# Abstracts

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### Technology, Health Care and Person-centeredness: Beyond Utopia and Dystopia. Thinking the Future.

# Content

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**Technology in informal elderly care by migrant Indian nurses**

Literature in the field of technology and healthcare has suggested that the use of information communication technologies (ICTs) in care is not always appropriate, and not even possible when care requires physical presence of the carer. But in what circumstances is care by ICTs indeed feasible, and what kind of care can be provided in this way? In this presentation I explore how technology influences informal elderly care that nurses provide at a distance. Today, many nurses migrate from India to work in Europe and elsewhere, while their parents, often in need of care, are left behind. My ethnographic study, in which I work across the fields of science and technology studies and anthropology, indicates that these migrating nurses tend to keep in touch with and provide care at a distance to their parents by means of everyday ICTs, particularly mobile phones and webcams. While talking on the phone they must only rely on their hearing, but cannot use sight, touch, taste or smell. If they use internet-based calling services that include a webcam, vision may be added to sound. I investigate what creative solutions the Indian nurses and their parents find to deal with the impossibility of touch, and how they enact care with the help of ICTs. Particularly, I compare hearing (i.e. in phone conversation) to hearing in combination with vision (i.e. in using webcams) to better understand the interaction between ICTs and senses in caring.

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**The impact of a person-centred web-based intervention on young informal carers of people with mental illness**

Background: Previous research show that young person's often take responsibility and offer care and support for significant others who suffer from mental illness. This adoption of responsibility has consequences not only for the mentally ill, but also for the carer. A person-centred support approach to provide the young informal carers of what they are in need of is according to previous research essential, and in need of. As the internet becomes increasingly fundamental to young people in their daily lives, person-centred web-based interventions may be effective in supporting those caring for a person with mental illness.

Objective: To analyze (according to stress, burden, quality of life, and self-efficacy) the impact of a person-centred web-based intervention (information, education, and support) for young persons who support family members or close friends with mental illness.

Methods: The study design was prospective and randomized. The sample consisted of young informal carers (N = 241; 16–25 y), where N = 241 completed structured questionnaires at baseline and were allocated to person-centred web-based support (N = 121) respectively folder support (n =120) regarding available support in the society for young persons who support someone suffering from mental illness.

Results: Data show that the stress levels were high in both groups at the start of the intervention, but decreased in the folder group, who also showed improvements in their caring situation (also different from the web-support group), general self-efficacy, well-being and their quality of life. The group who received person-centred web-based support showed significant increase in their well-being.

Conclusion: It is of great importance to measure the stress and caring situation of young informal carers of persons with mental illness in order to understand their situation. One type of support could be person-centred web-based, however our results indicate that individuals seek support depending on their individual preferences. Since the responsibility of care has shifted from the health care services to the family and friends of the person suffering from a mental illness, more person-centred care/support interventions should be investigated for further development.

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**Meeting the support needs of people suffering from COPD or CHF in Sweden: Exploring factors that enable the design of person-centred eHealth partnership service in Sweden - A qualitative study**

Introduction:
Several studies have shown the importance of providing person-centred care (PCC). Establishing and implementing care delivery based on the principles of person-centredness poses a challenge to health-care systems. eHealth and mHealth are growing at a rapid speed and are becoming more and more integrated with today's health care services. The aim of this study is to interpret and describe how patients who are diagnosed with chronic obstructive pulmonary disease (COPD) experience support from health care. The findings will be used to help design an eHealth partnership support for these people.

Methods:
A convenience sample of n=17 patients diagnosed with COPD and/or CHF was recruited via a Facebook page for peer-support, patient organizations and a flyer between April-August 2014. Volunteers were interviewed individually either face-to-face or by telephone. The interviews were transcribed and content analyzed.

Results:
Preliminary results show that the need for professional support in persons with COPD and /or CHF is not being met by the Swedish health care system. Instead, patients try to help themselves by turning to the internet to find information. The findings also indicate that the little support that they receive fails to abate their feelings of anxiety. The results also indicate that there is a lack of available professionals in health care who specialize in COPD..

Discussion:
Previous research on persons who suffer from COPD have shown that they struggle with death anxiety and feelings of shame as well as guilt. This is not something that persons with COPD easily admit to the professionals that they meet, because they need to not only feel comfortable to talk about their feelings, but they also need to feel that there is an interest in what they are experiencing on a daily basis. This study also points towards the need to address COPD and CHF patients' needs, a PCC telecare service in combination with mHealth services is a promising concept for this target group.

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**Ambivalence and Uncertainty: Reflections on Technological Advancements in Nursing**

Technology is significant to the history and future of nursing and development of philosophy(ies) of technology and nursing is fundamental to challenges related to discipline maturity and ultimately our role in leading person focused health care. In this paper it will be argued that debates about humanized and dehumanized care are expected in nursing given our focus on person, but ultimately are unrewarding. Advancing debates about technology, nursing and person focused care, now rely on development of our understanding of the central tenets of technology as a phenomenon and development of insight into challenges in health care disciplines such as nursing that arise from the tension between desired and unpredictable outcomes of technology. Both are inescapable and highlight ambivalence and uncertainty as important elements of our experience of technology. Contrary to the idea that progress is linear and known, ambivalence and uncertainty are grounded within technological advancement and are challenges to which nurses must both recognize and better address in care and practice. Interpretation will highlight popular culture and commonplace assumptions about technology associated with primacy of progress and neutrality. It will be stressed that our challenge is to focus on health care provision in practice that is both traditional in intent upon the human person, yet radical in expression. We nurses must seek in the first instance to confront the fact that advances in technology will lead to both expected and unpredictable consequences for our practice and for the people who experience the care we provide.

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**From 'wandering' to belonging: re-framing
the actions of men and women with
dementia and use of GPS technologies**

More and more individuals and organisations
are using technologies to support people with
dementia. Products such as the EASE bracelet,
which combines a Global Positioning Systems
(GPS) location system with activity monitoring,
and buddi technology, which can locate the
wearer, are being issued to individuals and
families affected by dementia by police forces
and public authorities. However, using GPS
technologies is ethically controversial and
divides opinion, particularly among health and
social care professionals. Some see it as an
infringement of a person's civil liberties
whereas others consider it an effective means
of maintaining a persons' safety.

The aim of this talk is to present and discuss
the latest research evidence on the use of GPS
technologies in dementia care, and to argue for
a re-framing of the topic from a bio-medical
perspective, which reduces people with
dementia to 'patients' and 'wanderers', to one
in which a person's rights, status, and
potentialities as active citizens are privileged.

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**The clinical simulation conundrum. Does
simulation diminish the capacity of the
student to foster empathy, sensitivity and
the ability 'be with' the person?**

With increases in technology, nurses and
midwives are required to possess a strong
scientific and biomedical focus. Consequently,
the emphasis of care has arguably shifted from
care-orientated to treatment-orientated practice.
This discourse is further compounded by
health care systems where a person can be
regarded not by the constructs that humanise
them but by those constructs which are defined
by their diagnosis (Todres et al., 2009). Such
models of care often result in the
objectification of the individual and their
subsequent dehumanisation (Borbasi et al.,
2012). Further, a reductionist approach to care
is likely.

Clinical simulation is gaining popularity as an
effective teaching and learning methodology in
nursing and midwifery. This methodology
permits the replication and amplification of
real life events, allowing participants'
opportunity to develop proficiency in action
and reasoning within a controlled environment
(Gaba 2004). Currently, the evaluation of
clinical simulation is primarily focused on
technical proficiency and includes aspects such
as the development of knowledge acquisition
and clinical reasoning (Kable et al., 2013) and
the promotion of student confidence (Blum et
al., 2010). However, literature is limited
regarding whether simulation can replicate the
humanistic aspects of care.

With increasing pressure to use clinical
simulation as a solution to address chronic
clinical placement shortfalls and deficiencies,
there is a risk that nursing and midwifery
educators are perpetuating a reductionist care
model which is technology and treatment
driven and is devoid of humanism (Hayden et
al., 2014). In other words, by using simulation
in the absence of an authentic clinical
environment, is the student fully able to

suspend disbelief and engage in person centred care or are we merely encouraging a student who can espouse the appropriate rhetoric that supports this philosophy? The emerging theory of the mirror neuron and its role in empathy may hold the answer to the question: Does clinical simulation diminish the capacity of the student to foster empathy, sensitivity and the ability 'be with' the person, understanding and connecting with that persons' unique human perspective?

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**Competence measurements of nurses working in elderly care as quality assurance: conceptual and epistemological concerns**

An increasing number of developed countries are moving towards a culture of measuring quality of care, but they all face challenges in public availability of data, homogeneity of measurement and choice of indicators to measure. The WHO has called for more comprehensive judgements of quality of care by asking for information on care processes in addition to standard outcome indicators of health care performance. There are strong arguments for comprehensive judgements as opposed to an outcome-oriented way of evaluating quality of care. Outcomes can be poor measures of quality of care, as they are only partially attributable to health services and may be strongly influenced by other factors such as lifestyle, environment or socioeconomic circumstances. Elderly care involves taking care of people who are chronically ill, in a palliative or terminal phase. In such cases, measuring outcome is problematic, at least if the outcome is measured in terms of recovery or survival. It may be more relevant to measure whether appropriate, individually targeted treatment that alleviates unpleasant symptoms is provided, and whether the care is provided in a respectful and empathic manner.

The Nursing Older People – Competence Evaluation Tool (NOP-CET) was developed as a means of contributing to the assessment of quality in community elderly care (Norway). The NOP-CET is largely concerned with the process of care, and measures in detail how treatment and care is provided to patients in an acute, chronic or palliative state, and can therefore be said to have a comprehensive approach to quality assurance by way of competence measurement. This presentation will be concerned with discussing conceptual, epistemological and measurement related concerns when using a quantitative approach to measure nursing competence. Questions that will be raised are: What epistemological

assumptions are quantitative competence measurement based upon, and how do these serve quality assurance a purpose? How can competence measurement move beyond behaviouristic foci to include cognitive processes and tacit knowledge? Where does one draw the line between individual expertise and collective competence? The presentation will conclude with a proposal of political and clinical implications of a largescale competence measurement performed in Norwegian community elderly care.

Key words: competence measurement, community elderly care, nursing staff, quality of care

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**Do we need to use such big words? Living at home with end-stage heart failure**

With increased expectation that older people remain living in their own homes for as long as possible, the monitoring of advanced treatments has become integral to routine home care nursing practice. In this paper my attention will be directed to the care of older persons living at home with advanced heart failure. This condition is characterized by bouts of deteriorating heart function. In the conventional treatment approach patients are expected to care for themselves by adopting particular ways of living and monitoring their condition. They are expected to use technology to measure blood pressure, weigh themselves daily, monitor intake of fluids, assess signs of impending attack, document assessments and respond in given ways. In many ways this is an individualistic understanding of what is involved in living with advanced heart failure at home. My previous research revealed that home care is collective work where different actors contribute to helping older people to live well at home. In this paper I will suggest ways to re-conceptualise home care for people diagnosed with heart failure, emphasising the relational nature of such practice. In developing this understanding I drew on findings from an ethnographic study of home care nursing focusing on 15 individuals diagnosed with advanced heart failure and their family. I explored the material practices involved in living with advanced heart failure and how personal preferences and identities shape that life. The participants reflected a constellation of different persons who related to their illness in various ways. Some of them tended to downplay or even ignore signs of a failing heart and objected to the use of the term heart failure. They preferred that others, home care nurses or relatives, monitor their condition and did not want to become familiar with the treatments. Other patients monitored their condition carefully, proudly showing the home care nurse their figures as she came for a visit. In some cases a relative might take charge of this monitoring. These findings highlight the complexity, materiality and contextual nature

of home care for people living with end stage heart failure at home.

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**Thematic issues and concerns of women undergoing advanced reproductive technologies and the interface with consumerism**

Objective: The purpose of this study was to examine the experiences of women who had undergone treatment with advanced reproductive technologies (ART).

Design: As part of a Northern California multi-center retrospective cohort study evaluating pregnancy and pediatric outcomes after infertility, a randomly selected group of women who conceived a pregnancy as a result of ART and delivered a live child underwent a one-hour telephone interview which included a qualitative component.

Materials and Methods: Structured interviews were completed on 350 women. The interview content included demographics, reproductive history, family history, as well as information about the health of the child or children conceived by ART. At the end of the interview, the women were asked the open-ended question: "Is there anything else you would like to tell (the researchers) about yourself?" This question was answered by 150 of the women, and responses were recorded, transcribed and analyzed using content analysis to identify emerging themes.

Results: Seven themes were identified that directly reflected on the women's experience of having undergone ART: (1) Very happy with decision to pursue treatment, (2) Concern for the long term health of the mother and child, (3) Regret over having undergone selective pregnancy reduction, (4) Inadequate counseling regarding the number of embryos transferred, (5) Difficulties associated with having a multiple pregnancy, (6) Deteriorated marital relationship as a result of infertility and treatment, and (7) Difficulties associated with being an older mother. The majority of the non-thematic responses related to infertility diagnosis and treatment, obstetric experiences, or the health of children.

Conclusion: The results of this study provide new insights into the experiences of women who have conceived a child or children as a result of ART. Presented here are a history of the technology and advances in ART highlighting the increases in complexity and ambiguity of when to use and who to use it on, the thematic issues and concerns raised by women conceiving by this technology, and the problems of consumerism vs. clear medical indications for use. Included are implications for practice and future research.

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**A sign of the times: technology materiality and institutional talk**

Since the publication of the UK's Francis Inquiry Report (2013) huge efforts have been made to 'reassure' the NHS visitor and the patient that care quality, standards and values are being upheld. This has resulted in a change of culture where expectation about behaviours and practices to has materialised into the widespread use of text publications.

Dorothy E. Smith (2005) ideas about institutional ethnography will be used to theorise about the increasing use of information technology to turn talk about practice into a form of materiality within health care institutions.

It will be argued that through this approach to the use of text, health service institutions demonstrate their dystopian condition through the use of a chaotic and confused publication of notices in public and private spaces to a range of readers and passers-by. In a health care system that makes claims about its intentions to provide person centred care, what does it mean to be cared for in a setting where my line of vision includes multiple notices issues that are irrelevant to me and my situation, and that distract and confuse me?

In this paper a case study approach is used to illustrate the way in which the use of information technology in health care institutions has changed. This has caused a separation of the corporate role of the institution from the practice of care giving. It is also represents a world where the nurse becomes distanced from the practices that humanise care: listening, talking, explaining and providing safe care and where essential talk has been replaced by thoughtless and meaningless text.

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Smith, Dorothy E. (2005) Institutional Ethnography: a Sociology for People. Oxford: Rowman and Littlefield

Christine **Ceci**[1], Mary Ellen Purkis[2], Francine Wynn[3] (plenary speakers)

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**'The changes that are going on'**

Writing in response to a question concerning the most pressing problems in philosophy of nursing, John S. Drummond, a philosophical nurse with poststructuralist leanings, emphasized an approach that was largely historical. In thinking nursing, he suggests, it has been "important to see the changes that were going on" (Drummond, 2013, 50). Consistent with his philosophical practice of "always looking to the outside" (50), Drummond suggests that for nursing, but not only for nursing, working to see 'the changes that are going on' is our most important obligation. Seeing, he further advises drawing on the work of Deleuze, is not something simple, but is itself a practice built upon 'a sensitivity to signs' (50). Concluding his responses to the interview questions, Drummond observed that he wished that this "discussion was just getting off the ground. There is much yet to be said" (52). In this paper we respond to this desire to stay with this problem, or perhaps more to the point, to stay with the question: how do we cultivate, support, enact a critical practice of seeing and what are the 'signs' that we should, in our present contexts, be paying attention to? Drawing on Drummond's work, as well as the works of other poststructuralist thinkers, we will work to elaborate both sides of the question. In memory of John S. Drummond 1949-2014 Dundee, Scotland

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**The Invisible Patient:  Caring in the Technological Peri-operative Environment**

Key words:  perioperative nursing, perioperative culture, technological environment, dance of caring persons

Due to the technological nature of the operating room and the limited time for awake interactions with patients, the presence of the perioperative registered nurse has drawn criticism from within, as well as outside, of the nursing profession (Bull & FitzGerald, 2006). In addition, a dichotomous conflict is seen between the economically driven and caring perioperative cultures (Lindwall, Von Post, & Eriksson, 2007; Lindwall & Von Post, 2009).

As a result of the above findings, the purpose of this paper is to illustrate the value of caring nursing theory in bridging the gap between a technologically driven economic culture and a caring perioperative culture.  Interviews with perioperative registered nurses, are used to explore the theoretical perspective of nursing as caring theory, particularly the Dance of Caring Persons model, (Boykin & Schoenhofer, 2001; Pross, Hilton & Boykin, 2011) as a way to bridge this gap and provide holistic patient care.

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**Transformation: Experiences of Patients, their Families and Nurses during Critical Illness in the ICU**

There are no studies in the literature that explore and describe the concept of transformation from the perspective of patients, family members and nurses during critical illness in the ICU. Qualitative research helped identify patterns associated with transformation to be able to operationalize the concept for use in nursing. Phenomenological studies aim at exploring and describing the experiences of individuals as they are lived in the world, and the meanings derived from the lived experience are the essence of the phenomenon. The purpose of this paper is to explore and describe the concept of transformation among patients, their families and nurses during critical illness. The concept 'transformation' is a theme illuminated from a qualitative phenomenological study conducted in the ICU in 2010. Fifteen participants were interviewed until data saturation was achieved. Using Van Manen's method of phenomenological research, 15 in-depth, open-ended interviews were conducted. Thematic analysis elucidated the experiential descriptions, essential relationships, and meaning structures of the ICU experiences of nurses, patients and family members during critical illness. Processes of transformation related to ICU experience during critical illness were noted among the patients, family members and nurses. The patients perceived that the ICU experience was a 'wake-up call,' 'the longest days of their lives' and that they were 'thankful to be alive,' while the family members found that the experience made them emotionally empowered,' and the experience strengthened their faith.' It was gleaned from the nurses that 'the experience made them grow as a person,' be more enthusiastic for learning,' and a 'realization that rendering good care equals family satisfaction thus their own personal satisfaction.' The findings described in this paper provide strong evidence that the self and the concept of transformation may be applied to other conditions aside from critical illness thus replicating studies with

different populations with the inclusion of the triad of patients, their families and nurses is needed. Such future studies may expand both the theory of perspective transformation and a better understanding of the process of transformation among the patients, family members and nurses in different context not only during critical illness.

## Kris **Deering**, Lecturer

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**The Have and Have Not have**

This presentation regards how aspects of Recovery principles used within NHS mental health care are being permeated by the free market trade virtues of neo-liberalism. For example the governmental post banking crash doctrine of prioritising individual achievement to reduce state burden. A consequence may be the withholding of services by calculating the financial costing of care dependent on a service's user's ability for self-reliance in utilising such care.

The session will begin with the development of recovery and neoliberalism in a bio political context. This will encompass the historic expanse of managerialism within health care organisations, which embrace epitomes of neoliberalism.  There will be consideration on how managerialism endorses regulatory practices for homogeneous good performance so clinicians prioritise choices that are equitable for the organisation limiting focus on individual service user's needs. For example the technologies of key performance indicators centring on service user's responsibility in self-governance in a bid to promote their own recovery.

A parallel process may emergence between professional autonomy and service users own autonomy over care, for both are seemingly influenced by an 'other' with greater stronghold on resources. For example the technologies of managerliasm in  observing work that promotes the organisation's sustainability guides the conduct of nurse, this is mirrored with nurses working with service users in reducing need on services through self-management, whilst  service users attempt to become more self-sufficient to reduce dependence. Arguably this facilitates some recovery principles to mimic action to assist austerity measures within organisations whilst affecting the person centred relationship, for autonomy appears accepted dependent on the virtuousness of one's choices to promote

another, or one's own independence away from service provision.

The presentation concludes on a need to change health service efficiency monitoring, which could begin with more service user involvement in coproducing statuary provision. For example being employed as purchasing commissioners would allow their inclusion in constructing methodologies that determine quality care. Though a change of citizenship terminology from service user to colleague may be required to have mutuality in decision making between those who have used services and those who supply the them.

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**The Electronic Health Record: Priorities of the Healthcare System and the impact on Trust**

Trust is essential to relationships between human actors in a multiplicity of interpersonal situations. In contemporary society these interpersonal interactions are increasingly mediated by institutions. In healthcare this mediation occurs by means of institutional priorities driven by regulations, risk management, payor requirements, standards of practice and accreditation standards. The introduction of the Electronic Health Record (EHR) has allowed health care institutions to align their priorities with the work done at the bed-side. In nursing practice this means that nursing work is increasingly structured to support these priorities.  This is resulting in a shift from the focus on the individual patient to supporting the priorities of the healthcare system. In this paper the authors argue that this shift has led to nurses relying more on the EHR rather than trusting the narratives and knowledge that patients bring to the interaction. This is accomplished by the transformation of patients into data points which allows the institution to track, survey and manage the information necessary to meet their priorities.

This paper draws on empirical work that examines the impact of the EHR on nursing work and human relationships. In this study the researchers interviewed 19 Individuals and held 8 focus groups with care providers working both in the community and inpatient settings. Additionally policies, accreditation requirements and regulations were analyzed to understand the ways in which they impact the structure of the EHR, the information that care providers need to gather when interacting with patients, and thus the work of care workers and providers. This study is approached and analyzed through the lens of philosophical and sociological work on trust and technology including the  work of Portr Sztompka, Annette Baier, Don Idhe and Albert Borgman.

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**Using Instrumentation Theory to Evaluate Patient Interaction and Accommodation to the Technology**

Nursing scholars have explored the relationship of nursing care and technology calling for reflective practices (Barnard, 2002, Sandelowski, 2000) that serve to promote technological competency (Locsin, 2005). Nurses embracing this challenge must consider engaging in critical analysis of the technologies in their practice. With the integration of technologies into health care, evaluating patient- technology interaction is an emerging responsibility for advanced practice nurses that will serve as the basis for providing patient centered care. This analysis describes the theory of instrumentation (Feenberg, 1999) as one method that nurses can use to critically evaluate the patient-technology interactions to gain knowledge of ways they can improve care and ultimately empower patients. Three examples: implantable defibrillators, CPAP devices and Augmentative communication devices are used to identify strategies for empowering patients to encourage patient centered decision-making. The patients' personal meaning of technology influences their ability to accept and accommodate to the technology. Nurses using this approach to technology will be able offer recommendations to patients that would improve and empower their decision making abilities and facilitate patient accommodation to the technology.

Moa **Goysdotter**, PhD, Senior Lecturer

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**Health anxiety in a digital age**

Health anxiety is a growing health problem that in a number of studies have been shown to correlate with increased digitization and amount of information on the Internet (e.g. Baumgartner & Hartmann 2011). The new diagnosis "cyberchondria" is used to describe people with health anxiety who use the Internet excessively to search for health information. The concept however, only explains a portion of the health anxiety problem emerging in the digital culture. An important part of the problem is the shift of responsibility where the individual is expected to take more and more responsibility for their own health (Lewis 2006). A symptom of this shift in responsibility is Quantized Self (QS)-technology by which biological bodily data is made accessible to users who in general are not educated in interpreting biological data. Eugene Thacker means that the human biological body and the computer no longer are possible to separate (2004) and this anthropomorphic relation is something that can be studied in the emerging movement around QS-technology that is called "self-hacking". Self-hackers use QS-technology in order to "optimize" their bodily organisms and "hack and control" them as if they were computers.

Health anxiety in the digital age consists of a combination of different relations between mankind and technology where the body is of central importance. By examining the emerging digital health anxiety from Don Ihde's three technology relations; background relations, hermeneutic relations, and alterity relations (Ihde 1990) I will try to deepen the understanding of health anxiety in the digital age, and complement the previous research made on "cyeberchondria".

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**Nursing, Caring and Technology**

Nursing is a caring profession.  Nursing care primarily refers to an other-referential relationship and actions (Benner, 1989, Leininger, 1978, Orem, 2001, Sumner, 2008, Watson, 1997).  Several accounts of caring in nursing derive more or less directly from Martin Heidegger's account of care (Benner, 1989, Sumner, 2008, Watson, 1988).  Yet Heidegger's account of caring is primarily self-referential.  That is, Dasein (a being like us for whom its own existence is an issue) primarily cares about its own existence.  We are interested in the world, other people, technology, etc. in so far as they are helpful or harmful to ourselves.  Heidegger uses the word "Besorgen," roughly translated "concern," to speak of our care of ourselves.  "Fürsorge," translated 'solicitude," speaks of the care of others (Heidegger, 1962 pp. 83n & 175n respectively). Solicitude, then, is closer to our understanding of the care seen in nursing. According to Heidegger there is a very intricate interplay between concern and solicitude, between care for ourselves and care for others.

There is contemporary concern about Heidegger's ethics given his close ties to the Nazi regime. Nevertheless, it is worthwhile to examine his ontological account of care as it continues to influence our contemporary discussion of care in nursing.  Of particular interest is the role of technology in the intricate relationship between care of self and care of others.  Maurice Merleau-Ponty discusses how instruments such as walking canes or musical instruments are "incorporate[d] into the bulk of our own body…and how they "dilate our being-in-the-world or change our existence" (Merleau-Ponty, 1962 p. 143).  Instruments and technology function to expand our ability to effect change in the world while at the same time altering our very being.  If instruments and technology change our relation to our own being and the care of our own being is intricately related to our care for others, the expansion of technology will have important ramifications for our understanding of care in nursing.

The goal of this paper is to examine this issue in the works of Heidegger and Merleau-Ponty as well as to briefly look at some of the contemporary research about the response to various kinds of technologies and suggest implications for contemporary and future nursing.

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**Signs of bacteria – Enacting Sore Throat**

In this paper I analyse the diagnostic process in relation to bacterial sore throat and how this disease comes into being, or how it is enacted, at two Swedish health centres. The empirical data analysed consist of interviews with nurses and general practioners as well as observations at the health centres. The concept of enactment implies that disease is relationally constituted in and through relations between human and non-human actors. In the paper the relations between health care personnel, bodies, symptoms, instruments, bacteria and other actors are investigated, and I discuss how different enactments of bacterial sore throat come to being depending on how these relations are organized. When doing this the clinical gaze - the diagnosing gaze that interpret signs of an underlying pathology on the patients body – is explored and in relation to the empirical material this gaze is investigated, that is, how it is employed and how it is established in relation to a number of human and non-human actors.

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**The elderly persons´ experiences of reporting health status in an ICT-platform**

Background:
More and more elderly persons are living in their own home and with support from home care due to health deterioration. This puts demands on society and especially health care to support health and self-care for the elderly persons. Therefore its essential to develop new innovative solutions which both enhance communication between the elderly person and the nurse and also increase the elderly persons´ involvement in their everyday care. An information- and communication technology (ICT)-platform was developed with content from the perspective from elderly persons, health care professionals and the literature. The platform is developed in collaboration with a Swedish company specialized in health care management consulting and new innovative care (Health Navigator). The aim with the project is to describe experiences an ICT-platform with focus on user friendly and acceptability by elderly persons living in own homes with assistance of home care nurses.

Method:
The study has a mixed methods approach advocated for the evaluation of new technologies within health care. The design is underpinned by the Medical Research Council´s complex intervention framework. Elderly persons > 65 years, living in own homes, with assistance from home care nurses have regularly reported health status for three months. They have also access to evidence-

based self-care advice with links to web-based pages and graph on reported health status. The home care nurse receive an alarm according to a risk assessment model and can instant contact the elderly persons for discussion the health concerns. Individual interviews with the elderly persons are conducted after the intervention on the experience of using the ICT-platform, with focus on user friendly and acceptability.

Results:
Preliminary results will be presented of the elderly persons experiences with focus on user friendly and acceptability of using an ICT-platform from reporting health status, using self-care advice and graph of reported health status.

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**The nature of telehealth relationships from a nursing perspective. Insights from a qualitative focus group study**

**Background:** As life expectancy increases globally, an ever-growing population suffers from chronic disease. Chronic heart failure (CHF) and chronic obstructive pulmonary disease (COPD) incur a heavy symptom burden severely limit patients' activities of daily life. Care for these patients is fragmented and fails to enable patients to live fulfilling lives. E-Health and person-centred care (PCC) are two current approaches to ensure accessible, high-quality and cost-effective healthcare provision. Combining both in a support service for persons suffering from COPD and/or CHF appears like a promising approach to reduce current gaps in care provision. This study examining relationships in telehealth is part of a multi-method project aimed at combining PCC and telesupport.

**The aim** of this study was to explore the nature of telehealth relationship from a nursing point of view. We addressed the following research questions: 1. What characterizes the telehealth relationship between telehealth professionals (THPs) and chronically ill persons? 2. How can PCC care be delivered via distance?

**Methods:** A convenience sample of 20 THPs working in a service centre providing telephone support and remote monitoring for > 11 000 CHF patients across Germany participated in four semi-structured focus group sessions. We conducted a qualitative content analysis of the interview transcripts.

**Results:** THPs felt that telephone care is a viable way to provide support to chronically ill patients. However, there was ambiguity within the data: THPs felt that they delivered PCC care, yet their concept of PCC was vague. The anonymity of telephone support fostered trusting relationships and preserved patients' dignity, yet could also create feelings of distrust. Language, communication skills, professional expertise and a set of personal values were identified as key to the delivery of high-quality telehealth.

**Discussion:** Combining PCC and telehealth appears to be a viable concept for innovative ways of care delivery to chronically ill patients, but THPs require specialist skills: extensive clinical expertise, communication skills and, most importantly, a firm grounding in the principles of PCC. Further development of PCC theories, documentation and education are needed for successful combination of PCC and telehealth.

Don **Ihde** (plenary speaker)

Professor of Philosophy, Stony Brook University
USA

**Listening to Cancer: A new science**

Recent adaptations of sonification processes have opened a new acoustic way of diagnosing cancers--the technician 'hears' the differences between healthy and cancerous cells. Sonification in arts now gets a scientific application. This lectue will describe this new science and reflect on the role of embodiment, percepual skills and the essential role of embodiment in science.

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**Exploring the relationship between technology and care: A qualitative study of clinical practice for nursing students**

Background/Objective: The aim of this study is to explore the interaction between technology and care in the student-patient relationship during clinical practice training. In the traditional discourse on nursing, technology is seen as insignificant or secondary to the actual work of caring. Using new insights from the social sciences field on how to understand technology, this paper focuses on the important, but somehow underrated, relationship between technology and the human element in clinical practice.

Methods: This article reports findings from a field study of Norwegian nursing students in hospital practice during second year training. Six women and three men participated in the study. The case-oriented analysis follows a cultural-analytical tradition in which the main objective is to investigate routines and ingrained conceptions in order to see familiar phenomenon and patterns in new ways. The main question was: How do Norwegian nursing students learn to handle technology and care in their education programme?

Results: With a socio-cultural perspective on student learning and data from participant observation, the findings of this paper show various ways in which the presence of technology influences the interaction between students and patients. The study demonstrates how technology creates challenges for students in their interactional bedside work. However, technology is also revealed as offering new opportunities for contact and care.

Conclusion: Technology and the human element are linked in complex ways in students' bedside work. This aspect of bedside care has not yet been given sufficient attention in the nursing education programme. In our view, this is a matter of concern; we conclude that nursing education needs to include updated and more nuanced perspectives that will better address this complexity.

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**Technical monitoring vs. patient-nurse interaction in a surgical setting**

The number of surgical procedures is increasing as well as those possible using regional anesthesia (RA). Under RA, the patient is sedated but conscious all or most of the time, compared to surgical procedures under general anesthesia, where the patient is unconscious. The care of awake patients has been predicted to become a prominent feature in anesthesia nursing practice, especially since conscious patients are aware of the carers' communication and the surrounding environment during surgery. The operating room is a highly technological and effective environment where patients are surrounded by sophisticated equipment, a high working pace, and great demands for safety, and the need for quick and immediate decisions. The nurse anesthetists' (NA) duty is to have a good grip on the technical and the caring aspects that involves monitoring, observation, ventilation and analgesia. The technical equipment can easily contribute to objectifying the patient, but patients do not desire the body to become an object of observation. However, when the patient is awake there is less technical equipment involved to be monitored by the NA during surgery, meaning there ought to be more room for communication and interaction with the awake patient. However, our video recorded data, interpreted with a hermeneutic approach, revealed the opposite. Even though less technology was involved it did not automatically mean that communication and interaction took place in a larger extent between the awake patient and the NA. The recordings showed that when the NA leaves the patient's perceptual field, the distance to the patient increases and the monitoring equipment was interpreted to step in and communicate on behalf of the patient. When the measurable and objective body alarms, the NA re-enters close to the patient. However, the patient's thoughts and experiences cannot be interpreted and looked upon as objects on the monitor, meaning that the patient can end up in the background visibly and audibly. The

presentation will therefore focus on the patient's body as the focal point in a highly technological environment; as it constitutes both the subject and the object of the intraoperative activities.

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**Mediating good patienthood – From an ethics of technology to an ethics with technology**

Ethics of technology typically addresses normative challenges regarding the design, implementation and regulation of technology, and merely indirectly with those of the user perspective. For instance, the main normative issue for a patient expected to use an assistive technology is not whether it should be made part of healthcare as such or what its socio-economic consequences are, but how this technology can be adapted to the patient's life. For some persons, having to rely on a medicine dispenser rather than family or home care services might be a daunting task, epitomizing a technical invasion of their everyday routines. Others might welcome the extrication and sense of freedom it can provide. Despite approaching the technology differently, both groups face the task of making the technology an integral part of their patienthood.

Technologized patienthood has some similarities to what Heidegger called thrownness: when we are born, we find ourselves always already within a world that is made up of various (social, technical, etc.) structures of meaning. In order to achieve anything in this world – from mere communication to self-realization – we need to adapt to and utilize this web of meaning. The web defines us as who we are, but more importantly, it also constitutes our possibilities to become; the potential to develop a given personhood and create a good life. For a care recipient, technologized patienthood harbors a similar ambiguity; technologies discipline – "demanding" a certain technical regime to be followed, but they also present us with possibilities to become a certain type of patient (Kiran, Oudshoorn and Verbeek 2015). In order to take advantage of and control the constructive potentiality embodied in technologies, it is important to approach them actively and discerningly. This is a realm of the care process in which ethicists can contribute, not by doing ethics of technology, but by doing ethics with technology. On the background of the philosophy of technological mediation (Ihde 1990, Verbeek 2005), I shall outline a framework aimed at critical-active strategies through which care receivers and care givers can co-construct a patient life that corresponds to the patient's notion of a good patienthood.

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**Considering destructive demands within relationship-based nursing care –relevant or not?**

Background
Relationship-based nursing care is a central part of the nursing discipline and often described as connected to moral or moral-philosophical related ideas such as love and compassion. Nevertheless, it has been documented that love and compassion are not always identified in the relationship between the nurse and the patient, thus begging inquiry into such a demanding relationship.

Aim
The aim of the presentation is to argue for considering destructive demands within the relationship-based nursing care. This is achieved by (1) exploring destructive demands based on phenomenological philosophy and (2) providing examples of nurses' experiences of destructive demands in everyday nursing care.

Method
The data consists of individual interviews and follow-up interviews with 13 nurses with varying work experience within the primary and secondary somatic and psychiatric health service, from inside as well as outside institutions. In this presentation, nurses' experiences of destructive demands in everyday nursing care are interpreted from the perspective of phenomenological philosophy.

Findings
Two themes are described: Everyday nursing care impacts strongly on nurses, causing them to constantly wonder how great a burden of work is possible to withstand. The themes reveal that nurses' life conditions can shift from good to less good or bad related to the fact that the patient and the patient's destiny affects nurses and their opportunity to create something good for the patient and themselves. This is interpreted as a change in the content of the demand from ethical to destructive, implying that the situation does not solely depend on nurses bearing responsibility for the way they act – it also depends on how the patients act.

Conclusion
Considering destructive demands related to relationship-based nursing care is important in being able to transcend utopia and dystopia. We need to articulate that radical, one-sided demands are based on relationality and a view of reciprocity and thereby expectations of life. In short, both nurses and patients are human beings in need of love and goodness.

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**Beyond Sanitary Dystopia and the End of Nursing : Redemption of the Nietzschean Overman**

Key words : Nietzsche Nursing Technology Dystopia

Nursing technology consists in an amalgam of logics and instruments developed and constantly improved through modern progress allowing validating, producing and supervising sanitary treatments. However, as in our hypermodern societies and lifestyles, technology monopolizes every day more space, time, energy and resources of our nursing practices (Alasad, 2002). It is possible to imagine a (post-human) future where much of human existence—and thus its related caring practices—sum up to activities and logics purely technical and instrumental. Here, we can foresee a world where instrumental dehumanization would reach its apex and where the cyborg/human machine would, from then, be repaired and maintained by other machines even more sophisticated. In this sanitary frenetic dystopia, there would be no more need for « human » nursing care, since human and caring values would progressively be reified in the spectrum of values pretending to pure technology and subsequent domination of flesh, spirit – life.

Given this sepulchral scenario, it appears to me that it is relevant to consider certain Nietzschean writings to address this possible sanitary tehnophillic dystopia. In fact, already in 1883, Nietzsche announced the coming of the overman—a post-anti-human and post-anti-modern being/ethical concept. However, even if Nietzsche did not explicitly give details on how to surpass our modern weak humanity, his writings suggest that the overman will not pretend to an excess of reason, technical and material exuberance. In fact, many Nietzschean writings point towards another outcome. So, in this rhetorical presentation, building from certain Nietzschean concepts and aphorisms, I will argue that sanitary instrumental dystopia indeed represents a

possibility; but most importantly, that it can be avoided/overcome if the light of the overman's commitment to natural (ipseity) and artistic (creative) ethics, as suggested in most Nietzschean arguments.

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**Effects of an interactive e-health innovation for early detection of patients reported symptom distress with focus on participatory care – studies in patients with cancer during treatment**

Background: It is well known that poorly controlled symptoms influence patients' quality of life and recovery process. Patients with cancer are often cared for as outpatients which put demands on the patients to be experts on their own health but also on the health care setting to deliver efficient and respectful but cost effective care.

This research program evaluates the effects of - an Information and Communication Technology (ICT) - platform- for use in a smart phone or tablet for assessment of symptoms and access to self-care advice and professionals in real time. Weaknessess of previous studies have been taken into account by using a theoretical framework and by developing the platform in co- design with patients and health care staff. The platform is developed in collaboration with a Swedish company specialized in health care management consulting and new innovative care (Health Navigator).

Aim: The hypothesis is that the intervention decrease symptom burden and thereby improves clinical management facilitating safe and participatory care.

Method: The design for the whole program is underpinned by the Medical Research Council's (MRC) complex intervention evaluation framework. Based on this, the ICT-platform was developed and tested for feasibility for optimizing before further evaluation in larger studies. Quantitative outcomes include health literacy, symptom burden and quality of life, disease progress and health care costs. Interviews concern participatory and meaningful care.

Results: Feasibility studies show remarkably low drop-out rate and that participants consistently used the application with individual variations. Patients using the application expressed a notion of feeling safe and well cared for knowing that someone monitored their reports and when needed could be in contact with a nurse. The alarm system was frequently engaged, the patients received support and in some cases even hospital admissions were avoided. The subsequent effect study showed that the patients using the application rated less symptom burden at the treatment end and that their symptom burden and functioning did not increase over time as for the patients not using the application.

Conclusion: The use of an interactive technical device seems to facilitate personalized and participatory care.

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**Technology as One Entity in a System of
Entities:  Social and Ethical Ramifications
for Nursing Care**

In this talk we examine the philosophical
implications of considering technology as one
entity in a system of entities, where each entity
may interact with other entities to produce
emergent properties of the system as a whole.
We investigate whether it is possible to
relegate the meaning and implications of
"technology" to that of mere "entity," thereby
shedding the preconceptions that come with
"technology." The concept derives from
related concepts in Family Systems Nursing
involving the integration of nursing, systems,
cybernetics, and family therapy theories [1],
Systems Research [2], and the Capability
Approach to Technology Adoption in which
technology is viewed as a means to empower
an individual's capabilities in order to achieve
a desired way of life [3]. We illustrate the
concept with several examples: (i) iPhone Siri
as an intelligent personal assistant [4], (ii)
robot therapy in which robot, family, and care-
takers comprise a system of entities [5], and
(iii) tele-presence robots as an empowerment
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**Can Robots Enhance the Human Condition of the Elderly? A View from a Group of Seniors 65+**

In Fall of 2014 we taught a 5-week course to seniors 65+ years of age entitled "Humanoid Robots for Elderly Care" at Rivier University in the US [1]. The purpose of the course was to assess how seniors' attitudes towards robots would change after living with and studying a robot for 5 weeks. To that end, the class worked with the humanoid robot NAO [2], read articles and watched videos of other robots in service of the elderly (e.g. [3]), and watched movies such as "Robot and Frank" and "Her." The seniors brainstormed about robot behaviors that would enhance their condition, whereupon the instructor implemented prototype behaviors in the robot to motivate discussion and critical analysis. A quantitative survey was issued in the beginning of the course and at the end of the course to determine changes in attitude. Further, qualitative contextual interviews with the participants were conducted in February 2015, several months after the course.  An analysis of the interviews was performed with the Alceste textual data analysis software [4]. In this talk we discuss the results, limitations, hypotheses, and philosophical implications generated by the study. The study complements our philosophical analysis on the possibility of robots as authentic companions presented at IPONS 2014 [5].

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Could application and reflections based on Julia Kristeva's philosophy to caring science bring a deeper understanding of what a life on a ventilator may be like?

This study presents findings from narrative interviews carried out with people (children and adults) who live their everyday life at home assisted by mechanical ventilator treatment due to respiratory failure. Treatment is often needed continuously or part of the time; generally at nights. The ventilator is connected to the bodies through a face or nose mask or a tracheostomy.

The presentation also addresses what a life at home on a ventilator may be like through the lens of the Bulgarian/French philosopher Julia Kristeva's writings. Most research on home ventilator treatment is biomedical. There are a few published studies describing the situation of people living at home on a ventilator and according to my knowledge there is no previous scientific work that have used the thoughts in Kristeva's philosophy applied to this topic, i.e. a caring science perspective. Kristeva writes about phenomena such as caritas, language, abjection, body, hope and love. Her work is considered as a fruitful contribution to nursing science and practice as her philosophy strengthen, expand and deepen the caring perspective. My argument is that relating her philosophical project to research about home ventilator treatment brings a broader understanding of this subject but her work may also add new ideas to earlier philosophers' and nursing theorists' writings as well as to nursing research as a whole.

Key words: Home mechanical ventilation, Julia Kristeva, narratives and caring science

Lindahl, B. (2011). Experiences of exclusion when living on a ventilator: reflections based on the application of Julia Kristeva's philosophy to caring science. Nursing Philosophy, 12(1), 12-21

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**A trajectory towards partnership in care - patients' experiences of autonomy in intensive care**

BACKGROUND Patients treated in intensive care are usually critically ill and in several ways dependent, both on staff and technical equipment, hence in a vulnerable condition. AIM The aim of the study was to describe and elucidate patient experiences of autonomy in an intensive care context from a caring perspective. METHOD The study was carried out between March 2013 and April 2014 at five county hospitals in south-east Sweden. The interviews took place on the general hospital wards to which the informants had been transferred following discharge from the intensive care unit (ICU). The patients (n=11), seven men and four women aged from 34 to 75 (median 54,5), had a variety of admission diagnosis mainly related to large surgery, severe infections and/or respiratory failure and an ICU care episode of two days or more. The data were analysed using Inductive Content Analysis. FINDINGS Patient experiences of autonomy in intensive care were shown as "A trajectory towards partnership in care depending on state of health and mutual understanding". This partnership begins with acknowledgement of the patient's dependence, and ends with the patient becoming a co-partner in care. It was experienced as varying between different states of dependence and independence and was guided by the patient's return to health. The different states of autonomy could also overlap and in a way that the patient could be in more than one of the states at the same time and that the recovery process could lead to increased capacity related to certain nursing care procedures but not to others. CONCLUSION Patients in need of intensive care wanted, as soon as their state of health allowed them to, to be involved in decisions about their care as this creates a trusting and healthy care environment. To enhance the autonomy of patients in intensive

care there is a need for greater awareness about the patient not only being a passive care recipient but also being an active agent and where involvement in decision-making and participation in care are crucial.

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**Sociological theory in nursing research – what is required?**

Many published nursing studies involve or might be considered forms of sociology. However, substantive sociological theory is not often described or critiqued in these studies (or commentaries thereon). This may be problematic. Nurse researchers who employ sociological concepts explicitly or implicitly assume positions relative to those concepts but, if these positions are not 'recognised', if they are not formally noted or theorised, logical muddle and incoherence can ensue. Conceptual confusion may occur within a single study. Alternatively, when the results of studies on allied topics are compared or judged alongside each other by nurses seeking to base practice on evidence, if differences in researcher conceptual thinking are not acknowledged, false or erroneous judgements about the consistency and possible significance of results may be concluded. Definitional problems notwithstanding, it could therefore be argued that nurse researchers (and commentators on research) should engage more fully and profoundly with sociological theory than is currently the case. And, if we concede that some and possibly most sociological nursing studies discuss theory superficially, then this potentially reflects negatively on the value of at least some of that work. These arguments clearly extend beyond sociological studies and, vis-à-vis theory more generally, noted nursing scholars assert that, for nurses, first, theorising is or should not be an end in itself. And, second, theory is of interest/importance only insofar as it beneficially enables discipline development and/or improvements in practice. Both claims have intuitive appeal. Yet it is difficult to specify how and where the line between (put crudely) care-focused or allowable theorising and abstract or non-care-focused disallowed theorising is to be drawn. Further, if the divide between potentially 'useful' and 'non-useful' abstract ideas/theory cannot be agreed then perhaps restrictions

should not be placed on the scope or range of theoretical emersion that nurses permit themselves. Dissolving self-imposed limits to engagement with theory may however, disturb established and cherished ideas regarding nursing's disciplinary boundaries and identities. Such a move might therefore be resisted.

Ann Therese **Lotherington**, Professor and Head of Department; Aud Obstfelder, Associate Professor, UiT, the Arctic University of Norway; Gøril Ursin, PhD-candidate, University of Nordland

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**Configurations of technology, gender and citizenship in care practices for persons with dementia**

Care is an object of public concern, central to our daily life and way of working. According to Norwegian authorities technology, gender and citizenship should constitute core elements in public care practices, performed in collaboration between professionals, the person in need of care, and their families, preferably in the home of the sick person. Thus, the promotion of good public care imlpy innovative organizational solutions and work methods were technology, gender equality, non-discrimination and responsible citizenry constitute fundamental values.

The aim of this paper is to explore care enactment in various situations involving collaboration between professionals, the person in need of care, and their families, and particularly analyse how technology, gender and citizenship enter into and shape the practices. Our analysis departs from interviews with families where one member recently have been diagnosed with dementia. Their stories about good and bad care situations help us to unravel the socio-material details enacting the situations, for example how different configurations of technology, gender and citizenship make differences in situations where the relatives seek security and control, recognition and activity, integrity and dignity for their spouses, and management of their own vulnerability and fragility.

Our theoretical approach is a fusion of Science and Technology Studies (STS) and feminist citizenship theories. This is an anti-essentialist approach that enables us to move beyond stereotypical ideals about good care and clear-cut distinctions between technology, gender and citizenship. According to this approach a care practice is an outcome of particular socio-material configurations. The care practices are

not fixed but shift with the alteration of the relations that make them up. Consequently, a care practice is not in itself good or bad. Rather, good or bad care should be understood as effects of interaction between the human and non-human actors enacting it. Therefore, to understand good care, we need context-specific analysis sensitive to the interaction between all potential material and non-material elements of a care practice

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**Preserving uniqueness through quasi-standardization: the role of templates in person-centred care**

Person-centred care is concerned to see the person behind the patient, as a unique human being with desires, emotions and specific needs in pursuance of enrolling the person as a partner in her/his own care and treatment procedures. Patient- and person-centred care are often highlighted as the antithesis both to disease-centred care and to institution-centred care. They have been described as strategies of seeing the patient and valuing the relational aspects of care in situations which otherwise are shaped by highly standardized protocols and templates.

In this paper I will challenge this notion of the opposition of person-centred care and technological devices such as templates and electronic patient records. Drawing on an observational study at a hospital ward and 14 semi-structured interviews at 4 other hospital wards, which all recently have implemented person-centred care I will show how templates and quasi-protocols are part of person-centred care. Inspired by Science and Technology Studies oriented towards medical and care work and practice I will explore the interrelation between templates and person-centred care workers, analysing how care work, practice and patient's stories are transformed through the templates. Close attention will be paid to the actual templates; their mutability and how they were transformed during my time in field, and to the practices of classification and categorization they support. Thus I will provide insight into how clinical practice is transformed, and into how person-centred care is defined in the given setting.

Key words: person-centred care, templates, care practice, quasi-standardization

Ingunn **Moser** (Plenary speaker)

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**The person-collectives of technologies, health care and person-centredness: from individualization to care for collectives**

This paper/talk explores configurations and matter-realizations of the persons and the care addressed by new health care technologies. For this it bases itself upon empirical data from two research projects on telecare/distributed care, one European and the other Norwegian, and analytical resources from the interdisciplinary academic field of Science and Technology Studies. These analytical tools enables one to trace how technologies make part of the material practices, ordering arrangements and collectives that carry and enable both people, persons, users and patients, and to investigate how it is that technologies carry inscriptions of and prescriptions for their users and the uses they imagine and seek to support. They make it possible to investigate how differently configured arrangements make possible different forms of subjectivity/personhood, embodiment, distributions of agency, boundaries and relations between the elements of which a practice and a collective are composed. The paper/talk argues for an understanding of the person and of person-centredness in care that acknowledges and takes into account the collective character not only of persons /patients, but of care, including the care that makes the objective of health care technologies and the welfare policies and futures imagined by and for them. There is an urgent need for health care technology development to turn to caring for person-collectives rather than for imagined individualized, self-caring and self-managing actors. But this also has methodological implications. Person-centredness in health care technology development and research needs to adopt a learning approach and a processual approach in imagining new health care services that matches and can adapt to the emergent and dynamic character of person-collectives.

Maurice **Nagington**, PhD, BNurs (Hons), RN; Karen Luker, FMedSci, PhD, BNurs; Catherine Walshe, PhD, MSc, BNurs (Hons), RN

School of Nursing, Midwifery and Social Work, University of Manchester
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**(Re)creating the home: The morality of technology in the home in relation to district nursing palliative care**

Previous research about the morality of care has theorised how the materiality of the home, nursing care and medical technology (such as intravenous infusions) interact with one another. However, this research has not considered the morality of how these concepts intersect with patients' and carers' subjectivities from either an empirical or theoretical perspective. This paper examines these intersections using Butlerian and Deleuzian moral philosophy to explore empirical data about palliative and supportive district nursing care (home care).

Semi-structured interviews were conducted with 26 patients and 13 carers about their palliative and supportive district nursing care. Three key themes about the home arose in the data: the essential nature of the home in maintaining patients' and carers' sense of self, use of technology to maintain patients at home, and a belief that district nursing care did not affect the home.

The theoretical work of Joan Liaschenko suggests that the introduction of medical technology leads to the home (something she implicitly conceptualises as a fixed pre-existing concept) becoming more hospital like, which she considers to be a morally problematic loss. However, Butler's work on performativity is used to critique this by analysing how the empirical data suggests that 'the home' can be thought of as always and already being in a constant process of (re)creation reliant on a wide range of technologies (such as heating, lighting etc) and care, all of which can be thought of as being discursive; as such the home cannot be considered 'lost'. With this in mind empirical data is further analysed using the Deleuzian concept of 'becoming-other' to explore the morality of and possibilities for performative (re)creations of the home and subjectivities.

The paper concludes that the home is (re)created via an interplay of material and discursive practices that impinge on and are (re)created through patients' and carers' subjectivities, the morality of this is reliant on the distribution of power over how subjectivities and the home are dialectically (re)created; not the use of technology and district nursing care in and of itself.

John **Paley**

Visiting Fellow, Centre for Health and Social
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**IPA and the myth of resident meaning**

Like several other methodologists of
phenomenology, Smith *et al.* (2009) adopt
what might be called the *axiom of resident
meaning*. This axiom is: the meaning which is
ascribed to a text by an interpreter does not
come from anywhere other than the actual text.
It is 'resident' in the text, so to speak, even if it
has to be distilled by an expert interpreter. As
Smith *et al.* suggest, the interpretation 'is not
usually based on importing a reading from
without' (37). Rather, all levels of
interpretation must be 'based on a reading
from within the text itself'. Connections can
subsequently be made to 'external' theory, but
the 'internal' analysis must come first (105). In
this paper, I will argue that the axiom of
resident meaning is wrong in principle. All
meaning comes from outside the text, and
marks an inference grounded in some 'external'
antecedent theory that the researcher holds. If
this is correct, then basing the interpretation
'on a reading from within the text itself' is
something that cannot be done in analytical
practice. Further, I will show, using examples
from *Interpretative Phenomenological
Analysis*, that the meaning ascribed by Smith
*et al.* to their data is not resident in the text, but
is derived from their own 'external' theories.
In general, meaning (in a non-lexical sense) is
not an attribute of anything. In the process of
interpretation, meaning is an inference based
on a theory held by the analyst. I will briefly
indicate some of the methodological
implications of this view.

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## Jeannette **Pols** (Plenary speaker)

Prof dr, University of Amsterdam
The Netherlands

**Good relations with technology. Empirical ethics and aesthetics in care**

In this talk I will discuss what an empirical ethics could look like in the study of technology, and why we need approaches such as empirical philosophy to study it. By working a set of cases, I will demonstrate how we may study technology use in nursing care. I will develop the idea of analyzing the impact of technology in terms of aesthetics rather than ethics. Finally, I will argue that the common methods for evaluating technology in health care are ill suited for this task, and why anthropological methods are preferable.

## Prof dr Jeannette **Pols** & Prof dr Dick Willems

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**Quality in daily life. The case of the feeding tube**

Quality of life measurements are done as a way to evaluate treatments and technologies in health. In the case of ALS patients, the feeding tube is one such technology that has been evaluated in this way, but results are indecisive. In the presentation we explore what quality of life relating to the feeding tube comes to mean if we do not attempt to measure it, but trace what good or bad it does in daily life. It turns out that the feeding tube becomes a different thing when patients move through different phases in their disease trajectory, making the relationships between quality of life and the technology complex and changing. The feeding tube is not a discrete intervention of which effects can be established, but in gets its shape, workings and values in the way it comes to relate to concrete and differing circumstances. Crucial is that this is not a matter of response shift, where people change their values and attitudes. This is the way quantitative researchers interpret the finding that patients change their judgment on the quality of their life. The feeding tube, however, changes its identity in relation to real problems the patients encounter. Apart of the tube's shifting identities, there are different appreciations of the aesthetics of the feeding tube as a thing that transforms the body. These will be hard to trace in scores on a questionnaire. Our conclusion is that the many differences should not lead to more attempts for quantitative evaluation, but to better conversations with patients to explore the possible qualitatively different effects the tube might have in their particular situation, supported by a list of these qualities obtained in attentive qualitative studies.

Mary Ellen **Purkis,** PhD

School of Nursing, University of Victoria
Canada

**The "figure" of the nurse: presence and
absence of care in a Smart Home**

A health care system increasingly reliant on
economic discourses to legitimate its priorities
and activities demonstrates a tendency to value
technological solutions over solutions that rely
on paid human labour. Drawing on readings of
contemporary literature arising out of the field
of health economics, this paper undertakes a
close and critical reading of research papers to
ascertain the extent to which the "figure" of the
nurse continues to be present in some form in
studies that seek to illustrate the benefits (for
families and for regional or national
economies) of so-called "smart" home
technologies. "Smart" homes are living spaces
into which technological devices have been
introduced in order to monitor the activities of
residents, usually older adults and typically
those living with one or more chronic illnesses.
The paper will focus primarily on the use of
"smart" home technologies in the instance of
seniors living with dementia.

The analysis will seek to ascertain whether the
traditional care provided by community-based
nurses to this population of home-bound
seniors is simply taken for granted in the
design and promotion of "smart" home
technologies or whether there is an evident
assumption that such human labour is no
longer required within the context of a
properly implemented "smart" home.

## Professor Mark **Risjord**

Philosophy Department of Emory College and The Nell Hodgson Woodruff School of Nursing, Emory University, Atlanta Georgia USA

**Evidence and Practical Knowledge**

Evidence based practice is something of an oxymoron. Evidence provides justification; yet, practice is not the sort of thing that can be either justified or unjustified. Justification is appropriate for "propositional knowledge," such as the knowledge that a treatment is effective. To have practical knowledge, by contrast, is to have know-how. It is the ability to do something, and abilities come about through experience and training, not by justification. Strictly speaking, then, there could be no evidence based practice.

This presentation begins with a critique of the idea that evidence could influence practice only by justifying beliefs and rules. As Benner argued in From Novice to Expert, expert practice does not rely on explicit appeal to rules. It follows that there could be no expert-level evidence based practice, and this is clearly an unsatisfactory conclusion. The root of the problem is the underlying conceptions of action and agency. The second part of the essay presents a novel rethinking of the concept of agency. This "ecological" conception of agency foregrounds the agent's relationship to the environment, focusing on what the agent is responding to in the environment, what possibilities for action the environment provides, as well as what the agent remembers.

The ecological conception of agency entails that evidence can support practice in new ways. We need to know what nurses are attuned to when engaging patients and what nurses see as possible courses of action. We then need to determine whether those attunements and affordances are the best way to bring about positive patient outcomes. This means that we need forms of evidence complementary to RCTs, but not the sort of qualitative research typically advocated by RCT critics. It also provides a different way of evaluating the technological environment of nursing and its relationship to practice. The final section of the presentation will explore these issues.

Derek **Sellman**, Associate Professor

Faculty of Nursing, University of Alberta
Canada

**Technology, language, standardization, and thought in nursing: If only it were so simple**

While it may be possible to think in the absence of language, it is highly likely – indeed, it is generally accepted - that language exerts a powerful influence on thought. If this is true then the creeping tide of endorsement by nursing's regulatory bodies and professional associations of the ideal of a standardized nursing language may not be quite the benign force that its advocates anticipate. The idea of a standardized nursing language gets much of its impetus and justification from the information technology that has been embraced with varying amounts of enthusiasm in health care and in nursing. A standardized nursing language, we are told, will enable the collection and analysis of comparable data regarding nursing assessments, diagnoses, and outcomes with an associated ability to determine and measure effectiveness, quality, and patient satisfaction. Good news for those who favour predictability and certainty; not such good news for those who are comfortable with the unpredictability and uncertainty of nursing practice. Not such good news either, for those who entertain the idea that restrictions on language lead to restrictions in thought.

The central question becomes: will the adoption of a universal standardized nursing language affect thought in and about nursing? Simply put, the answer must be a resounding 'yes'. For simply put, the answer assumes that technology changes language and that language changes thought. If only it were that simple. In nursing with its mandate for the pursuit of goods, the more apposite question might be: will the adoption of a universal standardized nursing language change thought in nursing for the good? In this short presentation I will sketch out some of the ways in which this question might be addressed in order to contribute to the debate between proponents and opponents of standardized nursing language.

Ingela **Skärsäter**, Professor; Magdalena Barkström, manager; Stefan Bergman, adj Professor; Patrik Dahlqvist Jönsson, clinical lecture; Fawzi Halila, ass Professor; Anne-Christine Hertz, manager; Jens Nygren, ass Professor; Anita Sant'Anna, University lecture; Jeanette Sjöberg, University lecture; Andreas Tylenius, eHealth coordinator

Halmstad University
Sweden

**Theme Health Innovation at Halmstad University  - research, education and collaboration for welfare technology**

In face of escalating health care costs, new technology holds great promise for innovative solutions and new more sustainable health care model. Welfare technology around a person allowing for greater autonomy and control in health issues and access to tailored information and personalized health behavior interventions. While this offers good opportunities for both public health impact, it also emphasizes the need for properly knowledge base and organizational structure to support a person-centred approach in the development of welfare technology in society.

Halmstad University initiated in 2014 a thematic research and educational initiative that has been named Theme Health Innovation. The initiative includes research, education and interaction with the community, region and industry, which in collaboration can contribute with innovative and sustainable solutions to social challenges in the health field. The starting point for the work is action based on societal and individual needs and development of venues for collaboration between different actors and levels of organization.

Theme Health Innovation aims to develop and affect people's ability to maintain and promote their health and prevent ill health. Health Innovations developed in encounters between different knowledge, skills and experiences, both within the university's research and education in collaboration with industry and the public sector. Health Innovations that are developed should be based on the needs from the people who will use the innovation, thus have an end user perspective.

At the conference, the Theme Health Innovation will be presented including the organizational structure, research as well as training in higher education that support the welfare technical development.

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Ingela **Skärsäter**, Professor, PhD, RN; Henrika Jormfeldt, Associate Professor, PhD, RN; Louise Doyle, PhD, MSc. BNS, RPN, RNT; Heikki Ellilä, PhD, RMPN, RN; Agnes Higgins, Professor, PhD, MSc, BNS, RPN, RGN, RNT; Brian Keogh, PhD, MSc., BNS, RPN; Marie Lahti, PhD, RN; Oona Meade, PhD, RN; Jan Sitvast, PhD, R.N, MSc.; Theodore Stickley, Associate professor, PhD, RN; Päivi Vuokila-Oikkonen, PhD, RN; Nina Kilkku, Dr. DP in Nursing, principal lecturer and the administrative coordinator

Halmstad University
Sweden

**To enhance Master's level education in mental health practice with eLearning materials - eMenthe: an European project**

There are wide differences in the quality and content of mental health nurse education throughout Europe. These are evident in the course structures, emphasis and specific content. This diversity between programmes creates possibilities for countries to learn from one another and to share and benefit from the diverse approaches. These concerns, challenges and development needs of mental health practice form the basis for the EU-funded eMenthe-project (2013-2016) which aims to enhance Master's level education in mental health practice by developing eLearning materials through a European co-operation. To this end, seven European universities from Finland, Ireland, Sweden, United Kingdom and the Netherlands have commenced a collaboration to enhance Master's level education in mental health practice - eMenthe.

The project's aim is to develop eLearning materials with an action research approach in collaboration with Master's level students from these universities and associated partners from clinical practice. eLearning materials on three central themes: recovery, mental health promotion and prevention, the role of families and caregivers will be launched for students in Master's level and clinical practice to use. These themes were agreed as common issues of concern for all partners prior to the application process.

During first phase, stakeholders were interviewed (N=139), including master level students, experienced psychiatric nurses, managements persons working in psychiatric care, service users and next of kins. The data was structured from a general point and also from a lifespan perspective, such as child and adolescence, adults and elderly. The analysis used a qualitative and descriptive design, using a brief manifest content analysis to examine patterns, themes and subthemes to achieve an understanding of the meaningful content focusing on nursing master levels. During the final year of the project (2016) eLearning materials will be made available to students undertaking Master's level education and professional nurses working in clinical practice. This dual approach to dissemination will support the professional competencies of practitioners as well as academic progression.

Carina **Sparud-Lundin** RN, PhD; Ulrika Josefsson PhD; Marie Berg RN, PhD, Anna-Lena Hellstrom RN, PhD; Ingalill Koinberg RN, PhD, Margaretha Jenholt Nolbris RN, PhD; Agneta Ranerup PhD, Ingela Skarsater EN, PhD

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**Use of participatory design in the development of person-centred web-based support for persons with long-term illness**

Background:
E-health solutions are increasingly developed to meet patients' preferences and promote their participation in their health care. This has led to increased interest in person-centred technology developed by means of participatory approaches. However, few studies explore the participatory design process from the perspective of person-centeredness including how it becomes materialized in the informational technology. This paper explores how applied participatory approaches and the design of four web based supports correspond to key areas of person-centeredness.

Aim and method:
The purpose was to create shared knowledge and understanding of each separate case and to generate relevant categories. Data was collected from four Swedish research projects. The analysis followed an inductive approach involving a step-wise cross-case analysis.

Results
A number of question areas describe the dialogue with the participants in the cases. The areas cover individual, social, and practical issues. The results of the dialogue are categorized into four support areas; psychological/emotional, personal, information, technical. By means of common as well as specifically developed technical solutions the support areas becomes visible in the design. Person-centredness will appear in the participatory design (PD) process as the approach promotes the development of a holistic view of the person and the illness and a partnership between patients and carers.

Conclusions
Our results contribute to a central development area within eHealth involving greater opportunities for the patient to actively contribute in real time, getting access to and add information, and sometimes interact directly with carers. However, it is concluded that neither participatory approaches nor technology for online information and communication can guarantee person-centeredness by itself. Instead, it is the design of the PD process and the forming of the actual use of technology together with the particular purpose of the web based support that shape person-centred online support.

Keywords

Long-term illness, participatory design, person-centred care, web based support

Edel Jannecke **Svendsen**, RN, Pediatric Clinical Nurse Specialist, Master of Nursing Science, PhD student; Reidar Pedersen, MD, BA, MA, PhD; Anne Moen, RN, Master of Nursing Science, PhD, Professor; Ida Torunn Bjørk, RN, Master of Nursing Science, PhD. Professor.

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**Providing the resistive preschool child with venous access; exploring parent-health care providers' unfolding interaction**

Parent-health care provider's interaction is an important context for understanding the care provided for preschool children during medical procedures in hospitals. Knowledge about this interaction is important because it can provide a better understanding of how restraint is used and occurs during usual medical procedures in hospitals. We explored parent-healthcare provider interaction in situations where newly admitted preschool children resisted Peripheral Vein Cannulation (PVC). The device used during PVC is a medical artifact necessary for providing the child with the medical intervention of fluids, antibiotics or other medication. We adopted the perspectives of symbolic interactionism when analyzing video recorded naturalistic occurring situations with six newly hospitalized preschool children where eight parents/close relatives, seven physicians and eight nurses participated. The main results comprised three patterns of interaction unfolding, resulting from the child's resistive actions and number of missed attempts of PVC. In the first pattern, health care providers and parents overlooked the children's strong protest through ongoing unworried distractive talk, while performing cooperative firm restraint. The second pattern occurred in those situations where there had been failed attempts of PVC; the parents stopped engaging in the talk and distanced themselves from the health care providers, some parents displayed strong verbal disapproval which also seemed to result in the parents using less firm restraint. In the third pattern the consequences of parental distancing were that health care providers in turn stopped addressing the parents. Instead they turned to each other and continued the ongoing unworried distracting talk or they totally stopped their verbal interaction, leaving the child's resistive actions unmet. The use of such approaches may be a way to exercise professional responsibility and power in order to fulfill the goals of the situation by deliberately defining the situation as any other everyday happening, consistent with symbolic interactionism. The knowledge of these changes in interaction may enable health care providers to prepare themselves for changes during the procedures and make more informed decisions about parental participation in these situations. The identified patterns may also promote discussions about how to deal with such situations in the best way.

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**Critical Illness as a Biographical Disruption**

Critical illness is a biographical disruption which throws a patient and their family into a state of confusion and uncertainty. It often strikes the sufferer without warning and dislocates them from their familiar environment. It disrupts their routine of life and forces them and their family to reexamine their future. Besides disrupting ones biography, it places their life in limbo disrupting or even shuttering their dreams and aspirations, often evoking fear and foregrounding death.

From a phenomenological paradigm, discussing biographical disruption brings into focus the question of intentionality as a way of existence in the world. Critical illness fractures the intentional arch of the patient by virtue of being critically ill. This is compounded by the state of unconsciousness which could either be induced to facilitate treatment in intensive care (ICU) or caused by the severity of trauma/critical illness the patient presents with thus impinging on the existentials.  This paper discusses critical illness as a biographical disruption in relation to intentionality and the existentials. It then discusses the burden of critical illness as a biographical disruption on the patient and their family; and then offers recommendations for future directions in management of this phenomenon.

Hilje **van der Horst**, Dr. and Maartje Hoogsteyns, Dr.

Sociology of Consumption and Households, Wageningen University
The Netherlands

**Beyond utopia and dystopia. Assistive technologies as mediators of utopian longings and dystopian fears**

People with impairments often use technical aids to assist them in their everyday activities. In medical discourse such technologies are evaluated for their functional effects. How is the absorptive capacity of incontinence products? How can we design an arm prosthesis that moves just like a normal hand? Technological developments, as well as the optimistic slogans uttered by the medical industry to warrant investments, have led to optimistic ideas about the possibilities of technologies to fully compensate impairments in the future. On the other hand, many technical aids represent a dreaded image of humans becoming increasingly dependent on technologies. Thus, technical aids infer both utopian and dystopian understandings of technology.

Earlier research has shown that both understandings do not acknowledge the highly complex effects of aids in our lives. Incontinence pads or artificial arms are not just a functional means to an end. Using these devices change how we can practically and socially relate to the world, how we experience ourselves and our impairments and, for that matter, how we define dependency.

Still, the utopian and dystopian images have an important part in how these technologies are designed. And they also influence the way people with impairments and medical professionals relate to those technologies. In this paper we will explore the following issues drawing on biographic interviews with 27 individuals with hearing impairments, incontinence or arm prostheses: How are utopian an dystopian images inscribed in and mediated by these aids and how do they affect users? And how do these images alter because of the everyday practices users engage in? We argue that utopian and dystopian analyses of technology will not help us understand what technologies will actually do, but that it is useful to analyse how such images shape the effects of assistive technologies and vice versa, as well as the way in which people use them (or not!).

Annemarie **van Hout**, Prof. M. M. Hettinga, Prof. D.L. Willems, Prof. A. J. Pols

Academic Medical Centre, University of Amsterdam
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The Netherlands

**New nursing care. Recognizing emerging interventions in telecare practices**

Technology to care at a distance is often presented as a new way of delivering care as usual, but just with a different logistic. We already know that technology is not neutral and therefore not just facilitates putting our intentions into practice, but changes these as well. Technology changes the twofold relation of nurse and patient to a threefold relation of nurse, patient and device. When technology is not neutral and even an active part of our relations, it is important to know what it contributes to the relationship. For instance, using technology from different spaces leads to the loss of some opportunities of care (touch, smell), and to the winning of others (like the opportunity for more frequent contact and less travel time).

In this presentation I will discuss how an iPad that is used for webcam contact between nurse and patient in mental health care changes that relationship. The iPad offers the unplanned use of an online chat function. The dynamics of chat contact offers a new form of communication with patients with shorter messages and quicker responses. It turned out that this dynamic helped to gain self-understanding of the patient. There is another side to this as well. Chatting is less controllable in volume and time and asks for available nurses.

Telecare brings unexpected spin offs that can be wanted or unwanted and need to be recognized and weighed by professionals. Based on ethnographic research of telecare practices from mental health care nurses we look in to these new forms of care in order to gain insights in how telecare brings new practices of nursing and how nurses can deal with these interventions.

## Peter-Paul **Verbeek** (Plenary speaker)

Professor of philosophy of technology, chair of the Department of Philosophy at the University of Twente
The Netherlands

**Technologies of care: on human-technology relations and the ethics of care**

Even though technologies play a central role in healthcare practices, their role in nursing has remained underconceptualized. If they are conceptualized at all, this often happens either in purely instrumental terms (technologies for more efficient care), or from the fear that technologies will threaten the quality of care (cold robots taking over work that warm human hands should do). In this lecture, I will connect current discussions in philosophy of technology with practices of nursing. Building on the theory of technological mediation, I will investigate how technologies play mediating roles in central dimensions of care. On the basis of this, I will argue for an expansion of the ethics of care to the design and use of nursing technologies.

## Beverly J. **Whelton**, PhD, MSN

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**The Theory and Conceptual Systems of Imogene King: An extension of a 2300 year old Athenian perspective to frame person-centered care for a global health community in the 21st Century**

For Aristotle, human substances are rational animals.  We share with animals, sensation, simple problem solving, appetites, emotions, and movement.  Harmonious working of these emotional and physical systems is health.  Humans have unique natural capacities of conceptual knowledge leading to freedom of choice.  Aware of these capacities of knowledge and choice,  King (1971, 1981) saw that when patients become active participants in identifying needs and transacting health-related goals they more actively embrace these goals whose achievement becomes evidence for evidence-based practice (Theory of Goal Attainment).

The individual and his or her physical capacities is King's personal system.   Norris Clarke (1999) uses the insights of phenomenology to add that human persons transcend their substantial being to enter into relationships.  Human transcendence is the matrix of King's interpersonal system, the space within which patient and nurse interact, the therapeutic relationship with goal development.   Humanity is the heart of health care within the personal existence of the nurse and the patient.  This is a global phenomenon that unites all health care.

Health care is provided within an organized delivery system that is King's social system, a complex interactive human community with formal and informal mission statements, goals and policies.

In our emerging world culture, nurses are called to assess not only the individual's particular physical, social, cultural and spiritual capacities and needs, family ability to care for them, social and economic stability of the family within the community, but also the impact of political, economic and technological developments within the patient's geographic region.  This assessment

with strengths and problem identification, mutual goal establishment, and subsequent interventions and evaluation of effectiveness extends from individual and their family to their community, state and country. The provision of health care, even to individuals is impacted by the socio-political structure, economics and technology available within the patient's global system. King did not write about a global system but she worked within one in her outreach to nurse educators. Nursing in the 21st Century provides health-care to individuals in a global community and must have conceptual tools for understanding and structuring data, processes and stabilities within these global systems.

Francine **Wynn,** RN, PhD, Senior Lecturer

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Canada

**Stiegler's Mnemotechnics of Care: Forming Deep Attention in Nursing Students**

In this paper I will draw on the ideas of Bernard Stiegler to open up the challenge of educating/forming baccalaureate nursing students in this epoch of what he calls 'Hyper-modernism'. Stiegler's philosophy of technology is based on his thesis that human culture is the product of technics through the prosthetic relationship between humans and its 'exteriorization' in matter. Concrete technical objects function as external or artificial tertiary memory (hypomnesis) that generate and accumulate knowledge and skills that are passed from generation to generation. A stone tool, the alphabet, a fountain pen, a book etc constitute such a materially based memory support that precedes and gives rise to our collective and individuated existence. Opposing the long history of mnemotechnical objects to the globalizing current mnemotechnologies, Stiegler asserts that digital technologies, by soaking up and dispersing attention (potentially changing our cognitive structures), threaten the traditional educational techniques of reading and writing that cultivate embodied deep attention and the long circuits of transindividuated accumulated generational knowledge. Attention formation is a fundamental aspect of all human society and to concentrate or capture attention is to form it. Stiegler argues that not only do these digital technologies and the underlying economic marketing industries investing in our perpetual consumption short circuit memory by relying on vast external stocking of metadata, but in addition, our individual capacity to select and challenge ideas, be critically self-reflexive, and act responsibly is potentially being re-shaped by this algorithmic and speeded up global system. Here I will advocate for the ongoing importance of the mnemotechniques of reading, note-taking, and art making for the formation of nursing students 'deep attention necessary to therapeutics of care.

Adelaida **Zabalegui**, RN, PhD, FEANS, on behalf of CTDI

Hospital Clinic of Barcelona
Spain

**Barcelona Hospital Clínic Nursing Model. A new perspective towards excellence**

INTRODUCTION
Nursing practice in Spain is mainly guided by Virginia Henderson´s model (1950s). So, there was a need of adapt our approach to nowadays patient and family care needs. Our project aimed to develop a new Nursing Model, a new caring framework, congruent with the Hospital´s philosophy in order to improve healthcare assistance, to boost knowledge and innovation, to develop professional skills and to boost the practice based on scientific evidence and leadership.

METHODOLOGY
First phase: Model development

Three questions guided our project: What do our patients need? How do we care for them? How do we want or should care for them? Methods used: Literature review, Focus groups (three focal groups with the participation of 22 nurses, 10 head unit nurses and 2 nursing auxiliaries), Interviews in depth and non-participative observation (22 interviews were performed to the morning and afternoon shifts in 11 units: 5 medical, 5 surgical and 1 medical-surgical), Opinion questionnaires for the patients (80 hospitalized patients) and patients complaints records (234 patients´ complaints filed during 2010 and 2011).

Second phase: Model implementation

Seven working groups: Organization of the patients care in the Medical Units, Communication between nurses and nursing auxiliaries/nurses aids, Communication between nurses and physicians, General supervision, Clinical quality and safety, New nursing roles: Advanced Nursing Role, Supportive tools: Technologies of Communication and Information. Another 5 working teams from specific healthcare areas: Surgical care, Intensive Care Units, Emergency Rooms, Diagnostic Centers, and other healthcare units.

RESULTS
We identified six key points of the "Principles of the Hospital Clinic´s nursing care": Empowerment of patients, use of scientific evidence and the best practices, keep optimum communication with the team and patients/families, improve professional nurses´competencies, implement advanced nursing practices and foster the nursing leadership for the best patients care.

CONCLUSIONS
The start line in care progress is involving patient directly to their own decision. It is important to consider them part of the health care system through all their life. This is the first care model design and developed by hospital nurses in our country, focused on a multidisciplinary approach and on patients' experience.

Joakim **Öhlén**, RN PhD, Professor

Palliative Research Centre, Ersta Sköndal University College, Stockholm and Sahlgrenska Academy at the University of Gothenburg
Sweden

**Complexities in suffering in the context of palliative care – using the ethical intension according to Paul Ricoeur as a theoretical resource**

To alleviate or relieve suffering is the central goal in most definitions of palliative care. However, it is common that the suffering and possibilities to alleviate suffering is not made explicit or even paid attention to in palliative care. Rather, it is sometimes taken for granted that patients' and family members' suffering and desolation can be transformed to relief and consolation through supportive, quality of life boosting or symptom relieving interventions. Here, an assumption is that the outcomes of such interventions are not obvious, and that the responsibilities of health care to alleviate suffering could be questioned. Further, suffering is often (routinely) divided into physical, psychosocial and spiritual dimensions or aspects as explicitly stated in for example the WHO definition of palliative care; different from ways the suffering person articulate. Particularly salient are bodily experienced and expressed suffering, which could encompass simultaneous physical, psychosocial and spiritual dimensions.

In this presentation different meanings of suffering will be reflected upon. For the articulation of a theoretical perspective, the ethical intension as stated by Paul Ricoeur will be applied: ".. aiming at the 'good life' with and for others, in just institutions" (Ricoeur 1992, p. 172). This vision points to the necessity to combine different ethical perspectives, and here it is used as a theoretical resource to illuminate different perspectives of suffering in the context of palliative care: focusing the individual; jeopardizing a good life for the person, focusing interrelationships; how suffering and alleviation is co-created interactively in relations, and focusing societal institutions; prerequisites for the population (groups) to be alleviated by means of for example guidelines and policies.

The aim is to use the three elements in the ethical intension to illuminate and reflect upon complexities in suffering, and articulate three differing but complementary perspectives on suffering. Together these perspectives are critical to enable alleviation of suffering in palliative care.

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**Is it possible to integrate tensions in opposing views related to notions of individualization and generalization in palliative care?**

There are concurrent societal, demographic and epidemiological conflicting challenges related to palliative care. Trends in globalization have led to culturally diverse and pluralistic societies with a range of perspectives of death and dying, and different expectations for palliative care. In addition, people are living longer with life-limiting conditions. Although specialized palliative care is available, including in Sweden and Canada, most people who are dying from chronic life-limiting conditions do not receive specialized palliative care, but rather utilize other health services, such as chronic disease management, primary care, intensive care or emergency room services. Within the field of palliative care the aim of the project is to integrate person-centred perspectives with standardization and measurement (including standard care plans, evidence-based practice guidelines, and patient- and family-reported outcomes and experience measures). Specifically, this presentation will focus on the initial and tentative exploration of tensions related to notions of individualization as opposed to generalization in palliative care. For the initial exploration we applied different lenses and perspectives including equity, cross-cultural, global health, person-centeredness, measurement validation, and quality indicators. Then tentative tensions between apparently opposing views were identified. For the integration of different views of international relevance to palliative care, a hermeneutic approach that is dialectic and communicative (based on Paul Ricoeur's hermeneutics) was applied. This perspective articulates possibilities to relate opposing views without neutralizing or diffusing their central features; thus a theoretical resource to not end up in a fixed or oversimplifying "model". This analysis is on-going. As a Swedish-Canadian collaborative initiative, with senior and junior researchers and graduate students from both countries, we target conceptual issues influencing ways societies and professionals respond to pressing, global needs in relation to the care of people with chronic life-limiting conditions approaching end-of-life.