

Visible persons, invisible work?

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Recently, many initiatives promoting a holistic view of the patient have been developed. In the last 20 years, different models and frameworks have been advanced to operationalize these different forms of holistic care. This article focuses on one specific case of holistic person-centred care, using the sociological theories of articulation work and invisible work to investigate the efforts involved in sustaining its realization. The article builds on a small ethnographic study conducted at a ward in a Swedish hospital implementing person-centred care. Following a nurse, and her patient, through a 'person-centred' admission process and its subsequent procedures, it is argued that person-centred care depends on nurses performing many new tasks which are rarely recognized and appreciated. Secondly, it is argued that nurses are continually asked to do what Anselm Strauss defined as articulation work, coordinating between these different new tasks and established duties. Thirdly, the article discusses the tensions arising when implementing a formalized model of care, which builds on a critique of standardization and objectification, and the work that is excluded and invisible in such routinized operationalization. Finally, it is concluded that while the successful implementation of person-centred care is often argued to rely on the willingness of nurses to surrender old habits, it seems rather to hinge on the skilled inventiveness of these nurses and their ability to overcome the practical difficulties they encounter.

Keywords: articulation work, invisible work, person-centred care, holistic care, nursing practice, shadowing

HEALTHCARE WORK HAS been described as a complex work activity, the core of which consists of 'managing patient trajectories', by investigating, monitoring and intervening to cure or relieve patients' problems (Strauss, 1985b). This has also been seen as entailing the ability to cope with 'the constant emergence of contingencies that require ad hoc and pragmatic responses' (Berg, 1999: 90). *Articulation work* is a form of work serving to get things 'back on track' after such unanticipated contingencies (Star, 1991; Star and Strauss, 1999). While this kind of work is immensely important it tends to be invisible to outsiders and is rarely acknowledged in official accounts. In this paper, I draw on the concept of articulation work to explore the new and additional work that is involved in implementing an increasingly prominent model of healthcare organization called person-centred care.

Person-centred care is a particular approach to holistic care, in which it is argued that by centring care on the patient as a person, inviting them to share their stories and preferences and participate more actively in the delivery of their own health care, patient satisfaction will increase, as well as efficiency furthering a more appropriate allocation of health care resources. It is commonly conceptualized as linked to the perceived limitations of the conventional way of doing medicine which dictates a 'clinical method focused on identifying and treating standard disease entities' (Mead & Bower, 2000: 1088). While holistic and humanistic care have been long discussed in sociological- (see for example: Jewson, 1976; Armstrong, 1979) and healthcare research (Rogers, 1951; Balint, 1957; Engel, 1977), we currently find increased efforts to bring about their realization through models of person-centred care (McCormack et al., 2012). This trend can also be found in Sweden, where for example the new patient law (SFS 2014:821) is argued to contribute to the increased patient-centeredness of Swedish healthcare (Winblad et al., 2015). Some social scientists have contributed to this development by arguing the importance of listening to the patient's voice and paying attention to their lifeworld experiences (Rier, 2010). Others have argued, however, that person-centred care is a feature of a larger personalization trend in society transforming recipients of social and medical care into consumers and furthering the commodification of welfare services (Beresford, 2014). It has also been argued that person-centred care implies increased self-surveillance of both doctor and patient aligning it with a neo-liberal political rationality in which individuals are governed at a distance (Osborne, 1994: 532).

However, few have studied the actual work that goes into implementing and upholding models and standards of person-centred care. In this paper, I examine one particular case of person-centred care in action which promises to make health care genuinely holistic through the introduction of a 'few simple routines' (Ekman et al., 2011; Ekman, 2014). Based on a small ethnographic study carried out at an internal medicinal person-centred care ward I seek to reveal the layers of work 'that goes on around a dominant narrative' (Goodwin, 2014: 48). Additionally, I investigate the tensions arising when trying to formalize a model of care that has its basis in a critique of standardization as giving rise to reductionism and objectification. In doing so I demonstrate how articulation work is especially important under such circumstances. Because while there exist formal descriptions of person-centred care, getting it to work in practice depends on the inventiveness and skills of caregivers in clinical practice.

Methods

This article is based on a small ethnographic study carried out at a hospital ward over a period of 3 weeks during the summer and autumn of 2014. The ward, which I call ward E, is a general internal medicinal ward, of a large Swedish university hospital, accommodating 28 patients. It is structured around four different care modules and three different specialities. In each module a nurse and an assistant nurse work as a team. The work is structured in three shifts (day, evening and night). In each speciality a team of doctors, led by a chief physician, also works. The patient clientele at ward E is very mixed, ranging from acutely ill and bed confined patients to chronically ill but self-managing patients who are scheduled for regular hospital visits.

When doing an ethnographic study of the ways of working of groups like healthcare professional the technique, and attitude, of *shadowing* has been discussed as advantageous (Czarniawska, 2007: 17). According to Czarniawska (2007: 17), shadowing means ‘following selected people in their everyday occupations for a time’, thereby moving with them through their day and being present for all their tasks. Shadowing also enables a view beyond the dominant narrative, especially in studies of organizations, as this approach encourages one ‘to learn what *is* going on, rather than what *should* be going on, as resulting from formal documents and even interviews’ (Czarniawska, 2007: 33).

Shadowing one physician, four nurses and three assistant nurses over three weeks took me all around the ward and the hospital. I attended internal meetings, witnessed handovers and rounds, saw medications being prepared and distributed, helped distributing dinner trays, witnessed patient admissions and so on and so forth. All the professionals that I followed approved my shadowing in advance. All patients that I encountered were informed about my presence and could choose to let me shadow the professional as they interacted with them, or they could ask me to leave. All participants have been given pseudonyms beginning with the first letter of their role. For example, nurses have all been given a name starting with N.

The excerpts analysed in this paper are taken from my field notes. Field notes have been conceptualized as both a marker of an ethnographer’s competence and at the same time ‘an embodiment of invisible work’ (Star & Strauss, 1999, p. 22). The excerpts presented here did not look as neat and comprehensible when scribbled down in field. Rather, I developed the notes to lengthy descriptions soon after completing my observations, and these have in turn been worked and re-worked to both summarize and unravel what I witnessed.

As described below I draw on concepts from the sociology of work, as defined by Anselm Strauss (1985b; 1988), to analyse my empirical findings. In coding the material, I have therefore constructed codes through theory, while also allowing for the empirical material to ‘kick-back’ and be anomalous and surprising (Timmermans and Tavory, 2012). Employing this abductive approach I generated theory driven codes such as *type of task* (with sub-categories, developed more inductively, such as *documenting*; *preparing medicine*; *talking to patients*), *coordination* which I specified as either

tasks following each other or as *simultaneousness*, and *breakdowns*. I also generated more empirically driven codes relating to *confusion*; *feeling of insufficiency*; and *definition of person-centred care*. The coding process was accompanied by memo-writing of my own preliminary interpretations and thoughts.

Before and during coding and analysis I have repeatedly read and re-read my field notes with a particular focus on the visibility and invisibility of the work that was carried out. Paying attention to in/visibility means that I have had to consider how the work is represented. Therefore I have also analysed written materials, instructions and documentation internally produced at the hospital ward. These were analysed and coded in tandem with my field notes. Taking advantage of the benefits of shadowing as an ethnographic technique for investigating what is actually going on rather than what *should* be going on, my analysis focused on similarities and differences between my field notes and written materials encountered in the field. I did so by using my theory driven codes on these written materials. This allowed me to see the variation in the content of the codes, and also when the codes did not coincide. Moreover, I could conclude that several of my empirically generated codes were not applicable to the written materials from the field.

The visibility and invisibility of work

My analysis is informed by theories relating to the visibility and invisibility of work. According to scholars in the micro-oriented sociology of work there is nothing that is given in what counts as work (Star and Strauss, 1999). Work that is visible is often associated with 'formal work that is authorised and documented' (Allen, 2014: 4). A lot of work, related to care and home-care, is often made invisible. Holding a hand, changing a diaper or coordinating care can be seen as work that 'just gets done' (Bowker and Star, 1999: 232), meaning that it has no voice, and that it is 'invisible both to friends and family, and to others in the paid employment workplace' (Star and Strauss, 1999: 12).

Star and Strauss (1999) suggest thinking of the visibility vis a vis invisibility of work not as two stable absolutes, but rather as two endpoints along a continuum. This means that work can be more or less visible. The creation of a non-person is one node in this scale. Here, the work is visible but the person doing the work is rendered invisible. An example of this is domestic and service work where '[o]n the one hand, employers usually oversee the work done, sometimes to an astonishing degree of micromanagement. On the other hand, the employees are socially invisible to the employers' (Star and Strauss, 1999: 16). The type of invisible work analysed in this paper is another instance on this scale. Here the workers are visible but the work they perform is invisible, relegated to the background. Nursing is a good example of this as nursing work has a long history of being deeply embedded and invisible both in terms of work descriptions and in terms of record keeping. This invisibility has also been a research topic in nursing studies (McWilliam and Wong, 1994; Latimer, 2000; Allen, 2004; Liaschenko and Peter, 2004; Allen, 2014; Urban, 2014). Nursing work that is routinized and planned is often depicted as visible (Jackson, 1997), while work

relating to social transactions, emotions and the creation of a therapeutic relationship remains hidden (Jackson, 1997; Liaschenko, 2002; McQueen, 2000). According to Bjorklund (2004: 114) the moral concerns of nurses are regularly dismissed, as nurses are often reduced to persons speaking for others rather than being regarded as persons speaking for themselves. Further, the biomedical structure of health care has been argued to obscure practicing nurses 'keen eye for ethical problems' (Bjorklund, 2004: 110). In general, this invisible work is not reimbursed, and it generates a lot of unseen costs, including the donation of free time and 'guilt, fatigue, adverse effects on their psychological, social and physical health' (Bjorklund, 2004: 116).

However, to make work visible is not without its costs, and invisibility is somewhat of a double-edged sword. While visibility can be used as 'resources for workers' own use in negotiations with management', it can also increase 'workers vulnerability to rationalizing agendas' (Suchman, 1995: 60). And while visibility can 'work against automation based on simplified notions of work' it can also lead to increased rationalization (*ibid.*). This means that visibility simultaneously can mean increased legitimacy *and* augmented surveillance and control (Bowker and Star, 1999; Star and Strauss, 1999). Therefore, making nursing work visible is not necessarily a good thing.

One important form of work which is often invisible is articulation work. The concept of articulation work was originally developed by Strauss (1985a; 1985b; 1988) to describe the linking together of tasks, 'the specifics of putting together tasks, task sequences, task clusters – even aligning larger units of work such as lines of work or subprojects – in the service of flow' (Strauss, 1988: 164). However, articulation is more than coordination. It also includes 'the meshing of the often numerous tasks, clusters of tasks, and the segments of the total arc'; 'the meshing of efforts of various unit workers'; and the 'meshing of actors with their various types of work and implicated tasks' (Strauss, 1985a: 8). Articulation is also work happening after breakdowns or unanticipated contingencies as it is 'work that gets things "back on track" in the face of the unexpected' (Star, 1991: 275; Star and Strauss, 1999: 10). Star emphasizes that this work is invisible to 'rationalized models of work' which means that 'representations of work and production that consider a smooth, unproblematic sequence of events as an adequate representation cannot, and will not, admit of local, unique, unexpected solutions to problems' (Star, 1991: 275). In other words, this means that work that is carried out to solve problems arising when routines in rational models breakdown won't be acknowledged, but instead will remain in the background. Furthermore, Gerson and Star (1986: 258) argue that without taking into account and understanding articulation work, we will only be able to provide an idealized representation of work and fail to describe actual situations.

Articulation work as an analytical concept has been used to examine the coordination of activities and tasks and collaborative practices between health care professionals (Goorman and Berg, 2000; Jonvallen, 2009). Grant and colleagues (2015) use it to investigate formal and informal work carried out by GPs and receptionists for repeated prescriptions. Timmermans and Freidin (2007) employ it as an analytical lens to understand how mothers take on a caring role for their children and how this affects

their participation in paid work. It has also been argued that articulation work is not only an ‘unplanned response to unanticipated contingencies’ but that it also includes routinized labour (Hampson and Junor, 2005). Furthermore, Hampson and Junor have convincingly argued that there are visible *and* invisible variants of routinized and un-routinized articulation work. Others maintain that articulation work is something done by ‘the invisible armies of nameless secretaries, support staff, technicians, administrative and other help, editors, and other backstage workers’ (Timmermans and Freidin, 2007: 1351).

Routines for seeing the person

Person-centred care was implemented at ward E in line with a particular model of person-centred care developed at a Swedish research centre. This model had shown, in controlled studies, to have positive effect on the efficiency of the care process, and as a result had been implemented at all internal medicinal wards at a large hospital. Ward E, which is situated at another large hospital in the same city, was not part of this change process. Inspired by this change process, person-centred care was implemented for a trial-period on ward E after a clinic board decision.

The model was presented to the staff by a researcher at a kick-off meeting at the end of the summer of 2014. This kick-off meeting functioned as an education day for the staff at the ward. Some of them had heard of person-centred care before and others not. During this meeting we learned that person-centred care builds on three cornerstones: *patient narrative*, *partnership* and *documentation*. These cornerstones were also called *routines* and had been further adapted and developed by a group of staff representatives and researchers from the research centre for person-centred care. The group had produced an assessment protocol to be used in assessment interviews, a patient diary, and instructions for how to write a care plan and how to document the procedure in the medical record.

We were informed that the assessment protocol should be used in assessment interviews with newly admitted patients. By asking the questions in the protocol the nurse would be able to elicit the patient narrative. Based on this patient narrative the medical team would be able to establish a partnership with the patient, a partnership which should be documented in a care plan. Further, it was emphasized that entries in the medical record should be written in such a way that patients could understand them. Preferably, one should write in the patient’s own words.

Before the end of the kick-off meeting, the researchers from the centre informed us about an ongoing study at the ward. In this study, data had been collected about how patients experienced the care they received, and about how staff experienced the care environment. This data would be followed up in six months. Another part of the study was to review patient records to analyse if person-centred care was visible in the documentation. One of the researchers told us that the aim of this was to discover if one could see the *person* in the documentation or if it remained ‘the same old objectification’.

To ensure the visibility of the person a leaflet on documentation routines was distributed to all staff-members. However, the only guidance available on this topic was the instruction to ‘formulate a patient story’. This can on the one hand be seen as leaving a lot of space for discretionary judgement on behalf of the nurse, who is to carry out the assessment interview. On the other hand this space is circumscribed by the verbal information to write this story in the patient’s own words. Moreover, to break down person-centeredness into, more or less, well-defined routines implies that one can see person-centred care as a series of tasks that need to be carried out and coordinated. As will be presented below, the coordination of these tasks and all the other tasks a nurse has to perform in a normal working day is not always so easy to manage.

Admission

To present the work around person-centred care I will introduce you to Nilla, a young nurse, and Patrick, her patient. Nilla and Patrick first met during a person-centred assessment interview. Before commencing, Nilla and I had participated in a meeting where we had learned that Patrick had a very low blood count, which according to the chief physician was a possible sign of internal bleeding.

Excerpt 1

Before starting the assessment interview Nilla has to find a room where we can sit and talk undisturbed. Patrick shares a room with three other patients so we cannot sit there. Fortunately, one of the examination rooms is available and Nilla leads the way.

To start off the interview Nilla explains to Patrick that this interview is person-centred, “But what is person-centred care one could ask”, she says and laughs, but without answering the question. She glances at the assessment protocol and asks, “could you tell me about why you came to the hospital?”. Patrick says that he has been feeling quite tired recently and that he therefore made an appointment with his family doctor. Since he had such low blood pressure his doctor encouraged him to immediately visit the emergency ward. We discuss Patrick’s goal for his hospital visit which he explains is to receive blood so that he will be able to participate in an important boule game tomorrow.

A person-centred assessment interview is not something that will happen without the articulation work of the nurse. At the outset, Nilla has to find a room where she and Patrick can sit and talk undisturbed. This is vital for person-centred care, but it is not mentioned in the written material given to the nurses, nor was it something discussed at the kick-off meeting. Oudshoorn (2008) has pointed to similar features of invisible work in telemedicine. Discussing the work of home-care nurses Oudshoorn concludes that nurses often have to perform many activities which are not included in the training they receive. In her case, this work includes reassuring patients that they are capable of mastering a new telemedicine technology. Invisible work in this definition is work

that has to be carried out, but which is not included in training and descriptions (Oudshoorn, 2008).

Something similar can be said to be taking place in relation to the excerpt above. Doing a person-centred assessment interview and eliciting a patient narrative is not just a matter of reading questions and following a protocol but requires the continuous efforts of the nurse to make the protocol workable and understandable. However, this is not something that nurses receive any training in. In fact, the only 'training' they received in this particular case was the provision of the type of information given at kick-off meeting. In this sense, nurses are being subjected to new demands. They have to master a potentially highly complicated task, namely eliciting a narrative, without prior instruction.

Documentation

The work that Nilla has to perform not only relates to carrying out the assessment interview, but is also connected to the documentation of the narrative. Therefore, person-centred documentation involves a lot of tinkering by nurses in order to align the assessment protocol with the electronic patient-record. However, this again is not the only kind of work that nurses have to perform.

Excerpt 2

Nilla opens a tab called arrival conversation, double-clicks on reason for admission and starts typing. She tells me that it is difficult to write what has been said during the assessment interview. Nurses are supposed to write in the form of direct quotations, she explains, but as she only took notes on some main points she has problems remembering what Patrick actually said. She asks me if I have any notes from the meeting, but I have to admit that my notes are useless in this situation.

Another problem to grapple with is what to write as reason for admission. Should she write low blood pressure as Patrick said, or low blood count which is the result of the blood test? Again she turns to me and asks what I think. If she writes blood pressure there will be an error which may lead to problems, but if she writes blood count she doesn't write in the words of the patient which she also perceives as wrong.

Once again, Nilla is expected to master a craft in which she has little prior training. The craft of unravelling stories through a few keywords is a skill that ethnographic researchers are trained in and develop over a period of years. Nilla is not an ethnographer, but a nurse and yet she is expected to listen and learn from a narrative, taking notes while doing this and then refining the narrative in the electronic patient record. Previous research also suggests that while nurses engage with patients' beliefs and values, the nursing records and information regarding the psychosocial aspects of care is often incomplete (Broderick and Coffey, 2013). This has been accounted for in various ways. Some cite a lack of nursing knowledge and confidence, while other

stress the high workload, time pressure and lack of supervision (Björvell et al., 2003; Cheevakasemsook et al., 2006).

Further, much coordination of different information and tasks is required for Nilla to be able to document the assessment interview. There is a plurality of tasks: on the one hand Nilla has to follow the person-centred care model which says that she should document Patrick's story in his own words, and on the other she has to account for the chief physician's assessment of Patrick. To do this she cannot depend on the documentation routine since it offers no instructions about what to do. The instructions concerning how to document can be found in the previously mentioned leaflet. When a patient is admitted from the emergency ward, as Patrick was, nurses should consult one routine described as 'Admission from emergency ward' which is presented in figure 1.

ROUTINE FOR ADMISSION FROM EMERGENCY WARD

- use admission notes from emergency ward
- assessment interview to be done by nurse, including patient narrative and advanced assessment, within 24 hours after arrival
- write complementing daily status, and physician should control medicine list

Based on the information above and in collaboration with patient create a Care plan in medical record, written by physician and nurse and handed over to patient after round.

Care plan

Open Care plan in medical record. There you find key words (headlines) to choose from. Use the following:

Health problem, formulate patient story and summarize advanced assessment

Goal, formulate goals with care, including goals formulated by patient

Planned treatment, write planned examinations, treatments, care, as well as patient's capabilities. Formulate patient's need of coordinating activities with e.g. relatives, nursing home and others

Expected length of stay, can be revised if needed.

Figure 1: Routine for admission from emergency ward

Two things can be noted in regards to this routine for admission. First, it is not only an attempt to guide the nurse through the admission process but also a means of formalizing person-centred nursing work. While the routine does not for example specify in detail how long time an assessment interview should take, it does set out parameters for what should be judged as a person-centred admission procedure. Here then, person-centred care seems to have more to do with following a set of instructions than adopting a holistic approach. Furthermore, the routine dictates that assessment interviews should be carried out within 24 hours of admission, leaving no leeway for things to be done differently in the face of varying circumstances. Second, the routine depicts the tasks that are specified as a ‘smooth, unproblematic sequence of events’ (Star, 1991: 275) and does not take into consideration problems that may occur or the articulation work that may need to be carried out. Suchman (1995: 59) has argued that representations of work always involve particular interests and perspectives and that the further away we are from the work of others the more simplified is our view of their work. Studying work at a law firm she discovered that document coding described by attorneys at the firm as a ‘mindless’ labour actually required quite complex interpretations and judgements. Narrative documentation is not exactly represented as unskilled work but neither is the complexity of the task appreciated. While the documentation routines make some work visible, and thus accountable, they simultaneously leave other dimensions implicit. Things that are left implicit are ‘doubly invisible: it is the residue left over when other sorts of invisible work have been made visible’ (Bowker and Star, 1999: 247). In concrete terms, the time spent on things related to person-centred care, and to making person-centred care work, such as thinking out ways of documenting contradictory information will be left implicit, while tasks included in the routine such as ‘formulate a patient story’ are rendered visible.

Coordination

The fact that Nilla decided to practice person-centred care on Patrick does not mean that her other tasks disappeared. She still had to take part in handovers and rounds, get familiar with her other patients (this day there were 6 of them), prepare antibiotics and distribute medicines, take blood tests, document distributed medications and write a nursing report for each patient. This involved considerable work coordinating all these tasks.

Excerpt 3

The last time Nilla documented a person-centred assessment interview she had to stay until 11 pm, and tonight she really wants to get the documentation out of the way. After attending to other tasks she says “Well, I guess I should continue. As you can see I am really hesitant to do this”. She continues writing in the form of direct quotations, but she often deletes what she has written and she does not look comfortable. During the rest of the evening, she often tries to sit down in front of the computer to write, but remembers other things that she has to do or is called away by one of her other patients. I leave Nilla when her shift is supposed to end, at 9.30 pm.

Although interruptions have been described as characteristic of caring work and not only associated with negative aspects (Grant et al., 2015: 317), the interruptions in Nilla's work have fairly severe consequences. The articulation work that Nilla needs to carry out, when dealing with the problems encountered documenting Patrick's narrative has to be done in-between, and after, other tasks she has to deal with. To solve this problem Nilla ends up working an extra hour at the end of her shift to finish the documentation. Both the work balancing the different tasks and the extra hour needed are invisible. They will not be registered in any official statistics (Hampson and Junor, 2005). Rather, they will – like the work performed by the technician described in Shapin's (1989) seminal article – be invisible in the historical accounts. In this way, making the person visible in the documentation of person-centred care appears to imply the performance of invisible work by the nurse.

Ironically, Nilla ends up spending more time engaged in the background work required to follow the person-centred care routines than with Patrick. This finding is also in line with prior research in which literature reviews have revealed that a 'considerable amount of nursing activity is centred on the creation and maintenance of clinical documentation' (Allen, 2004: 277). Although this could easily be dismissed as reflecting Nilla's potential incompetence as a nurse the opposite can also be argued. Nilla appears a highly skilled nurse, but she is asked to do so many tasks for which she has no formal training and for which she has to continually find ways of compensating for unclear routines and unexpected situations. In this sense, the difficulties of performing person-centred care have less to do with Nilla and more to do with the practices routinizing person-centred care as an alternative model of care.

Person-centred care outside the routines?

Taking the definition of person-centred care provided at the kick-off meeting seriously as building on the elicitation of the patient narrative and on partnership in form of an agreed upon care plan it turned out to be anything but straightforward to observe person-centred care in practice. After almost two weeks at ward E, I had not been able to participate in any person-centred assessment interviews. The situation changed when I met Nilla, but it also left me puzzled because prior to meeting Nilla I had observed so many situations which to me seemed person-centred.

Excerpt 4

Peter is at the hospital for an abuse related illness. Today, he will be discharged from ward E and moved to a rehabilitation home. It is early in the morning and Amy, an experienced assistant nurse is talking about Peter who has fallen during the night and injured his hand as he comes towards us. Rather than talking of his hand, Peter wants to talk about when he will be discharged. Amy is talking very animatedly and smiles and laughs when talking. She has a hand on Peter's un-injured arm. Even though Peter looks tired and worried he seems to relax somewhat when talking to Amy. Amy suggests that she can make some sandwiches he can take with him when leaving the ward as it will take an hour or two to travel to the rehabilitation home. A while later

Amy prepares sandwiches for Peter. She tells me that Peter likes to eat and that he easily gets frustrated when he is hungry. However, he has not been that fond of the hospital food. But as he likes sandwiches Amy has prepared quite a few of them for him.

An interesting paradox of person-centred care can be teased out through a close reading of this excerpt. On the one hand, person-centred care is said to be an approach to health care, or a way of being a health care professional. On the other, to advance its uptake person-centred care has been narrowed down to a set of routines. The paradox is that this streamlining and routinization of person-centred care leads to the exclusion of a lot of activities which could be considered highly person-centred. Like in this example when Amy looks beyond Peter as a difficult patient, and sees Peter as young man who needs to eat regularly but who doesn't really like the hospital food. Routinizing person-centred care, the person-centred work that Amy does on the ward will not be visible or recognized as such in any accounts or evaluations of person-centred care on ward E. Moreover, not even Amy considers the work she does outside of the set routines as person-centred. When asked if person-centred care has changed her work she says the assistant nurses are not part of the routines.

As previously argued, nursing scholars have long been highlighting the invisibility of care work and pointing out how their emotional and relational labour and moral concerns are regularly hidden and sometimes even dismissed (Bjorklund, 2004; Jackson, 1997; McQueen, 2000). Bearing this in mind, it is tempting to argue that the kind of caring work that Amy does deserves to be included in the definition of person-centred care and its routines. However, this does not necessarily imply that making all aspects of nursing work visible would be entirely a good thing. In a noteworthy chapter on the consequences of classification Bowker and Star (1999; see also: Timmermans et al., 1998) describe the efforts to build a classification system for nursing interventions. While the system makes a lot of nursing tasks visible there is also a risk of creating over-elaborate work descriptions: 'To tell veteran nurses to shake down a thermometer after taking a temperature puts them in a child-like position' (Bowker and Star, 1999: 249). Another risk is that the classification of tasks will be linked to determining the costs of services, which in turn will imply closer surveillance of nursing work.

By including more and more things in the definition and routinization of person-centred care there is a risk that the autonomy of nursing work will be reduced. Furthermore, nurses' space for discretionary judgement, inventing contingent solutions and tinkering might become more circumscribed. Rather, one might feasibly consider including fewer things, and making less work visible in the definition of person-centred care. As Star and Strauss have argued a lot of invisible work remains invisible for good reasons:

For example, workers – nurses or teachers come to mind as good examples – may quietly carry work reflecting a holistic view of the student or patient, carefully kept out of range of a more bureaucratic, reductionist set of organizational values. Sometimes positive invisibility comes with discretion, and with not *having* to reveal your work processes to others (Star and Strauss, 1999: 23)

In this view it is not so problematic that Amy's work is invisible, but rather that many of the tasks that Nilla has to carry out are specified and routinized.

Conclusions

In this paper I have shown how articulation work is still an important concept to understand the complexities of healthcare work. Shadowing healthcare professionals at a person-centred care ward I have aimed to highlight the background work sustaining person-centred care and the relevance of attending to 'what *is* going on, rather than what *should* be going on' (Czarniawska, 2007: 33). The success of person-centred care has been described elsewhere as depending on organizational cultures, and an ability to overcome a 'reluctance to give up old habits' (Carlström and Ekman, 2012: 175). This supports the view that if only health professionals would adopt a new mind-set so the new routines of person-centred care would be able to significantly raise the quality of care delivery. In this paper, I have attempted to question this view. My empirical reading suggests that the success of such practice may well depend on a lot of barely visible and poorly appreciated work.

Moreover, I have shown how the operationalization of person-centred care in the form of new routines to be followed gives rise to an interesting tension. Even though person-centred care is in principle opposed to standardized models of clinical practice, formalized routines and taxonomies are developed and used at the ward to initiate and safeguard person-centeredness. In so doing, person-centred care is transformed from an abstract model to a set of instructions to be followed. While this may lead to the advancement of person-centred care, it may also imply the increased scrutiny of nurses' work. Furthermore, activities which are not included in the routines are rendered invisible and unspoken both in official accounts and for the healthcare professionals performing them.

I have demonstrated that articulation work and invisible work are vital. While the routines for person-centred care present some basic standard instructions, no concrete guidance about how to perform person-centred care under different circumstances is provided. Therefore, all real person-centred caring is left in the hands of those putting person-centred into practice. The creativity and inventiveness of nurses is required in each case of person-centred care.

Furthermore, nurses do not only need to carry out a lot of complicated tasks, in which they receive little training and instructions, they also need to find ways of coordinating sometimes contradictory information and tasks. I have also shown that the available instructions only make visible some aspects of the work, leaving other invisible. These instructions also depict the work that need to be carried out as unproblematic. Therefore, when unanticipated situations arises nurses again has to perform articulation work – and all this while balancing the articulation with additional tasks and duties.

Introducing seemingly simple routines of person-centred care into practice is not easy but requires inventiveness, skills and sacrifices from nurses. In other words: what

could be interpreted as the reluctance of nurses to give up old habits reflects rather the practical difficulties they encounter when introducing person-centred care in a new context. While it may be tempting to make the invisible dimensions of person-centred care visible by including them in ever more specified routines, it may also be better if the routines are kept simple and advanced as practical guidelines. Arguably, what is required is an acknowledgement of the practical challenges faced when implementing person-centred care and thereby a consideration of the relationship of healthcare professionals to the system, structure and context of care.

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