Nurses go visiting
Ethics and gender in home-based nursing care

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To my family
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ABSTRACT

The overall aim of this thesis is to explore how nursing is constructed in home-based nursing care from the viewpoint of patients and nurses who are receiving or giving care. Since nursing both constructs and is in turn constructed by the context in which it serves, language plays a central part in those constructions and in this thesis. The thesis has been guided by social constructionism, meaning that the positions the patients and the nurses inhabits have been considered as social phenomenon constructed in discursive processes.

There are two ideas that guided this thesis. One idea was that home-based nursing care promotes the association of caring abilities in relation to nursing, women and the private sphere. Another idea was that the place where the care was carried out has ethical implications.

Data was collected from interviews with 10 home-based nurses (study I) working in community in the western part of Sweden and 10 patients cared for in their home by these nurses (study II). Nurses and patients were interviewed about their experiences of giving respectively receiving home-based nursing care. The interviews were transcribed verbatim and analyzed with a discourse analytic method in study I and II. The findings in study I show that the nurses described their subject positions as “guests” and “professionals” and that they have to make a choice between these positions, as it is impossible to perform both positions at the same time. Dependent on the situation, both an ethics of care and an ethics of justice were applied by the nurses, that is, to perform according to the subject positions of “guest” or “professional.”

In study II, the patients describe their own subject position as “safeguard” and the nurses’ positions as “substitutes”. These subject positions provided the opportunities, and the obstacles, for the patients’ possibilities to receive care in their home which included which kind of strategies, habits and activities the patients described and what tasks and how they considered or expected the nurses to perform. These findings are discussed within a theoretical framework, i.e. a gendered dichotomy of the private spheres versus the public spheres. Inherent in this framework is a discussion of the findings related to the habits that are essential in the nurses’ and the patients’ constructions of subject positions.
In study III, metaphors used by home-based nurses’ were explored as a means to discover values and norms held by nurses working in home-based nursing care. Ten interviews with nurses working in home-based nursing care (the same interviews as in study I) were analyzed and interpreted with a metaphor analytic method. In the analysis metaphoric linguistic expressions (MLE) were explored and patterns of MLEs formed two entailments. After exploring MLEs and entailments on an explicit surface level the analysis went to a broader underlying dimension of conceptual metaphors identifying the overall metaphor: “Home-based nursing care is an endless journey”. The metaphor “Home-based nursing care is an endless journey” exposed home-based nursing care in constant motion, thereby requiring nurses to adjust to circumstances. This adjustment required ethical maturity based on experience, knowledge, and creativity. The study III focuses on the importance of further developing reflections over experiences related to everyday ethical issues.

In study IV, the findings from study I were the starting point for a philosophical exploration of the concept “guest” and its relation to other adjacent concepts such as hosts and hospitality. The question to be answered was as follows: In what ways can home-based nurses’ description of being “guests” in patients’ home be understood? The exploration was based on Derrida’s philosophy of unconditional and conditional hospitality, Levinas’ philosophy of “face” and “the Other” and Arendt’s philosophy of “go visiting”. The findings indicated that the concept “guest” was not appropriate for the nurses to use when describing their position in home-based nursing care, since the concept was problematic for the content and the complexity of home-based nursing care. The findings also showed that exposing concepts as binaries is fruitful since they show relationship between concepts. Just illuminating the concept “guest” did not reveal the power relationship between the “guest” and the “host” and their relationship to hospitality.

The distinction between diverse ethical perspectives could be seen as problematic or as an opportunity. According to this study, the nurses used a plurality of different ethical ideas, such as an ethics of care, an ethics of justice, an ethics of virtue and an “everyday ethics.” A possible interpretation could be that this was a sign of a difficulty to maintain distinction between ethical theories in clinical practice.
Ethical issues in the private sphere are less commonly explored compared to ethical issues in the public sphere, for example in hospital care. As showed in this thesis, the distinction between the private and the public spheres was problematic. It does not describe two spatially separate spheres, but rather it describes functionally dependent activities, interests and relations, such as diverse areas of ethical ideas and “feminine” and “masculine” positions.

Home-based nursing care is a complex area and discourse analysis of the relation between home-based nursing care, subject positions, ethics and gender is more or less lacking. Exploring home-based nursing care outgrowing from discourse analytic perspectives and methods is rewarding for nurses’ practice, education and research as it opens up new perspectives of home-based nursing care.

Keyword: Home-based nursing care, ethics, discourse analysis, subject positions, gendered place, “feminine” and “masculine,” private and public, metaphors
This thesis is based on the following papers, which will be referred to in the text by their Roman numerals:


IV. Öresland, S. Lützén, K. Määttä, S. Norberg, A. Rasmussen, B.H. Nurses go visiting. In manuscript.

The original articles have been reprinted with the kind permission of the publisher.
PREFACE

The overall aim of this thesis is to explore how nursing is constructed in home-based nursing care. Since nursing both constructs and is in turn constructed by the context in which it serves, language plays a central part in those constructions and in this thesis. In recent years after my graduation as nurse, I have become interested in how discourses define our performance as professional nurses in a gendered profession, the picture we have about ourselves and each other, and the perspective we have of the patients we care for. My interest in language is also related to questions about ethics and gender and something one may call “ethical appeal,” a claim to act according to ethical demands inherent in concepts themselves. When we talk about nursing, we use concepts loaded with ethical appeal such as “patients” and “care.” According to my view, such “presumptions” influence how we perceive, understand and perform in nursing. In my experience as a teacher in nursing education, there has been an expressed interest in the role of ethics and gender in nursing from many of my colleagues. In our discussions, it appeared as if many nurses perceived ethics and gender as individual issues and not issues related to the structure of a specific caring context (for example, a hospital or a home). On a more theoretical level, questions about the language used in reference to gender and ethics with a focus on interactions between patients and nurses have not previously been investigated. These experiences and interests guided me in my decision to conduct this research.

DISPOSITION OF THE THESIS

The disposition for the thesis is as follows: The first section presents the background research on home-based nursing care and the theoretical framework. The second section presents the rationale, aims and methods used, including the epistemological framework used. The third section presents the findings in papers I, II, III, and IV, followed by a discussion related to the theoretical framework, i.e., within a gendered dichotomy of the private vs. public spheres. After the discussion, methodological considerations, suggestions for future research, implications for clinical practice, a summary and conclusion are accounted and described.
BACKGROUND

Home-based nursing care

The provision of care in the Western world has, during the last decade, been transferred from hospitals to other settings such as private homes (Johansson 2005; Boughton and Halliday, 2009; Bjornsdottir, 2009). This is also the case in Sweden (The National Board of Health and Welfare in Sweden, 2008), where the financial burdens for the society of hospital care is increasing (Thomé, Dykes, Hallberg, 2003; Modin and Furhoff, 2004). In the year 2006, 48,000 people 65 years and older were cared for in their own homes. In the year 2008, 250,000 people were cared for in their homes, and 217,500 of these were over 65 years old (The National Board of Health and Welfare, 2008). The transfer from hospital care to home-based nursing care (in the forthcoming called HBNC) can be a consequence of advancements made in treatment and shorter hospital stays. Another explanation could be that the number of beds has been reduced in hospitals.

The aim of HBNC, according to The National Board of Health and Welfare in Sweden (2008), should be; “patient focused, based on knowledge, appropriate, equal and given in proper time” (p.3). HBNC serves to prevent, delay, or substitute long-term and acute institutional-based services (The National Board of Health and Welfare in Sweden, 2008). HBNC in Sweden provides care for young, middle-aged, and aged people with diverse types of health-care needs, including mental and/or somatic health problems. This care can be given to people with stable or progressive diseases over longer time periods. HBNC is also appropriate in short-term situations, such as after surgery or in periods when family caretakers are in some way not able to provide care.

In Sweden, HBNC is financed by public means and organized according to economical variables such as personnel resources (The National Board of Health and Welfare, 2008). Some municipalities are financially responsible for rehabilitation, while in other places, the county councils have the responsibilities. Moreover, the municipalities have the financial responsibility to provide care and service to older people incapable of providing for their own needs. These persons often require additional care and service (Social Service Act, 2001; The National Board of Health and Welfare, 2008). Specifically, the county councils are responsible for medical health care given by physicians in special accommodations as well as in the patients’ home. Thus, it is apparent
that different organizations are responsible for HBNC and medical care in the home. Disparity of responsibilities in this organization of HBNC may influence the quality of service and care of the patient (Karlsson, Edberg and Rahm Hallberg, 2010) especially with the nursing role, the subject of this dissertation.

**Nurses in home-based nursing care**

Nurses’ performing HBNC can be employed by home-care agencies run by the municipalities (The National Board of Health and Welfare, 2008) or the county council as mentioned above. It depends on which health care provider has the overall responsibility for the organization of HBNC. In Sweden, registered nurses (RNs), enrolled nurses and nurses’ aids are assigned the responsibility to care for the patients in the patients’ own home, yet it is the RNs that have the highest level of education and are legally responsible for the nursing care provided. In Sweden, nurses after RN graduation might take advanced nursing practice courses related to HBNC. In the patients’ home, nurses are expected to be able to perform technical procedures as well as establish a satisfactory and goal-oriented patient-nurse relationship (National Board of Health and Welfare, 2005). Administration of drugs orally or as injections, dressing wounds, giving information about caring management and social and emotional support demands technical, ethical and communicative skills (National Board of Health and Welfare, 2005). In addition to HBNC, there are an increasing number of people who receive assistance by nursing aids and enrolled nurses with household work and other activities of daily living.

There are critical opinions about home health care. In a national assessment of home health care in Sweden (The National Board of Health and Welfare, 2008), the investigators found that that the requirements of good care in home health care were jeopardized, and the security for the patients’ care was threatened. According to the report, there were several causes for the jeopardized care: there was less access to care than there was need for care, the transfer of information among different health organizations was insufficient and the availability for care was not sufficient and equal. Moreover, the medical delegations to the nurses were extensive, and the availability of nurses and physicians was limited for the requirements of care. Moreover, achievements in technology have allowed for the installation of monitoring devices and advanced medical treatments in private homes in countries such as Australia (Duke and Street,
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2005) and the USA (Waters and Eder-van-Hook, 2006). This is also the case in Sweden. Studies have found that staff competence is not in agreement with work tasks in HBNC. Delegation of medical tasks, such as staff without formal nursing training giving injections of medication, has been associated with feelings of uncertainty among nursing staff and might affect the outcome of care (Brulin, Winkvist, Langendoen, 2000).

There are many concepts related to the care patients receive in their own home such as visiting nurses, home health care, home care, and home care services. In this thesis, two different concepts are used. In the beginning, the concept “home health care” was used when describing the organization of care and the care nurses perform in the patient’s home. In the time span between studies, a further development of thoughts concerning concepts used took place. In a research report from the World Health Organization (2002), the concept Community Home-Based Care is used and defined as:

...any form of care given to ill people in their homes. Such care includes physical, psychosocial, palliative and spiritual activities. The goal of community home-based care is to provide hope through high-quality and appropriate care, that helps ill people and families to maintain their independence, and achieve the best possible quality of life (p 6).

This definition seems relevant to my understanding, and therefore, HBNC will be used, as it more explicitly expresses a form of care given by nurses to people in their homes.

**Nursing as a gendered occupation**

Sometimes nursing is presented as a gendered occupation, as two main genders mutually exclusive - sometimes diametrically opposed. When presented, the gender dichotomy describes gender position as entailing gender specific traits, roles, rights and responsibilities according to the person’s sex. According to (Doane, 2010), such perception and understanding of gender dichotomy might underlie the foundations of understanding oneself and others.

According to a gender dichotomy, it is well-known that nursing is a gendered occupation, with a tradition historically based on women’s work (DÂntonio, 2007; Roth and Coleman, 2008). There is consequently a strong conceptual and
empirical association between the facts that most nurses are women and our “common sense” beliefs that the term nurse connotes a woman (Westberg-Wohlgemuth, 1996). In Sweden, for example, 89% of the working nurses are women (SCB, 2010).

In spite of nurses’ significance in health-care settings, they are often marginalized, which might negatively affect their sense of possibilities in their work (Simpson, 2004; Roth and Coleman, 2008). The marginal position of nurses is related to the subordinated status of women and devaluing of what is called “women’s work” (Ceci, 2001; Ceci, 2004; Nilsson and Zetterlund-Larsson, 2005; Roth and Coleman, 2008) and might also have an effect on male nurses doing “women’s work” (Evans, 2004; Harding, 2007; Loughrey, 2008; Roth and Coleman, 2008; Brown, 2009). This is not only because the notion of nursing is in itself gendered, but also because nursing is understood in relation to the categories “physician” and “medicine,” other gendered categories - in these cases, masculine ones (Roth and Coleman, 2008). Thus, as Benhabib (1987) and Gatens (1991) pointed out, just as women are defined by “lack” (that is, lacking what it takes to be a man), so nurses lack what it takes to be a physician.

In other words, nurses and nursing (and physicians and medicine) can be presented as a male or female occupation and/or as a male or female nurse (or physician). However, it can also be presented as a feminine or masculine occupation and/or as a feminine or masculine nurse/physician. When referring to masculine and feminine positions, it is not necessarily a position performed by men or women. The discursive function of a masculine position, for example, would not necessarily be enacted by men (Butler 1993; Määttä and Öresland, 2009). According to several authors (Butler, 1993; Simpson, 2004; Määttä and Öresland, 2009), masculine and feminine positions are normative discursive constructions and are not tied to particular sexed bodies. That is, behaviours and traits associated with females are often termed “feminine;” in turn, males’ characteristics and behaviours are often termed “masculine.” Stereotypical masculine traits can be vital in females, and stereotypical feminine traits can describe certain characteristics in males. Females and males learn and adopt gendered habits, virtues and positions depending on the social and cultural requirements of their families, communities, and cultures at particular points in history (Borgerson, 2007).
Place and health

The importance of place related to nursing care has become a focus in nursing research (Liaschenko, 1997; McDowell, 1999; Leonard, 2003; Peter, Macfarlane, O’Brien-Pallas, 2004; Jonas-Simpson, 2006). One reason for this could be that various health care models besides hospital care have grown more common. One way of understanding the relation of place and health concerns the construction of a social place in terms of interpersonal relationships between patients and nurses in that the nurses’ presence is therapeutic and contributing to a healing environment. One example is a study of Gardner (1992), who describes presence as a process where the nurses at first intuitively see the patients’ needs and then respond to those needs by being physically there in a supportive way.

According to Andrews (2002) it is not possible to separate the experiences of health and health care from the place in which it is experienced. In a literature review comparing nursing research and health geography, Carolan (2006) claimed that some nursing research is underpinned by an understanding that place has relevance for people’s health (for example, the home as a site of care has a positive impact on patients’ health and benefits patients in terms of autonomy and reliefs). There are critical voices, however, about the home as the best place for a person to recover and improve. Liaschenko (1994), for example, asserted that there is a risk that the “gaze of medicine” (i.e., the norms, values and routines that characterize much of traditional hospital care) is also transmitted to HBNC, thereby changing the “landscape of the home” (p.16) and not supporting the patients’ abilities for agency and choice. Another way to understanding the relationship of health and place concerns the role of everyday activity in constructing “healthy space.” which is, according to Dyck (2007), those (womanly) routines such as care for the elderly and the vulnerable and food preparation and consumption practice that marks out the symbolic, social and physical magnitudes of healthy space.

The private and the public

Home is often described in research literature as an ideal place and/or space where people can retreat and relax in a space that offers freedom and control (Dekkers, 2009). This understanding of home is founded on several associated ideas (Vaughn Roush and Cox, 2000) concerning the distinction between the
The inside, private world of the home is said to be an intimate space that provides a context for close, caring relationships, sometimes described as a feminine place. In contrast, the outside and public space is more diffuse and often associated with work, political engagements and non-family relationships (Mallett, 2004).

It has been commonly held that the public and the private are two separate spheres (Roth, 1999; Armstrong and Armstrong, 2005; Dyck, 2005). The private sphere has been associated with personalized life, women, femininity and home (Armstrong and Armstrong, 2005; Dyck, 2005). The public sphere, on the other hand, has been associated with the professionalized life, men, masculinity and work (Davis, 1995; Armstrong and Armstrong, 2005). This view assumed two areas in an ideal society: the public, which could be regulated by law, and the private, which should be free from interference from the state. This split between the state and the individual was thought to lead to a division, for example, between government and civil society and between homes and work (Roth, 1999; Bjornsdottir, 2009).

It is commonly held that a private place is a spatial place where the individual is the “owner” and thereby has the power over the place (Douglas, 1991; Liaschenko, 1994; 1997; Peter, 2002; Peter and Liaschenko, 2004). Place can also be understood as “privacy,” and has sometimes been used synonymously with the “private domestic sphere” where decisions and concerns about intimate issues of individual and family life are taking place (Allen, 2000). According to Allen (2000), there are three meanings of privacy connected to moral and normative dimensions: (i) physical freedom for the individual from unwanted observation or bodily contact; (ii) informational secrecy, confidentiality, or anonymity of information; (iii) freedom from unwanted interference, ability to make one’s own decisions and to act on those decisions. However, according to Magnusson, Lutzén and Severinsson (2002), professional care in the patient’s home means that invasion of the patient’s privacy is unavoidable.

These meanings of “the private” and privacy can be compared to “the public,” which sometimes is interpreted as “spaces” outside the household (Peterson, 2000; Armstrong and Armstrong, 2005). The term “public” often implies the opposite of “private”; it is that which relates to the community, the common good and those things that are available and shared by all. In opposition, “the
private”, signifies something closed and secluded, as signaled by the warning “private property; no trespassing.”

The distinction between the public and the private has been criticized, for example, by Benhabib (1987), who condemned the concept of the autonomous individual and the ethical tradition that the individual is seen as “a universal person” with the same desires and needs as others. According to Benhabib (1987), there is a transformation in the public and private spheres seen in late-capitalist societies, which is a result of a changing role of the state and the private home. With increasing state regulation of formerly private or household concerns, such as health care and care for the elderly, for example, the boundaries between the private and the public spheres are inevitably being reconfigured (Cotton, 2001; Jaeger, 2001). One example is HBNC, where nurses, as representatives of the public are entering other persons’ private homes (Armstrong and Armstrong, 2005).

Throughout Western history, women have been associated with the private sphere and men with the public (Arendt, 1986; Roth, 1999; Gal, 2002; Dyck, 2005). Since ancient times, history has been dominated by ontological assumptions of women as emotionally driven, dependent, and naturally responsible attendants of the family in the private sphere (Gerardi, 1995; McDowell, 1999; Gattuso and Bevan, 2000). Men’s roles in the family have commonly been related to the public, to rationality, to protecting the family boundaries and to providing the resources necessary in order to make the home a safe place for “bonding” among the members in the family (McDowell, 1999). Men’s work has often been connected to physical strength, intellectual strain, autonomy, outdoor activities and decision-making, performed with virtues such as fairness and courage (Davis, 1995; Peterson, 2000). Women’s work has often been seen as domestic work connected to the home, physical and emotional weakness, “connectedness” to others, and performed with virtues such as warmth, kindnesses, understanding, care, altruism, compassion and support (Davis, 1995). These gendered suppositions are also related to language and communication. According to Tannen (1992), women are thought to use “connected” language, which is characterized by the stereotypical feminine verbal display of care, concern, sympathy, listening rather than initiating, and promoting involvement rather than isolation. Thus, female communicative activities are stereotypically described in relation to co-operative virtues and strategies. Men’s communicative habits are, on the other hand, often stereotyped
by verbal dexterity and virtues such as confidence, honesty and directness (Tannen, 1992).

**Nursing ethics in home-based nursing care**

Ethical problems and responses to them are presumed to be undividable from the environment in which they occur (Chambliss, 1996; Peter, 2000; Peter et al., 2004; Liaschenko, 2006; Santos Salas, 2010). Up to today, hospital care has been seen as the norm for ethical issues in nursing research (Peter, 2002; Hauge and Heggen, 2007). According to Liaschenko (1997), place is influenced and controlled by different kinds of power and knowledge, including varying kinds of work that provide ethical concepts with diverse meanings, have different norms and values and are structured by different visions. All these factors work together to assign a person’s agency within a given place.

In HBNC, other ethical issues outside of hospitals might arise. For example, when nurses as outsiders cross the threshold of the patients’ private home, the integrity of the individual and the family might be affected (Magnusson, 2002). HBNC demands ethical choices and decisions that may include conflicting values and norms between the patients and the nurses, such as conflicts related to decisions about how to handle resources such as time allocation, patients’ participation, independency and the use of technology.

**Ethics of care and ethics of justice**

Some work in nursing ethics has pointed out two main areas of moral orientation – a “feminine” ethics of care and a “masculine” ethics of justice (Condon, 1992; Bowden, 2000). The ethics of care is described as a contextual and narrative thinking about moral problems, with an emphasis on emotions, responsibilities and care within relationships, often called “private questions.” The theory connects ethics of care to cultural expectations of femininity (Noddings, 1984). On the other hand, the ethics of justice is connected to cultural expectations of masculinity, which involves a formal and abstract way of thinking about ethical issues based on systems of regulations and a “general” sense of justice that generates principles independent of context (Kuhse, 1995).
The theories of ethics of care and of justice have been discussed from a feministic point of view. The feministic philosopher Benhabib (1987) asserts that the normative potential of an ethics of care lies in its specifically context-bound character. Women tend to take the standpoint of the “concrete other” in their ethical reflections, while most of the traditional conceptions, according to Benhabib, throughout the history of philosophy of ethics, are based on the standpoint of the “generalized others.” According to the standpoint of the “generalized others,” it is essential to be impartial when making a moral decision. To define ethics this way means that ethics can only be conceptualized from the perspective of the abstract autonomous individual.

According to Benhabib (1987), “an ethics of justice” is appropriated to a social order in which private and public spheres are understood as separated, as they were by 18th and 19th century philosophers, which traditionally have ignored ethical issues related to the private sphere. In this way, the experiences and interests of women were traditionally kept from the sphere of ethics and privatized. Nowadays, such a theory is not suitable and sufficient for societies in which “former informal private matters” such as health care are increasingly the responsibility of the public. An “ethics of justice” theory, according to Benhabib (1987), does not take into account “the private spheres’ ethical issues” such as ethical problems related to the “concrete others’” need of care in the person’s own home.

Virtue ethics

There is an affinity between virtue ethics and an ethics of care (Allmark, 1998). Both stress the complexity of the moral life, the inadequacy of rule-following as a guide to moral deliberation, and the importance of judgment in discerning the morally relevant features of particular situations. Both ethical perspectives share a number of positive features, such as an emphasis on the importance of character and the role of emotions in ethical decision-making (Allmark, 1998).

According to Arjoon (2007), a virtue is a quality trait that is well entrenched in its possessor, makes the possessor virtuous and is directed to a goal of human flourishing. As such, the fundamental question is not “what should I do” but “what kind of person should I be.” A virtue can be understood as a disposition or character, the ability and skills to choose and to act well in relation to others.
According to Arjoon (2007), virtues are not unreflective habits, but a disposition to perform, guided through practical wisdom. Virtuous character is sited in a “middle position,” which is sometimes referred as “a golden mean” between two vices, and mirroring a disposition to do the right thing, at the right time, with the right person, in the right way. For example, the virtue “generosity” is mediated between meanness and wastefulness. A person who has developed the virtue of generosity is often referred to as a generous person because he or she tends to be generous in most circumstances (Arber and Gallagher, 2009). Through exercising good performance, the individual provides good habits and thus becomes a virtuous person. If the individual, of diverse reasons, performs against her or his own good habits, vices are developed.

Central in the virtue approach to ethics is the idea of “community,” that is, groups of people that have something in common such as nurses. A person’s character traits are not developed in isolation but within and by the communities and discourses to which he or she belongs, including family and institutions and other private and public associations. As people grow and become established in the community, their personalities, virtues and habits are deeply affected by the values that their communities prize, by the personality traits that their communities encourage, and by the role models that their communities put forth for imitation (Borgeson, 2007). A virtue approach urges us to pay attention to the profiles of our communities and the habits of character they encourage and instil.

**Everyday ethics/housekeeping issues**

Ethical issues in health care have received much attention, and some consideration is given to the everyday ethics of health care (Smith, 2005; Wright and Braitman, 2011). Everyday ethics is not about “the big issues” such as life-sustaining subjects. It is not spectacular and may not attract the attention of “excitement” in the media or in ethical courses. According to Erlen (1997), everyday ethics concerns the relations and interactions that nurses’ face in their daily practice with patients, their families, and other health care providers. These encounters are contextualized by place, the issue at stake, and the position, status and performance of the people concerned (Liaschenko, 2006). The term “housekeeping issues” (Warren, 1989 p.78) refers to the everyday, routine issues that constitute a major part of health care work, performed by nurses, enrolled
nurses and assistant nurses and often ignored and invisible in the ethical canon (Warren, 1989; Liaschenko, 2006; Eichler, 2007).

RATIONALE FOR THE STUDY
HBNC is an increasing form of health care. The demand for HBNC is also expected to become more complex as the population becomes older, the financial burden of hospital care increases and inpatients are often discharged from the hospital earlier with multiple health problems.

As far as we know, women in the Western world have always taken care of children, the elderly and the sick in their homes. When care and treatment of the sick and the suffering became institutionalized and public, the assumptions and norms of female ability to care became considered as inherent in “women’s work” such as in nursing (Fletcher, 2006). Today, treatment and care of patients in their own homes has once again become a model of the organization of health care in the Western world, and as such, it might reconstruct the conceptions about nurses’ (womanly) natural abilities to care, both in hospital care and HBNC.

HBNC is a complex area, and discourse analyses of HBNC and subject positions, gender and ethics are limited. Thus, to study how patients and nurses described themselves and the care given and received in HBNC might be fruitful as a means to open up new perspectives in HBNC. The findings reported in studies I-III motivated and opened up a philosophical exploration concerning some concepts used by nurses in HBNC.
AIM OF THE STUDY

The overall aim of the thesis was to explore how nursing is constructed in HBNC.

The aim of this study was to explore how nurses in HBNC describe themselves (i.e., which subject positions they say they take) while caring for patients in the patients’ own homes.

Study II had two aims: To explore how patients receiving HBNC describe themselves (that is, which subject positions they inferred they take in the care they receive by the nurses in their own home), and to explore the subject positions patients describe that nurses take when giving care to them in the patients’ own home.

The aim in study III was to explore metaphors as a means of discovering values and norms held by nurses working in HNBC.

The aim in study IV was to shed light and discuss the relevance of using the concept “guest” when describing nurses’ position in HBNC.

METHOD

Epistemological framework

In this thesis, language plays a central role. The thesis is grounded in a framework of social constructionism, that is, in a theory of how we express ourselves in relation to others in a social relationship. In other words, the concepts we use play an active role in constructing and reconstructing our reality and our identities and our interaction with others (Burr, 2003; Sandvide, 2008). According to Burr (1995) and Wither Jørgensen and Phillips (2000), there are at least four premises that knit together the field of social constructionism.

According to the first premise, language has an important role in the social constructions of identities, relations and systems of knowledge. This includes a critical attitude to self-evident knowledge, that is, a critical attitude to knowledge taking the world and ourselves for granted. Our knowledge about the world cannot immediately be regarded as an objective truth, because we apprehend the world through our concepts. The physical world does exist, but
only gets meaning through discourses, i.e., “a certain way to talk about and understand the world” (Winther Jørgensen and Phillips, 2000 p.7). According to Burr (1995), this way to understand knowledge creates diverse consequences for investigation and research (e.g., that objective knowledge about the world is impossible to maintain).

The second premise is that our knowledge and how we perceive and represent our view of the world is historical, cultural-specific and contingent. Accordingly, human beings have no genuine, authentic and stable characteristics — essence (Burr, 1995; Crowe, 2000). This means that our view of the world and our identities could have been different in another time and place. The third and fourth premises are related to a connection between knowledge and social processes, and knowledge and social performance. Our way to apprehend the world and create knowledge about its content is constructed in social interactions where we develop norms about “mutual truth” and argue about what is true and false. Our conception of the world leads us to different social performances and gives, in combination with the social construction of knowledge, concrete social consequences (Burr 1995; Winther Jørgensen and Phillips, 2000). Thus, languages constitute the social world, identities and social relationships. In other words, discourses govern our apprehension of reality.

In order to understand patients’ and nurses’ descriptions of how it was to work as nurses and how it was to be a patient in HBNC, it was important to take a qualitative research approach. Since social constructionism includes epistemological premises concerning the role of language in the social construction of our experiences, a discourse analytic method was chosen (Arslanian-Engiren, 2002; Winther Jørgensen and Phillips, 2002).

In discourse analysis, theory and method are linked together. It is therefore important to be aware of and accept the underpinning philosophical premises when using discourse analysis as a method in empirical investigations. In this thesis, these underpinnings are rested in a social constructionist epistemological framework.

**Locating discourse analytic research**

Discourse analysis is to explore patterns of language in discourses and is concerned with how experiences are socially and historically constructed.
Discourse refers to a set of meanings, concepts, descriptions, and/or declarations that produce a particular version of an experience, event, object and person to the world (Burr, 1995). In a general sense, discourse is both the process of talk and interaction between people and the products of that interaction (Winther Jørgensen and Phillips, 2002; Crowe, 2005). What people say or write are examples of discourse, and, at any given moment, varieties of discourses will be in circulation. An approach in discourse analysis (Potter and Wetherell, 1987) is to look for patterns in the language associated with a particular occupation such as HBNC. A language pattern of this kind can also be seen as specific to particular circumstances and understanding language as situated within a particular social and cultural context rather than a particular interaction. According to Crowe (2005), it is the interlacing of words and phrases in different contexts that gives the words their meaning. When we attempt to grasp patterns in a text, we have to carry out that exercise against a cultural backdrop such as HBNC.

Discourses construct meaning and shape behaviour as individuals perceive the world and their experiences through discourse (Aranda and Street, 1999). Who we are depends on the circumstances in which we are placed and the discourses available in the situation in which we find ourselves. Thus, to know anything is to know in terms of discourse. According to Laclau and Mouffe (1998), a change in the discourse changes the social world, our identities and our relationships with others. Through language, we create representations of our experience, which is not only a reflection of an existing reality, but representations contribute to create the reality. This does not mean that realities don’t exist; meanings, representations and physical phenomenon do exist. However, these realities only obtain meaning through discourses (Winther Jørgensen and Phillips, 2002).

Subject position
In social constructionism, the traditional assumptions of a firm, inner identity are questioned. According to Crowe (2000), the traditional assumptions of identity are based on identity as a universal phenomenon, that is, rational, singular, knowable, and unitary with well-defined, stable and solid boundaries that distinguish exteriority from interiority. However, this is not to say that there is not just one identity in an individual. According to Dewey (1980), individuals

(Crowe, 2005).
grow and develop over time and in interaction with their natural and social environment. However, Dewey’s theory about multiple identities is not developed and grounded in the belief that identities are shaped by discourses.

The concept *subject positions* is central to the social constructionist epistemological framework, grounded in the belief that experiences and identities are constructed within social relationships and repeated performance and shaped by discourses. Social constructionism asserts that the individual has an ability to occupy and move among varieties of subject positions (Butler, 1993; Harper, 1995; Winter Jørgensen and Phillips, 2000; Edley, 2001). For each individual, the process of identification exists as the result of the facilitating of one subject position and the foreclosing of alternatives (Butler 1993; Crowe 2005) such as good nurse/bad nurse (Smith and Godfrey, 2002; Varcoe, Doane, Pauly, Rodney, Storch, 2004), female nurse/male nurse (Öresland, Jakobsson, Segesten, 1999; Chur-Hansen, 2002), easy patient/not easy patient (Breeze and Repper, 1998; Brännström, Tibblin, Löwenborg, 2000). The more an individual acts out the assumed subject position, the more likely that position will become socially identified. The subject position taken has ethical implications. For example, the ethical implications in relation to “patient” may be different from the subject position “customer.” The subject position “patient” has normative associations, sometimes viewed in terms of being powerless, submissive, and dependant on help from others (Ellefsen, 2002). In contrast, the subject position “customer” might be seen as an independent, powerful autonomous agent, making autonomous decisions (Wadhwa, 2003). According to Crowe (2000), the place we inhabit and our social interactions construct and reconstruct our subject positions. Since subject positions are constructed and reconstructed by social communities, the more an individual acts out the assumed subject positions, the more likely it is that position will become socially acceptable, which requires social interaction.

**Binary oppositions**

A powerful tool to discover and elucidate a discourse is to use binary oppositions (Potter and Wetherell, 1987; Winter Jørgensen and Phillips, 2000; Crowe, 2005). A binary opposition can be seen as a conceptual division into two parts. A list of such binary oppositions runs on endlessly. A binary opposition could either consist of a principal and logical contradiction (that is, as mutually
exclusive terms \textit{[either/or]} or consist of comparing valuing terms (e.g., \textit{more-or-less}). The tendency to create binary oppositions can be understood as a way to create order in a more-or-less chaotic world. Words in themselves are considered empty and are given meaning in relation to a specific context and in relation to other words such as through binary oppositions (Edly, 2001; Crowe, 2005). Those binary oppositions establish “chains of equivalence,” that is, chains that create meaning in discourses by linking and knitting together concepts that seem to express similarities and/or mutual belonging. Thus, according to Potter and Wetherell (1987) and Redwood (1999), exploring binary oppositions in a “chain of equivalence” is a method of understanding a subject position.

Binary oppositions have been viewed and criticized as an artefact in Western thought (Derrida, 1976; Winther Jörgensen and Phillips, 2000). According to Derrida (1976), language and thought is structured in binary oppositions, thus maintaining social hierarchies. He claims that there is a value hierarchy inherent in them. Both concepts in a binary opposition are dependent on the other part of the binary to be understood. One of the concepts is loaded with positive meaning and associations in relation to the other concept. By creating meaning in systems of binary opposition, power relationship is discovered through polarizations of the concepts and turned out without space for any “grey zones”.

\textbf{Metaphors}

Another tool in discourse analysis is to explore and elucidate a discourse by identifying metaphors (Wetherell, Taylor and Yates, 2001), which is used in this thesis. The metaphors we use are culturally determined and can expose embedded belief systems such as assumptions and values (Dexter and LaMagdaleine, 2002). Metaphors are, however, so embedded in everyday language that people are, for the most part, unaware of their presence, use and influence (Grey, 2000; Carpenter, 2008). Metaphors obtain their special significance through their interplay of two systems of associations and implications, which results in a shifting of both systems (Black, 1976). Hence, a metaphor acts as a “lens” through which a new realm is viewed. It is the relation to the context that provides the filter for the lens (Black, 1976).
Lakoff and Johnson (1980) connect metaphor usage to our everyday language and show how our thinking and perceptions are more or less influenced by metaphors. According to them, a metaphor does not occur only with language itself but in concepts, formed at the level of cognition through the process of mapping one cognitive domain onto another. Along with Lakoff and Johnson (1980), Kochis and Gillespie (2006) argue that domains are defined by metaphoric linguistic expressions (MLEs), explained as “*a linguistic manifestation such as a word, a phrase or a sentence, which in combination with related expressions functions on the surface as an indication that a conceptual metaphor and its interference might be operating below*” (p.571). That is, MLEs manifested in the text are an utterance of conceptual metaphors. In other words, identifying conceptual metaphors can be done through exploring MLEs.

Thus, analysis of metaphors is used to expose what is valued and held implicit (McAllister and McLaughlin, 1996). However, metaphors not only reveal our embedded belief systems but also shape our understanding of phenomena and lead us to think of the world in specific ways (Black, 1976; Sherwin, 2001).

**Situating the study – setting, information and requirements of participants**

Studies I, II, III were undertaken in a municipality located in the west of Sweden. In May 2005, I contacted the head managers at two home health care agencies in the municipality. These health care agencies organized general nursing care for the patients in their homes. One agency was located centrally, the other outside a town. Both agencies offered and provided HBNC around the clock. None of the agencies offered and provided HBNC to children.

An information meeting was arranged with the head manager, the section manager and the nurses at each agency. In this meeting, attended by 20-25 nurses, I introduced myself and informed the group of the research project; I told them that I was interested to know how it was to work as nurses in HBNC, what a working day looked like, what kind of care they managed, what conditions defined their relations with the patient and what kinds of patients they cared for during their working day. Since the studies also included interviews with patients in their own home, information about the study with the patients was
included in the informational meeting with the nurses. In brief, I wanted to interview the patients about how it was to be a patient in HBNC.

At this meeting, a written information letter about the study was given to all the nurses at the agency. The ethical principles according to confidentiality and voluntaries and the right to withdraw at any point of the study without stating a reason were explained. The nurses who agreed to participate were contacted by telephone in order to arrange a suitable date, venue and time to carry out the interviews. Each nurse who agreed to participate in the study was requested to ask one of her or his patients if she or he would like to participate. The potential patient participants were informed orally by their patient-responsible nurse (PRN) and by an information letter explaining the purpose and the aim of the study. The letter also included information about their right to participate voluntarily, the right to confidentiality and the right to withdraw at any point of the study without stating a reason and without influencing their care. Potential participants were selected on the basis that they had experience as a patient in HBNC, had no problem with memory and could articulate their experiences. The PRN informed the potential participants that in the case they agreed to participate, I make contact with them in a day or so. The patients were also informed that if they declined to participate, it would not influence their care. None of the asked patients declined to participate.

**Participants**

Ten registered nurses (RNs), one male and nine female, agreed to participate in the study. Their ages ranged between 42 and 59 years. Three of the home-based nurses were specialized in district nursing, one in intensive care, and the other six in medical and/or surgical care. All had experiences of providing care to people in both institutional and community settings. The range of community experience varied from one to several years. The RNs’ professional experience as nurses varied between 6 and 28 years. All of the nurses had a full or part-time job at the agency. They worked in a team with enrolled nurses (ENs) and a physician, who was medically responsible for the care of the patients. Every nurse was a patient-responsible nurse (PRN), that is, had the overall responsibility in the HBNC for the specific patient. This responsibility included contact with relatives, physiotherapists, physicians, home-aid services etc. The nurses visit approximately 5 to 10 patients per day, and besides visiting the
patients, they do a lot of administrative work such as follow-up work related to patient visits, documentation, planning for the next days, and reporting to each other about the day’s work.

Ten patients, three male and seven female were able and willing to participate, and their PRN passed on their agreement to me. Once interest in participation was noted, arrangements for the interviews were made. The ages of the patient participants varied from 46 to 92 years. Seven patients were living alone. Two patients managed the activities of daily living by themselves, while eight patients received some daily help from aids. None of the patients were bedridden. The extent and duration of HBNC was given, varying from three months to several years. Three patients needed daily visits from the nurses. The length of the visit varied between 15 minutes to one and a half hour and was dependent on what kind of care the patients needed. Seven of the patients suffered from varicose ulcers caused by vascular disease, which demanded wound dressing by the nurses. Some of the patients also suffered from diabetes and needed help with insulin injections daily and wound dressings several days a week. Two patients suffered from cancer that required intravenous infusion, wound dressing, support and information about care and treatment. Finally, one patient needed help with his urine catheter every fortnight.

**Procedure**

All the interviews with the nurses took place in the nurses’ offices. Before the recording started, time was set aside for a short open chat to “get to know each other” and to let the participants have the opportunity to ask questions. After that, a few broad, open-ended questions were initially put to the participants, and I asked them to describe their working day and to reflect on their relationship and care of the patients: how it was to work as nurses in HBNC, what a working day looked like, what kind of care they managed, what conditions defined their relations with the patient and what kinds of patients they cared for during their working day. Thereafter, I requested more detailed explanations and asked questions that focused on significant statements such as concrete details about what they meant by describing themselves in that specific way in the interviews. Ten interviews lasted from 60 to 90 minutes, were audio-taped and then transcribed verbatim into text by me. In this thesis, the findings related to the interviews with the nurses were denoted with the numbers I and III.
All the interviews with the patients took place in the patients’ home. Time was set aside for a short open chat to “get to know each other” and give opportunity to ask questions. Once again, the patients were informed about the ethical principles that ruled the study. After that, a few broad, open-ended questions were initially put to the patients, asking them to describe and reflect on their experiences with HBNC, followed by requests for more detailed explanations or questions focusing on significant statements, such as what they meant by describing the care they received in specific ways. The interviews lasted from 60 to 90 minutes, were audio-taped and then transcribed verbatim into text by me.

Transcription of the interviews

When using a discourse analytic method, the transcription of the text is important, because it is a tool to facilitate the analysis of the pre-recorded data. Through repeatedly listening to the interviews and the dialogue between the researcher and the respondent, the process of transcription becomes an integrated part of the analysis (Halcomb and Davidson, 2006).

According to researchers (Winther Jörgensen and Phillips, 2000; Taylor, 2001), the most important thing when doing a transcription is to ask oneself the purpose. In the present two studies, I conducted the interviews and the transcription. This is preferential, because it allows for reflections during the transcription (Taylor, 2001). The interviews were transcribed in spoken language and as literally as possible. Details such as hesitations (long pauses marked as “…..”), emotional expression (in words like “laugh,” for example), repetitions and strong expressions of special words (underscored), “slip of the tongue,” expressions, and interruptions of the researcher or the respondents (in brackets) were marked in the transcription. It was also important that the transcription be readable and not too “technical,” that is, that the text as a whole should disappear because of too many marked symbols. If there were any distinctions or peculiarities in the transcription, a question mark was used.

The whole transcript material contained 213 pages, single-spaced.
**Data analysis**

In study I (the interview with the nurses), the analysis was conducted in three steps. Initially, the interviews were read over and over again in order to get a broad picture of the whole and to identify subject positions in the text (Winther Jørgensen and Phillips, 2000; Taylor, 2001). It should be noted that the phases were not necessarily accomplished in a linear way, and there was an ongoing shifting between the diverse phases. In the analysis, there was also a continual shifting between description and interpretation and between what the text conveyed or expressed and the interpreted meaning, as has been proposed by (Tirell, 1998) When understanding was reached, it was time to return to the original text and look for more examples. In this step, single-subject positions that were manifest in the text were identified, i.e., “guest.”

In the second step, each interview was read and compared with the other interviews in order to confirm the subject position “guest” in the light of the whole. In the comparison between interviews, it became obvious that there was also an implicit subject position (i.e., “professional”) in the text.

In the third step, we were looking for patterns regarding similarities and differences between expressions related to the subject positions “guest” and “professional.” To confirm the subject positions, we marked sequences, words and sentences that were associated with each other as binary oppositions that were either manifest in the text or on the implicit level. The binary oppositions established “chains of equivalence,” that is, diverse clusters that were knit together in chains that constructed the subject position. Extracts of the text were coloured and pasted into different files. Following Mohr’s (1999) suggestions for coding, intuitive “tags” were assigned in the margins of the text. To increase the understanding of how the text was related to subject positions (Potter and Wetherell, 1987; Winter Jørgensen and Phillips, 2000), this step was guided by discourse analytic questions: what subject positions were available, how could we understand the subject positions constructed, and how was the subject position achieved? The analysis was made by three authors: SÖ, MWJ and SM.

In study II (the interviews with the patients), the analysis was conducted more like an ongoing process than a step-by-step method. Initially, the interviews were read over and over again with the purpose of achieving a broad picture of the whole. An inductive approach was used in order to identify patients’ descriptions of themselves manifest in the text (Winther Jørgensen and Phillips,
2000; Taylor 2001) in the same way as in study I. However, in study II, there were initially no obvious subject positions manifested in the data. Therefore, to make the subject position “visible,” we marked sequences, words and sentences that were associated to each other as binary oppositions. In other words, we went “another way” in the analysis--as we at first were looking at binary positions that were building the chain of equivalence--and out of this, the subject positions were interpreted. Several subject positions were examined and refused, as it was not possible to identify any corresponding chains of equivalence in the texts that were “building” a specific subject position. However, at last, two subject positions were interpreted: “safeguards” that described the position of the patients and “substitutes” that described the position of the nurses. The analysis was made by two authors: SÖ and SM.

In study III, data from the interviews with the nurses were analyzed in order to explore metaphors as a means of discovering values and implicit or explicit norms held by nurses working in HBNC.

In study III, the analysis of data was inspired by Kochis and Gillespie (2006). According to them, metaphor analysis can be performed in three steps. In the first step, the analysis was conducted as an ongoing process, going back and forth in the data to get a picture of the whole. In this step, each interview was read and compared with the other interviews in light of the whole.

In the second step, metaphoric linguistic expressions (MLEs), phrases or sentences were identified, and “tags” were assigned in the margins of the text (Moore, 1999). The tags were then pasted into different data files. In this process, patterns of MLEs emerged, and two entailments were formed. MLEs and their entailments were then organized into groups by similarities or differences.

In the third step, the analysis went from the explicit surface manifestations of MLEs and their entailments to a broader underlying dimension of conceptual metaphors. In this step, the entailments formed a conceptual metaphor that binds the entailments together.

The philosophical exploration of the concept “guest” in study IV was based on the findings in study I. A database search on the concept “guest” in databases such as Cinahl, Medline and Philosophers Index showed that Jacque Derrida, Emmanuel Levinas and Hannah Arendt where repeatedly referenced. Therefore,
they were chosen. The method used is an exploration of concepts applied by these philosophers.

ETHICAL CONSIDERATIONS

According to Slyter (1998), an ethical consideration indicated that patients may be a vulnerable group. Although described as a valuable resource, patients might also be identified as vulnerable due to a possible lack of autonomy. While patients are considered autonomous adults capable and competent of providing informed consent, their competence to refuse may be impaired.

The patients and the nurses were informed about the purpose and content of the study. They were also told that I would do everything possible to keep them from being identified in any publication. They were also informed that participating in the study was voluntary, their information would be handled confidentially and they could end the interview if they were discontent with any aspects without giving any reasons for the interruption and without any repercussions whatsoever. Furthermore, they were told that questions about the research could be asked at all stages of the interview. Consultation was done, and advice was given by the Ethics Committee at the Medical Faculty, Gothenburg University, Sweden (Dnr.246-05), dated 20-06-2005.
PRESENTATIONS OF FINDINGS

Paper I

In the study, the aim was to explore how nurses in HBNC describe themselves (i.e., which subject positions they say they take) while caring for patients in the patients’ own homes. The analysis showed that nurses described their subject positions as a “guest” and as a “professional.” Almost all nurses used the term “guest” to characterize their position in their relationship with patients. The position was constructed from binary oppositions such as we/them, patient’s world/nurse’s world, subject/object, asking for permission/intruding, and taking a low profile/obtruding (see Appendix Table I).

The nurses characterized the homes as the patients’ world, which meant that the patients, not the nurses, were in command. The patients’ homes were considered as places where patients, not nurses, set the daily routine. Nurses, therefore, had to observe certain rules of guest behaviour, such as respect for patients and their homes. This was done by taking a low profile, like a guest, when they visited the patients in their homes. They stated that they behaved the same when they visited the patients’ homes as they expected their own guests to behave when they were the hosts in their own home.

Although the nurses preferred the subject position as guest in the patients’ home, this was not always possible, and occasionally they took the subject position of professional. The professional position was constructed by a chain of equivalence that in turn was built up by binary oppositions: acting decisively/casually, not a personal friend/a personal friend, distance/closeness, matter-of-fact communication/confidence-building communication (See Appendix Table I).

The professional position was taken when the situation demanded a decisive stance. When differences of opinion occurred between nurses and patients, it was also necessary to be sensitive to the patients’ opinions, although the nurses insisted that they were experts in nursing and medical matters. Nurses also argued that it was necessary to have enough courage to stand by their own opinion and trust in their own experience. According to the nurses, the professional position included skills of balancing between concession or not.
**Paper II**

One aim in study II was to explore how patients receiving HBNC describe themselves; that is, which subject positions they inferred they take in the care they receive by the nurses in their own home. The analysis revealed that the patients described their own subject position as “safeguard” and the nurses’ position as “substitute.” This included the types of strategies and activities that the patients constructed for themselves and which strategies and activities they considered the nurses to perform. “To control” and “to secure” are two of the features of the subject position the patients described in their relationship with the nurses and the care they give. This is shown by a chain of equivalence that is built up by binary opposites as follows: patients’ territory/nurses’ work place; security/insecurity; independence/dependence; continuity/interruption; involvement/exclusion (See Appendix Table II).

The study showed that the patients experienced their private home as their own territory and expressed that this ought to give them precedence and the right to decide what to do, how and when. They also expressed that they felt secure and comfortable in their own home. This sense was related to familiarity with their routines, habits and objects. The patients emphasized the importance of their own involvement in the patient-nurse relationship and in the care, that is, to be involved in decisions and to be respected for their opinions. However, it could happen that they were excluded from decisions. Sometimes, they would speak their mind and hoped that the nurses would respect their opinion; in other situations, they were resigned, because they did not want a quarrel with the nurses.

The patients described the nurses’ position as a substitute for the patients’ functions and health, both of which were now failing and were related to the patients’ own will, needs and emotional ability. This position was constructed by chain of equivalence that was built up by binary oppositions of the following: doing for/doing against, fulfilling needs/incomplete achievement, good mood/bad mood (See Appendix Table II).

The patients described that the nurses often acted for them in accordance with their own will, especially when they wanted contact with their physician or the hospital. It also happened that the nurses did not act in accordance with the patients’ will, which was the case when medical and nursing issues were at stake. However, the nurses had the abilities to fulfil any needs the patients were
unable to fulfil themselves; for example, the nurses used their professional knowledge when helping the patients to manage their pain.

Further, the patients described that their need for personal dignity was sometimes incompletely achieved, since they felt that the tasks were more important for the nurses than for them as persons; however, the nurses’ personality was of great importance to the patients’ wellbeing. Good mood was supportive and stimulating and made the patients feel satisfied.

**Paper III**

The aim in study III was to explore metaphors as a means of discovering values and norms held by nurses working in HBNC. In the analysis of the interviews with the nurses, metaphorical linguistic expressions (MLEs) were identified (See Appendix Table III). The MLEs formed so-called entailments, clusters such as (i) *embark on a health journey towards an uncertain destination* and (ii) *nurses accompany the patients’ health journey by planning, control and communication.* The entailments and the MLEs were interpreted as expressions of an underlying conceptual metaphor, namely *HBNC is an endless journey.* The conceptual metaphor was created in a cross-domain map between the two conceptual domains of HBNC and travel. The conceptual metaphor *HBNC is an endless journey* indicated that HBNC changed according to the patients’ health condition.

When embarking on the “journey,” the patients required a “ticket”, that is, a referral from the physician. “The baggage” (the illness) was referred to when the nurses described the purpose of the patients’ health journey. The “stopovers” (the nurses’ performance) were dependent on the patients’ condition, which could improve, get worse, remain status quo or be in progress. The patients’ ability to manage their health journey could also be related to their ability to manage the journey alone. Sometimes, patients required help from others. The ability to travel alone or with help from others was related to the patients’ mental abilities or will.

The conceptual metaphor *“HBNC is an endless journey”* indicated that the nurses could be seen as a fellow traveller in the patients’ health journey. This companionship was guided by ethical rules such as “the patients decide,” “the patients are in focus” and “never use a situation for your own gain.”
metaphor “HBNC is an endless journey” suggested that nurses in HBNC could be seen as a conductor “examining” the patients’ “baggage” (illness). The conductor checked and confirmed if the “baggage” included the right “stopovers,” that is, the level and the performance of care. If the “tickets” did not fit the patients’ baggage, the conductor arranged another stopover that better fitted the patients’ baggage. However, the conductor was conscious of his/her power to decide how time had to be prioritized. The communication between the patients (the travellers) and the nurses (the conductors) was sometimes articulated by positive MLEs, but the nurses also pointed out that negotiation, nagging and persuading were common activities. Asymmetrical power relations inherent in the communications between the traveller and the conductor/conductress were also expressed.

**Paper IV**

The aim in this study was to shed light and discuss the relevance of using the concept “guest” when describing nurses’ position in HBNC. This was done by exploring the philosophies of Derrida, Levinas and Arendt and their theories on the concepts guest, host and hospitality. The study showed that “guest” needs an invitation to properly be called “guest.” The exploration revealed that the concepts “guest” and “nurse” are both binary and relational concepts. The concept “guest” is closely connected with the concept “host.” They are etymologically, linguistically and philosophically two sides of the same coin, intimately connected to the concept of hospitality. Accordingly, Derrida and Levinas also linked the concept “guest” to the ethics of hospitality.

This study also showed that one way to understand why the nurses described themselves as “guest” (I) is to interpret the concept “guest” in relation to Arendt’s (1978) metaphor “go visiting” (IV). “Go visiting” can be seen as an attempt to describe that the nurse enters the patient’s/host’s imaginary world, putting the own imaginaries aside and trying to see and act according to the patient’s imaginations. According to Arendt (1978), we need to guide our imagination to “go visiting,” which means taking into consideration the standpoints of others - their acts and judgments - without demanding any claim for universal applicability. To go visiting is to use one’s mind. Thoughts are “training your imagination to visiting” as Arendt (1978, p.357) puts it.
The use of the concept “guest” can be seen as pointing out a relationship between a host and a guest, and the codes and rules adherent in such a relationship. While using the concept “guest,” the nurses imply that they consider themselves invited by the patients and as guests subordinated to the patients’/hosts’ will and needs. This could imply that the nurses should pay the patients great respect and try not to violate their authority and rules.

DISCUSSION

The first three studies in this thesis included data from both patients and nurses in HBNC. They revealed different ways of speaking about HBNC and produced a picture of nursing care in the patients’ home. The fourth study is a philosophical exploration of the concept “guest” and adjacent concepts of “host” and “hospitality.” These concepts are embedded in the discussion, together with the empirical data. The intention of the following section is to discuss findings in a theoretical framework (i.e., in a gendered dichotomy of the public/private) and to present and discuss some findings in relation to habits that might be essential in the constructions of the patients’ and nurses’ subject positions. Another intention is to discuss the findings related to ethical frameworks.

The threshold as a border between the private and the public

When nurses step over the threshold into the patients’ home (I, II, III), they cross and overlap the boundaries of the private and the public sphere, which can be illustrated in the following way: When the threshold was passed, and the door was opened by the patients, the nurses, as representatives for the public, entered an unfamiliar land, a private world - the place and privacy of the patient, which otherwise were secreted from the public sight. This foreign land was partly strange for nurses. By allowing the nurses the right to entry, the patients gave them permission for a brief stopover and showed willingness to let the nurses stay for a while, provided that the nurses accepted, behaved and performed according to prescribed norms set by the society, the patients and the nurses together.
**Nurses as guests**

The findings in study I opened up a philosophical exploration. It was interesting that the nurses in HBNC described themselves as guests. To cross the threshold as a guest demands that a host offer hospitality (IV). Seen in the field of HBNC, the patient/host welcomes a known or an unknown nurse/guest into the patient’s/host’s home. Accordingly, there can be no guest without a host offering hospitality, and there can be no host without a guest receiving it. There can be no guest without a host who has the power to exclude or invite and a guest who has the power to accept or refuse the relationship (IV).

**Unconditional hospitality**

Hospitality can be either conditional or unconditional (Derrida, 1976; IV). When the patients offer unconditional hospitality to nurses, an inversion of positions must occur (IV). Accordingly, nurses become hosts and patients become guests. The former nurses/guests have taken over, and the former patients/hosts have become hostage, since unconditional hospitality demands that the host must release his/her authority and property and guarantee security for welcoming the guest to enter his/her home.

When patients offer nurses unconditional hospitality, the patient’s identity is violated in that the patient’s position as a host is inverted to the guest. If this is what the nurses meant by their descriptions as being guests in the patients’ home, it was requiring too much from the patients. Protecting place, habits, agenda, rules and routines (II) might be an expression of patients safeguarding themselves from not being a hostage in their position as hosts. Since the nurses were visiting the patient’s home with the purpose to give care, it seems like a contradiction if the patient/host had to give up his/her identity in order to be unconditionally hospitable.

**Conditional hospitality**

Hospitality can also be conditional (Derrida, 1976; IV). As such, it depends on social and culturally agreed ethical principles, duties, and virtues. Transformed to the context of HBNC, nurses/guests and patients/hosts have to behave according to societal guest norms. According to society, the patient, as the
“owner” of the house, ought to show hospitality to the nurse (I, II, III). A necessary condition for patients offering conditional hospitality was that the nurses show respect for them and their private place and privacy. Thus, respect can be seen as a virtue for nurses as “guests” in HBNC.

So, why is hospitality essential for nurses and patients in HBNC? According to Tefler (2000), hospitality is considered to be a moral virtue, and as such, it is conditional - in the language of Derrida (2000; IV). There are two intentions that lie behind any hospitable act: hospitality for pleasure or hospitality that is born out of a sense of duty (IV). Following O’Gorman (2008), people choose to pursue the virtue of hospitableness because they are attracted by an ideal of hospitality, but not for any prize. Seeing from the patient’s/host’s perspective, the nurse as a stranger could be a “parasite,” a kind of outsider that preys on the goods of the patient/host (IV). For example, when nurses do not present themselves with their names (I, III), the hosts have no obligation, according to conditional hospitality, to invite the nurses into their home (IV). When the patients discursively described themselves as “safeguards” regarding their place, routines, habits and objects in everyday life (II), it might be an expression from the patients that they considered the nurses as “parasites” and not as invited guests.

**Guests go visiting**

The analysis in study IV showed that the metaphor “go visiting” can be related to the findings in study I. It was notable that the nurses described themselves as “guests” and the inhabitants in the home as “a patient” (I, III). They never expressed the logical opposition to “guest,” namely “host” (I, III). If the nurses “go visiting” in the patient’s imaginary world (that is, taking the standpoint of the patient), the nurse ought to consider that she or he was perhaps not imagined by the patient as a guest. In the patient’s imaginary world, the nurse was possibly imagined as someone other than a guest such as a nurse. That is, there might be a possibility that the nurses’ imaginations of being a guest in the patients’ home was inconsistent with the patients’ imagination. Maybe the nurses only “go visiting” in their own imaginary world and didn’t confirm their (imaginary) position as a guest with the patients’ imagination.
In this way, Arendt’s metaphor has something important to say. The metaphor highlights that there is a risk that the patients’ expectations and the nurses’ expectations of each other’s imaginary positions might be dissimilar. Thus, nurses ought to consider visiting the others’ imaginary world in order to find out how patients want to be treated. According to Arendt (1958), the only way to find out is to communicate.

Hence, following Arendt’s philosophy the nurses’ descriptions of themselves as guests might logically interpret their activities in the patients’ imaginary world/home as “go visiting.” If this is the case, to use the concept “guest” might be compatible with the purpose and content of HBNC. However, the nurses must communicate with the patients about their imaginations as being guests in the patients’ home; otherwise, the relationship between the patients and nurses rests on uncertain ground. It is important to note that the nurses are in the patients’ home to do a job, outgoing from a medical referral, and are not invited as a guest to the patients’ home.

**Nurses as professional**

When the patients’ home becomes a place for HBNC, it becomes in some way a “public place,” and as such, a process of negotiation (I, II, III). When the nurses pass the threshold and enter the patients’ home as an “outsider,” as a representative for the “public” (Bjornsdottir 1996; Kirk and Glendinning, 1998; Bender, 2009), they take a subject position as professionals. In this position, the nurses’ main goal is to have nursing and medical control and to perform decisively for their patients as autonomous agents (I, III). As proposed by Davis (1995) and Turkoski (1995), an autonomous professional position seems to be loaded with “masculinity,” that is, with virtues such as rationality, autonomy and fairness (Tannen, 1992). To reach their goal, nurses purposely thought and performed in terms of means and ends. For example, the nurses deliberately chose and used ways of communication best suited to solve the medical and nursing problems (I, III). In other words, the performance of the nurses involved a careful consideration of the consequences of action in terms of achievement of the chosen predetermined outcome (I, III). To reach the goal, the nurses in the professional position used rational criteria in their decision-making, and the relationships with their patients in this position sometimes were characterized as a distanced relationship (I, III).
The nurses in HBNC visited a lot of patients per day, which demanded a lot of rational planning such as planning of their travel route to the patients’ home and the equipment they needed for the care (I, III). Thus, rational planning can be seen as an essential habit in HBNC. In addition, in order to manage the workload and time-schedule, the nurses prioritized among the patients and the time they spent with them (I, III). Such prioritizing was grounded in habits related to “rational fairness.” That is, the nurses planned their working day with the other nurses at the nursing agency so that the patients “fitted in” in the nurses’ schedule. The consequences could be that the specific patient was visited by a nurse he/she never met before (I). In such cases, the patients were treated as a means to reach the nurse’s “end,” the working time-schedule (I). When professional nurses prioritized among the patients at the agency, their choices were based on the “generalized others.” In other words, it was not consequence to the specific patient that ruled their choices. They wanted, for the most part, to be fair to all patients.

The professional position was also characterized by an interest and concern for the individual patient and his/her problems. Coexisting with rational calculations within the professional position was also sympathy and compassion for each patient and an honest inclination and engagement to protect and account for the “concrete other” - the specific patient who was weak and suffering (I, III). This can be interpreted as a determination and trained habit to be attentive to the weakness and suffering of the patients. According to Silfverberg (1999), attentiveness is a combination of engagement and will to help a person in her/his exposedness and includes feelings of sympathy and compassion, which are the preconditions and product of the choice of occupation. When the nurses tried to persuade patients to have a specific bandage for their leg ulcers, the nurses argued for their opinion, because they knew that the leg ulcer would be better treated, and with that treatment, the patient would recover faster (I). If the nurses tried to persuade the patients because they wanted to be appreciated and remembered as well-educated nurses, then the motive was not for the patient’s sake but for the nurse’s. Thus, it seems important that virtues such as attentiveness also include attentiveness for nurses’ own motives of their performance. Attentiveness can be seen as a virtue in HBNC.
In contrast to the guest position, the professional position seemed to construct differences and distance between nurses and patients. This became evident when nurses emphasized their professional nursing knowledge. However, the professional position could not be taken for granted and had to be negotiated and legitimized (I). The professional position seemed to be characterized by ethical principles of responsibility; thus an ethics of justice discourse was noticeable. However, the professional position was also characterized by norms of closeness, attentiveness and affiliation, and therefore, an ethics of care discourse was apparent (I). Thus, the subject position “professional” seemed to include habits and virtues related to both “femininity” and “masculinity.”

**Patients as safeguards**

As “safeguards”, the patients’ main goal was to have optimal control over the care they received by the nurses (II). As “safeguards,” they protected and secured their territory and their independence (II). The ownership of their home ought to give them precedence (II). Studies, however, revealed that the nurses didn’t always accept the patients’ ownership of the place as superior over the nurses’ medical and nursing knowledge. The nurses, therefore, questioned the patients’ right to make their own decisions (I) if it jeopardized their care. In some cases, the patients took a “masculine” standpoint, negotiated in a rational and direct way and referred to medical referrals and the physicians’ ordinations (I). In relation to the care they received from the nurses, the subject position “safeguard” was loaded with norms related to “masculinity” such as rationality, protectiveness, fairness, courage, controlling, independency and directness (II).

The patients’ expression of ownership can be compared to Liaschenko and Peters’ (2004) argument that ownership of a place *per se* designates power. Hence, the “ownership” of the home as a private place gave the patients the right to “co-care” with the nurses (II). This finding can be compared to a study by McGarry (2003) on community nursing. The study showed that the location of care *per se* placed the patient in a more equitable relationship with the professional.

Descriptions of a “breathing zone” - a metaphor of a symbolic zone where patients could be private and take a break from being a “patient” - was expressed (II). This could be interpreted that the patients saw themselves as a sick person
living in the “world of sick people,” longing to be a person living in the world of “healthy people” (Sontag, 1981). Such an interpretation was related to the patients’ confidence in the nurses and their wishes to know if and what they had in common with the world of healthy people. Thus, “the breathing zone” can be seen as a situation where the patient wanted to show him/herself as a whole person not demanding care from the nurses (II). The patients also wanted the nurses to show themselves as private persons, not just showing the “professional position.” “Chatting” and “small talk” were highly valued by the patients, compared to persuading and negotiating, which were not that appreciated (I, III). This can be compared to what Hauge and Heggen (2007, p.5) called “golden moments,” which was a description of situations where the staff in nursing homes shared their personal joys and difficulties with the patients and gave some time for a private chat with the residents.

**Nurses as substitutes**

When the patients described the nurses in HBNC, they described them as “substitutes” for their function and health, both of which were now failing (II). As a “substitute,” the nurses sometimes acted as spokespersons in accordance with the patients’ will, needs and emotional ability. However, as a substitute, the nurses sometimes “take over” the patients’ decisions. That is, a consequence could be that it was not the patients’ order that ruled the decision but the nurses’ own. However, when the nurses’ actions were performed with “good mood,” that is, with friendliness, niceness and encouragement, and a readiness to help and support, they used a kind of slyness and smartness that made the patients accept their suggestions about care (II). This slyness was a way to create a positive attitude in the patients and thus help the patients themselves handle their problems and worries.

The patients can be seen as disadvantaged compared to the nurses, whom, through their knowledge, maintain a position of power in relationship to the patients. Since the nurses are “substitutes,” the asymmetry in power between nurses and patients is not static, as it is dependent on circumstances (II). As Lupton (1997) pointed out, patients may move in and out of the roles of the active partner and the passive recipient of health care depending on circumstances. This was also the condition for the nurses in HBNC, as they sometimes moved in and out according to their taken position.
To sum up

To sum up, in the text above, I have tried to show how nurses and patients in HBNC described their positions as “guest,” “professional,” “safeguard” and “substitute.” It is interesting to note that the subject position the nurses described, they took. “Guest” and “professional” was not the same as the patients ascribed them. Hence, there was a discrepancy between the patients’ and the nurses’ apprehensions. The patients wished the nurse to perform as a substitute for their failing health, but the nurses had a different point of view. Such a discrepancy might limit the quality of HBNC. In times when the range of HBNC is expected to increase, it is extra important to be aware of and receptive to the divergence in subject positions between the nurses and patients.

Places as gendered

Place and care in relation to gender have been a topic in nursing research. There is an assumption that place constructs and reconstructs gender, that is, assumptions of the kinds of activities women and men are suitable for are related to the place they inhabit (Liaschenko, 1997; McDowell, 1999; Leonard, 2003; Peter, Macfarlane, O’Brien-Pallas, 2004). Also, McDowell (1999) claims that place contribute to the construction and reconstruction of gender, and Halford and Leonard (2003) assert that the home as a place has been seen as a place where gender is constructed and transferred. Home has long been socially constructed as a “woman’s place” (Quinn, 2010), and as far as we know, women in the Western world have always taken care of children, the elderly and the sick in their own or in others’ homes. There is, according to Dyck (2005), a connection between “women’s ‘taken-for-granted’ care in the home and the construction of place” (Dyck, 2005 p.236). As this caring activity often is hidden, Dyck (2005) called this place-making “hidden spaces,” since it is not open to the public. In line with this, Peter (2000) has described the home as a place where values and expectations about men and women’s activities are implicitly and explicitly expressed.

When care and treatment of the sick became institutionalized and public, the assumptions of a female natural ability to care became considered as inherent in “women’s work” such as in nursing (Fletcher, 2006; Loughrey, 2008). Today, treatment and care of patients in their own homes has become a model of the organization of health care and, as such, risks reproducing the affinity on nurses’
(womanly) natural abilities to care, both in hospital care and HBNC (Cartier, 2003; George, 2008). When the nurses belonging to a gendered profession enter the patients’ home, they enter a gendered place.

**The other as same or different**

In healthcare, “the Golden Rule” (“Do unto others as you would have them do unto you”) is often used as a rule for conduct and attitudes (Kothari and Kirschner, 2006). The idea of the Golden Rule also emerged in our studies (I, IV) in that the nurses wanted to treat the patients as they wanted to be treated themselves. Compassion, sympathy and engagement were implicitly and explicitly expressed as virtues related to the Golden Rule and could, according to Tannen (1992) and Peterson (2000), be described as “feminine” virtues.

The nurses’ declaration of the Golden Rule can be compared to Levinas’ (1985) statement that being ethical is being open to and unprepared for the radical difference (*alterity*) of the Other, which means that the Other is not the same as me (IV). According to Levinas, I must meet the Other unconditionally without any preconceived notions or knowledge about him/her. My relation with the Other is a responsibility that comes without expectation of reciprocity from the Other (IV). This means that ethics and the ethical imperative of responsibility are prior to the knowledge of the Other. The Other’s position has no significance to me, as I am responsible for the Other as other - as a human being rather than as a patient or a stranger. My potential to open myself in the direction of the Other without any conditionality establishes not only my potential to develop ethical relationships but also my capacity to be human.

Following Levinas (1985), the mission of care is to take care of the Other—the human being that faces me. Seen in the context of HBNC, when the nurse meets the Other - the patient - the need of protection is engrained (IV). Even *before* the encounter, there was a demand and thereby an already fixed bond between the nurse and the patient. This means from a theoretical, conceptual perspective, it was not a “patient” the nurse encountered; it was another human being. In an ethical conceptual perspective, the concepts “nurse” and “patient” have no magnitude in ideal encounters (IV). The “patient” is the known or unknown Other for which the nurse has responsibility.
Levinas’ philosophy on the mission of care can also be applied to nurses as fellow travelers in the patients’ health journey as they feel responsible for the patients’ health status (III). By supporting patients in their health journey, it was evident that the nurses took responsibility for the relation, as they tried not to patronize the patients (III). This can be compared to Doane and Vercoe’s (2007) proclamation that “relationship in this way ordain[s] the nurses to take responsibility for the relationship[,] ...since achieving health outcomes through ‘good’ relationships is assigned [to] the nurses” (p. 192). According to Noddings (1984), the responsibility for maintaining a relationship can be seen as a feminine virtue.

Following Levinas, Lavoie, De Koninck and Blondeau (2006), argued that the relation between the patient and the caregiver must be conceived in terms of proximity and asymmetry. They stated that the relationship is and must be asymmetrical: the patient is the one needing care and the caregiver the one who is giving care. It can never be the other way around; the care-receiver can never take care and have responsibility for the care-giver (IV). The relationship between the care-giver and the care-receiver is thus non-reciprocal. Thus, in this face-to-face encounter between the nurse and the patient, the encounter could not be considered to be an encounter on the same level. It is the nurse’s responsibility to be receptive to the need of the patient and give care to the patient. However, if the relationship between nurse and the patient is a relationship between, for example, a guest and a host, both the guest and the host are responsible - a priori - for the Other as other in their relationship (IV).

The nurses’ declaration of “the Golden Rule” can also be seen in the light of Arendt’s philosophy. According to Arendt (1958), the Other is both the same as and different from me. We are all alike, since we are humans, but development and exchange presupposes difference (IV). When we talk to each other, we bridge the gap between us as humans, and in so doing, we distinguish ourselves from the Other. If we were all the same with the same wishes and needs, no speech would be necessary. Thus, since we are humans, we are both the same and different; communication is required as an eye-opener for possibilities for understanding each other (IV).
Adapting to ethical circumstances

As Erlen (1997) and Liaschenko (2006) reminded us, the descriptive phrase “housekeeping issues” has been used to refer to day-to-day ethical concerns related to encounters among patients, their families and health care providers. “Housekeeping issues” are contextualized by place, the occasion and the position, status and performance of the people concerned. Since HBNC was carried out in the patients’ home, the label of “housekeeping issues” (Warren, 1989) seemed relevant for describing ethical matters that nurses maintained and that permeated HBNC (III).

HBNC embraced “housekeeping issues,” which was related inter alia to the nurse-patient relationship and the conceptions of the good of the patients in everyday care. As such issues were dependent on the situation (II), the nurses had to adapt to the circumstances and had difficulty following prescribed ethical rules. Instead, they had to forge a path alone. In this way, they navigated from the circumstances and let the situation determine the path. This ability demanded a specific kind of ethical maturity, which included responsibility towards the Other and, according to Liaschenko and Peter (2004), characterized an ethically developed moral agent. Ethical maturity included competence in discerning the moral relevant features of particular situations (III). Such competence was in turn based on the nurse’s experience, knowledge and virtues, i.e., receptiveness (III). Scott (2006) argues that the nurses’ receptiveness can be compared to Vetlesen’s (1994) declaration that “receptivity ‘awakens’ moral perception and gives it directions for moral judgement. The nurses’ ability to discern morally relevant features in the situation (III) can also be compared to Murdoch’s (1970) statement that ethical maturity is related to what we see, what we feel and what we think and is directed through the world around us but also against ourselves.

Moreover, Murdoch (1970) also emphasizes the character of imagination as it has a role in receptiveness. In study III, moral imagination was used by the nurses when they reflected on what it might be like to be a patient in a specific set of circumstances. Ethical imagination can also be considered a part of ethical maturity (Scott, 2000; Arber and Gallagher, 2009). It seemed that the nurses’ ethical maturity and responsibility were practical and enabled the nurses under changing circumstances to see, calculate and do what was good for themselves and conducive to the good of their patients (III).
As mentioned before, it is well known that nursing is a gendered profession with a tradition historically based on women’s work and womanly duties. “Housekeeping issues” have traditionally been seen as women’s responsibilities and are often described as duties related to presumed feminine virtues such as caring, altruism, purity, and compassion (Davis, 1995).

An endless journey

Values and norms that nurses hold by working in HBNC were also illustrated with the metaphor “HBNC is an endless journey” (III). Describing HBNC as a journey revealed how HBNC constantly oscillated between the patients’ condition, the patients and the nurses’ relationship, patients’ geographical localization and the various situations that appeared throughout HBNC (III).

The departing point for the “journey” was an assignment of being a patient and thereby cared for by nurses in HBNC. The place for care and the patients’ health problems were more or less defined by the referral from the physician, but the end of care - the destination of the patients’ health journey - was more uncertain and confusing, both for the patients and the nurses (III). When the patients were discharged from hospital care to HBNC or the other way around, the localization of care was changed. In study III, the nurses used prepositions such as “out,” “in,” “to” and “from” when describing movement between hospital care and HBNC. No such descriptions related to the end of localization for HBNC were found. Thus, there were differences between “being discharged to the home” or “to be discharged in one’s home.” Hence, it was not easy to tell when HBNC ended (III).

The problems related to ending HBNC could also be the nurse’s uncertainty about the patients’ ability to manage their health problems by themselves in their home. A consequence for HBNC could be nurses having difficulties “letting the patient go,” since they ought to be committed to be responsible for the outcome of their care (III). Hence, the metaphor “HBNC is an endless journey” was describing an indefinite period of caretaking due to confusion about the end of HBNC.
Methodological considerations

There are several ways to “do discourse analysis” (Wither Jørgensen and Philips, 2000; Taylor, 2001). According to Winther Jørgensen and Phillips, (2000) it is possible to create one’s own package by combining elements from different discourse analytical perspectives. In this thesis, for example concepts such as subject positions, chain of equivalence, and binary oppositions were used as tools for inspiration and guidance in the analysis. The concepts used consisted of a mixture from different theorists (Potter and Wetherell, 1987; Laclau Mouffes, 2001).

By using binary oppositions, a rather unexplored way to analyze different discourses and areas in health care, it was possible to open new ways to illuminate HBNC. A technique to look at opposite aspects in data is consistent with Potter and Wetherell’s (1987) concerns with rhetorical organization and variability in discourses and can be seen as a fruitful way to reach trustworthiness.

Exposing binary opposition, for example binaries such as dependent/independent, patients’ world/nurses’ world, feminine/masculine, is a way to illustrate and thereby possible subvert hidden values and norms that underpins dominant ways of thinking about ourselves and others. However, exposing binaries carries the risk that the norms and values inherent in the binaries remain. If this is the case in this thesis, my attempt to avoid them has not been achieved.

Performing discourse analysis means using oneself as an instrument (Taylor 2001, Winther Jørgensen and Phillips 2002). As researchers and authors we have chosen how we present and what we present of our research. These choices means that the studies in this thesis are a possible representation of identity constructions, but other representations are also possible (Burr, 1995; Winther Jørgensen and Phillips, 2000) it is our tones that are now being heard. One unavoidable factor that might affect the outcome of the studies was that I was alone as the investigator. The interaction during interviews always includes power and interaction changes dependent on the different positions of the interviewer and the respondents owing to such aspects as gender, age, class, professional expertise and personal experience, (Edin, 2006). In the study, I carried out all the interviews, and the factor that the respondents met someone who was a women and a nurse, probably had both obstructing and liberating
effects on the dialogue. However, I am not a home-based nurse. This fact can either be seen as an impediment, a bias, or as an opportunity. The fact that I am a nurse without any HBNC experience has probably left its imprint in the construction of the research process from the research questions, the data interpretation and the analysis, to the documentation in the thesis. The “nurse without any experiences as a home-based nurse” bias was in several occasions both useful and advantageous, as it allowed me to ask “stupid and naïve” questions about HBNC both to the respondent and in the analyses of the text. Exploring metaphors is a substantial part of discourse analysis (Potter, 1996). The exploration metaphors showed to be fruitful in revealing embedded values and norms hold by the nurses in HBNC that otherwise could have been hidden. Exploring metaphors can thus complement other methods of exploring ethical issues in health care while illustrating the ethical role that language plays.

An exaggerate interpretation of metaphors could, however, create a misguided representation of people’s experiences (Sandelowski, 1998; Carpenter, 2008). In study III, I tried to be aware of this and not to over-interpret the data, for example, I was looking for outstanding metaphors through repeated reading, since some metaphors often are not obvious until the second or third reading (Dexter and LaMagdaleine, 2002; Steger, 2007). Another way to avoid the over-interpretation of data was through recurrence, that is, I searched for metaphors that were repeatedly manifest in the text, identically or in a similar way touching at the same metaphorical concept. To meet these efforts and to strengthen the interpretation, the data was read, analyzed and discussed with senior researchers on several occasions as recommended by Dexter and LaMagdeleine (2002) and Steger (2007).

Most text produced by individuals includes a huge number of metaphors and I was not able to analyze it all; consequently, I had to select metaphors. Unfortunately, there was no absolute fixed process that definitively guided me to the “right” ones. However, I tried to identify alternative conceptual metaphors but the identified MLEs and their entailments did not support other conceptual metaphors. Although the procedure provided a structure for metaphor selection, another researcher might have selected other metaphors to create a different interpretation.

One difficulty in qualitative research is determining an appropriate sample. In discourse analysis, the size of the sample is not so important, since it is the
usage of language that is the focus, and rhetorical patterns can be maintained by few (Winther Jörgensen and Phillips, 2000). The sample is intentionally selected according to the needs of the study (Coyne, 1997). It was important that the respondents, (all the patients in study II) had experience with HBNC and could articulate their experience, since it was the language that was the focus in the analyses (Taylor, 2001). None of the patients in study II requested “hospital-in-home care” and they were rather vital in spite of their age. The results in study II were probably related to the patients’ health status. Another group of patients may have provided different results.

The sample in study I consisted of nine female nurses and one male nurse, and in study II, seven females and three males. There were no distinctions between descriptions as related to man or women. The reason for not distinguish between the sexes was at first that such distinguishing can create an ethical problem (anonymity) when separating the male respondent from the female respondents (I). However, the main reason was that when exposing binaries such as males and females, it could be a risk that the norms and values inherent in the binaries remain.

The goal of a discourse analysis is to search for “meaning” and to pay attention to good reasons and underpinnings of interpretive claims, i.e. to reach trustworthiness (Taylor, 2001; Nixon and Power, 2007). In this thesis, to avoid biased interpretation, several researchers were included in the research process, which was one way to reach trustworthiness (Taylor, 2001). Another way was to look for consistency (Potter and Wetherell, 1987). In this thesis, citations from the interviews are accessible in the text and in the appendix for the reader to gain insight into the discourse presented.

Further research

The thesis has provided a base for further research in HBNC. The question of asymmetry in power between patients and nurses was not explicitly enlightened and need to be more directly illuminated. The nurses described themselves as guests in the patients’ homes; one area for further research might be to investigate (for example by observation), if the nurses performed as guests in the patients’ homes, and if and how the patients acted as hosts in relation to hospitality. Another area of importance is the exploration of identity
constructions of family careers and identity constructions of patients in HBNC. A third area for research is the investigating of discourses about gender in political document as well as in policy documents related to HBNC. Further, the line between private and public spheres seemed to be ambiguous in HBNC, which can cause problems for both patients and nurses. This might be an important area for nurses to address in praxis as well as in further research. For example, research has been completed related to discharge planning from hospital care to HBNC (Boughton and Halliday, 2009), but less is known about the discharge planning from HBNC to other locations of care. Discourse analysis in relation to subject positions, ethics and gender in caring contexts is sparse. Further investigation in other contexts such as hospital care is needed. Philosophical exploration and analysis of concepts used in health care is required. There might be a risk that concepts such as “guest” and anecdotic metaphors about nurses such as “nurses are spiders in a net” will act as “semantic magnets”, that is, like a “buzzword”, a word rendered trivial that seems to fit in where it is used.

Implication for practice and education
This thesis contributes to the development of knowledge of HBNC as it highlights a number of factors that are important for health care practice and nursing education. It adds to a theoretical understanding of how place, ethics and gender interact in HBNC, and it also gives a methodological contribution through the application of the methods used. The thesis can be used by nursing teachers to question or challenge current norms and values about interactions and positions between nurses and patients. That is, it is important that nursing teachers questioning the concept of “guest” as a description of a nurse’s subject positions in HBNC. It is also important for teachers to highlight the power relationship between “guests” and “hosts” and the demand on hospitality related to the concepts.

Further, it is important that nurses and nursing teachers reflect on gender and the relationship between places (the patient’s home), nursing, and “housekeeping issues.” Norms and values can be challenged by dialogues and as Arendt (1958) puts it: the only way to find out if we disagree is to talk to each other. This can be done on different levels in everyday practice in the classroom, in everyday nursing practice and by managers.
Summary and Conclusion

An idea in this thesis was that home-based nursing care promotes the association between nursing, women and the private sphere. However, what in this thesis was described as masculine and feminine positions are normative discursive constructions and were not tied to a particular sexed body. For example, the subject position “substitute” was described as feminine, and the subject positions “professional” and “safeguard” were described as masculine. This categorization does not necessarily mean that a man has to be the safeguard, or a woman the substitute. This labeling was a discursive way to discuss how relatively implicit or explicit norms and values that were related to femininity and masculinity were inherent in the construction of the subject positions. The relationship between “femininity” and “masculinity”, were in this discussion understood as mutually constructed. One cannot talk about femininity without any assumptions about masculinity or vice versa, which is not the same as saying that the subject positions were mutually constructed.

However, there is not just one type of “masculinity” or “femininity”, there were “masculinities” and “femininities.” Further there was not just one “guest” or “substitute,” “professional” or “safeguard,” there were guests, professionals, safeguards and substitutes. For any given individual, a whole range of subject positions and norms and values were simultaneously at play: some of which might served to strengthen a dominant discourse of HBNC, and one’s subject positions within them, whilst others may destabilized and undermine dominance success in the discourse of HBNC.

The subject positions were also constructed in relation to ethical values and norms about how one ought to perform and which habits seemed appropriate in the subject positions. It was not the intention of this thesis to specify which habit and virtue each subject position inhabits, but to explore which habits and virtues it seemed that a specific social practice, i.e. the nursing care in the patient’s home, demanded in relation to the subject positions.

In this thesis, habits (and sometimes vices) were in play (for example taking a low profile, asking for permission, not barging in, “small talking,” planning, negotiating, advising, informing, distancing and so on). Those habits were related to virtues such as respect, confidence, rationality and attentiveness. Since a person’s characters traits are not developed in isolation, personalities, virtues and habits were deeply affected by norms and values prized by the communities,
related to the role models that their communities put forth for imitation. The habits and virtues presented in this thesis could be seen as something that both patients and nurses considered valuable in HBNC and something that might promote HBNC.

This thesis shows that habits, stereotypically described as “feminine” or “masculine” occurred in HBNC discourse and that the nurses discursively oscillated between them dependent on their situation. This thesis also showed that the nurses discursively alternated between “what kind of person should I be” and “what should I do” in relation to the situation. Further, the nurses’ discursively moved back and forth between an ethics of care, an ethics of justice and an ethics of virtue dependent on the situation. This thesis also shows that an everyday ethics related to “housekeeping issues” were prominent. Thus, it seems that the nurses’ discursive ethical perspective was eclectic.

This thesis moreover displays that it was important to illuminate those concepts that are used in the daily work of nurses or nursing teachers (for example, to illuminate the concept “guest”). The relationship between “guest” and “host” was in this discussion understood as mutually constructed. One cannot talk about guests without assumptions about hosts or vice versa, which is not the same as saying that the subject positions were mutually constructed. Furthermore, the thesis showed that it was important to expose concepts as binaries since binaries uncovered relationship between the concepts, which otherwise would have been hidden.
Historiskt har kvinnor i västvärlden vårdat barn, gamla och sjuka i hemmet. När vård och behandling av de sjuka och svaga blev institutionaliserat och en offentlig verksamhet följde normativa värderingar om kvinnors ”naturliga” förmåga att vårda med i det som sammanfattningsvis har kallats för kvinnors arbete, exempelvis omvårdnad. Emellertid är kunskapen om hemsjukvård och hur vården erfars och beskrivs av patienter och sjuksköterskor inte tillfylles. Eftersom behandling och vård av patienter i deras egna hem successivt har blivit allt vanligare är det intressant att undersöka hur patienter och sjuksköterskor beskriver sina erfarenheter av hemsjukvård i Sverige.

Det finns flera idéer bakom denna doktorsavhandling. En grundidé är att hemsjukvården som vårdform bidrar till förställningar om kvinnors ”naturliga” omsorgsförmågor i relation till omvårdnad, kvinnor och den privata sfären/hemmet. Den andra idén är att den plats vi befinner oss på bidrar till att skapa vårt genus, vårt sociala kön, och att platsen för var vården bedrivs har etiska implicatioron. Detta innebär med andra ord att sjuksköterskors handlingar, vanor och dygder formas av de positioner på den plats där sjuksköterskorna arbetar.

Hemsjukvård är komplext och diskursanalyser av relationer mellan hemsjukvård, subjektpositioner, etik och genus saknas mer eller mindre. Att studera hur det språk vi använder konstruerar och rekonstruerar våra relationer med varandra och vår omgivning, vilket är en grundidé i diskursanalys, är fruktbart för sjuksköterskors arbete, undervisning och forskning, eftersom diskursanalys ”öppnar upp” för nya perspektiv.

Denna doktorsavhandling baseras på fyra delstudier: I studie I och II är syftet att undersöka vilka subjekt-positioner sjuksköterskor och patienter beskriver att de besitter när de utför respektive mottar vård i patienternas hem. Syftet med dessa två delstudierna är att undersöka hur hemsjukvård är konstruerad ur sjuksköterskors perspektiv (I) och ur patients perspektiv (II). Designen är explorativ. I studie I, intervjuades tio sjuksköterskor som arbetade i hemsjukvård i en kommun i västra Sverige. I studie II, tillfrågades 10 av deras patienter om att delta i studien. Intervjuerna från både studie I och II transkriberades ordagrant och analyserades därefter utifrån diskursanalytisk metod. Resultatet
från studie I visade att sjuksköterskorna beskrev subjektpositionerna som ”gäst” och ”professionell”. Analysen visade också att de var tvungna att välja mellan dessa subjektpositioner, eftersom de inte kunde vara både ”gäst” och ”professionell” samtidigt, vilket berodde på de värderingar och normer som positionerna innefattade. Sjuksköterskorna utgick både från en ”omvårdnadsetik” och en ”rättviseetik” vilket skapade diverse etiska appeller, det vill säga implicita krav att agera utifrån den ena eller den andra subjektpositionen. I studie II, beskrev patienterna sin subjektposition som ”bevakare” och sjuksköterskornas subjektposition som ”substitut”. Dessa subjektpositioner utgjorde förutsättningar och hinder för patienterna att vårdas i sitt eget hem, vilket inkluderade vilka strategier, vanor och aktiviteter patienterna konstruerade och vad och hur de ansåg att sjuksköterskorna skulle handla och agera.

Resultaten från studie I och II diskuterades inom en teoretisk ram – inom en könskodad dikotomi relaterat till den privata versus den publika sfären. Inom denna ram diskuterades också de vanor och kunskaper som kan vara viktiga i de subjektpositioner som sjuksköterskans och patienternas beskrev. Publika versus privata sfärer skall i detta sammanhang bäst förstås som diskursiva fenomen som kan användas för att illustrera hur sociala realiteter som exempelvis platser, grupper, aktiviteter, interaktioner och relationer är relaterade till varandra.

Genom att använda diskursanalys och binära oppositioner vid analysen av intervjuerna med patienter och sjuksköterskor, belystes på detta sätt hemsjukvård ur ett nytt perspektiv. Subjektpositionerna som sjuksköterskorna beskrev, ”gäst” och ”professionell”, var inte samma positioner som patienterna tillskrev sjuksköterskorna. Det fanns med andra ord en diskrepans mellan patienternas och sjuksköterskornas uppfattning. Det verkade som om patienterna önskade att sjuksköterskorna skall vara ”substitut” för deras hälsa som är sviktande, men att sjuksköterskorna hade en annan beskrivning av sina subjektpositioner. En sådan diskrepans kan begränsa kvaliteten i hemsjukvården. Eftersom hemsjukvård som vårdmodell antas bestå och byggas ut, måste det första steget vara medvetenhet, öppenhet och förståelse för att patienter och sjuksköterskor eventuellt har olika uppfattningar.

Studie III var en kartläggning och en analys av metaforer för att avtäcka sjuksköterskornas normer och värderingar i hemsjukvård. Metaforen ”hemsjukvård är en ändlös resa” indikerade att hemsjukvård ibland inte har
något slut. Metaforen indikerade också att vardagens etiska frågor var relaterade till emotionellt, fysiskt och relationellt arbete, vilket ibland kan sammanfattas i begreppet hushållsarbete. ”Hushållsarbete” ställde ofta etiska krav, var kontextuell, relationell och innefattade ofta arbete utan slut och var ofta osynligt eftersom det inte efterlämnar någon ”produkt” som man kunde se och uppfatta. Det vill säga, hushållsarbets etiska krav var ändlöst arbete – precis som hemsjukvård.

I delarbete I framkom att sjuksköterskor beskrev sig som gäster i patienternas hem. Denna beskrivning var utgångspunkten för att vända sig till filosofer för en analys (studie IV) av begreppet gäst och närliggande begrepp. Resultatet av studien visade att ”gäst” är ett relationellt begrepp och som sådant relaterat till begreppen ”vård” och ”gästfrihet”. Resultatet visade också att begreppet ”gäst” inte innefattade innehållet och komplexiteten i hemsjukvård. Sammanfattningsvis visade studie IV att det finns risker att begreppet fortsätter att vara en ”semantisk magnet”, en sorts ”buzz word” – ett trivialt ord som verkar ”passa in” där det används.

Historiskt har det funnits en rörelse från att vårdas i det egna hemmet till att vårdas på sjukhus. Nu tenderar rörelsen att gå åt motsatt håll, d.v.s. att gå från vård på sjukhus till sjukvård i det egna hemmet. I ljuset av detta kan det finnas en risk att sjuksköterskor i hemsjukvård kan uppfattas som en rekonstruktion av ”the domestic women”. Sjuksköterskoras beskrivning av sig själva som gäster och patienternas beskrivning av sjuksköterskor som substiut visade att en sådan risk finns. Hemmet som vårdplats hade etiska implikationer. ”Ägandeskapet” av hemmet gav patienterna auktoritet att sätta normerna för hur sjuksköterskor skulle uppföra sig och handla i patientens privata hem. Sjuksköterskoras beskrivningar av sig själva som gäster kan ses som ett uttryck för detta. Å andra sidan, patienternas beskrivning av sig själva som bevakare och sjuksköterskoras beskrivning av sig själva som professionella belyste att det finns etiska innebörder i patienternas ”ägarskap”. 
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REFERENCES


Andrew, GJ. Towards a more place-sensitive nursing research: an invitation to medical and health geography. *Nursing Inquiry* 2002, 9: 221-238

Aranda, SK. Street, AF. Being authentic and being a chameleon: nurse-patient interaction revisited. *Nursing Inquiry* 1999, 6: 75-82.

Arber, A. Gallagher, A. Generosity and the moral imagination in the practice of teamwork. *Nursing Ethics* 2009, 16: 775-785


Bender, A. Clune, L. Guruge, S. Considered place in community health nursing. *Canadian Journal of Nursing Research* 2009, 41: 128-143


Coyne, IT. Sampling in qualitative research: purposeful and theoretical sampling; merging or clear boundaries. *Journal of Advanced Nursing* 1997, 26: 623-630.


Dexter, S. LaMagdeleine, DR. Dominance theatres, slam-a-tone, and cargo cults: Three illustrations of how using conceptual metaphors in qualitative research work. *Qualitative Inquiry* 2002, 8: 362-380.


Doane, PL. The tyranny of gendered space: reflections from beyond the gender dichotomy. *Gender, Place and Culture* 2010, 17: 635-654.


Eichler, M. Albanese, P. What is household work? A critique of assumptions underlying empirical studies of housework and alternative approach. Canadian Journal of Sociology 2007; 32, 227-258


George, A. Nurses, community health workers and home carers: gendered human resources compensating for skewed systems. GLOBAL PUBLIC HEALTH 2008, 3: 75-89.


Halford, S. Leonard, P. Space and place in the construction and performance of

Harding, T. The construction of men who are nurses as gay. *Journal of

Harper, DJ. Discourse analysis and “mental health”. *Journal of Mental Health*

Hauge, S. Heggen, K. The nursing home as a home: a field study of residents’
daily life in the common living rooms. *Journal of Clinical Nursing* 2007, 17:
460-467.

Johansson, L. Current developments in care of the elderly in Sweden. *The

Jonas-Simpson, C. Theoretical concerns. The possibility of changing meaning in

Jaeger, SM. Teaching health care ethics: the importance of moral sensitivity for

Karlsson, S. Edberg, A-K. Rahm Hallberg, I. Professional’s and older person’s
assessments of functional ability, health complaints and received service. A
descriptive study. *International Journal of Nursing Studies* 2010, 47: 1217-
1227.

Kirk, S. Glendinning, C. Trends in community care and patient participation:
implications for the roles of informal carers and community nurses in United

Kochis, B. Gillespie, D. Conceptual metaphors as interpretive tools in
qualitative research: A re-examination of college students’ diversity discussions.

Kothari, S. Kirschner, KL. Abandoning the Golden Rule: the problem with
“putting ourselves in the patient’s place”. *Topics in Stroke Rehabilitation* 2006,

Kuhse, H. Clinical ethics and nursing: “yes” to caring, but “no” to a female


Peterson, VS. Rereading public and private: The dichotomy that is not one. *SAIS Review* 2000, 1-29.


Quinn, B. 'Care-givers, leisure and meanings of home: a case study of low income women in Dublin', *Gender, Place & Culture* 2010, 17: 759-774.


Roth, LM. The right to privacy is political: power, the boundary between public and private, and sexual harassment. *Law and Social Inquiry* 1999, 45-71.


Sandvide, Å. *Våld i särskilda boenden för äldre – språk och sociala interaktioner.* Umeå University Medical Dissertations, New series NO1218 (Department of Nursing), 2008.

Santos Salas, A. Cameron, BL. Ethical openings in palliative home care practice. *Nursing Ethics* 2010, 17: 655-665.


Sherwin, S. Feminist ethics and the metaphor of AIDS. *Journal of Medical Philosophy* 2001, 26: 343-64.


Statistiska centralbyråns ([Statistic Sweden] 2010


Wright, D. Braitman, S. Relational and embodied knowing: nursing ethics within the interprofessional team. *Nursing Ethics* 2011, 18: 20-30.


Appendix
# Appendix

## Table 1 Examples of ‘guest’ and ‘professionals’ as subject positions

<table>
<thead>
<tr>
<th>Subject position</th>
<th>Chain of equivalence</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guest</td>
<td>Patient’s world ≻ Nurse’s world</td>
<td>Yes, that [the hospital] is our world. This [home] is the patients’ world.</td>
</tr>
<tr>
<td></td>
<td>We ≻ Them</td>
<td>In institutions one is almost automatically put in place as a patient. You [the nurse] automatically become an authority. You have a given role; in a way you are different. You show this with what you wear....The whole environment shapes this.</td>
</tr>
<tr>
<td></td>
<td>Subject ≻ object</td>
<td>I think it is easier to be engaged when you see the person because in the hospital, I think they become anonymous.</td>
</tr>
<tr>
<td></td>
<td>Asking for permission ≻ intruding</td>
<td>I ask if I can use the toilet or have a glass of water. I don’t just go into the kitchen and help myself. I am a guest and therefore I ask.</td>
</tr>
<tr>
<td></td>
<td>Taking a low profile ≻ obtruding</td>
<td>Maybe I stand and look at the bookshelves a little but I don’t go into their desk or turn on the music, at least not that actively; I am more passive.</td>
</tr>
<tr>
<td>Professional</td>
<td>Acting decisively ≻ casually</td>
<td>You have to take many decisions [in home care] and you can’t drag in your college again and again…</td>
</tr>
<tr>
<td></td>
<td>Not a personal friend ≻ personal friend</td>
<td>Even if a relationship develops into a friendship I’m not a personal friend.</td>
</tr>
<tr>
<td></td>
<td>Distance ≻ closeness</td>
<td>I have boundaries because my job is my job and my private life is my private life. I don’t mix the two.</td>
</tr>
<tr>
<td></td>
<td>Matter-of-fact-communication ≻ confidence-building communication</td>
<td>Yes but, it’s giving a little and taking a little. To find a balance, it’s difficult in the beginning, but when you have some experience of home care you learn how to handle people</td>
</tr>
</tbody>
</table>
Table 2  Examples of ‘safeguard’ and ‘substitute’ as subject positions

<table>
<thead>
<tr>
<th>Subject position</th>
<th>Chain of equivalence</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguard</td>
<td>Patients’ territory &gt; &lt; nurses’ work place</td>
<td>They have to accept that they are in my home and that I am the one who decides what should be done.</td>
</tr>
<tr>
<td></td>
<td>Security &gt; &lt; insecurity</td>
<td>It is safer to be at home, in one’s own flat and to get care than to be in hospital. I noticed that they [the nurse] were not really aware of all this. Then you don’t feel secure.</td>
</tr>
<tr>
<td></td>
<td>Independence &gt; &lt; dependence</td>
<td>In some way it is important that they the nurses come on time. Even if you don’t have anything to do, you organized your day. I noticed that they [the nurse] were not really aware of all this. Then you don’t feel secure.</td>
</tr>
<tr>
<td></td>
<td>Continuity &gt; &lt; interruption</td>
<td>And then a new girl comes, who is really green and who knows very little and has to ask me ‘What should we do here?’ And I say, ‘Well, you will have to look, you have it written down’.</td>
</tr>
<tr>
<td></td>
<td>Involvement &gt; &lt; exclusion</td>
<td>It is something special, otherwise it is handled by the nurses, and I think that is quite all right. It’s clear that they know best, that they have examined and discussed what should be done and I trust them completely.</td>
</tr>
<tr>
<td>Substitute</td>
<td>Doing for &gt; &lt; doing against</td>
<td>They [the nurses] helped me because I cannot do that myself. She was really pushing me about my blood sugar….i can take care of my blood sugar by myself, with help from my doctor.</td>
</tr>
<tr>
<td></td>
<td>Fulfilling needs &gt; &lt; incomplete achievement</td>
<td>The thing is, I can’t manage by myself. I can’t take care of sores and bandage my toes and leg I can’t do it myself, they have to do it. I usually ask a little. But, unfortunately, when one is as old as I am and has an interest in history, I would like to converse about things in the past….and they said ‘no I have never heard about this’….and then it becomes an empty conversation</td>
</tr>
<tr>
<td></td>
<td>Good mood &gt; &lt; bad mood</td>
<td>It means a lot that these girls say: ‘How is it? Can I have a look? It’s the positive [things] that one needs to hear when I look at the sore.</td>
</tr>
</tbody>
</table>
Table 3 Examples of MLEs and entailments that form the conceptual metaphor

<table>
<thead>
<tr>
<th>Conceptual metaphor</th>
<th>Entailments</th>
<th>MLEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBNC is a an endless journey</td>
<td>Patients go on a health journey towards an uncertain destination</td>
<td>“she had many illness in her baggage”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“you can see that he is on the right path”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“it’s going downhill for her”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“his state of health goes up and down”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“…there is no other way”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“choosing the path”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“we have to go further”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“we go there and change bandages”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“we are checking in on her, now and then”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“listen to the patient’s signals”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“it is a straightforward communication”</td>
</tr>
<tr>
<td>Nurses accompany the patients’ health journey by planning, controls and communication</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>