong. But of course they are responsible for their own learning, so they need to speak up. (Preceptor Gitte)

The logic of care production induces a barter mechanism into everyday clinical care education, in that students’ work efforts are exchanged for preceptors’ educational efforts. Clinical care practices and clinical education are split into two distinctive, mutually exclusive components of practice: a zero-sum game. Lack of resources, changes to the schedule, new or complex patients in need of extra care decrease the opportunities for learning. According to the logic of care production, a good student is a student who “takes responsibility by taking her share of the ‘boring’ work and makes the ward function,” as Gitte says. Our data support the preceptor’s reflection: some students, like Hannah, quickly assimilate this logic:

> Well, you need to look for it yourself. Nobody gives you anything if you just stand in the corner. You’ve got to show some […] but of course that’s what you do when you’re interested. If you’re ready to get busy, then you automatically get to do a lot. If you don’t offer anything […] I like to be given responsibility.

Through our observations of Hannah, we learn that she is liked; the nurses and her preceptor evaluate her as competent and she is offered an attractive part-time job in the unit.

Commonly, however, the students describe the practice of delegating basic care activities to them as frustrating. Some of them refer to these tasks as “boring work,” implying that it is hard for them to identify the learning potential or care value of the tasks. Contrary to the logic of care and the logic of education, care practices related to patients’ hygiene and the observation of basic biomedical values are referred to as “slave work,” a phrase that makes sense within the logic of care production, but has no meaning within either the logic of care education or the logic of relational care.

**Discussion and conclusion**

The paper illustrates how nurse students juggle a number of different care logics that frame clinical education. Thus, this paper can be seen to contribute an alternative understanding of the experience of student stress and challenges related to clinical placement that is reported in the
existing literature. Students are given the task of balancing the diverse demands and sometimes conflicting values inherent in the various logics as part of the process of learning to care.

The paper supports existing research in identifying a dominant trend of market dynamics in contemporary health care (e.g. Bakken et al., 2002; Blom et al., 2017; Hansen and Kamp, 2019; Wrede et al., 2008). However, as pointed out, the logic of care production coexists with the logic of relational care, which seems to be a logic of great importance to students, who are in fact highly motivated by the relational aspects that this logic attaches to care practices (Holen and Lehn-Christiansen, 2017; Lehn-Christiansen and Holen, 2019). Last, but not least, the paper draws attention to the logic of care education and how it shapes not just future caregivers, but also care practices, in a way that seems underexplored in current research.

The logic of care education is, first and foremost, relevant in the exploration of students’ struggles with learning to care. However, we will argue that this logic is related to a broader professional logic that is connected to the care needs of patients, as professional knowledge shaped by experience and/or research. Within this logic, no professionals know everything and care practices per se are characterized by insecurity and the unknown. This understanding is much in line with Freidson’s (2001) concept of “the third logic.” Within this logic, patients’ care needs are defined as a professional task to which professionals work out an adequate solution. It is a logic that is supported by the organizational structures of the hospital, placing emphasis on health care professional managers, morning conferences and other kinds of professional sharing and knowledge building. However, often it is the medical profession and the logic of treatment that shapes the organizing principles and not the professions and logics related to care. In this respect, the logic of relational care and care practices being based on this is also marginalized from within, as an appendage to the dominant medical regime.

Through our analysis of the three logics of care and how they unfold and entangle, we demonstrate how students embrace and defend care practices that are based on the logic of relational care; they attempt to understand and find answers to patients’ care needs, even if they stretch beyond the prescribed task. Often, it is the relationships with patients that give students the highly desirable feeling of “making a difference” (Holen and Lehn-Christiansen, 2017; Lehn-Christiansen and Holen, 2019). However, spending time with patients and building relationships is not highly valued by the logics of care production and care education; these logics value other practices of care. Most students pick that up; they learn that professional acceptance from permanent staff comes from balancing their engagement with patients with an engagement in the daily production of care and in educational assignments – even if these have no direct relevance to the patient care they are directly involved in.

**Empathy and care needs: What is really the problem?**

As pointed out initially, students’ ability to build patient relationships and to demonstrate empathy toward patients’ care needs is problematized in current research. Our paper points to the finding that, in general, it is the conditions for forming relationships with patients, rather than students’ ability to form relationships, that pose a problem. Our analysis thus offers a different perspective than the individualizing one, as we point to the challenges inherent in clinical placements. Students face mutually conflicting demands many times each day because each of the logics carries with it its own idea of “care,” making it hard for the students to “do right.” The issue of motivation must be addressed as a complex product of these circumstances, instead of as an inner psychological quality.

Inspired by Dahl (2017) and Ceci et al. (2017), we would like to suggest a reformulation of the question of students’ empathy; maybe the problem at hand is not students’ ability to read or emphasize with patients’ care needs, but rather one related to the way that these needs can be understood and articulated in the first place. Within the logic of care, the needs of the patient are attached to the patient’s “life with disease.” In this understanding, care needs become an articulation of the distinctive and highly personal life of the patient.
Within the logic of care production, care needs are prescribed and orchestrated through standardized care “packages.” Care needs become generic and “life with disease” becomes a peripheral context of little or no relevance to professional caregivers. The understanding of care needs very much depends on the logic(s) of care prevalent in our health care institutions.

The struggle over care needs implies a struggle over care values. Different care practices are made (in)visible and (less) valuable. Our analysis points to the finding that the logic of production is quite dominant and the educational logic often works along the same lines.

On the other hand, we find it relevant to ask if the professional judgment that is represented in the logic of care education is being transformed into a logic of production. Even if marginalized, the logic of relational care is present in clinical practice as a demand from patients (Martinsen, 2000) as well as in the practices of future nurses.

Relational care is a key motivation for future caregivers (Holen and Lehn-Christiansen, 2017; Lehn-Christiansen and Holen, 2019). If clinical care education transforms this motivation into overly ambiguous professional identities, it could provide an answer to why so many newly qualified nurses leave clinical practice. And what about the people in need of care? If the professional carers of the future are trained to be more aware of care production than of identifying and meeting patients’ unpredictable and messy care needs, what will be the implications for the care they can and will provide? We predict a continuation of the development toward caring practices where nurses deal with highly specialized care, while “basic” caring is delegated to lower-skilled care workers. This can be seen as the “natural” implication of our finding that the relational aspects of care are devalued in contemporary clinical practice. However, we are left with the question of how this devaluation of relational care practices is to be understood in the light of political and educational ambitions of providing not only high-quality, but also patient-centered care.

Through the analysis, we have provided empirical insights into the entanglement and tensions between the three different logics that meet in clinical care education: the logic of relational care, the logic of care education and the logic of care production.

This research did not receive any specific grant from funding agencies in the public, commercial or not-for-profit sectors.

Note
1. In Denmark, nursing education is organized in university colleges, which are different from traditional universities. A Danish nursing degree course includes 90 clinical ECTS distributed into five clinical placements, the first being a two-week introductory stay in a hospital unit during the first month of the course. A ten-week hospital placement in the second half of the first year is followed by two ten-week placements in the second year in elderly care and psychiatric care. During the third year, there is a five-month placement in either a hospital, elderly care or psychiatric care.

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Abstract

Purpose – The purpose of this paper is twofold: to explore how gatekeepers’ ways of regulating the researchers’ access to knowledge in/about care services reflect the systemic and interpersonal values that inform Danish welfare systems’ daily workings at the street level; and also explore how the authors’ methodological experiences mirror the value-informed regulatory strategies that professionals and users themselves experience in their daily encounters in the same local practices that the authors have studied.

Design/methodology/approach – The paper takes its empirical point of departure in a multisited ethnographic field study of the management of citizens with complex problems in Danish welfare systems.

Findings – By means of Michael Lipsky’s outline of access regulation, the authors will analyze the following regulatory strategies that are identified during the fieldwork: “Gatekeepers’ sympathy and creaming,” “Queuing and delay,” and “Withdrawal of consent and ‘no resources.’” The paper suggests that trust, shared goals and sympathy seem to be key to the process of getting access.

Originality/value – Despite principles of neutrality, equal rights and access to services in welfare systems, the authors’ experiences thus tend to support other research within bureaucratic and care organizations, which has found that interpersonal relations, sympathy, dislikes, norms and values, etc., can heavily influence timely access to services, tailored information and support.

Keywords Policy, Accessibility, Bureaucracy, Thresholds, Care values, Multisited ethnography

Paper type Research paper

Introduction

Gaining access to information and knowledge is important for researchers as well as for citizens in need of help and employees in care organizations, to inform their care provision and to “make things work” on a daily basis. In this paper, we explore how our methodological experiences of gaining access to knowledge in three types of care services reflect some of the systemic and interpersonal values that inform the systems’ daily workings. By identifying three pairs of bureaucratic, regulatory strategies (Lipsky, 2010), we wish to shed light on the quantity of thresholds that need to be accessed and on the gatekeepers that ensure access to the right kind of help or information in the everyday practices of care organizations.

The paper’s empirical point of departure is a large-scale, multisited ethnographic field study of the management of citizens with complex problems in Danish welfare systems. In this study, a citizen with complex problems is defined as a person who is simultaneously in contact with the drug treatment system, employment services and the psychiatric system. Given that the municipal employment and drug treatment services and the regional psychiatric services are currently geographically, organizationally and politically separated in Denmark, the study focuses on how the regulation or provision of citizens’ access to these types of welfare systems is conditioned by different political requirements, traditional organizational characteristics and professional views of the citizen. For example, a range of common uncertainties and tensions associated with inter-system regulation of sharing...
information about a case arose during a joint, interdisciplinary meeting about the management of the case of a 37-year-old male with complex problems:

Social worker, drug treatment: Is verbal consent sufficient, or do we need a signed consent form to have this joint meeting?

Psychiatric Nurse: No, not the written one. You only need the one that is scanned into your [electronic documentation] system […]. You need to fill one out once a year.

Social worker, employment: Yes, ours accounts for the entire time he is enrolled [but] a consent form is not a blank check that allows you to do anything, even though collaboration with other actors is ticked off. Things can change, as they say […]. So, I agree that it is best if the citizens are involved every time something new comes up.

Psychiatric Nurse: and because our patients are so disturbed. [Impersonating an example of a patient] “I do not remember that I allowed you to talk to her six months ago”. They are often extremely paranoid […], so, if they feel that we talk behind their backs, they really will have reason to be paranoid.

Social worker, drug treatment: That makes good sense.

The excerpt shows how professionals from the three systems negotiate their divergent views of the importance of the citizen’s consent. The example reveals how the professionals agree that external access to information and inter-system exchange of knowledge about citizens must be formally regulated either by verbal or written consent. It also highlights that information exchange and involvement of the citizen, and others, relies on the professionals’ judgments about the citizen’s condition and their discretion about whether or not to include other relevant sources of information. Paradoxically, this took place without the presence of the citizen at the meeting – despite the fact that his psychiatric, drug and employment problems and subsequent needs for support had been assessed. This exemplifies how professionals’ views of some citizens’ complex cases can frame how they emphasize or downplay the formal requirement of the citizen’s consent to share information and involve others. In this sense, the workings of these separate, yet interconnected, welfare systems are not only framed by different legislation and an array of national and local policies, but also often rely on professionals’ judgments and diverging notions of the citizen.

The study of citizens with complex problems thus raises the question of how the organizational and professional architecture of the systems may, in fact, position the citizens in a juxtaposed situation to get help.

Yet, gatekeeping and regulation of access to services and information is important, not only for citizens in need of help, but also for employees and researchers in care organizations who either try to provide services to or study the bureaucratic management of citizens with complex problems, respectively. This issue is a traditional topic in ethnographic research on field workers’ relations to informants and gatekeeping (Bondy, 2012; Reeves, 2010). Similarly, it is a center-stage discussion in research on public organizations and bureaucracies (Lipsky, 2010; Herzfeld, 1993) that often points to the overall observation made by Michael Lipsky (2010) that, on the one hand, gatekeeping and access to welfare services are regulated by government policy at the systemic level. These policies promote regulation of resources, time, manpower and public opinion influencing the playing out of access to care. On the other hand, Lipsky’s (2010) work emphasizes how service provision and citizens’ access to care also relies on the discretionary actions of professionals. At the street level, professionals’ personal views and professional attitudes toward citizens also determine citizens’ access to benefits and frame whether collaboration with and involvement of others is relevant for the management of the case. The dynamics between the values/ideologies of different policies at the systemic level and professionals’ ideals and value-laden attitudes at the
interpersonal level are inherently bound up in the daily management of citizens at the street level (Jensen, 2015; Frank and Bjerge, 2011; Brodkin, 1997; Herzfeld, 1993). In the discretionary process, different systemic and interpersonal values can thus be emphasized or downplayed by professionals in the management of a particular case, as well as from case to case, and different regulatory strategies can either facilitate or obstruct access to care services or knowledge about care practices (Jensen, 2015; Frank and Bjerge, 2011; Brodkin, 1997; Herzfeld, 1993). Informed by Lipsky’s (2010) work, the purpose of this paper is to explore how gatekeepers’ ways of regulating the researchers’ access to knowledge, in/about these particular types of care services, reflect the systemic and interpersonal values that inform the systems’ daily workings at the street level. Moreover, we also aim to explore how our methodological experiences resemble the value-informed regulatory strategies that professionals and users themselves experience in their daily encounters in the same local practices that we have studied. By means of Lipsky’s (2010) outline of the different regulatory strategies, we will answer both issues, not by addressing them in two separate sections, but by analyzing our own and the informants’ experiences. The regulatory strategies are: “Gatekeepers’ sympathy and creaming,” “Queuing and delay” as well as “Withdrawal of consent and ‘No resources.’” These will guide the presentation of the analysis below.

**Background**

The issue of gatekeeping and regulation of information and services in care organizations is a key topic in studies of bureaucracy and public organizations (Jensen, 2015; Møller and Harrits, 2013; Frank and Bjerge, 2011; Gubrium and Holstein, 2001; Van Maanen, 1978; Brodkin, 1997). This issue is important for interrelated reasons. First, it speaks to the very nature of welfare services by shedding light on values underpinning the question of who is entitled to receive which kinds of services. Second, the workings of such service systems can make it difficult for professionals to provide services to citizens with complex problems and lead to negative consequences for citizens who do not get access to timely and tailored help (Ness et al., 2014; Hansen and Bjerge, 2017).

According to Lipsky (2010), gatekeepers’ regulation strategies encompass the time spent on accessing services (queuing arrangements, timing of services, coordination and service delay), regulation of information (withdrawal of information, service availability or tight application processes) and population differentiation. The latter can imply the institutionalization of stereotypical tendencies, which are often receptive to prejudicial attitudes among professionals, constitutive of the division of populations based on assessment of needs (triage), favoring of citizens with greater chances of benefitting from services (creaming) and professionals’ sympathy (worker bias) (Lipsky, 2010). Yet, the values of both the systemic and the interpersonal level condition the gatekeepers’ regulation of access of researchers, professionals and citizens with complex problems who require knowledge and assistance from service providers to perform their job or recover, respectively.

The systemic level is informed by historical, political and institutional frameworks, enveloping prevailing values in the organization of the welfare state, social and health care policies and laws, resources, public agendas, etc. (Lipsky, 2010). In relation to the above-mentioned three welfare systems, previous Danish research shows that different ideological views underpin these systems (Oute et al., 2015; Bjerge et al., 2016; Bjerge et al., In preparation). First, drug treatment is framed by health policies and social service policies which, respectively, frame regulatory prescription medicine and psychosocial interventions (Bjerge et al., 2016). In the latter, the user is presented as a potentially resourceful person with the ability to become responsible and self-managing (Bjerge and Nielsen, 2014; Socialministeriet, 1998), while, on the other hand, for example, the guidelines for Opiod Substitution Treatment depict drug users as citizens who are not fit to make
rational decisions. Thus, this policy frames the understanding that control measures are needed (Bjerge and Nielsen, 2014). Second, employment policies drawn up by the Ministry of Employment direct specific funds to employment projects. In employment policies, the citizen is portrayed as someone who should contribute actively to society by, for instance, documenting that she or he is actively seeking employment (Holm Vohnsen, 2017; Arbejdsmarkedsstyrelsen, 2016). Third, the Ministry of Health and the Danish Health Authority and/or the Ministry of Social Services and The National Board of Social Services are responsible for overseeing the regulation of prescription medicine, psychiatric treatment and psychosocial interventions. In Danish health care policy, a psychiatric patient is commonly seen as a weak or vulnerable person, who lacks the proper understanding and responsibility to identify with the diagnosis and comply with treatment or care (Sundhedsstyrelsen, 2007; Oute et al., 2015). In spite of political emphasis on autonomy and patients’ rights to informed consent, psychiatric patients are often regarded as someone in need of professional protection, surveillance and medical control (Oute et al., 2015).

At the interpersonal level, certain ideals and value-laden views also inform the practices of professionals that users and researchers engage with in order to gain access. In our research project, professionals are mainly social workers, teachers (and other types of educational staff), nurses, psychiatrists, managers and administrators. Their ways of managing their jobs are not only framed by laws and ideologies of the system in which they are employed but they are also related to phenomena such as professional training, prior experiences and personal values, all of which influence the strategies they deploy in interaction with other professionals, users or researchers. For instance, psychiatric policy and professional values do intersect, as professionals often identify as parental subjects whose role is to safeguard the patients who are, often, considered weak and incapable of making valid consents about their mental health without the permission of professionals (Oute, 2017). Moreover, it is well known that dually diagnosed persons with co-occurring mental illness and substance and alcohol use are often denied access to psychiatric services (Oute et al., 2018). This exclusion process originates in a professional view that these drug- and alcohol using patients are “bad” patients while mental health professionals often sympathize with and favor good patients who are perceived to be more likely to submit themselves to professionals’ categorizations and gain from professional treatment, due to the incentive of creaming patients with positive effects of treatment. However, access regulation can also be conditioned by a paternalistic professional identity in psychiatry as it often works as a framework within which professionals consider themselves obliged to control the patient’s right to determine the relevancy of the patient’s perspective on his/her health issues and consent to involve others in these issues (Oute and Bjerge, 2017; Bredahl Jacobsen, 2006). On the contrary, in psychosocial drug treatment services, professionals often establish a relationship with the citizen based on equality and trust (Frank and Bjerge, 2011; Lilly et al., 2000), understanding, for example, drug use as a social phenomenon to be handled through social reform and educational tools (O’Malley, 1999; Houborg, 2010). Therefore, there is often a notion of how “going an extra mile,” e.g. in terms of willingness to help citizens navigate other care organizations outside the drug treatment system, is essential to the work these professionals do (Bjerge and Bjerregaard, 2017; Bjerge et al., forthcoming). In employment services, the main task is to get unemployed citizens to obtain employment or participate in courses to make citizens become available for employment, and the field is highly regulated in terms of who receives what at what time based on which criteria etc. Despite many individual professional’s ideals, incentives in the form of economic sanctions – and thereby control of citizens activities – are the measures most commonly used (or at least feared by citizens), and the professional’s individual space of discretion is often rather limited (Bjerge et al., Forthcoming; Bjerge et al., in preparation). Taken together, these forms of systemic frameworks and interpersonal attitudes rely on
different values that inform the regulation of access to care, collaboration and knowledge across the geographically and organizationally separated systems (Lipsky, 2010; Brodkin, 1997). However, few ethnographic studies have scrutinized the dialectics between the systemic and interpersonal values/ideologies that condition gatekeepers’ regulation of access to care and knowledge in the above-mentioned service systems.

**Methods and materials**

Our empirical data stem from a large, qualitative study, examining the management of citizens with complex problems (Bjerge et al., In preperation; Christensen, 2017). An adequate, official definition of what counts as a “complex problem” does not exist. However, in recent Danish policies, the term is being used repeatedly, and is often broadly defined in the following way:

> [...] a complex problem consists of multiple problems present at the same time [...] In many cases [e.g.] the misuse of drugs will not be reduced if the user’s mental illness is not taken care of. At the same time, misuse of drugs can obstruct the kind of treatment that is provided to patients who only have one problem. (Socialministeriet and Indenrigsministeriet, 2016, p. 13)

Thus, complex problems can entail numerous elements such as drug use, mental illness, homelessness, a criminal record, unemployment, severe health problems, etc., all related to different types of welfare organizations such as drug treatment centers, psychiatric wards, shelters, the prison system, employment services, hospitals, etc. As noted above, our project focuses on citizens who are enrolled in drug treatment, psychiatry and employment services, and investigates how these different problems necessitate different types of services with different administrative tools, different professional approaches and different types of national and local policies. Taken together, this composition of care organizations, professional approaches and policies constitutes a complex web of overlapping, and potentially conflicting, ways of managing and helping citizens. The analysis reflects on our experiences of gaining access to care systems during fieldwork conducted between the Autumn of 2015 and the Summer of 2017.

Due to the complex nature of the study, we draw on a multisited ethnographic approach (Marcus, 1998; Shore et al., 2011). Rather than relying on the classic notion of the field as a single site, the field is perceived as fluid. This means that the field can span from everyday activities, “through local institutions, to national and international agencies and governing bodies” (Shore et al., 2011, pp. 27-28). Thus, the field of study transgresses time and space and relies on empirical materials drawn from multiple sites. In this line of thought, the study investigates how care services targeting citizens with complex problems are articulated and enacted at multiple sites and how these services are interpreted and put to work in conjunction with an array of local, social and institutional processes. The circulation of policies and professional objectives that constitute how the political construction of the citizen with complex problems, and the ways in which he or she should be managed at the street level are contested by, for instance, professional identities or value-laden attitudes toward the citizen, in practice and transformed across time and space. Hence, the empirical materials and our reflections on access regulation from the fieldwork can be seen as an assemblage of the political-practical configuration of the management of access in the contexts of care for citizens with complex problems.

**Sites**

The management of citizens with complex problems was investigated in all of the aforementioned types of welfare institutions at three geographical sites: a municipality in the capital area (A) and two municipalities located in the area of two large provincial cities (B, C). These sites were selected because they differ significantly in size, but also have a
considerable number of citizens with complex problems and offer the three forms of welfare services. Such a selection of settings enabled us to identify a broad and varied selection of citizens, professionals and institutional sites that were conducive to the attempt to access services while also requiring that we worked closely with gatekeepers and negotiated access across nine sites.

**Materials**

To gain as differentiated and detailed knowledge as possible about how access to the field sites mirrors the often contradictory frameworks of, and understandings within, welfare service systems, the overall study relies on several types of data (Holstein and Gubrium, 2008; Agar, 1987). By means of following intertextual references, we collected approximately 8,000 pages of national and local policy documents framing practices in the above welfare systems (Nygaard-Christensen *et al.*, 2018). Moreover, the first author negotiated access to collect citizens’ records from each of the systems in all of the geographical sites; i.e. 45 (3 × 3 × 5) records. Eventually, a total of 30 records consisting of approximately 3,500 pages was collected as the research team failed to gain access to records from the psychiatric system in site B and employment services in site A and B (Oute *et al.*, in preparation). Using an interview guide covering three themes (policies in practice; daily management of citizens and navigating requirements; and reflections on future possibilities for action and change) derived from the overall research issue, the members of the research team produced a total of 69 and 11 formal, semi-structured interviews with professionals and citizens, respectively. Even though the interviewees were asked specific questions referring to the main themes from the interview guide, the semi-structured approach also allowed the interviews to follow unexpected routes and cover new and more wide-ranging themes. Data from records and interviews were collected during the 14 months of fieldwork in two employment-oriented workshops for citizens with complex problems (A, B) and a temporary, employment-oriented housing facility for dually diagnosed individuals (C). In these settings, the researchers observed daily (and nightly) interactions among professionals and citizens with complex problems, participated in staff meetings, shift hand-overs, joint collaborative meetings between case workers, social workers, nurses and occupational therapists (OTs) from the different municipal subsystems and the regional psychiatric treatment system (Nygaard-Christensen *et al.*, 2018; Bjerge *et al.*, forthcoming). Finally, text messages from, and e-mail correspondences with, gatekeepers about our access to the field sites were included in the data set. Taken together, the participatory observations and the, at times, unexpected trajectories of the semi-structured interviews provided the researchers with a deeper understanding of the complications of the everyday management of citizens with complex problems. For instance, they revealed a strong resemblance between the researchers’ and professionals’ frustrations related to obtaining consent and sharing information across the gaps between systems, inspiring this paper’s analytical focus on the strategies that were used to facilitate or obstruct access to knowledge and help in/across the systems.

**Gatekeepers’ regulatory strategies**

The data from the fieldwork showed that the gatekeepers’ value-laden articulations concerning accessibility did not only signal the individual’s personal values, but rather they reflected a range of strategies, resembling the common forms of regulation as pointed to by Lipsky (2010). In particular, gatekeepers used three sets of strategies that either facilitated or obstructed our own and the informants’ access to knowledge and care services. Access was facilitated by gatekeepers who sympathized with and favored (creaming) our endeavor, whereas our failed attempts to gain access to information or care were hampered by professionals’ somewhat uniform ways of regulating our access by way of using queuing
and delay arrangements and strategies such as withdrawal of consent and no resources. These strategies are outlined below.

**Gatekeepers’ sympathy and creaming**

Paraphrasing Lipsky’s idea that street-level bureaucrats tend to favor citizens with greater chances of benefitting from services as well as those citizens with whom they sympathize, we experienced how, in particular, the latter was key for gaining access. Given the complex organization of the welfare systems, our access to information in them was negotiated with multiple gatekeepers at several geographical locations. As also experienced by our informants, the systemic level and interpersonal precision of the entry points were characteristic of our efforts to access each of the systems. In order to identify a gatekeeper who understood and favored our wish to gain access, a common lack of clarity about how and where to do so required that the research group reflected on how and from whom to get access to do the fieldwork in the systems. Due to our lack of experience with accessing multiple field sites at the same time, we spent a lot of time reflecting on what level of the municipal management to approach to pitch our project and who to ask for permission to access the systems. This is described in a field note written up at an early stage of the fieldwork:

> Our project spans several units of support, as the citizens’ problems can involve employment services, social services, and drug/alcohol rehabilitation services. The larger municipalities have several managerial levels and the frontline staff that work with the citizen’s problems are often at “the bottom” of several managerial layers. Should we only ask permission from the frontline staff’s immediate managers or also the managers of the entire centres? Or should we ask the directors of the entire administrations? We ended up using different strategies and starting off at different levels. (field note, October 2015)

The research team continually considered where and to whom, in the organizational structure, our requests for access should be directed. Based on who we knew from previous work and the present field study, we used different strategies to locate a gatekeeper, whose position was constituted by what we thought of as the “right” interpersonal and systemic properties: a person who would not only trust the researchers but also find the study significant enough to collaborate about it and, at the same time, had the formal authority and position in the systems to grant us access to make enquiries in their field of practice. Throughout the entire fieldwork, we informally talked to, interviewed or corresponded with a range of different professionals from each system in order to identify such gatekeeper(s).

These experiences also resemble the experiences and considerations pointed out by several citizens with complex problems, who participated in the study. For example, it came clear in the way a young woman addressed this issue:

> Like I said, I think that the system has a hell of a lot of cracks in it, because you have to get the right case worker to get the right output. (woman, 20 years old)

This young woman has been in contact with all three types of welfare systems over the course of more than a decade. She explains that the workings of the systems are somewhat incoherent. By expressing frustration, she articulates a potential risk of spending a lot of time being stuck in the cracks of the system if one does not “get the right case worker.” By the right case worker, she refers to a professional who would be sympathetic to her situation, willing to act upon it and, at the same time, be knowledgeable about where to gain access to information and services.

Similarly, our process of trying to gain access to the fields was in most cases delayed and time-consuming. In some cases, the amount of time spent on gaining access was, however, significantly reduced, depending on the gatekeeper’s position and approval of our work.
For instance, our initial access to conduct field work in municipality “C” was negotiated with a high-ranking gatekeeper in a substance use treatment center, who was in a position to approve the conduct of the study in the municipality. This site was chosen as the researchers knew the area from previous research whereas the particular access point was chosen because a member of the research team had previously worked with this person who was considered likely to sympathize with the researchers and our endeavor. First, we established contact with the gatekeeper, and oral and written information about the study was subsequently given. Then, the gatekeeper organized a joint meeting among ten key social workers and educational staff, all of whom were employed in the drug treatment and employment systems. These professionals were selected by the gatekeeper, because they were considered especially knowledgeable about the study population. The gatekeeper’s way of managing our wish to access the municipal systems coincided with their official collaborative approach to working with citizens in the municipality – called “relational coordination” – which, time and time again, was highlighted by local gatekeepers and employees across the field sites. One social worker from the employment system articulated it as follows:

   Here [in our municipality], it has been decided that we must collaborate using relational coordination. This is a small town, so it works really well because we all know each other. (field note, May 2016)

Thus, the fact that several professionals were able to attend the meeting at the same time can signal the political articulation of this way of managing the complexity of the different professional actors’ views within the different municipal (and at times regional) systems. The negotiation between different perspectives and the joint construction of adequate responses to the citizens’ complex cases often required that the professionals either tinkered with fitting the services to fit the individual case or tinkered with the interpretation of the individual to fit the available services (Nygaard-Christensen et al., 2018). This process, making the constantly changing case and the available services fit, emerged during a joint meeting involving several employees from across the relevant sectors who were involved in managing the particular case of a citizen called Marianne. The meeting was led by a high-ranking manager who, in line with the rest of the involved social workers, arguably sympathized with Marianne and articulated a strong belief that their efforts would lead to a positive transformation of Marianne’s situation. In this sense, sympathy and creaming might have framed a view that the joint meeting offered an opportunity for the professionals to scope and agree on which resources were available for them to craft an adequate response to her complex situation (Nygaard-Christensen et al., 2018). In an interview conducted after the joint meeting, a social worker, Lise, commented, “Sometimes we need to confirm that we’re all going in the same direction, because if we professionals can’t figure it out […] I mean, it’s hard enough for citizens to understand the system.” As with collaboration between the actors involved with managing Marianne’s case, the collaborative approach also enabled the professionals’ joint approval of our access to their system, given that we, as researchers, were allowed to ask permission to and discuss the possibilities of conducting the study in their fields of practice. Yet, the professionals’ joint consent to this and their way of coordinating our request to do research not only paved the way for our access to municipal and regional institutions, this framework also corresponded with the overall focus of the research project. Hence, our wish to study the dynamics between policies and practical concerns in these specific systems can be seen as creaming as the researchers’ interest in inter-systemic collaboration about citizens with complex problems reflects an implicit recognition of their joint efforts to help citizens with complex problems. However, this could also have been facilitated by the gatekeeper, who may already have trusted and had sympathy for the researchers, based on previous experience. Despite the fact that these interpersonal circumstances may have influenced the gatekeeper’s willingness to invite us
to talk to the employees about the project, the rather rapid process of gaining access might also signal concurrence between the aims of the study and a key policy for the professional management of citizens in that particular municipality in which the gatekeeper was obliged to abide. This suggests that the gatekeeper might have sympathized with the researchers but perhaps more importantly the concurrence points to a case of creaming. That is that the gatekeeper and the practitioners that we encountered during the initial meeting favored collaboration with the researchers due to a perceived greater chance of reciprocally benefitting from the research conducted into their systems that potentially would reflect positively on the professionals’ practices. As we shall see below, our efforts to access other parts of the systems highlight how professionals also regulated access to these systems in cases where the project seemingly did not match their political-practical ideals of good practice. In those cases, our access was impeded using several forms of queuing strategies that encompassed prolonged (if any) responses to phone calls or emails, time regulation (delay), meetings being postponed and contact information being withheld (information withdrawal).

Queuing and delay
As with gatekeeper sympathy and creaming, queuing and delay strategies are not only reflections of the gatekeeper’s personal preferences and ideals but also signal a broader set of political requirements and organizational characteristics. These strategies often emerged in situations in which we sought information about how to get in contact with particularly knowledgeable professionals working with citizens with complex problems. For example, to make contact with a manager, we had to go through another employment manager. This frustrating and time-consuming situation is written up in the following field note:

In the municipality [“B”], I sought access via a gatekeeper [at the drug treatment center] who knew a new manager in the Employment service system who could help me into one of the services offered to citizens with complex problems. Over the telephone, another manager from the employment system tells me about a service that offers support for citizens with complex problems that employment caseworkers do not know how else to support. However, I do not get the direct contact information for the manager of this service as the employment manager will not provide me with the direct information and says that the contact has to go through her. Despite repeated phone calls to her over several months, I am not given this information. It ends up taking about 3 months from the first contact on the 3rd of December 2015 until the manager sends me an email the 24th of February 2016 inviting me to come and present the project to him. At this point, it still remains uncertain whether he or his employees will allow me to do fieldwork there. Luckily we are granted access, and the fieldworker can, after a meeting for all employees in the service, finally start conducting the field work in April 2016. (Field note)

The fact that the first manager held back information can be seen as a form of queuing arrangement or service delay functioning as a form of regulation of the pathway, not only between the drug treatment and employment service systems, but also as a barrier within the employment service system itself which hindered our access to knowledge about the appropriate service. The example does, however, raise new questions about the framework for and understanding of the organization of daily practice, in the managers’ initial way of delaying our entry. What does the fact that the manager from the employment system held back information about other professional actors and the accessibility to other systems reflect? Several options seem possible. Does the example reflect a municipal or national drug policy framing the understanding that control measures are needed to protect vulnerable citizens? Or could judgmental attitudes about citizens with complex problems frame an understanding of a privileged administrative practice for professionals, in which they maintain a position to regulate access to information about citizens with complex problems which has been described in previous studies (Ness et al., 2014; Hansen and Bjorge, 2017)?
Or does the above mirror a way of trying to be a helpful and effective gatekeeper who does not pass anybody on to the next person before being absolutely certain about who the right person might be? Time and time again, these options seemed possible in a large range of other examples, where the researchers’ emails and phone calls were ignored or when we were asked to wait. Yet, examples like these suggest that barriers were put in place at the entry points of the systems, as well as in the interpersonal relations within the welfare institutions. Thus, such experiences are exemplary for the above-mentioned issues of not getting the right caseworker to be able to proceed and/or of delayed access to the information needed.

This was accentuated during an informal conversation with a citizen from municipality “A.” With constructive facilitation and help from a local middle manager, who, arguably, sympathized with the researcher and the aim of the study, the researcher had formally asked the citizen for his consent to participate and let the researchers use his record as documentation in the study. The citizen, a 27-year-old man with a several year-long treatment career for his mental health and substance use problems, stated that:

“I would be glad to help you, man! The systems do not talk together at all. That is a huge problem. So, of course you can see my record. I cannot do anything and it really ruins your life when you cannot get help.” (field note, August, 2017)

During the conversation about his consent, the man pointed out that he felt trapped and powerless when he was either told to wait for his turn, put on hold or had his case referred on to a new manager, who often wanted the same or additional information about why he asked for help. He described how this form of queuing or prolonged service delay made him feel ridiculed, frustrated and could even worsen his condition when his access to help was put on hold, further delayed or even rejected. This suggests that citizens with complex problems, professionals and/or researchers are dependent on gatekeepers in the right position to navigate the fragmented systems because it is likely that one is ignorant about, and possibly bewildered and made powerless and passive by the complex pathways into and between the systems – whether one tries to pilot them to get help or access to professional collaboration or data.

Our efforts to access the psychiatric system at the geographical site of “B” were particularly exemplary of these ways of regulating access by using queuing arrangements. Here, our interactions with the professionals highlighted how access was regulated using the political requirement of informed consent, but they also suggested how value-laden views at the interpersonal level could also frame the delay:

“Today I was going to see “Kirsten”, a nurse at a project, bridging psychiatric and drug treatment. As we already knew each other and shared interests, I asked her to do an interview. We also planned to have an informal talk about how we could gain access to patient records and to interview more of her colleagues. A few hours before the meeting, I received a cancellation by email: “I just talked to my boss about our appointment today. He wants to run it through the ward management [who already knew me from my time as a nurse practitioner and my previous studies of involvement of patients and relatives in psychiatry] in relation to [our right to be] sharing information from patients’ records.” (field note, October 2016)

The manager’s suggestion that the interview with the nurse might lead to a violation of Danish Health Law (Sundhedsministeriet, 2016) signals a delay strategy, despite the fact that the nurse had willingly consented to talk to the researcher. It begs the question as to why the manager rejected our request to talk to the nurse about their work and about who one could approach to gain access to patients’ records. On the one hand, the manager might be unsure if the project aim would lead to a breach of confidentiality and data protection, according to Danish Health Law (Sundhedsministeriet, 2016). In this case, the example highlights the use of a strategy of regulating access in the form of queuing and withholding
information, in accordance with the individual patient’s rights. On the other hand, it also begs the question as to whether the researcher, who had previously conducted and published studies on social issues in psychiatry and worked as a practitioner in the same institution, was in bad standing with the management (Lipsky, 2010)? Does the manager’s cancellation signal that their political and professional framework for good practice was at odds with the management’s expectation of the researchers’ focus? If so, does it imply that the management was not interested in letting social scientists investigate practices within psychiatry, where medical professionals historically have worked hard to uphold professional authority (Miller and Rose, 1986; Rowe et al., 2011)? In this case, the regulation could also reflect a strategy of delay due to lack of sympathy for citizens (or patients) with complex problems, such as unemployment and co-occurring mental illness and drug – or alcohol use. As pointed out in previous welfare research and ethnographic research in psychiatry, the professionals’ temporary rejection of our access to study citizens with complex problems resembles the exclusion of researchers and dually diagnosed people, who are often believed not to identify with health care professional authority and accentuate the positive effects of the system representatives’ practices (Lipsky, 2010; Oute, 2017; Oute and Bjerge, 2017). Little information was given, however, regarding the manager’s personal motivations and reasons for delaying the appointment and overruling the nurse’s openness and judgment. Resembling findings from recent research on patient participation and caregiver involvement in psychiatric treatment (Glasdam and Oute, 2018; Priestley and Mcpherson, 2016), the manager’s judgment and the cancellation of the appointment thus highlights that Danish Health Law (Sundhedsministeriet, 2016) is often actively used as a means to delay or entirely block researchers’, relatives’ and professionals’ access to help and/or information within psychiatric treatment organizations.

In response to the initial denial of the appointment with the nurse, the researcher suggested that he could come by the ward as planned and give oral and written information about the study to the manager in order to ensure adherence to Danish Health Law. Shortly after, the researcher received the following e-mail, stating that:

[…] he [her boss] is not available today and he wants to have a green light from the ward management before doing anything. As an alternative, we could talk after working hours. He is wondering why I booked an interview with you during work hours, as it is not related to our work here, and therefore he wants the go-ahead from the management before it can be arranged. But I am thinking that it couldn’t be a problem if it is after working hours. (field note, October 2016)

The e-mail suggests that the nurse is placed in a Catch-22 situation. On the one hand, her boss requires “a green light from the ward management” and views the project as being unrelated to the work. On the other hand, her suggestion to “talk after working hours” articulates a clear interest in cooperating about the project and helping us to get access to information. The fact that our request positioned her in a situation in which she could be subjected to criticism (i.e. harm) by her manager if she provided the research team with information meant that the situation signaled the possibility of unethical conduct on behalf of the researcher if he engaged further with the nurse. As divergent views have to be managed within the psychiatric system, the example thus puts on display how external access to information is delayed and put on hold by emphasizing a political requirement. As we shall see below, this coincides with a well-known protective strategy for professionals to safeguard knowledge about weak and vulnerable patients and information about their condition (Priestley and Mcpherson, 2016; Oute, 2017).

Withdrawal of consent and “no resources”
As with the researchers and the participating citizens with complex problems, the professionals often felt frustrated and disempowered by the inter-systemic values and
barriers and the subsequent time-consuming processes of gaining access to knowledge in order to provide adequate and coherent services. This became clear during an interview with a nurse from city of “B” who was employed at a project aiming to bridge psychiatric and drug treatment for patients in need of help from both systems:

Yes, it takes a hell of a lot of time [to gain access to and share information across the systems]. The problem is that we cannot see that each of us might have received consent [from the patient]. We often sit there, and you do not know if the person from the other system has the information you need. There is really no connection between the systems. (Psychiatric nurse)

As suggested above, the nurse also articulates that collaboration and access to information between the three types of welfare systems can be disrupted by the protective use of the requirement of consent. In this sense, she points to a risk of disconnecting the systems, because one does not easily get the “information that you need” if the citizen has not given his or her consent to share information, as consent to share information is pivotal to regulating professionals’ or researchers’ access to information and collaboration with the systems’ representatives (Oute, 2017).

Given that our requests to retrieve formal information through the above-mentioned nurse could position her at risk of harm, a formal request to collaborate was directed to the management in order to understand their reasons for their above-mentioned refusal. The formal request included the project protocol and specified procedures complying with legal requirements for patients’ consent, research ethical standards in the health field and information about data protection. In the request, we asked for access to collaborate with the psychiatric professionals as follows: for psychiatric professionals to identify eight to ten patients fitting the inclusion criteria and ask them for their informed consent to access their records on site, and to interview professionals during working hours about their management of citizens.

Subsequently, we received a formal e-mail from a local high-level manager, rejecting the possibility of collaborating and getting access to patient records in the system:

I have discussed the case with our lawyer. We cannot allow researchers to have access to the patients’ electronic records. If you have received informed consent from the patient or a vicarious consent from the Danish Health Authority [which previously had the formal authority to grant legal access to retrieve information from records to be used in research projects] and a permit from the Danish Data Protection Agency, we can provide information from the patient’s record. This requires that we know very specifically what information is needed. We can only provide information about the things to which the patient has specifically consented. (e-mail correspondence, Psychiatric Manager)

This correspondence mirrors a common way of obstructing access that, on several occasions, was identified among psychiatric professionals at all of the three geographical sites. First, the fact that the manager “discussed the case with [the] lawyer” articulates a strategy of withdrawing information by referring to requirements set out in Danish Health Law (Sundhedsministeriet, 2016). This protective strategy involves the manager proposing that the researchers must spend several months meeting a range of legal requirements about patients’ consent and data protection in order to apply to the Danish Patient Safety Authority for vicarious consent (Sundhedsministeriet, 2016). Given that these requirements had already been addressed and met in the initial, formal request and in the protocol, the manager’s claim is exacerbated by stating that “we can only provide information about the things to which the patient has specifically consented” and, thereby, rhetorically ignoring the request to provide help with identifying patients for the study. In doing so, the manager paradoxically limits the opportunity to gain access by reasoning that they can neither allow researchers to have access to the patients’ consent nor to their records because the researchers have failed to apply for provision of “information about the things to which the patient specifically has consented.” This raises the question as to
why the manager withdrew the opportunity to get informed consent and thereby blocked our access to information. Several options seemed possible.

Do the manager’s actions reflect a common psychiatric policy framing the outlook that control measures are needed in order to protect weak and vulnerable patients from the researcher, as pointed out in previous qualitative, psychiatric research (Juritzen et al., 2011)? Or, could the common perception of patients as being weak and vulnerable frame a value-laden understanding of a privileged administrative practice for professionals in which they uphold their legitimate position to regulate access to information on behalf of the patient (Hansen and Bjerge, 2017; Ness et al., 2014; Oute, 2017)? Or, do the manager’s discretionary actions mirror an idealized way of being an alert and law-abiding civil servant who wants to emphasize patients’ legal right to confidentially and consent, and, if so, why were the researchers not given the opportunity to ask patients for their consent? These questions were elucidated by a psychiatric professional who articulated some connections between the withdrawal of the citizens’ consent and professionals’ reasons for involving others:

Interviewer: who decides the timing [of involving others in psychiatric treatment]? Is it you, your colleagues or the patient?

Psychologist: If it is possible, it is discussed with the patient. Based on what they describe, we evaluate it at our interdisciplinary conference in which psychiatrists, psychologists and nurses take part. Then, we decide what would be relevant right now. And then we make contact with their therapist if they are already in contact with the drug treatment centre. [...] But of course, the citizen has to consent to us making contact, but when we have his/her consent, we try to figure out how their treatment is going and what they think.

Here, the psychologist talks about how the citizen’s consent is seen as a requirement when the psychiatric professionals have decided that “it is relevant” to invite the drug treatment therapist to support the psychiatric treatment. The professionals relied on a protective interpretation of the requirement of the patients’ consent that implied that the patient is required to accept or comply with the treatment plan as proposed by the professionals (cf. Oute, 2017). As indicated above, this protective approach suggests that the consent can be used as a regulatory strategy to ensure that professionals can withdraw information or not share it with others until the professionals consider information exchange and collaboration to be favorable and timely in relation to the psychiatric treatment plan. This example suggests that the aforementioned manager’s response to our request to ask a small number of patients for their consent could have been framed by an equivalent custodial logic, where professionals see themselves as the experts who, without the involvement of the patient, are to decide if, when and how information exchange and collaboration is relevant. Thus, the combination of the legal requirement of the patient’s consent and the professionals’ protective values, arguably framed the professionals’ subsequent requirement for the researchers to apply for a vicarious consent from the Danish Patient Safety Authority (and not the Danish Health Authority as stated in the above e-mail from the manager). By contrast to the gatekeepers who sympathized with and favored inter-systemic and intra-systemic collaboration, the manager’s proposal can be seen as a value-laden, yet meaningful strategy, not only to delay our access to information, but to entirely withhold information about the patients’ mental health condition and professionals’ practices. This, however, suggests that the denial of access could have been framed by the fact that the researchers’ interest in inter-systemic collaboration did not fit well with the custodial logic that was often identified at the entrance point to the psychiatric systems. Time and time again, this access regulation strategy was used when professionals argued that they could not participate in collaboration with the researchers or with other systems’ representatives because they lacked resources (e.g. lacked time or staff). In fact, this
strategy was also emphasized in the final paragraph of the above-mentioned e-mail, where the manager from the psychiatric system blocked our access to ask patients for their informed consent. The manager did so by adding that getting informed consent from patients “requires that we have the necessary resources to locate that information – and currently, that is somewhat difficult.” As encountered in several other cases throughout the project, this manager’s discourse implicitly neglects the possibility of collaborating about obtaining informed consent from patients to access their records, by making it clear that all of the above requires “the necessary resources,” which are currently unavailable.

In response to the manager’s proposal, the researchers applied to the Danish Patient Safety Authority (a newly formed division of the former Danish Health Authority that now has the formal authority to grant legal access to retrieve information from records to be used in research projects) for a vicarious consent to access 15 patients’ records for the purposes of the study on May 2, 2017. After providing the Danish Patient Safety Authority with supplementary information about the target group and particular information sought for on August 8, 2017, the researchers received the following formal, e-mail rejection of the application on December 12, 2017:

Based on the present [application], the Danish Patient Safety Authority has decided that there is patient contact during the semi-structured interviews with the users. Therefore, there is a direct possibility to inform the patient about the project and to let the patient consider if the patient is willing to consent to recorded information being provided for the purposes of the research project. The Danish Patient Safety Authority makes the assertion that oral information about the study should be supplied with short, written information [for layman] about the project, and that the involvement of the patients cannot be seen as a hindrance for the completion of the study.

The rejection of the formal application to access information from patients’ records thus reflects a paradox. Whereas the Danish Patient Safety Authority seems to emphasize the ideal that patients themselves are given the opportunity to consent to participating and allowing the researchers to access their recorded information, the psychiatric professionals tend to emphasize the ideal of regulating access to the patients and their information using a protective strategy. This, paradoxically, not only suggests the requirement of informed consent is politically idealized, but it also suggests that intra-systemic, professional values frame how professionals often limit researchers’ and others’ possibilities of attaining patients’ consent to access their information.

However, this strategy emerged in a variety of both formal as well as informal ways across several geographical and institutional sites during the fieldwork. For example, one psychiatrist from site “B” explained that “I figure that my time is best used treating patients’ illnesses rather that talking to teachers and case workers in the municipality” (Psychiatrist, field note, March 2017). Similarly, when we discussed the early stages of our negotiation about access to citizens’ records in site “A,” the field workers were told that “There was too much going on and we did not have the time” (Case worker, field note, August, 2016). During the fieldwork, our informants from the regional psychiatry service at site “A” and “B” also provided some evidence that they encountered similar articulations. For instance, a middle manager from a drug treatment setting kept telling the researcher that “it is impossible to dance [i.e. a metaphor for collaboration] with people from psychiatry – everybody knows that they are busy doing their own thing” (field note, April 2016). Similar articulations also emerged throughout a range of meetings and interviews in the same settings. By using equivalent descriptors, such as “rigidity,” the informants referred to a widespread belief that their social tango was characterized by a lack of reciprocity which previously has been described as a lack of conceptual common ground in dual diagnosis research (Davidson and White, 2007). By doing so, the informants suggested that psychiatric professionals use the argument of “no resources” as a means to withdraw information and disrupt collaboration between drug treatment and psychiatry. Similarly, a frustrated portrayal of delay
arrangements and arguments of no resources were also presented by a social worker from the regional psychiatry department, who stated that “it is really difficult to work with [some] drug treatment-oriented housing facilities, as we are told to wait if they say that they have no available places right now. Then, we have to keep patients here for a long time, because we cannot just put them out on the street after a long treatment period” (field note, August, 2016). This suggests that these strategies are used, not only in psychiatric institutions but across several of the welfare systems that we entered during the study. Repeatedly, the strategy of referring to there being “no necessary resources available” was experienced after we had gained formal access to a given center: the most time-consuming experiences were in city of “B.” The research team had quickly gained access to a center because two of the researchers had previously worked with the manager and co-manager. The managers expressed their sympathy toward the research project. As part of the project, the employees at the center had promised to help identify users for interviews and ask them for their consent to read these users’ individual records. But, despite the fact that immediate formal access was provided, it took us more than a year of frequently visiting and contacting the center to follow up on the process. Although users were regularly absent from their appointments with professionals, the employees argued that there was “scarce time” to identity the citizens and that meant that the researchers were only put in contact with five users. This suggests that “going an extra mile” for someone and adding to their workload by helping researchers was not a priority within the professional framework of a busy working day. On the one hand, this suggests that the professionals were working hard to provide timely services to citizens and that the professionals experienced that they had limited resources available for them to participate and collaborate with the researchers and others. On the other hand, this also brings to the fore that the very notion of limited resources is often used as regulatory strategy. The professionals’ use of this strategy suggests that it reduces the interference of others in their work and diminishes the use of collaborative measures that are not immediately favorable for the professionals despite collaboration being considered a virtue in order to close systemic gaps, share knowledge and provide more coherent and tailored services to citizens with complex problems.

Discussion and concluding remarks
This paper shows how gatekeepers’ ways of regulating the researchers’ access to knowledge in/about particular types of care services reflect regulatory strategies that professionals and citizens themselves experience in the daily workings of the systems. As pointed to, this is hardly breaking news as field workers’ relations to informants and gatekeeping are common topics in ethnographic research (Bondy, 2012; Reeves, 2010). However, this paper’s contribution is twofold. First, it adds to the literature by analyzing how our first hand experiences of trying to gain access to information and data provided us with important insights in relation to understanding the nature of our object of study: professionals’ and users’ experiences of the bureaucratic management of citizens with complex problems. Second, it also contributes to ethnographic work on gatekeeping and field relations by casting light on how certain political and professional values underpin access to care services. But in spite of the similarities between the political and professional frameworks, constitutive of our access to the same services, it is important to bear in mind that there is, at least, one important difference between our experiences and those of our informants. That is, of course, that we were allowed access to the field based on their sympathy, good will and interest in the project, whereas citizens with complex problems and professionals have legal rights to support and information. Another difference is that consequences of being subjected to regulatory strategies such as queuing, time regulation and information withdrawal included more work, frustrations, revising our time line, etc., and the possibility that we would have had to give up our project, had we not been met with
sympathy and interest from most of our informants. As suggested above, the consequences of being subjected to regulatory strategies as a citizen with complex problems can potentially be much more dramatic and devastating, resulting from the incapacity of the systems to provide timely access to tailored help, professionals' lack of awareness about available resources for support, and/or willingness to provide help and support due to stereotypes or protective attitudes toward the citizen (Møller and Harris, 2013; Jensen, 2015; Brodkin, 1997; Lipsky, 2010; Van Maanen, 1978; Gubrium and Holstein, 2001).

Although the use of regulatory strategies seems to be a generic trait of welfare organizations, our study contributed to this literature by elucidating a common distinction about the conditionality of accessibility and regulation in the care organizations involved. This distinction refers to how access to knowledge and service provision is conditioned not only by the divergent political ideologies across the welfare systems but also by the, at times, conflicting values and understandings of the citizens which, in part, are shaped by our or the professionals' social background and professional socialization (habitus) (cf. Bourdieu, 1986). For example, employees in the medically dominated psychiatric field could be reluctant to invite social scientists, because psychiatric professionals' lack of conceptual common ground between medical and ethnographic research could underpin misunderstandings of the possible purpose and use of the research project (Davidson and White, 2007). Moreover, the ideals for ethnographically sound research in medical fields (particularly psychiatry) also rely heavily on the long-standing paternalistic view of patients as weak and inept in conjunction with the legal-ethical requirement that participants must be considered in a proper state of mind to be able to make a valid consent to partake in a medical trial (Oute, 2017). This differs from the more processual and reflexive nature of ethnographic research ethics, including the ideals of listening to marginalized individuals' voices (Hoeyer et al., 2005). In this respect, our research practice and attempts to gain access could be interpreted as unethical from a medical point of view. In line with previous research, this suggests why medical ethics were used to justify regulation of access to information in the psychiatric field (Hoeyer, 2007). Yet, it also seems feasible that the managers' knowledge about previous social studies in psychiatry and previous researchers' unethical conduct simply could have caused mistrust and suspicion about the research agenda. This could have led to the decision to block our access in order to avoid the risk of having their already socially contested professional practices being the subject of critique. By contrast, some of our failed attempts to get access were experienced while trying to access to the employment and drug treatment services. Especially, we experienced a higher degree of success in our efforts to enter the municipal drug treatment systems. Historically, the drug field has been open to social researchers. Our process of gaining access perhaps also signals an alignment between the professionals' relational approach and good interpersonal relations between the researchers and the gatekeepers. In relation to the employment system, we experienced a similar interest in our project and much openness toward helping us to gain access amongst the professionals. However, a rather bureaucratic and strict legal set-up of this system (due to economic sanctions) at the systemic level made access to some types of information difficult. Altogether, trust, shared goals and sympathy seemed to be key to our process of getting access. However, the "good will" of many of our informants was sometimes hindered by the systemic set-up of the different systems. Despite principles of neutrality, equal rights and access to services in welfare systems (Weber et al., 2013), our experiences thus tend to support research within bureaucratic and care organizations, which points to interpersonal relations, sympathy, dislikes, norms and values, etc., heavily influencing timely access to services, tailored information and support. Yet, this seemingly trivial insight calls into question whether, how or to what extent the informal values and personal preferences that often inform street-level bureaucrats' discretionary actions
might outweigh political requirements and users’ legal rights in care organizations? If so, how do professionals’ discretionary actions align with practices that support recovery in citizens with complex problems? This paper thus suggests that there is a need to develop a deeper understanding of how professionals and citizens with complex problems work creatively to balance personal or professional values with the need to meet diverging requirements at the thresholds of the systems. This implies that more research is needed to gain a clearer picture of the kind of work in which citizens and professionals actively engage in order to provide timely and tailored help to other kinds of citizens such as individuals with co-occurring mental health and substance use problems or socially marginalized minorities.

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How “care values” as discursive practices effect the ethics of a care-setting

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Abstract
Purpose – This paper examines how certain care values permeate, legitimize and authorize hospitalized-older-adults’ care, technologies and practices. The purpose of this paper is to expose how values are not benign but operate discursively establishing “orders of worth” with significant effect on the ethics of the care-setting.

Design/methodology/approach – The paper draws from a discursive ethnography to see “up close” on a surgical unit how values influence nurse/older-adult-patient care occasions in the domain of older-adults and functional decline. Data are from participant observations, conversations, interviews, chart reviews and reviewed literature. Foucauldian discursive analytics rendered values recognizable and analyzable as discursive practices. Discourse is a social practice of knowledge production constituting and giving meaning to what it represents.

Findings – Analysis reveals how care values inhere discourses like measurement, efficiency, economics, risk and functional decline (loss of capacity for independent living) pervading care technologies and practices, subjugating older adults’ bodies to techniques, turning older persons into measurable objects of knowledge. These values determine social conditions of worth, objectifying, calculating, normalizing and homogenizing what it means to be old, ill and in hospital.

Originality/value – Seven older adult patients and attendant nurses were followed for their entire hospitalization. The ethnography renders visible how care values as discursive practices rationalize the social order and operations of everyday care. Analytic outcomes offer insights of how dominant care values enabled care technologies and practices to govern hospitalized-older-adults as a population to be ordered, managed and controlled, eluding possibilities of engaging humanistic patient-centered care.

Keywords Nursing practice, Older adults, Care values, Discursive ethnography, Functional decline, Hospitalization

Paper type Research paper

Introduction
While scouring the literature on “value in health care,” “values of care,” and “care values,” it became clear prevailing definitions of value resembled Wegner’s (2016) claim that “the simplest definition of value in health care is: Value = Quality/Cost” (p. 276). Wegner goes on to comment about addressing the equation by saying: “typically experts meet and develop a group of quality measures” (p. 276). We argue here that these kinds of truth claims reflect a contemporary rhetoric of “care value(s)” equating “value in health care” with efficiency and cost-effectiveness organized to produce priorities of care and “measurable” care outcomes accordingly.

This paper is a critique of how care values are derived. The aim is to expose how truth claims about care values are figured and in effect discursively shape how care practices are structured, organized and practised hegemonically. This results in such values being rarely questioned. We are not interested in generating findings that establish what is right or wrong nor to create alternate truth claims. Our aim is to use discourse analysis as a form of critique to render visible the power of these truth claims and reveal the assumptions,
discontinuities and contradictions in how care values are discursively formed, consequently shaping care practices. For analysis empirical data were generated from research literature on care values for comparison with data from participant observations, conversations and patient care documents in an ethnography (Moreau, 2017) focused on everyday nurse/hospital patient care occasions. Discursive analytics make visible and illustrate how the language of care values in this literature inform and shape how nurses perform and talk about their care values. The rhetoric of “value” aligns with contemporary political-economic demands for health care system austerity in the literature and in hospital care practices. Such values deeply influence the ethics of a care-setting. For example, Wegner is a physician who referenced experts’ definition of quality to justify how care values are defined by a politics of unquestioned medical knowledge and expertise using evidence-based medicine (EBM). Further, underlying the language he used is an assumption that applying “expert knowledge” is “the way” to arrive at value in care-settings based on economics using a number defined as a “quality” measure (previously defined by the expert group) divided by its cost ensuring cost effectiveness – a prime requirement of contemporary health care.

What is not clear in literature on health care value(s) is the meaning and consequent effect of the words “value” and “values,” whether as verb or noun. Of particular interest in our analysis and critique is how values inherently impact the ethics of a care-setting. Especially as it is not clear how the discursive effects of prevailing health care “value(s)” located in and used by research initiatives influence the development of care technologies like assessments and clinical pathways (CPW). What these initiatives fail to do is identify and examine how privileged values of care languaging and structuring of such technologies are instrumental in informing, ordering and managing contemporary care practices and priorities of care. For example, ethnographic data referred to above reveal how values of efficiency, objectivity and linear progression reside in a trajectory of patient recovery organized within a CPW; a care technology intended to enable care providers to focus on tasks designed to get the patient, as an object of concern, through the hospital system in a set time. CPWs are a technology set by discharge statistics producing measurements and norms as standards aligned with specific illness or procedure timelines.

Of particular interest here are older adults as they take up the majority of hospital beds and targeted as a population most likely to suffer functional decline and as such predicted to cost inordinate amounts of health care dollars (Moreau, 2017). The underlying assumption is that older adults will drain the health care system as they are “an additional financial and clinical burden” (Castelli et al., 2015, p. 1). As Weber et al. (2015, Slide 82) claim: “a geriatric storm of epic proportions is brewing.”

This paper examines how certain care values, identified across domains of reviewed literature and in an acute hospital setting, permeate, legitimize and authorize hospitalized-older-adults’ care, technologies and practices. The purpose is to use a discourse analysis of the literature on care values to expose how such values are not benign but hegemonic in their operations. Hence, care values are revealed as operating discursively, establishing “orders of worth” that dominate and shape the ethics of a care-setting. Moreover, we aim to explore how the influence of these derived values is unstable, dependent on which values are privileged, taken up, ignored and/or resisted in determining care priorities in any practice setting. The paper draws on literature we reviewed and analyzed alongside a discursive ethnography[1] on hospitalized-older-adults’ care in relation to functional decline, to “see up close,” to examine and illustrate how a rhetoric of values plays out in the literature and redistributed in the actualities of a hospital setting with significant effects.

**Discursive ethnography: getting up close and analytical**

A discursive ethnography proved to be an invaluable way to observe and examine what happens when care values are redistributed from literature into the development of care...
technologies that structure care practices for hospitalized-older-adults’ care. Ethnography allowed a way in “to see” how discursive practices operate in the interstices of hospital time and space, constituting hospital practices in the care of older adults. This methodology enabled examining care values in the domain of nurse/older-adult-patient care occasions focused on mobility and possibilities of functional decline. For the purposes of this study, functional decline was defined, as it is predominately defined in geriatric literature, as a measurable decrease in a person’s socio-biocapacity to undertake their activities of daily living (ADLs) such as feeding, toileting, bathing and mobility, resulting in further impairment with losses in independent function. Functional decline as a discourse structures the CPW to be an assessment tool that values objectivity and efficiency, normatively constituting older adults’ bodies as measurable objects to be ordered, managed and controlled. Functional decline is the lens through which the group under study was problematized in this clinical situation.

In the study, during a period of more than a year, seven patients, 75 years or older, cognitively intact, hospitalized for surgical repair of a fractured hip due to a fall were followed from admission to discharge. For the most part, each patient participant was discharged before the next was enrolled to enable focused attention on each patient. Patients were followed in contrast to the nurses as the interest was to observe the trajectories of patients’ hospital experiences and examine how their potential or actual functional decline was addressed or not by the various nurses who cared for them. As per ethics approval nurses caring for patient participants had consented to be observed and to converse about their care practices. Data were generated from reviewed literature, participant observations of nurse/patient care occasions focused on mobility[2], conversations, interviews and chart reviews. This methodology enabled examining care values because it surfaced how discourses of objectivity, economics, efficiency, functional decline, risk, surveillance and measurement dominated in the discursive formations of care technologies and nursing care practices.

Before moving into study details, analysis and insights gained, we provide descriptions of how discourse is defined to be useable as a strategy for analysis of power/knowledge/truth functions inherent in discourse and the observed practices in the unit. The discourse of EBM is used as an example of how truth claims are established and certain values of care become privileged in the domain of hospital care as outlined above.

Discourse, EBM, truth claims and values of care
Discourse, using a Foucauldian approach, is defined as a social practice of knowledge production that constitutes and represents objects. The power of discourse is that it produces knowledge and is produced by knowledge; specifies truth, delimits objects, subjectivities and social realities, defines time and space (Foucault, 1972).

A Foucauldian methodology of discursive analytics rendered discourse visible, hence amenable to analysis in the literature and hospital domains. Discourse’s power/knowledge function, its discursive effects or the “doing” of discourse also became amenable to examination. This approach exposed how power relations are inherent in discourses. The event of a discourse, known as discursive practice, is the “doing” of what a discourse “does.” The visibility of discourse as event revealed how one discourse appears and dominates whereas another not. The paradox of discourse is despite its constitutive power and potential danger, it is always unstable, contingent on unspoken “a priori rules” or conditions of possibility: the position of who is writing, speaking or performing a discourse, how one is represented or credentialed, located when/where enables a discourse to appear or not. For example, Wegner (2016) gives authority and legitimacy to his discourse on care value because he is a physician published in an internationally recognized medical journal located on an accredited university website.
How discourse was defined in terms of knowledge production and the operation of discourse as contingent on “a priori rules,” made discourse amenable as a tool and strategy for purposes of discourse analysis in the study. For example, the social and intellectual context of EBM is the discipline of medicine, a socially legitimized and authorized condition of possibility (which is an “a priori rule”) that makes it feasible for EBM to operate “within the true,” that is, presumed to operate via authenticated truth claims (Foucault, 1981). The biomedical health care model has comparable credibility and authenticity, as it too is structured by tenets of (bio)medicine (application of medicine to clinical practice). As such EBM and the biomedical model are considered epitomes of science dominating the structuring of hospital care policies and practices. They operate as discursive practices producing “a particular set of codified relations between a precisely constructed knower and a precisely constructed object, with strict rules which govern the formation of concepts” (O’Farrell, 2005, p. 89). Djulbegovic and Guyatt (2017, pp. 415-416) exemplify such a claim that EBM places “the practice of medicine on a solid scientific basis […] a coherent heuristic structure for optimizing the practice of medicine.”

Further, EBM as representative of the discipline of (bio)medicine determines values of care, what is to be known or excluded, valorized, subjugated, heard or not heard in the enactment of the biomedical model in contemporary health care (Foucault, 1981). Statements describing EBM as practices of “critical appraisal, development of systematic reviews, and clinical practice guidelines [standardization]” (Djulbegovic and Guyatt, 2017, p. 415) are authenticated by the authors’ credentials, the journal of publication, and authorized citations used to substantiate ideas presented (“a priori rules”). Within these bodies of literature EBM establishes truth claims privileging certain knowledge and related care values establishing “orders of worth,” while eliding or ignoring others. The discourse of functional decline in geriatrics as outlined above was produced accordingly by EBM establishing truth claims privileging care practices reliably measuring socio-biophysical decline in older adults (CPW) based on values of cost effectiveness and efficiency. Functional decline as a measurable entity became highly valued as a profound marker of morbidity and mortality in hospitalized-older-adults (Beaton and Grimmer, 2013; Thomas, 2002). A care value that emphasized and highlighted the specter of “all those old people” who will likely, naturally, inevitably decline with age causing the use of inordinate health care dollars. Labels such as “bed blocker,” “a social stay” and “a placement problem” ensued eroding/destabilizing the position of older adults on the spectrum of “orders of worth” in health care. Nurse/patient observations revealed how mitigating functional decline to minimize hospital lengths of stay were care priorities, revealing the discursive power of EBM and the biomedical model to shape care values.

Defining “value/s” is difficult because their meaning can be ambiguous, contingent on whether intended or taken up as noun or verb. Meaning and understanding is dependent on intention/purpose, position and/or standpoint of the writer as well as that of the reader. As a physician laments “‘Value’ is a word that has long aroused skepticism among physicians, who suspect it of being code for ‘cost reduction’” (Lee, 2010, p. 2481). The word(s) “value(s)” therefore, when taken up in discourse indicate particular ways that practices can/could be supported, legitimized and authorized from a range of positions, knowledges and/or actions. “Value(s)” are contingent on economic, moral or social framings of the older person as an object of concern in the health care system.

*What the literature says*

Value […] should define the framework for performance improvement in health care. Rigorous, disciplined measurement and improvement of value is the best way to drive system progress […]. Since value is defined as outcomes relative to costs, it encompasses efficiency. (Porter, 2010, p. 2477)
This perspective of value in health care, juxtaposing “disciplined measurement” with “improvement” and “outcomes relative to costs” (p. 2477) assumes common knowledge of the central importance and worth of contemporary health care in achievement of austerity measures, this attested to by Bohmer (2011, p. 2045) who claims health care values are about “the ratio of outcomes to long-term costs.” Likewise, Doggett (2014, p. 15) in the Consumers’ Health Forum of Australia says “one issue everyone can agree on is the importance of getting maximum value out of every dollar that we invest in our health system.” A King’s Fund[3] report on the UK National Health Service (NHS) argued the NHS needs to focus on “improving value and engaging clinicians at all levels in delivering better outcomes at lower costs” (Alderwick et al., 2015, p. 3).

What appears dominant in literature on health care value is how frequently value is interconnected with discourses of measurement, economics and efficiency. Value becomes discursively associated with achieving economic efficiencies in the delivery of health care with desired measurable outcomes. Writing on care value is saturated with discourses of EBM or conversely EBM is a discourse saturated with the word value. For example, Porter’s (2010) statement above about needing “rigorous, disciplined measurement” (p. 2477) infers standardization, a valued tenet of (bio)medicine as economic efficiency. Bohmer (2011) using EBM discourse positions the value of measurement as “an integral part of accountability and performance management” in line with “clinical practices are consistent with the most recent science” (p. 2046). These discourses are hegemonic, assumed or unquestioned as legitimized truth claims, “true” to science, demanding values of accuracy, objectivity, rigor and validity to produce authorized knowledge about priorities, quality measures and health care value(s).

These truth claims ostensibly engage “common sense,” an attitude that takes for granted everyone knows which health care values should count. Declarations set up a discursive regime of truth/knowledge/value that constitutes values of economy, accuracy, precision and optimization as primary; with EBM fundamental to producing knowledge of how to achieve efficiencies for “improvement” and “progress” in health care, implicitly/explicitly aiming for cost effective outcomes in hospital care.

**Governing hospitalized-older-adults: rhetoric of care**

A common ideological position offered in “aged care” is the assumed shift to humanistic person-centered care (Counsell, 2016) as underpinning the ethics of care for the older adult. This discursive shift in position could be traced in literature on care values, geriatric literature (Kogan, et al., 2016) as well as in the participant observations and conversations with nurses. However, discursive forms of values observed as social practices in the study were unstable, contingent on the privileging of one discourse over another, who was speaking and how positioned.

**Key terms and discourses defined**

Before going further, a few words about key terms and the discourses central to the study to contextualize the discussion. On the hospital unit where the ethnography took place a key term was mobility in reference to a person’s capacity to move. Mobility is tacitly the privileged side of the binary of mobility/immobility with immobility code for functional decline, loss of ADLs as defined above. Mobility was considered important and highly valued for independent living hence privileged over immobility which assumed loss of independence. Mobility was a post-operative event when either the patient self-mobilized or a care provider got the patient up. Mobility was accomplished by a series of incremental steps scripted by the CPW, from dangling legs at bedside to eventually standing then walking in anticipation of “getting back to normal,” as many of the nurses said, inherently
privileging the value of normality over abnormality and independence over dependence. Mobility was highly valued as a goal. Health care authorities have persisted in demanding the need to assess, measure and predict hospitalized older adults’ high risk for functional decline as necessary to prevent inordinate health care costs. Functional decline as a discourse constitutes knowledge of the aging body as predictable and measurable inevitabilities of deterioration with loss of independence. Functional decline discourse is produced by authorized biomedical knowledge, EBM and pre-established scientifically validated objective measurements of a patient’s socio-biophysical status, commonly referred to as ADLs (Katz et al., 1963). ADL technology is a scale structured by numeric levels from independence to dependence, determined according to pre-established norms, hence a normative assessment practice amenable to assessing and predicting functional decline (Feinstein et al., 1986). As such ADLs inform the design and structure of the CPW used to guide provision of care accordingly, to address any decline or to avoid or mitigate the actual or real risk of functional decline. Accordingly, entangled with functional decline discourse in the CPW were discourses of risk, measurement, care and desire. Functional decline discourse became and remained increasingly lexically associated with risk discourse.

Risk discourse enabled functional decline to become heightened as a valued discourse associated in care technologies. Older adults as the majority in hospital populations and framed as inevitably declining were represented and positioned as a risk to the system. Risk discourse made meaning of the problem of inevitabilities of decline in old age hence silently discursively determining the order of one’s worth when old, ill and in hospital, a rhetoric of care. These entangled discourses enabled structuring old age as a statistically calculable probability of loss of independence assuming old people required care, a bio-political ordering of a life. This thinking with consequent practices for ordering, managing and controlling hospitalized older adults as a risky population is directly related to the re-engineering of health care.

Re-engineered health care and health care values

Re-engineering of health care involved “market-based compensation reform […] wherein health care executives [were] looking at every function within hospitals […] to meet new needs at the lowest possible cost” (Martin, 1996, p. 27):

> Exploring innovative business models [LEAN] will allow us to meet the ongoing challenge of financial pressures by developing and implementing new service concepts that take advantage of new technologies and apply relevant research results in order to achieve sustainable, efficient and effective services. (Health Authority (HA) annual report, unnamed to maintain confidentiality)

This HA statement illustrates how hospitals can operate as market-driven organizations taking up LEAN principles to produce more outputs or profits with minimal resources and least waste. Principles that embrace values of economic constraint, efficiency, measurement, standardization and minimization, elements of a hospital’s biomedical model of care leaving little room for a person/patient’s unique needs. For example, a patient’s length-of-hospital-stay (LOS) becomes governed by CPW technology, individualized by the statistical average for minimum LOS for each diagnosis or procedure, not by the patient as person. Hence a CPW can reduce treatment variations and minimize LOS, meeting LEAN principles of eliminating waste.

CPWs are valorized because they promote and value ways “to reduce variation, improve quality of care, and maximize the outcomes for specific groups of patients” (Lawal et al., 2016, p. 35). A CPW, a series of check boxes structured as lists of step-by-step and day-by-day tasks, defines how much/when to mobilize the patient post-operatively;
a regime of care anticipated as doable for the “normal” or average patient, normalizing a recovery trajectory and LOS. The CPW incorporates values of safety, objectivity, measurability and efficiency. Such tools are highly valued as instrumental in rationalizing, calculating and governing health care and attendant costs by “predicting prognosis, planning placement, estimating care requirements, choosing types of specific care” (Feinstein et al., 1986, p. 413).

A CPW has little space to script, record or account for the older adult as a unique person, without names attached there would be little if any identity to whom the record belongs. Porter (2010) sums up such connections between health care values, care technologies, assessment practices and EBM: “in practice, quality usually means adherence to evidence-based guidelines” (p. 2478). There are no “people” in these discourses structuring these kinds of care technologies, just objectified bodies to be ordered, managed and controlled. How these practices play out as care values, orders of worth and ethics of care, as observed in the ethnography, is next.

Engaging discursive analytics: “care-setting” business and ethics

The central focus of the ethics of care is on the compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibility. (Held, 2006, p. 10)

Ethics, like values are difficult to define as they depend on how framed, interpreted, spoken by whom, where, and how enacted for what purpose. Ethics can play out quite differently as discursive practices forming knowledge “produced through plural and contingent practices across different sites, each of which involves the material and symbolic” (Bacchi and Bonham, 2014, p. 173). For example, the International Council of Nurses’ (ICN)[4] (2012) defines ethics as “inherent in nursing, a respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect”. These ethics are discursive practices embedded in a nursing discourse producing knowledge of what constitutes or at least should be care values based on rights, demanding dignity and respect for those cared for by nurses. Moreover, meaning making from such definitions is contingent on situation and circumstance. The following excerpts from observations of nurse/patient care occasions, conversations in the field and reviewed literature speak to the tensions of how values as discursive practices are contingent, unstable and messy.

How nurses’ care practices and talk of care inheres with care values
Observations of nurses mobilizing older adult patients in a context of their wanting to address or mitigate functional decline offer illustrations of the interconnectivity of seemingly contradictory discursive practices of care. In particular, how the requirements of the CPW can create for nurses a powerful interpellation appearing as common sense in disguise (Fairclough, 2001). Discourses of EBM, measurement, efficiency and economics are ideologically linked in theory and become common sense when manifest in a care technology like the CPW. This assemblage of discourses together constitutes an ethic of care as the straightforward, objective and efficient accomplishment of nurses’ work. Fairclough (2001) refers to such practices as having the ideological effect of responsibilization that influenced the social worth embedded in the care tools and practices. The priorities in the care setting were organized in a hierarchy of values with standardization, efficiency and objectivity at the top. The demands of the unit’s care technologies left little space or time to value, for example, “extra” time to communicate with the patient about their unique needs and priorities and to alter care accordingly. However, there were exceptions as expressed by Nurse Taylor who used a Sara lift[5] on her own to get Ruby (in her nineties) up to the bathroom wherein Ruby had been designated a
two-person Sara lift” for safety reasons in line with CPW standardized mobility requirements. Taylor explained:

It was a spur of the moment decision to do this when Ruby rang to go to the bathroom I was busy with another patient also in the bathroom next door and I did not want to keep him waiting. Ruby moves really well with the Sara lift no problem, all went quickly and smoothly.

Taylor had been observed at other times as well to get patients up confidently and efficiently on her own to expedite meeting the patients’ need to mobilize. When Ruby was asked how this was for her she was all smiles and happy to be so quickly and smoothly taken to the bathroom to “relieve” herself. Later in conversation with Taylor about her decision making in relation to the quotidian dictates of the CPW she commented:

I can’t say you know on “day 1” you have to be getting the patient up because some people can’t um so yeah each patient is different in how far and how fast they progress. So, I have to take it by each case they give you.

Taylor’s use of the pronoun “I” is a subject position of owning and taking personal responsibility for one’s own practice. In this case expressing a value of empathy and respect for the patient’s unique needs. She showed resistance to the standardization and de-humanizing effects of the CPW that erased unique differences from one patient to the next. She demonstrated a resistance to the dominant discourse of care laced with values of objectivity and efficiency without naming it as such.

Nurse Lily was observed on several occasions to take time to cajole and entice Gladys to get up in a chair as per the CPW, explaining the need to avoid functional decline. Despite being offering comfort measures, Gladys consistently refused. Lily talked of how she sets care priorities indicating how her values of patient needs first inform her ethics of care in tension with the hospital’s ethics of normalized care as per the CPW quotidian mobilizing requirements. For Lily, patient comfort was a value that did not always align with the standardized requirements of the CPW. She talks of her values in caring for Gladys:

My priority is first of all comfort for the patient [pause] one big one for me is getting back to mobility. I mean not everyone can get back to how they were pre-op but you know just getting back mobility. The fact is it’s one of their big tickets to discharge is for them to be mobile but not everyone can be that, you know, get back to the pre-fall, pre-surgery so that’s one big thing.

Lily’s talk showed ambiguity about priorities, her values of care. Comfort, a first priority changed to “getting back mobility.” However, her using the discourse marker “I mean” rationalizes how “mobility” may not be the norm, for everyone, as assumed and valued by the CPW. How Lily strings together mobility with discharge reflects her sense of responsibility to both patient and the CPW’s script of daily mobility embedded with values of normativity and objectivity. Her comment “not everyone can be that, you know, get back to the pre-fall” is counter to normativity. It reflects values of empathy and respect for the dignity and uniqueness of the individual as expressed in a person-centered ethics of care. However, as her talk moves between her values and organizational values she, not necessarily wittingly, demonstrates how ethics in a care setting were not necessarily stable.

Nurse Martha demonstrated responsibility and her ethics of care a little differently. Martha was observed being patient and soft-spoken, talking at length with Gladys who despite knowing the value of mobility post-operatively showed little interest in moving on her own. Gladys wanted to be cared for. Martha struggled to accomplish patient care by meeting the patient’s personal needs while trying to get the patient to do self-care. Whereas her talk had an undertone of keeping to a plan very much resembling the CPW:

The most difficult was maintaining her […] getting her to change just a little bit […] was hard trying to convince her to move around a bit more. […] She knows the risks. She knows the benefits so she gets to make the choices […] she knew what she was doing.
Martha was engaging what Biebricher (2011, p. 469) refers to as the technology of responsibilization. As observed in the ethnography, a technology operating as an individualization of risk by moving over to the patient the need to self-govern, to take personal responsibility for her own actions. Martha’s interactions with the patient and her talk included discourses of self-responsibility, risk, desire, moral obligation and functional decline embedded in the conceptual domain of mobility manifested in her drive to have the patient move her limbs. Imbued in Martha’s talk were values of humanistic person-centered care of respect for the patient determining her own capacities and abilities and to make choices accordingly. Yet Martha also took time to “convince” using rhetoric to entice the patient to align with values embedded in the CPW, to keep to a predetermined normed regime of tasks, to mobilize. This “mixed” approach took a toll on Martha who lamented:

I got worn down and ah trying [...] for me it was hard to maintain an upbeat kind of energy at times.

Martha’s talk and practices seem a mix of patient-centered care and making the organizational regime of standardized care compelling as “she knows the risks” of not moving. Yet Martha is resigned saying “she gets to make the choices [...] [...] she knew what she was doing.” Martha illustrated her moral distress as she tries to balance what seem competing values, hers, the patient and the organization. She found it exhausting to the point of burdensome. As other nurses in the study, she illustrated how the organizational values of routine and standardized care are privileged and most often are, by default what established the ethic of care.

The contingency of care values. A unit leader, Myrna was observed to work diligently to ensure a balance of hospital discharges each day to allow “enough” beds for incoming patients having surgery that day. Beds and surgeries were implicitly interrelated goods and services, desired commodities critical to organizational economic rationalities. She upheld the organizational values of efficiency and cost effectiveness to promote the value of a smooth-running hospital. Yet, also witnessed was her anguish over trying to fairly, reasonably and ethically figure out which patient could be discharged home perhaps sooner than the CPW dictated, to make room for the next “consumer.”

Bill, in his mid-80s, was a patient participant observed in nurse/patient care occasions to work hard to follow the nurses’ instructions and mobilize incrementally more each post-operative day, clearly following the regime of the CPW. However, he illustrated how care values in direct relation to the ethics of this care-setting were not stable but contingent on circumstances, conditions of possibility. He was an “ideal patient,” a highly motivated patient who unconditionally surrendered to care practices manifest by his not questioning but complying with instructions on how to mobilize. He was observed to need minimal cueing or encouragement to mobilize as he kept to a regime of care outlined by his nurses. He enacted the technology of responsibilization via an ethic of self-care and ethic of self-governance expressed as “I know the more I do the better it is so I will get up anytime despite it stretches my [affected] leg.” Although he also expressed anxiety about being ready for discharge as he winced with pain when mobilizing and worried whether or not all was in place at home ready for his return:

I’m feeling a bit stressed in that it takes effort and hurts a bit but I have to do this, keep moving if I want to get home and I want to go home as soon as possible.

His desire to get better and go home as soon as possible was influenced by his worry about his wife who needed care he felt obligated to provide despite his own vulnerabilities.

In the end Bill was discharged home on his fourth day post-operatively, a day before the usual five as per the CPW. Bill was observed to be given a choice that day by his nurse: either go from his private room into a multi-bed ward to accommodate the hospital need to put an infectious patient into a private room or go home. The organizational ethic of care
that day was about infection control, bed management and ensuring the right patient in the right bed:

The bed was a commodity needed for hospital services and Bill an entity that needed to be relocated so the bed was in the right place for the right person. Beds are a complex entity, a commodity of invaluable worth organised ultimately according to illness or procedure and categorised to align with respective care providers’ expertise for best practices (Allen, 2015). Although Bill’s story could read as a success especially with his “early discharge” to accommodate the system, the violence of the managerialist practices of the organizational discourse, right bed/right patient, had been used to coerce Bill into a position of responsibilization. (Moreau, 2017, p. 185)

Bill was positioned on short notice to take some personal responsibility in the decision regarding his hospital discharge. This scenario was an interplay of practices that shaped the ethics of the care-setting and order of worth, infection control (a rationale based on biomedical science) was prioritized in a hierarchy of values.

The privileging of care values: orders of worth. This kind of ordering of worth is about privileging of practices and values that reflect how hospitals are typically run as an enterprise of customer service, the marketization of health care. Findings in the ethnography illustrate how the hospital operated as a:

[…] for-profit operation using the ABF(6) model to rationally calculate the most efficient economic way “to do” care and using governance models based on the tenets of biomedical science (Lown, 2007) to get patients through the system, a critical factor of the Throughput model. (Moreau, 2017, p. 186)

There were other patient participant observations and stories like Bill’s with findings that also revealed how orders of worth are enacted based on care values foundational to performing technologies of responsibilization defined as:

[…] practices of governmentality interwoven with practices of self-care and self-formation that led to political subjectification of Bill. The political subjectification took place in relation to governmental practices but did not reduce one to the other (Dean, 1994, p. 158), instead were a complex discursive interplay of subjectivities, models and practices contingent on time, place, situation and circumstance. (Moreau, 2017, p. 186)

In this story Bill, as a moral agent, took self-responsibility to be well enough to be discharged home to care for his ailing wife. He was self-responsible by working hard to be “back to his normal” as per the CPW, independent in his ADLs. Simultaneously, he was an object of surveillance as the nurse had assessed his ADL capacities to meet the CPW criteria of being “well enough” for discharge home. These were truth games, mutually developed and interconnected “processes of subjectivation and objectivation that made it possible for the subject qua subject to become an object of knowledge” (Foucault, 1984, p. 942) amenable to a calculated assessment to decide if ready for discharge.

As such, these practices of surveillance and objective calculable assessment are care values inherent to managerialist practices that constituted Bill’s subjectivity. A subjectivity made up of his compliance with daily tasks, incrementally increasing his capacity to be mobile again. These practices were shown to be hegemonic and naturalized as taken-for-granted unquestioned disciplinary techniques embedded in the CPW structured by discourses of risk and functional decline. Such discourses determined priorities of care, what was to be done by whom, how and when to prevent or mitigate risks of functional decline. These were practices Nurses Lily and Martha also engaged as technologies of responsibilization; practices that perpetuated “a violence and coercion on […] clients and workers […]. structural and personalizing in its effects” (Rudge, 2011, p. 167). This kind of violence and coercion was also expressed in Nurse Randy’s actions and words, by her distress in having to comply with organizational policies and practices as a priority, lamenting “we rush, rush, rush at the end of
our shift to get everything charted.” Almost everyday over the year of field work such rushing to “do” one’s “charting” was evident as nurses were observed not wanting to be disturbed to ensure “all” their required charting was done, in particular the CPW check boxes.

Nurse Ben is even more explicit about the violence and coercion of hospital values. He was observed worrying about a patient’s blood work outcomes, home arrangements and imminent discharge. He was observed keeping a close eye on the lab results and talking with the patient and family several times in effort to ensure all was in good order. In conversation he explained his actions:

If there are unexpected events I find it really stressful. If there’re, if there’s [pause with deep sigh] an organizational push to do things you are not necessarily comfortable with, like discharge people before you think they’re ready or their family’s not ready that’s quite stressful.

Another perspective on values assumed as part of a person/patient-centered-care approach is ironically offered by EBM based on the objectivity of (bio)medicine. Djulbegovic and Guyatt (2017, p. 420, italics added) claim “EBM has aggressively promoted the need to consider patient’s values in every preference-sensitive decision […] [focusing] on individual patient values.” “Aggressively promoted” was associated with the practice of “n-of-1” randomized control trials with a reference to Guyatt et al.’s (1990) study, despite that study’s conclusion: an “n-of-1” trial “can further increase the scientific rigor of [physicians’] clinical practice” increasing likelihood of providing what is “best for the patient” (p. 298). Further, Djulbegovic and Guyatt’s (2017) words “has,” “promoted,” “need” and “consider” discursively render claims of person-centered care as potentiality, not established practice. “Consider” can be taken as perhaps “listen to the patient,” not necessarily “do” as the patient decides. Just how a patient is central to decision making is ambiguous. This EBM discourse does not seem to change how a CPW is a “text” beyond representing nurses’ work as measurable tasks nor offering patient-centered options as expressed by the nurses. However, if nurses and patients become aware of and understand what EBM discourse “does” it affords a place for them to resist the power and violence of EBM. This analysis offers understanding of how EBM informs the hospital’s biomedical model of care and how it orders what care is to be authorized, valued and privileged.

Conclusion
This paper rendered visible and examined the linkages between dominant care values and discourses that permeate care technologies and practices, performances of care, organizational structures, policies and practices. Analysis enabled explicating the power and coercion of the dominant ethics of a care-setting. Analysis revealed how viewing values as discursive practices is a valuable research tool and strategy to illuminate how patients and nurses are subjugated and governed by social structures, practices and processes of the health care system and hospital organization.

Discursive ethnography we argue is one of the only means to see “up close” and render visible the powerful effects of care values as discursively influencing and shaping the ethics of care in a tertiary hospital setting. This study’s analytic outcomes revealed how only certain discourses appear, come to dominate and operate, produce knowledge, establish truth claims and influence what nurses and patients make of the setting. As a methodology it made visible how care values, as discursive practices, were not benign but hegemonic, establishing social conditions of worth and enabling hospital policies and practices to govern the priorities of care for older adults. Outcomes point to the importance of nurses knowing and understanding the power and violence of discourse, to see how it can shape their care practices counter to their care values. If discourse and how it operates is not made visible, these constitutive effects with knowledge production are unseen or unheard and therefore cannot be readily questioned, troubled or resisted.
The kind of critique of value(s) as engaged within this paper provided a means to recognize how health practitioners and patients were “subjects of what we are doing, thinking and saying […] and the possibility of no longer being, doing, or thinking what we are, do, or think” (Foucault and Rabinow, 1984, p. 46). The examination of what dominated in the orders of worth in literature and hospital setting established how concepts, such as functional decline, were mobilized to produce, constitute and limit to mere rhetoric, the ideologies of the ethics of care towards the older adult as motivated entirely by patient-centered care. This examination also produced material evidence to show how researchers, care providers, and patients can argue for more than consideration of preference to enact possible resistance to the singular view of “value” as only cost.

The implications are that researchers in geriatric care need to take up this recognition and understanding of how the dominant model of biomedicalized hospital care discursively elides, delimits and constrains care values inherent to humanistic person-centered care approaches. The study highlights the necessity to ensure the being, doing, and thinking of person-centered care truly values, represents, and positions older adults as sentient persons central to care technologies and hence practices. Further research is necessary, building on the insights, study tools, strategies, and outcomes provided here, to develop care technologies that provide space for valuing the older-adult-patient as a unique sentient person central to care. Despite how older adults are represented as risky business and despite how cost restraints and efficiencies are highly valued care priorities, older adults are to be positioned as more than objects of care and a population to be ordered, managed and controlled.

Notes
1. Participants have pseudonyms and are presented in a manner to protect their privacy and maintain their anonymity. The ethics application was approved at the hospital as number J2012.02.
2. Why a focus on mobility is discussed in the later section “Key terms and discourses defined”.
3. The King’s Fund is an independent charity working to improve health and care in England. Our vision is that the best possible health and care is available to all. available at: www.kingsfund.org.uk/ (April 9, 2018).
5. A Sara lift is a mobility device to safely assist a patient to raise from sitting to standing position then transfer to another place.
6. Activity Based Funding (ABF) is a goods and services accounting business model “based on the volume and mix of patients actually treated […] [where hospitals] are paid on the number and complexity of activities/interventions, [thus] there is incentive […] to increase volume” (Cohen et al., 2012, p. 25).

References


Further reading

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The practice of selecting for values in nursing

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Abstract

Purpose – Research on the processes by which universities select candidates for nursing courses has tended to focus on the development and application of standardised methods. This methodological emphasis has extended to research on “values-based” selection in nursing, which is intended to sustain discrimination between applicants on the basis of their “personal values”. The purpose of this paper is to expand the range of methodological resources available for research on values-based selection, by examining how this is done in practice – by contrast to how it should be done. We analyse interactions between selectors, applicants and various materials deployed during the interview processes to show how values are made manifest, empirically. We conclude by discussing the implications of treating values as interactional achievements, rather than essentialised – i.e. purely “personal” – attributes.

Design/methodology/approach – We draw on methodological principles associated with actor network theory (ANT), which aims to describe how facts are produced through interactions between various actors. Data are presented from an ethnographic study of selection events at three UK universities. Our methods consisted of observation of selection events and interviews with academic staff, administrators and service users and carers, all of whom were involved in selecting candidates.

Findings – When selection is treated methodologically as a social practice and analysed empirically as an ongoing series of interactions, “personal values” can be seen as the effects of a negotiation during which connections are formed between different actors – i.e. elements involved in the selection process. Difference and same-ness in values become visible as the effects of “translation”, in the sense defined in the ANT literature, rather than as fixed attributes which precede selection.

Originality/value – This study makes an original contribution to research on values-based selection by analysing how this is done in practice.

Keywords Nursing, Ethnography, Selection, ANT, Values-based recruitment (VBR)

Paper type Research paper

Introduction

In 2013, The Francis report, published by the UK Government, produced recommendations following an inquiry into failures in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2008. The report made recommendations about the importance of changing professional culture in nursing, including making the assessment of “essential shared values” an integral part of education and recruitment in the nursing profession (Francis, 2013, pp. 4-5).

Subsequent to the report’s publication, the UK Government issued a series of policy papers detailing processes intended to put these recommendations into practice. In “Patients first and foremost” (DH, 2013), for example, the Department of Health emphasised the role of “values” for bringing about a culture change. The same publication introduced a concept of “values-based recruitment” (VBR), by means of which the presence of values should be assessed and assured. Health Education England (HEE) (2014), the regulatory body responsible for supervising the implementation of VBR, went on to define it as follows (p. 6):

Values Based Recruitment is an approach which attracts and selects students, trainees or employees on the basis that their individual values and behaviours align with the values of the NHS Constitution.
The values that nurses are meant to exemplify are described in several associated policy papers, and evoked in terms of “NHS values” (NHSE, 2015) or the “6Cs” (DH, 2012, p. 5): care, compassion, competence, communication, courage and commitment. It is on the basis of these statements that higher education institutions (HEIs) have been instructed by HEE to incorporate a “value-based-element” into selection events.

In the literature review commissioned by HEE (2014), and which is intended to be used as evidence for selection process policy in HEIs, values are described as characteristics displayed by applicants. Several methods are recommended, to identify such values in a way which is fair, reliable and valid. To substantiate these recommendations, HEE (2014) draws on research in the field of work psychology, in which applicants and organisations are treated as entities with discrete properties, which are subject to observation and classification (e.g. Callwood et al., 2014; Land, 1994; McGraw et al., 2018; Perkins et al., 2013; Salvatori, 2001). It is this conceptualisation of the object of study which accounts for the prevalence of correlational studies in research on selection into nursing. These compare, for example, entry qualification scores with grades attained during study or attrition (McCarey et al., 2007; Snowden et al., 2015) or specific personal traits such as emotional intelligence established via completion of psychometric inventories with compassionate actions in clinical settings, measured in grades awarded by clinical mentors (Rankin, 2013). In the field of work psychology, then, observation tends to be understood to leave properties unaffected, with sampled observations (snapshots) treated as justifying judgments relevant to more general circumstances, outside of what is being observed. The context in which observation takes place is analysed as a subtractable variable, so long as the tools with which observation is performed are skilfully or expertly designed (see e.g. Arnold et al., 1991). What is measured at one point in time is treated as identical to what is measured at another point in time, both earlier and later. In other terms, method is made pure: its validity is theoretically independent of its users and the context in which it is used.

These methodological commitments, constitutive of work psychology as a field of research, mean that there has to date been very little empirical research into how selection happens in situ; how it works in context, and in practice (as an exception see Taylor et al. (2014), who discuss the importance of operationalisation of selection methods in their interview-based study). Justifying empirical investigation requires making different methodological commitments: ones which place emphasis on the situated nature of social activity, and which therefore call for the practical investigation of such activity. Outside of work psychology, several studies have done this, and explored job interviews empirically, focusing on the characteristics of talk in such situations, and the interactional discursive strategies such talk manifests. Campbell and Roberts (2007) analyse 40 videotaped job interviews and describe specific discursive techniques in terms of the performance of identity. This allows them to distinguish between applicant identities which are fully integrated with organisational discourses and “hybrid” identities where personal and professional narratives conflict.

Campbell and Roberts (2007) argue that shared “discursive backgrounds” (p. 247) – that is, knowledge of organisational discourses – aid the integration of personal and professional identities. This has the effect of disadvantaging applicants from ethnically different backgrounds who do not have such knowledge. Similarly, Scheuer (2001) argues that the social backgrounds of applicants affect the way communication takes place and is judged, with Van De Mieroop (2018) also emphasising that applicants perform identity work through talk in interview interactions. These studies (and others, e.g. Llewellyn, 2010; Van De Mieroop and Schnurr, 2018) highlight that what is said and seen in interviews is an interactional achievement: a discursive negotiation between applicants and interviewers in the context of a specific organisation, or context. Such studies do not focus on the method
which interviewers intend to apply, but rather on how discursive interactions produce specific identities and organisational outcomes.

This paper aims to extend this methodological approach to interviews in HEIs. It differs from the above discourse analytic studies, however, in two respects: it focuses on selection events for entry into nursing courses, rather than individual and professional job interviews; and it incorporates an analysis of various resources for signification and interaction, rather than talk only. Our aim is to study how values (and other qualities) emerge in interactions between materials, selectors and applicants.

Theoretical framework

A more philosophical way of characterising the methodological difference between much VBR research, and the approach we intend to take in this paper, is to describe it in terms of ontologically determined research and epistemologically determined research (Andersen, 2003). Ontologically determined research is concerned with what is “out there”, with methods determining “what exists, or what reality is” (Andersen, 2003, XII; citing Pedersen, 1983). In this tradition of research, the object of study is treated as a delineable, discrete entity, independent of ways of knowing it. By contrast, epistemologically determined research is concerned with how we know what is (treated as) “out there”, with methods focused on determining the conditions which enable the object of study to become knowable. In other words, the object of study is de-ontologised or de-essentialised. For instance, epistemologically determined research asks how an identity, or a value, can be known, rather than what is (someone’s) identity or value.

Actor network theory (ANT) is epistemologically determined; it is a body of research which historically has asked how truths are produced, and notably, how scientific facts are made. We draw on it for two reasons: it enables us to study the conditions of possibility for attributing “values” to applicants; and it also expands the range of resources implicated in such work beyond talk, as per the interview studies described above. This is important, as nursing selection events involve not only talk, but also a wide range of other materialities, notably documents and a range of different kinds of interviewers. Below, we explain which theoretical concepts within ANT have informed our study. These have largely been developed by Latour and Woolgar (1986) as well as Law (2004) and Berg (1997). Our focus is on the concepts of translation, scale, inscription device and hinterlands.

Latour and Woolgar (1986) develop the concept of translation which Hamilton (2011, p. 59) evocatively summarises as an ordering “of the messy complexities of everyday life […] for the purpose of the project at hand”. Latour and Woolgar (1986) detail how scientists do not “find”, or simply “observe” nature for the existence of, a specific substance. Such substances are brought into being through a series of scientific practices.

First, a substance needs to be made visible. Through this process what has been invisible or inaccessible becomes visible and is made accessible. In other words, translation allows for entities to be understood to exist “out there” retroactively; it is the means by which the thing being represented becomes the thing itself (Latour and Woolgar, 1986). Latour and Woolgar treat translation as a framed and a framing process; substances take particular shapes because they are researched in particular ways. In laboratories, for instance, scales can be adjusted: what is small/invisible (a substance) becomes large enough to be a point on graph paper and what is big/difficult to handle (the world out there with uncountable interferences) becomes, in a laboratory, small and accessible (see also Latour, 1999a).

In addition, inscription devices, which transform a material into a figure or diagram, already contain the specific shape of the material to be found, as they are built on specific ideas about the properties of such a material and the ways in which to “do science”. Law (2004) uses the term “hinterland” to evoke this set of practices: it is a kind of backdrop for understanding the world in a specific way.
Selection into nursing does not take place in a laboratory. However, the way in which Latour and Woolgar show how scientists bring entities into being and treat them as existing prior to and independently of their appearance through inscription devices is analytically relevant for understanding how “values” are found in selection events. During such events, selection is treated as a test for the existence of a quality existing prior to and independently of the application of a method. However, one can analyse how selectors, like scientists, perform a series of translations in order to make such qualities visible. They engage in various practices to translate what is invisible – values – into something which is measurable and can be recorded and kept track of across the times and spaces of the interview process. Values take particular shape precisely because of this translation work; because of the specific scales which are applied and the inscription devices which are deployed. Selection in nursing has its own hinterlands, a set of practices which successfully create some connections where others would have also been possible (e.g. between a statement and a value it manifests). In this hinterland, scaling allows national health policy – as we describe it above, in terms of values necessary for entry into a professional culture – to become the same as selection events in HEIs.

This paper, then, attempts to make visible the work which is necessary to translate applicants from unknown entities into entities with specific, non-contingent qualities. In order to do so, we will focus on technologies of talk and writing, technologies which we will argue make it possible to assign values to applicants, and also, importantly, delete this translation work from final records, so that “values” are made to appear a property of applicants rather than of a set of negotiations between actors.

Methodology and methods
Ethnography
The study’s design, guided by engagement with ANT, followed ethnographic principles. Atkinson (2015) understands ethnographic research as making “general intellectual commitments” (p. 58) based on “sensitising ideas” (p. 9). In what he calls “ethnographic abduction” (p. 56, original emphasis) he outlines the general approach to ethnographic designs:

[…] on the basis of observation (in the most general sense), one draws out possible analytic ideas that speculatively answer the question: What might this be a case of? One considers what general pattern or configuration might give rise to the observed phenomena.

Participant observation
The paper is based on ethnographic work conducted as part of doctoral study (Klingenberg, 2018[1]) and discusses data generated during fieldwork at three English HEIs between 2014 and 2015. The first author, MK, who is a nurse and admissions tutor, planned and conducted the research with the second author advising throughout the research process (and the completion of this paper). For this study, MK observed 22 “selection events”. A selection event consisted, in general form, of introductory talk, interview procedures and, in two cases, maths and English tests. At one site, a selection event lasted a full day, at the other two sites half a day. Observation entailed “everything that was going on”, not just interview encounters.

The decisions of where to observe selection were pragmatic in the sense that access needed to be established in a relatively short time and with relatively few obstructions. We decided to compare selection events at different universities. This decision was, at the time the study was conceived, based on a notion of hoping to find a “good way” of doing selection. It was only through subsequent analytical work that this notion was understood to be limiting. Three different interview methods were observed: group interviews,
traditional interviews where two selectors interviewed one applicant and multiple mini-interviews (MMI), where an applicant circulated through five interview stations, each lasting 6 min (for a description and evaluation of this more recently developed interview method see Rees et al., 2016).

However, rather than discussing the differences between these methods, this paper will focus on patterns shared, specifically in relation to the attribution of values engendered by such approaches.

For Atkinson (2015), it is important for the researcher to attempt to view things from another’s perspective, “however imperfectly” (p. 40). For this study, this means that although MK did not get involved in “actual” selection (he did not contribute to final judgments), he participated, observed and talked about observations. He did not just turn up for the moment where applicants met selectors, he was present before applicants arrived, set up camp in offices where he photocopied, made coffee, chatted about his life and the lives of people who participated in his research. He invigilated and marked maths and English tests, gave applicants good news, became a tour guide for applicants and a sounding board for academic staff.

Data collection
Data were collected through fieldnotes from observations as well as formal and informal interviews with academic and administrative staff across all HEI. Such interviews either followed a semi-structured approach or were unstructured. The researchers also had access to various materials, such as photocopies of interview forms (including selector judgments) but also standard e-mails by which selection was communicated to applicants and, where applicable, with Microsoft PowerPoint™ presentations used during selection events.

Data analysis
This study followed what Atkinson (2015, p. 56) described as a comparative method. Through concomitant fieldwork, engagement with theory and empirical literature, patterns were sought to observe which were then, again, subjected to further engagement with literature, and related through further interaction to participants. This interplay between the substantive and the formal is a persistent feature of ethnographic research (Hammersley and Atkinson, 2007). Specifically, fieldnotes and interviews were extended through the use of analytical notes (often written as footnotes in transcripts or in specific note books). Formal interviews with selectors and administrative staff were audio-recorded and, in general, repeatedly listened to with only parts that were seen to exemplify developed ideas being transcribed verbatim. Throughout data generation and analysis, a reflexive approach was taken, especially in relation to MK’s position as a nurse and admissions tutor. Through frequent reflective notes and analytical discussions with CP, MK sought to be both “self-aware and researcher-self-aware” (Taylor, 2011; cited in Greene, 2014, p. 9), attempting to ground analysis and the testing of prior prejudices in data. This process led to the development of initial codes which were later condensed into analytic concepts. These concepts eventually served to discuss patterns found across all observed selection approaches, especially what we saw as the practices that engendered the trajectories of statements in the selection process.

Findings and discussion
In the following, we will outline how statements of various kinds were translated, in the ANT sense, into applicant attributes. We will begin by discussing two specific strategies applicants employed when talking about themselves and their relation to the hinterlands of selection for values.
Talk: heroism and exclusivity

At all three sites of observation interviews consisted of what selectors called “values-based-questions”. These questions could be general, such as: “What does nursing mean to you?” or “Tell me what values you bring to nursing?” In response to such questions, applicants often talked about why they wanted to become nurses, what made them different from people who are not nurses and different from people who are already working as nurses. Through such talk, nursing and applicants were enacted as exclusive and heroic propositions, with exclusivity establishing an applicant as being like a nurse and heroism establishing an applicant as being different from a practising professional.

One way in which exclusivity was further performed was to talk about characteristics or actions that made applicants different from their peers who would not be studying nursing, for example being the most approachable of their friendship circle or being able to deal with vomit and faeces when others were not, as can be seen in the following exchange during a group interview:

Interviewer, looking at one applicant specifically: What about you, what would your friends say about you?

Applicant: I am committed, passionate especially about science, I am a practical person, couldn’t do 9 to 5 job, every day is different in nursing. (Interviewer moves to next applicant)

Like in the exchange above, nursing was often differentiated from other professional fields. Applicants would often talk about appreciating the irregularities of a nursing job (“I couldn’t do a 9-5 job” or “I love the fact that no day is the same”). Other professions were said to do things differently, for example doctors would not be as good at talking to patients as nurses and health care support workers had no responsibility or could not do everything a nurse does, such as giving medication. In addition, characteristics or traits were talked about as if they are particular to nursing. For example, applicants talked about being caring, empathetic, compassionate, respectful, “going the extra mile” and wanting “to make a difference”. A heightened form of this strategy was the insertion of the term “natural” as in, for example, “I am a naturally caring person”. This positioned applicants as not only caring but also as someone who cannot do anything other than being caring, and, importantly, will remain caring as this trait formed part of their make-up.

The strategy of heroism in the translation of applicants into manifest values was observable in two ways. Applicants talked about how they had acted better than people already employed in healthcare settings. Either they emphasised being able to do things other nurses had failed to do (e.g. engaging a lonely resident in a nursing home who had been treated as a lost cause by the regular staff) or talking about identifying “bad practice” and raising concerns which led regular staff to change their practice, as can be seen in the following exchange from an MMI:

Interviewer (reads out question): The Francis report highlighted major problems related to the delivery of care at the Mid-Staffordshire NHS Foundation trust. The report declared that it was a lack of courage by some nursing staff that contributed to the delivery of substandard care. One of the “6 C’s of Nursing” is courage; what does courage in nursing mean to you?

Applicant: I work as a support worker in a hospital on a very busy ward. If at any point there aren’t enough nurses I will go to the manager and ask for more staff. Also, there was this doctor who went to see a patient but did not wash his hands. I went to him and politely reminded him that he needed to do that although I was really anxious. (Interviewer writes notes and moves on to the next question)

In these strategies of exclusivity and heroics, traces of the hinterland of VBR become visible. The concept of “courage” and the nation-wide publicising of the effects of culture, of not raising concerns because of fear of reprimand, permitted and even required applicants
to display heroism. HEE’s (2014) description of values as durable and not subject to being faked was translated into questions based on the idea that applicants are “naturally” caring or compassionate, that nurses are born not made (an idea which has for years been contested, e.g. Muncey, 2000; Street, 1992). It is through such translations that the scale of an issue was manipulated (Latour, 1999a, b). An issue that was declared a large-scale problem (care practices in the NHS) was made manageable by emphasising some of the components that may contribute to it (“what does courage in nursing mean to you?”). Through declarations that practising nurses are responsible for shortcomings, and nursing applicants are the solution that will bring in the change (HEE, 2014), nurses are made into the problem and not nurses the solution. Introducing the notion of value was an important move in this translating practice: values were treated, in selectors’ questions, as the sole basis of action, as specific to individual actors and based on individual agency. Through questions about values, then, an applicant was translated into a future nurse, with the two made equivalent: nursing and applicants for nursing are made the same, with values investigated as already in place. The assumption such questions point to is that if an HEI recruits the people who already have the “correct” values, these people will resist the structural and cultural pressures and maintain values in the face of adversity (see e.g. HEE, 2014). The consequence that such questions have is that other reasons for problems (staffing levels, steep hierarchies and focus on targets) are made invisible.

Talk: selectors with applicants

Once uttered, applicant talk was translated by selectors. Selectors, who were very often already part of the nursing profession, established the contexts in which such translations were successful, as this example from a group interview demonstrates:

Interviewer: What do you think will be the difference between you now and you in three years?

Applicant: As a registered nurse, I have more responsibility than as a healthcare support worker, I will give out medication and may run a ward.

Interviewer: You will give medication, yes. I think being a registered nurse has more to do with accountability, with knowledge and the ability to make decisions. You can do observations now, but as a registered nurse you will think about what you are doing. (To another applicant in the group:) What do you think?

The selector here states her own view on what the difference between pre- and post-degree course should entail. A somewhat reduced version of the applicant’s statement remains in the selector’s translation, which is in addition juxtaposed to a version of the “right” answer. By emphasising one concept (medication) and ignoring others (responsibility and running a ward), the selector makes some concepts less important than others.

Another example of negotiations during interviews demonstrates how selectors orientate conversations:

Interviewer: What would I hear from your friends if I asked them about your strengths?

Applicant: I’m the mum of the group; I am always caring. Whenever anybody has a problem, they know they can come to me and they do.

Interviewer: What do you mean by “mum of the group”? How does this fit with strategies like the promotion of independence and self-care?

Applicant: You’re right.

In this example, the interviewer first places the object (strength) into a specific non-nursing context, only to translate the statement, once an answer is given, into a different, specifically nursing related context. By focusing on the term “mum” and linking it to a specific feature of
nursing, the applicant’s statement becomes questionable, and calls for justification. Being caring and approachable becomes unrelated to nursing through the assignment of different contexts by the interviewer. It is therefore in the translation work of the interviewer that the credibility of the applicant’s statement is established.

Such negotiations between applicants and selectors were frequent and seemed based on certain mantras, which formed part of their hinterlands and could be observed through repetition in selection interviews or during conversations with selectors about what they “looked for in an applicant”. For example, in interviews with MK, selectors talked about issues in relation to the professionalisation of nurses, the problems with the public view that “anybody can do nursing when they would not dare say this about medicine”. Furthermore, the continuous introduction of additional nursing roles into the healthcare system (Traynor et al., 2015) was seen by some selectors as an example of de-professionalisation. For those selectors, talking about “mums” and not clearly defined boundaries between healthcare support workers and nurses may have been proof of the threats they had experienced and, in their response, enacted or re-enacted precisely the boundaries they saw as being threatened.

**Talk: selectors about applicants**

As long as applicants were present, they could be part of negotiations, re-orienting their statements towards ideas of nursing. But at all three sites, selection continued after applicants had left the interview location. At this point, observations were translated into judgments through further transformation of applicants’ words and actions, as the following example demonstrates:

Member of faculty: And, partly her body language as well, she was very forward and didn’t really, apart from kind of joining in discussions in someone else’s bit, I think it really put off (name) next to her

Service user: I think she really almost, I don’t know whether it was conscious or unconscious, but she excluded the other members

Member of faculty: And if we talk about team working and interpersonal skills

Service user: There wasn’t anything about team working; actually, she’s going to be the saviour, that sounds a bit weird, but that’s, you know, I’ve worked with people like that and I don’t want her to come through my door, actually.

What this excerpt illustrates is how selectors often emphasised some of the applicants’ words and actions, and in so doing, de-emphasised others. They also added content to the words applicants had spoken – for instance, in the conversation above, the service user adds an idea of the applicant acting like “a saviour” to fill in the absence of “anything about teamworking”. In addition, service users and patients were invoked through the phrase “I don’t want her to come through my door, actually”. In an environment that declares patients to be at the centre of everything (NHSE, 2014), a service user not wanting to be cared for by a future nurse made an applicant’s statement unsuccessful.

Another example of interviewer work was the re-framing of the same concept as either positive or negative. Work experience, for example, could be discussed as having a negative effect by having corrupted an applicant’s “lovely values” or positively as giving applicants clear insights into the “realities of nursing”. Similar instances of orienting the same category to different outcomes were observed, for example, in the discussion of regional accents or an applicant’s authenticity. Some selectors treated accents as lack of academic ability, yet others as signifying the ability to interact with patients “at their level”. In relation to authenticity, applicants were discussed as over-rehearsed or under-prepared, having done their research or having been coached, being genuinely caring or “faking it”.

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**The practice of selecting for values in nursing**
Concepts to be considered were inscribed in interview forms and instructions. Interview forms differed in the amount of instruction given. Especially at the site conducting MMI, interview forms and instructions were extensive, barring selectors from talking beyond stating and repeating questions. MMI are seen to be highly structured instruments which seek to eliminate selector bias, yet selectors here struggled with the same issues observed during group and 1-2-1 interviews: applicants just did not talk in the way interview forms anticipated, making it necessary for selectors to do extensive translation work on applicant talk. In addition, selectors in MMI communicated the same level of idiosyncratic judgment when talking about their work. These idiosyncrasies, not expressed in talk whilst interviewing as such talk was prohibited, became apparent in written notes.

**Writing**

Selectors often wrote during or after interviews had finished. However, what they wrote and what meaning was attached to the writing was shaped by the materials employed in selection. Interview forms only allowed for specific texts to be created. This was partly due to the space allocated. Some selectors used the back of interview forms, wrote very little or nothing at all. Writing here constituted the production of summaries similar to those created during talk about applicants but with one major difference: what selectors did during an interview, even if talked about during conversations – and most of the ideas about applicants selectors shared in conversations with MK afterwards – were not recorded. What was recorded were words applicants had said, as in the following example: at the site conducting MMI, an applicant mentioned that:

\[ \ldots \text{you have to be tough; it's not an easy job. You can't cry in front of patients.} \]

On the interview sheet, the words written down are:

Emotional resilience.

This is not just an example of efficient note taking. “Resilience” was talked about by selectors as a highly desirable quality in nurses and nursing students (this is also done in the literature on nursing (e.g. Jacelon, 1997; Stephens, 2013)). The selector here therefore translates words that describe particular ways of being with patients into a desirable trait. Even where selectors wrote much more than in the example above, they only ever recorded some words applicants had said and/or the translation of those words into nursing concepts. Selectors never recorded what they themselves did even if they had discussed with each other their own or another’s influences on applicant talk, such as in references to prompting.

Not all selectors wrote things down. Selectors, where they did not write, stated that they needed to pay attention or that they only wrote when an applicant was to be rejected. As this judgment can only be made after some time during the interview, transcriptions in these cases constituted further reductions: in only transporting the reasons for rejection, everything that could be understood as a counterargument disappeared from record. This process was accelerated through repeated translations which made their origins less and less detectable.

Worded summaries were turned into scores: numbers that represented certain qualities of applicants. A multitude of statements were translated into four or five numbers. Scoring, however, performed additional functions to the “recording” of applicants’ words and actions. Scores allowed selectors to compare applicants. Such comparisons would have been difficult to perform based on words alone because written records were not sufficiently different from each other. Translating written words into scores introduced this difference. The following statements, written by selectors in response to the same
question (answered by different applicants), demonstrate how difficult it would have been to compare written records, by contrast to comparing numbers:

- It is difficult/hard to do; confidence comes hand in hand with courage; maybe nurses didn’t know their job; lack of compassion; staff may be afraid because they could be singled out. (3)
- To see something but immediately raise concern about practice, fear of what might happen to you for doing it, being bold. (3)
- 6Cs; doing good for patients/staff; talk on behalf of patients; shortage of staff-talk to manager; more staff core; example to challenge Dr wash hands. (4)
- One of 6Cs, stand up for right; undone-back to normal; Francis; duty of care. (2)
- Remember why? Important things in nursing; choice; policies are in place; best care. (1)

It is through the translation of words into numbers that the first two statements become equal, the third statement being made the best and the last the worst. Meaning here does not precede actions; it is a result of the action itself. Yet, as with all inscriptions made during and after interviews, the traces of how scores had been generated were not recorded. The Number 3, in the statement cited above, says nothing about nervousness of applicants, indecisions and negotiations of selectors or how a statement on an interview form such as “Identifies a strength and relates objective data” (the descriptor for the score 3) is made to relate to the number itself.

Furthermore, scoring allowed statements about applicants to be transported outside of interview contexts. Local incidents, words uttered in response to questions, conversations held between an academic and a service user in a room somewhere in the UK, become equivalent to future academic achievement and care practice. Latour and Woolgar (1986, p. 182) used the term extension for this untested (and in effect untestable) belief that things that have been verified to happen or exist in one clearly defined space will happen somewhere else. Extension was a major practice in all interviews at all sites. Selectors acted as if what applicants did or said (for better or worse) during interviews could be translated into words or actions outside of the interview context.

Selectors often mentioned in interviews with MK that they were planning to assess the effectiveness of their method through follow-up studies, in which selection scores were compared to essay or overall degree grades. Similarly, the literature on selection (e.g. Rees et al., 2016) judges effectiveness of methods on inter-rater reliability, a statistical method which analyses the similarity of scores given by different selectors. Yet, the scores did not record any information about how they were produced. Scores that were similar were treated as equivalent of genesis. Yet, this equivalence was a product of the deletion of the work selectors did; it was the effect of the disappearance of the traces of translation itself. In numbers (or indeed written feedback) no selector input or “method” was made visible, only reference to the applicant remains, as in the following example of written feedback given to an applicant after her interview performance:

Did not attempt to make decisions/make conclusions.

This statement existed as a tick box option on an interview form, but even where such pre-stated feedback was not inscribed selectors often used routinised responses, such as “Hadn’t thought things through”, or “Didn’t answer in enough depth”. Through these statements, responsibility was assigned to the applicant. By deleting all the work of selectors and the material traces which affected this work and made some things possible (but not others), only the applicant remains as an entity to which the outcome of selection could be linked.
This then was the final step in translation: words, having been transformed into different words and different words again, became world (Latour, 1999b), became the applicant. Through a series of what Berg (1997) calls “summaries”, the content of multiple sources of information was reduced into one statement. This statement then formed the basis of further actions with all other concerns as well as the conditions in which such concerns were presented, moved into the background. Talk and writing here can be seen to be selective actions, and for Latour and Woolgar (1986), it is precisely this selective recording, this emphasising of what is made important through translation and made unimportant through omission, that orders actions into one narrative where other narratives could be possible.

**Conclusion**

The study this paper is based on is, to the best of our knowledge, the only one that examines selection in nursing ethnographically. In this paper, we have demonstrated that contrary to claims made elsewhere in the literature about values as essential and observable through applied methods, having qualities such as values is an effect of the interactions between interview materials, selectors and applicants.

One of the difficulties which selectors faced was that establishing a set of qualities consistent with all nurses constructed applicants as similar in precisely those ways that formed the basis for differentiating between them. Applicants were not only made the same in terms of potential nursing qualities, but also needed to be different from each other in order to be distinguishable. Despite HEE’s claim that applicants consist of specific qualities, such as values, independent of selection method, in practice these qualities could be seen to be assigned, both by applicants to themselves but, more often, by selectors. Whether a quality was successfully identified was the result of negotiations between applicants, selectors and the materials of selection. However, this work was progressively deleted from the record, purifying method, selectors and applicants alike.

In terms of the significance of this study, conducting it has allowed MK to reevaluate selection and made it possible to articulate to fellow selectors how over-emphasising design perpetuates a myth of method – as well as values – as pure, overlooking contributions of selectors and applicants alike in the construction of a “right” or “wrong” applicant. In MK’s own professional practice, selector reflexivity is encouraged through discussions prior to and after selection interviews with individual decisions discussed, explained and challenged.

Such reflexive activity serves as support to remind selectors that the decision about whether an applicant will be offered a place and therefore by implication is “right” for nursing (or not) is an effect of the circumstances in which such decisions are made, rather than a property of the applicant only. Beyond MK’s own professional practice, the study also makes it possible to highlight the value of empirical inquiry into VBR, and make the case that research should not only focus on finding more and more structured or “better” selection methods, and also look closely at how values are enacted in situ – how they are the product of a set of interactions. This has extensive implications for conceptualising the relationship between selection practices and professional culture. The method adopted by this study suggests that values can be understood as the product of a set of ongoing relationships, which change over time and in relation to a range of actors, rather than fixed, stable and located in individual professionals.

Such an insight is important as it suggests the importance of re-evaluating the “quick fix” to the problem of professional culture in nursing, put forward by the Francis report. It highlights the need to re-introduce some of the complexities that seem to get lost in the prevailing discourse on VBR. In this sense, this paper is meant to stimulate debate and invite responses from practitioners and policy makers. The issues discussed in this paper are unlikely to be nursing-specific and similar tensions may be present in other healthcare-related and value-driven professions. Selection could therefore be researched...
ethnographically in fields such as physiotherapy and medicine. In each case, professional culture and its values could be treated methodologically as interactional achievements, rather than individual attributes.

Note
1. Citation removed from manuscript to ensure anonymity for review.

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“Bring yourself to work”: rewriting the feeling rules in “personalized” social work

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Abstract

Purpose – The purpose of this paper is to explore how feeling rules are constructed, experienced and contested within personalised social work practice. It considers how organisations seek to shape practitioners towards certain forms of emotional display in increasingly market-oriented conditions. It contributes to our understanding of the place of “backstage” emotional labour in seeking to shape and direct social work practice.

Design/methodology/approach – A single immersive ethnographic case study of an English social work department was undertaken over a period of six months.

Findings – This paper reveals embedded tensions that emerge when practitioners are caught between traditional bureaucratic function, the incursions of the market and feeling rules of relatability, commitment and creativity.

Originality/value – This paper contributes to the scant literature on frontline experiences of personalisation in children’s services and the importance of “backstage” emotional labour for shaping and directing social work practice. Importantly, it considers the complexity of emotional labour within an organisational context, which is neither fully marketised, nor fully welfarised, a position many welfare organisations now find themselves in.

Keywords Social work, Personalisation, Emotional labour, Feeling rules

Paper type Research paper

Introduction: “bring yourself to work”

I have a way of thinking about where I put people and one of the questions I ask myself is, “Does this person bring themselves to work?” Somebody who brings themselves to work, so they understand themselves, you know, the philosophy “know thyself” – they know where they’re coming from, they understand their own prejudices. People that bring themselves to work, they’re the people who love what they do, so work isn’t tiring its energising. That person is likely to be able to embrace the personalisation work and there are no limits. The person who quite likes to be a local government functionary is going to struggle.

This was the first, but not the last, time I encountered the managerial call for social workers to “bring themselves to work” within the organisation I was immersed in. On this occasion, I was interviewing the director of the child and family service; I had been based with one of his social work teams for the preceding two months at the time of his interview. His call was a central plank of his broader quest to reorient the emotional bonds of the work being undertaken. On the surface, his account appeared as a call for relatability, familiarity and authenticity when working with families. He emphasised a form of self-work, self-knowledge and emotional accountability; features deemed essential to the task at hand and were set in contrast to the abject subject, “the local government functionary”. His call was to be enacted within a changing organisational context, one of personal budgets, talk of “markets” and “commissioning”; yet one also regulated for its fidelity to bureaucratic rules.
and professional values of care. Here, my interest was piqued, and I began to explore how managers in this site sought to remake the affective dimensions of social work and equally how social workers responded. Over the coming months of ethnographic fieldwork, the central imaginary of the “bring yourself to work” professional provided the moral tone at the heart of the managerial quest to remake the organisational feeling rules. It became clear that these discursive invocations became performative expectations, matrices of new forms of address and accountability were forged to demonstrate fidelity to this spectre and the reworked feeling rules that accompanied it. As such, the emergence of this figure at the same time of the implementation of a localised form of personalisation was no accident, rather, the two went hand in hand and reflected broader trends, exerting influence over professional welfare practice caught as it is between traditional bureaucratic function, the incursions of the market and affective discourses of relatability and responsiveness.

Over time, the imaginary of the “bring yourself to work” professional emerged as a central figure in rewriting the “feeling rules” of the organisation. Embedded in this process was a growing concern that professionals “display” their affective connection to their work, rendering it a site of audit and assessment. Yet, social workers themselves responded differently to these demands to display their emotional labour in internal processes and paperwork. As I traced the twin threads of desire and discipline centred around this imaginary at a time of change, Hochschild’s work (1983) on emotional labour, feeling rules, and their display came to the fore.

This paper takes up those threads to consider the emergence, disciplining and frontline response to the rewriting of feeling rules in this organisation at a time of change. It addresses these features in three steps. First, it explores the construction and reiteration of the “bring yourself to work” imaginary by managers. Here, the paper explores the imaginary as a product of managerial desire and as a crucial linchpin for altering organisational culture at a time of change. Second, the paper turns to how feeling rules and their display centred upon this imaginary became disciplined into everyday practice through ceremonies, auditing practices and rituals. Finally, the paper considers the ways in which professional social workers subverted, resisted and reworked these feeling rules to their own ends. The paper contributes to the scant literature on frontline experiences of personalisation in children’s services (Whitaker, 2015; Mitchell, 2012a, b) and the importance of “backstage” emotional labour for shaping and directing social work practice (Gibson, 2016, 2019). Importantly, it considers the complexity of emotional labour within an organisational context, which is neither fully marketised, nor fully welfarised, a position in which many welfare organisations now find themselves in.

Hochschild’s “emotional labour”
For the purposes of clarity, it is important to track Hochschild’s (1983) conceptual contributions before turning to the substantives of the case at hand. Hochschild’s work rests on the distinction between what she refers to as “emotion work” and “emotional labour”. Emotion work is the experience and process of managing and presenting emotions in our private lives, this “work” is undertaken with family, friends, partners. Emotional labour, by contrast, is “[…] the management of feeling to create a publicly observable facial and bodily display” (1983, p. 7) by, in her original formulation, service workers. In the “public sphere” of emotional labour, those working on the frontline experience the commercialisation of feeling as “private sphere” feelings are mustered, managed and deployed into a package of emotions consumed by customers as a commodified interaction. The organisation is central to this process of commodification as it shapes and seeks to control the form, timing, giving and withdrawal of emotional feelings, moods and their display so that they come “more to belong to the organization and less to the self” (Hochschild, 1983, p. 198). The script which seeks to “codify” emotional display, and which is the central focus of this paper, Hochschild calls the “feeling rules”.
Feeling rules and their display
Hochschild’s (1983) work on emotional labour considers not only the accomplishment of cultivating and managing emotion at work, but how workers are encouraged to align their genuine emotion with an organisation’s “feeling rules”. Feeling rules are the social norms that seek to guide what to feel, when to feel, where to feel, who to feel with, for how long to feel and how fervent our emotions should be. They are an organisational frame that guides actors to interpret their work and work-related encounters through appropriate displays of emotion. The precise nature of the feeling rules, their construction, implementation and how they are experienced varies. But they share a common feature: they inscribe managers’ attempts to re-work employees’ interpretative schemas. Feeling rules come to be through interaction; through the complex of interplay between colleagues and clients; and through managerial supervision, appraisal and training. They are not a free-standing list of prescriptions, they are not definitions of emotion floating above the accomplishment of everyday work, rather they are aspects of the interaction order, feeding and shaping local cultures and practices. They are thus both a medium for encouraging some ways of being and doing “work” and an outcome of repeated embodied practices that are organisationally recursive (Williams, 1998).

Feeling rules are also concerned with governing emotional display. These display rules cover when and how to show requisite emotion as laid out in the organisation feeling rules. Display rules refer to standards for organisationally appropriate emotional expression in work-related contexts. Organisations set and impose display rules implicitly and explicitly to provide employees with a sense of “how we do things around here”. Induction, recruitment, training, written policy, performance appraisals and supervision are all sites for enculturating employees into display rules (Hochschild, 1983).

Feeling rules backstage
In keeping with Hochschild’s gaze, much research on emotional labour focuses upon “service encounters” – between sales staff and customers, nurses and patients, teachers and pupils. This paper does not delve into the well-trodden terrain of the ways in which professionals regulate their display of emotion to give rise to, suppress, or manage the responses of others in such encounters. In the case of social work, this “frontstage” terrain of interaction between social worker and family has been covered adeptly by a number of authors (Ferguson, 2016; Winter et al., 2018; Lavee and Strier, 2018). Nor does this paper attempt to assess the “impact” of emotional labour on workers as others have done (Timmons and Tanner, 2005; Turnbull, 1999; Leeson, 2010). Instead, this paper is concerned with the “backstage” – how management sought to imbibe and encourage the display of feeling within internal team practices and how professionals responded. The lens therefore is geared inwards – towards the organisation itself. In this ethnographic case, managerial attention was centred upon the demonstration of feeling in written accounts and in the marginalia of social work documentation. This is unsurprising given the “invisible” nature of much social work activity, which takes place away from the managerial gaze (Pithouse, 1987). Social workers, in practice, retain a high degree of autonomy through the “unmanaged spaces” (Bolton, 2005, p. 102) that still exist within the interstices of organisations.

To rewrite the feeling rules often demands a rupture in policy and practice, or a shift in the cultural orientation of an organisation (Turnbull, 1999; Johnson, 2015). This case was no different and to understand how the “bring yourself imaginary” came to emerge, it is necessary to consider the rupture provided by the implementation of “personalisation”.

Personalisation: the context for the rupture
Much has been written about personalisation (cf. Needham, 2011; Houston, 2010; Garrett, 2012) – the swathe of loosely linked policies that have gripped the minds of English
policymakers and politicians over the past decade. Central to these initiatives is the narrative of “choice and control”. However, how this is to be realised, from whose vantage point and with which tools remains deeply contested (Lymbery, 2013).

Personalisation has become known for its ideological and linguistic flexibility, which offers both political potency and frontline ambiguity (Needham, 2011). First, it promises “choice and control” to service users. In the English case, this has been symbolised by devolving finance to service users enabling them to purchase support from the public, voluntary or private sector. In this regard, it builds upon the “culture change” and “modernising” agendas of New Labour’s Third Way (Newman and Vidler, 2006) and upon successive conservative measures to “open up” markets in public sector provision. It is the market that provides the new axis around which professionals are to rotate, as service users are given choice and control through the devolution of financial power, symbolically and practically through the creation of personal budgets from which they purchase services, goods and support.

Second, personalisation accelerates the redefinition of the subjectivity of the citizen and of the public service professional. The state and its actors no longer “fix” problems, or “fit” individuals to services; rather they guide, support and enact the voice and will of service users through their frontline encounters and purchasing behaviours. Citizens are not merely buying support to meet socially defined need; they are enacting a right to choose, building a biography around their choices. There is a shift from an internal emphasis on bureaucratic rules to an individualised orientation within hitherto public welfare work (Gilbert, 2002; Clarke, 2004). In place of directives about organisational processes and regulatory requirements, the personalisation agenda seeks to invest work with meaning. Gone are the days of a language of inputs and outputs, rules and procedures, instead are encouraging mantras of flexibility, liberation and creativity.

It is these mantras that feed into the construction of the “bring yourself to work” imaginary. The personalisation agenda commonly paints a picture of “freedom” and “choice”, enabling social workers to “reclaim” and “return” to true social work practice (Hudson, 2009; Duffy, 2010) – relational and immersive, a “new spirit” as Garrett (2012) notes, freed from the suffocating bureaucracy of the past. Freedom is conjoined with the demystification of the welfare state and of professional power and expertise, in particular. Garrett (2012) makes his argument wisely, for at the same time as the projective tenor of feeling, hope and authenticity permeates think pieces about personalisation, there is next little discussion of the place of social work in official policy pronouncements and guidance (Lymbery, 2013).

The creation of quasi-markets, the broadening of social work roles, combined with a heady emotive backdrop in Bourdieusian terms, “remakes the world” for professionals on the frontline who find themselves positioned precariously within these various demands and expectations (Latimer and Munro, 2015). As Bjerge and Bjerregaard (2017, pp. 100-101) depict, in such spaces professionals are, “caught in a twilight zone […] a work situation characterized by pluralistic, often paradoxical demands and conceptions of welfare services; between ideas of entrepreneurship and private sector strategies and practical, material conditions grounded in more traditional principles of public administration”.

**Introducing the case and method**
The data discussed derive from a six-month study of a team of children’s social workers and their managers, who were tasked with implementing personalisation in their everyday practice with disabled children and their families. The aim of the study was to explore how personalisation gets done on the frontline of social work practice. It is concerned with the work of social work explored through an organisational ethnography. Its focus was on the performances of personalisation, which unfold at the intersection of people, systems and
practices in the everyday work of one team. The research paid particular attention to changing performances of face/identity work, of altered practices of account-giving and of new interactions with audit wrought by personalisation operating within a mixed economy of welfare. Participant observation enabled me to focus on the less-explicit aspects of organisational life, including, as addressed here, shifts expectation around emotional display and its governance (Hammersley and Atkinson, 2007).

The team consisted of eight social workers and was headed by an experienced team manager. The team carried out social work with families who had a disabled child, and were tasked with implementing a local form of “personalisation”. Families were encouraged to take a personal budget in order to purchase support for their child, from a “menu” of services offered by the public, private and voluntary sectors. This represented a significant departure from the team’s former practice. Workers continued to undertake statutory duties of assessment, review and home visits, but were additionally responsible for finding and brokering services on behalf of families, and costing and auditing personal budgets.

The fieldwork consisted of 400 hours of observations. Observations included everyday activity in the team office, team meetings, management meetings, group supervisions and one staff training day. Lunch breaks were shared with team members when possible. I engaged in informal conversations in the office, attended meetings and shared car journeys to and from events. I recorded fieldnotes during the day, and typed them up the same evening alongside the creation of analytic memos – notes to myself of ideas and questions to follow-up on. My observations were supported with semi-structured interviews with all staff. Interviews explored the changing nature of social work practice, the challenges of delivering “choice” and the move to personalisation. The interviews lasted between 90 and 120 mins, and were recorded and transcribed verbatim. Ethical approval for the research was given by the University of (blinded for peer review) ethics committee.

### Data analysis

On exiting the field, fieldnotes, documents and interviews were transcribed and uploaded to NVivo. Following Charmaz and Mitchell (2001), a modified grounded theory method was used to analyse the ethnographic data, which enabled me to explore key incidents and events. Memos were written whilst in the field supporting me to “puzzle out” (Becker, 2014) threads and traces of inquiry to pursue further. This also befitted the abductive analytic strategy of the study as a whole (Blakie, 1993). On exiting the field, interview transcripts were analysed for their thematic content using researcher-generated codes, which had emerged as key lines of inquiry in the field, e.g. costing, child protection, “gatekeeping”. I then coded at three levels – locally emergent categories for analysis (participant talk), my own categories built upon observation in the site and meta-level themes (policy discourse). I placed primacy on local turns of phrase, concerns, methods of work provided by participants. They offered nuance and complexity to the self-generated or meta-level themes and acted as a check on my own sensemaking. I annotated fieldnotes with thoughts, events and related speech, forming a kind of analytic chain. These were then read against coded transcripts to engage in a form of falsification.

### Bring yourself to work emerges: personalisation as rupture

In my interview with the director, I asked questions about how personalisation came to emerge in the site, what key organisational moments were and the place of devolved finance. His responses were rich with personal references and anecdotes from his own professional history and ambition (cf. Whitaker and Atkinson, 2019). He told me that the emergence of personalisation in the site was part of his “journey” and was part of his “commitment to being a cradle to grave worker, as long as they keep employing me to do what I am doing. I’m likely to be doing this for the next ten years and I’ll continue that trajectory”.

“Bring yourself to work”
The team was aware of his long-term commitment to changing frontline practice that his professional biography reflected. It was a touchstone for local sensegiving activity (Gioia and Chittipeddi, 1991) – a living example of what commitment, passion, empathy in practice looked like. This was noted by all team members, “we’re 100% being driven by him” said one, whereas another commented, “the ideas about this way of working very much sits with X [the director]”. His deputy, the group manager, told me during a car journey, “he’s there to spread the gospel”. As we spoke, his biography became interwoven with a specific worker imaginary of his own – the “bring yourself to work” professional:

I have a way of thinking about where I put people and one of the questions I ask myself is, “Does this person bring themselves to work?” Somebody who brings themselves to work, so they understand themselves, you know, the philosophy “know thyself” – they know where they’re coming from, they understand their own prejudices. They’re the people who love what they do, so work isn’t tiring its energising. That person is likely to be able to embrace the personalisation work and there are no limits. The person who quite likes to be a local government functionary is going to struggle.

The account is future-directed, professionals are cast as becomings – which management, led by the director, sought to realise through training, supervision and managerial directive. They are committed, creative, reflexive, they love what they do as it is an extension of the self. One way in which they bring yourself to work figure seeks to muster emotional connection is through the willing and enthusiastic breaching of the boundaries formerly separating “home” and “work”. To “bring yourself to work” is a call to marshal one’s personal and affective resources. The director made this explicit as he told me:

The most consistent message I have for my team is that the disabled children we work with should be considered in the same way as you’d consider your own. The wishes and dreams of the children we’re supporting should be the same wishes and dreams you’d want for your own children.

The allusion to family life for professionals working with children is a powerful one. It provides a useful way of capturing the emotional and social skills of workers in a recognisable familial frame – enhancing the required emotional labour of the work itself. The relational quality of “wishes and dreams” and the deliberate quashing of personal/professional boundaries seek to forge collective identification. In Hochschild’s (1983, p. 56) terms, the organisation is seeking to bring “genuine” emotion into line with institutional ambition. Rather than hide, suppress or deny those unique elements of self that make up the individual person at work, family practices and ambitions are encouraged.

To bring this figure to life, a number of ritualised encounters between employers and managers were created. Group meetings, various presentations, training sessions were core to this activity. He explained:

I’m trying to slowly inject values partly through documents, partly through if you sit in any meeting with me, I drop in on the monitoring group or team I will give little lecturettes on topics, so people will have a few minutes, bite-sized, I’m now going to “tell you”. It won’t matter that some people won’t be able to articulate things quite as clearly as I do in a small “p” political way. But if they internalise the practice, that somehow they internalise the increasing respect for families, showing care, compassion, enthusiasm, empathy, that’ll be a success.

To “bring yourself to work” is about undertaking specific forms of emotional labour – compassion, enthusiasm, empathy, commitment, creativity. Here, and in many other instances including the “lecturettes” I witnessed, the director attempted to specify the kinds of emotional labour required of successful, and thus exemplary, employees. Over time, this codification of emotional labour became ubiquitous and familiar, a backdrop to everyday working life. They became the feeling rules, the expectations for the display of emotion.
During one of his “lecturettes” in a management meeting he said:

I want our staff to deeply engage with families and show that in their work. I want our teams to really get to know these children, to have and show the children they support the same care and ambition they have for their own children. I want to be able to see the child in the documents. It’s about high expectations and having them for yourself and for the children we work with.

He wanted to see social workers draw upon what Hochschild (1983) would call “private” emotions in their work. This close identification was referred to in our interview together:

I want staff to really identify with families, someone who seeks to see the best in families. You know, someone who manages and absorbs their crankiness, puts it down to them having a bad day and moves on. If you bring yourself to work, you’re flexible, you muster and manager your own sentiments carefully, you reflect on them, aware of your prejudices.

Feeling rules were not merely geared to impression management, or as Hochschild (1983, p. 35) put it “surface acting”, but were concerned with the production, enculturation and maintenance of a certain kind of morally imbued professional identity. The organisation sought “deep acting” (Hochschild, 1983, p. 35), where valorised feeling is self-induced in the undertaking of professional practice in line with organisational desire and expectation.

This was a local interpretation of the place of emotional labour under personalisation, but management had much to draw upon from the broader landscape. The demand for relational connection, to “bring yourself to work”, has been rendered explicit in works by the thinktank IPPR (2014), who argued for “deeper relationships” between workers and citizens whilst assuming that the emotional labour, this requires, is an endless resource. Workforce Scotland (2015) encourages public sector workers to “be brave, sensitive, mindful, daring” in their work. These two examples belie the backdrop of numerous studies on corporate culture, which, over the past two decades, have discovered similar calls for workers to emote and “be themselves” (Spicer, 2011; Fleming and Sturdy, 2011). The local authority at hand is not the first to call for workers to “bring themselves to work”; on the contrary, they were tapping into a much larger zeitgeist.

The “bring yourself to work” professional is cast in opposition to another imaginary, “the local government functionary”:

For too long, local government functionaries weren’t thinking. They were doing things for panels and paperwork, not for children and families. What we’re doing is injecting back into the workforce a sense of value and purpose. So for me there’s something about success will be workers being able to engage in the creative process. The person who quite likes to be a local government functionary is going to struggle because what we’re doing with personalisation is about conversations and engagement, offering ideas, personal responses. Now the people that love what they do, that isn’t tiring, it’s energising. But those just doing the mechanics, but don’t understand why and engage with it, well it’ll always be hard work for them.

The local government functionary is tied to process in a factory-like world of fixidity. The “bring yourself to work” professional is supple, weaving patterns of engagement; the local government functionary is “unthinking” a procedural being, one devoid of deep reflexivity with the self and the work. The functionary’s unwillingness to “bring themselves to work” or to align their personal affect with their professional work casts a question over their practice and suggests a moral failing. The functionary is “just doing the mechanics”. Ritualised encounters that sought to move practice away from the functionary were commonplace, but the organisation went further – building an informal architecture to monitor and assess the adept display of feeling rules associated with bringing themselves to work. The demonstration of feeling rules became key indicators for auditing professional practice.
Disciplining and auditing the feeling rules

Over the years, social care has been identified as an environment rife with micro-management and tight monitoring (Parton, 2008). Social workers report increasing pressures to display their decision-making activity through clunky Information and Communication Technology technologies, online case notes and reporting, increased surveillance through repeated inspections (Hall et al., 2010). They at every turn must “show their working out”. The director’s emphasis on personalised responses and the adept display of feeling has to contend with such a context. To “bring themselves to work” must be enacted within bureaucratic confines, which demands social workers display accounts of their work at every turn.

The feeling rules (to demonstrate commitment, empathy, passion, creativity) became performative expectations through the bi-monthly meeting of the so-called “Monitoring Group”. The director, his deputy, the team manager and other managers from across the children and families service group attended these meetings. I was told that this organisational routine was about lightly surveying the paperwork social workers had submitted from initial assessment through to family spending and purchasing decisions. I was informed that the group was there to “monitor” what was being purchased and how.

Yet, in the eight meetings I attended, which commonly lasted for 3 hours at a time, this “light touch” was not apparent. There was a much deeper scrutiny at play. Paperwork submitted by social workers was pored over, looking for evidence not only of coherence between the child’s assessed needs and family spending decisions, but that social workers were “deeply engaged”, with their work. Group members would scan documentation for evidence of “engagement”, “commitment”, “creativity”, and that workers were “building meaningful relationships” with families. The group evaluated assessments and financial plans, but they were also keenly exploring how well the feeling rules were being performed. This meeting provided a space for the moral interrogation of the work and of the person undertaking work with that family.

The group could send workers back to re-assess children, to re-calculate budgets, or could criticise workers for a “lack of engagement”. The feeling rules were invoked in evaluating how successfully workers had “ingested the values”. The monitoring group could become agitated if they felt workers were not taking “ownership” for their decisions. The director saw this as evidence of “workers not thinking for themselves”, and saw the budget process as a useful device to tackle a culture of “buck-passing”. He told me that the practice of commissioning was a facet of a new culture:

Social workers are posed with a fundamental shift where they have the power to commission directly with and on behalf of a family. All of this forces decision-making and accountability, they are required to be more responsible for decisions made and to account for them – I hope people will become proud of their work.

Managers would often complain that the paperwork submitted did not demonstrate the requisite level of “ownership”. Fieldnotes from one of the monitoring group meetings demonstrate this:

Manager 2: Some of them [social workers] are stating in their paperwork “subject to ratification by monitoring group”. It makes me cross. It’s the shifting of responsibility to us. It’s their work. Their family. They need to justify it, show us they really get the family.

Director: They’re [social workers] posed with a fundamental shift, they have the power to commission directly with and on behalf of a family because they know [his emphasis] the family. If I can see the child, see the relationship then they can practice with money now.

Manager 3: All of this should force decision making and accountability, they are required to be more responsible for decisions made and to account for them. I’m just not seeing the deep engagement.
Director: I know, I hope people will become proud of their work. But it’s an adjustment taking ownership, documenting how they got there.

Manager 2: I’ll have a word in supervision. They’ve got to show us they get it.

The ambition was that the introduction of costing, commissioning and auditing practice would promote a culture of “personal ownership and engagement”. The rationale for rewriting the feeling rules, while expanding market-based “choice”, was premised on understanding family preferences, routines and aspirations in a deeper way: one that required emotional labour.

Workers were accountable by proxy as reams of information and paperwork generation were bundled together, tying professionals to their work through an extensive paper chain. Not being able to demonstrate “real engagement” had consequences. Workers would comment on being told to re-assess children for eligibility or to provide a more precise support plan. As documented in the fieldnotes above, supervision could become a site to “have a word” – to correct a lack of emotional display in written work. Social workers could feel guilty when this occurred:

I feel bad that what I’ve written apparently isn’t what managers want and you’ve almost let the family down because you haven’t justified it in the correct way even though you know that the family need it.

Following a supervision, a worker told me they were chastised for producing paperwork, which was not “real” and did not “capture the child”, whereas all were encouraged to take steps to better “engage” with their work commonly through the provision of training. This chimes with Gibson’s work (2019), which underscores how important feelings of pride and shame are for organisations when seeking to construct and alter forms of practice. Workers’ organisational identities could be de-stabilised and threatened by being cast as the “local government functionary”. As Alvesson and Willmott (2002, p. 629) found that “defining a person by defining others” is a powerful way to regulate identity. Being cast as a recalcitrant body, “not getting it”, “not moving on” could be a source of real discomfort. As Bolton and Boyd (2003, p. 304) suggest, the ceremony of surveillance “opens the emotional labour process to critical scrutiny”.

Frontline responses
The schism between the feeling rules and the culture of quantification and process was felt on the frontline. It led to the creation of two strategies: “getting by” through discretion, and “getting back” through resistance. For those “getting by”, the accounting work was a “sideshow” to the “real work” of spending time with families. For instance:

I have been really naughty, so far I’ve put in no paperwork and I probably will get pulled up on it at some point. But to me, why fill in all this paperwork for something that does nothing? To me it’s just extra paperwork that I don’t really have the time to do, and unless it’s going to make a difference to my kids at the end of it, I’m not doing it!

Another stated: “All I’m concerned about is that my families get what they need at the end of the day”. Those team members are using the same feeling rules to “get by” within the organisation; by focusing on the work they had done, and by emphasising the interactional heart of their work, they espouse the feeling rules as an act of subversion against bureaucratic demands.

They sought to deliver on the promises they had made to get “closest to the child” and to “deliver for the family” by challenging the organisational “roadblocks” they identified. Those workers were keen to demonstrate their active agency, often in spite of the rules of the organisation. They made clear their emotional labour to managers and peers in person,
spending as much time with families as possible. In doing so, they live by their own conceptions of appropriate emotional labour. They, thus, work around the organisation’s demands. They were far from being “crippled actors” (Bolton, 2005), but maintained their “authentic selves” by working against organisational procedures. In speaking the language of engagement and relationships, they felt they were able to ignore the strictures of documentation. As Johnson writes of the phenomenon in a different setting, “the internalised service principles and related feeling rules had been turned around against the company” (Johnson, 2015, p. 123).

Importantly, this is not a case of “two tribes”, as though management and staff were fundamentally at odds. There was a commonality of discursive repertoires used to describe what it means to do and “be” a social worker. Much of this was encompassed in the “bring yourself to work” imaginary – to relate, to have integrity, to practice with compassion and passion. Over a coffee with two workers, this shared vocabulary became apparent:

I love it! I love, I like the whole sense of being able to empower people and letting them decide where they want their life to go. So to me that’s the optimum bit of what your role should be, facilitating somebody to pick and choose. I’m here with a lot of enthusiasm for that. I think it’s being more respectful, committed; you have to think on your feet, try things out. It demands more from you. There’s a lot of back and forth time with families, you go and suggest things, you let people think about it then you go back another time.

The other added:

I try to always keep my practice as person-centred as I can which is difficult as sometimes I feel that it ends up being very process-centred. So much paperwork! I keep bringing it back to the person, to their needs, the whole time trying to think creatively, you know what could they do, thinking a bit outside the box. It’s hard to show that in the forms, but I do my best to show that I do get these families.

But as others have found (Sveningsson and Alvesson, 2003), discourses of identity are received and interpreted in specific contexts, they are open to contestation and challenge. Organisations cannot simply “impose” professional identities, even where concerted action is taken to rethink and reorient work, through role change or rewriting the feeling rules (Watson, 2008). For a number of workers, the feeling rules were out of step with the practice and procedural demands of the work. The imaginary simply did not hold in the face of changing practice demands. These workers adopted a strategy of “getting back”, which pivoted on quiet resignation and resistance. During a team meeting, one said pointedly to the team manager, “We used to do social work, now we do costings”. In reply, another said they were concerned about “being outsourced”, as much of their work was “an admin job”. The feeling rules – “being there for the child” and “deep engagement with the family” – were experienced as incompatible with costing and audit. Here, the procedural work has introduced “competing bases of identification” (Knights and McCabe, 2003, p. 1589). These social workers found themselves caught in a shifting nexus of contradiction and struggle over what it means to “do” social work. Where some workers brushed off demands, several spoke of being “resigned to their fates” or were considering moving roles: “I don’t want to be in this team for too long. You want to protect your job and not be outsourced”. Many felt precarious. They experienced a dissonance between the costing work they were now tasked with and the moral appeal – the “calling” – of the vocation they had qualified in. This group saw the feeling rules as strategic manipulation (Goffman, 1959) to achieve a market-based system: “it’s all about the money; I can’t be committed or enthusiastic when it’s about cost”. As one quipped loudly during a training session, “I feel like a mathematician these days. It’s not what you come into the job for”.

For these workers, the feeling rules were experienced as a displacement device to smooth over the incongruities between cost and care rationalities (Trydegård, 2012;
Waerness, 1984). When managers appealed to them, they were often met with a form of “soulless conviviality” (Gorz, 1989, p. 145): workers would go through the motions of the work but would “not be taken in by it”.

Conclusion

The “bring yourself to work” imaginary was a talismanic figure for the organisation. It was a central figure for rewriting the feeling rules, becoming the blueprint for the kind of emotional labour the organisation sought to inspire. In exploring the contours of the “bring yourself to work” professional, this paper in line with others (Gibson, 2016, 2019) has identified the importance of “backstage” emotional labour in shaping what is possible and permissible in contemporary welfare practice. This imaginary was concerned with the production, enculturation and maintenance of a certain kind of morally imbued professional identity. It stood in contrast to the “local government functionary”, which hovered as warning for staff, demarcating poor practice and conduct. These twin figurations show the importance of imaginaries for steering and shaping both professional practice and its emotional display.

During my time in the site what emerged was less a resistance to the feeling rules per se, to be committed, empathetic, passionate, creative, to forge “deep relationships” through this emotional labour. Many of the frontline team were keen to work in this way. Rather, the problem was the commodification of those connections, and the requirement to demonstrate them on demand through impersonal chains of documentation. The introduction of marketised tools (personal budgets) within an existing framework of bureaucratic demand curtailed the ability to “live by” those feeling rules. Many social workers did want to “bring themselves to work” but the procedural demands of that work undermined that calling.

This social work team found themselves enmeshed between market practices, bureaucratic forms of accountability and affective invocations. This is because the feeling rules were rewritten whilst the social work role became still more heteromorphic. Professionals were to be entrepreneurial support planners, adept diagnosticians, orchestrating commissioners, detailed reporters, accountable agents and family advocates. Accounts of professional judgment were interwoven with processes of calculative decision making and emotional labour as boundaries between them became blurred. This is important for other welfare bodies who are considering implementing their own form of personalisation, for it will be always already caught within existing frameworks for accountability and process. Personalisation is layered on top of pre-existing statutory and professional systems, it does not remove them.

The tropes of corporatized idealism (creativity and flexibility) rubbed up against bureaucratic necessity (to account for, capture and audit spend) and professional values (care rationalities and ethical practice). This gave rise to discursive and practical contradictions. Social workers experienced contradictions between managerial exhortations to emote and to relate – to “bring themselves to work” – and the disembodied processes of paperwork generation and financial audit. Yet, it would be wrong to suggest that these professionals were alienated from their emotional labour in the way Hochschild (1983) described. There was little indication that workers felt a loss of control or ownership of their labour. There was, however, a schism between the demand to act within the feeling rules and the organisation’s emphasis on cost, quantification and bureaucracy.

Taken together, feeling rules and their surveillance cannot be simply disentangled from the upheavals of role and practice caused by an expansion of a policy culture of marketisation. Whereas many saw costing and auditing as a mere tool to deliver upon the promise of choice, for some it started to dominate the work. This led to the workaround by those “getting by”, enabling them to “stay true” by resisting the strictures of paperwork generation. For others, this led to collective actions of “getting back”. Managerial attempts
to rewrite the feeling rules are not intrinsically alienating nor do they result in the production of docile bodies “transmuting” their feelings (Hochschild, 1983, p. 19). Yet, when the tools of the market collide with the call for individual emotional display, a space is created with the potential to commodify relational and interactive exchange; the qualities of affective bond become ripe for audit and assessment.

336

References
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