Economization of Home Care in Ontario: A Critical Ethnography of Nursing Actions

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Abstract

Many nursing theorists consider caring the essence of nursing practice. Yet, the meaning of caring is still elusive in nursing theories. This confusion in conceptualizing caring is exacerbated by the neoliberal socio-political and economic transformations of our societies that infuse nursing practice with economic efficiency values – a condition that threatens the ethical dimensions of nursing. This critical study analyzes nursing actions in home care in Ontario and empirically reconstructs the normative dimensions of care based on nurses' own perceptions of good care. The findings are used to critique current healthcare transformations through a critical theory of nursing actions.

This study is situated in the tradition of the Frankfurt critical school and pursues an emancipatory interest. Axel Honneth's theory of recognition is the principal theoretical foundation complemented by Jürgen Habermas' theory of communicative action and the interests of knowledge, in addition to the concepts of phenomenology and corporality. It uses critical ethnography as a methodological approach. Data collection included audiotaped semi-structured open-ended interviews with 18 nurses working for two different home care providers in Ottawa. Analysis demonstrates that the patient must be recognized on three dimensions: love, legal rights, and solidarity. Care is a specific form of communicative action in which patients should participate equally in decision making. Nursing actions comprise a hermeneutic-phenomenological dimension of "deep knowing" that respect the corporal and personal needs of the patient. Healthcare transformations and economic efficiency measures reinforce technical and standardized forms of care, which lead to pathologic practices that neglect patients' corporal needs, thereby reifying patients. Nursing actions combine both technical and corporal aspects that characterize their "double logic."

This study provides elements for a critical theory of nursing actions. Findings highlight that nurses have a vision of how nursing care should look like, but the reality of home care makes it rather impossible to realize this vision. Economization leads to a systematic violation of multiple dimensions of recognition and to reification. Nurses must resist these social pathologies and this study provides some theoretical tools to engage in this struggle.

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List of Abbreviations

ALC	Alternative Level of Care
ASD	Autism Spectrum Disorder
CCACs	Community Care Access Centers
CIHI	Canadian Institute for Health Information
CNO	College of Nurses of Ontario
EBN	Evidence-Based Nursing
EBP	Evidence-Based Practice
ER	Emergency Room
GDP	Gross Domestic Product
LHINs	Local Health Integration Networks
LTC	Long Term Care
MOHLTC	Ministry of Health and Long Term Care
MRM	Modeling and Role Modeling
MSAs	Multiple Service Agencies
NHS	National Health System
NPM	New Public Management
OHC	Ontario Health Coalition
PPE	Personal Protective Equipment
PSW	Personal Support Worker
RN	Registered Nurse
RNAO	Registered Nurses' Association of Ontario
RPN	Registered Practical Nurse
SCDNT	Self-Care Deficit Nursing Theory
SCT	Social Critical Theory
SPOs	Service Provider Organizations
QBP	Quality Based Practice

Introduction

> *Patients in hospitals feel depersonalized… clients wonder if therapists really care about them…Caregivers are rewarded for efficiency, technical skills, and measurable results, while their concern, attentiveness, and human engagement go unnoticed. (Philips & Benner, 1994, p. 1)*

What Philips and Benner (1994) noted in their book *Crisis of Care* over almost four decades ago is still relevant today in a culture of economized healthcare that increasingly alienates the patient and diminishes conditions of compassionate interaction in the name of efficiency and promoting quality of care. Despite emphasis in nursing theories on the significance of the relational and moral aspects in the caring practice of nurses, there has been weak evidence on the ability of nurses to translate these moral values into their field of clinical practice. It is not only the lack of theoretical and practical consensus on the definition of caring that is contributing to the inability of nurses to make ethical decisions that are patient-centered. What worsens the situation is the global rise of neoliberal rationality since the 1980s, which has continuously oriented nurses to focus on productivity and efficiency values that significantly influence the moral aspects of nursing as well as the role of nurses to advocate for patients' rights. The prevalence of technical-economic rationality in healthcare has created a state of chaos for healthcare professionals and nurses in particular. Their "caring" work is underscored by a corporate healthcare system that judges their performance by quantitative and financial values incompatible with the unique "relational" and "invisible" nature of caring practices. Managerial economic rationality has been accused of governing the nursing workplace with economic values that threaten the practice of good care and dehumanize the patient. In this sense, there has been

enough evidence in the literature that nurses are failing to engage in a meaningful relationship with the patient that enables them to provide compassionate and personalized care.

In this vein, healthcare reforms in Canada have been centered on finance and cost containment measures that have shifted nursing from its main focus and have created dissonance between nursing values and the practice of care. In Ontario, community healthcare services such as home care and Long-Term Care (LTC) services have been undergoing continuous transformations under neoliberal rationality for the purpose of providing more efficient and quality care that responds to the specific needs of the population. Yet, care provided to home care recipients has been described as profit-oriented, uncompassionate, inequitable, and not considerate of the personal needs of patients. Moreover, when the COVID-19 pandemic hit Canada, shocking news was coming out through the media about residents/patients being neglected and treated inappropriately in the LTC facilities in Ontario. The Canadian Armed Forces, whom the Ontario government requested to assist in the care of residents in LTC homes because of the severe shortage in staffing during the pandemic, released what was known as the Military Report. The media highlighted the devastating news that seniors lived in very miserable situations in LTC facilities. Patients/residents were crying for help with nobody responding to their needs, frail residents were not able to reach food placed on tables, patients with pressure ulcers were left bedridden for days, others received inadequate wound care, and infected patients were placed with healthy residents in overcrowded rooms where short-staffed caregivers had little access to personal protective equipment (PPE), along with other very disturbing information about abusive and aggressive behaviours towards the patients/residents from staff. What worsens the situation is that despite the deaths of hundreds of LTC residents/patients, no

effective measures from the side of policy makers have been taken to promote care and stop this toll.

In the context of the political and technical-economic rationality that I argue suppresses nursing values and disrespects the patient, this critical study aims to engage nurses in reflective thinking. Reflective thinking here is understood as awareness about institutional, economic, and socio-political factors that make it increasingly difficult for nurses to engage in a practice based on their professional values. The theoretical conclusions from this study contribute to the envisioning of an alternative reality in which practice is strongly linked to an ethics of care mainly based on Axel Honneth's theory of recognition. Nursing is understood in this study as a theoretical-practice discipline and the study reconstructs ethical norms of care by empirically analyzing what nurses actually do in their everyday work and how they define the ethical foundations of their actions. Thus, this study starts with nursing actions and does not provide abstract normative claims. The ultimate aim of this critical study is to provide elements for a critical theory of nursing actions that not only informs nurses' ethical decisions in clinical practice, but also equips them with the theoretical tools to criticize the economic transformations that systematically violate the idea of justice in healthcare and to provide a kind of care that respects the human nature of the patient. Choosing critical ethnography as a methodology and selecting a critical theoretical framework in this study are intended to pave the way for redefining care based on ethical norms that prioritize the needs of patients as human beings who deserve recognition and respect for the right to be the author of their own lives.

Thesis Organization

This thesis is structured as follows. Chapter one will provide background and rationale for the research problem. It will also provide a very brief overview of the research methodology

chosen, including the general purpose, research objectives, significance of the study, and my positioning as a researcher.

Chapter two provides a literature review of three important fields: the different definitions of care in nursing theories, the economization of healthcare and the rise of neoliberalism along with the introduction of managerialism to nursing, and the negative impact of economization on ethical nursing practice. Following will be a review of literature that confirms the need for a critical theory of nursing actions. This chapter provides key in-depth information that supports the critical positioning of the study.

In chapter three, I develop the critical theoretical framework adopted in this study. In order to formulate the normative dimension of nursing actions, I mainly rely on the critical theory of recognition developed by the social philosopher Axel Honneth. In addition, I use Habermas' theory of communicative action and his theoretical considerations of knowledge and interests. I will also briefly discuss phenomenological-corporal approaches to demonstrate the particular significance of these dimensions in conceptualizing nursing actions. This critical theoretical framework will be used to formulate a broader critical conceptualization of nursing actions.

In chapter four, I will define my methodological approach of the study. I chose a critical ethnographic approach because it contextualizes the phenomena under study in order to reveal the hidden assumptions, agendas, and ideologies defining realities and influencing nursing actions. A critical perspective is adopted to enable nurses to gain theoretical emancipatory knowledge that can be used to challenge and critique the culture of healthcare economization and reconstruct a reality that honours their own nursing actions. The chapter explains the methods and procedures implemented to accomplish the study including data collection and data analysis.

Chapter five provides an overview of the home care sector in Ontario. This chapter was created to provide background information to enable the reader to integrate what participants revealed in their interviews about their work environment and the context of home care. It entails detailed information about essential aspects pertinent to home care including its historical evolution, challenges, payment system, and nursing workforce, all of which show the impact of neoliberal rationality on home care.

Chapter six presents the empirical research results. This chapter is written based on emerging themes of the study. Findings are primarily grouped to answer the research questions and to meet the general aims of the study. They reflect what nurses do and how they define "good" care in addition to the barriers to what they have described as "good" care. Based on participants' verbal accounts, this chapter offers an analysis of the findings that are grouped into four major themes.

Chapter seven provides a discussion of the findings by interpreting the results in light of the chosen theoretical framework. The first part of the discussion reconstructs normative dimensions of care based on thematic findings. The reconstructed norms are utilized in the second part of the discussion to provide a critique of the healthcare system. Based on the theoretical discussion, the study presents implications and recommendations as critical reflections to provide the first elements for a critical theory of nursing actions. The chapter then closes with a summary of the study's limitations. Lastly, chapter eight constitutes a short conclusion that will present the usefulness of the ontology of recognition as a basis of a critical theory of nursing actions.

Chapter One: The Research Problem

Background and Context

Many grand nursing theories conceptualize caring as the essence of nursing practice that differentiates it from other healthcare professions (Leininger, 1988; Watson, 1988, 2005; Matsuoka, 2007; Baughan & Smith, 2013; Cook & Peden, 2017). For more than 50 years, nursing theories have affirmed the centrality of caring in nursing as a moral practice based on compassionate relational interactions that aim to understand and address the subjective needs of patients and acknowledge the holistic nature of human life (Benner & Wrubel, 1989; Boykin & Schoenhofer, 2013; Dossey, 2010; Gastmans et al., 1998; Leininger, 1988; Watson, 1985; Swanson, 1991, 1993; McCrae, 2011; Zamanzadeh et al., 2015). These scholars identify a positive caring attitude as an important indicator for the quality of holistic nursing care that respects patients' personhood and enhances their well-being (Watson, 1988; Matsouka, 2007; Barclay, 2016; Labrague et al., 2017). Despite its ubiquitous acceptance in nursing publications, there is a lack of theoretical precision in defining the actual meaning of caring and the extent to which nurses can incorporate these relational, patient-centered, and holistic values of care in their actual clinical practice and caring actions (Lundh et al., 1988; Morse et al., 1991; Oldnall, 1996; Henderson, 2006; Nelson & Gordon, 2006; Matsuoka, 2007; Newman et al., 2008; Cole et al., 2014; Blasdell, 2017; Pajnkihar et al., 2017). This ambiguity could be, as some argue, due to the idealistic nature of theories and disagreement on the ontological foundations and the focus of caring in nursing theories (Morse et al., 1991; Rutty, 1998; Adams, 2016; Cook & Peden, 2017; Hoeck & Delmar, 2017). For example, Jean Watson (2003) integrates some philosophical views of Levinas and Buddhism to define love and caring leading to a transpersonal caring situation, Benner and Wrubel (1989) establish the primacy of caring on Heidegger's philosophy of concern

and engagement, while Leininger (1988) bases her theory of cultural care on an anthropological background to confirm the necessity of cultural congruency for effective care. Lack of a clear conceptual understanding of care makes it difficult for nurses to integrate these caring values into theoretically informed clinical decisions in their everyday practice, thereby deepening a theory-practice gap already present in nursing (Kitson, 2018). Without a clear critical-theoretical foundation, nurses are at risk of serving organizational interests and other external rationalities (MacDonald, 1995; Karnick, 2014). What makes the meaning of nursing care more elusive in current nursing practice is the ongoing global neoliberal transformations of healthcare in most Western societies that can best be described as based on a political and technical-economical rationality that manages rising healthcare costs by implementing industrial techniques and market-based competitions to promote economic efficiency and increase productivity (Turkel & Ray, 2000; Camfield, 2011; Drummond, 2013; Thorne & Sawatzky, 2014; Duncan et al., 2015; Hoeck & Delmar, 2017). The application of such economic rationality required the introduction of managerialism, which is a particular form of management that gives undue privilege to market forces and profit-making processes (Beardwood et al., 1999; Rees, 1999; Hau, 2004; Duncan et al., 2015). This is particularly problematic because these transformations lead not only to domination of the market economy that expands the commodification of healthcare services and increases inequality in healthcare, but also increases precarious working conditions of nurses. These conditions confront nurses with systemic shortages of material and human resources that make it increasingly difficult for them to provide a kind of care that is oriented toward patients' needs (Collins et al., 2015; Souza et al., 2017; Gunn et al., 2019; Nairn, 2019).

For example, in Canada and more specifically in Ontario, the restructuring of the healthcare system has been driven by a political-economic rationality that uses managerial power

and industrial management techniques, like Lean management approaches (developed originally by car manufacturers most notably Toyota). These approaches manage healthcare problems through the reducing of the nursing workforce, intensifying workloads, and implementing standardized care to reduce costs and increase productivity (Beardwood et al., 1999; Shannon & French, 2005; Randall & William, 2006; Fine et al., 2009; MOHLTC, 2013; Duncan et al., 2015). In order to balance the budget deficit, restructuring has led to continuous cuts in both hospitals and community care funding, which reduced the number of hospital beds per person and diminished the quality of health services provided to Ontarians in the community (Ontario Health Coalition, 2015a, 2017a, 2018). Nursing care was targeted through continuous layoffs of Registered Nurses (RNs), increasing the workload of nurses who were being replaced with less trained and knowledgeable staff at a time when hospital patients were growing older and becoming sicker, requiring more professional care (Registered Nurses' Association of Ontario, 2016, 2017, 2019). Moreover, home care services in Ontario have been privatized and have been delivered on a market-oriented basis since the mid-1990s, whereby competitive private contractors would bid on government contracts and get selected based on certain quality standards that guaranteed delivery of services at the best competitive price – which, according to proponents of this rationality, means the lowest expense to the public (Randall & William, 2006; Ontario Home Care Association, 2008).

The rhetoric of neoliberalism claims that reliance on market forces will produce better outcomes, more efficient utilization of resources, and higher satisfaction of patients at a lower cost (McGregor, 2001). But the reality of Ontarians receiving home care service reveals that they are caught in a healthcare system that is described as profit-oriented and inequitable, providing care that is inadequate, uncompassionate, not holistic, and deficient in recognizing the specific

needs and cultural orientation of patients (Randall & Williams, 2006; Ontario Health Coalition, 2015a; Wojtak & Stark, 2016; Yakerson, 2018). The implementation of a business culture in the Canadian healthcare sector, and particularly in Ontario, reduced quality of care due to austerity measures, and diverted nurses' attention from providing care based on professional humanistic values to providing care based on quantifiable economic norms – a diversion that challenged the ability of nurses to practice according to their professional caring values and reconfigured their perception about "good" nursing care (Beardwood et al., 1999; Rankin & Campbell, 2006, 2009; Rankin, 2009; Austin, 2011; Beardwood & Kainer, 2015). This is why nurses must begin to take their ethical mandate seriously and decisively advocate for a fundamental change of healthcare politics, for better working conditions for themselves, and for social justice for their patients (Kagan et al., 2009; Coburn, 2010; Chinn & Kramer, 2011).

Despite the changes in the delivery of healthcare due to economic developments, Canadian nurses' *Code of Ethics* is still calling for professional nurses to act as ethical agents who advocate for the delivery of good quality care through compassionate interaction and meaningful communication in order to understand patients' needs and concerns in a relationship of trust and respect for the right of self-determination (Canadian Nurses Association, 2017). Some scholars assume that this situation is causing nurses to suffer ethical dilemmas and moral distress secondary to cognitive dissonance because they are not able to practice based on a caring relationship that fits their professional values and that responds to the specific needs of the individual patient (Siebens et al., 2006; Goethals et al., 2010; Sumner, 2010; Austn, 2011; Cribb, 2011). In fact, they argue, it seems that nurses are left to struggle in a paradoxical position between two conflicting loyalties: loyalty to the healthcare system to provide efficient care based on organizational guidelines and standardized quality indicators; and loyalty to their professional

values to provide ethical care to their patients (Austin, 2011; Hillman et al., 2013; Goodman, 2014; Johnstone & Hutchinson, 2015). Others contend that the paradigmatic shift in healthcare to a business competing for efficiency and financial outcomes significantly influences nurses' working conditions as well as jeopardizes the ability of nurses to provide care based on compassionate relationships and moral caring values that aim to fulfil the best interests of the patient (Beardwood et al., 1999; Parker, 1999; Wall, 2010; Austin, 2011; Faith, 2013; Hussey, 2013; Rudge, 2013; Duncan et al,, 2014; Latimer, 2014; Duncan et al., 2015). This situation is aggravated by the fact that this economic rhetoric often refers to traditional nursing values, thereby hollowing out their meaning. Furthermore, this economic approach has been broadly accepted in nursing with not many empirical and critical analyses to determine the actual consequences of the corporate and commercialized healthcare context on the ethics and values of caring practices (Lundh et al., 1987; Oldnall, 1996; Bowden, 2000; Tonuma & Winbolt, 2000; Nelson & Gordon, 2006; Austin, 2011; Gallagher, 2013; Cole et al., 2014; Morley & Jackson, 2017). Healthcare transformations in Ontario and elsewhere in the world have incorporated significant challenges to "care," the very basic core of nursing, which urges nurses to question the validity of traditional caring values in representing current nursing practice and to rethink the meaning of "care" based on what nurses really do in the actual work setting in their vital contribution to the complex and demanding healthcare system.

The question remains how nurses working at the bedside define their professional values, how they understand compassion, and how exactly they themselves understand and define caring relationships. How are nurses experiencing these transformations and how can this fore-mentioned ethical dilemma be understood theoretically? These are some of the questions this study tries to address and to provide some preliminary answers. Without the support of an

overarching theoretical body of knowledge that informs practice, nursing care is facing the risk of being transformed into a set of tasks that serve the economic mandate of healthcare organizations and align with an external rationality of the biomedical field (Chambers, 1998; Clarke, 1999, 2011; Aggleton & Chalmer, 2000; Karnick, 2014). Furthermore, nursing care is also threatened by its potential use as a marketing tool and its conceptualization as a service commodity in a commodified healthcare service market (Toffoli et al., 2011; Hussey, 2013). The current technical-economic rationality prevailing in society requires development of a nursing knowledge that is not only theoretical but also empirically guided by what nurses do in their practice to provide ethical and high quality care to patients (Hoeck & Delmar, 2017; Kitson, 2018).

Starting from what nurses do at point-of-care will help to avoid abstraction of knowledge in a profession that is described as a "practice discipline" (Kitson, 2018). This empirical approach needs also to be critical in order to address meso- and macro-political and socioeconomic factors that influence nursing practice and contribute to social justice and equity in healthcare (Friesacher, 2017; Willis et al., 2017; Aranda, 2019; Gufnn et al., 2019). A critical theoretical approach to nursing actions can provide the normative dimensions that constitute the basis for a form of knowledge that guides ethical nursing practice and provides elements for patient advocacy (Holmes & Warelow, 1997; Mill et al., 2001; Friesacher, 2017). Thus, the perspective of this study is that nursing is a theoretical-practice discipline and in urgent need of a critical theory of nursing actions.

Purpose of the Study

The general purpose of this critical ethnographic study is to analyze the action of professional nurses who provide care for patients in the complex home care sector in Ontario that

– according to many nursing scholars – is characterized by a growing business culture and an increased economization of work processes (Randall & Williams, 2006; Yakerson, 2018). The aim is to better understand what exactly nurses do in their everyday clinical settings, how they themselves understand their actions when they provide care, what their ethical ideals of nursing care are, and how they struggle to realize them in their everyday actions – despite the regulations and standards of the institutions or healthcare system. The study will specifically focus on exploring the subjective meanings that nurses attribute to "good" care and how such caring ideals are influenced by the work environment and the broader context. Identification of what is "good" and what "ought to be" is an important goal of critical theory that is concerned with normative and ethical foundations of nursing actions (Mill et al., 2001; Madison, 2005). By exploring what nurses do and what they perceive as good care, this study aims to reconstruct ethical norms of care, critique the economization of healthcare, and provide reflections on the theoretical and ethical dimensions of nursing actions. This form of analysis will offer a new theoretical insight into the meaning of care that can provide important cornerstones or elements for a normative critical theory of nursing actions based on empirical findings, one that is not solely derived from a deductive theoretical approach. The latter approach would suggest external criteria or idealistic values that are set up as ethical standards for nursing practice and that could be used to evaluate nursing actions (Friesacher, 2017). But the starting point for this critical study is to examine nursing actions that take place in actual work settings. It emerges empirically from what nurses actually do in their everyday practice, which provides an opportunity to rethink the meaning of nursing care by revealing the normative foundations of care embedded in nursing actions when nurses try to realize what they understand as good nursing care in their interactions with patients (Pols, 2014).

Nursing actions are conceptualized throughout this study as a form of social action in which nurses interact with patients, who are usually in a vulnerable situation and in need of care (Sumner & Fisher, 2008; Sumner, 2010; Friesacher, 2017). Studying social actions means revealing and explaining the motives and subjective meanings that individuals attach to their behaviours to explain the ultimate ends and values towards which human action is oriented (Weber, 1968). Moreover, understanding nursing action as social action implies that the daily behaviours of nurses can be understood by interpreting the subjective meaning and rationality behind nurses' actions, in addition to the impact of the context on nursing actions (Weber, 1968; Friesacher, 2017). By exploring the subjective values behind nursing daily actions and the external impact on these actions, the study can reconstruct norms of care and provide a critique of the influence of the external rationality on such intentions and actions.

Research Objectives and Questions

According to the general aim of the study, the specific objectives of this research are to:

1. Understand what nurses actually do when providing nursing care.
2. Identify nurses' beliefs about important aspects of what they consider "good" nursing care when interacting with patients.
3. Explore the influence of institutional, economic, and socio-political contexts on nursing actions.
4. Provide theoretical and ethical reflections that establish the foundation for a critical theory of nursing actions.

Based on these specific objectives, this study will address the following research questions:

1. How do nurses describe their everyday work?

2. What do nurses see as the most important characteristics of "good" nursing care when interacting with patients?
3. How do contextual factors (organizational and external) influence how nurses actually provide nursing care?
4. Reflection: What are the most important dimensions that constitute the normative foundations of nursing actions as defined by nurses?

Study Significance

This research represents an original empirical attempt to reconstruct the ethical norms of nursing actions based on the three dimensions of recognition theorized by Axel Honneth (1995). What makes this form of analysis different from other theoretical perspectives of nursing ethics is that it does not start with a predetermined set of idealistic and transcendental ethical standards of care that are either adopted by institutions external to nursing or internally pre-established in ethical codes of nursing conduct (Friesacher, 2017). Rather, it starts from actual nursing actions and the way nurses describe their everyday practice in order to reconstruct normative ethical dimensions that are immanent to nursing practice.

This study will contribute to the literature about caring as an emancipatory praxis where nurses advocate for patients' rights, dignity, and social justice despite the rigidity of the work context (Ray & Turkel, 2014). It will also provide nurses with the necessary theoretical insights to criticize the increasingly precarious working conditions in home care and elsewhere in healthcare. The emancipatory methodological approach used in this study proposes that a critical theory of nursing actions must provide the tools for nurses to critically analyze the working conditions and societal developments they are a part of (Mill et al., 2001). Because caring is generally seen as the essence of nursing practice, defining nursing's good caring based on an

emancipatory interest enables nurses to understand their position within an economized context. These insights are not only necessary for nurses to foster a good caring environment, but also to realize the influence of managerial authorities and the broader societal context on their work and to highlight that it is their responsibility to intervene in the political sphere if they really want to advocate for their patients.

Positioning of the Researcher

I have always been confused over the real meaning of nursing care and the differential characteristics that should separate nursing as a caring profession from other healthcare professions. During my long years of clinical and academic teaching in nursing institutions, I have always questioned my professional identity as a nurse. When I first chose to study nursing at a university, I was told that when I graduate as a nurse, I would be a leader, a decision maker, and a recognized healthcare professional. Yet, after more than 15 years in clinical nursing in Lebanon, I have found myself no more than a traditional nurse, searching for identity and struggling for professional existence. Even after building my expertise as an intensive care nurse, I was not able to feel the pride of being a professional in the same way my friends did in other professions such as engineering, law, and environmental sciences. Many of my relatives and patients as well were praising my skills by calling me an “angel” or “half a physician,” but these were terms that were only reinforcing my low self-esteem and deepening moral injury. Identity confusion was the reason behind my search for answers that I was not finding within the borders of clinical nursing that was focused on providing bedside care for the patient.

Moreover, when I emigrated to Canada as a skilled nurse, I was faced with the obstacle of registering to become a registered nurse. Despite my broad experience in clinical and academic nursing, I was asked to go through a long process of a minimum of two years to receive my

license for practice as a registered nurse. At that point, I felt de-recognized by a system that had neglected my broad experience by asking me to start the same way junior nurses do. This feeling of inequity negatively influenced my life as a father of four children who came to Canada looking for a better life and work opportunity. This personal lived experience of de-recognition along with my low sense of self-esteem strengthened my interest in conducting this emancipatory study with the aim of maintaining self-realization and gaining recognition as a professional nurse who contributes to the betterment of healthcare.

As a primary researcher, I believe that power structures, context, and history influence social interactions and shape perceptions of people in society. I also believe that economic-political rationality has spread widely in public life and influenced all aspects of social relationships including nurse-patient interactions. Based on this perception, I have come to recognize that satisfactory answers require extending my vision to study not only the micro level of nursing practice but to include organizational structures and external socio-political factors and ideology that influence the work of nurses (Rudge, 2011; Goodman, 2014, 2016). This perception was further strengthened by the political orientation of my personality, which explains the reason for choosing a critical methodology in the design of my research topic.

Chapter Two: Literature Review

Introduction

In order to build a comprehensive understanding of the concept of caring and the practice of care in an economic context, a review of the literature was undertaken to identify current and previous research articles and seminal publications related to the topic under study. I built my body of references searching the databases PubMed (Medline), CINHAL, Medline (Ovid), and SCOPUS. In addition to nursing and caring, I used the following search terms: nursing knowledge, nursing theory, nursing ethics, managerialism, neoliberalism, and health economics. Seminal literature on nursing theory was identified and reviewed. This included but was not limited to the theoretical works of Leininger, Watson, Benner, and Erikson in addition to other analytical studies and conceptual analyses focused on exploring caring theories and patterns of nursing knowledge such as the comparative analysis article of Morse, Bottorff, Neander, and Solberg (1991), Carper's (1978) patterns of knowing, and the text of Chinn and Kramer (2011) that integrated emancipatory knowing into nursing knowledge. Literature focusing on critical analysis that problematizes the nursing situation due to economic rationality and the managerial discourse was selected due to its relevance and connection with the rationale and critical methodological approach adopted in this study. It is worth mentioning that the literature review was not limited to a specific period but was updated according to emerging relevant articles and references identified during the period in which I conducted by research.

Based on the search strategy, this chapter is organized into four parts. The first part is focused on how nursing theorists define care based on different conceptualizations of caring and the focus of caring in nursing as a profession. The second part deals with the economization of healthcare and the rise of neoliberalism along with the introduction of managerialism into

healthcare, particularly nursing practice. The third part includes detailed accounts about the impact of economization on ethical nursing care in clinical practice. The last part focuses on the literature that highlights the need for a critical theory of nursing actions. The chapter then closes with a summary.

Definition of Nursing Care

Caring is universally accepted by nursing theorists as a fundamental attribute that is central to nursing practice (Matsuoka, 2007; McSherry, & Watson, 2012; Darbyshire, & McKenna, 2013; Labargue et. al, 2015). There is a common belief among nursing theorists that caring is a relationship of understanding the lived experience of the patient with love, concern, dedication, and commitment to protect the needs of the patient (Matsuoka, 2007; Blasdell, 2017). Caring is only sufficient, however, when it is directed to meet the specific needs of the patient through a subjective and compassionate relationship that recognizes the holistic dimensions and the unique nature of the human being (Corbin, 2008; Baughan & Smith, 2013; Mecugni et al., 2015; Zamanzadeh et al., 2015). Despite consensus on the centrality of care in nursing practice, there is no clear-cut theoretical definition of the concept of nursing care (Henderson, 2006; Blasdell, 2017). This ambiguity could be, as some argue, due to the idealistic nature of theories and disagreement on the ontological foundations and the focus of caring in nursing theories (Morse et al., 1991; Marjorie, 1995; Rutty, 1998; Adams, 2016; Cook & Peden, 2017; Hoeck & Delmar, 2017). In order to understand the confusion underlying the conceptualization of care and its enactment in clinical practice, it is imperative to clarify the different ontological foundations from which nursing theorists construct their definition of care or caring and the different epistemological bases of knowledge in nursing as a caring discipline.

Meaning of Care in Nursing Theories

Madeleine Leininger (1988,1991), based on her anthropological background, postulates that care is a human constant that can be found in all cultures and at all times in every human society/community. The only difference between different communities is the way care is carried out and that is why care is dependent on the cultural context in which it is provided. Therefore, professional care must be culturally congruent because the cultural background of the patient influences behaviours needed to provide care and maintain health. Leininger developed her Sunrise Model of transcultural nursing in the middle 1950s when she noticed that nurses were not well oriented to understand the cultural background that affected the behaviour of patients (Cohen, 1991). Leininger (1998) confirms that understanding the cultural background, through gaining insight into clients' beliefs, values, and social practices that vary with the different cultures of patients, is necessary to guide personalized care and resume well-being. She explains that caring is an interdependent relationship that aims to help care recipients by following both humanistic and scientific methods. She points out that the humanistic nature of caring should be highlighted in today's healthcare system, which fails to value this essential attribute of human life (Leininger, 1998). In order to discover the specific care compatible with the culture of the patient, Leininger (1991) directs nurses to combine the emic dimension of care, which is the perspective of the patient influenced by the cultural and social-economic context in which the person lives, with the etic dimension of care, which is the professional knowledge and scientific based interventions to alleviate suffering.

In 1979, Jean Watson introduced her metaphysical theory of human caring that emanates from different philosophical backgrounds such as existential phenomenology, interpersonal, transpersonal psychology, Buddhism, and others which have influenced her conceptualization of

human caring (Rafael, 2000; Watson, 1988). Throughout the 1980s, Watson developed her transpersonal caring theory that focused on the moral relationship between the nurse and the vulnerable patient based on love and a transpersonal relationship aimed at gaining knowledge about the mind, body, and spirit of the patient (Watson, 1994; Saeyc, 2000). Her theory views care as "being-in-the world" of the patient, acknowledging the wholeness of the human person (Rafael, 2000). In order to establish the ethics of love and caring of the heart and soul in human relations, Watson (2003) integrates multiple philosophical perspectives from Levinas about the ethics of love and compassion, in addition to the spiritual enlightenment from Buddhism, to support her transpersonal caring approach.

According to Watson (1994, 1988, 2002), care originates from a relational ontology in which all people are connected with each other in a caring relationship and function in unity with *caritas* and altruism to survive and be nourished as human beings. She believes that caring is successful through intersubjective transpersonal relationships that transcend into authentic and trustful nurse-patient relationships, which come together in a deep human-human spiritual connection and which reach a "caring moment," unveiling the subjective meanings and lived experience to discover the possibilities of healing (Watson, 1985, 1988, 1999). In a transpersonal caring situation both the nurse and the patient change and enrich each other's lives because they share a unique experience of unity (Watson, 1985, 1988). It is through a spiritual connection with the patient that the nurse helps the patient to activate his or her inner healing capabilities. Caring is thus the capacity to connect to the inner self through meditation and other mindful practices, which are very different from the biomedical definitions of health and disease.

Watson (1994, 1999) perceives care as a science that is subjective, reflective, and interpretive in its epistemology, and considers the authentic presence of the nurse with the

patient to reach understanding at the cognitive, behavioural, and affective levels as vital for a helping-trust relationship that accepts expressions of positive and negative feelings. She warns that transpersonal human caring cannot be achieved through the positivist deterministic pathway that has threatened and submerged caring values by the recent wave of medical technology and the spread of managerial-bureaucratic organizational constraints (Watson, 1988). She adds that by sustaining care in the nursing profession, nurses will reveal their effective contribution to society and civilization.

Benner and Wrubel (1989) in their seminal work, *Primacy of Caring,* consider care a primary condition for human relations based on the existential phenomenology of Heidegger. In the nursing context, they consider care a primary requisite in nursing practice that aims at an emotional and phenomenological connection between the nurse and the patient to discover the lived experience of the patient. They explain that caring means being involved with the lived experience of the patient to the extent that the nurse identifies patients' concerns and understands the meaning of their situational experience. How the patient experiences an illness as either stressful or manageable depends on his or her lifeworld, which is a complex interplay between the patient's background meaning, his or her concerns, and unique biographical experiences. Benner and Wrubel (1989) differentiate between disease as the biomedical definition of being sick, and illness, which is the personal experience of sickness that alters emotional balance and disrupts balanced human functioning. They explain that nursing caring focuses on the latter and is therefore fundamentally different to the medical gaze. In this sense, a caring attitude that connects nurses with the lifeworld of the patient enables the nurse to understand what events are stressful and significant for the person, and this understanding creates the possibility for receiving help that enhances coping with illness. Benner and Wrubel (1989) argue that

phenomenological caring, as a primacy in human relations and a central concept to nursing, cannot be limited to medical or controlled technical skills but requires personal interaction and involvement to understand individual concerns, background, skills, and practices that are necessary to enhance coping options and achieving equilibrium. In the same vein, they dispute the separation of body and mind that follows the biomedical model, which they argue does not provide the level of involvement needed to discover the situational meanings of illness nor the complex lived experience of the patient as a human being.

Helene Erickson, the primary author of the Modeling and Role-Modeling Theory (MRM) in nursing, based her work, along with other co-others, on multiple theories such as Maslow's theory of needs, Erikson's theory of psychosocial stages, and Piaget's theory of cognitive development (Erickson, Tomlin, & Swain, 1983). Based on these philosophical foundations, Erickson explains that understanding human needs and human developmental stages facilitate unconditional acceptance and understanding of the patient's unique world and perspective, which allows the nurse to provide care that is holistic, nurturing, and unique to the patient (Walsh, VandenBosch, & Boehm, 1989). In MRM, nursing interventions are designed to meet an individual's physiological, psychological, social, cognitive, and spiritual needs. Only when these dynamic and holistic components that influence health are met, will health and the well-being of the patient be achieved (Erickson et al., 1983). This theory combines aspects of both art and science, in which the nurse collects and analyses data to provide care through purposeful interventions based on interactions that aim to understand patients' specific needs (Sappington & Kelly, 1996). What is important to retain is Erickson's emphasis on the spiritual dimension of care, where the patient and the nurse are on the search to achieve a spiritual dimension, meaning a connection with a transcendent spiritual being – or God. The nurse assists the patient to follow

a spiritual path which, in turn, helps the patient perceive a high level of well-being despite the objective reality of being sick (Erickson et al., 1983).

In opposition to the above-mentioned theories, Orem's (1985) theory of care and self-care is based on a post-positivist approach combined with a system of theoretical perspectives. Her complex Self-Care Deficit Nursing Theory (SCDNT) is actually a general theory composed of three related theories: the theory of self-care; the theory of self-care deficit; and the theory of nursing systems. People require nursing when they are unable to provide for themselves or their dependent others the amount and quality of care that is necessary to maintain health and well-being. Self-care actions are associated with conditions that influence human ability such as age and health status. Such actions should be performed by the individual to maintain life, health, and well-being. Self-care or dependent care is performed "purposively," meaning it is not instinctive but performed rationally based on ability and conditions of illness. Orem (1985) argues that knowledge, skills, and competencies are required to fit the needs of the patient and to empower them to re-engage in self-care. Nurses have the abilities to determine if nursing help is necessary or "legitimate."

In SCDNT the right of the individual for self-care is the ideal focus of nursing. Nursing care aims to assist ill patients to resume capabilities of self-care to satisfy their "universal" needs for breathing, getting water and food, elimination, daily activities, rest and so on. For Orem (1985), self-care needs can be achieved through the "nursing process," a method to determine the self-care deficit. This method represents the technical components of nursing in which nurses collect data to assess needs, reveal concerns, and identify a diagnosis in the care plan, and then implement practical caring interventions to achieve the stated goals and evaluate outcomes. Orem emphasizes that the nurse must coordinate between technical requirements and

interpersonal skills to maintain a therapeutic relationship and at the same time, promote the psychological and physiological functioning of the patient.

Confusion and Contradiction in Defining Care

Based on the above discussion of nursing theories, many nursing scholars have concluded that despite agreement among nursing theorists on the essentiality of relational, phenomenological, and humanistic approach to care, there is still no shared definition of the complex concept of care or caring (Lundh et al., 1988; Morse et al., 1991; Matsouka, 2007; Cook & Peden, 2017; Pajnkihar et al., 2017). Blasdell (2017), who analyzed the conceptualization of caring in a number of nursing theories, concluded that caring is one of the most confusing concepts in nursing because its definition is dependent on the different paradigms adopted by theorists. Lundh et al., (1987) criticized nursing theories for being either highly abstract or being focused on instrumental processes and rational thinking that is not compatible with the relational nature of caring in nursing.

Although Leininger's theory is beneficial in providing care that is congruent with patients' cultural needs, this focus of caring has been criticized for lacking consensus on pedagogical approaches that can educate and prepare nurses for practical competence in responding to the various needs of patients who belong to a broad variety of cultural backgrounds (Campesino, 2008). In addition, the rise of mixed populations and multicultural communities with "fragmented" identities, especially in Western societies, challenge transcultural caring theories that define each culture by a set of definite and distinct beliefs and practices. Moreover, emphasis on understanding culture makes it appear as if the problem in care is located in the cultural background of the patient rather than in the context of the disease process and the symptoms that are of significance in nursing care and nursing education.

Morse et al., (1991) criticize the idealistic nature of Watson's theory, which requires the caring nurse to discover his or her own "inner power" through mental and spiritual growth to promote "instances of transcendence and self-healing" (Watson, 1988, p.74). They also critically examine the transpersonal caring relationship in which both the patient and the nurse need to reach a state of "spiritual union" to become "capable of transcending self, time, space and the life history of each other" (Watson, 1988, p. 66). Morse et al., (1991) find that such philosophical explanations transfer care to an idealistic position that is difficult or impossible to attain.

Ben-Sira (1990) disapproves of the reliance of Benner and Wrubel (1989) on compassion and feelings rather than on developing a reliable and accountable professional practice based on a practical body of knowledge. He explains that if care is the underlying feature of nursing, then it should not be limited to the subjective actions of the nurse guided by a "common-sense approach" (Benner & Wrubel, 1989, p. 519) but must have empirical basis and behavioral outcomes that inform nurses in their clinical endeavor to meet patients' actual needs. Otherwise, caring as a vague concept may formulate a threat to the theoretical basis of the discipline, a condition which places nursing at risk of losing its standing as an academic profession.

Lundh et al., (1987), consider Orem's theory a representation of a rational and goal-oriented model of care. They explain that her theoretical approach is situated within the empirical-analytical tradition, whereby care and caring are understood as instrumental nursing actions that are categorically limited to "natural self-preservation." They criticize that instrumental rationality could not represent the norms of care or what actually happens when nurses provide good care because nursing actions are usually based on emotional relationships that aim to identify patients' specific needs (Lundh et al., 1987). Thus, they argue, the idea of

care and caring in Orem follows a biological model in which nurses operate according to standard values, promoting an expertocratic exertion of the power of nurses over patients.

Cook and Peden (2017) explain that the fact nursing theories are established on knowledge derived from different disciplines of contradictory origins such as medicine and social sciences makes it difficult to define caring or establish a focus for the concept of caring. While multiple theorists prioritize patient knowing and the emotional presence of the nurse as the main focus of caring, others refer to technical aspects of nursing care and understanding the disease process as central to nursing care. Cook and Peden (2017) conclude that unless nursing theories succeed in identifying the focus of caring, the value of caring itself as a representative concept for nursing has to be questioned.

In their comparative analysis of how nursing theories conceptualize caring, Morse et al., (1991) explain that caring is poorly developed as a theoretical basis that can guide nurses in their clinical practice. They suggest resolving the loose link between caring and nurses' daily actions, particularly patient outcomes, and to bridge the abstraction in theories with clear behavioral terms that inform clinical practice in order to close the theory-practice gap in nursing. By the same token, Clarke (2011) argues that dependence on the idealistic definition of caring could not help nurses working in real clinical settings nor does the adoption of the biomedical model proclaimed by another profession. She advises nurses to accept the "practical" nature of nursing and work out a body of knowledge that addresses questions that emerge from nursing practice or else nursing care may change to a set of tasks structured and delivered by external authorities.

Lack of Critical Perspective

What is noteworthy also in the comparison of these theories is the fact that power asymmetries are not really reflected. Providing dignified care that preserves the identity of the

patient should be complemented by an emancipatory healthcare approach that is crucial in meeting health needs (Hammerschmidt et al., 2007; Williams, Rycroft-Malone, & Burton, 2017). This approach requires nurses to assist in the promotion of health, the maintenance of patient autonomy, and the preservation of healthcare values relevant to the patient. In their critical review of nursing theories, Lundh et al. (1987) accused nursing theorists of lacking a critical perspective and an inability to connect with concrete problems faced in nursing care, such as the conflict between nursing values and the reality of scarce resources in work settings and with various professional and management categories. Although nursing practice is embedded in complex social situations, nursing theorists, according to them, are not putting enough effort to advance nursing knowledge and practice through critical realism approaches that aim at understanding underlying complexities in healthcare. It seems as if theorists assume that healthcare is situated in equitable societies where everyone has equal bargaining power to access care independent of larger structures of power and domination (Gustafson, 2005; Campesino, 2008). Apart from a description of ethics that described advocacy as a power that nurses could use within the borders of a clinical setting (Benner, 1984, 1994), most of these theorists have failed to accommodate important philosophical questions in areas such as the centrality of social justice in healthcare.

In their scholarly contribution to nursing, Chinn and Kramer's (2011) model of nursing knowledge was focused on the idea of emancipatory knowing as a pattern of nursing knowledge, which situates social justice and political processes within nursing action that aim to promote equitable health and social conditions. Chinn and Kramer's model of knowing stems from the proposition that nursing knowledge development should be directed by what is valued and important for the discipline. They built their model on Carper's (1978) fundamental patterns of

knowing in nursing. Carper identifies four foundational patterns of knowledge that represent the rationale for nursing practice and the knowledge needed to solve clinical problems. These patterns of knowing are: empirical (scientific knowledge based on measurable, controllable, and predictable knowledge needed for technical clinical practice), aesthetic knowing (the art of connecting different elements to produce an integral whole based on intuitive knowledge), personal (related to individual insight into oneself and others as a fundamental requirement for a therapeutic relationship with the patient), and ethical (taking the right decisions in complex conditions to alleviate suffering and promote health). Although Carper emphasized the need for implementing ethical codes in practice, she did not specify or recommend a moral position that determines what is good and how to make moral decisions. This liberal position was criticized as leaving the nurse in a void by not knowing how practically to implement ethical knowing in clinical work (Porter, 2010). Chinn and Kramer (2011) introduced emancipatory knowing as the fifth pattern of knowing to Carper's framework. They added this reflective approach to assist nurses to reveal institutional and contextual processes that produce health and social inequities. They reoriented the epistemological focus of nursing knowledge beyond the dominant empirical dimension towards critical and ethical knowing that is essential to enable nurses to address social inequities and sociopolitical processes that support human rights in a clinical setting (Peart & Mackinnon, 2018). They provided nurses with practical strategies to guide them through reflection and action to achieve social change, or what is known as nursing praxis (Chinn & Kramer, 2011). When all five patterns are integrated, the achievement of social justice, emancipation, and change become possible. The model directs nurses to ask critical questions such as who benefits from such outcomes and what are the barriers for autonomous actions, which enable the identification of problems and alternative solutions to enhance equity and

justice (Chinn & Kramer, 2011). However, Chinn and Kramer did not propose fundamental preconditions or normative dimensions for supporting patient equity to guide nurses in their advocacy for patients' rights.

This brief overview of the different ontological foundations and epistemological approaches to nursing care and caring highlights how difficult it is for nurses to grasp the "real" meaning of caring and to incorporate caring into their clinical practice. Nevertheless, these difficulties are exacerbated by the emergence and dominance of the neoliberal rationale in nursing and healthcare. A powerful economic-political discourse derived from neoliberal rationality has spread globally and is changing the healthcare sector through increasing rationalization to a marketplace that provides services based on economic ethics rather than the relational and humanistic caring ethics of nursing (Parker, 1999; Latimer, 2014; Rudge, 2015; Souza et al., 2017; Hoeck & Delmar, 2018; Aranda, 2019; Nairn, 2019). The growing influence of the economic orientation of the healthcare system that threatens the very foundations of nursing ethics has been criticized by numerous nursing scholars. In what follows, I will highlight some of the work that tries to explicate the principles of neoliberal rationality and investigate the influence of political economy on healthcare in general, and nursing care in particular.

The Economization of Health Care: Neoliberalism and Managerialism

Neoliberalism and healthcare.

Critical nursing theorists have demonstrated that the prevalence of economic discourse in healthcare throughout the world was the consequence of the rise of neoliberalism in the 1980s, which emphasized the need for austerity as a guiding principle for public policies and strict budget discipline by promoting efficiency and productivity (Coburn, 2010; Rudge & Thorne, 2013; Nairn, 2019). In her explanation of the impact of politics on healthcare, and drawing on

feminist theory, Aranda (2019) clarifies that the economization of public life, the increasing costs of healthcare, and the spread of austerity measures, diminish equality in wellness among people and make access to needed healthcare less available. This change in the healthcare context and the dominance of economic discourse in public services make it difficult for nurses to integrate ethics of care into good professional practice (Meulenbergs et al., 2004; Austin, 2011; Kagan et al., 2014; Aranda, 2019). Neoliberalism, in its economic aspect, is a rationality which believes that corporations and individuals are motivated by self-interest and profit-making and thus, promotes private markets in which individuals and corporations engage in free competition. By encouraging competition, the argument goes, markets would reduce costs and guarantee satisfaction of the public more than reliance on government and state services alone (Rees, 1999). In the healthcare sector, proponents of this rationality believe that corporatization and market competition give private providers the incentives to minimize costs in an effort to maximize their market share, which consequently drives the price of care delivery down and improves access to more effective, efficient, and more affordable healthcare service (Bamford & Porter-O'Grady, 2000). The restructuring of the economy through this mode of economic policy promotes the development of Lean production practices that aim at eliminating workforce waste by downsizing staff and keeping only those who can move flexibly between tasks, thereby improving productivity, reducing work time through utilizing technological instruments, intensifying workload, and standardizing labor processes (Sears, 1999).

To provide a context for this study it is important to remind the reader of *The Excellent Care for All Act* that came into force in Ontario in June 2010. This act is comprised of four main guiding principles: an organizational focus that must be centred on meeting quality care based on patient needs; a quality improvement plan that must be put in place to achieve goals; the

alignment of policies and compensation plans to support quality of healthcare and efficiency in using resources; and finally, a quality of care that must be based on best evidence and standards of care (MOHLTC, 2013, 2018). The guiding principles of this law introduced a strategy that increased the number of hospitals and healthcare organizations adopting Lean management practices (Fine et al., 2009; Baker, 2014). In addition, as of 2011, hospital financing from the government of Ontario shifted from global funding, in which hospitals were paid one lump sum for medical services, towards a patient-centered funding system that was deemed to be financially more sustainable and efficient (Li et al., 2020; MOHLTC, 2020). Through this approach, hospitals are reimbursed based on the quantity of patients who are provided care according to Quality Based Procedures (QBPs), which are standardized quality services supported by best practices with a fixed price per service provided by the government. Because hospital funding has become dependent on "informed" fixed prices multiplied by the number of patients served, hospitals have developed an interest in efficiency measures and discharging patients as early as possible in order to increase funding to allow them to invest their savings into the next fiscal year (Li et al., 2020; MOHLTC, 2020).

Nursing scholars and other public advocacy organizations have highlighted that a focus on finance and cost containment due to limitations in government funding has reinforced the requirements of management authorities in hospitals to develop various business strategies such as cutting services, laying off registered nurses, assigning care tasks to less educated and unlicensed workers, and decreasing the length of patient stays (Beardwood et al., 1999; Ontario Nurses' Association, 2016; Registered Nurses' Association in Ontario, 2016; Ontario Health Coalition, 2017a). Since the mid of 1990s, there have been continuous cuts in hospital budgets and other healthcare services including nursing personnel (Fisk, 2000). According to nursing

researchers Rankin and Campbell (2006, 2009), hospitals and other public healthcare settings in Canada are highly rationalized for cost containment and economic efficiency strategies that make publicly funded healthcare systems operate in an environment resembling market-oriented and profit-driven organizations. Based on statistics that will follow, the Ontario healthcare system was suffering a critical situation even before COVID-19 hit, but the pandemic has made the situation more visible and worse. According to the Ontario Hospital Association (2019), the province had the lowest number of total hospital beds in the country in 2017-2018, with 2.2 hospital beds per 1000 population compared to an average of 3.2 in other provinces. Compared to the average expenditure of all other Canadian provinces, the Government of Ontario spends $389 less per person on hospital care (Ontario Hospital Association, 2018, p. 2). Moreover, in 2017 Ontario had the lowest RNs per 100,000 population in the country with just 669 compared to an average of 828 per 100,000 people in the rest of Canada – 23.8 per cent higher than in Ontario (Registered Nurses' Association of Ontario, 2019, p. 30). Due to such continuous cuts, it is no surprise that in 2017, more than half of hospitals in Ontario were operating with more than a 100% occupancy rate, with some hospitals exceeding 140% (Ontario Hospital Association, 2018, p. 4). Although this situation was not sustainable and amid warning of capacity crisis, the provincial government continued moving forward with its assault on the publicly funded healthcare system.

Neoliberal policies are not only oriented to cost cutting but also aim at decentralizing government control and transferring authority to local regions and private markets because privatized services, according to proponents of neoliberalism, make more efficient use of resources (McGregor, 2001). Liberal and conservative provincial governments promised to implement an administration that would be closer to communities, better suited to act in their

interests and provide more efficient services at a local level (McGregor, 2001; England et al., 2007; Yakerson, 2018). These principles are at the core of New Public Management (NPM), which is a form of governance that shifts welfare services formerly provided by the state to private corporations and for-profit and non-profit organizations (Sears, 1999), and encourages citizens to become more actively involved in preventing health risks (Rhodes, 1996; Camfield, 2011). Thus, neoliberalism is a strategy not only concerned with efficiency measures and cutting costs, but also with reconfiguring society through deregulation of public services and liberating an entrepreneurial spirit in individuals and private organizations in order to involve the population in supporting the economic competitiveness of private markets (Harvey, 2005). This form of responsibilization occurs as a deregulating process by which the government detaches itself from providing services and encourages community members to be more responsible for their health and to pay for their own services when needed (England et al., 2007). This devolution of responsibility does not necessarily mean that patients have decision-making powers or autonomy but rather means problems have been directed to a population that often does not have the resources to manage or solve them (England et al., 2007; Brown, 2015). Instead of protecting and insulating public services from market influences in order to maintain social justice and equality in accessing needed services, governments have taken a passive position and made people become more responsible – and blamed – for choices they have made in a context that is beyond their control (Barry, 2005).

Managerialism and Nursing Practice

Market-driven economic policies, corporatization, and Lean production is criticized by critical nursing scholars as bringing about a particular form of management called "managerialism" that implements business models, exalts financial accountability, and gives

extreme privilege to market forces (Beardwood et al., 1999; Hau, 2004; Gilbert, 2005; Maben et al., 2007; Wall, 2010). The global economization of healthcare and the rise of managerialism in nursing and other social services are well documented in the literature (Rees, 1999; Tsui & Cheung, 2004; Gilbert, 2005; Randall & William, 2006; Austin, 2011; Drummond, 2013; Duncan et al., 2015; Rudge, 2015). This form of industrial management deals with individuals of an organization as components of a market who are conscious enough to be efficient in reducing costs and increasing productivity (Rudge, 2013; Dalal, 2017). Because uncertainties in health services can result in unseen costs, the practice of care is controlled through surveillance techniques such as audit and protocols that make nurses accountable to managerial technical rationalities (Goodman, 2014).

Managerialism has been broadly discussed in critical nursing literature. Some argue that because managerialism governs nursing practice through rigid organizational structures and standardized forms of care focused on quantitative indicators and financial administrative outcomes, care is reduced to a set of technical tasks, routines, and obligations that restrain the ability of nurses to advocate for patients and provide care that is compassionate and patient-centered (Tonuma & Winbolt, 2000; von Dietze & Orb, 2000; Sumner, 2010; Wall, 2010; Austin, 2011; Curtis, 2013; Rudge, 2015). Others see this form of management that controls care based on efficiency and productivity values as a violation to the moral values of professional nurses who are committed to providing high quality care centred on meeting the individual needs of patients (Brophy, 2008). Due to disagreements with professional expertise, managerialism uses its authority to disempower and colonize professionals by the new managerial values (Gilbert, 2005). This take place through protocols and policies that standardize forms of care securing nurses' subjugation and produces certain types of nursing subjectivities that are

prepared to induce particular forms of knowledge relevant to the dominant discourse (Hau, 2004). In this sense, rigid protocols and standards are mechanisms that limit the clinical autonomy of professionals (Lawton & Parker, 1999; Harrison & Dowswell, 2002; Broom, Adams, & Tovey, 2009; Traynor et al., 2010) as well as the autonomy of the patient by treating her/him as an object of care rather than a human being with personal needs (Hyde et al., 2005; Boykin et al., 2014).

Managerialism enhances the adoption of scientific-based findings to rationalize its strategies in providing quality care (Mannion et al., 2005; Dalal, 2017). Nurses accepted the evidence-based movement because codification and formalization of nursing knowledge promised to accelerate the professionalization of a discipline striving for professionalism and differentiation from the adjacent medical profession (Traynor, 2009). Yet, the scientific technical rationality that is dominant in healthcare determines health and illness according to objective criteria with reference to laboratory results, standards of care, and evidence-based data (Granero-Molina, 2014; Rolfe, 2017). Although scientific-empirical knowledge can help to explain and predict what is of concern to nurses in their field of practice, the relational dimension of caring is not amenable to calculative and measurable descriptions (Porter, 2010). The positivistic perspective of knowledge does not take into consideration the subjective elements essential to understanding the phenomenology of human illness (Goldenberg, 2006). Benner and Wrubel (1989) insist that patient care cannot be planned ahead of time because the lived stress of a patient in existential crisis is too complex and unique to be managed by a standard equation or technical method that cannot reflect the specific situational meanings and multifaceted options of individual illness.

Moreover, adopting the reductionist cognitive and empirical epistemology in nursing practice without critically thinking of the consequences can lead to conformity with dominant economic discourses and control of professional practice (Holmes et al., 2006). Evidence-based practice not only suppresses intuitive and tacit knowledge required for professional caring, but also codifies care in formal, technical, and explicit lists or statements, which make professional practice amenable to external evaluation and control based on the predictability of the work (Traynor, 2009). From an economic point of view, codification of professional knowledge replaces professional judgment with elements that can be simply stated in protocols and guidelines that standardize knowledge in commodified business tasks, which can be reproduced in the competitive market at a lower price in a process of monopolization and deprofessionalization (Epstein, 2013). According to Brophy (2008), the breaking of clinical skills is a managerial strategy that exposes professional nursing to the vulnerability of being replaced by less expensive technicians and unregulated healthcare workers who can fulfil the assigned tasks. In nursing, codification is represented in competency-based practice that can be understood as a political instrument to govern nursing knowledge and facilitate marketization and commodification of nursing services (Foth & Holmes, 2017).

Another aspect of economic developments in healthcare criticized by many nursing scholars is what they call instrumentalism (Sumner, 2010; Sedgwick, 2013; Goodman, 2016). Managerialism adopts instrumental rationality – a mode of reasoning that identifies problems and works on resolving them by targeting specific ends through the most efficient and cost-effective method with little attention to consequences on human relations or social practices that are essential components in nursing care (Goodman, 2014). Because managerialism employs clinical guidelines and protocols that guide individual decisions about what to do and the way things

should be done (Timmermans, 2005; Dalal, 2017), such strategies result in a "managed" form of care that follows technical rules and standardized forms of care. These strategies threaten the discretion of professional judgement as well as the intersubjective relationship between professionals and their patients whose personhood should be respected when deciding on care (Kohlen, 2015). In his study of the ethics of care amid marketization of healthcare, Sedgwick (2013) explains that the managerial instrumental method considers patients as customers or consumers looking for a reasonable price in the health "market" with no interest in understanding their personal condition or the nature of relationship with them; a condition that threatens the ethics of care.

In conclusion, within this technical-economical rationality, nursing care has been rationalized and instrumentalized (Ceci et al., 2017) and a business model is infiltrating the consciousness of healthcare providers, shifting healthcare into a private market governed by politics and commerce (Drummond, 2013). In this sense, nursing scholars have criticized that under neoliberalism, nursing practice has been guided by market-based values to focus on increasing productivity in a "health market" that implements scientific protocols and pays less attention to the primacy of human caring (Boykin et al., 2014; Hoeck & Delmar, 2018). According to many scholars in nursing research, the global spread of economic logic has controlled the ethical behaviour of healthcare professionals with tight regulations and economic norms, constraining the practice of nurses that according to nursing ideals should prioritize the interests of patients (Beardwood et al., 1999; Hau, 2004; Kälble, 2005; Brophy, 2008; Hartzband & Groopman, 2011; Kursen, 2011; Toffoli et al., 2011; Debesay et al., 2014; Rudge & Throne, 2015).

Impact of Economization on Ethical Nursing Care

Ethics and values in nursing care.

Because nurses usually deal with patients who are in vulnerable situations, they are expected to act within an ethics of care that determines what is good for the sick individual seeking healthcare (Gastmans et al., 1998; Gallagher, 2013). Although the words "ethics" and "morals" are often used interchangeably in the medical and nursing literature, they are not synonyms. The term ethics is related to a process of "reflective analysis and evaluation" that judges what is good or bad in terms of human action, whereas morals is a "prescriptive" command or instruction that "regulates human behavior or conduct" (Maurice & Warrick, 1977, p. 343). Thus, ethics is related to the responsibility to evaluate a situation and make a reasoned decision to act, while morals is related to the duty and obedience to follow the rules related to what is right or just. In fact, nurses' actions are considered ethical behaviours that aim at providing good care and making clinical decisions that are in the best interest of the patient (Gastmans et al., 1998; Goethals et al., 2010).

Nursing theorists as well as nurses both identify compassion or "emotional engagement" as a necessary value that characterizes good quality nursing care (Benner & Wrubel, 1989; Harrowing et al., 2010; Horsburgh & Ross, 2013; Blomberg et al., 2016). In addition, nurses perceive values of integrity, accountability, and respect for autonomy and dignity of the patient as foundational to the ethics of nursing (Rose et al., 2018). Although nursing theorists emphasize that caring values are deeply embedded in nursing practice, the economic, political, and technological transformations significantly jeopardize the realization of caring values by nurses in clinical practice (Adams, 2016). Healthcare and nursing practices are part of the sociopolitical and economic context that shapes ethical reasoning in clinical settings and challenges the ethical values of care (Green, 2012; Mercer & Flynn, 2017). With organizational focus on economic

costs and the restrictive course of the scientific-medical model, relational and ethical care have become difficult to attain. Emphasis is on providing faster care through technological methods, evidence-based practice, and standardized care protocols, which challenge core values of nursing and leave little room to build artful relationships that understand human experience and fit the particular needs of the individual patient (Enzman-Hagedron, 2004; Austin, 2011; Mercer & Flynn, 2017; Henry, 2018).

The Credibility of Caring Activities in an Economized Context

Critical nursing theorist Trudy Rudge (2013) emphasized that in an economic context defined by industrial processes as a model for the delivery of services in the healthcare system, nurses increasingly define good quality care as productivity, cost effectiveness, and time efficiency. Knowledge related to relational caring and emotional understanding is not considered credible, but rather delegitimized and undervalued by the popular economic, technical, and scientific discourse (Wall, 2010). Alaszewski (2005) demonstrated that technical care based on standardized procedures created a feeling in nurses that their knowledge and caring skills are undervalued compared to technical knowledge and guidelines. Instrumental rationality controls professional practice and directs nurses to adhere to calculable tasks and standards that take precedence over engagement in such practices as compassionate patient care (Roberts & Ion, 2014, 2015). Other scholars discussed that in the technologically oriented healthcare system, nurses pay little attention to care and delegate it to nursing assistants because nurses' focus is on tasks that are medically oriented and considered of more value to the system (Marañón & Pera, 2017). The reductionist focus of the modern healthcare system on reducing costs and enhancing efficiency requires acceleration of care processes that do not leave enough time for nurses to know their patients and orient management authorities to overlook nurses' inability to

communicate with patients and provide emotional care (Debesay et al., 2014; Zolnierek, 2014). Organizations that adopt Lean management with a focus on controlling resources and the acceleration of processes spare little or no time and social space to establish relationships that attend to the emotional concerns of patients (Macdonald, 2007; Almerud et al., 2008; Debesay et al., 2014) . Brophy (2008) emphasized that managerial authorities are found to be less attentive to nursing care ideals such as holistic care and are more interested in other visible and quantifiable activities such as bed occupancy and number of discharged patients. Collecting empirical quantitative data to prove economic efficiency has become more important for managers than the initial work of professionals (Dalal, 2017). In fact, a mere focus on traditional caring activities is no longer functional in serving contemporary healthcare requirements, in which healthcare professionals are expected to utilize technology and provide economic and faster care that responds to the high pressure on hospital beds and the growing number of community patients who are in need of healthcare (Allen, 2014). Relational and holistic aspects of care are not easily quantified and thus, are difficult to attain in the cost-effective discourse, especially with the reduction in number of nurses and with time constraints (Oldnall, 1996). The moral ecology of nursing is threatened in such a healthcare environment that devalues human relations and considers both nurses and patient as commodities (Weiss et al. 2009; Sumner, 2010). According to Pellegrino (1999), who studied the moral consequences of the commodification of healthcare, considering healthcare as a commodity in the competitive healthcare market has damaging effects on the ethics of patient care. He concluded that healthcare is a human right and thus protecting healthcare from economic and market effects is a social obligation. In this perspective, the political economy imposes a stressor on healthcare

professionals to uphold their ethical standards within a work culture that is focused on financial principles and fiscal outcomes (Faith, 2013; Rudge & Thorne, 2013).

Deficient Forms of Care

According to Barnard & Sandelowski (2001), efficient human care as defined by an economic rationale creates an environment for nurses to provide impersonal care that dehumanizes the patient. Goodman (2014) warns that managerial instrumental rationality governs the perception of health workers with certain norms and habits that may spoil not only the compassionate intersubjective relation with the patient. It also threatens the ethical essentials of care by introducing distorted forms of social relationships into the clinical practice of nurses that contribute to conditions of indignity and neglect in care. According to Robert Francis (2013), who examined causes of poor care and unnecessary deaths in the Staffordshire NHS Foundation Trust in England, the failure of nurses to provide appropriate care is attributed to a loss of core caring values of compassion and respect and to a "culture of complacency" that prioritizes cost containment values and interests of corporates over patient safety (Francis, 2013, p. 10). Roberts and Ions (2014, 2015) explain that habituation of poor care was not likely due to individual pathologic behaviour, but rather to an instrumental rationality that spreads in healthcare organizations and socializes inappropriate and dehumanizing care. Willis et al. (2017), who studied the influence of NPM on nursing care, conclude that cuts and austerity measures negatively influenced quality of care provided to patients and increased workload on nurses that contributed to instances of "missed care." Some nursing theorists state that the spread of inequality in the ability to access healthcare is institutionalized and practiced by nurses under the influence of socio-economic and political discourse structuring the provision of healthcare (Kagan et al., 2014; Marianne, 2014). The widespread failure of compassionate nursing care is

also due to the failure in recognizing the dignity of patients (Hayter, 2013). According to Jacobson (2009), the violation of dignity in healthcare has become prominent with the rise of neoliberalism and the focus on rigid routines and control of expenses rather than individual crises and meeting patient needs. The detachment of individual values is considered a violation of personal choice and personhood of patients that could lead to behaviours of indignity such as rudeness, disdain, discrimination, and even assault (Jacobson, 2009; Barclay, 2016).

Nursing scholars de Vries and Timmins (2016) assume that in today's healthcare system, decreased attention to caring values has led to erosion in the practice of care. From his perspective, Sumner (2010) explains that when nursing care is replaced through services provided with a purely scientific and instrumental rationality, then the caring relationship is destroyed and the nursing social contract to provide accountable and compassionate care is violated. With increased focus on funding problems and budgeting balances, nursing care is becoming oriented towards routine tasks that fit organizational goals rather than patient needs in a process that detaches and dehumanizes the patient (Tonuma & Winbolt, 2000). From a Marxist point of view, Taussig (1980) explains that the commodity structure of capitalism creates contradictions in healthcare through a culture that focuses on the disease rather on human relations. Unless nursing professional actions aim to satisfy the specific individual needs of patients, the scientific and technical skills of nurses will be inefficient and empty of ethical significance (Mecugni et al., 2015). The technical-economic rationality prevalent in nursing practice has contributed to dysfunctional care that breaches the moral commitment of nurses to act according to ethical professional values and advocate to protect the rights of patients (Rudge &Thorne, 2013; Goodman, 2016).

Patient Advocacy

Nursing theorists and nursing associations concur that advocacy for patients is a particular ethical value in nursing (Canadian Nurses Association, 2006; Alidina, 2014). However, nursing scholars like Rodney et al. (2009) explain that in the case where organizational policies compete or conflict with patient interests, nurses have a moral obligation to advocate for the right of patients and implement efforts to make choices based on their own values and caring ethics. Galuska (2016) assumes that the inability to protect the rights of the patient leads to the erosion of public trust and threatens the ethical obligation of nurses to act as patient advocates. Yet, acting as a patient advocate is a fundamental value of professional nursing practice in which the nurse protects the patients' rights of self-determination in meeting their needs and attaining or maintaining autonomy (Alidina, 2014; Galuska, 2016). Hank (2013) contends that advocacy for patients must include social advocacy, meaning nurses must address aspects of social justice by focusing on organizational, social, economic and political factors that negatively influence well-being, create inequity in healthcare, and constrain the delivery of care to patients who are in need of the service. According to Marianne (2014), the complexities of the healthcare system and the spread of inequities that influence the health and well-being of individuals require nurses to advocate for social justice especially for vulnerable and marginalized patients.

Although the advocacy role of nurses is reinforced in codes of ethics, it is poorly defined in operational terms (Cole et al., 2014). Hanks (2013), who studied social advocacy in nursing, concluded that nurses do understand the importance of social advocacy, but the concept is not well incorporated in practice and graduate nurses are not well prepared to practice as advocates at the societal level. He adds that what is lacking is an approach to articulate social advocacy and contribute to change through actions that challenge the status quo at political and societal levels.

One main obstacle to advocacy is the restriction of individual autonomy of patients imposed by the organizational hierarchy in the healthcare context that dictates policies and rules and that limit individual options and choices. Unless the organizational culture is conducive to advocacy, engaging in patient advocacy would not be sufficient (Cole et al., 2014).

Paradoxical Situations and Ethical Dilemmas

Despite the change in the provision of the healthcare system and the strengthened attention on financial values and economic efficiency that threatens nursing caring values, Canadian Nurses' *Code of Ethics* is still holding professional nurses accountable for providing compassionate and ethical care that honours dignity and respects patients' autonomy in making informed decisions about their health and well-being (Canadian Nurses Association, 2017). Dignity and personhood are further emphasized by reminding nurses when dealing with patients that they should "take into account their values, customs and spiritual beliefs, as well as their social and economic circumstances without judgment or bias" (Canadian Nurses Association, 2017, p.12). Yet, the financial efficiency values dominant in the Canadian healthcare system do not support the humanistic moral path of nursing care (Austin, 2011). According to Rankin and Campbell (2006), Canadian nurses are engulfed in a financially oriented public agenda that has shifted nursing from its main moral concerns and created dissonance for nurses about their identity. This shift is placing nurses in ethical dilemmas because they are unable to advocate for patients and provide good care that identifies individual needs based on compassionate relationships (Goethals et al., 2010; Austin, 2011). Tension between the two opposite ethics is worsened by power relations and managerial pressure to conform to organizational goals and role expectations (Cribb, 2011). Within this ethical dilemma, nurses are caught in a paradoxical situation where they are required to act according to their professional values and respond to

needs of patients, but at the same time they are being held accountable to managerial values that require them to provide care based on economic ethics and standardized formulas (Hillman et al., 2013; Goodman, 2014).

The Need for a Critical Theory of Nursing Actions

Multiple nursing theorists and scholars have stated that global emphasis on the economic and biomedical standards as foundations of healthcare raises pressing concerns that some aspects of nursing, as a profession grounded on values of compassionate interaction, holistic care, and respect of patients' unique traits and situations, are no more sustainable or have become excluded or impossible to practice and lost (Mannion et al., 2005; Read, 2007; Gallagher, 2013; Adams, 2014; Rudge, 2015). In the current healthcare environment, nurses are practicing with a positivist philosophy that disagrees with nursing's original caring nature (Thomas, 1995) and essential nursing values such as compassionate relationship with patients, advocacy, holistic care, and other ethical aspects of care are not well incorporated into nursing practice and are difficult to apply (Oldnall, 1996; Liaschenko & Peter, 2004; Gallagher, 2013; Adams, 2014; Rudge, 2015; Pajnkihar et al., 2017).

Green (2012) states that articulating an ethics of care in nursing practice requires attention to the theoretical underpinnings of nursing ethics and its role in guiding clinical practice. In the same vein, Yancey (2015) contends that without a solid base in nursing theories, nurses are at risk of taking clinical decisions without an adequate perception and understanding of the meaning of nursing situations as caring phenomena. Because they are not able to theoretically rationalize their professional practice, nurses refer to managerial and other external rationalities to validate their activities (Clarke, 1999, 2011; Aggleton & Chalmers, 2000). Thus, nursing care is prone to change to a set of tasks that serve organizational interests and external

demands (MacDonald, 1995; Karnick, 2014). According to Maben et al. (2006), it is evident that a theory-practice gap is preventing nures from realizing the potential of their work, resulting in work distress, burn out, forms of neglect in care, and distortion of job expectations. Lack of conceptual clarity on what caring is deprives professional nurses of theoretical principles that could guide them in their daily practice and leaves them confused in their clinical judgement and with the impression that theory is detached from their practice (Colley, 2003; Kitson, 2018). An absence of a theoretically informed definition of nursing care reflects a crisis situation that requires nurses to work transparently towards establishing a firm base of knowledge pertinent to nursing practice (Clarke, 2011). But confusion about the theoretical basis of care does not mean paying less attention to a concept that is needed more than at any time in the past to ensure that nursing practice is not rendered into a set of assigned mechanical tasks (Adams, 2016).

Hoeck and Delmar (2018) emphasizes that nurses have a social mandate for assisting patients to achieve their well-being and thus, nursing ontology and epistemology need to be developed and amended based on societal needs and developments. Thomas (1995) contends that nursing theories and ethics address the demands of a changing society and nurses should look for new ways of gaining knowledge that does not perpetuate domination and oppression in practice. The spread of an economized culture focused on financial and fiscal outcomes requires looking beyond nursing clinical borders into the political-economic rationality within which nursing practice takes place (Faith, 2013; Duncan et al., 2014). A critical framework that examines ideology and politics that shape the provision of healthcare services in general, and nursing care in particular, is required (Rudge, 2011). Adopting a critical perspective not only allows nurses to reflect critically on their behaviour and develop awareness of what constitutes good care (Goethals et al., 2010), it also provides emancipation through the critique of domination,

revealing connections between political, economic, and social powers shaping practice (Mill et al., 2001). Karnick (2014) emphasizes the critical need for a theory based on nursing practice. A critical theory that is informed by practice and has its norms derived from the clinical lifeworld of nurses can maintain conditions of good life and represent principles of social freedom, equality, and justice (Holmes & Warelow, 1997). Identifying normative dimensions of care based on empirical data of nursing action can justify ethical care in an economized context (Friesacher, 2017). An emancipatory perspective to care can empower nurses to advocate for social justice and patients' rights in the complex system that provokes inequity among patients (Chinn & Kramer, 2011; Marianne, 2014). This approach can illuminate actual work conditions lived by nurses, counteract accepted social reality, and promise actual transformation in the right direction (Mill et al., 2001; Wall, 2010). A critical theoretical framework with its emancipatory praxis not only gives nurses opportunity to challenge the status quo but also reconstructs reality by developing new meanings and insights that serve nursing professional practice and the clinical interests of nurses (Thompson, 1987; Kagan et al., 2009).

Summary

In their attempt to explain the meaning of care or caring, nursing theorists refer to different ontological foundations that broaden the meaning of care and contribute to ambiguity and contradiction in the conceptualization of a definite meaning of caring. The different epistemological approaches to nursing also make nurses confused about the focus of nursing in clinical practice. This complexity in understanding and enacting nursing care is exacerbated by the global rise of neoliberalism and the emergence of a political economy as a dominant discourse in healthcare. The introduction of managerialism and the implementation of business methods and market-based models in healthcare, associated with government underfunding, has

led to cuts in services and layoffs of healthcare professionals, thereby increasing workload and decreasing quality of care provided to patients. The practice of care based on business and economic efficiency values has influenced the provision of care and reconfigured the perception of nurses around the meaning of good care, which has made it difficult for nurses to practice according to their professional caring values. The prevalence of a technical-economic rationale in healthcare has left nurses unsure about the ethics of their practice. Nurses are left to struggle between commitment to their professional values and their accountability to the efficiency goals of the organization. Failure to take ethical decisions informed by nursing theories has increased the vulnerability of nursing to change into a set of commodified tasks and activities that follow managerial and other external rationalities to justify their actions. Some scholars consider this a situation that necessitates a critical theory of nursing that is not abstract in its foundation but realistic and based on what nurses do in their real clinical work. A critical theory based on empirical findings of nursing action is recommended in the literature to identify norms of care that can guide nurses in taking ethical decisions amid a complex healthcare context dominated by technical and economic efficiency values.

Chapter Three: The Theoretical Framework

Introduction

This chapter will describe the overarching theoretical framework that guided the methodological approach of the study. In qualitative research, theories serve as the foundations of the researcher's assumptions (Giacomini, 2010). They also represent the epistemological "lens" that orients and frames data collection and analysis and the identification of phenomena under study and the relationships between them (Anfara, 2008). Critical Social Theory (CST) was adopted as a theoretical approach in this study. Researchers usually utilize critical theory to critique problems of domination and alienation in society and explore tensions between the spread of ideology in social life and the ideals held by social individuals (Creswell, 2013). Critical theorists go beyond the notion of empirical research in that they adopt a normative theoretical framework to connect theory and practice with the aim to unveil hidden discrepancies between the subject's reality and how this reality "should be," according to the norms defined through critical theory (Polit & Beck, 2012). Because critical researchers are usually interested in addressing issues of injustice and inequality through their politically orientated thinking and analysis of social phenomena (Carspecken & Apple, 1992), I would like here to remind the reader that it was my personal experience as a nurse and my interest in politics and sociology that has driven me to undertake this research from a social critical theoretical perspective.

Before going into more depth with the discussion of the theoretical approach, I provide a brief overview of the content of this chapter. The following section will present a short description of Critical Social Theory (CST) historically associated with the so-called Frankfurt School in Germany (Turner, 1996). I will focus on the aim and epistemology of CST which coincides with the emancipatory goals of the study. After that I will discuss the concept of

nursing action, which constitutes the building block of this study. I will show how starting from nursing action is coherent with the interest of CST in the critique of society based on the empirical reality lived by social individuals (Antonio, 1981). Then, I will discuss in detail the theoretical framework that informed the study.

Critical Social Theory

Critical Social Theory, as I use it in this study, originated in the Frankfurt School, which developed in Germany in the first half of the 20th century with the work of scholars such as Herbert Marcuse, Max Horkheimer, Theodor Adorno, and many others (Fuchs, 2015). After the rise of German Nazism in 1933, many of these theorists were forced to emigrate to the US and other countries where they continued to develop critical theory (Kellner, 2009; Bronner, 2011). The term critical social theory "was launched in 1937 by Max Horkheimer, the Director of the Frankfurt Institute for Social Research" (Turner, 1996, p. 56). This tradition of critical theory developed a Marxist analysis of capitalism further and combined the emancipatory-Marxist perspective with a psychoanalytical perspective and the work of Weber on rationalization to better understand how capitalism dominates and determines the way people experience their life and act in society. Horkheimer, Adorno, and their colleagues also provided a profound critique of the perceived neutrality and objectivism of technical knowledge developed by natural scientists, who believed that knowledge can only be achieved through empirical inductive observation and logical scientific deduction (Polifroni & Welch, 1999; Bachmann & Moisio, 2020). Frankfort school critical theorists believed that technical knowledge and scientific rationality contribute to social domination and oppression of individuals, and they aimed to understand how socio-economic conditions shape human experience without any noteworthy

form of resistance. They criticized post-positivists' conviction that the methodologies of natural sciences should also be used in the humanities.

According to critical theory, individual knowledge and actions cannot be separated from the wider economic context because knowledge is not neutral but determined by particular political and economic interests (Giacomini, 2010). Thus, this form of critical theory analyses how knowledge is distorted in a capitalist society in order to identify better forms of knowledge that are not exploitive (Porter, 1998). Critical theoretical approaches aim to liberate the subject from an ideology that keeps the subject in the belief that how the world exists is the result of a rational and natural evolution (Leonardo, 2004). By enabling the subject to realize that the world in which he or she lives is the result of societal, economic, and political conditions, critical theory challenges the subject to act against his or her oppression (Carspecken, 1996). Emancipatory knowledge constitutes the core of critical theory where people can share their own perspective and reach agreement without external pressure or interference (Ray, 1999). Emancipation is the process by which individuals become aware of the ideology, behaviours, and processes that prevent them from living their own life and serving their own interests (Thomas, 1993; Polifroni & Welch, 1999). Accordingly, the focus of a critical theory is social praxis and implementation of strategies that prevent domination and maintain social justice, preserving the dignity and identity of individuals who are owed the right to act as autonomous members in a society free of coercion (Aluwihare-Samaranayake, 2014; Ray & Turkel, 2014).

CST is interested in an immanent critique that focuses on exposing tensions and contradictions between existing social interactions and the ideals held by individuals with the aims of identifying contextual oppressive factors and alternative possibilities that liberate individuals from domination (Antonio, 1981). One of the main aims in using a critical approach

to guide this study was to connect the micro level of what nurses do in their actual daily clinical practice to the meso level of the organizational structure and to the macro level of political and economic structures that can shape and influence the actions on the meso and micro levels (Cook, 2005; Friesacher, 2017).

Nursing Actions: The Starting Point

In order to analyse nursing care from the perspective of nurses themselves, the starting point is nursing actions that take place in daily clinical practice. Analysing nursing actions means that the study will start with the micro level and focus on nurses' descriptions of what they actually do when caring for their patients. It also means that the analysis will not start from a predetermined set of idealistic ethical principles of care that are either externally defined or internally established but will rather identify norms immanent in the actual clinical practice of nurses as described by the participants (Friesacher, 2017). Based on a sociological perspective, I will also define nursing actions as a particular form of social action. In sociology, a social action is any behaviour that is meaningful to the acting persons and can be understood by revealing the subjective reasons and rationality that the individual attaches to his or her actions (Weber, 1968). Thus, in this empirical study, nursing actions are not predefined but rather understood as social actions that can be interpreted and understood by analyzing the way they are carried out and in respect of their intended and actual consequences. Furthermore, understanding nursing actions as social actions implies that explaining nursing actions are not limited to an analysis of intended meaning of actions but rather interpret human behaviour as influenced by context and actions of others (Weber, 1968). Contextual analysis of nursing actions resonates with the basic assumption of critical theory, which states that actions are shaped and controlled by macro factors such as social conduct, social norms, and economic-political constraints dominant in culture

(Carspecken, 1996; Polifroni & Welch, 1999). This approach is also congruent with the form of immanent critique that aims to critique society through empirical social analysis, which exposes internal contradictions between the ideals held by social members and existing social norms (Antonio, 1981). Axel Honneth (2015) proposed that common ideals of justice in society should not be determined based on abstract principles that are neutral or external but through empirical analysis of ethical dimensions and social norms that take place in society during social interactions. He considers that the immanent norms in social actions that make these social interactions possible in the first place and that are mostly opaque to the actors, can be reconstructed empirically and used as normative founding blocks for a critical theory. Honneth explains that these norms can be present either explicitly or implicitly in the social interaction of individuals (Buckwalter, 2016). Applied to nursing care, this theoretical approach would contribute to an ethics of care, which is based on empirically generated norms that emphasize relationships between people and analyses normative dimensions in the local interactions between nurses and their patients and in which nurses try to realize what they see as good practice (Pols, 2014). These reconstructed norms promise to offer new theoretical insights to the definition of care derived from nurses' accounts as well as provide opportunity to critique the current nursing situation (Friesacher, 2017). A framework that starts from the point of practice of nurses can avoid the problems of abstraction and idealism that have made it very difficult to relate nursing theory to clinical practice (Kitson, 2018). Such a critical theory of nursing actions can also empower nurses to act according to their own definition of care that serves the interests of the discipline (Cook, 2005; Friesacher, 2017).

Theoretical Framework

The analysis of the empirical data in this study is informed by a number of critical theories that are used to arrive at a theoretical conceptualization of nursing actions. In what follows, I will briefly summarize some pertinent aspects of Jürgen Habermas' discussion of the relationship between knowledge and interest (1987a) and his work on discourse ethics and communicative action (Habermas, 1984, 1987b). Habermas' seminal work, *Knowledge and Human Interest*, will be used to define my critical stance and to situate myself in the tradition of critical theory. I will also dwell on Axel Honneth's theory of recognition (1995), which is the principal theory informing this study. Honneth broadened Habermas' theoretical dimensions of communicative action by considering recognition of identity a necessary antecedent to communication and human relations. Habermas' work on communicative action in combination with Honneth's theory of recognition will provide the theoretical foundation to better understand what nurses actually do in their everyday work. However, nursing actions entail a very specific form of social interaction, one that is not limited to verbal communication and talking but extends to the personal aspects of private life including intimate bodily contact. The theoretical framework will be complemented with considerations of phenomenology and corporality (Merleau-Ponty, 1962; Benner & Wrubel, 1989; Schmitz et al., 2011) as decisive approaches to analyze nursing actions. I will demonstrate that this dimension of corporality is part of how Habermas conceptualized the practical interest of understanding (See Appendix A for theoretical framework diagram). Lastly, reification as analyzed by Honneth (2008) will be presented as a result of "forgetfulness of recognition" and as a critical perspective of the standardization of care and the ongoing neoliberal transformations in nursing practice. This critical theoretical framework is expected to identify connections between nursing actions and contextual factors

shaping the work of nurses and provide a better chance of developing a critical theory based on nursing actions as defined and understood by the participants themselves.

The Three Interests of Knowledge

Habermas' *Knowledge and Human Interests* is his first systematic work aimed at renewing the critical theory of the first generation of the Frankfurt School, scholars like Horkheimer, Adorno, Marcuse, and others. In his inaugural address at the Frankfurt institute in 1965, Habermas (1987a) criticized positivism, which had spread widely since the early 19th century, and was considered decisive to determining the truth of scientific statements and the only possible way for any scientific practice or inquiry, including social sciences, to develop. The predominance of the scientific experimental methodology of natural sciences, reflected in objectivism, observation, control, and prediction, placed scientific-technical rationality or the "philosophy of science" at the top of the "hierarchy of evidence," while "the knowing subject" and the practical experience of the human subject was removed from the system of knowledge formation (Habermas, 1987a, p. 67-68). Habermas rejected the positivist condition of knowledge formation, which separates the subject and the object. Instead, he tried to recover the "repressed" role of subjective experience and self-reflection in the production of knowledge (Granero-Molina et al., 2015; Rolfe, 2017). Thus, Habermas refused subordinating the social sciences to the positivist epistemology of the natural sciences (Rolfe, 2017) and criticized empirical-analytical sciences structured in a "law-like manner" that led to the "illusion of objectivism" and removed the role of "self-reflection" from the boundaries of scientific disciplines (Habermas, 1987a, p. 69). By reducing knowledge formation to what can be observed and measured, theoretical knowledge would be narrowed down to a form of science that excludes the practical knowledge of understanding that cannot be quantified (Granero-Molina et al., 2015).

In contrast to the empirical-analytical scientists who emphasize that knowledge is free from any interests, at least in the context of justification, Habermas (1987a) states that knowledge is bound to human interests, which are historically rooted and thus denied the possibility of neutral or pure knowledge that is independent of the observer. He believes that actions and behaviours are shaped by knowledge and the perceptions individuals have about reality. He insists that scientists have common knowledge interests, which act as "cognitive strategies" that characterise their respective scientific approaches, guide their inquiries, and influence the results. Accordingly, Habermas differentiates between three interests: technical, practical, and emancipatory. Technical interest leads to empirical-analytical knowledge that is interested in control and prediction. Technical knowledge focuses on rational actions embodied in natural sciences that try to explain nature in terms of cause and effect. This knowledge is interested in studying reality based on dependent and independent objects and tries to control variables to reach a specific result. It is motivated by the interest to objectify processes through control by quantifiable measurements (Granero-Molina et al., 2015). But even in this kind of research it is necessary that scientists in the scientific community must come to minimal agreements about what the legitimate objects of research are, and what tools and methodologies they are allowed to employ (Habermas, 1987a). Yet, this dimension of empirical-analytical knowledge is concealed in the post-positivist's conceptualization of sciences. Thus, Habermas, based on the perceived interests of knowledge, criticized the conceptualization of empirical-analytical sciences as purified of subjective processes of understanding and considered neutrality an illusion of the post-positivist's scientific community.

On the other side, practical interest is what drives historical- hermeneutic sciences aiming to understand social life through phenomenological-hermeneutic methodologies (Habermas,

1987a). Unlike empirical-analytic sciences, which emphasize objectivity and distance from the objects they study and exclude the researcher as an experiencing subject for the sake of objectivism, knowledge in this branch of human sciences focuses on interpreting situations during intersubjective interactions with attention to understand reality as perceived by another person. Habermas (1987a) concludes that the main difference between empirical-analytical natural sciences and the practical or human sciences is the "orientation of the knowing subject" (p. 141). He explains that while in technical interest, the subject is excluded or actually excludes himself as an experiencing subject (researcher) for the sake of objectivism, knowledge in human sciences is produced through empathetic understanding of oneself and others that is deep and subjectively constructed.

Habermas was not only critical of the positivism in technical interest but also in the phenomenological and hermeneutic sciences that aimed to arrive at another form of positivist knowledge, this time based on understanding. Understanding the subjective meanings held by individuals alone was not sufficient without recognizing that subjective meanings are deeply embedded in and shaped by the dominant social, economic, and political contexts (Kim & Holter, 1995). Habermas criticized both technical and practical knowledge interests, which produce nomological forms of knowledge that are accepted as true and diminish the possibility to criticize and change societal conditions. He proposes a third "critical" knowledge driven by emancipatory interest that can increase awareness of reifying forces and free individuals from conditions of domination (Habermas, 1987a). He proposes that a critical perspective would enable the subject to self-reflect and analyze the societal condition in which it lived in addition to providing the tools to critique and change oppressive situations. Combined with the interest in understanding oneself and others, this critical dimension reveals distortions of reality and

provides individuals with the chance to act together in order to change the world. The outcome of critical knowledge is self-liberation and the development of the autonomous person, who functions according to his or her own interest rather than according to imposed conditions. When individuals interpret and reflect on their situation, they become aware of the potential to act autonomously with no pressure and to take an active role in their own life (Granero-Molina et al., 2015).

This third reflective interest opposes the non-reflective epistemology of technical interest that has created a "false consciousness" about positivism in nursing (Rolfe, 2017). It also offers legitimacy to critical theory as a scientific endeavour that considers hermeneutics and phenomenology as an epistemological approach. By combining reflectivity, understanding, and critical perspectives, Habermas paves the way for nursing to establish an alternative epistemology to technical rationality based on an understanding of social actors (Rolfe, 2017). Because hermeneutics and phenomenology are reciprocal and intertwined, understanding and interpreting the subjective meanings of the 'life-world' of social actors requires exploring the phenomenological and subjective meanings that individuals hold about actions or situations (Staudgil & Berguna, 2014). In this vein, the critical reflective interest of knowledge gives credibility to the tacit knowledge acquired over experience and is considered more important than the explicit and visible knowledge in terms of professional practice (Polanyi, 1966). In nursing, this knowledge is related to the "know how" part of care that comprises the art of nursing practiced by the experienced nurse, who refers to embodied experience and intuition in managing clinical situations rather than to pre-established protocols that guide the novice nurse in "what to do." (Benner, 1984).

In the context of the third "critical" knowledge theorized by Habermas, Chinn and Kramer (2011) acknowledge the significant impact of Habermas' emancipatory interest on critical scholars in nursing. They propose that Carper's (1978) four patterns of nursing knowledge (empirical, personal, aesthetic/artful, and ethical) should be approached through emancipatory praxis that addresses institutional as well as contextual social and political factors interfering with nursing practice and patterns of knowing. Despite the fact that nurses' ethical knowing drives them to address health and social inequities, the socio-political processes are not always well understood. Thus, Chinn and Kramer (2011) added a fifth pattern of "emancipatory" knowing, which establishes the basis for a theory of knowledge development in nursing. Although they suggest integrating critical emancipatory knowledge as an overarching approach of the four patterns of knowledge, they do not develop a critical theory with normative dimensions that can justify nursing actions and guide nurses in the implementation of such a critical perspective in a clinical setting.

It is worth noting at this point that this research is situated in the domain of critical theory and follows an emancipatory interest. From this position and based on empirical findings, I will try to develop a nursing approach that would combine empirical-analytical knowledge with other different forms and patterns of knowledge, with an emphasis on the critical framework that can equip nurses with the normative dimensions of care that can be used as tools to criticize transformations and look for alternative ways of care that fit the interests of both nurses and patients. I hope that the theoretical framework adopted in this study will give insight into what nurses do in real clinical settings in order to establish the foundation for a critical theory of nursing actions. A critical approach to care that is established on clear philosophical-theoretical

underpinnings can inform and justify nursing practice, enabling nurses to resist the domination of a technical-economic rationality and work towards advancement in professional practice.

Phenomenology and Corporality

Phenomenological approaches have been used in nursing sciences for quite some time, because it seemed as if the emphasis on a phenomenological dimension of care would provide a valuable way to differentiate nursing care from care provided by other healthcare professionals in the medical field (Benner & Wrubel, 1989; Friesacher, 2017). Probably the most sophisticated philosophical approach to nursing care from a phenomenological-hermeneutic perspective was developed by Benner and Wrubel at the end of the 1980s. In what follows, I will draw on their work and on the work of non-nursing phenomenological philosophers to conceptualize why understanding this dimension has outstanding significance for a critical theory of nursing care. According to Benner and Wrubel (1989), phenomenology is based on the ontology that a person is a self-interpreting "being" who is not predefined but becomes defined through the course of life (or biography) in a non-reflective manner that is not merely rational. When people are "situated" in an experience of an event (like an illness), they try to make sense of this event or situation. They do so by engaging in meaningful interactions with others and by interpreting and trying to understand the situation and its immediate context. They understand a specific situation in terms of its meaning to the "self" based on knowledge and experience accumulated over their course of life. In this sense, "being" precedes knowing because knowing is the result of life events that made a "being" what it is – and thus, every being experiences and interprets a situation differently depending on biographical background. Unless we are able to unravel the subjective perceptions that persons have of their own life experience, we cannot know what is

meaningful to a person because meanings and concerns are personal, situational, and embodied (Benner & Wrubel, 1989).

According to Hermann Schmitz, a German phenomenological philosopher, phenomenology is a description of experience relevant to a specific person in a specific time and specific context with no attempt to generalize experience (Schmitz et al., 2011). It reflects how things are perceived from a personal perspective influenced by a specific context, culture, and historical background. Schmitz explains that this specific and privately embedded phenomenological experience has been distorted by theories and conceptual frameworks of abstraction (that Habermas characterizes as empirical-analytical sciences) which assume that all facts are scientific, observable, and objective. He adds that in this scientific paradigm, what is left behind is the value of the embodied personal experience of the "feeling body," or what he calls the "corporal body," which constitutes a rich source of feelings and meanings necessary for a holistic understanding of situations. Thus, Schmitz makes an important distinction between the physiological or biomedical body (in German *Körper*) and the lived and experienced corporal body (in German *Leib*). These two dimensions are not easily compatible with each other, because they are based on competing conceptualizations of the body.

Merleau-Ponty (1962) provides an important explanation to understand the corporal body and its embodied meanings and feelings. He explains that people perceive themselves and the world based on experiences that are situational and changeable in space and time. He denies the assumption that the body is a passive object (corpus) and asserts that the corporal body is a precious source of information and a central descriptor that shapes perceptions and action according to place, time, and interaction with other people. He theorizes that the corporal body is an ambiguous entity that constitutes the body and is constituted by it at the same time. Our body

is involved in the everyday life through which it embodies knowledge in a fluid, ongoing, and dynamic manner. Correspondingly, Merleau-Ponty develops an understanding of bodily mediated knowledge as a system constituted of an integrative nexus of "self-others-world" (Merleau-Ponty, 1962, p. 69), which means that the body is in dynamic interaction among itself as a subject, people outside it, and the material environment, all situated in the living world of the body.

The superiority and precedence of corporal perception is a constant topic for Merleau-Ponty (1962) who considers perception the pre-reflective basis that precedes consciousness and is situated between the subject (mind) and the object (physical being) representing both entities. Perceptions are embodied as tactile, visual, olfactory, or auditory ways. Similarly, Schmitz describes the corporal body as an entity usually filled with emotions, perceptions, subjective orientation, and bodily feelings that take place in response to the external atmosphere (Schmitz et al., 2011). He considers affective involvement the main characteristic of corporality that gets engaged with what is going on in the immediate context and reacts promptly through body gestures that reflect different interpretation such as pain, joy, sadness, distress, shame, etc. Merleau-Ponty (1962) critiques the reductionist view of empirical realism and idealism because both types of knowledge diminish the value of the life-world perception and sensation and fail to explain the phenomenon of the "situated body." He confirms that knowledge, which is rooted in experience and embodied in the social person, is central for learning and understanding. According to Lloyd (2010), the focus on the cognitive-scientific sources of knowledge, which is the dominant discourse in Western society that considers the human mind the main processor of knowledge, legitimized the assumption that knowledge is objective and measurable. The cognitive stance also led to a decontextualization of information and the production of guidelines

and frameworks that alienate individuals from their sociocultural environment, thus marginalizing corporal information and the subjective experience of individuals. However, learning is a social practice that is constructed by social subjects who embody knowledge during their course of social interaction (Lloyd, 2010).

For Schmitz, the corporal body that represents the "affective atmosphere" of situations has been challenged by the Cartesian model that limits human understanding to the material body studied by measurements, statistics, and experimentation while ignoring sensations and perceptions of the "feeling body" (Schmitz et al., 2011). He explains that the aim of this dualism is to understand the self and the world in a routinely universal manner by dissecting the person into two separate spheres: a material body and a soul or a mind. Consequently, the private inner world of the person is eliminated and the significance of emotions in specific situations is lost and missed from understanding the human experience. Yet, failure to connect the subjects to their inner spheres and emotions deprives them from self-ascription, or the ability to identify something with oneself through affective involvement with one's own experience. Denying this form of understanding that explains one's own feelings while diverting the focus to external "objective" sources for interpretation of such inner and subjective situations, diminishes the locus of identity that defines the self as something peculiar, singular, and different from others. Failure of self-ascription while giving external interpretations to private meanings and inner situations induces objectification of the person (Schmitz et al., 2011). Schmitz confirms that redefining the relation between the body and the thinking mind in a non-dualistic manner is only possible through a phenomenological approach, which describes the lived experience in a holistic manner that recognizes the personhood of the individual.

In nursing care, Friesacher (2017) explains that corporality is related to the perception of the internal and subjective experience of illness lived by the patient. It reflects the real nature of the person revealed through a relationship of "being with" in the lifeworld of the person to understand the internal atmosphere and real situation of the patient through his or her own perspective. It is thus a concept that prioritizes the subjective self-experience of the patient over the objective approach that aims to distance and control the body. Benner and Wrubel (1989) consider phenomenology an essential approach to nursing care through which nurses access the internal world of the patient and reinterpret meanings about illness in order to help patients cope with illness, which they define as a status of imbalance that results from disease affecting the physiologic functions as well as the psychological balance of the body. Similarly, Sebold, Kempfer, Girondi, & Prado (2016) propose that "being-in-the-world" of the patient represents care that requires understanding the existential status of the patient in a medium of a subjective relationship of concern and esteem. Accordingly, nursing care based on conversation and "being-with" or "being-in-the-world" embodies responsibility for the others' needs in a state of harmony and respect that enhances autonomy and self-determination of the patient (Sebold et al., 2016).

Theory of Communicative Action

As emphasized earlier in this chapter, a critical theory must go beyond the phenomenological understanding by integrating an emancipatory dimension that enhances autonomy and self-determination of individuals. In a first step, I will refer to Habermas' ethics discourse developed in his monumental work on communicative action as a critique of capitalist societies inducing control and dominance (Kim & Holter, 1995). In the process of developing his theory of communicative action, Habermas critically assessed the concept of purposive rationality as described by Max Weber, who explained that rational actions can be construed and

guided by means-end analysis. A person acts because he or she wants to arrive at a specific goal. Weber called these forms of actions instrumental actions. Habermas criticized purposive rationality because it is success-oriented and utilitarian and follows an economic rationality, a characteristic of capitalism and commodification that reduces human actions to economic reasoning (Habermas, 1984; Hyde et al., 2005). Habermas then discussed another form of Weber's conceptualizations of action based on what he called a "value-oriented" rationality. In this case, actions are understood as based on considerations of moral values and ethical principles that the actor believes represent his/her own values. The actor acts in the way he/she does because he/she is convinced that this is the morally right thing to do. Habermas argued that this description is limited because it does not include the fact that actions are often negotiated between subjects and are based on rational argumentation and self-reflexivity that are deeply rooted in the linguistic communicative mechanisms of social actions (Habermas, 1984). Human beings always live in community with others and are always negotiating what to do and how to act. This is our human condition; we depend on others and we are in constant discussions about what should be done. We are not the sole subject that deliberates about the consequence of certain actions or the ethical value of an action, but we are rather in intersubjective exchange with others who help us decide how to act. This is what Habermas identified as communicative action – action that consists of dialogue among multiple social actors who exchange valid arguments and achieve a consensus about how to act.

This understanding of communicative action is distant from the purposive/ instrumental rationality of capitalist social structures and economic thinking (Habermas, 1984; Hyde et al., 2005). Communicative action is a form of communication between equal participants who enjoy freedom of speech and the free exchange of arguments without coercion or imposition by force.

For Habermas, in order to arrive at a consensus through communicative action, participants must be open to criticism, able to acknowledge others' points of view, can counter them with valid and rational counterarguments, and are willing and able to admit if they are mistaken. This form of communication must happen in a democratic process of cooperation and rational interaction to achieve mutual understanding and agreement. Thus, Habermas's (1984, 1987b) theory of communicative action differentiates between instrumental rationality that is purposive and success oriented, and communicative rationality that is oriented towards mutual understanding and consensus. Negotiation, understanding, and mutual agreement mainly through linguistic communication are the main features of communicative action (Bolton, 2014).

Habermas (1990) considered communicative action a moral action that takes place when equality and the right for self-determination are fulfilled in a free society, where all parties can participate without intimidation in a conversation about decisions that concern them all. He considers communicative action an attempt to meet one's needs while respecting the needs of others. He intertwined rationality with linguistic argumentation and defined it as "that type of speech in which participants thematize contested validity claims and attempt to vindicate or criticize them through argumentation" (Habermas,1984, p.18). This ethical discourse of communicative action is only valid when all participants have linguistic understanding and "communicative competence" in terms of the abilities to listen, argue, and give reasons for their options (Habermas, 1990). He considers actions rational as long as participants provide good and reliable reasons to convince other participants through verbal communication about the validity of claims (Habermas, 1984). Furthermore, participants must be truthful, meaning they must believe in what they argue for. Thus, according to the conditions of communicative action, agreement is senseless unless based on rational communication where each side negotiates using

valid claims to reach mutual agreement. Without communicative rationality, any agreement that is not reciprocal creates a state of coercion and oppression (Habermas, 1984; Polifroni & Welch, 1999).

Habermas (1987b) moved forward with his rationality and communicative action to develop the concepts of "lifeworld" and the "system," which represent two opposing social spheres. Lifeworld represents people's own assumptions, interpretations, and the knowledge they utilize in defining and dealing with particular situations (Bolton, 2014; Habermas, 1987b). The lifeworld in this meaning is closely related to what I have discussed earlier in regard to hermeneutic and phenomenological understanding of the person's lived experience. According to Habermas (1978b), it is within our lifeworld that we engage in communicative action and raise questions and validity claims in order to rethink the social order and justify our actions. This lifeworld is counteracted by the influence of the "system" that encompasses market forces, the law, bureaucratic authorities, and political economy (Bolton, 2014). Such components of society follow technical-scientific rationality that is success-oriented and mediated by the "steering media" represented by power structures and monetary regulations (Habermas, 1987b; Hyde et al., 2005). Within the logic of the system, decisions about social action become instrumental and based on a means-end analysis. In modern societies, components of the system supported by the steering media bypass the consensual communicative rationality of peoples' lifeworld and reproduce another type of lifeworld based on material values and purposive rationality (Habermas, 1987b). Under the effect of the steering media and political economy, purposive rationality can expand into social life and normalizes success-oriented actions (Habermas, 1987b). As a consequence, social actions will change from communicative actions to task-oriented actions that will replace mutual understanding by individualistic utility calculations. In

this vein, a critical theory of communicative action embodies a prominent political dimension in which citizens in the public sphere raise validity claims in a democratic process that attempts to influence the legislative institutions of the system (Habermas, 1996; Škerlep, 2014).

Habermas (1984) alerts us that purposive rationality can not only penetrate the lifeworld of social actors through the assistance of the steering media but also through the institutionalized practice of professionalized experts. The pathologic impact of the dominant political economy can even infiltrate into the private spheres of social life and symbolically reproduce capitalist ideology in our social interactions (McCarthy, 1984). Language itself and communication processes become objects of domination and create a culture that serves the bureaucratic forces of the system (Habermas, 1988; Fuchs, 2014). In conclusion, under capitalism, communicative action is suppressed, and instrumental rationality penetrates institutions, legal systems, and social relationships, which results in paradoxes in rationality leading to a "consciousness crisis" and colonization of the lifeworld with pathologic social norms, identities, motivations, and actions that carry the consequence of social life reification (Habermas, 1984, 1987).

Theory of Recognition

Axel Honneth broadens Habermas' theory of communicative action by criticizing that in order to be able to participate equally in the communicative processes, one must first of all be recognized as a person. Also, while Habermas restricts communicative action to the rational exchange of valid arguments, Honneth contests that this is a too-narrow conceptualization of communication because it does not address the moral expectations and emotional experience of individuals, especially those who are not engaged in negotiation or whose voice is not heard or neglected (Honneth, 1996). In his book *The Struggle for Recognition,* Axel Honneth, a German philosopher and a social critical theorist, attempts to answer the question of what it means to live

a good life. According to Honneth, critical theorists who have handled social problems have failed to provide an answer based on normative dimensions that are empirically rooted (Honneth, 1996). Honneth agrees with Habermas that the economization of social relationships, as a consequence of capitalism, leads to domination and reification of social relations (Petherbridge, 2013). He also agrees that intersubjective interaction constitutes the normative basis for social critique. However, he departs from the concept that social pathologies are merely due to conflict between the lifeworld of social groups and the system (of the market or the state) and considers the use of linguistic rational argumentation an insufficient norm to resolve social conflict. Honneth does not abandon the need for communication that aims to understand the perspective of subjects to achieve social integration and social justice, but he places the concept of recognition at the centre of social conflict as a necessary precondition for rational linguistic communication and social justice (Honneth, 2008; Strydom, 2011). Honneth emphasizes that recognition is the basic precondition for social interaction and differentiates between three necessary dimensions for recognition: love (attending to emotional concerns), legal rights (respect of rights and values that are protected by the law on a universal basis); and solidarity (providing social worth and value of individuals). These three dimensions will be discussed in detail later on in this section.

Based on Hegel's conception of recognition, Honneth perceives the refusal to recognize some people in society – marginalized persons, for example – as the main trigger for social conflicts. Recognition is the fundamental precondition for being able to develop and maintain self-realization (Honneth, 1995, 1996). He asserts that before communication, individuals must first of all be socially visible by being ascribed a certain positive status and being granted social identification as individuals during intersubjective relations (Honneth, 1995). Even though

persons might be “seen” in a visual sense, many are not “seen” in a more profound way, or what Honneth called recognition. There is a need for another dimension to be added to the simple optical fact of seeing. In order for someone to be perceived as a person, an individual needs to be respected and acknowledged at a deeper dimension, one that constitutes the biographical particularity and uniqueness of the human character, race, and gender. This is the basis of recognition that Honneth (1995) considers, not as a courtesy but as a human need and a legal right. This conceptualization of recognition implies that we cannot relate to each other from a neutral cognitive stance because human interaction is primarily based on an affirmative stance, empathetic understanding, and positive recognition of the other (Honneth, 2008). For Honneth, affective identification with the emotional situation and concerns of others and giving value to their experience is the necessary basis for recognition that affirms the human personality of others (Lazzeri, 2011). Not only that, but we as human beings living in social communities also depend on the recognition of the other because we are only able to exist socially if we ourselves are recognized by others (Honneth, 1995, 2008). Only if this mutual recognition in social interaction is fully realized for all persons living in society or community, can we say we are living in a just and equal society. And only if people are granted recognition by others, can they develop self-realization, self-confidence, self-respect, and enjoy their right for self-determination. However, the reality of our current capitalist societies is a systematic violation of the right for recognition due to an ever-increasing number of people who are denied their legal rights and others who are systematically excluded from society or unequally treated (Honneth, 1995; Petherbridge, 2013).

Thus, Honneth’s (1996) social philosophy is situated in the tradition of critical theory as developed earlier in this chapter because it provides normative foundations for a critique of

society. Violation of a person's right to being recognized is a social pathology that excludes a person's possibility for self-realization. The focus is thus on the moral experience of individuals in which lack of recognition in any form of disrespect such as neglect or insult or denial of rights, leads to pathological social relations that violate moral expectations and stimulate social struggle to achieve recognition and justice in social life (Honneth, 1995; Blunden, 2003).

Philosophical Foundation of Recognition

Honneth (2015) proposes that societies based on the ethical ideal of social justice are truly free only if they realize ethical norms of recognition in all spheres of societal life. Individuals are "free" only if they have authority and control over their decisions and interact with others based on mutual recognition. Honneth's philosophical considerations are based on Hegel's conceptualization of recognition in Hegel's early work, the *System of Ethical Life*, but the idea of recognition did not disappear completely from Hegel's later works, reappearing in his *Phenomenology of Spirit* (Blunden, 2003). In the second chapter in this later book, entitled "Self-consciousness," Hegel demonstrates that a subject gains consciousness about itself only under the condition that it enters into a relationship of recognition with another subject. For Hegel this was the transcendent fact and a precondition of all human sociality. Only at the moment that the subject realizes that it is bound to its human counterpart is it able to control its instincts because it realizes that it depends on other human beings. This step of anthropological development, that Hegel called "spirit," sets human beings apart from non-human beings in the world. Following Hegel's universalist view of rights, Honneth (1995) theorizes that recognition should be equal for all individuals irrespective of social roles and should be protected by the legal system (Honneth, 1995).

For empirical support of his theory, Honneth turns to the work of developmental psychoanalyst Donald Winnicott on emotional recognition in the mother-child relationship. A child must first of all identify with her/his figures of attachment and be emotionally recognized by them before she/he can develop self-confidence and expand cognitive understanding of the surrounding world that is apart from the child and independent of its will. Honneth also refers to sociologist George Mead's social psychology to demonstrate that we cannot ignore how society views us because we come to know and realize ourselves based on the recognition response and confirmation of people around us (Honneth, 1995; Presbey, 2003). For Honneth, recognition during intersubjective interaction promotes the moral experience of individuals by protecting their personal identity and preparing the conditions for self-realization and self-determination (Blunden, 2003; Honneth, 1995). Based on the social psychology of George Mead, Honneth defines self-realization as the positive perception of oneself based on respect and recognition by others. It is the interpretation of who we are as human beings with unique values and traits as reflected in the words and reactions of people around us (Honneth, 1995; Presbey, 2003). Honneth (1995) also defines self-determination as the person's ability to control conditions under which one's own life is determined, with no external coercion. Self-determination represents a state of dignity and autonomy that enables us to make choices and decide about one's own life. Moreover, in his explanation of the consequences of lack of recognition, Honneth refers to the philosophy of John Dewey, which connects emotions to whether our intentions and moral rights are satisfied or not (Presbey, 2003). Dewey assumes that reactions to moral injustices are not neutral but emotional, meaning that when one's moral rights and expectations are violated by others – such as in the case of humiliation – emotional reactions of disappointment and

frustration are the consequence. Accordingly, emotional tensions result from the conflict between one's moral entitlements and the lack of recognition by others in society.

The Three Dimensions of Recognition

As mentioned above, Honneth (1995) believes that recognition by others is at the core of human integrity and self-understanding. Honneth identifies three necessary normative dimensions for recognition in order to maintain social justice and ethical life in a society characterized by mutual recognition between individuals who enjoy the right of self-realization and self-determination. The three spheres or dimensions of recognition represent the lifeworld of individuals in their struggle for justice, equality, and liberty in society (D'Avila & Saavedra, 2011). These three domains of recognition are: love that recognizes the emotional and physical needs of the individual, necessary to build trust and self-confidence; legal rights that recognize everyone's rights and values in a universal manner to build self-respect; and solidarity that provides social honoring of each individual in community to preserve social esteem (Honneth, 1995). The three proposed domains for ethical life are considered necessary conditions, meaning that violation to any of the three dimensions will threaten the right to identity recognition.

Love and self-confidence.

For Honneth (1995), love represents a fundamental relational component in the private sphere in which relationships among individuals depend on reciprocal emotional engagement and support. Honneth explains that it is through this affective and emotional bond from parents and close friends that individuals' psychological and physical well-being is protected. The principle of love and care is dominant in close relationships where emotional connection and bodily proximity are fundamental for the development of self-confidence. However, the

dimension of love recognition is not only limited to the family and close friends but extends to other forms of emotional bonding with others in society. This type of love recognition Honneth (1995) describes as "being oneself in another" and represents a "symbiotic relationship" (p. 105) where individuals can be physically separated but still emotionally attached by an emotional bond to the other. Based on the work of developmental psychoanalyst Donald Winnicott, who explains that care in childhood is a precondition for the development of autonomous identity, Honneth draws on the example of mother and child to clarify his conception of love (Honneth, 1995; Wernet et al., 2017). It is through love and emotional support that the child learns to be dependent on the loving care of the reliable mother to meet his or her emotional and physical needs. Trust in the continuity of love by the caring mother, generated through the stage of intersubjective dependence, produces self-confidence in the child to move from a state of complete dependence toward a state of relative dependence and then after to a completely autonomous situation. Based on Mead's theory that one's own needs are always dependent on and maintained by significant others, when the individual is self-assured that one's unique value is recognized by others through emotional bonding, then self-confidence will develop (Honneth, 1995; Presbey, 2003). In this sense, the dimension of love in recognition represents a positive emotional and nurturing relationship that is a necessary precondition for social justice and the development of a therapeutic sense of self-confidence, which prepares the person for self-respect and further autonomous participation in public life (Honneth, 1995).

Withdrawal of emotions or failure to maintain a mutual bond of love results in pathologies in relationships and serious problems that undermine self-confidence (Honneth, 1995). This could occur in any instance of physical or psychological abuse such as when a person feels that one's body is under the control or at the mercy of somebody else (Presbey,

2003). Any harm to physical integrity or humiliation will violate the recognition of love and will lead to loss of trust in oneself and the surrounding environment, which aggravates the struggle to be recognized (Honneth, 1995). Also, violation of this form of recognition could also take place when a person feels isolated, or his or her emotional needs are neglected.

Legal rights and self-respect.

In this domain, the rights and interests of each and every individual citizen in society are protected by the legal system (Honneth, 1995). Once an individual is recognized as a member of a society, he or she is entitled to the same rights as any other autonomous person in this society. This maxim of justice is realized through the principle of equality. This kind of recognition should be regarded from the stance of cognition and not from the stance of affection because it is related to the envisioning of individuals as responsible authors of their rules and as beings entitled to legal protection and recognition by the law. Based on Mead's assumption that a person can only develop respect for itself after having experienced the respect of everyone else in society, guaranteeing legal rights to individuals will enable them to develop self-respect because they know that their unique values, interests, and chosen way of life are respected by other social actors (Honneth, 1995; Presbey, 2003). This also implies that human dignity is based on legal recognition and the acceptance of rights and values by the social members. For Honneth (1995), legal recognition should not depend on one's social role but must be granted universally in order to protect equally the interests of all members in society without any exceptions. All individuals deserve equal legal rights despite differences in traits, physical abilities, beliefs, social class, race, and gender, etc. This universality of rights empowers each individual to make autonomous decisions based on his or her respective values and it ensures that society respects everyone's values as long as they do not interfere with the rights and values of others.

Whenever one's legal rights are granted and recognized, self-respect along with self-esteem will be maintained and promoted (Honneth, 1995). If legal rights are neglected by others or even suspended or withdrawn in society, feelings of shame arise, leading to a demeaned and degraded sense of self-respect. If one is denied legal recognition, such as in the case of restricting autonomy or denying access to care, this implies that self-respect as well as social acceptance and social integrity have been violated and denigrated. Whenever legal rights are excluded or denied, moral expectations are violated, which will eventually trigger a struggle for recognizing legal rights as a necessary condition for social justice.

Solidarity and social esteem.

According to Honneth (1995), solidarity and social esteem are part of the concept of recognition that is closely linked to the dimension of legal rights and the universality of values, which guarantees that every individual is respected and honored within the social structure. Solidarity indicates that there is shared consensus of values, traits, and abilities that offer social esteem to individuals. This domain of recognition is experienced by the individual when he or she is able to meaningfully participate in a community and is perceived as part of a common social project (Honneth, 1995; D'Avila &Saavedra, 2011; Terkelsen et al., 2019). Again, based on Mead's theory that one's positive contribution to society is part of intersubjective collaborations, providing value and social esteem to individuals and groups should be shared socially and accepted despite differences in traits, abilities, beliefs, social class, race, and gender (Honneth, 1995; Presbey, 2003). It is through this form of recognition of values and ideals that individuals visualize each other's characteristics as unique, justified, and contributing to social life. Within this environment of a plurality of values and individuality of choice, everyone can enjoy social worth and feel recognized, by all members of society, as a significant contributor to

society. This dimension of social recognition, in which social members sympathize with each other and respect their differences, promotes the sense of self-esteem and self-determination in each individual in the social group (Honneth, 1995; Meulen, 2016). Furthermore, Honneth asserts that solidarity usually emerges when certain members of society are not treated equally or face a challenging situation that endangers their social projects (Iorio, Campello, & Honneth, 2013). Although solidarity has an emotional base of sympathy that ties together members of shared goals, it also extends to an active form of cooperation in which esteemed members of a community progress into social and political support actions. In this sense, solidarity is seen as a social action of a group of people who share feelings of respect and work together toward a shared goal (Iorio et al., 2013).

This domain provides the opportunity to be recognized as a contributor to the whole and assures that others' values will not be denigrated (Honneth, 1995). Forms of disrespect found in this category involve insults or a lack of appreciation of traits, abilities, or manners of belief that will deprive individuals of being valued by other members of a given community or society. The lack of social appreciation of a person that results in his or her debasement and stigmatization will negatively influence human dignity and self-determination, thus mobilizing feelings of conflict and igniting political struggle to achieve self-liberation and moral recognition (Honneth, 1995; Wernet et al., 2017). To deny solidarity to a certain social group will prevent members of this group from attributing social value to their activities and thus they will fail to recognize any pride in their contribution to society. They will not enjoy the social esteem and collective honor needed for solidarity.

Recognition Versus Reification

In his book *Reification: A New Look at an Old Idea*, Honneth (2008) reinterprets the concept of reification. Reification is a central concept in Marx's analysis of capitalism, and it was later revised by Marxist philosopher Georg Lukacs, who still defined reification from a purely economic perspective. Honneth rejects Lukacs' reductionist explanation of reification in utilitarian and economic terms. Instead, he argues that other forms of reification such as racism cannot be integrated into a Marxist analysis of a capitalist economy and thus, an alternative and broader explanation is needed to understand processes of reification of others and the self. Honneth (2008) insists that reification is the result of "forgetfulness of recognition," the abandonment of the originally given affirmative stance, because this forgetfulness results in experiencing the elements of our surroundings as mere objective entities, as objects of no emotional character. Thus, reification is "a type of human behavior that violates moral or ethical principles by not treating other subjects in accordance with their characteristics as human beings, but instead as numbness and lifeless objects, as things or commodities" with no attention to emotions or any real interest in understanding the perspective of the other (Honneth, 2008, p. 19). He concurs with Lukacs in that capitalism and its commodity exchange leads to a particular form of reification in which the rationality of commodity exchange and calculability of human operations infiltrate all areas of social life, transforming them into commodities themselves. The social becomes increasingly understood in quantitative terms and is evaluated based on its contribution to capitalist monetary profit. Accordingly, Honneth (2008) states that the economic orientation of social life causes a shift in subjects' perceptual processes and attitudes through which they lose their ability for empathetic engagement and understanding of the other. Contrary to a relationship of involvement and care, a reifying attitude is that which denies or deflects from this primary mode of engagement and supports a "detached" and distanced mode of observation

and instrumentalization. This reifying attitude is a required behaviour in an environment where relations are based on profit calculations because emotions cannot be calculated and do not contribute to economic transactional operations (Honneth, 2008).

The conceptualization of reification as "forgetfulness of recognition" enables Honneth (2008) to criticize physio-biological approaches that explain human behaviours through the mere analysis of brain activity and neural functions, because these explanations convert human beings into "senseless automatons" and mere things without considering the qualitative dimensions of human nature. Honneth (2008) characterizes the physio-biological approach as a "reifying perspective" because it forgets the personal perceptions and emotional character of human subjects. A pure cognitive stance occurs when a subject perceives a situation by "dissecting it into emotional and cognitive elements" (p. 38), allowing the subject to abstract from the emotional elements and instead engage in a seemingly affectively neutral stance, which is actually a manifestation of reification. Adopting a dualistic "subject-object" cognition illustrates a "neutral stance" that excludes the emotional components from a relationship (Honneth, 2008).

Lukacs understands reification as a "second nature" and a "distortion" from an original attitude and Honneth argues that recognition is the original attitude, which forms an underlying norm that can explain the sociological and psychological bases of non-reified social relations (Honneth, 2008). Thus, Honneth concludes that recognition precedes cognition and communication, and when we forget that our cognition is originally based on the preceding recognition, we fall into the trap of reification. For Honneth (2008), recognition is an anthropological constant, because only by taking the perspective of the significant others (usually the parents), can a child acquire the ability to perceive the world. It is the affective connection and interdependence with a second person that prepares the child to reach a stage of

independence in cognition. In other words, our "objective" conceptual knowledge and understanding of reality is originally based on affective interactions and acceptance of others' perspectives. Once we lose the awareness that recognition made us into who we are, we deal with each other as insensate objects. In this vein, Honneth considers that forgetfulness of recognition is similar to "amnesia" about the origin of behaviour as based on engagement, care and understanding.

Opposing empirical-analytical scientists who believe that truth can only derive from a neutral and cognitive stance, Honneth criticizes those who conceptualize knowledge as purely "objective" because they did not study people originally as objects of knowledge, but constructed this scientific knowledge based on interactions with people who disclosed their subjective thoughts and feelings. Their efforts to gain knowledge were based on accessing other individuals' thoughts and mentality. Thus, scientists usually forget that their scientific cognition is originally rooted in interaction and recognition. Not only this but scientists themselves have experienced a process of emotional recognition in their early life and without such a dimension of attachment, they would not be able to provide a picture of the world that they consider abstract and empty of qualitative and emotional characteristics. Thus, for Honneth, objective sciences (like biomedicine) are the outcome of forgetfulness to the first attachments and interdependence with others around us. By forgetting the primacy of the dimension of recognition, our relationships become reified, because our interactions are not affectively neutral or purely cognitive but are primarily affirmative with a caring character. Honneth uses the example of a child with autism spectrum disorder (ASD) to highlight that these children are structurally prevented from emotionally identifying with a concrete second person due to "emotional blindness," which keeps them entrapped within their own perspective on the world. Children

with ASD do not see, or rather they do not feel, that facial expressions, bodily movements, and communicative gestures give expression to attitudes. They are blind to the expressive mental content of such phenomena, or rather to their meaning. These forms of corporal expressions filled with feelings are also an important part of interactions between adults.

Honneth (2008) described two mechanisms that make us lose sight of the primacy of recognition in our interaction, but recognition nevertheless continues to "haunt" our consciousness. First, in our social practice, we become so concentrated on achieving certain goals that we become "one-dimensional" in our thinking, to the extent that we fail to be attentive to the more important and original goal of recognition and emotional engagement with the other. Our cognition becomes "rigid" and causes denial of the antecedent of recognition. In this sense, goals become separated from context and we forget to interact with the individual as a human person. Second, the influence of modes of thinking and institutionalized practices makes us believe that we do not depend on recognition in our relations with the others. These modes of thinking restrict our practices and make us so selective in interpretations that we understand events and occurrences only through the narrow frames provided by these modes. Our attention is reduced to only those factors we are able to identify within these modes of thinking. This biased interpretation leads to "forgetfulness of recognition" and emotional detachment.

"Forgetfulness of recognition" leads to deactivation of empathetic engagement that results in "social pathologies," in which people are treated from a purely cognitive stance as "things" with no recognition of their human identity (Honneth, 2008; Lazzeri, 2011). Based on the ontology of recognition, Honneth insists on the significance of emotional engagement, protection of legal rights, and social honouring as the three necessary dimensions for good life

where people can develop self-realization and act autonomously within non-reified social relations (Honneth, 1995).

Summary

In this chapter, I introduced CST as an overarching theoretical approach that guided the methodology of my study. I then discussed the concept of nursing actions as a particular form of social action. I presented the theoretical framework that informed the conceptualization of nursing action throughout the study, which began with Habermas' theoretical considerations about knowledge and interest. There he criticized the neutrality of empirical knowledge and proposed critical knowledge as a third reflective knowledge that can liberate individuals from domination. I situated myself and this study within the tradition of critical theory that, according to Habermas, pursues an emancipatory interest that empowers people to act autonomously. Corporality was discussed as an approach fundamental to the practical interest of Habermas, which enables understanding of the lifeworld of the person.

I then discussed Habermas' critical theory of communicative action, which is meant to empower individuals to engage in rational communicative argumentation and to provide a safe space for everyone to raise their voice. Communicative action is based on the idea that everyone must be allowed to participate equally in decision-making processes and to achieve consensus about what should be done. Finally, the chapter discussed Honneth's theory of recognition by Axel Honneth (1995), who postulates that justice in social interactions is primarily an ethical endeavour aimed at moral recognition, which respects and preserves the identity of each and every individual. He insists that recognition must precede communication and developed three necessary dimensions for ethical life and social interaction: love, legal rights, and social esteem. I proposed that the theory of recognition is a broad critical emancipatory framework that can

ensure justice in social life. Lastly, reification was presented as a pathologic consequence of the "forgetfulness of recognition," whereby lack of emotional engagement or understanding of the feelings and perceptions of others leads to the treatment of others as things from a "detached" stance empty of any emotions. Utilization of this framework in the analysis of empirical data about nursing action is expected to provide new insights into the conceptualization of nursing care.

Chapter Four: Methodology

Introduction

Methodology is the process in which the researcher justifies the choice of research methods by explaining and analyzing how she or he approaches the research problem. Also explained are the selected strategies used in the study including site selection, sampling technique, data collection, and data analysis (Carter & Little, 2007). Critical ethnography has been chosen as the methodological approach for this study. A brief overview of critical ethnography followed by paradigm analysis that explains the ontology and epistemology of critical ethnography will address the key features of this qualitative approach. Explicating the philosophical underpinnings of the approach will pave the way to justify this methodological choice to explore the study's research objectives and to answer its research questions. I will demonstrate that Honneth's approach of normative reconstruction is best met by critical ethnography. I will then briefly summarize the methods and procedures of this study and the processes followed to conduct this study and obtain ethics approval, recruit the participants, and perform data analysis.

Critical Ethnography

Critical ethnography originated in the late 1950s and early 1960s, when researchers interested in studying the "remote cultures" of colonized groups, with the aim of understanding these foreign cultures and avoiding conflict with them, started to be criticized for giving "no voice or word" to the colonized people, further perpetuating their marginalization and oppression (Mantzoukas, 2010). Marxism, neo-Marxism, Weberian theories, feminist critical theory, and political theory all influenced early critical ethnographical studies (Lecompte, 2002). A main assumption in critical ethnography is that the actions and perceptions of people are shaped and

mediated by the power dynamics and values embedded in culture and that culture itself is a product of power relations and socio-economic conditions (Polit & Beck, 2012). Critical ethnography contextualizes social phenomena in order to reveal the hidden assumptions, agendas, and ideologies defining "realities" (Hardcastle et al., 2006). It is described as a politically oriented research methodology that addresses historical, social, economic, and political dimensions of culture that contribute to injustice and inequality (Bann-Barrett, 2009).

Critical ethnography shares with classical ethnography the central trait of describing the culture of a group by portraying their shared perceptions, values, behaviours, and language (Streubert, 2011; Creswell, 2013). But in contrast to classical ethnography and the way nursing theorist Madeleine Leininger conceptualized culture, critical ethnographers understand culture not as something static or as an essence, but rather conceptualize culture as a web of symbolic meanings that are constantly shifting and transforming (Carspecken, 1996). Thus, culture is constantly made, re-made, and transformed and this broad definition of culture comprises what Habermas and others understood as the "lifeworld," where meanings and norms are always open to critique and discussion (Habermas, 1987b). Therefore, critical ethnography does not merely describe discernable patterns in order to "objectively" represent participants' reality, but rather analyses reality with the aim of increasing the awareness of participants about how their life is constructed, and the role played by power differentials (Holmes & Smyth, 2011).

The primary aim of critical ethnography is to unveil the power relations processes that create the participants' reality (Faubion, 2001). A prominent feature of critical ethnography is its emancipatory dimension, which determines what aspects of "culture" participants might find useful, beneficial, and practical in order to transform their reality through an emancipatory praxis

(Spencer, 2001). It is through this dimension that critical ethnography aims to empower participants to fight for a freer, equal, and more just society.

This dimension of critical ethnography overlaps with the perspective of critical theory and critical research in general. As discussed in my theoretical framework, critical research as it is understood in this study addresses issues of inequity, dominance, gender, race, repression, and hegemony and other axes of domination, to change the status quo (Carspecken & Apple, 1992 Polifroni & Welch, 1999). Researchers who subscribe to critical theory usually understand themselves as having an ethical responsibility to address processes of unfairness and injustice within a particular lived domain (Madison, 2005). They act as advocates who work for the emancipation of alienated and marginalized individuals in society (Thomas, 1993). By increasing awareness of power dynamics and interpreting how culture is shaped, critical researchers empower marginalized participants to work against oppression and domination (Carspecken, 1996). They move from "what is" to "what could be" in order to contribute to social justice (Madison, 2005, p. 5). Increasing knowledge and raising awareness about oppressive ideologies is not the only goal for critical ethnography; the ultimate purpose is to move toward political action and policy change that can redress injustices and remedy inequalities (Kincheloe & McLaren, 2005; Wuest, 2012). Therefore, the chosen methodology for this study is a kind of natural fit with the theoretical framework proposed in chapter three.

Ontology and Epistemology

Critical ethnography has its philosophical underpinnings rooted in critical theory (Carspecken, 1996), which situates it within a historical realism where reality is assumed to be "shaped by a congeries of social, political, cultural, economic, ethnic and gender factors, and then crystallized (reified) into a series of structures that are now (inappropriately) taken as 'real,'

that is, natural and immutable" (Guba & Lincoln, 1994, p. 110). Critical theorists start their inquiry by meticulous analysis of the problem from different social, historical, economic, and political perspectives, including accepted norms and the dominant language (Polit & Beck, 2012). Historical realism accepts that some true reality exists but has been distorted and blurred by the dominant forces that create specific worldviews and cultures (Lecompte, 2002). Dominant ideologies, taken for granted, circulate widely in social life and prevent individuals from arriving at a true understanding that serves their own interests (Polifroni & Welch, 1999).

Critical ethnography deviates from the epistemology of classical ethnography's emphasis on value-free and objective representation of social reality by adopting a normative theoretical framework that is meant to close the gap between theory and practice (Polit & Beck, 2012; Scotland, 2012). Also, through active involvement with the participants during the research process and initiating them to engage in self-reflection, participants become aware about the discrepancy between their lived reality and how the situation "should be" (Polit & Beck, 2012). Therefore, critical research interviews are different from interviews done in classical ethnography in that they take a dialogical, reflective, and confrontational nature to approach the research problem (Thomas, 1993). Researcher and participant sit together to create a cultural scheme that exposes historical, economic, social, and other factors that have created the current reality of the participants (Streubert, 2011). The interview aims to go beyond superficial meanings and expose personal, cultural, and political aspects of decision making (Thomas, 1993; Hardcastle et al., 2006). Critical discussion promotes awareness for nurses by allowing them to reflect on their personal values and beliefs, cultural history, and the positioning of such reflections within a framework of power imbalances and colonized relationships (Ogilvie et al., 2008). As participants realize the difference between the lifeworld meanings they hold and the

meanings influenced by the system, whether organizational or political, they become empowered to influence their local practice (Cook, 2005). This mode of reflection gives rise to new kinds of thinking that constitutes the foundation for change (Thomas, 1993).

Critical Ethnography and Symbolic Interactionalism

Critical ethnography shares some theoretical assumptions with the Chicago School of Pragmatism. Proponents of pragmatism assume that reality is based on symbolic interaction that constructs social reality and individual identity (Thomas, 1993; Bryant & Charmaz, 2010). Critical ethnography provides an opportunity to reflect on actions that appear grounded in reality and empowers participants to challenge symbolic forms of practice (Thomas, 1993). It considers that values and beliefs have become normalized and recognized as accepted precepts in a particular field through symbolic interaction without subjects being aware of how these accepted precepts emerged in the first place (Thomas, 1993; Brann-Barrett, 2009). According to symbolic interactionism, human beings act based on meanings they learned through social interactions (Blumer, 1969). Blumer believed that the world has different realities based on different meanings assigned by different social groups and cultures. Because symbolic interactionism believes that symbols are modifiable by changing interpretive processes (Blumer, 1969), it corresponds to the critical paradigm, which considers that "reality is alterable by human action" (Scotland, 2012, p. 13). In this sense, increasing awareness about realities and emancipation refers to the "process of loosening and revealing the limitations of symbolic meanings constraining our modes of thinking or acting and moving toward realizing alternative possibilities" (Thomas, 1993, p. 4).

Norms and Truth

Carspecken (1996) highlights that the focus of critical ethnography is not to discover the truth represented in the lived reality of participants but rather it validates conditions through which reality wins consensus. He contends that social consensus usually represents the symbolic domination of power relations and that "truth" in critical ethnography does not mean describing reality based on social consensus as this description only reinforces domination. Accordingly, exploring domination requires attention to what people do versus what they ought to do and what they say compared to what they want to say. In this perception, Carspecken follows Habermas (1984, 1987b) who asserts that agreement is senseless unless based on rational communication where each side negotiates using valid claims to reach mutual agreement. Without rational linguistic communication, any agreement that is not reciprocal creates a state of coercion and oppression (Polifroni & Welch, 1999). For this reason, critical ethnography relies not merely on symbolic meanings to represent reality but exposes such meanings that constitute cultural determinants of the dominant power system manipulating reality (Mantzoukas, 2010). In this study, truth about the realities of everyday routines will be checked for validity by comparing it to what is expressed by nurses about what constitutes good care.

Critical Ethnography to Study Nursing Actions

Based on the above description, critical ethnography constitutes an appropriate methodology to examine nursing actions in an economized context that follows neoliberal rationality. Because nursing caring actions takes place under structures of medical, managerial, and other forms of bureaucratic domination (McPherson, 2003; Liaschenko & Peter, 2004; Beagan & Ells, 2009; Wall, 2013; Rudge, 2015), critical ethnography provides an opportunity for participants to examine the interaction between their actions and the socio-economic and

political contexts in which they work. The knowledge generated through this study will help to widen participants' understanding of their actions; it will encourage them to question their accepted reality and to perhaps understand more that it is the result of power relations and political agendas (Thomas, 1993). Critical ethnography's reflective epistemology helps nurses to reflect on their work environment and provides a critical perspective on how this reality is shaped through management, economic rationality, and organizational values (Rudge, 2015; Wall, 2010). It enables them to critique the economization in healthcare and reveal the influence of dominant political, economic, and social powers on their practice (Cook, 2005; Rudge, 2015). Through this interactional epistemology and self-reflection, participants can begin to examine the ideology behind taken-for-granted norms, thus become enlightened and freed to judge reality and look for an active role in a situation similar to communicative action (Polifroni & Welch, 1999). Critical ethnography also informs nurses that current reality is only one possibility and that it can be altered, redefined, and reconstructed by honoring nursing practice based on the professional and ethical values that serve nurses' roles in dealing with patients (Thompson, 1987).

Defining Culture

Because critical ethnography is intertwined with studying culture (Creswell, 2013; Streubert, 2011), it is imperative to understand what culture means. For Carspecken (1996), culture is the totality of social beliefs, behaviours, norms, values, and symbolic meanings that structure individual identity. He affirms that culture is discovered through interaction and communication that reveal the meaning and interpretation of action and language. Creswell (2013) asserts that culture is determined by what people do and say in terms of behaviours and language. He adds that investigating culture entails uncovering the norms and the tacit rules embodied in ideology, which provides shared systems of meanings and symbols that give

justification for common beliefs, assumptions, attitudes, actions, and language used in a particular society. According to Thomas (1993), culture could not be understood without exploring the dominant ideology that gives legitimacy for social roles, social policies, and economic attitudes; factors that are usually not recognized as producing the culture and social life of people.

For the purpose of this study, the economized nursing home care culture will be described and analysed in a manner that is adapted from the dimensions provided by Edgar Schein (1992) in his book *Organizational Culture and Leadership.* Schein (1992) was interested in studying corporate culture and leadership roles in organizational change. He defines culture as "a pattern of shared basic assumptions that was learned by a group as it solved its problems of external adaption and internal integration" (p.17). He reveals that understanding organizational culture requires understanding the three levels of culture: artefacts, adopted values, and lastly, the underlying assumptions that reveal hidden complex behaviours and contradictions. He explains that artefacts are visible physical infrastructure, observable behaviours, organizational processes and policies, rituals, norms, and patterns of action that are easy to catch but difficult to understand without talking to people and examining what they mean by acting and behaving in a specific manner. Schein (1992) believes that culture is not represented by visible artefacts only but by the facts and occurrences that take place under the surface and shape the behaviour of individuals. He elucidates that behaviours and activities cannot be fully understood without exploring the values, beliefs, thought processes, and attitudes that employees adopt and are willing to share and reflect on. Because behaviours and actions are not necessarily coherent or justified by values provided by actors, incoherencies and contradictions are expected to emerge. In order to comprehend such inconsistencies, it is necessary to explore underlying assumptions.

Such assumptions, which have developed over time as taken-for-granted values are usually hidden beliefs that are decisive to understand what is going on in terms of behaviours and perceptions, and why certain things occur while others fail to take place (Schein, 1992). In a later article about organizational concepts, Schein (1996) further clarifies that organizational culture cannot be studied through a mere focus on individual behaviours and norms but should extend to norms that spread across an organization, especially those defined by management and leaders. He also emphasizes that assumptions are tacit norms that are not usually verbalized but accepted as shared perceptions. These are taken-for-granted powerful forces functioning within and determining organizational culture (Schein, 1996).

This study is limited to what nurses said about their norms and actions. It did not include personal observation of behaviours and interactions of nurses with each other and management, nor did it include observation-based analysis of how nurses use documents and policies during their caring actions. Cultural analysis will be limited to the second and third levels developed by Schein (1992). Adopted values and beliefs about good care verbalized by participants during interviews will be contrasted against underlying beliefs and assumptions prevalent in the organization that will be derived from nurses' responses about barriers to good care and factors influencing or constraining the carrying out of the kind of care they wish to provide. This form of cultural analysis fits well with the methodological approach followed throughout the study.

Honneth's Method of Normative Reconstruction

Identification of what is "good" and what "ought to be" is an important goal of critical theory that is concerned with providing normative foundations for nursing practice (Mill et al., 2001). This goal coincides with the emancipatory aim of critical ethnography that according to proponents will assist participants to think critically about their social reality and raise their

awareness about oppressive conditions and how things "could be" (Carspecken, 1996; Madison, 2005). In the theoretical framework, I discussed how participants' narratives about their daily caring practice will be used to reconstruct ethical norms of nursing action. Reconstructing ethical norms will be conducted according to Axel Honneth's (2015) conceptualization of normative reconstruction. He considers that social interactions are based on normative ideas about how to live together in an equal, free, and just manner. He asserts that empirical research can be used to explicate these immanent normative foundations, which he described as a way of reconstructing social norms and values embedded in the concrete experience of social members. D'Avila and Saavedra (2011) emphasize Honneth's belief that in democratic societies, ethical norms implicitly permeate all social spheres and are embedded in social interaction. His method of normative reconstruction aims to explicate these intrinsic norms that can then be used to critique social practices that have been transformed (e.g. through economic rationales, or ethnic/racial ideologies, etc.) and thereby violate these intrinsic norms held by social actors.

Honneth (2015) based his approach of normative reconstruction on four essential principles. First, normative analysis of a certain social group is represented in the understanding of shared values and ideals that comprise the actual actions and practices definitive of the social reality of a specific community or social group. Second, these norms are neither idealistic in an abstract way nor independent from reality but derived empirically from the real experience and actual actions of social members. Third, normative reconstruction will uncover actions and practices that represent actual shared values, particularly those exercised by free and autonomous social actors. Fourth, normative reconstruction is a method of social criticism that shows how existing reality represented in existing institutional practices prevailing in certain communities is not compatible with the standards and values shared by social members. It reveals tensions

between adopted normative values and existing institutional practices that fail to comply with norms adopted by social members. Thus, this method of normative reconstruction represents actual reality in an objective manner, one that is derived empirically to reveal possibilities for alternative truths (Honneth, 2015; Buchwalter, 2016). For the sake of this study, normative reconstruction of good nursing care will be derived from nurses' verbal accounts about their daily caring actions, their personal motivations behind their stated actions, their defined values about the most important aspects of good nursing care, and how they perceive the influence of the ongoing transformations in home healthcare in Ontario.

Methods and Procedures

Sites selection and gaining access.

The main interest of this study is to understand how nursing care is provided in an increasingly economized context. The reason for choosing home healthcare is that I assumed that nurses in home care are working under more autonomous conditions, meaning that they are relatively distanced from physician control and also further away from direct managerial surveillance. It was expected that nurses in home care could be more independent in ethical reasoning and deciding on caring actions because in contrast to those working in hospitals, they cannot directly confer with colleagues or physicians nearby (Wall, 2013). However, home care in Ontario is dominated by managerial considerations where business values and financial efficiency measures are prioritized (Fisk, 2000; England et al., 2007). In addition, home care health services in Ontario operate within a privatized profit-making model, and are usually described to be inequitable, under-resourced, and not able to meet the complex needs of patients discharged from hospital to the community (Ontario Health Coalition, 2015a; Yakerson, 2018). Neoliberal policy makers in Ontario have targeted home care services through market-oriented

strategies and managed competition plans, which have governed the delivery of care (England et al., 2007; Wojtak & Stark, 2016; Yakerson, 2018). In fact, home care has become the fastest growing division in Canada due to the increased aging population and increased demand on the limited number of hospital beds (Kitchen, Williams, Pong, & Wilson, 2011).

The research proposal was approved by the Ethics and Research Integrity Office of the University of Ottawa (see, Appendix B for ethics approval). Because critical ethnography endeavours to uncover injustices and intends to work against power imbalances, access to organizational settings is complicated because the management seem to be anxious that the data obtained might be used to criticize their organization (Carspecken, 1996). Gaining access requires flexible negotiation with gatekeepers or key personnel who have the power to provide access to the organization (Madison, 2005). Consulting with colleagues in the public healthcare sector and other nursing staff who are familiar with home care services in Ottawa helped me to get in touch with the directors/managers of four home care providers operating in Ottawa. Two home care providers or what is usually known as Service Provider Organizations (SPOs) allowed me to recruit professional nurses (RNs & RPNs) and the management agreed to participate in the study and share their experience as well. A copy of the ethics approval along with a study information sheet were attached to the email sent to the providers (see Appendix C for study information sheet). The two participating SPOs will be described in more detail later in chapter five during the presentation of results.

Sampling and recruitment.

During the first meeting with the directors, it was made clear to me that nurses in home care service are usually over stretched with their assigned workload and have very limited time to share their experience in a research interview. Based on this percept, a sampling method of

convenience was chosen. Convenience sampling is an efficient sampling technique when recruiting participants working in a specific organization where the participants are not known to the researcher (Polit & Beck, 2012). A main assumption behind convenience sampling is that members of a target group are willing to participate and are accessible to the researcher as a "convenient" source of data (Etikan et al., 2016).

After deciding on the SPOs, a meeting was organized with each director of the two selected sites in the presence of two managers. It was decided that managers of the organizations email an information letter explaining the nature and purpose of the study with the contact number and researcher's email to all English-speaking professional nurses employed by the institution. Recruitment flyers that explained the nature and purpose of the study were also posted in common areas of the selected institutions after permission from administration (see Appendix D for recruitment flyer). In addition, I asked the managers themselves to participate in an interview to enrich the content and data of the research. All managers attending the meeting agreed to participate. Although it was intended that I attend a staff meeting to introduce the study, this did not take place because the home care administration did not feel the need to do so before checking the response rate of their nursing staff.

Nurses were asked to respond directly to the primary researcher whose email address and cell phone were stated clearly in the emailed information sheet. Responding nurses were considered prospective participants interested in the topic. The first respondents were selected by this convenience sampling method and were informed via email (see Appendix E for the email sent to selected respondents) about their involvement in the interviews. Snowball sampling and a second wave of recruitment among graduate nurses at Ottawa University who work in home care was approved by the Ethics Office, yet none of these alternative techniques was utilized because

of sufficient response rate from the first participants. When repetitive patterns of data were evident, the rest of participants who had indicated an interest in the study were informed by email that their readiness was appreciated but they would not be interviewed due to data saturation.

Inclusion and exclusion criteria.

Professional nurses (RNs and RPNs) who provide direct nursing home care to patients and who are able to communicate in English were the target group intended for recruitment. In this sampling technique, Personal Support Workers (PSWs) were not included. PSWs are excluded because in Ontario, they are not considered professional nurses but unregulated workers (College of Nurses of Ontario, 2013). Moreover, nurses who speak French exclusively were not recruited because the primary researcher cannot speak French. Nurse managers and nursing staff from the two different home care settings were interviewed. Although I did not have control over the years of experience of the nurses because of the convenience sampling method, the demographic findings showed diverse years of experience that ranged from 4 to 34 years (as shown later in the demographic description of the sample in the findings chapter). This broad sampling of nurses yielded diverse perspectives about nursing care actions and offered the chance to confront the different standpoints about nursing actions and norms of caring practice. This variation and diversity in the final sample would increase the probability of multiple dimensions, interests, and perspectives, which are ideal in qualitative research to enrich data and challenge emerging concepts (Polit & Beck, 2012; Creswell, 2013). Patterns of beliefs that emerge from such a diverse sample would be of special significance in gaining a deep and comprehensive understanding of the culture under study (Polit & Beck, 2012).

Sample size.

Sandelowski (1995) acknowledges that sample size is dependent on the study approach and the researcher's judgement about quality of data collected. Although there is no definite formula to determine the number of participants, she advises the researcher to find a balance between a too-small sample that does not allow saturation and "undermines credibility" of the findings and a very large sample in which thorough understanding and deep analysis are difficult to achieve. Sandelwski (1995) considers a sample size of 10 adequate in critical studies. Creswell (2013) recommends a number of more than 20 for ethnographic studies to clarify patterns of the culture group. In this study, 20 interviews were initially proposed with recognition that this number might need to be increased based on richness of the data collected. However, interviewing stopped at the 18th participant due to the fact that no new concepts were added to my data. Final interviews were only fitting the already existing concepts. In qualitative research, sample size is considered sufficient when the repetitive nature of data determines and confirms data saturation (Morse, 1994). After data saturation, the final sample included a total of 18 participants.

Data Collection Method: Interviews

Interviewing participants was the data collection method of this study which aimed to gain an understanding of what nurses in home care do and how they describe nursing actions as healthcare professionals working within an increasingly economized context. According to Spencer-Oatey (2012), if researchers want to understand "why" people in a certain culture behave in certain patterns and reproduce them through their actions, they need to uncover the subjective reason and rationalization for behaviours or actions and identify how culture predetermines these actions. Spencer-Oatey concludes that the researcher's only way to achieve

this is through interviews, which will reveal the underlying values and assumptions of the participants. Moreover, linguistic communication between researcher and participants can reveal norms and ideology prevalent in the workplace through the descriptions provided by participants about their daily practices and routine behaviours in clinical practice (Polit & Beck, 2012).

One-on-one interviews were conducted. All interviews were audiotaped and then transcribed at a later time. At the beginning of each interview, after I obtained consent for the interview, I asked a very brief set of questions about category of employment (RN or RPN), total years of experience (in hospital nursing and in home care), and the reason for choosing the home care sector as a work site, in order to collect demographic data and establish a rapport with participants. Interviews were planned to be semi-structured and open-ended in order to give the nurses a chance to express their opinions about the research objectives/questions. The purpose of the interview guide was to explore not only how nurses described "what was going on" in their workplace and how they define good care, but also to uncover organizational assumptions and other broader factors that impact nursing practice. Interview questions were developed based on the literature review of nursing actions in clinical settings (See Appendix F for interview guides for nurses and managers).

Although ethnographic studies may range in duration from several months to more than one year (Creswell, 2013), data collection for this study took place over a period of three months, from June to August of 2019, during which all interviews were conducted (almost six months before the worldwide COVID-19 pandemic hit). I interviewed participants individually at a time that was convenient for the participant. The average time of all interviews was 44 minutes. All interviews took place in a private room located in the main office of the home care agency. This room was provided by the administration of each of the home care agencies and was considered

convenient for nurses who used to come periodically to the main office to receive supplies and get a brief report on their assigned patients. The two clinic nurses were interviewed in a private room in the clinic where they provide service to patients. I personally transcribed all the recorded interviews and entered transcribed data into computerized software (MAXQDA) that allowed me to easily store and locate data for reading and review of findings. MAXQDA plus 2020 version (https://www.maxqda.com/what-is-maxqda) is a qualitative and mixed methods data analysis software distributed by VERBI software in Germany. The software was used to attach codes to quotes and to group codes into themes in a hierarchical format. MAXQDA was useful for indexing and retrieval of data, which I myself coded and grouped into themes.

Ethics Requirements

The study adhered to the approved protocol of the office of Research Ethics and Integrity Office at the University of Ottawa. All potential participants were reminded that they could contact the primary researcher or thesis supervisor for any inquiry related to the nature or purpose of the study. They were also advised to contact the office of Research Ethics and Integrity at the University of Ottawa if they had any question regarding the ethical conduct of the study. A copy of the information sheet was emailed to every participant with the invitation to participate in the study. A remuneration of $20 was provided to each interviewee before starting the audio-recording in appreciation of the time spent contributing to the study.

Because critical ethnography tries to uncover situations of domination and disempowerment, unforeseen events or consequences may arise, placing participants in a vulnerable situation (Carspecken, 1996). Streubert (2011) proposes that participants should be made aware of such possible risks. A consent form was signed at the beginning of each interview and each participant was reminded of his or her full right to withdraw from the study at any time

or even refuse to answer any question without any negative consequence (see Appendix G for Consent Form). Participants were informed that this research was conducted independently from the organization in which they were employed and their decision to participate (or not) would in no way affect their professional involvement and/or employment.

All participants were made aware that their personal information and interview data would be anonymized and kept confidential, and all electronic data would be stored in a secure computer protected by a password. All hard copies would be kept in a locked cabinet in the locked office of my supervisor at the University of Ottawa. Only my thesis supervisor and primary researcher would have access to the list of participants and other related research data. Participants were also reassured that their identity would not be revealed in any future report. Only anonymous results using pseudonyms of the participants and organizations would be shared with committee members and appear in future presentations and publications. After the data analysis period, hard copies would be shredded, and all electronic data would be securely deleted from computer five years after the data collection.

Data Analysis Method

In this study, the caring actions of participants were analysed based on verbatim accounts collected during interviews with the participants. Critical ethnography moves from the mere objective and traditional description of reality to the value-laden judgment of reality that exposes contextual power conditions that produce a specific version of reality (Thomas, 1993; Carspecken, 1996; Holmes & Smyth, 2011). Based on this fundamental characteristic of critical ethnography, thematic analysis was chosen as a method for data analysis. Thematic analysis is a theoretically flexible method that allows coding and identification of themes across a variety of epistemological and ontological positions including critical realism. The flexibility of thematic

analysis permits “sitting between the two poles of realism and constructionism” (Braun & Clarke, 2006, p. 81). This method of analysis enabled me to aknowledge the experiences and meanings reflected by participants (realism) without neglecting the impact of the broader social context on those experiences and meaning (constructionism). Through this peculiar trait of thematic analysis, I was able to explore reality as stated by participants without neglecting how powerful discourses structure that reality. Essential requirements to utilize thematic analysis are clarity and transparency in addressing epistemological and theoretical assumptions that the researcher holds about reality and the nature of the data collected (Braun & Clarke, 2006). This requirement is compatible with the value-mediated epistemology of critical ethnography (Scotland, 2012) in which analysis and interpretation of data are framed by theories of domination and oppression rather than relying solely on the inside perspectives of participants (Carter & Little, 2007). In this study, my positioning as a researcher and my theoretical assumptions were presented in a transparent manner at the end of chapter one where I discussed my motivation and interest in conducting this study and in chapter three where I positioned myself within the critical emancipatory dimension of critical theory.

Data analysis was not distinct from the process of data collection. It was an iterative and ongoing process starting from the first interview (Creswell, 2013). From the beginning of data collection, I met regularly with my supervisor to reflect on the interviewing process, to refine the questionnaire, and to discuss the coding of data and development of themes. Data analysis began by examining the participants’ verbal perspectives for the purpose of identifying codes and potential themes. I transcribed each interview and did a thorough reading of the transcript to familiarize myself with the information provided and the message each participant intended to deliver. The software I used allowed me to develop an intimate connection with my data. I

looked for perceptions and behaviours of participants through back and forth reading with reflexive notes taken to scrutinize how concepts and meanings are connected and how they could be coded and then collated and grouped.

Coding and Developing Themes

In order to capture the meanings provided by participants, open coding of verbatim accounts was adopted in data analysis. In open coding, I did a line-by-line review of data to identify concepts and phenomena and conceptualize patterns (Streubert & Carpenter, 2011). Meaningful pieces of data were coded to identify their meaning. Open codes used to represent the data were formulated using the exact words of the participants or terms that were similar or close to the participants' words. Special attention was paid to behaviours, routines, values, policies, and standards of care in order to portray the culture as perceived by participants. Because in open coding (that is actually linked to and derived from the data itself) "researchers cannot free themselves of their theoretical and epistemological commitments" (Braun & Clarke, 2006, p. 84), I was also attentive to code key statements that addressed nursing actions and showed relevance to the research questions. After each interview, I used the existing codes as a base to interpret the next interview. New codes were generated whenever needed. Open coding was necessary to present factual detailed information provided by participants with a focus on critical elements that described their daily life experience (Wolcott, 2008; Creswell, 2013). This is needed for the researcher to describe behaviours and values in the natural context of participants (Carspecken, 1996; Streubert, 2011). Analysis in this form is perceived as an endeavour to reflect and understand a reality that will be later analyzed through the critical theoretical framework adopted in the study.

After coding all data, I started collating relevant codes in order to develop main or major themes (the two terms are used alternatively). This phase of data analysis was approached with the research objectives and questions in mind. In this sense, developing themes was focused on what nurses do, why they do what they mentioned, how they define good care, and the influence of the context on their actions. Maxwell and Miller's (2008) strategies of similarity and contiguity were followed to identify relationships among codes. In similarity-based relationships, combining codes was based on the explicit resemblance or sharing of clear relational features that are easily recognized. In contiguity-based relationships, codes were subsequently combined based on the conscious perception of association or connection within a certain context, or by cause-and-effect relations that occur as consequences of the influence of a certain concept, process, or action on another. Accordingly, open codes were aggregated whenever they fit well with each other.

In this phase of analysis, relevant codes developed into potential themes or what Braun and Clarke (2006) prefer to call subthemes. Following the same stated strategies of relationships, subthemes were merged and consequently four major themes were developed, representing the different dimensions of data relevant to the research questions (see Appendix H for thematic analysis chart). Codes that did not seem to fit into the developing themes were dropped into a "miscellaneous" theme, something that was suggested by Braun and Clarke (2006) as a temporary holding that can be discarded after the main themes are reviewed, refined, and confirmed. This method of data analysis entailed elucidation of the meanings, roles, and consequences of participants' actions and institutionalized practices, and how the local and wider context influenced such actions (Cook, 2005; Hammersley & Atkison, 2007). Moreover, it

explained the type of knowledge and behaviours required to maintain the system (Carspecken, 1996).

Trustworthiness and Rigour

In qualitative research, peer review is a validation strategy that provides an additional external check of the research process (Creswell, 2013). Memos and notes of self-critical accounts during interviews and during the descriptive and theoretical phases of data analysis were periodically debriefed by a peer (in my case, my thesis supervisor) who used to critically ask questions about meanings of such notes, methods used, and interpretation of data. In order to improve reliability and validity of results and for the sake of overcoming bias in data, space and person triangulation was used (Streubert & Carpenter, 2011). Space triangulation refers to collecting data from two different sites while person triangulation involves interviewing different levels of people: managers and staff nurses as well as junior and senior nurses. This strategy credits the methodology with additional congruency that reduces bias of data.

Due to the value-laden character of critical inquiry that influences data analysis by the researcher's assumptions and ideology (Scotland, 2012), critical researchers are not interested in objectivity per se but rather in reflexivity "to guard against personal bias in making judgements" (Polit & Beck, 2012, p.179). Creswell (2013) clarifies that reflexivity is practiced by having researchers be aware of the biases, values, and experiences that they bring to the study and by having them reflect on how such traits may shape the interpretation of the findings. Berger (2015) explains that reflexivity aims to monitor the research process to prevent the "colonization" of others' perceptions. Researchers should be explicit about their background, values, and conceptual perspectives that influence the methodology utilized to manage the research topic (Reeves et al., 2013). They should also be cognizant of the fact that their position

should not be static but open to the influence of participants whose empirical experience is under study (McCabe and Holmes, 2009; Emerson et al., 2011). Accordingly, in this study, I was transparent about my epistemology and theoretical orientation as a researcher where I presented the critical theoretical framework that I believe can give new insights into nursing caring action. When I started the analysis, I was always aware of my epistemological position as a researcher and in order to alleviate my bias and orientation, I was constantly asking myself if data could be presented in a better way to reflect a participant's own perspective. During the whole interviewing process, participants were given the chance to present their own ideas and express their input in a non-judgemental manner and were encouraged to be reflexive in their responses about their caring actions.

Summary

In this chapter I have described the methodology and methods used to study the research problem. I explained the theoretical underpinnings of critical ethnography to show its compatibility with critical theory adopted for this study and to prove the usefulness of this approach in analyzing nurses' action, thereby achieving the stated goals of the study. Critical ethnography has been chosen because it provides opportunity for nurses to reflect on their practice and explain how their subjective ideals differ from the synergetic forces shaping their caring practice. I explained my particular method to analyze culture in addition to the normative reconstruction method proposed by Axel Honneth that will be utilized in the theoretical discussion of empirical data. After that I provided details about the methods and procedures implemented to accomplish the study including the method of data analysis followed to manage data and develop themes. The chapter closes with the strategies used to validate the findings.

Chapter Five: The Home Care Environment in Ontario

Introduction

This chapter provides an overview of the essential aspects pertinent to the home care sector in Ontario. It provides background information to enable the reader to integrate the information that participants revealed in their interviews with the larger socio-economic and political context of home health care. I will provide a brief overview of the historical development of Ontario home care. The description will highlight how a neoliberal rationale systematically dismantled publicly insured healthcare, and home care in particular. In what follows I will discuss five aspects: (1) Home care as a publicly funded but not insured sector; (2) the historical evolution of home care governance and the most recent transformations introduced by the provincial Conservative government; (3) the challenges home care is facing; (4) the payment mechanisms and the monitoring of service providers' performance to determine their eligibility for government funding; and (5) a description of the nursing workforce in home care.

Home Care as Publicly Funded but not Insured.

Home care usually refers to the necessary caring services in patients' homes that consist of, among others, nursing care, support with medical equipment, rehabilitation, physiotherapy, personal care, home support services, and social work and education for patients and their relatives (Canadian Home Care Association, 2015). The *Canada Health Act* implemented in 1984 represents Canada's federal health insurance legislation, Medicare, which is built on five pillars that must be respected by the provinces/territories in order to receive federal funding for publicly insured healthcare services (Health Canada, 2018). These criteria are: public administration; comprehensiveness; universality; portability and accessibility. *The Canada Health Act* affirms that basic medical needs related to hospitals and physician services in clinics

are covered by Medicare, which guarantees that such services are shielded from competitive marketing and are accessible to the public (England et al., 2007).

In Canada, home care belongs to long-term residential care which are listed as extended healthcare services under *The Canada Health Act* (Health Canada, 2018, p. 8). In addition to home care, extended healthcare services include nursing homes (known as LTC facilities) and other community healthcare services such as clinics and ambulatory care centers. Because they are situated outside the financially covered universal healthcare services deemed medically necessary and protected by Medicare, all extended healthcare services are publicly financed but not insured. This vague position enabled neoliberal policy makers to systematically undermine all long-term residential services by cutting services, privatization, and market-based reforms through which the government distanced itself from providing services and allowed competition among private and for-profit organizations to offer public services (Fisk, 2000; England et al., 2007).

Historical Evolution of Home Care Governance

Since its implementation in the 1970s, home care in Ontario has been run by the private sector whereby corporate service providers funded by the government deliver a range of services that are supposed to safeguard living conditions to enable patients to stay in their homes (Ontario Home Care Association, 2008). Starting in the mid-1990s, Canadian healthcare policies have been influenced by a neoliberal rationality that aim to correct budget deficits by cutting back public and social services, including healthcare, and encouraging private for-profit organizations to provide services previously provided by the government (Fisk, 2000). In this sense, neoliberalism led to the reduction of financial federal support to the provinces, a reduction which targeted public services provided to the population. Despite the systematic defunding, in 1992

the total ratio of health expenditure to the GDP increased, reaching 9.8% of the GDP for the first time compared to 6.8% in 1979 (Canadian Institute for Health Information (CIHI), 2019). In response to this sharp increase, the federal government reduced its contribution to the provinces even further and forced provincial governments to decrease their expenditures even more. Provincial governments began to turn their focus to more community-based and preventive health services than the more traditional and centralized care that had a heavy dependence on acute care institutions and a focus on curing (Barker, 2007).

In 1993, the New Democratic Party (NDP) government in Ontario passed the *Long-Term Care Act* which combined more than 1000 for-profit and charitable home care agencies into 200 Multiple Service Agencies (MSAs) for the purpose of involving the public in coordinating health in community services including home care and LTC (Williams, 1996, England et al., 2007). Before this Act, home care was provided only by non-profit agencies funded by government through local municipalities. The Act constituted the first entrance of for-profit companies into the home healthcare sector. Although this step was taken to meet the needs of clients and service providers with certain considerations to quality of care, it was criticized as undervaluing charitable efforts, transforming home care into a business in an extremely bureaucratic context (Layton-Brown, 1994).

In 1995, the Conservative government under the leadership of Premier Mike Harris promised to restructure government and change social policy under the slogan the "Common Sense Revolution." Fiscal austerity, cost containment, reduction in both tax rates and the public workforce, and welfare cuts characterized public services under this revolution and heralded a shift to marketized services (England et al., 2007). In 1996, the Conservative government replaced MSAs with 43 Community Care Access Centres (CCACs) created to manage and

supervise LTC healthcare services in 43 local regions (Ontario Home Care Association, 2008; Randall & Williams, 2006). The CCACs were developed to provide a single point of access to diverse healthcare services with the aim of linking hospitals with home care and other community services (Ontario Association of Community Care Access Centres, 2014). This reformation was associated with the introduction of "managed competition" into home care, whereby private service providers (non-profit and profit-oriented agencies) in the market of home care competed to bid on the publicly funded contracts with the idea of ensuring appropriate public access to the best quality requirements with the lowest minimum price (Randall & William, 2006). Marketization of home healthcare contributed to the deregulation of public services, the decentralization of government authority, and a new form of social life (England et al., 2007). Competition among providers in the market was not adequate due to expensive requirements associated with the bidding, which resulted in high costs of services by companies who were able to afford the bidding (Randall & William, 2006). Freezing of public funding in 2001 led to decreasing nursing hours provided to patients by 22% between 2001 and 2003, thus, instead of decreasing cost and improving quality, service fees increased and quality was undermined by limited resources (England et al., 2007). Moreover, instead of less state control of the market, which is supposed to be self-regulated, there was an internal contradiction with more government intervention to control and manage the private market.

In 2003, the government of Ontario was challenged by a large deficit of $5 billion, almost half of which was related to health expenditure (Barker, 2007). The sustainability of healthcare created therefore a central challenge to the management and administration of healthcare at the federal and provincial levels (Doberstein, 2020). The provincial government decided to address the deficit by the fiscal year 2007-2008 through a seemingly more collaborative and efficient

model of healthcare that involved the public in policy making with less central control by the government (Barker, 2007). In 2006, the Liberal government of Ontario created 14 semi-autonomous Crown agencies called Local Health Integration Networks (LHINs) with the promise that LHINs would enable decision making at the local level and respond to the needs of citizens in the community (Doberstein, 2020). The idea of the LHINs emerged as part of the plan developed to integrate and coordinate the healthcare system by combining the efforts of hospitals, physicians, home care providers, long-term care homes, and other health services for the purpose of running healthcare in a more efficient, cost-effective, and participatory model that responded to local needs (Sheppard, 2019).

The multiple number of CCACs were reduced to 14 to match and support the 14 LHINs in supervising, funding, and coordinating delivery of health services in hospitals and communities within specified geographic boundaries in Ontario (Baker, 2007). Home care continued to be contracted out to service provider organizations (SPOs) through a competitive process that aimed to improve productivity in a cost-efficient manner through the implementation of specific performance standards (Randall & William, 2006). The CCACs role was to oversee the daily operation of service providers with accountability to the LHINs (Auditor General of Ontario, 2015). The promise was that the introduction of LHINs would decentralize policy making by delegating authority from a state-control model to a participatory model where specialized organizations, professionals, and citizens were given an opportunity to influence policy (Doberstein, 2020).

However, there was no transparency or adequate consultation with the public. Community engagement in decision making was absent and the LHINs were conducting several meetings around healthcare restructuring that were closed to the public (Ontario Ombudsman,

2010). Regional restructuring of healthcare meant that the Ministry of Health would prescribe the general direction of healthcare policy while the regional authorities would assume responsibility for how providers would be financed and coordinated, and how healthcare services would be delivered (Barker, 2007). Within this multi-layered system of decision making where multiple managers of service providers decided on care delivery and provision, the government appeared no longer accountable for the outcomes of healthcare provision because the decisions were made by the managers of the LHINs (Barker, 2007). Not only that, but the decisions were made without any democratic accountability because the managers of the LHINs were not elected representatives from the local community but appointed by the province (OHC, 2015b).

In 2015, the Office of the Auditor General of Ontario conducted an in-depth audit on the general performance of CCACs and their high administrative costs in response to a request from the Legislature's Standing Committee on Public Accounts. The audit concluded that to achieve equity and quality in home care, structural changes were needed for the financial operations and service delivery of the CCACs (Auditor General of Ontario, 2015). Findings of the report put the government under pressure to promote efficiency by managing funds to serve direct patient care, increase equity in care regardless of the geographical location of patients, ensure easy access to home and community care, and reduce bureaucracy in home and community care (Church, 2015).

In 2016, *The Patients First Act* was passed to reform the provincial healthcare system by dissolving the CCACs after criticism of their deficient performance. The goals of the Act were derived from a proposal that focused on the coordination of care between primary care, hospitals, and home and community care, to reduce bureaucracy, to strengthen accountability to patients, and to attain equitable access care for patients in community and home care (MOHLTC, 2015).

The Ministry of Health promoted this Act by emphasizing that it would bring care closer to home and community and empower patients to be more active partners in planning for care that would be appropriate to their needs and compatible with their culture (Donner et al., 2015). The Act transferred the responsibility for the CCACs to the LHINs, who were given the authority over community and home care to enact their mandate to integrate and coordinate care among hospitals, primary care, and home and community care (Sheppard, 2019). Although *The Patient First Act* was promoted as a means to transform the healthcare system and to change the character of the LHINs through an integral model of care, whereby primary care physicians along with nurses and other care givers coordinate care to make its delivery more accessible to all patients, changes in this direction did not materialize and the primary goal was never achieved (Wojtak & Stark, 2016). Moreover, this step was expected to increase financial efficiency and the integration of healthcare services to achieve continuity of care and equity in healthcare services to patients. However, shifting responsibilities from CCACs to LIHNs did not result in evident savings in the budget (OHC, 2017b). Instead of more money being invested in direct patient care, LHINs were criticized for consuming huge administrative fees (Doberstein, 2020) and the struggle of contracting home care to profit-making agencies continued to exist (OHC, 2017b).

In February 2019, the newly elected Conservative government decided on a radical transformation of healthcare in Ontario. The LHINs have been eliminated and have been replaced by a "super agency" that supervises local healthcare services including home and community care (Bell, 2019a). From their inception, Conservatives criticized the LHINs for spending too much money on administration, money that could better be used to serve patients' needs. They also criticized the LHINs for being inefficient in integrating healthcare services to

improve access to care (Hendry, 2019). In December 2019, the Ministry of Health started gradually merging the 14 LHINs and other major health agencies in Ontario into 5 Health Teams based on 5 geographic regions in Ontario (Hendry, 2019; MOHLTC, 2019). The Health Teams will work under the above mentioned super agency, called Ontario Health, with the government's promise that this step will place the interest of the patient at the center of a sustainable healthcare system that integrates services, ends inefficiencies, ensures quality care, diminishes wait times, and lightens overcrowding in hospitals. Furthermore, the government claimed that the merging would help to control the huge costs of the LHINs and ensure better coordination between hospitals and other community healthcare providers, thereby better serving patient needs (Hendry, 2019; MOHLTC, 2019).

Dismantling the LHINs did not change the basic idea of decentralized management adopted by the government. The creation of Ontario Health Teams was followed by the introduction of the *Home and Community Care Act 2020*, which removed the cap on support services needed for home care patients and left decisions about care needs to home care providers (Legislative Assembly of Ontario, 2020). But according to OHC (2020a), without solving the problem of underfunding and staff shortages, the *Act* is interpreted as a step forward in the decentralization of home care services, in which the authority and control of home care is handed off to the private for-profit home care providers who bid on contracts through the newly established Health Teams and decide on the care provided to patients. Without supervision from the LHINs and without solving the problem of underfunding, private home care organizations – who are mainly for-profit companies – are unaccountable for their services and increase their profit margin at the expense of quality of home care services (OHC, 2019, 2020a).

It is important to remind the reader that this transformation coincided with the COVID-19 pandemic when home care suffered a severe shortage of healthcare workers (Pfeffer, 2020). Patients and families raised their voices about the interruption of services during the pandemic and the lack of and delay in coordination in receiving the necessary supplies that were vital for the health and well-being of patients (Ireton, 2020). Reports of the situation in long-term care homes, that are subject to the same policies as home care, revealed shocking details about the negligence and maltreatment of residents who were left with no assistance to meet their very basic needs such as bathing and feeding, and with no adequate safety or isolation measures taken to prevent the spread of COVI|D-19 (Adam, 2020, Military Report, 2020). Long-term care homes were not only understaffed but were also lacking accountability in providing adequate caring services. Improper care was related to cuts in funding, privatization, and systematic neglect by the government (Malek, 2020). It is also worth mentioning that the empirical data of this study were collected before the pandemic, during the period of healthcare transformation when the LHINs were in the process of being dissolved, whereas the data analysis took place when the COVID-19 pandemic influenced all aspects of life, including the healthcare system.

Government officials claimed that the privatization of the home care sector and the creation of the CCACs and the LHINs would lead to better integration of services and ensure better access to care in a more efficient and participatory model that responds to public needs. Furthermore, the government argued that the transformation would result in the decentralization of public services. Actually, the transformation achieved quite the opposite by adding an extra layer of bureaucracy with no visible public engagement, consuming high administrative fees, failing to coordinate services more effectively, and increasing inequity for accessing care (Auditor General of Ontario, 2015; Barker, 2007; Hendry, 2019; Sheppard, 2019). Although the

newly established Health Teams are expected to coordinate directly with service providers (Benner, 2020), what is missing in recent transformations is a system of integrated services that facilitates access to care with a central vision of care that is patient-centred (Sheppard, 2019). Although quality standards are always mentioned as an essential element of contracts, cost remains the main determinant of work performed with minimum acceptable standards and absence of public accountability (OHC, 2001). It is argued that what is needed for a balanced home healthcare is not less supervision of service providers but a non-profit system that integrates healthcare services with accountability to the public interests (OHC, 2020b). Without clear accountability measures from the government, the quality of care provided by private agencies in the market leads to the deterioration of healthcare, and healthcare care services will continue to be profit-oriented, fragmented, and insufficient to meet patients' needs. The results of this system became blatantly clear with most of the COVID-19 deaths occurring in LTC homes.

Challenges to Home Care

The development of the home healthcare system has been facing several challenges in Ontario. Three factors are considered constant challenges that constrain the ability of home care agencies to provide patient-centered care: the demographic transition, meaning the growth of the aging population; an increase in the referral of discharged patients from overcrowded hospitals; and underfunding (Home Care Ontario, 2018, 2020). Each of these three challenges will be addressed with detailed explanation.

Aging population.

Those whose age is 65 years and above represent about 17.5% (around 6.5 million) of the total 37,589,000 Canadian population (Statistics Canada, 2019). By 2036, this proportion is expected to rise to about 25% (CIHI, 2011). Seniors use healthcare services more frequently and

utilize the system more than any other age groups. For example, in 2009, about 45% of the healthcare expenditure of the provincial and territorial governments was on seniors who accounted at that time for only 14% of the population (CIHI, 2011). In 2018 in Ontario, the number of seniors above 65 years was 19.8% (around 2,355,000) out of a labour force of 11, 897,000 people 15 years and over (Statistics Canada, 2018). The number of seniors in the province is expected to double in the coming two decades with an increasing complexity of care needs, a condition that imposes economic constraints and requires transformations in the healthcare system, particularly in community and home care, to ensure sustainability of health services (Ontario Association of Community Care Access Centres, 2013; Home Care Ontario, 2018). For example, in 2014-2015, about 60% of clients receiving home care in Ontario were senior citizens (Auditor General of Ontario, 2015). Meeting the needs of a growing aging population that utilizes a broad range of resources remains an active concern for the government of Ontario as well as for all provincial governments (Ontario Home Care Association, 2008; CIHI, 2011; Kula, 2019; MOHLTC, 2015).

Increase of discharged patients.

The number of patients discharged from hospitals to home care increased by 42% between 2008 and 2012 (Home Care Ontario, 2018). Because in 2011 hospital reimbursement shifted to Quality Based Practice (QBP), where hospital payment became dependent on the number of patients with a specific diagnosis treated according to QBPs (Li et al., 2020; MOHLTC, 2020), hospitals became interested in early discharge of patients to increase the influx of money from the government. Early discharge from hospitals placed LTC facilities including the home care sector under pressure to accept the increased number of discharged patients (Home Care Ontario, 2018). Another problematic situation placing pressure on home

care is hospital congestion, which has primarily been caused by the high number of Alternate Level of Care (ALC) patients who are ready for discharge but either cannot go home because care at home is not available or they are waiting for a place in long-term care centers (Home Care Ontario, 2018). Due to continuous underfunding and cuts in healthcare services, Ontario has lost more than 18,000 hospital beds in the last 20 years, a condition that has contributed to the emergence of "hallway medicine" in hospitals (OHC, 2018). ALC cases, which have increased to record-high numbers recently, are also the main contributors to this practice where patients are treated in hallways, conference rooms, and hospital lounges (Home Care Ontario, 2018). In September 2019, there were 5,372 ALC patients in Ontario compared to 3,533 in 2014. This increase in numbers that accounts for 17% of hospital beds reflects a lack of access to services outside the hospital. Moreover, "the total number of days of stay in hospital for ALC patients as of September 2019 was approximately 75,000, which is a 25% increase from the almost 600,000 days for all ALC patients waiting in September 2018". (Ontario Hospital Association, 2019, p. 13). As a consequence of hospital overload, in January 2019, 10% of patients waiting in the emergency department for admission remained an average of over 41 hours compared to the 32 hours of wait time during September 2018 (Ontario Hospital Association, 2018, 2019).

Due to the increased strain on home care, the Conservative government budget for home and community care was increased by $155 million for the year 2019, which is almost 14% less than the 2018 budget of $180 million (Bell, 2019b). However, most of the increase in funding will be put towards faster discharge after elective surgery, which will also increase pressure on home care. Without a well-coordinated home and community care system, readmission of discharged patients will likely increase, and hospital overcrowding will continue. According to

Home Care Ontario (2016), the cost of caring for terminally ill patients at home is approximately 10 times less than the price of providing care in hospital. Although home care plays a critical role in creating an effective and sustainable healthcare system, which can relieve hospitals in a cost-effective manner (CCACs, 2016), accepting a huge influx of patients and receiving a growing number of the aging population will only increase the complexity of the situation in the home care sector (Home Care Ontario, 2018).

Underfunding of home care.

Although funding for home care increased from $1.76 billion in 2009 to $2.5 billion in 2015 (Auditor General of Ontario, 2015), the increase in funding has not grown proportionally to the continuously increasing demands of home care patients (Home Care Ontario, 2016, 2018). The overall patient volume has more than doubled from 2004/2005 to over 700,000 patients in 2014/15, and the complex care of patients has increased to approximately 70% compared to less than 40% in the last five years (Auditor General of Ontario, 2015). In 2016, more than 729,000 clients received publicly funded home care services and more than 39 million visits were delivered – including from PSWs, professional nurses, and other professional workers (Home Care Ontario, 2018). Despite demographic challenges and the increase in volume and complexity of referred patients, the home care budget has remained stagnant at 5% of the total health expenditure for more than 10 years. The increase in demand on home care has not been met with an annual budget increase. To convert this into numbers, in 2017/2018, home care funding was limited to $2.7 billion out of the $53.9 billion allocated for healthcare in the province of Ontario (Home Care Ontario, 2018). Considering the increase in the number of patients, funding per individual patient decreased from $3,486 in 2002/2003 to $3,396 in 2013/2014, representing a

3% reduction rate at a time when patients are becoming sicker and their care is more demanding (OHC, 2015a).

Due to the government's systematic underinvestment in home care and the market-oriented mechanism of care delivery, promises of equitable access to care based on patient needs ended up with Ontarians who need home care to be financially responsible for obtaining their health services regardless of their socio-economic status (Yakerson, 2018). From this perspective, it is estimated that every year 150,000 Ontarians purchase 20 million visits/hours of home care services (Home Care Ontario, 2020, p. 14). This statistical data resonates with the critique of the neoliberal rationale that aims, through the reduction in quality and efficiency of public services, to force individuals to buy services from private providers in the market, deepening already existing inequities to needed care (McGregor, 2001). Instead of being a public service that would benefit each member of the society, neoliberalism transformed home healthcare into a service sold by private companies, whereby access to certain services depended on one's financial resources (Fisk, 2000). In this sense, cuts in the home care budget and the privatization of healthcare services threaten the mission of Medicare's principles of universality, accessibility, and public administration (Fisk, 2000).

Increased financial pressure pushed Service Provider Organization (SPOs) to call continuously for an increase in annual budgets to be able to manage the increasing demands of home care patients. In 2018, home care providers requested an increase in its annual funding to 6% of the total health care budget (Home Care Ontario, 2018). Most recently, Home Care Ontario recommended the government immediately provide a 5% increase to contract rates for home care in the 2020-21 budget (Home Care Ontario, 2020). The cumulative effect of underinvestment in home care has pushed the health teams and home care providers to decrease

quality of care through increasing the workloads of nurses and other caregivers, which in turn results in more stress and less patient satisfaction. Another effect of this transformation is the continuous shortening of the time available for home visits and an increasing shortage in personal support services (Home Care Ontario, 2018, 2020).

Payment Mechanism and Performance Monitoring

Home care providers are paid based on "billable annual hours," which necessitates scheduling staff as efficiently as possible to fit the high number of referred patients (Home Care Ontario & Ontario Community Support Association, 2017a). They try to spread resources as much as possible and increase the workload on staff, increasing the stress on care givers and the dissatisfaction among patients (Home Care Ontario, 2018). The underfunding of home care has already led LHINs to move from a one-hour visit for particular patients, such as wound care patients, into portions of 45 minutes, 30 minutes, and even 15 minutes for care that technically requires more time than the time allocated. This is particularly deplorable as the majority of patients are frail and require prolonged assistance due to their physical mobility problems (Home Care Ontario & Ontario Community Support Association, 2017a; Home Care Ontario, 2020). In Ontario this form of home healthcare that is based on efficiency measures is leading to the "Uberization" of healthcare services (Wojtak & Stark, 2016). This form of home care is a non-functional model that is focused on the number of visits covered rather than on meeting the individual needs of patients (Yakerson, 2018). Most recently, during the COVID-19 pandemic, and due to severe staff shortages and increased demand on home care, nurses were pushed to conduct up to 15 visits per day compared to an average of 8 to 10 visits per day last year, resulting in fragmented care and gaps in providing services (Pfeffer, 2020).

All contracted service providers are paid per-visit and billing rates cover wages, benefits, transportation, and professional development of employed staff (Auditor General of Ontario, 2015). CCACs already required that all service providers had to submit quarterly reports and annual summaries on their own performance to meet a set of patient-focused performance indicators (CCACs, 2016). CCACs monitor the performance of service providers and accordingly decide whether to continue payment, issue a performance improvement notice, withhold payment, reduce the volume of referred patients, or terminate their contract (Auditor General of Ontario, 2015). These mechanisms are still in place after the recent restructuring of Ontario healthcare. In order to standardize care and evaluate the quality of care provided by SPOs, the government, or more specifically the LHINs, adopted an assessment matrix that includes a set of performance indicators (see Appendix I for performance indicators) with a scoring formula for each indicator, which allows numerical assessment of the total performance of the service provider (LHINs, 2018).

Based on the specific requirements of the performance indicators, the government contract was described by SPOs as "prescriptive" (Home Care Ontario, 2018). CCACs and LHINs require SPOs to accept 94-97% of the monthly referrals offered. Referrals are sent through the computer system Health Partner Gateway (HPG) and SPOs are given only 30 minutes to accept or refuse referrals, with no option to negotiate needs or question the patient's condition beyond the information provided that includes only the name and treatment of the patient (Home Care Ontario & Ontario Community Support Association, 2017a; Home Care Ontario, 2018).

Due to increased pressure on hospitals to discharge patients and free beds, the referral of discharged patients poses a critical challenge ton SPOs, especially when services are needed on

the same day or on weekends, when home care managers are required to locate and assign staff who can deliver appropriate care for patients admitted to the home care services (Home Care Ontario & Ontario Community Support Association, 2017a). Moreover, SPOs are supposed to do their best not to send the referred patient back to the emergency room for any unplanned visit or within 30 days of hospital discharge, otherwise the quality of their performance would be negatively influenced (Health Quality Ontario, 2017, 2019). This quality indicator has put professional caregivers under additional pressure to prevent any possible complication. They frequently spend unpaid extra time to assess, detect, and address any health issue that can prevent hospital readmission (Home Care Ontario, 2019).

Clinical pathways and guidelines adopted for a number of cases such as wound care, hip replacement, and knee orthopedic cases (LHINs, 2017) are very specific as to the outcomes that must be achieved within specific time frames, similar to the QBP followed in hospitals. For example, surgical wounds are expected to close completely in 8 weeks and knee-replacement surgical cases should be able to perform 90 degrees of flexion in 28 days, which is not always possible to achieve within the expected time frame, a condition that has left nurses uncertain about what they should do when outcomes are not achieved within the expected date (Auditor General of Ontario, 2015). The nature of performance indicators reflects the huge pressure on the shoulders of the SPOs and professional care providers to provide quality care in order to maintain contract conditions and continue to receive payment.

The Nursing Workforce in Home Care

Registered nurses play a fundamental role in the provision of home care services along with a wide range of other specialists such as Occupational Therapists (OTs), Physical Therapists (PTs), Social Workers and unregulated Personal Support Workers (PSWs) who all work for

home care providers/agencies to meet the needs of patients at their place or residence (Home Care Ontario, 2020). Nursing is the most utilised professional resource in home care practice (Canadian Nurses Association, 2013). Unlike the hospital setting, home care nurses struggle on a daily basis to travel to their workplace, which changes in location with each visit (Canadian Nurses Association, 2013). The stated aim of home care nurses is to support, maintain well-being, or improve the quality of life for patients in their homes (Mildon & Underwood, 2010; Home Care Ontario & Ontario Community Support Association, 2017b). Home care nurses are expected to give care, coordinate services, and advocate for patients in a relationship that respects the dignity and partnership of patients and their families. They require clinical expertise with a broad base of knowledge about health and illness across the lifespan of their patients. In their clinical practice, home care nurses are supposed to act autonomously, competently, and with confidence (Home Care Ontario & Ontario Community Support Association, 2017b). They generally have advanced communication skills and critical thinking to judge emerging complex situations.

In home care, frontline nurses are either Registered Nurses (RNs) or Registered Practical Nurses (RPNs). Although RNs have a higher education and a deeper knowledge base that qualifies them to care for highly complex, unpredictable, and high-risk cases which often have negative outcomes (CNO, 2018a), both RNs and RPNs work closely in home care and they both practice to the full scope of their ability to meet patients' needs. These needs often entail complex procedures such as chemotherapy, pain management, wound care, peritoneal dialysis, and palliative care (Home Care Ontario & Ontario Community Support Association, 2017b). They both perform their responsibilities with a high level of autonomy and have equal access to patient information and system services. Statistics on nurses working in home care

sector are limited. According to the RNAO (2019), in 2017 there were 95,350 RNs and 43,100 RPNs employed in Ontario. Gender distribution showed that the percentages of male RNs and RPNs employed were 7 and 9.1 respectively. That year the community sector employed 19.9% of nurses, compared to 18.4% employed in 2010, with home care nursing being among the top five employers (Ontario Home Care Association, 2011, p. 5).

Home care nurses are known to be paid less than their colleagues working in other healthcare settings. Because of the nature of their work and also due to the disparity in wages between home care and hospital nurses, it is extremely difficult to recruit these nurses (Home Care Ontario, 2020). For example, in 2011, RNs in the home care sector had an average hourly wage of $30 compared to $37 for RNs working in hospitals. Similarly, RPNs in home care had an average wage of $21.1compared to an average of $26.5 for RPNs working in hospitals (Accenture, 2014). The government's competitive contract bidding that favors the agency that is ready to provide care at a lower price results in home care nurses being paid lower wages with fewer benefits compared to their colleagues working in hospitals, a condition that produces a lower status for home care nurses, destabilizes their work conditions, and leads to their shortage (England et al., 2007). It is noteworthy that during the COVID-19 pandemic, around 3000 patients were waiting for home care services in Ottawa due to a critical shortage in nurses and PSWs (Pfeffer, 2020). Officials from the MOHLTC estimated that 800 nurses and 6000 PSWs are needed in the LTC centres and community care services including home care (Payne, 2020b).

Although PSWs are not included in this study, a brief overview of their situation and roles is essential for a comprehensive understanding of the home care context. In Ontario, PSWs are required to complete a certified program of a few months to become formally educated but their role is not regulated so they have no defined job description (Saari et al., 2018).

PSWs supply the majority of home care services (around 74%) by providing supportive physical care to patients in their activities of daily living to ensure independence, safety, and well-being (Home Care Ontario & Ontario Community Support Association, 2017a). They also undertake some complex activities delegated to them by regulated health professionals such as nurses and physiotherapists. These delegated activities may include but are not limited to wound and stoma care, enteral feeding, catheterization, and assistance in manipulating feeding pumps and home ventilators (Barken et al., 2015). In their struggle to fulfill care requirements efficiently, home care providers shift tasks downward to others less educated and less skilled to ensure the continuation of services with minimum cost (Barken et al., 2015). Yet this delegation of care compromises the quality of care by providing inadequate and fragmented care by staff who are not well prepared to do the job (Denton et al., 2015).

Data on the number of PSWs working in Ontario is scarce. In 2016, there were 100,000 PSWs working in Ontario, 90 % of which were female. Thirty-eight percent of the total number of PSWs worked in home care and the community sector (Hillmer, 2019). The shortage in PSWs is also due to their low wages and the nature of the work required of them (Home Care Ontario, 2020). In 2018, the minimum wage of PSWs was raised to $14 per hour but the publicly funded home care wage was still 9.2% lower than wages in the LTC facilities and 18.7% lower than in hospitals (Home Care Ontario, 2020). Most recently, there is still a 19% wage gap for PSWs compared to their colleagues working in hospitals (Pfeffer, 2020).

Summary

This chapter provided some background information to better understand what participants reflected on in the interviews. Increasing the quality of care was the declared aim of the radical neoliberal transformation of the healthcare system and was to become the main

indicator for measuring the success of the transformations. However, the implementation of a competitive bidding process in home care, efficiency measures, and cost containment were the main determinants of healthcare. Aging population, increase in hospital discharged patients, underfunding, shortages of staff, and cutting of services were prominent features of home healthcare transformations that also resulted in an increase in inequity and a failure to provide adequate patient centered care. The next chapter will present the actual reality of home care as described by nurses themselves in their daily interactions with patients.

Chapter Six: Results

Introduction

In this chapter, data collected on the daily actions of nurses working in the privatized home care sector in Ontario will be analyzed. Findings are primarily structured to meet the goals of the study by answering the three questions of the research. These questions are: (1) How do nurses describe their daily actions? /What do nurses do in the real clinical field? (2) What are the most important characteristics of "good" nursing care? /What subjective values motivate nurses in their work? and (3) How do contextual factors (organizational and external) influence how nurses actually provide nursing care? /What are the barriers to "good" nursing care? Transcribing the recorded interviews provided a good opportunity for a deep understanding of the data and to link it to theoretical concepts. Data analysis involved the direct interpretation of meanings and consequences of nursing actions and the way these actions were influenced by the local as well as the wider context (Hammersley & Atkison, 2007).

Thematic analysis led to the development of four major themes. The first theme revolves around a very specific kind of nurse-patient relationship that is very intimate and directed to the patient as a "whole" person. The second theme revolves around the core values guiding good nursing care. The third and fourth themes represent challenges to the enactment of good care. The third theme is more focused on funding and that inappropriate forms of care related to service cuts and this underfunding, while the fourth theme is directed towards frustration with standardized nursing work, discontent with the healthcare system, and the moral impact of the challenging work environment on nurses. Table 1 shows the four major themes and their corresponding subthemes that emerged from the process of data analysis.

1. “Knowing on a deeper level”: A very specific kind of nurse-patient relationship.
2. “Treating the patient as a human being”: Values guiding good nursing care.
3. “Doing a lot more with less”: The impact of underfunding and cutbacks on quality care.
4. “Challenged and frustrated”: Policies and work environment not conducive to good care.

Table 1: Outline of Themes and Subthemes that Emerged from Analyzing Nursing Daily Actions

	Major Themes	**Subthemes**
1-	**“Knowing on a deeper level”** A very specific kind of nurse-patient relationship	a. Knowing the very personal dimensions of life b. Understanding the “whole” person c. Involving patient in care d. Providing intimate bodily care
2-	**“Treating the patient as a human being”** Values guiding good nursing care	a. Demonstrating genuine concern and emotions b. Showing respect c. Providing help and advocacy
3-	**“Doing a lot more with less”** Impact of underfunding and cutbacks on quality care	a. Funding as the determinant of quality care b. Time pressure and inappropriate care c. Premature hospital discharge and inadequate access to care
4-	**“Challenged and frustrated”** Policies and work environment not conducive to good care	a. Bureaucracy and standardized care b. Discontent with healthcare policy c. Caring within difficult work conditions

Detailed data about each major theme and subthemes will be presented after a description of the demographic data of the interviewed participants. A wide range of quotes from different participants (nurses and managers) has been selected to reflect the different voices and perspectives of participants. It is essential to mention here that this study, particularly the data

collection, was conducted during the period when the Ontario government decided to dismantle the14 LHINs and replace them with the 5 Health Teams. Data collection was finished about 6 months before the pandemic of COVID-19, which influenced the whole healthcare system, particularly extended healthcare services which include LTC facilities, home care, and other community healthcare services.

Demographic Description of Participants

Participants were recruited from two different private SPOs (which cannot be named for anonymity reasons) operating in the home care sector in Ottawa. The two participating healthcare organizations are among the major home care providers in Ottawa. The first SPO is a local charitable non-profit home healthcare and community support organization that offers a wide range of services in Ottawa such as nursing care, in-home physiotherapy, and personal support services, in addition to other palliative care and health education programs for caregivers. This SPO provides care to different age groups who are suffering from disease or recovering from illness or accidents. Most provided services are covered by provincial health insurance while some other services are provided by volunteers. The second SPO is a leading for-profit provider in home and community healthcare that manages and provides home care services across Canada. It has branches spread all over the country and is considered a trusted provider of healthcare services funded by the government. Services of this home care provider are not limited to those funded by the government but extend to other medical and non-medical home care services outside government financial coverage, which are paid by insurance companies or by individual patients in need of care.

Home care services are usually provided to patients directly after their discharge from hospitals and according to a needs assessment done by the CCACs (this role was later shifted to

LHINs) who refer the patient to one of the contracted SPOs (Ontario Home Care Association, 2008). According to a nurse manager who was interviewed, the majority of patients who receive home care services are cases of "wound or palliative and then we [SPOs] do have clients coming out either from surgery or those who are being discharged from hospital receiving chemotherapy due to cancer treatments" (Transcript P B 7, Pos. 11). It is worth mentioning that services are usually provided at home upon discharge or in clinics run by the SPOs whenever the patient's condition is stable and he or she is physically able to receive the service in the clinic.

As shown in table 2, a total of 18 interviews were conducted (see Appendix J for full demographic data of participants). Participants included 16 female and 2 male professional nurses. I interviewed 10 RNs and 8 RPNs including 4 managers (1 RPN and 3 RNs). One of the managers has a master's in nursing and another has a BA in business in addition to her Bachelor in Nursing Sciences. The third manager has a Baccalaureate Degree in Nursing while the fourth is an RPN with a two-year Nursing Diploma. Among the staff nurses, 12 were home care nurses who conduct home visits and 2 were clinic nurses who take care of patients in community clinics that belong to their respective home care agency. The average total years of experience of all participants in general nursing – home care and hospital nursing – was 17 years (ranging from 4 years to 34 years) while the average experience in home care nursing was 10.6 years (ranging from 6 months to 19 years). Despite the lack of control over convenience sampling, the final sample included senior and junior nurses, which enriched the data with the perspectives of various age groups.

Table 2: Demographic data of participants

Category		N= 18
Gender	Male	2
	Female	16
Category	RN	10
	RPN	8
Position	Staff Nurse	14
	Nurse manager	4
Place of work	Home care	12
	Community Clinic	2
	Management	4
Years of experience in general nursing (hospital and home care)	1 year	-
	2-4	1
	5-9	3
	10-14	4
	15+	10
Years of experience in home care nursing	1 year	1
	2-4	4
	5-9	3
	10-14	4
	15+	6

Theme 1: "Knowing on a Deeper Level": A Very Specific Kind of Nurse-Patient Relationship

A major theme that evolved when nurses were asked about their daily actions in clinical practice was "knowing on a deeper level." In the interviews, nurses talked about a specific form of care that goes beyond a patient's medical treatment and the routine of superficial modes of communication that aim to fill the electronic file of the patient. They described this dimension of care as particular to what nurses do in their daily interactions with patients, where they go "deeper" to a more intricate sphere of knowledge that is personal, private, and difficult to explore. As explained by one RN:

> I think we go deeper with the patient; I think we get to know them more [on a] personal level, we often get to know their families, how they feel, you know what their history is, what their future plans are. I think we just get to know on a deeper level. (Transcript PA 6, Pos. 13)

In order to know the patient "on a deeper level" nurses spoke about a specific kind of relationship that is so complex but fundamental to explore and understand what is going on beyond their assigned tasks. One RPN said: "The biggest thing is developing that relationship with the patient so that you understand not just what you're walking in the door to do" (Transcript PA 8, Pos. 37). In this theme nurses described care in terms of understanding the patient as a whole and emphasized the need to involve the patient not only to understand his or her personal perspective but to have their input and make choices. According to nurses' accounts, the dimension of "deep knowing" was not limited to cognitive understanding but extended to touching the physical body that was identified as a characteristic of nursing caring action. Based on the data analysis, four subthemes were developed under this theme: (a) Knowing the very personal dimensions of life; (b) Understanding the "whole" person; (c) Involving the patient in care; and (d) Providing intimate bodily care. Each of the subthemes will be explained based on what nurses said in the interviews.

Knowing the very personal dimensions of life.

When asked about their regular daily activities and the important things they do during home visits, nurses gave multiple descriptions about a common form of action that was considered essential to nursing care. Although nurses are usually scheduled to fulfill certain tasks that are usually technical in nature and related to the patient's medical condition, participants frequently mentioned a specific kind of "knowing" that goes far beyond the technical aspects of the assigned work. They gave multiple accounts that reflected on the essentiality of exploring and understanding personal concerns of the patient to develop "that understanding" that was

related to the "biggest issues" considered important for the patient. Understanding the personal issues of the patient was prioritized over the technical tasks that were looked at "later" during caring interaction, as one RPN noted:

> The first things that we do is just explain to them what we're there for … and start developing that understanding and talk about any concern that they have. What the biggest issues are, surrounding the reason that we're there, whether it's for wound care or palliative care. Just getting to understand and know them at the sort of personal level and focusing on the assigned task stuff later. (Transcript PA 8, Pos. 11)

Because "knowing" was perceived by participants as patient-centered rather than task-oriented, nurses were focused on exploring the "primary concerns" that reflected what the patient perceived as the "most important" issues for them. Such "primary concerns" might not even be related to the medical diagnosis, which could be "secondary" from the perspective of the patient. This form of knowing is complex and demanding because it identifies problems by exploring the subjective concerns and interpreting the meanings patients have about their own condition. As described by an RPN:

> The important thing is to get what they feel they need, what the most important part of their care to them is? For example, somebody who has a giant wound on their leg may say that it's the wound pain that's the problem; they're not so much concerned about the healing, but it is really painful for them. So, we focus on that as the primary concern while we try to heal the wound. Where if somebody else might have a concern that is entirely unrelated to the wound, and it maybe a safety concern, maybe they have [had] a fall that caused the wound. The wound is secondary in that case because they are worried about the fall and what could happen in the future. (Transcript P A 8, Pos. 17)

"Deep knowing" is thus concerned with the personal needs of the patient and requires collecting information that is personal and biographic in nature. Because computerized data are usually focused on biological data and filling boxes related to the medical condition of the patient, it was not possible to gain this form of "knowing" through cybernetic resources. Interacting with patients through verbal communication was indispensable to have insight into

the patient's "real situation," as one RN explained: "You can look at the computer, you get the referral from the doctor … so you're looking at the history and the referral information and then of course speaking with the client is necessary for understanding the real situation" (Transcript P B 6, Pos. 11). Nurses described this form of "knowing" as a relational dimension that involves building a trustful and honest relationship as a prerequisite to prepare patients to share personal information. It is a difficult mission that requires "having honest conversations where they [patients] begin feel comfortable to share things … that are very difficult for them to share" (Transcript PA 2, Pos. 45). So, it is not a transient communication that takes place during a quick visit that prepares for disclosure of such "difficult" information. One RPN explained that nurses need to "communicate with patients and have them trust you [the nurse] to be able to open up to you" (Transcript PA 5, Pos. 75). Building a trustful relationship that allows "deep knowing" and sharing of information is not an easy job. Building trust is a demanding process that does not develop on the first visit but requires an adequate amount of time to recognize various aspects that influence the patient's health condition. The following quote from an RN reflects the significance of the time factor in establishing trust that leads to sharing personal information about the patient: "I've learned, over the years, it usually takes about four visits before a patient is going really to trust you to say the truth. Usually very rarely do I get in front of somebody for the first time and they share a lot of information about themselves" (Transcript PA 4, Pos. 64).

Trustful communication with patients takes place with no preconceived perception but with an acceptance to all what may come out of them. As one RN said: "… just be a kind of blank slate like I am someone who can listen to you, I am open ears … a person whom you can rely on" (Transcript PA 1, Pos. 57). A relationship of acceptance and being non-judgemental was required so that patients could feel relaxed to reveal their "innermost" secrets and concerns that

are not easy to communicate. Going so "deep" and "intimate" requires that "different level" of a trustful relationship that allows patients to reveal personal information that they may not reveal even to their own family members. Establishing that level of trust in a relationship that goes so deep is a particular characteristic that differentiates nursing care from care provided by other healthcare professionals. The particular nature of this relationship was explained by an RPN:

> I try to be very open so that they always feel comfortable talking to me, opening up about innermost secrets and thoughts and that can be scary for them to share that kind of thing. I want them to be confident and comfortable in divulging information to me … For a lot of our clients, we get pretty intimate with them so there's kind of a whole different level of trust. That's probably the number one differential …We definitely go a lot deeper than other health care people. A lot of time clients will divulge information to us that they haven't even divulged to their own family. (Transcript P B 2, Pos. 13-14)

During interviews, nurses talked about the significance of listening to patients as a pathway to gain their trust and access important personal concerns that patients have in mind. Yet, this form of listening should not be perceived as a passive action. It is a form of attentive listening with full focus on what the patient says with no distractions that could divert attention from what that patient is releasing about the "other things" related to his or her personal concerns. One participant said: "You really have to listen to people out there. What they're doing. You've got just to listen and see. It's not always a wound that we're seeing. It's like, it might be they're dealing with other things" (Transcript PA 5, Pos. 21). This previous quote indicates that it is not always clinical competence that is required to provide good care but communication skills and interpretive abilities that qualify the nurse to explore what these "other things" could be. The use of "other things" indicates how difficult it is for nurses to verbalize what these could be because they are very unique to the person and related to a patient's own inner world or private sphere of life that could not be predicted. The term "other things" appeared also in another narrative which further reflects the importance of exploring personal

aspects that are not only complex but also demand a lot of time to be spent with the patient. "Trying to get to know them after a couple of visits … it's the subsequent visits when you get to know that person or when you have spent a little bit more time with them that you can realize some other things" (Transcript PA 1, Pos. 25-26).

"Deep knowing" was not empty of the emotional component that was necessary to recognize patients' own emotions to understand their personal experiences about their illness. One participant stated that "I think one of the biggest things you do is compassionate listening to them [patients] and then you can validate their feelings and their experience" (Transcript P B 6, Pos. 71). "Deep knowing" was not possible without listening, which provides the conditions to discover information hidden inside the patient who is the "tenant of the body." Exploring information "residing" or embedded inside the body of the patient is necessary for the nurse because the patient is considered the most "valuable" informant about what is "going on." The significance of listening to the patient and exploring reality from the perspective of the patient himself or herself is reflected in the following account of an RN:

> I had a patient say one time "I've been the tenant of this body and it frustrates … I am telling stuff and they don't listen to me." Yeah and he said "what do I know? I've been the tenant for forty-five years" and to me that is so right … any health care [person] whether you're a nurse, physician whatever, has to listen to the patient. They might not know what's going on, but they've got valuable information and I always try to convey that to them. (Transcript P B 8, Pos. 15)

Developing that "deep level of knowing" equips the nurse with enough information to have the needed intuition to predict if "something is off" or going wrong with the patient even before the patient talks. It is something that can be sensed by the intuition of the nurse due to a "deep level of knowing" and involvement that could only be achieved when the nurse has established a personal caring relationship that could not be attained when care is given in a rush,

nor when caring is limited to filling the required documentation. A home care nurse reflected that:

> We developed a relationship where I can look at her and say, "something is off, like what's going off with you?" I think you develop that kind of relationship and she's as "you know too well and you're right, I am off today. I am feeling a bit more nauseated, and I am worried about this coming back," and this kind of stuff. So that's why I stay more at the personal side rather than come in and do blood pressure, do that documentation paper that we always do and say okay have a good day. (Transcript PA 3, Pos. 18)

Although thematic findings on the aspect of time pressure will be analyzed later on in the chapter, it is imperative to mention that from the beginning of the interviews, time restrictions did not disappear as a barrier to the essentiality of listening to the patient and developing that level of knowing and understanding of what is important for the patient before proceeding into the technical task. As one participant said: "I think the first thing is to listen. It's not to get in and out. Like, listen to what they need to tell you comes first and then you might do what you are supposed to do" (Transcript P B 8, Pos. 17).

Understanding the "whole" person.

Nursing care based on "knowing on a deeper level" was tightly connected to a comprehensive view that understands the "bigger picture" of the patient from a "broader spectrum." Nursing care was understood by nurses as a holistic form of care that requires having good knowledge about "everything" in order to understand the different dimensions of a patient's life. This form of understanding the whole big picture was described as a particular way to differentiate nursing care from care provided by other healthcare disciplines.

> Understanding of the bigger picture I think sets nursing apart from a lot of different agencies, a lot of different professions …We have to be very good in everything we do and have a broader spectrum of things that we can assess or put together to understand the patient. (Transcript PA 8, Pos. 29)

This holistic approach to care was based on the nurses' conceptualization that a disease state not only influences a specific organ by the altered physiology of the body but extends to cause an imbalance that affects the whole well-being of the patient. Thus, nursing care is considered 'different' because of this holistic view that tackles the different aspects of a person's personal life. One RN said:

> We know that the whole person is being affected by the situation that it isn't just a wound or it isn't just cancer …When you're in nursing, you can see that they're really trying to deal with all the different aspects of the person there. It's a holistic approach and I don't think everyone, every other health professional relies on this whole holistic approach as much. (Transcript P B 4, Pos. 27)

A holistic approach takes into consideration the whole personal life of the patient, who is not treated as a "client" who represents a specific medical case stripped of its personal elements and social context that contribute to the patient as a whole person. One nurse manager explained: "We're not just looking at client number five, we're looking at the person, the whole person and the whole person's family that's a part of this journey for this client" (Transcript P B 7, Pos. 20). This holistic approach views the patient in an artful manner that prepares the nurse to care in the best possible way to promote the well-being of the patient. As one nurse said: "… I look at it as looking at the person as a whole and seeing what things can be fixed or managed that would make them live better or live easier" (Transcript PA 1, Pos. 48).

Within this holistic domain, and specific to home care, nurses were looking at everything in the patient's personal life and the surrounding context. Again, this holistic approach was going deeply into the very personal details of daily life at home. In their inclusive view of the home environment and living conditions, the nurse looked at different dimensions including physical abilities to perform basic daily activities, family relations, connection with the community, and even the "socio-economic" situation that helps them identify deficient areas that need

intervention. Looking at the "whole" patient as a person was very helpful in planning and setting goals that are practical, realistic, and "tailored" to fit the specific patient. Such different aspects of personal life at home were reflected in the following two quotes:

> We look at the whole patient. We look at their home environment, the nutrition, the shoes they're wearing, can they wipe themselves when they go to the bathroom, how is their mattress, you know, how to bake, have they been outside in the week or they're stuck in their house? You know like what matters to them, did they see pharmacist, we look at everything. (Transcript P A 7, Pos. 33)

> Nurses look at everything in the home. They look at the surroundings of [where] they live, their socio-economic status, their support systems, their mental health, as well as what's going on physically …They look at the person as a whole and the person as a part of a family unit, the person as a part of the community, and we tailor our care to that. (Transcript P B 5, Pos. 39)

Understanding the bigger picture requires nurses to gain a situational awareness about the home environment. Nurses gather enough details to gain insight into the general condition of the patient and whether patients are capable of managing alone or in need of assistance to care for themselves. "When I walk into someone's home, usually I get a sense, an awareness about how their environment is. Whether they are taking care of their home … or if they are not taking care of themselves" (Transcript PA 4, Pos. 18). This insight also contributes to the art of nursing whereby the nurse gathers enough information and utilizes different resources to formulate a comprehensive knowing about the patient that qualifies them to adapt care based on what "works with them." This meaning of holistic "knowing" was reflected by a nurse manager who said:

> We really get to know our clients. You know, we get to know their whole situation, we get to know all of the family dynamics, we get to know personal stuff of the client, we get to know what's going on … nurses I think really get to know the clients, and they get to know what works with them, what doesn't work with them. (Transcript PA 10, Pos. 39)

Competence in academic knowledge and technical skills were also utilized in understanding the person's situation. Thus, holistic knowing was not only limited to

understanding the personal and contextual dimensions of the patient but extended to the health status and medical condition of the patient, which required nurses depending on their academic background and technical skills to care for the complex medical situations of their patients. As one nurse manager explained:

> The scope of practice has evolved into the high technological requirements that allow people to be discharged from hospital and live longer in their home environment … They're [nurses] more educated [in] that they have a deep level of knowledge and technical skills to be able to understand what was going on with the patient and manage more complex situations and treatment. (Transcript P B 7, Pos. 28)

Academic knowledge and clinical experience enabled nurses to think critically and make clinical judgements about the condition of the patient. "Nurses are educated to be critical thinkers and to use their thinking, like we're educated, that we have the valuable knowledge and experience to assess and evaluate the condition of our patient" (Transcript PB 8, Pos. 33). In this perspective, nurses in home care were described as being well prepared to act as autonomous individuals and "exceptional critical thinkers" who can evaluate and manage unexpected and variable situations which may arise when they are alone in patients' homes. One nurse manager said:

> They're literarily going into homes independently, again they need to feel confident in working independently in the home and they need to be exceptional critical thinkers, problem solvers, even in terms of feeling you know, being exposed to situations which may not be what they anticipated. (Transcript P B 7, Pos. 17)

Referring to their academic skills and critical abilities, nurses were doing a holistic assessment to identify the main reasons contributing to the medical condition of their patient. One nurse provided a detailed clinical account that explains how she utilized her advanced academic background to investigate the reason a patient fell through a holistic mode of care that looks for every possible cause contributing to the problem:

> If it's somebody that has a fall, I might say, well do you know why you [had] this fall? And then I'll try to do a little investigation while we're doing the dressing change and talking and looking at cardiac history, seeing if there's a history of fainting or if there's something physical with the knees, orthopedic or neurologic or it maybe you know something with diabetes so trying to get a feeling why something happened and so I am looking at the whole patient. (Transcript P B 4, Pos. 7)

Involving the patient in care.

"Deep knowing" and exploring the personal dimension was not possible during a brief conversation with the patient. This particular and personal level of knowing required a particular form of communication that respects the patients' role and gives them enough time to get involved in their own care. As one RN said: "I think it's very important to take the time and talk to the patients and treat them with respect by involving them in care" (Transcript PA 6, Pos. 47). This involvement was based on a relationship that is guided by the patient through a conversation where patients are given the chance to explain their own condition and share their perspective. One RN explained that: "the relationship is very much their needs and what they're hoping from the care. Thus, including them in the conversation about what's going on with them is essential because it's about them" (Transcript PA 4, Pos. 74).

In this subtheme, nursing care was described by participants as an "interactive process" that considers the patient an essential contributor to the course of care. It is a process where both the nurse and the patient interact with each other and share information to decide on treatment. Because nursing care is not "performed" but practiced according to the "pertinent" needs of the patients, the input of the patient is invaluable in the 'art' of caring when deciding on the right things to do. The following quote by an RN indicates the necessity and importance of the role of the patient as an active contributor to caring:

> You miss so much if you don't listen to the client … Nursing is an interactive process. You don't give nursing to somebody; in my mind you don't perform nursing, you don't

> do nursing on somebody. When you're with the client you're really practicing nursing and the word practicing means pertinent to me [patient] like practicing an art … they know what are their needs, right? You need to get their [patients] input to decide on care, right? (Transcript P B 6, Pos. 25)

The above interactional relationship implies that care is not limited to the nurse assigned to take care of patients but involves both the nurse and the patient as partners. Although it is a relationship that involves both sides, it is mainly a patient-centred process of interaction in which the role of the patient is primary in shaping the course of care. The significance of the patient's participation in care was reflected in the following quote by a nurse manager:

> This is a patient-centred experience. It is not only care being provided to them but with them and they need to be part of this process from the very beginning so that we can recognize what their expectations and means are from this care experience. (Transcript P B 7, Pos. 20)

Because it is a "patient-centred" process, nursing caring options cannot be imposed from one side. Care takes place "when the nurse doesn't dictate what the client needs to do. The nurse has to have a discussion with the patient and explain these are the benefits that can help" (Transcript P B 3, Pos. 39). Thus, it is a process of discussion that involves the explanation of options. In an ideal situation, nurses stated, caring takes place in a relationship of open communication where the nurse involves the patient in a discussion about treatment goals and the consequent advantages and disadvantages to reach a mutual agreement based on a good understanding of care options. One RN explained: "You discuss the possible interventions or treatment plan with the client and benefits or the costs service, the burden of the possible treatments and together with the client you agree on a plan" (Transcript P B 6, Pos. 11). When people are involved in a dialogue, they not only understand what is being done and the consequences of options, they are also given an opportunity to make choices with no pressure from the side of the nurse. An RPN explains:

> Okay, you are choosing to do this. By choosing to do this action, not taking your insulin, there is a consequence to the action, that I want you to be aware of, and it is your choice to do it, but there is a consequence to it … I would give them the opportunity, have choices, we could do this or this. That or that. Which way would you like to go? So that they can decide on what they want. (Transcript PA 8, Pos. 70)

The perception of the managers regarding patient involvement was noticed to be different from that of nurses despite convergence in many aspects. At the time managers were more focused on activating the patient to be a more responsible partner, nurses were more focused on what patients needed to do to feel comfortable. Similarly to nurses, managers talked about patient engagement through listening that revealed expectations of patients and attending to their voice in developing care plans. However, they used terms that placed responsibility on the patient such as the patient's "ownership" of health. One nurse manager said: "You have to give the clients ownership of their health care … they have to be empowered to choose, make some choices about their healthcare and take responsibility for consequences" (Transcript PA 9, Pos. 24). This manager's perspective of patient involvement aimed to empower patients to be responsible and accountable agents for choices related to their own health despite the reality demonstrated in the coming themes that reveal that patients are discharged abruptly and not able to access services that they needed. In the form of responsibilization that the managers desired, patients are supposed to become individually empowered and independent partners in choosing their own treatment and accessing services. Another nurse manager explains:

> Our nurses empower [patients] to act independently and by choosing among available options of care they become able to advocate for themselves and seek the best possible care for themselves. We ensure that they're well informed about everything in their care and what connects to them and this creates a stronger ability for them to access care and be a part of their own care. (Transcript B7, Pos. 17)

On the other side, the nurses' perceptions were more focused on involving patients within a relationship of understanding their perspective to choose care that better fit their situation. As

one RN said: “I always tell them [patients] I am not on the viewing end of this proposition, if you tell me the compression bandage I put on is too tight then it’s too tight” (Transcript P B 8, Pos. 17). Thus, it is an involvement that aims at choosing the best possible choice that meets the needs of the “involved” patient. Listening to patients and hearing their real concerns and problems was considered a priority in this domain because “sometimes what I [nurse] imagine is best for the client is not necessarily going to be best for the client, so you adapt it to meet what the needs of the patient are” (Transcript PA 1, Pos. 79). Moreover, listening to the patient as a contributor to his or her own treatment embodies respect for the choice of the patient as a designer of the particularity of care that makes them comfortable. As one RPN explained: “A lot of them are very particular about how they like to have their dressing done. Just how they like to have things done” (Transcript P B 2, Pos. 41). Although patient involvement in care was found to facilitate treatment and enhances chances of healing, a patient’s disinvolvement or disagreement on the care plan might spoil the course of treatment. One RN noted that “If you start doing an intervention that the person doesn’t want or doesn’t believe in it’s not gonna work” (Transcript P B 6, Pos. 25).

Providing intimate bodily care.

A fourth subtheme that emerged under deep level of knowing was related to physical bodily care. This aspect transfers the knowing of the patient to another intimate dimension related to the physical touching of private body areas. In this intimate relationship, knowing moves from mental knowledge about physiologic health status and the general social-emotional condition to another level of knowledge concerned with physical privacy and bodily touching that takes place when performing certain procedures. Nursing care is distinguished by physical touch and bodily contact, a dimension that requires touching of private and sensitive areas when

performing specific procedures. “This is a whole like more hands on, I mean for a lot of our clients require some other procedures such as catheterization are quite intimate. There’s nobody else who gets that intimate with them” (Transcript P B 2, Pos. 23). Nurses reflected the reality that patients who need physical and body care are usually referred to nursing because of this specific need. The scope of practice for nurses was described to include the physical bodily aspect as an essential element that differentiates nursing practice from other caring disciplines. This implies that nursing as a profession cannot be narrowed to technical or theoretical aspects detached from the patient because physical touching and bodily care are essential for nursing practice. A nurse manager explained:

> The scope of practice for nurses is different from the scope of practice for occupational therapists, physiotherapists, social workers … it really involves, I think the physical, mostly the physical demands of one’s health and wellness …when you look at why people are referred to nursing, it is much more oriented around a physical need to deliver skills that are required for one to improve health. (Transcript P B 7, Pos. 22)

Exposure of private body parts is difficult and an embarrassing action that is not easily managed. It is a situation that requires a high level of trust to induce a comfortable environment when performing intimate procedures where the patient is usually situated in an uncomfortable situation. A nurse manager explained this perception of intimate relations:

> That is like bowel care, I mean that could be considered somebody who just had a mastectomy, like for somebody to be open like that with another person, that’s difficult. That’s like catheter care. That’s the care that makes other people uncomfortable. (Transcript P B 5, Pos. 53)

This bodily aspect of nursing also requires different kinds of skills to guide the nurse in dealing with such uneasy situations. This is especially important for patients who are sick and in a vulnerable condition, which necessitates the nurse being well informed about certain skills that prevent crossing the private personal boundaries as well as professional boundaries to protect the dignity of such vulnerable patients. Data showed that nurses were using their own artful skills

and referring to their own experience to reduce the uncomfortable feelings of their patients when performing intimate procedures. The following two quotes reflect these meanings:

> People are very vulnerable when nurses are looking after them, they are depending on them. Even the area they're working on, they're under changing them or they're bathing them and so … Pretty personal in general. There's a lot of topping [removing clothing] involved during that process and trying to make the person feel more comfortable. Where the other professions wouldn't be doing that, doctors wouldn't be doing that. You know, they bring in the nurse to do the more intimate personal things. (Transcript PA 5, Pos. 27)

> … just seeing the matter most vulnerable so a lot of clients will say I feel very uneasy about this because you don't just take your clothes off in front of anybody. So, it definitely can make people feel very uneasy. So, I just try to distract, I mean we will talk about the weather, talk about anything so that they don't think that I am over analyzing things. It also helps to kind take their minds off what is happening. When we're done I always offer to help them get dressed again and be as respectful and non-judgmental as possible. (Transcript P B 2, Pos. 49)

Physical touch during intimate body care was also presented as a form of care that can be interpreted by the patient as good or bad based on how the nurse performs the touching. Having enough time was considered crucial for a positive interpretation of this aspect of care. On the other side, when performed in a rush, the patient will read bodily touching as a sign of disrespect or lack of interest in caring.

> People can tell just from the way you touch them, whether you care, if you are rough, if you're gentle, if you're rushed, you take your time, if you leave things tidy. Ask them at the end if they're comfortable … you've got show them that you care, you are thinking about what they need. Not just that I got my job done and I have gonna run. (Transcript PA 2, Pos. 104)

Surprisingly, nurses were referring to the mother-child nurturing relationship to explain the origin of physical bodily care as the traditional job of the woman as a mother. This explanation reinforces the significance of emotions and compassion as a trait of nursing care. It also implies that such an intimate bodily relation during certain procedures requires setting professional boundaries to avoid the violation of rights of both sides. This motherly perception of nurse-patient relation was reflected in the following two quotes:

> I think that nurses have a special sort of, typically nurses are women. I know that over time, that's changed, but I find that you have that nurturing motherly, you know a man is more accepted nowadays to be nurturing and more maternal taking care of babies. (Transcript PA 4, Pos. 66)

> I think people tend to drop their guard, or whatever they have that feeling, to what a nurse is. It's almost like the motherly care. Now we have fantastic male nurses, but it is that feeling you get, that … you just have that thought in your mind that you can or maybe relax a little bit depending on the person of course. But yeah, we're doing a little more personal thing. (Transcript PA 5, Pos. 25)

Summary

This theme has shown that "knowing on a deeper level" is an essential dimension in nursing action. It is a dimension that demonstrates how very personal aspects of life are not easy to explore nor to divulge by the patient. It is a dimension that requires much listening and understanding in order to identify the primary concerns of patients and to grasp the personal situations lived by them. "Deep knowing" is not limited to one aspect of patient life but extends to include all facets of a patient's personal life including the home environment, physical abilities, family situation, and socio-economic status, all of which are required to build a holistic view of the patient. Understanding the patient as a whole enables the nurse to provide care in an artful manner that fits the specific needs of the patient. Descriptions provided in this theme imply that nursing caring actions could not be limited to the technical aspects that were considered as secondary in importance compared to knowing the patient. In this form of knowing, the patient is involved as an active contributor in the course of care. Nurses described care as a process whereby patients share their perspective, discuss care, decide on choices, and agree on a course of care. Nurses also mentioned that deep knowing extends to the dimension of bodily touching and direct physical care where the nurse performs intimate procedures that place both patient and the nurse in a difficult situation, further complicating the dimension of "deep knowing."

Theme 2: "Treating Patients as Human Beings": Values Guiding Good Nursing Care

When asked about their subjective goals and motivations for practicing nursing and their perception of "good" care, nurses referred to the significance of certain values in a fairly consistent manner. These values were presented as enduring principles that guide nursing's caring actions despite contextual challenges. A major theme that emerged in this dimension is "treating the patient as a human being." In their daily actions, nurses were attentive to respecting the needs of the patient as a human being who is in need of help. This moral focus of care was emphasized because patients receiving home care are mostly frail and dependent on nurses to meet their needs during their illness (Home Care Ontario, 2018). In such a critical condition, patients may either find it difficult to ask for help or may not be able to do so at all because of the severity of their illness. In this theme, nurses demonstrated caring for their patients through reflecting on the emotional concern they had for their patients. They were concerned about them as human persons and not only as medical cases who need treatment. Meeting the needs of the patient as a human person and not as a "diagnosed" medical case was essential when providing good care. One RN described this moral approach to caring for patients as human beings who are usually sick and in a vulnerable situation:

> … try imagine myself in their situation. It can be difficult for some people to ask for help and you have to realize that … try to treat them as would one be treated, and we have to treat them with respect … just as a person … I think what's important too is treating them as a human being. Sometimes people treat them as the diagnosis or as the condition or something like that. (Transcript PA 1, Pos. 73)

In their interviews, nurses expressed their commitment to the following three constant ideals, which evolved as subthemes: (a) demonstrating genuine concern and emotions, (b) showing respect, and (c) providing help and advocacy. These three subthemes will be presented in what follows.

Demonstrating genuine concern and emotions.

Genuine concern about a patient's condition is considered an essential aspect of good caring actions. Real interest in caring for a patient as a person was the main rationale that motivated the nurse to care. This concern was considered a precursor for "whatever" other care the nurse would provide to the patient. Without this deeply embedded "level of willingness" to help the patient as a "person," there would be no development of the different "deeper" levels of care the nurse provides. Genuine concern was demonstrated through communication, compassion, and emotional attention during interactions with the patient in his or her vulnerable situation.

> If you develop a rapport with someone and have genuine concern for their well-being, I think that forms a strong base for whatever you are going to do after that. To be a nurse definitely requires a level of willingness and ability to care for the people that you're seeing … I think that allows you to provide a deeper and more pertinent, more relevant level of care because you're focused more on the person than on what you're being told to do … and to demonstrate to them through various means, through compassion, through listening, to demonstrate that I do have a genuine concern for them as a person. (Transcript PA 8, Pos. 21-25)

Good nursing was connected to the perceptions and ideals nurses have about the human nature of patients. Again, empathy and understanding the situation of the patient were central to helping patients. Placing oneself in the patient's shoes was an analogy that one participant used to express the significance of dealing with the patient as a "human" and a "person" who needs care. Not showing concern about the patient was described as leaving the patient uncomfortable with the impression of being disrespected by the nurse who is only trying to solve their problem from the technical perspective without being interested in understanding their situation as a person. It is empathy and showing emotions that makes the patient feel respected and establishes trust in the nurse-patient relationship. Thus, emotional attention, indispensable for good care, builds trust, and makes the patient feel respected. As on RN explained:

> Good nursing care means. . . I think a lot of it depends on people's [nurse's] ideals too on how they see them [patients] as humans, you know, how much empathy they have, how much may be understanding of the situations, how much do they try to put themselves in the place of that person … I think if the client doesn't feel that he has somebody that's showing concern or just kind of looking down at him trying to treat a problem then he wouldn't feel comfortable … if he feels more that there is empathy that is coming toward him, there's understanding, I think a trust develops because of this situation. (Transcript P B 4, Pos. 23-29)

In their interviews, nurses asserted that empathy as an emotional component constitutes the foundation for care that reflects real interest in a patient. Nurses also revealed that an emotional connection contains within it a broader humanistic approach that encompasses the consideration of the patient as a "person" and not as an object of care. This form of genuine relationship moves nursing care beyond delivering assigned technical services to attention to the patient as a "human being deserving respect. The following two quotes reflect the above stated meanings about the significance of emotions in a type of caring that is interested in the patient as a human being who should not be reduced to a specific problem to be treated:

> Make sure that the client can feel empathy, feels that the nurse is interested in her. She's not just, you know, not just a leg that you are bandaging and whatever, but there's a person who needs a bandage. You treat them as a human person, you know? (Transcript PA 2, Pos. 59)

> Passion and caring are related to the person who is attached to the problem you are treating. So, if the problem is a sore on the foot, and you are only looking it as that and not the bigger picture of why the sore could possibly be there then that I think, that is not compassion and caring because in compassion you are interested in the whole real picture. (Transcript PA 4, Pos. 113)

Compassion as a value of "good" care was described in terms of physical presence and body language that reflect "presence with" and engagement. This indicates that good care does not necessitate physical activity, it is an action of "not doing" a physical action but simply an act of "sitting down" with the patient in a status of engagement and full attention to know and understand the patient. It was very interesting to hear that being focused on the computer to fill

the required documentation was interpreted as a "distraction" that diverts attention away from 'understanding" the patient. Good care is realized as a matter of emotional attention and body language that reflects interest and engagement with the patient, more so than fulfilling tasks required by the service provider:

> I think sometimes you can be compassionate in your body language. Sometimes. It's your presence with them and [to] really be engaging and that could be through the body language of sitting down with them and not hunched over the computer typing and distracted. I take the time to get to know you and your family. (Transcript PA 9, Pos. 24)

Presence with the patient in a state of not doing anything but showing emotional expressions of understanding and empathy were further explained as a condition of "being there" with the patient, which represents a state of harmony that induces a comfortable feeling in the patient that somebody is concerned about what he or she is going through. These issues of concerns and connections with the internal lifeworld of the patient are indicative of a therapeutic relationship that provides the nurse with the intuition to understand what the patient is "going through". It also makes the patient "happy" when meeting the nurse who has the ability to connect with him or her, share emotions, and understand the patient's situation.

> You know, like I understand what you're going through, I can see that you are upsetting, I can see that this is happening, and just showing being there for them . . . just kind of being empathetic here. People are happy when I show up, cause like oh this is the nurse that will listen to me today. (Transcript PA 7, Pos. 29-31)

The significance of emotions in the practice of care was again revealed as a differential characteristic of nursing. Although doctors and other health professionals are available in hospitals, nurses believe themselves to have something different. Patients feel comfortable when the nurse shows up because nurses "have the heart" to care about their concerns. The term "heart" can be understood here as a term that is usually loaded with meanings of sympathy,

compassion, and care about the others. One RPN expressed this meaning about the nurse in the following quote:

> Patients who come home from hospitals they say, the doctors are there, they came, but the nurses they are the ones who do all the work and they're the ones that have the heart; and I think it's true, there is something special about nurses. (Transcript PA 2, Pos. 94)

Having adequate time for care was again mentioned as a crucial factor in providing compassionate care. If nurses are too busy with the number of home visits to their scheduled patients, then they are not going to have the opportunity to interact emotionally with their patients and develop feelings of compassion and caring. When the nurse is in a hurry to carry out an assigned task during a home visit, he or she will not have time to develop compassionate relationship nor will patients feel that the nurse is really interested in them. The significance of having adequate time to show interest and compassion to the patient is demonstrated in the following two quotes:

> I think people need to be in there and actually show that they want to be there by actually going in and taking the time to ask questions …So I think those are the ways that nurses demonstrate caring and compassion. (Transcript PA 10, Pos. 33)

> If you are in a hurry, you are not going to develop much of a compassionate relationship. It depends on the person and how rushed you are. The patient should feel that you are interested, that you are here right now for him or her. (Transcript PA 2, Pos. 80)

Showing respect.

Respect for the patient as a human being was presented as an essential value of good care that characterizes the nurse-patient relationship. It is a multi-faceted dimension enacted in the everyday clinical practice of nurses. Respect was considered fundamental for a healthy and successful nurse-patient relationship. It helps to create an environment of trust which makes the patient feel comfortable about care and the course of treatment. Lack of respect spoils relationships and induces anxiety, making the patient less confident about the treatment steps

taken by the care provider. Respect in the relationship reassures patients that they are in safe hands and with people who really care for them.

> If the patient doesn't have a good relationship with the nurse, there's nothing there. If they're not trusting, they're going to question everything you do and they will just be really anxious about the situation. So I do believe, a really healthy respectful relationship between the nurses and the client is key. (Transcript P B 2, Pos. 17)

Respect was described as a necessary trait when considering the needs of the patient. Whatever the needs of the patient, the nurses believed that regardless of who the patient is or how vulnerable they are, they should be cared for and valued as a human being. One RPN said: "every human deserves respect. That's really what I think no matter who you [patient] are. All needs should be dealt with respect especially if you're not feeling well … and that's really my motto" (Transcript PA 5, Pos. 29). This multi-faceted form of respect carries the implication that patient's right for self-determination is respected and recognised by the caring nurse. Respect for patient's values and ideals was considered a must when conducting home visits. One RPN said: "Anytime you enter someone's home you have to respect their ethics and values" (Transcript PA 3, Pos. 56). Unconditional respect of values without being judgemental was essential to create an environment conducive of trust that prepares the patient to share personal information. Acceptance without criticism or imposing values was especially important when nurses met people of different cultures and backgrounds. Caring with an unconditional acceptance of values was explained by one RN: "… and I show respect by always listening, not pushing my values on someone else, and creating an environment where it's safe to share information and that they won't be criticized and no negative comments coming from me" (Transcript PA 4, Pos. 62). A universal approach of respect was also adopted by the nurses irrespective of faith, religion, or values of the patient. Although they might not agree with the faith of the patient, nurses would ask them about personal preference and would be ready to assist and provide care in accordance

with their patients' beliefs. This approach toward care charges nursing action with a universal dimension of respect.

> Good care means respecting everybody's needs, respecting everybody's faith and ideals. I am not one of faith but I go into a lot [into] homes where there is a different faith and I have to respect that and I do so. What can I do to help you? You know as far as your faith, religion or anything like that. (Transcript P B 1, Pos. 23)

Another facet of respect is respect for a patient's choice and wishes. One example of this form of respect is recognizing a patient's desire to remain at home during a chronic illness or when in the terminal stage of a disease. As one RPN said: "allowing more people to stay in home to pass to die, there is respect there. Because many people want to stay home to die but they don't have anybody to be with them" (Transcript PA 3, Pos. 54). So, receiving care at home is by itself a reflection of respect for a patient's choice to be treated in the place where they have decided to stay. Another form of respect around choice was mentioned when patients were approached with an attitude of respect for their perspectives on their care, making them feel that their input was valued and the information they shared was fundamental to the planning of their own care. What matters during over the course of treatment are patients' perspectives on their situation because they have the right to determine what and how tasks should be done on their own bodies. One RN perceived this as the basis for acting in the best interests of the patient:

> I think that the basis for good nursing is to approach patients with an attitude of respect to [let them know that] their information is valuable. We should respect the information that they're trying to give and their opinion about care … and at end of the day it's their bodies that [are] cared for (Transcript P B 8, Pos. 15)

When nurses talked about respect, they often mentioned signing the consent as a mandatory task that informs patients about their legal rights and responsibilities. One RN revealed: "We always respect the rights of patient by signing the consent on the first visit. It's only done once in one visit, the first one" (Transcript PA 4, Pos. 14). Signing the consent form

was explained as an authorization to contact healthcare professionals on behalf of the patient, and as an approval to convey reports about the patient's condition to other nurses. This meaning of the consent form was revealed by an RN who explained: "In the consent form, they [patients] are giving us permission to call the doctor if we feel it's necessary and they're giving permission for the next nurse to read what I wrote and so on and so on" (Transcript PA 6, Pos. 45). When nurses discussed the necessity of the patient signing the consent form, it was mentioned as a document presented only once. The consent was not mentioned as a tool that involved the patient in a real dialogue around patients' preferences and perspectives. The interviews revealed that the nurses make a distinction between the formal aspects of the consent form required by the service providers and what they consider as the daily choices in treatment that are not really represented by this form. This perception about consent was expressed in the following quote:

> There are ethics and values that the organization has. We give the consent to each client when we do their admission because we are supposed to do that …There is a folder that we give and it has got ethics and values which are [centred on] home care and the client's rights and their responsibilities. (Transcript PA 3, Pos. 119-120)

Because the setting of the home care sector is different from that of the hospital, patients are visited on their own property, which has its own atmosphere. This particular characteristic was frequently mentioned by nurses who talked about measures they take to respect the personal "atmosphere" and "belongings" of the patient. One RPN said: "I try to keep the supply boxes tidy, so the room is tidy, I mean be respectful of their belongings and atmosphere" (Transcript PA 2, Pos. 70). In such a private context, the nurse was considered a guest who is supposed to respect the property that belongs to the patient. This kind of respect was reflected in the following quote made by an RN:

> As a home care nurse, you're entering somebody's home as a guest. So, there's a certain level of respect that the nurses show to their clients when they're entering their home like

> taking off their shoes, cleaning all their mess after … I mean showing respect for the property of the patient. (Transcript P B 5, Pos. 35)

Being present in the patient's own home also requires respect for the home environment, that is, the context of work. Because nurses usually visit their patients regularly, especially during a terminal illness, they get familiar with what is going on with patients and their family members. They become part of an environment that they do not have control over. They are placed in a critical position whereby they have to accept and respect whatever is going on despite the fact that they may not be comfortable with everything they witness. A nurse manager shared her insight about respect for the home environment:

> I think respect is very critical in home care particularly whenever you're in the client's home. It's their home okay, so you have to be very respectful of their home environment although you will not always see the most perfect behaviour. (Transcript PA 9, Pos. 15)

Time was again mentioned as crucial for showing respect during home visits. It was central to bring satisfaction to patients. Nurses were unhappy when they had to rush care, where they just had time to finish the task and leave. They considered their inability to spend enough time with patients a kind of disrespect to patients' dignity, leaving them feeling as if they had not been treated as a human being.

> We don't like when our patients will tell us this nurse she was in a big hurry and she just comes in and does her thing and leaves. I think it's very important to treat them like a human being, you know treat them with respect and dignity. (Transcript PA 6, Pos. 47)

The nurses also mentioned that respect was important when providing bodily care due to the sensitive nature of physical care and bodily touching especially when caring for private body parts. One RPN explained:

> People are private and nobody likes to be touched and bothered and nobody wants to be sick. So, you [as a patient] need to feel like whoever is looking after you and doing something with somebody's private parts, is just respectful. Make sure that you're working while they are covered as well as possible (Transcript PA 2, Pos. 106).

Providing help and advocacy.

Under the theme of treating the patient as a human being, nurses frequently described their desire to help patients and advocate on their behalf as a primary aspect of their care. Their desire to "help" patients was often considered a main motive behind choosing nursing in the first place: "… and I just thought that I could apply what I learned and help people, that's all what I want, to help people" (Transcript PA 6, Pos. 7). Helping patients to maintain their needs as human beings was another main concept in this subtheme, as mentioned by an RN: "It's important to help people meet their needs, to live in a safe environment and have enough food and other basic living conditions just as a human being … that they have everything they need" (Transcript PA 4, Pos. 20). In their interviews, nurses stated that they were available to support all patients, particularly those who are alone or in need of help to access some services. "They [nurses] are able to advocate to other avenues in the healthcare sector for the client that may not be able to seek care … that's where the advocacy comes in" (Transcript P B 5, Pos. 17). The value of help and advocacy emerged frequently during interviews as something over and above their assigned caring activities. In this sense, nurses were ready to do "anything and everything" that was within their capabilities to assist patients, resolve their problems, and improve their well-being. One nurse said:

> For me personally, I like to help by always doing anything and everything that I can to help people with what they have, to try to engage other services as needed, to always focus on doing everything that I possibly can for each individual person to resolve whatever issue is happening with them. (Transcript PA 8, Pos. 25)

The nurses demonstrated readiness to promote the health condition of patients irrespective of the effort required. One nurse showed no hesitancy in "help[ing] in the most important and best thing for them [patients] whether it be a difficult decision or not" (Transcript PA 8, Pos. 23). Nurses showed a highly ethical intention to assist patients and create a perception

in patients that nurses are always available to support them and enhance their conditions. This feeling of being valued by a caring nurse was central in providing good care. “I want them [patients] to think of nurses as someone who is gonna help them with their life, we’re gonna help them get better, whatever the situation is” (Transcript PA 6, Pos. 35). Supporting sick patients and making them feel that their life is meaningful to others was a main objective for the nurses. Promoting the self-esteem of the patient was mentioned by one participant as the reason behind providing care and assistance. She mentioned that she wants to “make people feel that they matter and that you’re [nurse] there to help them when they need help” (Transcript PA 5, Pos, 33). This motive behind caring actions reflects an intention to make people feel that they are of worth and value especially when they are feeling isolated because of their illness. Because patients in home care may not have visitors with whom they can socialize, nurses were sometimes spending more time communicating with their patients for the sake of making them feel valuable and meaningful to others in the community. “Sometimes people don’t get any visitors so it’s not like I can stay and have a cup of tea with everybody but just to sit, engage in some normal conversation that makes them feel that they matter” (Transcript PA 2, Pos. 74). Even in conditions were there was no hope of recovery, nurses demonstrated an ethical responsibility to make the patient feel as good as possible. Although converting misery to happiness is not an easy job, the nurses were doing their best to find a strategy that could help patients accept their disease and find a certain level of comfort. As one RN expressed:

> I aim to make them feel better and if you are talking about a palliative sense, where someone cannot be cured, I want them to feel better on a daily basis like, you know, obviously some anxiety is normal … to get to that acceptance point where they can live happy with their cancer or something like that. (Transcript PA 1, Pos. 59)

Because the nurses were caring holistically for their patients, they became “the biggest eyes and ears” (Transcript P B 1, pos. 27), those who can put things together and understand

what is going on. They were described as the "central hub" through which they identified problems, coordinated care, followed up on patients' needs and advocated for them on a larger scale at the level of healthcare system whenever needed:

> We would be the ones that would know that an OT [Occupational Therapist] is required. We would contact the PT [Physical Therapist], we would contact the doctor. We're kind of the central hub, we know when the patient needs more pain medication. We know when a wound is infected. (Transcript PA 6, Pos. 17)

Their continuous contact with the family and with the patient's environment enabled these nurses to understand the bigger picture. Thus, they were prepared to be the best advocates who could contact other healthcare professionals to provide the patient with the needed help, service, or supplies. This sense of nurses' ethical obligation to advocate for their patients was reflected in the words of one nurse manager:

> They are seeing family dynamics and they're seeing their environment. They're truly an advocate for that client in the realm of healthcare. Because they can see all of the pieces of the puzzle that make up the client, they are able to advocate to other avenues in the healthcare sector for the client that may not be able to … that's where the advocacy comes in whether they need to contact the healthcare provider or something like that. (Transcript P B 5, Pos. 17-19)

In addition to advocating within the domain of the healthcare system, the nurses also mentioned that advocating in the political sphere was another possibility to address the needs of patients. One RN considered that the credible knowledge base of nurses qualifies them to support patients in the political domain. As she stated: "we have valuable knowledge and experience and skills that we could advocate on behalf of our patients. We can get political in terms of contacting our political vice [local politicians]" (Transcript P B 8, Pos. 33). Because nurses are focused primarily on providing patient care, this claim was remarkable and was not mentioned by any other nurse in the interviews.

Although advocacy was meant to assist patients who are not able to get what they need, nurses were explicit in saying that advocacy did not cancel keeping patients informed of the steps taken to improve their condition. Protection of the right for patient autonomy was revealed in the following quote by an RPN:

> I think the biggest thing in advocating for our patients is working on their behalf in everything that we do, focusing first on what their wishes are and trying to access whatever supports and services we can for them and always ensuring that they are understanding what we are doing, why we are doing it and that they agree with what we are doing. (Transcript PA 8, Pos. 68)

Advocacy and help were not meant to encourage dependency on the nurse but, on the contrary, to assist patients to resume their state of independence. As one nurse said: "For me definitely the most rewarding thing behind support is when people get back a little bit of their independence" (Transcript PA 8, Pos. 19). The nurses assisted patients to regain their independence by helping them get as much control as possible over their life and to rebuild self-confidence.

> My goal is to offer them support to make them improve their life and that they can carry on their own. I think that people take pride in knowing that they can be autonomous in their decisions and choices and be able to enjoy the best life that they can at that time … People feel that if they can control little things and it's successful, then they may want then to go on and try take control. (Transcript PA 4, Pos. 40-44)

Summary

In this theme, having a genuine concern about patients was considered the basis for good caring activities, where the nurse becomes emotionally concerned about the patient and is there for him or her as a person. Showing emotional concern was considered a precursor for good care – treating the patient as a person who deserves not only technical care but also an understanding of his or her situation as a human being. In this section, nurses also presented various aspects of

respect as a core value for good nursing action. For them, there was no unified meaning of respect, but they considered it an essential value that is present in almost all forms of interaction with patients. Finally, participants strongly believed that advocacy was an ideal of good care, where they demonstrated their internal motivation to help along with readiness and availability to do whatever possible not only to act on behalf of patients to get better or adapt to their illness, but also to make them feel that they are of value to others in the community.

Theme 3: "Doing a Lot More With Less": The Impact of Underfunding and Cutbacks on Quality Care

When asked about the barriers that dissatisfy them and interfere with their attempt to provide what they have described as good care, participants talked about cutbacks and limitations on the availability of services as major factors that negatively influence quality of care in the home care sector. Cutbacks of services and supplies as a result of low budgets in the home care sector place nurses and other healthcare providers in a situation that challenges their ability to provide good care. A nurse manager explained the complexity of the work environment by saying: "I think that pressure would be anywhere in healthcare to tell you the truth. We're all being asked to do a lot more with less" (Transcript PA 9, Pos. 96). A major theme that emerged in this dimension was "Doing a lot more with less" in which underfunding and efficiency measures have led to austerity conditions that structure nurses' performance according to quantitative criteria and have contributed to deterioration in the quality of care. Three subthemes developed out of this theme: (a) Funding as the determinant of quality care, (b) Time pressure and inappropriate care, and (c) Premature hospital discharge and inadequate access to care.

Funding as the determinant of quality care.

Most participants described the financial operating mechanism that governs home care services. In this perspective, cuts have been a major threat to the availability of these services as well as undermining consistency in the level of care provided. Funding is a dominant factor that determines the quality of nursing care, affecting the consistency of services that are permitted or able to be delivered. When services are diminished due to inadequate funding, the quality of care is jeopardized. As one RN stated:

> I think the biggest way comes down to funding, the budget changes every year, availability of services change every year so we can't always provide the same level, the same quality of care as we did the year before. Whether it's better or worse, year by year, it's constantly changing so we never, we don't always have the same contentment with our care because we don't always feel we're able to give as good as we were last year. (Transcript PA 8, Pos. 64)

Care was perceived as the outcome of negotiation between home care agencies and the government around funding and payment. In this aspect, "cutting corners" and restricting services were presented as efficiency measures that put nurses under pressure and restrained the quality of care they could provide. The nurses complained that the continuous implementation of "efficiency" measures taken by the government and service providers have become so challenging that clients themselves are placed at "risk." This implies that care is sometimes provided with the lowest level of resources possible. One RPN revealed that:

> Care is related to the amount of money that the government pays the agency to pay us. So, when our agency [SPO] goes to negotiate how much the provincial government is willing to pay through the LHINs and they keep on cutting corners and cutting corners, then all that does is put our clients at risk, because we're to a point now that we're very efficient. (Transcript P B 3, Pos. 49)

Quality of care was limited by the criteria determined by the LHINs to evaluate the performance of SPOs based on a set of statistical formulas that do not represent the real work of nurses or the real needs of patients. For example, as one RN said: "One of the things, the measures the LHIN keeps forcing on us, is number of visits per day, and it's statistics … But I

still see it's a false matrix for evaluation of performance" (Transcript P B 8, Pos. 35). As mentioned in the previous chapter, this matrix, or what is officially known as "performance indicators" (See Appendix I), is a statistical document through which the LHINs quantify the performance of SPOs with the aim of maintaining annual funding from the government. In order to maintain an influx of money from the LHINs and save their contract, home care providers are required to accept referrals of discharged patients even at critical times when they are not well prepared to accept patients. This implies that what is important for the government is not quality of care but that the fact that SPOs accept whatever number of patients is referred to them despite the unavailability of qualified staff prepared to provide appropriate care. Any rejection of referred patients negatively influences the matrix scores and thus the annual funding. One manager was very explicit about these challenges imposed on the SPOs:

> With the Local Health Integration Network, we have a certain percentage that we are required by our contract to service and we don't know when those referrals are gonna come in. And there are times when we have to refuse referrals and say to the LHIN we can't service this right now, offer to another provider, but that is held negatively against us so it would show on our matrix that we're not actually accepting the amount of referrals that we have agreed to accept. Even though it may all happen at four o'clock on a Friday, and we still have to staff to facilitate that, or it's still seen as not meeting the contract. (Transcript P B 5, Pos. 85)

In addition, the interviews revealed another form of pressure placed on the nursing staff but this time internally from the administration of the SPOs. Nurses are in a critical position to respond to the demands of the Board of Directors of their respective organizations. The Boards demand that the company runs with a certain margin of profit to balance the budget. This balancing process is only possible by assigning more visiting hours to each nurse to increase government funding that is primarily based on calculating the number of home visits conducted. Thus, quality of care is described as a component of another financial matrix that aims to balance the budget of the SPOs. Financial calculations drive managers to add more visits on nurses

within the limited time available during the day to deal with the increased referrals of discharged patients referred from the LHINs. Within this management style, care provided by SPOS is structured to fit budget calculations rather than patient needs. Nurses face a large challenge to satisfy the goals and requirements of their employers. They are expected to meet the complex care needs of their assigned patients in addition to any new referrals that may emerge at any time. The following quote by a nurse manager represents a typical managerial industrial strategy that overloads staff to maximize output despite the diminished quality of care that does not consider the complexity and specific needs of patients.

> We also have a board that we report to, who expect a certain turn of revenue to come through and so we do balancing in terms you know at what level is [it]okay for our nurses to be, what quality is okay in order to either balance the budget or turn some profit to avoid budget deficit. That's a balancing act and at the end of the day, it's driven by one matrix which is how many clients can a nurse see in a day? That's the matrix that goes up to the board. It's seen as a financial matrix, but it drives the board's understanding of where we are at financially. So that's a real challenge for me because as complexity increases in the home, and you know, nurses need to be spending more time doing specific skills. (Transcript P B 7, Pos. 48)

Based on the above descriptions, nurses are struggling in an environment that is described as "efficient" but is actually a highly rationalized context that has increased the responsibility of nurses to conduct more home visits, secondary to decisions taken by the SPOs to strike a balance between an increased number of referred patients and low government funding. This implies that amplifying the caring efforts of nurses and caregivers in a timely manner to fulfill the demands of the system is a common perception of the good care required by both government and the SPOs as well. But from the perspective of the nurses, this perception is not true. The implementation of efficiency measures is equivalent to them to the deterioration in quality care. As one RPN explained, "You can't be more efficient and still provide quality care. It's a difficult thing certainly" (Transcript P B 3, Pos. 49). Accordingly, there is a clear distinction on what

quality of care means between the healthcare system and SPOs on one side, and the nurses on the other.

Moreover, increasing the number of visits was further complicated by a shortage of staff, which was also linked to underfunding. One nurse said that "They [SPOs] don't have enough staff to do the care, and sometimes it's whatever they are funded to right? Funding is one of the big things because not everybody gets what they need" (Transcript PA 3, Pos. 92). In fact, it is not only lack of adequate funding that was responsible for the inability to recruit enough staff, but also the disparity in wages between home care and hospital nurses. The outcome of this disparity discouraged nurses from choosing home care as a workplace, which further contributed to the problem of shortage and deterioration in quality of care. One nurse manager stated that:

> Right now, we have a chronic nursing shortage in home care because of the inequality in pay and compensation for the job. So I feel like if nurses were being paid the same, whether they work in the hospital or clinic or in home care, there may be more nurses that choose to work in home care and that will allow nurses to spend more time with their clients. (Transcript P B 5, Pos. 77)

The shortage in PSWs was also related to limitations in funding and cuts in services, further decreasing the number of support care hours available to patients. The number of hours of PSW service provided to patients has shrunk over time based on government decisions to decrease the budget and limit healthcare expenditure. The provincial government's financial cuts have diminished quality of care even for those with a terminal illness who are in dire need of assistance. Critically ill patients are entitled only to a number of support hours decided upon by the government and not according to their acuity level or needs. One RN explained:

> When I first started in home care, we had a lot more like personal support worker hours by the government, the provincial government would give someone thirty days of daily PSW at end of life or shift nursing, but the government decided to tighten the funding and it went down to like forty hours a week. So, if you know you [patient] are dying you get forty hours that's it. (Transcript PA 7, Pos. 51)

Time pressure and inappropriate care.

Inadequate time for care was also related to the limited amount of money paid by the government and the continuous efficiency measures taken by SPOs to adapt to the available funding. In their attempt to provide service to the continuously increasing number of discharged patients, the LHINs rationed care by reducing the length of visits assigned for patients. Rationing care by decreasing the length of visits was interpreted by participants as an efficiency measure taken in order to provide services to all referred patients. One nurse said that "this is just to fit people in" (Transcript PA 5, Pos. 50). The increased number of patients seen per day was at the expense of the duration of such visits. This meant that it was not always possible for nurses to provide quality care within the short time limit. Nurses stated that the number of patients seen per day is directly proportional to the time spent with each patient, which consequently influences quality of care. One RN described: "It's just the nature of the beast in terms of the job that the more clients you have, the less time you can spend with each person, so there's a kind of give and take in that sense" (Transcript PA 1, Pos. 81). Nurses were well aware of the fact that patient satisfaction with care could only be achieved in an environment free of time restraints where the nurse is able to interact with the patient and allow him or her to express their concerns about their personal issue. One RN explained that:

> Nurses whom the patients are the most satisfied with are nurses who take the extra time. They are nurses who are not in a rush. You know they actually talk to you and look you in the eye and ask how your kids are, that kind of thing. (PA 6, Pos. 25)

Although the increasing the number of home visits came in response to the commitment of home care providers to accept new referrals and not breach the conditions of their contracts signed with the LHINs, the nurses were extremely challenged by time restraints that disregarded the patient's requirement for care. Because they were not given enough time to do their work,

they were trying to condense their efforts and rush. They were totally occupied by timing and were always worried about utilizing extra time that would take from the time allowed for the next patient on their schedule. Spending more than the assigned time required nurses to postpone or reschedule their next patient which only added to their burden. Nurses refused the type of care that made them rush and always thinking of the next patient rather than focusing on providing good care. They considered this type of care disrespectful to the patient who deserved receiving adequate care and attention. One RPN reflected:

> Time restraints, probably that's the most difficult. I am not allotted enough time… and if they then take too long, then that is just kind of domino that affects the rest of my day, and things get late and I have to reschedule clients …I just can't condense my day in the seven and a half hours. I don't like when the client feels rushed. And I know a lot of our clients feel rushed … I don't want to be going and say, okay … I need to go and see my next client. And I think I would feel very very slighted if that was me in their position (Transcript P B 2, Pos. 31-34)

The nurses tried to quickly finish one patient and reach the next patient without delay. The pressure of time not only prevented them from providing proper care according to their patients' needs but also made for an aggravating and stressful environment, provoking anxiety and impairing clinical judgement necessary for providing good care. One RN revealed that:

> Like first of all, when you feel like under the gun to see nine or ten patients in a day, like in a seven and half hour shift … it increases my anxiety … like oh my God it's taking me longer to get to this patient, I still have six more to go. Then my critical thinking is impaired. (Transcript P B 8, Pos. 35).

Because efficiency was implemented to allow for the highest number of visits to cover all patients referred from the LHINs, SPOs were mindful that time allocated for care might not be compatible with the complexity of the referred case. A nurse manager said: "Because of complexity, the clients require more tasks … and you haven't been given extra time to do them but there is more of them to do" (Transcript PA 9, Pos. 58). The nurses were expected to provide all care needed by the patient within a limited and specific period of time but the allotted time for

care was not always sufficient to perform their tasks, especially in complex situations or when a patient's condition deteriorated. In some instances, the time allotted was simply not reasonable compared with the complexity of the patient. One RPN discussed this threatening situation:

> Nurses aren't given the appropriate time … there's a gentleman that's in our clinic now with a chemo … so he has got a VAC [Vacuum Assisted Wound Closure], he has got a PICC [Peripheral Inserted Central Catheter], he has got IV antibiotics, it's not an easy place to VAC, and we've got thirty minutes [laughter] that's frustrating. So, I've just sent an email to ensure that this doesn't happen and that we have the appropriate time. (Transcript PA 5, Pos. 48)

Lack of enough time left the nurses unable to identify exact care needs and deprived patients from the kind of care that takes into consideration all dimensions of the patient's life to decide on the best care that he or she deserves. As one RPN said: "I don't like being rushed with the client. I think that really doesn't help … [you need to] see the whole picture and to make sure patients are given the care that they deserve" (Transcript PA 5, Pos. 21). The pressure of time was considered a barrier to listening and talking with the patient, developing the type of knowing that was previously identified as one of the main dimensions of nursing actions. One RPN said: "It is hard to take the time to really listen to somebody. I mean if we aren't pushed for time so much" (Transcript PA 2, Pos. 53). Because cuts in services have resulted in diminished time spent with the patients, the nurses are not able to communicate with patients in a way that establishes emotional connections, enabling them to explore their concerns and discover their holistic needs. The nurses were not satisfied with the high number of patients that prevent them from being able to provide the type of good care they would like. One RN outlines how time pressure negatively impacts these dimensions of caring:

> So, the less time you have to have a conversation with someone, the less good care you're going to get, in my opinion … you might not get the whole picture if services got cut, you're gonna lose the compassion and the caring conversation, yeah, we can only do so much. (Transcript PA 4, Pos. 111)

The nurses revealed that they were dissatisfied with the current form of rushed care because they wanted to do better job but having a lot of patients pushed them to work too fast. As one participant said: "I feel like I'm rushing … I feel like I am not giving the best care that I could … I just feel like I am not doing a good job" (Transcript PA 6, Pos. 27). Caring under this time pressure was described as "delivery," because delivery was perceived as a quick service "delivered" to customers in the shortest time possible rather than something that was based on the knowing and understanding that responds to the patient's specific needs. One RPN said: "Well you're running off your feet … I do believe that will interfere with your ability to care. It is not care but delivery …You want to do it, but you don't have the time" (Transcript PA 8, Pos. 92). The nurses rejected this type of care that deprived them from listening to the needs and perspectives of the patient. "It's not to get in and out, like, listen to what they need to tell you first and then they might listen to you" (Transcript P B 8, Pos. 17). Because nurses were trying to be time-efficient in their home visits, patients sometimes compared the model of care to something like the fast food restaurant Kentucky Fried Chicken, where success is measured by the speed of conducting business. The more people get in and out, the more efficient and productive work is. Although nurses were striving to cover the high number of assigned visits, the short time allocated to each visit left patients with the impression that they were not more than a number on a work list that had to be ticked off. It was obvious for the nurses that this form of quick care that was focused on the task rather than the patient did not reflect their desire to demonstrate respect to their patients rather than having them feel treated as an object of care or a case to deal with. These meanings of rush in care delivery were reflected in the following quote made by an RN:

> I've heard clients complain that some nurses come in and, they said it in a funny way, they said it like KFC [Kentucky Fried Chicken], that's what he called it. Meaning you go,

> you do … you get your stuff and you're out … think that's somebody that's trying to be efficient and trying to make sure she can get in her ten visits that day … I think that's important that they [patients] don't feel like they're just, you know, a number in a blood lab or something like that. (Transcript P B 4, Pos. 56)

Rushing care was explicitly described as an indication of being disrespectful to patients by both the nurses and patients alike. Taking enough time was seen as a means to develop a therapeutic relationship between the nurse and patient. The more respect the nurse shows, the more respect she receives from the patient. One RPN explained that:

> Some people would say 'oh, that person just came in and out not even said hi.' You know let's just slow down and be respectful. We're in their home, we're providing a service. I want the clients to respect me providing the service, but I also want to respect them because I am in their home providing that care as well. (Transcript P B 1, Pos. 66)

Inappropriate care was presented in this subtheme as directly related to efficiency measures and the pressure of time, and time constraints were presented by the nurses and nurse managers as regular daily occurrences rather than exceptional or rare occurrences. Nurse managers were well aware of the fact that the high workload on nurses prevented them from providing the best care they could due to the restricted time allowed for each visit. One nurse manager said: "Right now, the nurses feel very obligated to see all of the clients who require care, and it's not that they're not providing good care, but they could potentially provide better care if they were given more time" (Transcript P B 5, Pos. 79). This implied that management authorities were well informed about what was going on, but they accepted the time constraints because they had to prioritize the quantity of patients covered per day over the quality of care provided by the nurses.

Because nurse managers were aware of the high number of visits that the nurses were obligated to conduct and the pressures of time on their shoulders, they were trying to allow patients to vent their complaints to reduce tension rather than holding nurses accountable for the

rapid and inadequate care. They tried to reduce tension because they knew that the home care situation requires nurses to "do more work with less bodies" and resources. One nurse manager recalled that:

> We do get calls from clients and why they really rush to the visit today, well, I know what's going on in the back … there's fifty clients to be seen but I can't really say that to the patient right? So all I try is to deflect it … sometimes just giving them that time to hear up, have their voice heard, totally de-escalates the whole situation … you're trying to do more work with less bodies. That will definitely impact care. (Transcript PA 9, Pos. 92)

Managers' attempts to preserve their contracts through increasing productivity affected the performance of the care providers. Because they believed that becoming more efficient was the way to deal with the influx of patients, some home care agencies adapted to rushing the provision of care and their nurses were conducting a huge number of visits, which negatively reflected on the quality care they could provide. A nurse manager said: "Some private home care providers go in and some nurses slip [move quickly through] to sixteen clients a day where others slip to ten from a profit space. The quality gap is huge on that type of experience" (Transcript P B 7, Pos. 52). Along the same lines, another RN added: "I think some nurses, I don't think it matters if you give them four patients or you could give them fourteen patients, and they're good at … they're gonna cut corners everywhere" (Transcript PA 6, Pos. 27). Because they know that efficiency is what the management is focused on, some nurses take on a large number of patients just for the sake of making good money at the end of the month. One nurse manager explained that:

> . . . so what happens with nurses is that they can see up to whatever many clients they want to see, in an eight hour day, they can see eight, ten, twelve … and I think that comes down to what I said, they run in-run out right? Not something they all like very much but in order to make a happy pay cheque at the end of the week. (Transcript PA 10, Pos. 84)

The inability to have adequate time meant that some fundamentals of care were difficult to achieve. The length of time available for care was sometimes not enough to perform technical

skills or procedures according to nursing standards, violating a fundamental requirement of nursing practice. One RN contended that "Sometimes the standards aren't met that's for sure" (Transcript P B 6, Pos. 54). Adopting efficiency strategies not only deprives nurses of the chance of getting to know their patients and understanding their needs through communication skills that attend to their personal needs but also results in incidents of neglect in care that can lead to a deterioration in the health condition of patients. Prioritizing profit over the needs of care can end up with health complications that could have been avoided if more time was assigned to provide proper patient care. Practicing nursing on a financial basis is considered incompatible with the basics of nursing care that places patients' interests at the centre of attention. These meanings were reflected in the following quote by an RN:

> I am doing the Doppler and I am asking all these questions and they [family] said, 'oh the other agency didn't do all this,' and I said 'really? '… well, they're private for profit. I could see more people if I did that you know? This is a client we're seeing now because he ended up in the hospital with a bone infection from that wound … We shouldn't be having people making money. I philosophically disagree with it and I think it's inefficient. (Transcript P B 6, Pos. 61)

Premature hospital discharge and inadequate access to care.

The complaint that patients were discharged from hospitals in an abrupt manner without proper planning was a common issue that appeared in interviews and developed into a separate subtheme. The decision to discharge patients into home care is taken by hospital administration based on efficiency calculations. According to the participants, hospital administrators want to decrease hospital overcrowding and reduce long waiting lists in hospitals. One RN explained: "They don't want anybody waiting in the hospital, so community care is like the dumping ground to get people out. They don't want that long waiting time in the hospitals" (Transcript P B 6, Pos. 63). Instead of using the word "discharge" many nurses used the term "dumping,"

which to them indicated a lack of respect for patients who were sent home without adequate planning. As it will be demonstrated, the nurses argued that dumping patients led to inadequate forms of care that to them humiliated the patient and disrespected their medical needs.

Abrupt forms of discharge were particularly problematic on weekends when the hospital decided to discharge a patient without checking first to see if he or she was clinically ready and without preparation ahead of time so that SPOs could make sure that staffing and supplies were arranged. Sometimes patients were discharged due to hospital understaffing. On other occasions, the discharge decision was taken in response to the patient's own wish to be discharged or to a family request to have their loved one die at home. Hospital discharge without adequate preparation implies a neglect of patients' personal needs, and it also negatively impacts the practice of nurses and caregivers in home care. One nurse manager contended that:

> Friday nights [were] especially bad on a holiday weekend because the hospital wants to dump them [patients] out on the weekend because they have staffing issues, so they send clients home. Unfortunately, maybe not in the best of health, maybe not really ready for discharge, sometimes the clients will sign themselves out of the hospital … maybe they have a loved one where the loved one wishes [them] to die at home … the hospital made this decision to discharge them without things being set up. (Transcript PA 9, Pos. 64-66)

Nurses were frustrated because hospitals were discharging patients without providing them with appropriate medications, supplies, needed equipment, or support personnel. These problems were exacerbated by the unavailability of PSWs, whose presence is necessary to support weak and sick patients in basic life activities. In other instances, a delay in services led to the deterioration of the situation and made it difficult to provide care. Instead of receiving the needed care to speed up recovery, lack of access or a delay in finding appropriate services contributed to the development of complications that only worsened the condition of the discharged patient.

> Clients are leaving the hospitals, sometimes on the weekend or whatever, and they are not let out with appropriate pain medication … if you [the nurse] show up there and stayed, don't have the supplies to look after them. . . then that's frustrating. (Transcript PA 5, Pos. 42)

> Certain things like occupational therapists or physiotherapists or even [things] as simple as personal support workers to help people shower and bath and things like that … we feel that they need it but it's the delay between when we ask for those things and when they are enacted … we might wait two or three weeks and that whole time, that person is not able to have access to those services and [is] potentially worsening as the days go by without access to them. (Transcript PA 8, Pos. 35)

In addition, communication regarding the patient between home care nurses and hospital staff was deficient. Information on the referred patient was restricted to what came from the LHINs which was often very little, fragmented, and many times did not reflect the real condition of the person. The nurses were very dissatisfied with the type of information they received about discharged patients. They were expected to go to the patient's home and provide care without being well informed about the patient's actual medical condition or what was done to the patient in the hospital. They were expected to provide quality care for a patient that they did not have enough information about. Sometimes nurses were surprised at the lack of critical information especially for those who were suffering a terminal illness and required specific supplies and specialized caring skills.

> Communication between nurses and staff that are involved in the care is so disjointed … it doesn't flow from one place to the next … I don't know very often what they did in rehab or in the hospital or what medications or anything. I often don't know what happened and then the information goes to the LHIN, they sort through it and then I get this little, about three sentences long about the patient. It's useless. (Transcript PA 4, Pos. 91)

> We get information that sometimes is not appropriate … I went to someone for a catheter change and this lady was palliative. I was there for three hours and just trying to set up a palliative case load … she needed everything else too, like she was at end of life, and none of that came to us. (Transcript PA 5, Pos. 87-89)

Moreover, reaching doctors to facilitate access to needed care was not always possible and many responses came very late. One RPN said: “Currently I had a family doctor who was very difficult to get a hold of. Two weeks to respond, could never got contacted on the phone” (Transcript PA 8, Pos. 45). The inability to access doctors who are usually needed to order a drug or sign official documents for the referred patient was not uncommon. A nurse manager said: “if you don’t have a doctor to write you an order … if we don’t have a doctor to sign on the death certificate? These kinds of cases are very difficult to deal with” (Transcript PA 9, Pos. 64). When patients were discharged, especially on weekends and holidays, there was often no doctor available to consult on emerging issues that needed medical follow up. There was not always access to professional health services in the area where patients lived. Nurses were left to struggle alone because nobody was covering the absence of the doctors. They were stuck between the unavailability of doctors and their commitment to help patients who usually did not want to go to the ER and wait the long hours. As one RN who explained:

> [Patients] need access to the interprofessional team closer to where they live and on a more than twenty-four seven-days basis … Most of the doctors don’t even open on Friday … I send a referral to someone to try to get to see infectious disease and they [community clinic staff] said ‘oh no they can’t because the doctor is on vacation for two weeks.’ I was like ‘the doctor is on vacation! this is infectious disease. Isn’t anybody covering the doctor people are sick every day of the year?’ … You know nobody wants to go wait in the ER for twelve hours. (Transcript P B 6, Pos. 63)

Because of the early and unplanned discharge of patients, nurses were sometimes confronted with the option of sending patients back to hospital because patients were simply not ready for discharge. One RPN said: “We sometimes get clients that are sent home to us but shouldn’t be sent home, they should be in hospital, so we want to send them back, and I think that’s a big challenge as well” (Transcript PA 5, Pos. 42). Discharging patients who are not stable and “shouldn’t be sent home” raises serious concerns about the ethical basis upon which

the decision for discharge was taken and the right of the patient to be in stable condition before being discharged from hospital. Although nurses were doing their best to manage the care of discharged patients, calling paramedics to send the patient back to the emergency department for readmission was a last resort. But this was not an easy decision to take by SPOs because, according to what one manager revealed, this challenging step required providing detailed information to justify noncompliance with the standard of care contained in the contract that inhibited readmission within 30 days of discharge.

> It is in our best interest to try to do what's best for the client but any time that we're sending a client back to the hospital, we're generally doing some sort of an assessment in the office as to why the client went back to hospital … In this case with the LHINs, some of those performance benchmarks are: keeping the client in the home so not having to return to the hospital within thirty days of discharge … if it's a client that has just been recently discharged from the hospital and they return to the emergency room, regardless of what the reason is that they return to the emergency room, that does get recorded on our matrix. (Transcript P B 5, Pos. 25-29)

During their interviews, nurses presented many stories about patients who were left with no adequate care. Because of cutbacks, SPOs were providing nursing care and PSW care according to the hours decided by the government. The consequence of this limitation was that many patients were left alone despite their frail condition and their compelling need for physical assistance. Participants' statements confirm that the most common reason for leaving patients alone with no assistance was the cutback in services that directly influenced the availability of PSWs, who provide the majority of services in the home care sector (Home Care Ontario & Ontario Community Support Association, 2017a). Leaving needy patients alone with no PSWs due to cutbacks was addressed by one RPN:

> We see a lot of older people by themselves, they really can't function that well at home, they're alone because of the cutbacks that have been done for the personal care, that affected them in some way … a lot of people cannot do a lot of things. We've had the cutbacks in services for clients, one of them was personal care. (Transcript PA 3, pos. 36)

Patients and their families were often left alone in uncertainty, not knowing how to deal with their critical situations. Cuts in services left them with the only choice of hiring staff privately to stay with their loved one, but due to a shortage of healthcare providers, it was sometimes difficult for the family to even find a PSW or a shift nurse (who stays with the patient for eight hours or more). The situation became even more complicated when the patient and his or her family were not able to afford to pay for a PSW or a nurse. One RPN said that:

> Patients and their families were left to figure out what they're gonna do for that care … Sometimes it's hard to get a support worker or a shift nurse to be with that family and that dying client … and [the family] can't afford it because it is expensive to hire a PSW or a shift nurse. (Transcript PA 7, Pos. 51)

Cuts in services left its toll on family members who were willing to show respect for their loved ones in their last days of life but were not able to do so because not all patients or families were financially prepared to pay the expensive cost of care. One RPN was explicit about the traumatic impact of cuts on people who were in need of care but did not have the money to pay for it:

> It's stressful to the family because now they have to pay out of pocket for private. Not everybody has that luxury so it's just frustrating … they don't have the money to throw that out. But they still want to respect their family member who is passing away. (Transcript P B 1, Pos. 56)

The nurses provided many devastating accounts describing sick and elderly patients who were left alone with no attendance at times when they were very weak and their safety was jeopardized. Not providing such vulnerable patients with needed services particularly with PSWs was for them evidence of maltreatment and negligence in care that ignored not only medical needs but also very basic human needs and rights such as having food to eat. The nurses reflected on the ample evidence of the neglect in care of the frail patients who were in real need of help and assistance:

> They [patients] are unsteady, unsafe, they could have fallen in the shower even if we have OT come in and give them a bench. Well they still have to get undressed and get in there, they have episodes of confusion … and they have no family and they're making their meals and you know, those sorts of things, really I feel they require care for safety. (Transcript PA 7, Pos. 57)

> [Hospital personnel] had sent her [patient] home with no commode, she had a wheelchair, but she wasn't able to transfer into the wheel chair … I don't think she had any family with her, she was probably in her fifties, but she didn't know how to deal with her broken leg. She didn't have crutches … I thought she was maybe sent home prematurely because she didn't have a commode chair. She had no way to be able to eat. Like she didn't have anybody to go get food for her. (Transcript P B 4, Pos. 19)

> I had a one client who, again was sent home too early, she got up to go to the bathroom, she sat on the toilet, and she couldn't get off the toilet, and nobody knew she was there. I kept calling around the phone and nobody was answering because the phone was in a different room and she couldn't get off the toilet. Finally I just went to see that client, and I knocked at the door and fortunately the door was unlocked, so I went in and there she was … her legs were too weak to be able to carry her body, they were just buckled under her … She could have been sitting there all night and it could have been a very serious situation. (Transcript P B 4, Pos. 21)

Based on what the nurses revealed in their interviews, leaving patients alone without attendance despite their sick condition did not seem to be an isolated occurrence but more likely a systemic problem in the home care sector. Although some nurses tried to advocate for patients and talked to their managers about dependent and vulnerable patients who had nobody to even prepare food for them, there was no effective action taken to resolve the issue. Nurses were not able to change the situation and considered the issue beyond their capabilities and beyond nursing's scope of practice despite its negative influence on patients' well-being.

> So, when us as nurses go and there's nothing we can do, you know honestly, what can we do? We can't do anything because we are there for a different purpose even though it's their well-being … sometimes these clients don't know who came, but what can I do? Yeah, it's funding but on my end our hands are tied. I have one lady she has ALS [Amyotrophic lateral sclerosis] … she lives in an apartment by herself and she was telling me the other day that her appetite has decreased. She can never get [out] the bed … so she relies on three personal care workers a day to come see her. Now remember that's for palliative care and for that, they are only given forty-five minutes to be with her … she gets a PSW in the morning, afternoon and the evening … I talked to my manager about it

> but nobody has time to make her a proper meal but… When you think about it they only have forty-five minutes. How? (Transcript PA 3, Pos. 38-40)

Summary

In this theme underfunding and the cutting of services were identified by the nurses as the main determinant undermining quality of care. Efficiency measures taken by the government and the SPOs that forced the nurses to visit the highest possible number of patients per day was considered an impediment to good care as defined by them. Thus, quality of care was not understood by the participants in the same way as did the government and service providers. The pressure of time and the singular focus on the number of visits conducted per day hampered almost all aspects of good care. It is not only that there was not enough time to establish a caring conversation with the patient but the concept of efficiency that was adopted in home care led to incidents of neglect in care. These efficiency measures pushed hospital administrators to "dump" patients outside hospitals prematurely without adequate coordination with home care providers. In this theme, nurses provided multiple accounts of sick and frail patients left alone without adequate care due to underfunding and the inability of patients or their families to pay for their own healthcare. In their vulnerable situation, patient's needs for healthcare and even very basic human needs were ignored by a system primarily focused on efficiency measures.

Theme 4: "Challenged and Frustrated": Policies and Work Environment not Conducive to Good Care

This theme developed as a consequence of the implementation of efficiency measures that were described by the nurses as a challenge to the values of good nursing care. However, this theme is more focused on workplace policies, government healthcare policies, and the emotional impact of the participants' experience in the home care sector. It entails descriptions

and explanations given by participants about their frustration with current healthcare transformations and policies that create a work environment not conducive to good care. Three subthemes emerged out of this theme: (a) Bureaucracy and standardized care in which participants talked about rigid clinical policies, protocols, and guidelines that restrain the ability of nurses to provide "good" care, (b) Discontent with healthcare policies where nurses explained how the focus of the healthcare system was not patient-centred, and (c) Caring in difficult work conditions where nurses reported high levels of anxiety due to a difficult work environment not supportive of good care and leading to moral crises and burn out.

Bureaucracy and standardized care.

At the same time as participants described their practice to be based on research findings and the best available evidence, they complained about rigid clinical policies, protocols, and guidelines that structured their work and placed them under the pressure of working within a set of rules that they felt were not compatible with the nature of their caring actions. In this subtheme, the nurses explained that in their daily clinical work, they followed scientific and research findings that supported their "professional care." As one nurse stated: "Professional care should be evidenced based. I strongly believe that it's an evidence-based discipline and I feel that you need that specialized knowledge based on research" (Transcript P B 6, Pos. 29). Despite their scientific base and their focus on critical thinking mentioned elsewhere in this chapter, nurses were expected to comply with protocols and best practice guidelines that were required by the LHINs when performing care. One manager said: "So, we follow the LHINs' guidelines in terms of providing nursing care in home care. Those guidelines really indicate a process by which the nurse follows care which I am sure is based on theory and evidence" (Transcript P A 7, Pos. 7). Thus, nurses had an obligation to adhere to the prescribed steps of the scientific

protocols and guidelines when they performed assessments and developed care plans to manage patients' conditions in home care. Compliance with clinical guidelines was evident in the nurses' interviews. As one participant said: "I am following sort of the best practice guidelines with regard to the wound [care] depending on what kind of wounds they are" (Transcript P B 8, Pos. 11). Along the same lines, another nurse also added: "We also have some guidelines for how we determine whether the client needs to be seen by a vascular department" (Transcript P B 4, Pos. 9). Nurses were expected to abide by these scientific and evidence-based practices because they were presented as a foundation for providing high quality care for patients. One nurse manager explained that "The care plan itself is really defined on evidence-based practice so in the home care environment, we typically include a variety of different resources that enable our nurses to provide high quality nursing care to clients" (Transcript P B 7, Pos. 11).

What was problematic for nurses was that these clinical policies, guidelines, and protocols implemented to provide quality care based on evidence were controlling their ability to perform good nursing care. In this conflicting situation, nurses criticized the restrictive nature of the work culture and model of care that prevented them from giving the type of good care they wished to provide. Clinical protocols that were supposed to be evidence-based were criticized for their prescriptive steps that did not always fit the actual clinical situation of the patient and thus, hindered nurses' commitment to provide good patient-centred care. The nurses complained about the rigid rules and regulations that were not always helpful but sometimes controlled and limited the nursing care that aimed to serve the best interests of the patient. For example, one of the clinical protocols adopted by the LHINs and home care providers instructs nurses that if the patients' wound does not close within a period of eight weeks, then the vacuum machine used to assist in wound closure must be removed even if the wound is improving in terms of healing.

Although home care protocols are supposed to be based on scientific evidence, participants criticized standardized protocols adopted in home care since they were not always seen to contribute to the well-being of the patient. Setting a time frame for wound healing left nurses struggling to stabilize and improve the status of the patient within a specified time frame. One manager revealed the restrictive nature of these protocols:

> There are always limitations to work. I find that always bureaucratical limitations, it comes from the LHIN where you can do this but you can't do that. For example, if you have a client on a VAC [Vacuum-Assisted Closure] therapy, there were times where you're progressing really well, the wound is going very well to closure, but you'll have an eight-week limit, that is it. Doesn't matter how well the wound is doing, eight-week time you're done. (Transcript PA 10, Pos. 51)

Professional autonomy and clinical judgment were constrained by standard criteria and the scoring system adopted by the LHINs to evaluate the acuity of patients. Even when nurses advocated for patients' needs based on clinical evaluation, their perspective often went unnoticed. For example, when nurses advocated for their patients to receive more PSW hours, they were rejected by the rigid scoring system that did not permit transfer of patients to another category of higher acuity although they deserved clinically to be transferred. Bureaucracy was seen as an impediment to good care and to patient advocacy as well. Not being able to bypass the rigid administrative limitations of protocols and categories, nurses were left upset in a vague position, unsure about how to manage within the inflexible nature of the healthcare system. The classification system which categorized patients' needs was said to be based on fixed and standard methods of treatment rather than on the actual medical situation of the patient. The following two quotes represent some of this frustration.

> … and the frustrations of talking with the LHIN, trying to get some support from them, and trying to transfer to a palliative team even though they [patient] may technically not fit the standard scoring qualifications … A lot of it probably boils down to bureaucracy. Just the rules and regulations that are in place (Transcript PA 8, Pos. 45-47)

> If I see someone whose wound is deteriorating, as it happened yesterday, and I called the doctor right away and said I believe this person needs to be on palliative case load. But they don't meet the requirements according to the LHINs category or scoring whatever that is. So, it's just frustrating for me just to go in with tunnel vision in the way. (Transcript P B 1, Pos. 45)

Nurses rejected the standardized methods of care prevalent in the academic preparation of nurses, describing them as not "patient-centred." They considered specificity in care a main characteristic of nursing care. Because the human condition changes from one day to the next, good care was described as one that should not follow a fixed protocol or formula but should be flexible and adapted to fit the specific individual condition of the human patient. The rigid nature of protocols and guidelines made more difficult the complexity of the nurses' artful work to provide care that fit patient needs. One RN asserted that no one protocol could fit all conditions because human needs are not universal but personalized and individualized:

> We can't try to fit a patient into a little box or what we're reading in the textbook or what we've been taught in class. There's, you know like, this kind of a patient, and that kind of a patient, I feel like we can't do that in a general way but each individual patient is specific. I think protocols and guidelines are not patient-centred. In order to provide good care, you have to look at that patient as an individual and sometimes that care has to be tweaked a little this way or that way in order to work for that patient. The same protocol or guideline is not gonna work for everybody. We just have to see the patient as a person, as a whole. (Transcript PA 6, Pos. 11).

The nurses complained that care coordinators assigned patients to staff based on a list of patient names without consideration of the variances in care among the listed patients. One nurse said: "It is a little hard when [coordinators] give us a list of clients for the day cause the coordinator, has really no idea. This one is gonna take ten minutes but this one might take an hour and ten minutes" (Transcript PA 2, Pos. 55). By the same token, nurses complained about the fixed predetermined time allocated to each visit irrespective of the patient's situation. The standard but limited amount of time available for each case was criticized because the nurses thought that clients were seen as machines or "robots rather than as human beings. They argued

that patients have needs for care that are not "constant" or identified beforehand but are situational and change from one time to another. As one RPN stated:

> None of our clients are robots. Their conditions are constantly changing, their human, that's the way the human body is … we can't just put a definite time stamp on each client. It just doesn't really work that way. On a good day, this is how long it should take. On a bad day who knows how long it could take. (Transcript P B 2, Pos. 35)

As mentioned previously, nurses interpreted the diminished time they had for care as a way to "fit people in" and they had to adapt to the increased number of refereed cases that required treatment. Similarly, nurses blamed care coordinators for allocating a constant time for care for all patients, which resulted in "neglecting" the specific individual needs that required a flexible time model to conduct assessment and care. One RN stated that:

> The coordinators are just not looking at each case, they might just think, get everybody an antibiotic in 30 minutes, 30 minutes but there is negligence in there, and if there was time, then we could have seen that person for longer in the afternoon … so, I could have an appropriate assessment done. (Transcript PA 5, Pos. 50)

One of the last thing nurses talked about in this subtheme was the computer documentation system, which was also criticized for being standardized and not "interested" in information that nurses wanted to document about changes in their patients' condition. They described that computerised programs were focused on specific types of data that contributed to the efficiency calculations rather than patient specifications. One RN criticized the orientation of the electronic documentation that she believed served the interests of the organization and healthcare system:

> The [computer] system isn't even interested in the specifics that I want to put in there. It's more interested in that I didn't answer that question and I didn't answer this question. And if you answer this question, you have to do this thing and it wasn't interested in my information that I had. It's an electronic substitute … so, they want to do all these efficiency stuff. (Transcript P B 4, Pos. 44)

Discontent with healthcare policies.

This subtheme is focused on nurses' complaints about transformations in the healthcare system and how healthcare policies induce a provision of care that is not patient-centred. Based on the interviews, it was found that frontline nurses are usually not aware of changes in healthcare policies despite their having a direct effect on their work. Nurses were left in the shadows, uninvolved and uninformed about changes and transformations in the healthcare system that have a direct influence on the provision of care. One RN said: "Unfortunately, I feel I am uninformed in terms of political policies that have been put in place" (Transcript PA 1, Pos. 87). On the one hand, this implies that nurses are usually immersed in their caring obligations and not well oriented to the significance of political involvement on their work. On the other hand, nurse managers were able to see that political transformations in the healthcare system had an impact on the care provided to patients, but they asserted that they did not have any control or influence on such changes. They were neither involved nor consulted about decisions taking place, but were only in a position of adapting care in the best possible manner to fit the changes. As one nurse manager said:

> Transformations in healthcare policy create an enormous amount of discontent and disruption to the system … so there's always been some political thing that somebody thinks I can do it better … and we don't have a lot of control over them, like we just manage the best we can. (Transcript PA 9, Pos. 71).

Rrecent transformations, particularly those related to dissolving the coordinating role of the LHINs, were frustrating for a number of participants who blamed changes in healthcare for not being patient-centred and not placing the interests of patients at the "forefront" of these changes. They mentioned that amid these transformations, clients have been "forgotten" and their needs were "neglected." Nurses were worried that recent changes will negatively influence

care provided at homes especially for the "frail elderly" who were the most vulnerable and in great need of assistance. One nurse manager made the following comment:

> Clients are going to get lost when the care coordination dissolves … it's the client who is going to be impacted because they're going to be either forgotten or left behind… so that's the biggest piece. I believe that's not at the forefront of this transformation and is being neglected. And that's going to hurt clients living in their homes, mostly the frail elderly and the chronically ill. (Transcript P B 7, Pos. 42)

When then patient is "forgotten" and care is provided in a context where services are either cut or delayed, the situation will become very complicated in the home care sector. Moreover, when nurses talked about shortages of PSWs, the healthcare system was accused being "detached from reality" especially when it comes to poor people who live on a minimum income. One RN explained the existence of a "huge gap" between government promises about transformations that are taken to ensure high quality care and the actual reality of care provided in home care, especially for those with limited financial income:

> I find there's like a detachment from the reality … they're not going into someone who is on disability making ten thousand a year, living by themselves in poverty who can't afford to even buy a bus pass or go out and get groceries … I find there's been like a huge gap with the reality that is happening versus what they want to happen with the healthcare system. (Transcript PA 7, Pos. 55-60)

Nurses in many instances contended that they were worried about patients who were neglected and left alone in critical situations. Such patients were suffering very serious diseases and "can't do anything," not even call for help when they need it because they either have an altered level of consciousness or have difficulty moving. Neglect in the care of patients in their most vulnerable life stage was disappointing to nurses, as one RN reflected:

> I am even worried about them being alone because if something goes wrong, and they have a bad back and can't bend over to remove the bandaging or the compression, then and there is something wrong, maybe they had a blood clot and we didn't know it … they can't do anything about it and they already have dementia, then you're really in trouble. (Transcript P B 4, Pos. 13)

Participants also blamed the government for not putting enough emphasis on community care due to the traditional influence of the medical model that directs most funding towards hospitals and treatment in acute care centres. They explained that the significance of the home care sector and services provided by home care nurses in the community are not well emphasized by the government, and that unless the healthcare system gives value to the significant contribution of the home care sector and respects people's choices, healthcare policies are not expected to improve caring conditions.

> Unfortunately, the ministry is most familiar with acute care … that's what's been funded and that's where they spend most of their time … I think less effort has been put to understand and evolve the home care sector … we need to put more value on people's choice of where they want to live and how they want to live versus just a traditional view of the medical model of healthcare. (Transcript P B 7, Pos. 42 - 45)

Healthcare policies were criticized for not being focused on community health and not keeping individuals safe and healthy, which could be of financial benefit to the government budget. The nurses thought that cuts in services in public health and community care were an inefficient financial strategy because deterioration in health contributes to increased hospital admissions and consequently increases healthcare expenses.

> The best client is the one you don't have, okay? If you're managing health outcomes for people, they wouldn't be getting sick the way that they do … Reduction of services or delay in services will impact continuity of care … you end up with sicker people, you have more readmissions to hospital. If your community link is broken your ER [emergency room] expenses are gonna go up. (Transcript PA 9, Pos. 88-100)

Caring within difficult working conditions.

All the above-mentioned problems in the healthcare system are on the shoulders of the home care nurses and caregivers who are expected to provide good quality care in difficult working conditions. Based on what they said in the interviews, it is obvious that nurses are very upset with healthcare policies and the implementation of efficiency in home care. The work

environment was seen as an impediment to care and a contributing factor to the increased incidence of nurses' sickness and absenteeism due to the increased workload and the number of extra hours nurses have to work. One RN participant encouraged nurses to raise their voices to address the negative consequences of the efficiency measures adopted by home care agencies. She was very explicit in revealing the shortcomings because of the focus on the number of visits at the expense of time spent in providing care.

> That's not helping anybody. How do they think that's being more efficient? That has to go to the head of the organization and then they have to bring that up in their meeting and say like this efficiency is not working because look what's happening, look at the number of sick nurses, look at the number of overtime hours … efficiency of making sure that they were able to see nine clients in a day, efficiency meaning that they're really trying to cut down on the amount of time that the nurse takes to see each patient. (Transcript P B 4, Pos. 37-39)

The home care environment is usually demanding and stressful, characterized by many difficulties that are peculiar to its nature. For example, nurses are usually required to drive to patients' homes, which is problematic especially in bad weather and traffic congestion which may take from the time assigned for the patient's visit. Continuous changes in the workplace based on the different addresses of assigned patients are often a problem of "inconsistency" in getting to work. One RN explained:

> You've got to be able to deal with all this, like there's no consistency. Like every day I am not driving to the same workplace. There's no routine, you drive to different remote places, so you've got to be able to go with that then you get into the patient's setting. (Transcript P B 8, Pos. 39)

The nurses also complained about working with difficult patients who have mental issues or are involved in substance abuse, where their lack of cooperation can complicate the caring process. One manager explained that "Mental health is a big issue that impacts care … but really the issue in them is substance abuse" (Transcript PA 9, Pos. 98). Another major problem is the language barrier, which can result from those who don't speak the language the nurse is familiar

with or from those with an altered mental status, both of which impede communication and effective interaction between the nurse and the patient. One nurse said: "It can be difficult if that client is unable to have a conversation whether they have dementia or whether it's just old age and confusion … In the community we see different people and there are often language barriers" (Transcript PA 1, Pos. 25).

Driven by their ethical obligations, nurses were doing the best they could to help patients and promote their well-being. One RN said: "The nurse is going to be thorough … she is not gonna leave the home until he or she knows that everything is gonna be alright. I can't walk out if they [patients] are not well" (Transcript P B 4, Pos. 19). This ethical obligation in nurses was the motive behind caring activities that fall beyond their professional responsibilities such as assisting patients in showering and getting dressed. They were ready to do anything to satisfy patients' needs.

> The support workers as you know provide extra care for getting people dressed. If they're not there, helping them in and out of the shower, things like that, things that would not typically be within our nursing scope of practice in this field, but we feel, we need to provide in order to be providing the best care for a patient as possible … we feel ethically driven to provide the best possible care. (Transcript PA 8, Pos. 55)

At the same time, because nurses were committed to help patients, they were working for "free" at times when they were supposed to be taking breaks and relaxing with their family after duty hours. One RPN complained: "Nurses today work for free … I work through my lunch hour you know. I stay after 4:30 to finish a client" (Transcript P B 3, Pos. 49). In such difficult situations, nurses were "constantly trying to balance family and work, family and work, family and work" (Transcript PA 6, Pos. 11). Despite all of the problems mentioned and the sacrifices the nurses made to provide good care, they are prone to litigation, which was not uncommon in the workplace. Patients threaten nurses with losing their licence for problems that may arise in

the home care context. One manger stated that patients were telling nurses: "You've got that license to protect me, if you, kind of don't follow what you are supposed to be doing, you're at risk of losing your license" (Transcript PA 10, Pos. 37). Litigation was also described by another nurse manager to be a common behaviour used by patients to protect their right to receive good care. She said that there are patients threatening nurses "I am going to sue you, I paid for my healthcare, for all these years … Litigation is something we hear a lot of … 15 years ago we haven't heard of. Now it's quite common for people" (Transcript PA 9, Pos. 104).

Amid such a difficult work environment and the many efficiency measures put in place that made not enough time for care, the nurses feel they are left to figure out how to perform good care. They struggle in a work environment that restricts their practice rather than supports them to provide good care. They believe they are working in an environment where they have no power over its restrictive conditions. One RN said: "I wish that we [could] have some more support … I wish I could do a bigger assessment for end of life need but I couldn't, so my hands were tied on that" (Transcript P B 1, Pos. 45). The underfunding of the home care sector and service cutbacks make caring a challenging mission to achieve because removing some services has a direct impact on quality patient care. One manager explained with some insight that in such conditions, caring will be provided through "alternative ways," meaning the "go in go out" method that rushes care. She also revealed that nurses have tried to stick to their values but then they "kind of throw their hands up" and gave up to a reality that is beyond their capabilities to fix:

> When there's funding cuts, the clients actually don't get some of the services that they need or products that they need. So, I think that becomes a bit of challenge then, you have to find alternate ways to get them what they need … I would like to think that nurses would still hold up their ethics and their standards of care … I think that sometimes they just kind of get frustrated … I do think that there are some nurses that just kind of throw

> their hands up in the air … you've got nurses that will go in go out and just get the day done. (Transcript PA 10, Pos. 63-69)

Although nurses are driven by their ethical obligation to help people, the context of work is very frustrating and not conducive to good care. The nurses feel threatened in a work environment constrained by factors that prevent them from providing better care. They are constantly thinking about the list of patients they have to visit each and every day, which creates a state of conflict and unresolved confusion that jeopardizes the mental health and well-being of nurses. They are not given the opportunity to practice the type of care they wish to provide. The cumulative effect of frustrations from the work environment is high levels of anxiety, moral crisis, and burn out. As one RN reflected:

> It's hard because then it ends up impacting your own life. And that can snowball from there because it can, if you do it too many times, then you can end up getting burned out or whatever, you can just end up with … a lot of anxiety, you might endanger yourself to have a traffic accident because you just have too much on your mind. So, it can put the nurse into more jeopardy … There's definitely a crisis what you call it. It's almost … a moral crisis I don't know if there's another name for it. I can't think of what it is. But you have this conflict inside of you all the time like this isn't, you know, this isn't what I signed up for, I wanted to be able to do more. (Transcript P B 4, Pos. 35-37)

Summary

In this theme, although the nurses consider their discipline as based on scientific evidence and research findings, they are frustrated by the rigid and standardized nature of work protocols and guidelines that restrict their ability to provide good care and respond to the specific needs of the patient as a human being. The nurses rejected treating patients based on a universal formula in which patient treatment is based on a standard model of care. They complained of healthcare policies and transformations in the healthcare system, accusing them of not being patient-centered but focused on efficiency measures that disregard patients' needs and create a gap between reality and government expectations. Finally, participants complained of the different

problematic obstacles that are particular to the home care environment and challenging to their caring expectations. As a result, the nurses are in a state of conflict, anxiety, and burn out because they are not able to provide the kind of good care they wish to in an environment not conducive to good care.

Chapter Seven: Discussion

Introduction

This chapter will present a discussion of the findings based on insights from the theoretical framework adopted in the study. The particular significance of this research lies in the utilization of the theory of recognition as an analytical tool to analyse data. It represents an original attempt that utilizes the three dimensions of recognition to reconstruct the ethical norms of nursing care based on empirical data obtained from interviews with the nurses working in the home care setting. The reconstructed norms, which are derived from an analysis of nursing actions, will be used later as a tool to critique the healthcare system as described by nurses working in the home care sector. Accordingly, this chapter is organized into two main parts. Part one is focused on the reconstruction of ethical norms of nursing actions and part two, which will be outlined later, has its emphasis on the critique of the home healthcare system based on these reconstructed norms.

In part one I will explain how normative reconstruction, the guiding principle of this section, was based on the normative claims explicated from the nurses' narratives during their descriptions of their daily actions. After that, I will show that the way nurses described nursing action as a form of interaction with the patient oriented towards understanding and reaching agreement on treatment can be conceptualized as a form of communicative action theorized by Habermas (1984). I will then refer to narratives that describe patients in an asymmetrical power relation with the nurse; those whose extreme illness leaves them without a choice about care and no ability to argue about the best way to proceed with their treatment. I will show through empirical evidence that caring for such vulnerable patients who are dependent on nurses and who may not even have the linguistic ability to share their perspective requires first of all recognition

at the personal level as human beings whose emotions, values, and rights are respected. According to Honneth (1995, 2008), recognition of the personal identity of the person precedes communication, whereby individuals must be socially visible and respected by ascribing them a certain positive status and granting them individual identification during interactions. It is respect for the biographical particularity and uniqueness of a person with the affirmation of human personality that constitutes the basis of recognition (Honneth, 2008). As discussed in some depth in chapter three, the three dimensions of recognition proposed by Honneth (1995) will be used for the theoretical discussion of the findings. Furthermore, the empirical findings underline the complexity of nursing actions as forms of interaction that penetrate deep into the very personal aspects of a patient's life. Based on what has been discussed in chapter three, I will interpret these findings according to the theoretical approaches of corporality and phenomenology (Merleau-Ponty, 1962; Benner & Wrubel, 1989; Schmitz et al., 2011; Friesacher, 2017). I will show that the corporal and physical forms of communication and interaction, as described by the interviewees, are central elements in the act of recognition and constitute a significant component of nursing actions.

Part One: Normative Reconstruction Based on Normative Claims

Normative reconstruction in this study will be based on analysis of nursing action represented in the nurses' verbatim accounts about their daily clinical interactions with patients. As discussed in the methodology chapter, this form of normative reconstruction originates from existing nursing practice immanent in nursing without referral to external ideals of care (Friesacher, 2017). After repetitive reading and deep analysis of the narratives in the first two major themes, I concluded that what nurses were describing about care and the way they were striving to care was actually a description of normative dimensions of care. Even without them

being aware, nurses were expressing the ethics of nursing care and justifying how they conducted their daily work and the way good care should be provided within their work context. They were raising normative claims about what nursing care is and the best possible way to bring about good care. Actually, nurses were providing normative dimensions about care based on their own empirical experience, which enabled me to reconstruct ethical norms that were implicit in nurses' accounts to make them explicit in the light of the critical theoretical framework adopted in this study. In this section of the discussion, normative reconstruction will be based on narratives from two major themes generated in the data analysis: "Knowing on a deeper level" and "Treating the patient as a human being."

Nursing Action as a Specific Form of Communicative Action

Findings in the subtheme of "involving the patient in care" provided an explanation about how nurses perceive the nature of interaction when caring for their patients. Nurses stressed the importance of listening to the needs of patients and what they preferred to be done because they know what is "going on" and what is "pertinent" to them in specific situations. The nurse and the patient interact with each other to decide on the right thing to do based on input from the patient, who is considered an active contributor to the course of treatment and whose perspective is valued and respected. Nurses described care as an "interactive process" between the nurse and the patient who gets involved in a discussion and negotiates care that fits his or her needs.

This description of nursing action as a bilateral process of interaction where decisions are not dictated by the nurse but decided upon with the patient remind me of how Habermas defined social interaction in his theory of communicative action. Habermas (1984) argues that communicative action is a conscious interaction of negotiation where participants interact with each other on an equal level through rational argumentation, cooperation, and mutual

understanding to reach consensus in an environment characterized by freedom of speech with no imposing forces. Thus, what nurses mentioned about the bidirectional communication in caring action can be understood as an intersubjective relation between the nurse and the patient who communicate with each other and exchange information during the discussion of treatment issues in a dialectical mode to achieve consensus (Kim & Holter, 1995). When questions are raised about illness and treatment and enter a justifying process of discussion that leads to consensus between the patient and the nurse, then communicative rationality is validated, and a rational acceptance of treatment becomes a caring norm of effective care that respects the patient's perspectives and concerns (Sumner & Fisher, 2008; Sumner 2010). In this sense, communicative rationality is compatible with the profession of nursing because it is based on interaction and collaboration between the nurse and the patient who should both agree on the course of care as autonomous actors (Friesacher, 2017). This finding supports the literature that rejects the compatibility of strategic rationality with nursing care because the nature of nursing interactions and effective treatment is a double-track communicative course of action that is based on mutual understanding and agreement (Kim & Holter, 1995). Kim & Holter conclude that the "applicability of critical theory and the theory of communicative action to nursing is evident when we view nursing practice as involving collaboration and mutual process between the nurse and client which also necessitates the empowerment of clients and enhancement of their lot within the health care system" (p. 216). Thus, the dialogical and collaborative discussion about treatment in communicative action empowers patients to raise their voices, negotiate options, and take an active role in deciding on care as an autonomous, self-determined person (Solum et al., 2008). When given the chance to express their needs through involvement as active contributors to their health, patients become more responsible and more accountable for their own treatment.

Therefore, based on the empirical findings discussed in chapter six, nursing actions are ideally conceptualized as a form of communicative action where both the nurse and patient interact with each other on an equal basis and engage in a rational dialogue to reach consensus on the course of treatment.

The Need for Recognition Theory

Habermas (1990) considers that both parties must have the chance to participate in decision making about their own cases as equal subjects in a coercive-free environment. He also considers linguistic competence an essential medium for a rational argument to reach mutual understanding. Yet, thematic findings, particularly the two themes "doing a lot more with less" and "challenged and frustrated," entailed multiple narratives about patients in asymmetrical power relations, completely relying on care offered by the LHINS and service providers without them having the choice to decide on their own care. Patients did not have the needed knowledge to rationally argue about the best way to proceed with care while the nurses were well equipped with professional knowledge and competence that empowered them to decide on steps of care and course of treatment. Some patients were trapped in a rigid technical environment that denied them any chance to engage in a dialogue to raise their voice, which deprived them of adequate care based on needs. Others were so ill with a condition so overwhelming, confusing, and threatening to their existence that they had significant levels of distress that disturbed their thought processes. They were in a critical status of uncertainty and imbalance that did not qualify them for negotiation on an equal basis with the nurses but were nevertheless dependent on their care. Furthermore, some patients were too frail or mentally confused to engage in lengthy rational discussions or even to communicate verbally at all. Participants also described neglectful forms of care within this context of inequity where patients' needs, including very basic human

needs, were not fulfilled appropriately and sometimes disregarded. Such conditions not only fall outside the restrictive dimensions of communicative action, but they are also more likely due to a lack of respect for the human identity of patients and neglect of their right to share their opinion and receive adequate care. Thus, a broader framework for interpretation was required.

In his theory of moral recognition, Honneth (1995) criticized communicative action because it neglects the moral experience and personal identity of individuals who are not engaged in a dialogue, or their voice is not heard. He proposes instead the theory of moral recognition with empathetic engagement as a precondition for successful communicative action (Honneth, 1995, 2008). In order to ensure recognition and social justice, Honneth (1995) suggests three necessary ethical dimensions of recognition. As mentioned earlier and discussed in chapter three in more detail, social visibility, according to Honneth, is more than the mere act of neutral perception because it implies three dimensions that lead to recognition: love that is necessary to develop self-confidence, legal rights necessary to develop self-respect, and solidarity required to promote self-esteem. Friesacher (2017) confirms that the dignity and autonomy of patients who are going through an existential crisis, including those who are sedated or not fully conscious, must be preserved and respected. He adds that neglect in care, maltreatment, or inappropriate forms of care provided to vulnerable patients are not merely the result of a lack of communicative competence but rather the result of a lack of recognition that impacts the identity of these patients. Friesacher further emphasizes the imperative for nurses to respect these three ethical dimensions of recognition in order to ensure the provision of ethical care that protects the identity claims of patients and prevents pathologic forms of care and injustices, thereby disrespecting and derecognizing the human nature of patients. Violation of any of the dimensions of recognition not only indicates that the recognition of personal identity

is lacking but also implies that the patient's right of self-realization and self-determination are breached. In the following discussion I will show how the three dimensions of recognition were embedded in what the nurses discussed about their interpretation of good care and the way they were striving to provide it in the context of their practice.

Love in nursing action.

In the subtheme "demonstrating genuine concern and emotions," nurses demonstrated that they understood good care in terms of the emotional attention directed at the patient as a human person who is in need of empathy and understanding. Participants understood genuine care to be a complex interplay of compassion and concern for the patient. This authentic care was considered the foundation for whatever caring intervention was provided to patients. In order to provide good care adapted to the needs of the patient, the nurse ensures "that the client can feel empathy, feels that the nurse is interested in her … as a human person" (Transcript PA 2, Pos. 59). The affective component of care was further considered a "strong base" and a precondition for a successful and trustful caring relationship that respects the patient unconditionally as a human being.

From the theoretical perspective of Honneth's concept of recognition, the relational dimension of love is best understood as an emotional bond or an empathetic engagement with individuals through a caring approach that acknowledges their needs and aims to satisfy them (Honneth, 1995, 2008). Recognition charged with positive emotions directed towards others in need of help is required to build self-confidence during social interaction (Honneth, 1995). In nursing, the dimension of love is represented in affective relations of caring and concern directed to meet the physical and psychological needs of the patient (Friesacher, 2017). Therefore, in nursing care, love as a compassionate and emotional bond is an important component in the

caring relationship that enhances the self-confidence of clients (Wernet et al., 2017). When patients feel cared for by a concerned nurse, a healing atmosphere of trust prevails in the relational connection between the patient and the nurse, enabling the patient to develop or maintain self-confidence. This self-confidence helps them to regain physical integrity faster and once they achieve physical integrity, they have a better chance to become independent. Due to the significance of love as an emotional bond essential for effective caring relationships, the participants described nurses as different in comparison to other healthcare professionals, using expressions like nurses "have a heart," which implies that they have emotions of empathy, compassion, and the ability to understand how a patient feels and experiences a situation.

Considering the fact that Honneth (1995) based the dimension of love on the private and intimate sphere of family and close friends, data analysis supports that this dimension in the form of care is a characteristic of nursing actions. Nurses working in the home sector have accepted that they enter the private sphere of the patient and take on the role of significant others (Terkelsen et al., 2019). While the dimension of love as an emotional identification with the patient is difficult to attain in healthcare environments defined as rational, scientific, and focused on cure (Read, 2007), there is no doubt that emotional components in care are essential for effective caring relations (Watson, 1985; Leininger, 1988; Benner & Wrubel, 1989; Swanson, 1991; Gallager, 2013; Blomberg et al., 2016). By considering love an essential dimension for ethical care, nurses' caring actions appear as particularly complex because the nurse must be able to navigate the ethical challenges and responsibilities of being so close to the person but still protect the person's autonomy and independence.

The analysis clearly highlights that nurses in their caring actions must be willing and ready to perform different roles and assume responsibilities far beyond the assigned technical

tasks (Terkelsen et al., 2019). Love as one dimension of recognition is a decisive element of ethical care reflected in statements in the interviews that described the many invisible caring actions that are not part of required roles defined by the SPOs. Hence, the powerful motivation of love or what participants expressed as genuine empathy, concern, and care mobilizes good intentions in the nurse to enter the lifeworld of the patient and explore the whole personal and daily life of the patient. This includes the aspects of care participants mentioned in the interviews such as checking on their home environment, their nutrition status and the availability of someone to prepare food for them, their ability to wipe themselves when they go to the bathroom, the condition of the mattress they sleep on, etc. Without entering the private sphere of the patient and developing that deep relationship, nurses would not be able to look at the patient and predict that something is not going well with him or her. It is probably the dimension of love that prepares nurses to accept and carry the ethical obligation of doing whatever is possible to make their patients happy and to provide an environment in which the patient feels accepted, valued, and cared for. Moreover, this dimension of recognition comprises the way nurses provide intimate bodily care by strengthening the patient's self-confidence, even in a situation in which the person appears as particularly vulnerable. This form of care that appears on first view a mere technical task is actually a very complex nursing action that can only be provided effectively by experienced nurses who are well prepared to understand the existential situation of their patients (das Gracas & dos Santos, 2009).

In conclusion, the dimension of love is represented in the verbal accounts of nurses when they talked about their daily actions and their understanding of what constitutes good care. Because emotional attention is necessary for the development of self-confidence and preserving human identity, love as a part of recognition provides a normative dimension to the ethical

relationships in nursing caring action. Failing to understand the feelings and experiences of the patient implies a lack of recognition of the human identity in intersubjective relationships or verbal communication (Wernet et al., 2017; Cummings, 2018). Any form of maltreatment, neglect of personal experiences, or failure to show concern regarding the needs and suffering of the other indicates that the loving or caring dimension of recognition has been violated (Friesacher, 2017).

Respect of legal rights in nursing action.

In the subtheme "showing respect," participants explained how they understand respect in regard to patients' medical and psychological needs, values, beliefs, property, environment, personal choice, bodily touch, etc. Respect for patients' legal right to be informed about the course of care and planned interventions was mentioned by participants when they talked about signing the consent form upon admission to the home care service, an aspect that will be discussed later in more detail in the section concerning the critique of the ongoing transformations of the Ontario healthcare system. The nurses' inability to find clear expressions to identify the exact meaning of respect indicates their lack of a clear definition of respect. In fact, respect was presented as a broad frame for all needs and rights including the right of self-determination of each patient as the author of own life. Moreover, respect of needs was presented as a universal right for all human beings, whereby "every human deserves respect. That's really what I think no matter who you are. All needs should be dealt with respect" (Transcript PA 5, Pos. 29) regardless of faith, beliefs, and ideals. Based on the thematic analysis, it seems that nurses do not have a clear theoretical conceptualization of what they mean by respect nor are they able to identify the focus of respect.

In light of Honneth's theorization of recognition, participants' statements can be subsumed under the dimension of legal rights. In the legal dimension of recognition, Honneth (1995) asserts that the rights and interests of each and every individual must be respected and recognized as legal rights protected by the law. He insists that legal rights must be recognized on a universal basis regardless of social class, background, or traits and values of individuals in society. In Canada, basic healthcare needs are legally safeguarded with respect and consideration of the values of patients and family enshrined during the process of planning and delivery of care (Health Canada, 2018). People feel that their rights and unique values are now protected by the law which enhances their sense of self-determination (Wernet, et al., 2017). Applying legal recognition to healthcare implies that all care needs of the patient must be socially recognized as legal universal rights that respect the values of patients (Friesacher, 2017; Wernet, et al., 2017). When care is provided based on the principle of equality before the law, where respect is given to all needs and values of each individual, then caring actions become ethical, and safety and equality are ensured (Friesacher, 2017). The respect of legal rights means that individuals are recognized as autonomous members who deserve respect in their values, interests, and chosen way of life (Honneth, 1995). This perception of rights is very close to what participants described about the different facets of respect that regard the right of self-determination of each patient. In this sense, the dimension of legal right is proposed as a theoretical term or expression that represents all facets of respect mentioned by the participants.

Moreover, in the subtheme "Providing help and advocacy," many participants perceived themselves as advocates for their patients by helping them to navigate the complicated healthcare system in order to secure resources and provide them with the needed support and services. This form of advocacy can also be conceptualized as advocacy for what nurses believe patients are

entitled by law to receive or access. Disrespect of rights and values indicates injustice and a violation of legal rights, which motivate patients to engage in a dialogue or struggle to reclaim their rights and resume legal recognition (Wernet, et al., 2017). When patients are in an existential crisis and are denied recognition of their rights, the nurse is ethically obliged to advocate for patients to claim them and thereby maintain their patients' self-determination, because autonomy and equality in care must always be sustained and recognized (Friesacher, 2017).

In conclusion, Honneth's conceptualization of recognition within the dimension of legal rights was the theoretical basis used to represent the nurses' statements that mentioned the multi-faceted nature of respect that also included advocacy for patients to access services they are legally entitled to receive. According to the theory of recognition, when people feel that their right to receive care, which respects their unique values, cultural particularities, and specific needs is protected by law and recognized by others in society, their sense of self-respect will be enhanced (Wernet et al., 2017). Any neglect or denial of legal rights or any form of inequality or inability to rightfully access care will lead to a degraded sense of self-realization. This violation should motivate individuals to struggle and engage in communicative dialogue to protect rights and preserve their identity.

Solidarity in nursing action.

In the subtheme of "providing help and advocacy," narratives also showed that in their daily actions, the nurses were willing to help people meet their health needs and other basic needs as "human beings." This perception of need is different to what was included in the last section about needs addressed by legislation and regulations. What participants discussed here goes beyond patients' legally guaranteed rights to the dimension of promoting the self-esteem of

patients. This means that the nurses' intent to help patients was based on the consideration that patients are human beings who deserve to be considered worthy especially in situations where they were in real need of help and assistance. Because the nurses knew their patient holistically at a deep level, they were able to realize when alterations in health condition occurred and were ready to communicate with physicians or other healthcare professionals on their patients' behalf. Nurses were ready to do "anything and everything" to assist their patients and support them to resume their well-being in order to "make them feel they matter, and that you're [nurse] there to help them when they need help" (Transcript PA 5, Pos, 33).

What nurses were actually doing by their advocacy was not only securing what they thought the patient deserved in terms of healthcare needs and rights, but they were also demonstrating an explicit message of support and appreciation for the significance and unique value of their patients. Because caring actions usually take place in situations of asymmetrical power between the professional nurse and the patient experiencing a severe crisis (Friesacher, 2017), nurses have an ethical obligation to support the needs of patients and advocate on their behalf them to make them feel that they are of valuable and important for the community despite their vulnerable situation of being sick or socially isolated. The aim of making patients feel worthwhile and valuable to others in society was explicit in another participant's account who encountered those who are alone and without visitors; she decided to just sit with them and "engage in some normal conversation that makes them [patients] feel that they matter" (Transcript PA 2, Pos. 74).

This form of advocacy and support can be interpreted using Honneth's dimensions of solidarity. In solidarity, individuals feel respected, honoured, and socially esteemed by community members (Honneth, 1995). They feel socially worthwhile as a result of others'

respect for their unique traits as a person during social interactions (Honneth, 1995; Presbey, 2003). In nursing, solidarity is realized by respecting the needs and values of patients and by advocating to protect the dignity and social esteem of individuals whenever care needs or patient's autonomy are threatened (Friesacher, 2017). Showing concern for patients in their vulnerable state and recognizing their personal choices are important for maintaining self-esteem and social integrity. The idea of making patients feel respected and valued is further expressed in thematic findings when a participant mentioned that she wanted her patients to "think of nurses as someone who is gonna help them with their life, we're gonna help them get better, whatever the situation is" (Transcript PA 6, Pos. 35). This is a clear and strong message of support and solidarity because readiness to do "whatever" is needed reflects the worth, value, and significance of the patient to the helping nurse.

The thematic findings revealed solidarity with patients and support for their needs on different levels. For example, at the organizational level, nurses contacted their managers to ensure good quality care for their patients. They also communicated with the LHINs and other various healthcare professionals outside the boundaries of the service provider organizations. Thus, ensuring that patients receive appropriate treatment because of their worth as human beings reflects social recognition and appreciation and signals to them that they are perceived as contributing members to the community, which in turn promotes self-realization and social esteem for the patient (Wernet et al., 2017). Mistreatment, neglect of rights or disrespect in care is degrading to the person and disables that social esteem and recognition in the community. The existence of many forms of help, support, and advocacy in the context of home care indicates that solidarity was a normative dimension of good care.

However, as Friesacher (2017) explains, in order to ensure recognition in nursing, the lived experience of the individual patient must be considered the foundation of care. He asserts that a phenomenological-hermeneutical case understanding with a particular focus on the perceptible body or what he calls the corporal body of the patient is a core component of nursing actions. In the following section, I will demonstrate how the thematic finings revealed this complex way of understanding patients.

Corporality in Nursing Action

When nurses were asked to describe their everyday caring activities during home visits, "knowing on a deeper level" constituted a major thematic finding. In this theme, nurses emphasized the importance of knowing the patient through a specific relationship that goes so deep that nurses arrive at "knowing the very personal dimensions of life" that are difficult to explore. They described a relationship that is so intimate that patients disclose sensitive information and expose their "innermost secrets … that they haven't even divulged to their own family" (Transcript P B 2, Pos. 13-14). It is a deep relationship that creates "a whole different level of trust." Even when nurses were assigned to do simple technical tasks, they were focused on exploring the "other things" that are of primary concern for the patient but difficult to express in definite words. It was interesting to observe that participants had difficulties in verbalizing what exactly they meant by this form of "deep knowing."

What nurses also described about showing concern and compassion through the idea of "presence with" and "being there" with the patients to understand their personal and "biggest issues" other than their medical problem can be explained through the theoretical concept of phenomenology and corporality. The words nurses used to describe this aspect of care are related to exploring the internal and subjective experience of the patient and are associated with the

patient's personal perceptions about illness (Friesacher (2017). Schmitz et al. (2011) clarify that feelings and perceptions are embedded in the corporal body; for others to be able to interpret or understand them they need to get into a close intersubjective relationship that allows access to the unique experience of the person. In this sense, corporality must be considered a key concept in nursing care that can only be explored and understood by "being with" the person in his or her lifeworld. Through this intimate relationship it becomes possible to connect with the corporal body, enabling the nurse to explore the private and personal experience of the patient (Friesacher, 2017). Because the physical body is intertwined with the experienced body or the person's corporality it is not enough to focus on the physical body alone. We must take into account the corporal dimension of the body if we want to understand how a person might experience a situation (Schmitz et al., 2011).

Patients, particularly in older age, often experience their illness as an existential crisis that disrupts not only their bio-physiological equilibrium but also their general well-being with a huge impact on their emotional health. Therefore, a phenomenologic-hermeneutical approach to care is considered essential to understand patients' conditions to assist them in coping with illness, which is the status of emotional imbalance, malfunctioning, and loss of autonomy experienced by a patient as a consequence of the disease (Benner & Wrubel, 1989). Benner and Wrubel (1989) assert that properly coping with illness requires understanding the phenomenological world of the patient through a genuine concern, which leads to a trustful relationship and emotional involvement that explores the background and meaning of the patient's experiences. Only then is it possible to interpret the meanings a patient attributes to his or her health situation. We are able to define meanings because our bodies have the capacity to know and embody knowledge that results from previously learned knowledge, acquired skills,

and life experiences that allow us to give immediate meaning to situations we are involved in (Benner & Wrubel, 1989). Exploring concerns and meanings embodied in patients was mentioned in the narratives when one participant talked about the patient being "the tenant of this body" that contains "valuable information" needing to be explored and investigated (Transcript P B 8, Pos. 15). Another participant discussed exploring the "other things" and the "primary concerns" that are usually hidden inside the patient. The idea of "tenant of the body" can be connected to the explanation given by Schmitz about using phenomenology as an approach that gives individuals the right to self-identification, ascribing meaning to their own situation and expressing feelings and perceptions related to their own experiences (Schmitz et al., 2011).

In order to explore personal meanings and to understand the lifeworld or the personal life of the patient, a hermeneutic method is needed that enables the interpretation of the embedded perceptions related to the immediate context people live in and interact with. It is through interpretation of the situation of others that a nurse can make sense of and understand the meanings that are constructed subjectively by the patient (Khairy & Mosleh, 2014). Interpreting these very personal meanings is also linked to the subtheme "understanding the whole person," when the participants described how they tried to know their patients in a holistic way by taking into consideration their physical abilities, daily activities, family relations, connections with community services, economic situations, nutritional status, emotional states, and even the ability of patients to clean themselves after toileting. Thus, capturing the corporal experiences of illness adds a hermeneutic dimension to nursing actions that enables the nurse to link the inner and private personal experiences of patients with their context of living or what was earlier conceptualized as "being with" in their lifeworld (Friesacher, 2017). The participants clearly

indicated that deep and holistic knowing is an essential requirement to devise a comprehensive care plan that fits the particular situation and unique needs of the patient as a person.

It became apparent that the difficulty participants faced in verbalizing this dimension of care in clear and definite terms, when they talked about exploring "other things" and "primary concerns" in the interviews, is probably due to the complexity and imponderable character of defining the "being-with" and "being-in-the-world" of the patient. It is an act of entering into a diverse world of possibilities that connects the nurse to the lifeworld of the patient in an attempt to understand the existential experiences of illness beyond the dimensions of the physical body and disease (Sebold et al., 2016).

Furthermore, to connect with the subjective and phenomenological world of a patient is such a complex and multifarious task that it cannot be achieved by following a standard methodology, but rather it requires the practical knowledge of the expert nurse who can see the whole picture through engagement with and awareness of the patient's situation (Benner, 1982). In this sense, knowing the phenomenology of the patient is a task of indeterminacy that cannot be formalized or rationalized but depends on the informal knowledge derived during knowing the patient and the tacit embodied knowledge of "know-how" that arises in response to clinical practice (Tanner et al., 1993). Benner (1982, 1984) clearly delineates that the expert nurse promotes coping by resorting to a form of knowledge that is tacit and linked to intuition. This kind of knowledge is not based on rational calculations or external conditions of knowing but is phenomenological, making it impossible to verbalize the reasoning behind certain actions and decisions. In this vein, Friesacher (2017) confirms that nursing actions are characterized by indeterminacy and uncertainty that cannot be limited to rational interaction but are rather relational and emotional, requiring the use of hermeneutic skills to interpret the subjective

corporal dimension that is so intricate and obscure. According to Merleau-Ponty (1962), the way people perceive themselves and the world around them is not universal or ideal in terms of meanings and sensation but is based on a corporal-perception in which the lived body is a major contributor to embodied knowledge. The phenomenological and meaningful impressions of corporality are innate to a person and cannot be abstracted (Schmitz et al., 2011). In conclusion, this section has shown that nursing actions are characterized by indeterminacy, uncertainty, and understanding the uniqueness of each individual through the phenomenological-corporal dimension that could not be formalized.

The unpredictability of nursing actions is also related to the aspect of bodily touch that appeared in thematic findings when participants described "providing intimate bodily care" as an important part of nursing action. Caring activities that include working with the body of the patient always imply corporal aspects of care, transforming what is normally considered private and intimate into the known and public (Friesacher, 2017). In their clinical practice and in the process of "knowing" the patient, nurses access private body areas and gain information that cannot be formalized or generalized because they are particular to specific patients (Tanner et al., 1993). Bodily care transfers knowing from the mental level to another dimension related to bodily touch. In this sense, the nurse knows the patient not only through verbal communication but also through physical examination and body touching. By touching the body, the nurse touches the "being" of the patients whose organs constitute one part of the totality of the patient's existential experience of a situation (das Gracas & dos Santos, 2009).

Based on the narratives in the first two major themes addressed in the results chapter, the concept of corporality can be reconstructed as a normative dimension in nursing action. Participants implicitly perceived that this dimension is essential for "knowing" the patients as a

"whole" and treating them as human beings. Knowing the patient through a hermeneutic-phenomenological case understanding makes the action of caring a complex and subjective process that cannot be objectively determined or standardized.

Summary

Based on thematic analysis, the first part of the theoretical discussion was able to extract the normative dimensions of care that were implicit in the nurses' accounts. Good nursing care was found to be a form of communicative action based on negotiation that takes place between the nurse and the patient as equal partners who discuss the patient's health condition and course of treatment to reach agreement on care. The three dimensions of recognition were also found embedded in the daily practice of nursing. Love, legal rights, and solidarity were reconstructed as normative dimensions for good caring action that falls outside of communicative action. What nurses described about knowing their patient in a relationship blended with emotions and concerns about the patient as a person was conceptualized through the corporal-phenomenological approach to care, which was considered an essential norm for nursing action that aims at understanding the lifeworld of the patient. In the second part of discussion, I will demonstrate how the reconstructed ethical dimensions of care have increasingly encountered restrictions through a highly rationalized healthcare system that adopts economic efficiency and rigid technical orientation affecting nursing actions.

Part Two: Critique of the Healthcare System

Introduction

As mentioned earlier, nursing care is characterized by asymmetrical power relations between the nurse and the patient, who is usually in a particular vulnerable situation. Patients often experience their illness as an existential crisis that makes them overly dependent on the well-intentioned nurse to satisfy their needs (Friesacher, 2017). From this follows that a critical theory of nursing must provide normative claims in order to prevent the abuse of power in these asymmetrical relationships and an emancipatory dimension that would enable nurses to criticize societal conditions that negatively impact the equal provision of care to vulnerable persons (Mill et al., 2001; Friesacher, 2017). The three ethical dimensions of recognition developed in the first part of this discussion and the conceptualization of nursing action as a specific form of communicative action with a corporal dimension will serve as the normative foundation for the critique of the ongoing neoliberal transformations of the home healthcare system.

In the discussion that follows, I will show that implied in the participants' statements is that preconditions for patients' self-realization and equal participation in social life are violated in the daily clinical practices in homecare and that unless patients are recognized as whole persons whose identities as human beings are preserved, good care cannot be realized. The following discussion will criticize the measures that are often presented as "neutral" steps to increase the efficiency and effectiveness of the Ontario healthcare system. However, I argue that they actually lead to pathologic forms of care that violate the normative dimensions of recognition. Based on these theoretical considerations and in connection with the empirical findings, I will also show how the neoliberal rationality underlying the ongoing economic

transformations in home care makes it increasingly difficult, if not impossible, for nurses to provide the kind of care they identified as good in the interviews.

This part of the discussion is structured around three broad aspects: first, I will show how efficiency measures, particularly time constraints, performance indicators, and standardized forms of care not only diminish quality or care provided in home care but also violate the dimensions of good care and prevent nurses from providing care, as discussed in the first part of this chapter. These violations are what Honneth (1995) identified as social pathologies – and in the context of home healthcare these are pathologic forms of care and injustices – that preclude the possibility of recognizing the identity of patients, leading to a practice of care that Honneth would characterize as a form of reification. In addition, this discussion of nursing actions uncovers how different forms of knowledge with often competing knowledge interests must be combined in order to provide adequate nursing care. In nursing actions hermeneutic-phenomenological case understanding intersect with technical-standardized forms of care, an aspect that will be discussed in light of the theory of knowledge interests (Habermas, 1971) introduced in the theoretical framework. I will demonstrate that nursing actions in clinical practice can best be conceptualized based on what Friesacher (2017) called the "double logic" of nursing action. This part will also demonstrate how inadequate access to care and underfunding deny the legal rights of patients and lead to pathologic conditions that have a detrimental impact on the human identity of patients.

Second, I will discuss how managerial rationality prevalent in home care reinforces pathologic forms of care in a culture that systematically derecognizes the personal identity of patients on almost all dimensions of recognition, a condition that imposes a constant ethical dilemma on nurses who are wanting to provide good care that respects the patient as a whole

person but who are restricted by the economized logic of the healthcare system. Third, the critical perspective of the study leads to a set of critical theoretical and practical considerations that contribute to nursing knowledge and are valuable to note. I will discuss these implications for nursing education, practice, healthcare politics, and future nursing research. The sum of critical reflections provided by this study will establish the foundation for a critical theory of nursing actions based on recognition. Finally, this chapter closes by presenting research limitations.

Efficiency Measures and Violation of Recognition Dimensions

As mentioned in chapter six, participants often complained about the fact that they had to "do a lot more with less" and that they felt "challenged and frustrated." When nurses talked about the barriers they encountered to provide what they perceived as good care, they criticized the financial mechanisms that govern home care. In the subtheme "funding as the determinant of quality care," nurses considered that healthcare and quality care are mainly structured and determined by budget considerations and fiscal calculations. Underfunding and the implementation of efficiency measures were identified as the main mechanisms that negatively influenced quality of care. In almost all the interviews, participants identified a number of existing healthcare practices as barriers to what they previously described as good care. The common barriers they mentioned were the pressure of time, standardization of care, and inadequate access to care. These three factors will be discussed in the light of the normative dimensions of care reconstructed in the first section of this chapter with particular emphasis on the three dimensions of recognition.

Time pressure.

Underfunding, shortage of staff and the SPOs' obligation to care for a continuously increasing number of complex patients discharged early from hospitals pushed SPOs to condense the workload of home care nurses. Instead of hiring more nurses, SPOs augmented the number of home visits per day and shortened the length of each visit, which contributed to high levels of stress in the healthcare staff and a decrease in patient satisfaction (Home Care Ontario, 2019, 2020). The nurses in this study complained that the increase in the number of patients assigned to each nurse with a daily shift of seven and a half hours forced them to provide care in a rushed manner. In the subtheme of "time pressure and inappropriate care," participants emphasized that providing care in a rush did not give time for adequate "caring conversations" necessary to understand the "whole picture" of the patient and his or her individual and subjective conditions. Nurses were aware of the fact that forcing them to visit more patients meant spending less time with each one, interfering with their ability to provide good care with emotional engagement. They revealed that due to the increased complexity of discharged patients they felt "like under the gun" because they were always in a stressful situation, striving to provide adequate care and reach the next patient on time. Overall, spending less time with patients spoiled the relational aspect of caring due to inadequate communication with them and they were unable to show the compassion and sympathy that is needed for phenomenological understanding and deep knowing of the patient.

Participants' complaints about time pressure in providing care are congruent with other studies demonstrating that time constraints violate the ideals of caring. Nursing scholars have demonstrated how inadequate timing has negatively impacted what they identified as relational caring and compassionate interaction with patients (Latimer, 2014; Terry et al., 2017). Such

complains also resonate with studies about nursing care in work environments funded through payment per patient. These studies show how this funding scheme leads to the situation where nurses and other healthcare professionals become too busy and detached from patients due to the increased number of admissions, which in turn results in less time spent in communication and little or no time to care in a compassionate manner (Youngson, 2012; Needleman, 2013).

Yet, from the theoretical perspective taken up in this study, time restraints go beyond the complaints of decreased quality care. Time constraints strike at the ethical foundations of intersubjective caring relations where less time spent with the patient indicates denial of the right to be recognized particularly on the corporal dimension that was discussed in chapter three and presented in the first part of this chapter as a normative dimension of good care. Ethical care, as developed in this study, requires an emotional and loving bond directed towards the physical problem as well as the corporal or experiential dimension of the patient's illness (Friesacher, 2017). Participants realized that communication is not restricted to verbal communication but extends to the corporal dimension. For example, when nurses talked about holistic care, it was mentioned that "they look at the person as a whole and … as a part of a family unit, the person as a part of the community" (Transcript P B 5, Pos. 39). Yet many of them complained that they have not even been given the time necessary to listen to the patient. Exploring the corporal aspects of a patient's lifeworld requires attentive observation to the different aspects of personal life and establishing a trustful and caring relationship to understand how the patient feels, how he or she meets their basic needs, and what a patient actually needs to resume well-being. Again, these findings are supported by the literature describing the negative consequences time pressure has on patient care, including an inability to "know" the patient and obtain enough information from his or her own perspective through communication (Chan et al., 2013). Benner and Wrubel

(1989) contend that a phenomenological-hermeneutic case understanding is essential for the nurse to grasp the particular situation of the patient and identify the specific individual strategies required for effectively coping with illness.

Thus, time constraints made it extremely difficult to establish communication that explores and understands the corporal dimension of the patient's experience, making the person's lifeworld unattainable and the patient feel disrespected (Wernet et al., 2017). The limited time allowed for home visits makes it impossible for the nurse to "be there" in the lifeworld of the patient and to show emotional concern in order to explore internal perceptions about his or her illness (Benner & Wrubel, 1989). But as discussed in the first part of this chapter, without such an emotional bond that I defined as a form of love and care that includes corporality, an important dimension of recognition is violated in nursing actions. Honneth (1995) defined the dimension of love as a part of recognition, a strong emotional attachment between individuals interacting with each other that creates a feeling of interdependence and trust that one's needs will be satisfied. When patients are in vulnerable situations, they need to feel that the nurse is concerned about them and cares about them, which assists them to resume their physical integrity and build self-confidence to become independent again (Friesacher, 2017). Thus, nursing actions are characterized by the patient's dependence on the caring nurse. The absence of emotional attention in caring deprives patients not only of a loving and "nurturing" relationship that contributes to recovery (Terkelsen et al., 2019), but also prevents them from perceiving themselves as valued persons who deserve this kind of attention (Wernet et al., 2017). Failure to provide a form of care that connects with the lifeworld and uniqueness of the patient leads to the patient being objectified, and this lack of emotional recognition precludes feelings of concern, trust, and understanding in nurses' caring relationships (Iorio et al., 2013; Friesacher, 2017).

Several of the participants revealed during their interviews that patients often complained about staff who "just came in and out [and] not even said hi" (Transcript P B 1, Pos. 66). These complaints suggest not only that the nurses did not have time to talk with the patient and listen to his or her concerns, but that patients felt omitting even simple greetings demonstrated a lack of respect. Therefore, the fact that the nurses had to rush meant that patients' emotions, concerns, and human identity were forgotten under the stress of racing to the next patient on the assigned list of care. When the nurses provide only technical care without any attention to emotional engagement or the corporal-phenomenological lifeworld of the patient they unwittingly contribute to "forgetfulness of recognition," or what Honneth (2008) called reification.

Neglecting the dimension of love also denies patients their right to self-realization and self-confidence (Friesacher, 2017). To remind the reader, self-realization and confidence are outcomes of a genuine relationship of care in which the nurse shows interest in exploring the personal and private aspects of the patient and his or her lifeworld. In this sense, limiting caring time is a major threat not only to the ability of the nurse to understand and explore the subjective lifeworld of the patient, described by participants as a process that requires ample time to build a relationship of trust, but also to the ability of the patient to enjoy self-realization as a unique individual person. According to Schmitz et al. (2011), ineffective communication with the patient and the failure to establish a trustful relationship prevents patients themselves to connect with their own internal corporal world and to express their personal experiences and inner feelings. Thus, time pressure also denies patients the right of self-identification. If the nurses' work environment does not provide patients with a chance to participate in their own care decisions, then moral problems will arise because self-determination has little meaning in a situation that prevents patients from having an autonomous interaction and enjoying free consent

on actions that affect their cases (Solum et al., 2008). I have explained in the first part of this chapter that a successful communicative interaction is one in which patients feel respected as human beings whose lived experience and needs are acknowledged and valued. In a time-restrictive context that was supposed to be highly efficient from an economical perspective, participants found they could not explore the lifeworld of the patient because the necessary communicative processes were pushed to the margins. Time pressure made it impossible to engage in an authentic and equal process of communication aimed at achieving a consensus about what interventions should be performed or what should be done in the course of care. Habermas (1984) emphasizes that in order to achieve real consensus through communicative action, participants in the discussion must be freed from all constraints or any imposing condition. Thus, in the nursing caring context, a discussion must go on until a consensus is achieved between both the nurse and the patient. But based on what participants described, the time constraint was a main barrier to the conditions of communicative action and in many instances, the time allocated was not enough to establish a "caring conversation" with the patient nor even to complete the technical task assigned to them. Moreover, reducing the time for home visits so that only technical tasks could be carried out not only diminished chances for self-determination but also reduced the chance for support and solidarity and brought factors of degradation and humiliation into the relationship with the patient (Wolff, 1998; ter Meulen, 2016). Thus, time restraints hamper the essential conditions for recognition of the patient, who has the right to be respected as a person with feelings and concerns and not simply as a medical "case," a view that disregards his or her unique phenomenological characters as a human person.

Disrespect of the patient as a person due to the pressures of time was explicitly expressed by one participant who complained that the rush in care made the patient feel "very slighted"

(Transcript P B 2, Pos. 34). Another participant explained that the focus on doing the assigned tasks quickly during home visits does not respect the "dignity" of the patient as a human being. In this context, participants described care as a "delivery" of services that resembles those offered by "KFC" because "you go, you do … you get your stuff and you're out" (Transcript P B 4, Pos. 56). Because the nurses were in a hurry to finish up and leave, they did not spend time considering the emotional needs and interests of a patient as a person. What patients were missing in this context was their ability to express their feelings and share their perceptions about their illness experience. Patients often felt insulted because the task-oriented mode of care led to them feeling ignored as humans and gave them no chance to share concerns and feelings, nor did it provide nurses with the opportunity to show a caring attitude. This system is focused on efficiency and increasing productivity with no attention to the emotional concerns of humans (Sears, 1999; Ritzer, 2011). It is a task-oriented model of care that is termed "noncaring" because it is focused on diagnosis and treatment without consideration for the psychological dimension and feelings of the patient (Watson, 2009, 2012).

Standardization of care.

The normative foundations of what participants in this study described as good care were also restrained by the standardized technical procedures, protocols, clinical guidelines, and required indicators implemented by the LHINs to guide and evaluate the performance of service providers. From a critical perspective, these clinical policies and surveillance technologies are the materialization of instrumental managerial strategies used to control uncertainties that may result in what is perceived as inefficiencies contributing to rising financial costs in health services (Goodman, 2014). In order to rationalize their operations and legitimize their control over the performance of professionals, managerial authorities operate on a scientific-research

basis and employ standards and protocols that guide individuals about what to do and the way things should be done (Dalal, 2017).

These best practices or evidence-based approaches rely on a narrow post-positivist definition of science that is instrumental and pays little attention to the consequences on human relations or social practices, which are essential components in nursing care (Rutty, 1998; Goodman, 2014). Based on an instrumental rationality, managers and policy makers identify problems and implement solutions that appear as the most efficient and cost-effective approaches to achieve goals (Sedgwick, 2013). Many participants perceived the implementation of standardized care as contradicting their vision of good care. In what follows, I will demonstrate that a standardized form of care is a systematic violation of the different dimensions of recognition.

Performance indicators.

In the theme "doing a lot more with less," nurses complained about the performance indicators (see Appendix I) used by the LHINs to assess and evaluate the performance of SPOs. Because monetary compensation of SPOs depends on their quantitative efficiency, the LHINs contracted with individual SPOs based on a set of binding performance metrics, meaning that the respective SPO would only be paid according to its compliance with the predefined metrics (Auditor General of Ontario, 2015).

Because of its quantifiable nature, the performance indicators, or what was commonly known among home care nurses as the "matrix," was criticized for its focus on statistics and was described as "a false matrix for evaluation" (Transcript P B 8, Pos. 35). Participants were frustrated about the increase in surveillance that focused solely on achieving quantifiable and numerical data to evaluate efficiency of the SPOs. Performance indicators are purely

instrumental and focused on eleven algorithms: The percentage of accepted referrals, number of visits per month, number of patients readmitted to hospital within 30 days, percentage of outcomes achieved based on clinical pathways or guidelines, along with other criteria, are all numerical indicators that measure efficiency with no interest in the subjective input or preferences of the patient. Only one criterion aims to evaluate the convenience of timing visits to the patient, but even this category is meant to merely calculate the number of visits "not missed" by service providers, which also reduces it to a measurable efficiency indicator. There is no space reserved for the patient to indicate individual concerns and express expectations. Based on this, the aspect of effective communication that the participants identified as fundamental for a form of care they identified as good is not part of the categories included in the matrix of care evaluation. The lack of space for patients to discuss or select treatment based on their personal situation or perceived needs thus reflects the use of an instrumental rather than communicative rationality that is more aimed at strengthening patient autonomy and self-determination (Habermas, 1984; Hyde et al., 2005).

It is somewhat surprising that not readmitting the patient to the hospital within 30 days after discharge is an indicator of good performance. In the interviews, nurses described that they were hesitant to send patients back to the hospital within this period despite patients' deteriorating conditions for fear of negative impacts on their matrix record. They were also worried about refusing to admit referrals at times when they were short staffed and/or they considered the patient unstable. They were more concerned about breaching the conditions of the performance indicators regarding the percentage of patients they must accept. From the literature, it is well documented that these indicators enforce a form of care that humiliates patients by not paying attention to their specific needs. In economized healthcare settings,

nursing practice is structured based on a corporate instrumental rationality that benefits organizational goals by accelerating caring processes to increase productivity in a form of care that detaches and dehumanizes the patient (Tonuma & Winbolt, 2000; Rodney et al., 2009; Rudge, 2013).

However, my critique again goes a step further. When a patient's condition deteriorates, and healthcare providers avoid sending him or her back to the hospital due to considerations related to the matrix or in order to increase the efficiency of the healthcare system, then this form of care is more than about neglecting needs and denying a patient's right to receive appropriate care. It also represents an assault on the very identity of the patient who is denied recognition as a human being (Wernet et al., 2017). This kind of healthcare environment systematically neglects the dignity of a patient in favour of the goals of efficiency, which threaten the very basics of nursing care (Friesacher, 2017). This is also a leading cause for the "forgetfulness of recognition" and for the concept of reification, as discussed by Honneth (2008), who explained that reification occurs when "institutionalized practices" aimed to achieve specific organizational goals limit our abilities to meaningfully engage, perceive, and interpret our social context. Thus, these practices lead to a selective unidimensional interpretation of social situations and make us forget not only the intersubjective context of our practice but also the primacy of recognition as the base of interaction with the other. Applied to the context of home healthcare, the implementation of the quantitative indicators by service providers leads to nurses becoming so focused on meeting the expected goals of their SPO that they become detached from the context of their caring practice and forget what is more important ¬ that patients are human beings who deserve emotional attention and respect for their needs and identity.

Rigid protocols and clinical guidelines.

Although participants argued that caring actions are based on their professional academic background and kind of critical thinking that qualifies them for independent practice in home care, they still had to follow the guidelines and protocols imposed by the LHINs because the evaluation of the providers' performance and quality of care was based on them. The Ontario provincial government emphasized that the quality of care delivered in the home care sector is based on the best available evidence upon which standards of care are developed (MOHLTC, 2017). Although nurses acknowledged the importance of evidence-based findings and scientific knowledge to help them in their decision-making processes, they criticized the standardized forms of care based on a universal formula that treated all patients without considering the specific nature of nursing care needed in the individual case. The rigidity of policies, protocols, clinical pathways, and guidelines did not respond to the situational and individual needs of the patient.

As stated in the thematic findings chapter, one participant reflected on her frustration about the negative consequence of a clinical protocol that allows only limited time for using a vacuum-assisted device on wounds regardless of the actual condition of the patient. Attempts by care coordinators to increase the duration of using this intervention based on their clinical judgement was criticized for violating the consistency of care that was meant to be standardized among all SPOs (Auditor General of Ontario, 2015, p. 56). Moreover, some of the participants described how they tried to adapt their interpretation of protocols to the specific situations of their patients, but their efforts were to no avail. For example, one nurse recalled a situation in which she was advocating for one patient by recommending palliative treatment in order for the patient to receive more hours of care. Her recommendation, which had been based on her

professional judgement, was rejected due to lack of conformity with the standardized category or scoring system adopted by the LHIN to measure and determine a patient's acuity.

Many nursing scholars have criticized the fact that nursing care is increasingly becoming organized around an instrumental rationality that reduces care to its technical-scientific mode with little attention to its bidirectional nature that aim to satisfy the specific needs of the patient (Backes et al., 2009; Goodman, 2016; Hyde et al., 2005; Rolfe, 2017; Sumner, 2010). In this controlled mode of care that follows predetermined steps, efficiency and reasonable pricing of care seem to be given the ultimate importance regardless of deterioration in condition or quality of service (Sedgwick, 2013). In addition, technical rationality has colonized even the documentation of nurses, minimizing their ability to describe the needs and sickness experience of their patients (Hyde et al., 2005). The participants in this study criticized the electronic documentation system because it made it impossible for them to include information about a patient's actual condition due to the way the software was designed, with its sole focus on matters of efficiency that are of primary interest to the administration and management of the service providers.

From the perspective on recognition taken in this study, care must prioritize patients' needs and must be tailored to fit their specific situation based on individual assessment, otherwise the right for equity in care is violated (Friesacher, 2017; Wernet et al., 2017). Participants realized that there are other dimensions to care that need to be included if the patient is to be treated fairly and recognized as a human person rather than a client with an assigned number on their daily list of home visits. One participant stated explicitly that standardized steps of care should be "tweaked a little this way or that way in order to work for that patient. The same protocol or guideline is not gonna work for everybody. We just have to see the patient as a

person" (Transcript PA 6, Pos. 11). In the nursing literature, protocols and standards have been criticized because they control nurses' clinical judgement and professional autonomy and make it impossible to establish intersubjective relationships between nurses and their patients (Lawton & Parker, 1999; Kohlen, 2015). A rigid conceptualization of care precludes the idea of self-determination as a necessary condition for developing an autonomous role in communicative action (Kim & Holter, 1995). When patients are prevented from sharing their concerns and preferences and if their feelings, needs, and perspectives are disregarded or unsupported, their self-perception as persons diminishes and their social esteem deteriorates as well (Honneth, 1995; Wernet, et al., 2017).

This section of the discussion supports existing critiques of evidence-based nursing (EBN), which is considered a derivative of evidence-based medicine (EBM) (French, 1999). EBM belongs to the scientific tradition compatible with the bio-medical definition of cure, which uses statistical measurements and randomized controlled trials in order to decide on the effectiveness and efficiency of any treatment method (Askheim et al., 2017). However, what the participants emphasized in this study is that clinical situations are to a great extent individually experienced and can neither be standardized in advance nor can they be measured statistically. Nursing care that is solely based on evidence-based practice (EBP) marginalizes and excludes hermeneutic-phenomenological case understanding and knowledge because its positivist epistemology acknowledges as scientific only what can be quantified, measurable, and standardized (Rutty, 1998), jeopardizing the caring values of nursing (Holmes et al., 2006). Separating the body and mind by following the biomedical positivistic approach disregards the individual history and context of the patient and does not provide the level of involvement needed for both the nurse and the patient to achieve successful coping in illness (Benner

&Wrubel, 1989). Applying research findings based on objective empirical observations without implementing the interpretive approach to illness is a mechanical method of care that suppresses the intuitive role of the professional as well as the narrative role of the patient experiencing illness (Greenhalgh, 1999). The cognitive scientific approach also makes it impossible for individuals to ascribe meaning to their own experience because it marginalizes the corporal dimension as the source of feelings and meanings necessary for understanding situations in a comprehensive manner (Schmitz et al., 2011). Explaining situations based on external and abstract criteria while depriving the person from expressing his or her feelings and individual meanings to situations based on embodied perceptions and personal experiences reflects a lack of respect for the personhood of the patient. I will discuss this aspect in more depth in the following section.

Reification in Empirical-Analytic Nursing Action

Based on the theoretical framework adopted in this study, care that is based merely on EBP is not limited to the technical aspects that prescribe work, but must be understood as a form of reification. It is not solely that patients are not able to share their perspective or to participate in decision-making processes, but on a deeper dimension, patients are denied recognition. As shown earlier in the discussion, the corporal-phenomenological aspects of care are marginalized in a conception of the body as an object which can be controlled and manipulated through technical interventions. This reduction neglects hermeneutic case understanding and other dimensions of recognition which reinforces reification of the patient.

Honneth (2008) criticized the reifying perspective of the scientific-biological model that explains human nature from a completely “objective,” “neutral” and detached cognitive stance based on physiological findings without consideration of the emotional experience and the

lifeworld of the person. By reducing the person to a scientific object who can be observed and about whom quantifiable predictions can be made, this kind of technical knowledge gives the impression that we can observe each other distantly and neutrally without being in a relationship. According to Honneth (2008), a pure cognitive stance occurs when a subject analyzes a situation from an affectively "neutral" stance (as in empirical-analytical sciences, like EBP) by "dissecting it into emotional and cognitive elements" (p. 38). This form of "objectively" observed and scientifically studied information is only possible when we "forget" that this kind of scientific knowledge is itself the result of affective interaction and acceptance of others' perspectives. From this standpoint, Honneth (2008) defines reification as the "forgetfulness of recognition," which means that in the course of acquiring scientific knowledge, we tend to "forget" that our current cognition is originally based on an antecedent of recognition (Honneth, 2008). As clarified in the theoretical framework, Honneth (2008) explicated that scientists initially did not study people as objects of knowledge, but they constructed their scientific knowledge based on what people disclosed about their subjective thoughts and feelings. Empirical-analytical scientists also forget that acquiring scientific knowledge was only possible because they themselves were "corporal beings" recognized in their early life through emotional interaction with significant others. Thus, empirical-analytical scientists usually have overlooked that their abstract cognition is originally the result of intersubjective emotional conditions that surrounded their thinking processes. Accordingly, what evidence-based approaches "forget" is the fact that this detached form of scientific research is only possible because we passed through a socialization process of emotional attachment, love, and care that recognized us and made us what we are. By adopting a "neutral" stance and treating others from a "detached" position with no empathetic engagement, we "forget" to recognize the human identity of the other and the

significance of interdependence in interaction, and consequently fall into the trap of reification in relationships. Thus, adopting a "subject-object" sort of cognition like in EBP approaches is a form of reification because the researcher takes the position of a "detached" observer who ignores the emotional and affective dimensions of the relationship with the observed "other." Therefore, the other is perceived and treated as a "lifeless object" or "automaton" with no empathetic involvement or any attempt to understand his or her perspective. Lack of affective intersubjective relations violates conditions necessary for recognition and, in the case of nursing practice following EBP and the technical method of clinical guidelines, places patients in a vulnerable situation denying them the right of recognition (Wernet et al., 2017).

Some of the participants' statements indicated that they understood about reification even if they were not aware of the term itself. For example, one participant criticized care delivered in a rush as making the patient feel like "just, you know, a number in a blood lab or something like that" (Transcript P B 4, Pos. 56). Another participant refused to accept the standardized time slots allocated for care because patients are not "robots" who can be treated with the same formula. These expressions are actually very close to Honneth's terminology around reification like "automaton" or "things". Without them being theoretically aware, participants were describing an environment that through the implementation of efficiency measures, accelerated the use of standardized care that led to the systematic reification of patients.

The "Double Logic" of Nursing Action

The first part of this discussion chapter showed that a hermeneutic-phenomenological case understanding of the patient is a significant dimension of nursing actions. It is a dimension characterized by indeterminacy and uncertainty because every patient is considered a unique case that requires a singular understanding of a situation that cannot be formalized nor standardized

(Wrubel & Benner, 1989; Schmitz et al., 2011; Kohlen, 2015; Friesacher, 2017). Yet, this phenomenological-hermeneutic case understanding is difficult if not impossible to realize considering how participants described their work environment. When technical and scientific knowledge are emphasized over caring behaviours, values of compassion, understanding, and support become jeopardized (Li et al., 2016). The nurses interviewed insisted that protocols and guidelines need to be modified to fit the particular condition and needs of the patient. They acknowledged that standardization of nursing care and empirical-analytic logic must be supplemented by an understanding of every single case based on hermeneutic-phenomenological logic that enables the personification of care. Therefore, nursing actions are characterized by different forms of knowledge that are sometimes based on competing logics and require very specific competencies and skills that nurses need to acquire in their field of practice. According to Granero-Molina (2012, 2014), the three interests of knowledge mentioned by Habermas (1971) in his theory of knowledge and human interest should not be separated in the field of clinical nursing. While technical interest in the empirical-analytical sciences that aims to provide explanations and predictions is required to provide safe care supported by scientific evidence, practical interest, which is relational, hermeneutic, and phenomenological, aims to achieve an understanding of the unique subjective experiences of illness through interpretation. The latter is required by the nurse to gain access to the biographic history and the specific lifeworld of the patient. Participants who argued that it was necessary to adjust the standardized steps of care to fit the patient's condition were likely referring to the artful aspect of nursing actions, where the nurse gains personal knowledge and understanding of the patient through verbal communication (Henry, 2018). As one participant said, "The word practicing means

pertinent to me, like practicing an art … You need to get [patients] input to decide on care" (Transcript P B 6, Pos. 25).

What is problematic in the modern healthcare system is the separation between technical and practical-interpretive knowledge and the exclusive focus on empirical-analytical scientific evidence and research processes that guide the clinical work of nurses (Granero-Molina, 2014). The domination of the biomedical and economic rationality that standardizes care restricts the relational aspects and proper knowing of the patient (Tanner et al., 1993; Goodman, 2014; Pajnkihar et al., 2017). Technical forms of care do not give nurses the chance to use tacit knowledge and the intuitive skills necessary for professional practice (Polanyi, 1966; Benner & Wrubel, 1989). This impedes the art of nursing care that is primarily based on effective relationships to understand a patient's situation, which are supported by technical methods to meet a patient's needs (Henry, 2018).

What seems easy to achieve becomes rather complex on closer inspection. With Habermas' conceptualization of knowledge and interest, it becomes clear that these different dimensions of nursing actions – technical and practical – are based on competing interests and require different, if not opposing, logics of action. The methodologies, methods, and analytical approaches in both approaches cannot easily be reconciled. That is the reason why participants felt overwhelmed sometimes by practicing in a context that requires them to "reconcile" these two opposing interests in their everyday actions. Participants often felt perplexed over their inability to provide what they defined as good care. The individual phenomenological situation of the patient was not compatible with the technical and standardized nature of care implemented in home care.

According to Friesacher (2017), nursing caring actions are different from the actions of other healthcare professions because nursing actions are characterized by a combination of technical empirical-analytical scientific knowledge and practical hermeneutic-phenomenological knowledge. This is what Friesacher called the "double logic of action," which is a very complex form of action particular to nursing. Friesacher argues that nurses must be able to connect to the lifeworld and corporal experience of patients and by doing so they must be able to go beyond the rigid boundaries set by protocols and guidelines that are based more on a technical knowledge interest. When the lived experience of the patient is identified as the starting point of care, the above discussed forms of reification can no longer emerge. Care based on the double logic of action recognizes not only the patient's emotional and physical needs, but it also enables a patient's self-realization and self-determination whereby the patient can enjoy the right of being the author of his or her own care.

Although organizational reforms based on economic values in the modern healthcare system require nurses to acquire scientific knowledge and technical competencies that abide by organizational policies and guidelines, nurses still have the ethical mandate to provide good care that protects individual needs and promotes the well-being of the patient (Turkel & Ray, 2000; Goethals et al., 2010). Because nurses practice in a milieu of technical-economic domination (Latimer, 2014; Hoeck & Delmar, 2017), emancipatory knowledge, which is the third knowledge interest of Habermas, becomes primary, and the sense of autonomy and self-determination of nurses as well as patients must be treated as paramount. Emancipatory interest is based on self-reflection in the sense that the researcher reflects on the consequences of the theory/research on society, particularly on those at the margins of or excluded from society. This emancipatory interest will help to uncover the constraints patients encounter when trying to satisfy their needs

and to receive adequate care (Peart & Mackinnon, 2018). The idea of emancipatory interest helps to develop a critical perspective on a system that denies basic rights to healthcare and that curtails patients' rights to live a self-determined life. It enables autonomous practice for nurses that enhances their freedom to make decisions about their patients in a less standardized manner in order to suit the subjective needs of patients and safeguard their dignity (Granero-Molina, 2014). Thus, an emancipatory nursing theory should provide nurses with the tools that enable them to critique their socio-political context and advocate for compassionate and holistic care that promotes the well-being of the vulnerable, and installs equality and equity in healthcare (Kagan et al., 2009, 2014; Walter, 2017).

Inadequate Access to Care

Apart from their critique of time pressure and standardized care, participants also discussed another barrier for the provision of good care, namely, the injustices and inequities of the healthcare system. The statements I summarized under the subtheme "premature hospital discharge and inadequate access to care," described caring practices that must be characterized as neglect of care, since depriving vulnerable patients access to adequate care leaves them without anyone to consider their needs. Such pathologic manifestations of care violate the dimension of legal rights as described in the theoretical framework and thus represents another form of systemic derecognition of patients.

In the thematic findings, many of the nurses felt that hospital discharge decisions were based mostly on considerations of efficiency by the hospital management rather than strictly on a patient's health condition. For example, one participant stated that hospital administrators were deciding on patient discharge because "they don't want that long waiting time in the hospitals" (Transcript P B 6, Pos. 63). This situation is supported by the reality of hallway medicine and

increasing wait times for patients who are in need of hospitalization (Home Care Ontario, 2018; Ontario Hospital Association, 2019). This aspect is closely related to the earlier discussion about the reification of patients that has become the main characteristic of modern healthcare systems, which prioritize economic processes and deny recognition of the patient as a person (Friesacher, 2017). In this vein, many participants talked about patients who had to be readmitted immediately after discharge because they were basically discharged in an unstable condition, therefore denying them their legally guaranteed right to receive good care based on their needs and violating their right for self-determination because their perspectives had not been considered in the decisions taken regarding their own discharge. Moreover, the nurses often used the term "dumping" to describe patient discharge; to them, the hospitals perceived homecare as a "dumping" ground for patients who were sent home, often prematurely, before supplies, medications, nursing staff, and PSWs could be organized. Some of the services required, like occupational and physiotherapy, could take weeks to be available. In many instances, particularly on weekends and holidays, nurses complained that communication with the physician was not possible. The use of the term "dumping" to represent the "disjointed" process of patient's discharge is by itself a clear sign that the nurses recognized the disrespect and humiliation of the patient, who should be treated with dignity and not as something to be disposed of.

The Canada Health Act legally guarantees safe and high-quality access to basic healthcare services to all Canadians equally (Health Canada, 2018). However, participants complained that patients were often denied recognition of their legal right to access adequate care based on their needs. This violation of the dimension of rights disrupts self-respect, which, according to Honneth (1995), can only develop secondary to recognition of legal rights by other

people in the community. Thus, deprivation of rights to access adequate care is by itself an attack on recognition that impedes the ability of the patient to realize himself or herself as an autonomous person with protected rights and unique values.

The participants also pointed out that hospitals justified "premature discharges" by asking patients to sign a consent form that was officially expected to represent respect of the patient's legal rights. Although they mentioned that patients at times signed themselves out of hospital, it did not necessarily mean that the right of self-determination was actually recognized even if the patient was in good mental health and fully conscious. Signing a consent form when one's health is not stable, or supplies are not in place at home, does not indicate that the right for autonomy of the patient was respected. Premature discharge where the patient consciously accepts the risk represents a shift in the ethics of healthcare practices (Weiss et al., 2009). Patient readmission to the hospital on the same day they have been discharged implies that the decision to discharge the patient was made without profound consideration of the patient's situation even in cases where the patient signed the consent form. Although the form is considered a legal document that ideally should prove that the patient has been informed about all interventions and alternative possibilities, it does not mean that patients have been fully informed of the consequences of their decision.

Participants described the consent form as a necessary document required by the service provider that had to be signed only once during the first home visit. However, the nurses viewed the signing as a task to be done rather than as a tool to provide the patient with a real opportunity to participate in the decision-making process. According to Friesacher (2017), in modern capitalist healthcare systems, informed consent is not meant to strengthen the autonomy of the patient but is considered a measure to subjugate the patient who "voluntarily" accepts to assume

responsibility for risks that may emerge in the context of medical or care interventions. This resonates with the critique of the economized healthcare system as one that diminishes the autonomy of patients by treating them as objects of care rather than as human beings with real needs (Boykin et al., 2014). However, from the perspective of recognition, patients' rights for self-determination must be recognized and its realization requires a communicative action approach capable of safeguarding the autonomy of all. Only then will the needs of patients be fully addressed and patients' rights and values protected (Wernet, et al., 2017). Without consensus based on real negotiation and discussion of consequences, the consent is only a formal document employed to occlude recognition through disrespect and dehumanization of the patient.

Inadequate Care Due to Inability to Pay

The nurses pointed out that as underfunding restricted the number of PSW hours, some patients who were in desperate need of a nurse or at least a PSW to take care of them were in a critical situation. As one participant noted, "They can't afford it because it is expensive to hire a PSW or a shift nurse" (Transcript PA 7, Pos. 51). Although some families wanted to show respect to their loved member who were terminally ill, they were neither prepared to provide the level of care required nor able to cover the financial expenses of care that was supposed to be funded by the government. Due to the underfunding of the home care sector, the nurses stated that patients and their families were often left alone to figure out who would take care of their loved ones. They were confronted with situations that often developed into particularly stressful and challenging conditions. Although the Canadian Health Act states that "Canadians should have equitable access to required medical care based on their need and not on their ability and willingness to pay" (Health Canada, 2018, p. 2), home healthcare policy is based on a neoliberal

rationale that transforms rights to healthcare into individual responsibilities to attain healthcare regardless of socioeconomic conditions (Yakerson, 2018).

This shift in emphasis on individual responsibility emerged in the statements presented in the subtheme of "patient involvement." For example, a nurse manager talked about involving patients in their care by giving "the clients ownership of their healthcare" (Transcript PA 9, Pos. 24), which suggest the idea of responsibilization and accountability for one's own care. Yet, when patients' legal right to access adequate care is not recognized, responsibilization for one's own health becomes empty of meaning, particularly if the patient who is expected to be accountable for his or her healthcare needs is in financial hardship. This development must also be seen against the backdrop of the increasing unequal distribution of wealth in our societies. Fisk (2000) explains that the systematic defunding and the cutting of services in the home care sector in Canada and the simultaneous proliferation of private for-profit service providers negatively influenced the ability of Canadians to enjoy equal access to appropriate healthcare, particularly low-income citizens. Despite the fact that public healthcare should be guaranteed through federal and provincial government funding, many patients are deprived of appropriate care and are left alone with no provision of services because they are not able to pay for it themselves. According to Wernet et al. (2017), not recognizing citizens' right to access needed care provokes social injustice, threatens their ability for self-realization, and makes it impossible for them to develop or maintain self-esteem. Although nurses were frustrated that patients were left alone and could not get urgently needed assistance through a PSW, they asserted that their hands were "tied" because they perceived the transformations in healthcare as a consequence of political decisions that they could not influence because political action was considered beyond their scope of practice. Although political advocacy is a main component of solidarity in

Honneth's conceptualization of recognition (Iorio et al., 2013), participants did not recognize the significance of the ethical-political dimension in care. Even though one participant mentioned the probability of referring to political deputy of her area, there was no evidence of actual involvement in political action to advocate on behalf of patients. Advocacy understood from the perspective of recognition must include mobilizing patients' rights into the social and political spheres. This aspect of recognition is particularly urgent for patients who are not able to speak for themselves due to their medical conditions or because they find themselves in an existential crisis (Friesacher, 2017).

What struck me most during the analysis of the interviews was the number of heart-breaking stories about seniors and other vulnerable patients who were left alone without any form of assistance and who had no family member able to take care of them. As described in chapter six, nurses talked about patients being left alone for long hours, lying in bed or sitting in a chair not able to move or to get up on their own because of their weakness. Some patients did not even have anybody available to prepare their food. These patients were not only denied satisfaction in having their emotional needs met, as well as their legal right to access adequate healthcare, but also their very basic human needs. They were left without any recognition of their humanity in a healthcare system that has been undergoing continuous transformations under the claim of integrating different services to ensure better access to healthcare (Sheppard, 2019). But these government promises and claims contradict the reality described by participants who talked about patients being neglected and not valued as human beings. This is a clear example of reification whereby individuals are deprived of even minimal forms of recognition in all dimensions. They are deprived of emotional attention and denied rights or any value as human beings. In such a reifying context, patients feel degraded and humiliated, which has a very

detrimental impact on their self-esteem with a high risk of "identity collapse" (Honneth, 1996, p. 132).

A Culture of Systematic Reification

The above pathologic forms of care discussed as manifestations of reification cannot be understood as isolated occurrences and failures of individual responsibility. They must be understood as the result of a systematic rationality governing home care and violating all dimensions of what the participants in this study defined as good care. The analysis of the interviews revealed that nurse managers were aware of the negative impact of efficiency measures on the quality of care that I conceptualized as systematic deprivations and violations of recognition. For example, one manager revealed that "[nurses] could potentially provide better care if they were given more time" (Transcript P B 5, Pos. 79). Also, when nurse managers received phone calls from patients complaining about negligence because nurses were in a rush, managers provided a space for patients to ventilate instead of trying to resolve the problem because "there's fifty clients to be seen but I can't really say that to the patient right? … You're trying to do more work with less bodies" (Transcript PA 9, Pos. 92). Because monetary compensation of the SPOs is dependent on compliance with the quantifiable performance indicators, policies, and guidelines required by LHINs, nurse managers and care coordinators try to reinforce and justify such performance metrics that ensure efficiency of the provided services.

This aspect again overlaps with findings in the literature that explain the deterioration in the quality of care is not the result of individual deficit but due to a managerial rationality that is more focused on financial calculations and less attentive to emotional aspects and human relationships (Maben, 2008; Wall, 2010; Austin, 2011; Goodman, 2014; Traynor et al., 2014). In the economized healthcare environment, the kind of knowledge and skills I earlier discussed as

intersubjective and phenomenological understandings of patients is delegitimized and undervalued (Wall, 2010). Caring skills and relationships are not acknowledged because they are not visible nor measurable and cannot be counted in the statistics that indicate profit-making in the healthcare market (Maben, 2008; Toffoli et al., 2011; Robinson, 2013). Economic requirements were identified by Honneth (2008) as one of the root causes of reification because social elements are subsumed and treated in a commodified societal structure according to the value of their contribution to the profit-oriented processes in society. This is also true for nursing practice where the corporal dimension necessary for care based on recognition has been marginalized because it is hardly compatible with the emphasis on profitability of the commodified healthcare service market (Friesacher, 2017).

Moreover, data analysis showed that the managerial rationality that aimed to conduct the highest number of visits per day regardless of the quality of care provided has often been internalized by many nurses who were ready to comply with efficiency measures and rushed care "in order to make a happy pay cheque at the end of the week" (Transcript PA 10, Pos. 84). Thus, the ability to increase their pay contributed to deterioration in the quality of care, which sometimes ended in serious complication such as a "bone infection" that was secondary to wound care that had been done in a rush (Transcript P B 6, Pos. 61). According to Goodman (2014), the spread of instrumental and managerial rationality in the nursing clinical context has the potential to spoil compassionate care and normalize certain pathologic practices, contributing to conditions of indignity and neglect that dehumanize the patient and threaten the foundations of ethical nursing practice. In a highly controlled environment based on instrumental rationality, nurses have adopted a "false consciousness" by accepting norms of practice that prescribe the delivery of nursing care in a standardized form empty of compassion (Sumner, 2010). Based on

the theory of recognition, it is concluded that in a highly controlled work environment, policy makers and the managerial rationality structuring the performance of nurses in the home care sector reinforce pathologic norms of caring practice that violate the three essential dimensions of recognition and conceal reification in caring practices. Paradoxically, these pathologic forms of care in the home care sector were taking place at a time the Ontario provincial government established five Health Teams with the aim of placing "patients first" and assuring Ontarians, particularly in the community sector including home care, that they would receive high quality and integrated healthcare services whenever and wherever needed (MOHLTC, 2019). Derecognition in care was also taking place when the stated aim of SPOs was the assurance that people receiving home care service would obtain the best quality care (Home Care Ontario, 2020).

In conclusion, I want to refer to Schein's (1992) perception of organizational culture that was adapted to fit the methodology of this study. As described in the methodology chapter, a profound understanding of home care culture must be based on analysing daily actions that can reveal possible incoherencies or contradictions between values adopted by nurses and the existing practices that occur due to organizational assumptions embedded in the daily routines that prevent the enactment of adopted values. This description of culture is in harmony with critical theory and ethnography that aims to analyze culture through exploring how people interact and the assumptions embedded beneath reality (Carspecken, 1996). Based on the reconstructed norms of good care, it is concluded that there is a high level of incoherence and contradiction between the values of good care adopted by the participants and the pathologic forms of care taking place in daily care practices. Participants defined good care in a way that corresponds to the three dimensions of recognition, including respect of the corporal dimension

of patient and the recognition of the patient as a whole person. But existing caring practices in home care do not provide time and space for communication with the patient in order to establish a caring relationship that can lead to the "deep knowing" of the patient and the gaining of a hermeneutic-phenomenological understanding of the individual person. The restrictive mode of care provided in home care does not give patients space to share their own perspectives and to negotiate care as autonomous participants. Patients are also denied recognition of rights to access adequate care and sometimes left alone with no care or attention to their very basic human needs.

Based on the subtheme "funding as the determinant of quality care," the narratives clearly indicated that fiscal calculations and government funding were the main factors shaping the provision of care in the home healthcare sector. From a management point of view, quality care or good care was mainly guided by the financial matrix of the SPOs, which are focused on implementing efficiency measures to conduct the highest possible number of visits to meet the increasing number of discharged patients. Efficiency of the system and the attainment of statistical goals of care that secure revenues were more important to the management than providing care based on emotional connection and the understanding of a specific situation. Rushing care, with its negative impact on patient recognition, is the daily practice of home care nurses that is accepted as routine under the binding efficiency requirements of the system. Focusing on the number of patients visited per day without attention to the lived experience and emotional concerns of patients leads to a culture focused on technical tasks rather than on "understanding the whole person." As has been demonstrated throughout the discussion, a culture that prioritizes the needs or goals of the system over the needs of the patient is a pathologic culture that leads to "forgetfulness of recognition" and reification in relationships.

Ethical Dilemmas in a Pathologic Culture

In this last section of the theoretical discussion, I want to highlight that the analysed conditions above are leading to continuous ethical dilemmas in nursing practice. In the subtheme "caring within a difficult work environment," the nurses emphasized that they would not leave a patient's home unless everything is "alright" with the patient. In addition to the stress of driving from one home to another and struggling to catch up with the next visit on the list, nurses were trying to assist with tasks even if it was not within their responsibilities, tasks that included assisting a patient in "getting dressed" or "taking a shower" or anything else that would help a patient feel comfortable. Nurses were totally focused on patient care during home visits and often postponed updating their computer documentation until they were home. Furthermore, many nurses were not taking breaks during their shift, describing their work as free," and which took time from their own families. Work overload is related to the impact of the neoliberal rationality that depends on frontline workers to fill the gaps that result from early discharges and cuts in services, and continue to care for patients particularly those who cannot afford to pay beyond the services funded by the government (England et al., 2007). According to Yakerson (2018), lack of opportunity to obtain adequate care based on needs leads to an intensified load on nurses and caregivers who are pressured to carry additional responsibilities beyond their scope of practice. From the perspective of recognition, these additional responsibilities that nurses were assuming to satisfy their ethical obligation during home visits can be interpreted as attempts to convey to patients that they are being valued, respected, and recognized in a healthcare system focused on funding and values of efficiency.

Despite all their sacrifices to satisfy their patients' needs, nurses spoke of situations where they faced litigation for deficiencies in care that were actually due to problems in the system rather than the failure of an individual nurse. Ironically, nurses were held accountable for

the safety of patients in a system that has “forgotten to recognize” patients due to its main focus on economic efficiency. In such a challenging context not only are patients refused any form of recognition but nurses also are not recognized by leaving them at risk of facing professional disciplinary action for unpredictable problems that patients may encounter (Beardwood & Kainer, 2015).

The cumulative outcome of challenges and frustrations was described in the thematic findings as a situation of “moral crisis” that leads to “conflict,” “burn out,” and “a lot of anxiety” because “this isn’t what I [the participant nurse] signed up for, I wanted to be able to do more” (Transcript P B 4, Pos. 37). Nurses wished they could provide care that recognizes the patient as a person who deserves emotional attention, respect, and appreciation but the context was not conducive to good care. The type of care provided in home care has become mainly technical with no or little attention to empathetic interaction and understanding of individual situations. The healthcare system has reinforced an “efficient” mode of care that derecognizes patients on the three ethical dimensions necessary for good care. Due to continuous rationalization in an economized environment, nursing practice has become so complex because nurses have to make clinical decisions by combining two different logics that have different origins and contradictory methods of thinking (Foth et al., 2015). Trapped between these two logics, nurses have to deal with the tensions arising out of the requirements of the system and those of their ethical values (Jakobsen & Sørlie, 2010). Consequently, ethical reasoning has become so difficult because it is no longer a purely cognitive process that is adapted according to patient needs but a decision that must conform to contextual factors and the expectations of others, which creates moral distress that negatively influences caring outcomes (Goethals et al., 2010). Many of the nurses tried hard to “hold up” their ethical standards” but they “gave up” and joined others who “go in go out” in

their caring practice. In a context of reification that prevents good care and violates all dimensions of recognizing the human identity of patients, nurses find themselves in their daily practices contributing to a pathologic caring environment.

Summary

In this chapter participants described good nursing action as a specific form of communicative action where the nurse communicates with patients and utilizes hermeneutic skills to understand the corporal-phenomenological dimensions with the aim of understanding the lifeworld of the patient before proceeding into the technical aspect of nursing action. I argued that nursing actions are based on the three dimensions of recognition that are the necessary preconditions for communication and ethical care that respects the corporal needs and the identity of the patient. The second part of the discussion provided a critique of the healthcare system in home care with reference to the normative dimensions reconstructed in the first part. It was argued that time pressure, the criteria for performance indicators of SPOs, the standardized forms of care, and inadequate access to needed care are pathologic forms of care that violate all normative dimensions of good care and lead to "forgetfulness of recognition" and reification in relationships. Technical- economic rationality was found to diminish the chances for corporal-phenomenological knowing that identifies the specific needs of the patient, thereby depriving the patient of the right for self-realization and self-determination. The "double logic" of action is concluded as a characteristic of the nature of nursing actions, which combines technical and practical knowledge at the same time. This combination of the technical and the practical, when integrated with an emancipatory critical approach, will guide nurses to take into consideration the contextual factors influencing the provision of care and preventing the enactment of good care that is characterized by the three dimensions of recognition. The managerial rationality in

the healthcare system that dominates home care reinforces a culture of systematic derecognition. In such a pathologic environment nurses find themselves in an ethical dilemma, struggling for recognition for their patients in a system where reification is prevalent.

Implications and Recommendations

The critical methodology of the study has led to a set of theoretical and practical considerations that are valuable as a foundation for a critical theory of nursing actions. This study contributes to nursing knowledge by describing nursing actions as ethical actions that aim to recognize the whole patient. The three ethical dimensions of recognition that respect the human identity of the patient must be addressed through a critical, emancipatory dimension that would enable nurses to analyse contextual conditions and understand their impact on the practice of caring action. These contributions have significant implications for nursing education, nursing practice, healthcare policy, and future research.

Implications for nursing education.

This study concludes that nursing actions are "double logic actions" where even the very simple technical tasks require understanding of the corporal-phenomenological aspects of the patient. This implies that good nursing actions cannot be reduced to the technical dimension, or based solely on quantifiable evidence. The corporal-phenomenological dimension of nursing care must become an important focus in nursing education. Nurses require specific training to acquire the complex knowledge and skills that prepare them to connect with patients, explore concerns, and implement care based on assessed needs. Nursing educators need to incorporate knowledge from the humanities to facilitate students' understanding of the many different circumstances of patients' lives (Henry, 2018). This factor also requires reconsidering the pattern of knowledge adopted in the nursing curriculum. Exploring the corporal dimension of care

requires reinforcing tacit knowledge, a professional trait built experientially over time but one that is devalued by the dominant EBP discourse that emphasizes formalized, objective, and measurable forms of knowledge (Traynor, 2009). Although this form of intuitive knowledge is difficult to demonstrate in measurable terms, the expert nurse can refer to this embodied knowledge in order to manage situations without referring to the prescribed standardized steps (Benner, 1982, 1984). Nursing education needs to reinforce and validate this form of relational, corporal, and hermeneutic knowledge that is not considered credible in the current discourse of positivism and economic efficiency. Through simulation scenarios during clinical education, nurses can become more prepared to utilize the hermeneutic approach in an artful manner to interpret and understand the situation of their patient and adapt empirical knowledge and skills according to assessed needs (Henry, 2018).

Moreover, based on the normative dimensions of care reconstructed in this study, the training of nurses must attend to the three dimensions necessary for ethical care – love, rights, and solidarity – which guarantee recognition of the personal identity of the patient. These must be addressed as a precondition to communication with the patient. Thus, academic education must provide students with the tools to integrate biomedical, evidence-based practice with a caring approach based on recognition, communicative action, and hermeneutic-phenomenological case understanding. This approach must be widened through a critical emancipatory dimension that would enable nurses to realize the organizational and contextual conditions interfering with the provision of care. When nurses engage in learning opportunities that encourage reflective thinking, they become aware that in a highly controlled and standardized environment based on efficiency measures and instrumental rationality, they have been normalized to accept pathologic forms of care that reify patients by neglecting their right to

be recognized. Critical education for nurses not only liberates them from the traditional obedient identity of nursing that follows technical modes of instruction but also provides the chance for challenging existing socio-cultural and political factors involved in healthcare that cause inequity or dehumanization in the provision of healthcare (Mosqueda- Díaz et al., 2014). It is through engagement in reflective education and emancipatory knowing that nurses can develop the needed knowledge to advocate for their patients and transform the context of caring into one that prioritizes patients' needs and recognizes them as human beings who are owed the right to self-realization and self-determination.

In addition, the study results showed that the corporal dimension of care is not limited to formal knowledge but extends to bodily touch. Providing bodily care should not be devalued because this dimension is important in getting to know the "being" of the patient. Professional nursing education should not distance the nurse from the body of the patient but rather provide methods and techniques of how to communicate through bodily touch. From the perspective of corporality, bodily care is a professional action that provides the means to explore the physical and existential world of patients (das Gracas & dos Santos, 2009). Delegating direct body care to auxiliaries deprives nurses the opportunity to gain intimate knowledge about their patients (Tanner et al., 1993).

Implications for nursing practice.

The research findings suggest that advancement in professional nursing practice should not be just technical but should be based on enhancing relational and hermeneutic communication skills that aim at understanding the phenomenology of the patient. Professional advancement should be dedicated to promoting caring actions that deal with the patient as a whole person who deserves respect and recognition. Yet, advancement in nursing practice in

Ontario is often contrary to these findings. Recent information revealed that the College of Nurses of Ontario (2018b, 2019, 2020) has recently coordinated with the Ministry of Health to expand the scope of practice for RNs and RPNs to include additional activities and procedures that were previously prohibited and considered as controlled acts performed by physicians only. Professionalizing in nursing cannot be achieved through assuming more technical and medical responsibilities that result in competing with scientific disciplines and physicians (Granero-Molina, 2014; Foth et al., 2015).

Time pressure and rigid protocols emerged in the study as major factors impeding the enactment of good care by limiting chances for the "deep knowing" of patients and not giving a chance for patients to express their needs through communicative action. Managers and administrators should adopt a more flexible work environment that provides nurses with enough time to interact with their patients and promote clinical autonomy at work, both of which can help nurses provide patient-centered care that respects personal needs and recognizes the patient as a human person rather than as an object of care.

Although participants in the study blamed healthcare politics for the deterioration of quality care during the healthcare transformation, they did not engage in any effective political action to change the situation they described. In general, they considered politics to be beyond their responsibilities. However, ethical caring values are also politically determined (Aranda, 2019). For many years nursing practice has been described as apolitical because nurses were not aware of the significance of politics and they were not trained to have political skills to participate in political action (Wilson et al., 2020). Based on the study results, nurses need to be present in the public domain and advocate on behalf of patients to regain recognition and rights for them. They should start practicing social advocacy, which is a professional trait in nursing,

and engage with the government to contribute to the public good. Nurses need to support their professional nursing organizations such as the CNO and the RNAO, who are working to empower nurses to advocate for their patients and to train them on strategies to enhance their skills in order to engage in political action.

Implications for healthcare policy.

Based on the findings of this research and considering the essentiality of each of the three necessary dimensions of recognition, deficient forms of care that are currently taking place in the home care sector as well as in LTC homes, which has become particularly apparent during the COVID-19 pandemic, cannot be resolved by the mere focus on budgeting measures to alleviate staff shortages and service cuts. These measures, which are only statistical and instrumental, do not address the real problem that is deeply entrenched and mediated by political and economic decisions. What emerged in the context of LTC facilities during the pandemic, which are similarly funded to home care, should not be surprising. The data I collected about one year prior to the pandemic highlight that the overwhelming pathologic forms of care as revealed by the military report on the horrific conditions in the LTC facilities (Adam, 2020, Military Report, 2020) are the result of a healthcare culture that systematically violates the dimensions of good care I have identified in this study. Forms of neglectful care and mistreatment reflect a basic disrespect of the human dignity of residents and bring reification in a system that denies all dimensions of identity recognition.

Moreover, healthcare policy makers should be made aware that these problems cannot be solved by creating accelerated, tuition-free programs to train PSWs and then sending them to work in the LTC sector (MOHLTC, 2021). It is not a matter of the quantity of caregivers that precludes good care but more the qualifications of care givers that make the difference. Turning

to “gig” workers (Mojtehedzadeh, 2021), temporary contractors hurriedly prepared to respond without enough preparation to provide safe and quality care to patients, will not solve the problem. Hiring lesser-educated caregivers is not sufficient to address the complex responsibilities in the “double logic action” required. Only well-trained professionals can assume such complex duties of exploring corporality and respecting the personhood of the patient. Policy makers need to realize that unless the healthcare system is able to respect patients on the three dimensions of recognition, pathologic forms of care will continue to exist. Even securing the legal right to provide adequate access to care on an equitable basis will not maintain fairness and justice in care based on the ethical dimensions of good care. When emotional needs of patients (especially the elderly in home care and LTC) are denied, fairness in care cannot be attainable, and patients’ suffering will continue to escalate (Fenn, 2020).

Implications for future research.

This study is an attempt to empirically reconstruct the normative/ethical dimensions of care in the light of Honneth’s theory of recognition. It is meant to provide the first elements for a critical theory of nursing actions. These elements need to be more systematically developed and applied to other areas of nursing expertise. It would particularly be important to further develop the notion of a critical nursing theory and how it could be used to criticize the ongoing transformations of healthcare services on a global scale. It is also important to better develop how nurses could apply the theoretical considerations of this study to their everyday practice. Further studies could sharpen the critique of the three dimensions and broaden the theoretical and practical aspects of this theory. Although I suggest using the concept of the three dimensions to restructure nursing reality and provide norms that promote ethical reasoning and social justice within the restrictions of an economized healthcare system, further insights from nursing

researchers are required to explore the strengths and challenges of the dimensions of recognition from the perspective of patients seeking healthcare.

Future research is recommended to study critically nurses' awareness of the significance of socio-political factors in shaping the provision of healthcare and in determining the magnitude of the nursing role to fulfil its social mandate to contribute to justice in care. Moreover, researchers need to investigate the methods by which nursing professional bodies support nurses in their involvement with socio-political matters inside healthcare organizations and in the public sphere. Additional research is also required to explore barriers, such as fear of retaliation (Martin, 2016), to practicing social advocacy for nurses working in healthcare settings.

Limitations of the Study

The data collection method in this ethnographic research was limited to interviews. Had I added observation of nursing actions as an additional method of study, this would have contributed to a better understanding of how nurses actually perform their actions, how they interact with each other and approach management, and how they interact with patients in the real field of care. Observing nurses at work would have provided an opportunity to verify if they "sugar-coated" their answers. Furthermore, participants for this study were selected using the convenience sampling method because those working in home care are usually too busy with their assigned workload and have very limited time to share their experience in a research interview. In an ideal situation, purposive sampling would have provided richer details about caring actions and the perception of good care in the home care context. Moreover, in both home care agencies, interviews were conducted in a room provided by the administration in the main office building of the agency. Although participants were reassured about the confidentiality of their information, the freedom to withdraw from participation at any point in the interview, and

that their enrolment would not threaten their employment or have any negative impact on their future career, the location of interview and the exposure of their identity may have inhibited them somewhat.

The interviews were limited to a sample of nursing professionals working in two home care agencies in Ottawa. The culture of the work described in this study is thus mainly related to these participants and their social context. Including more agencies would have enhanced the ability to gain broader insights about caring action. This particular limitation feeds into the ongoing debate about the generalizability of qualitative research, which is usually limited to the culture and social group represented in the study sample (Gobo, 2004; Creswell, 2013). Finally, the results of the study are based on data collected at a particular point of time, which means that the results might have been different if they had been collected at another point.

Chapter Eight: Conclusion

This study started by providing an overview of the arguments made by nursing scholars who emphasized that care has always been acknowledged as a core element of nursing as a discipline. The difficulties begin if one searches for a consensual and clear theoretical definition of what care actually is or should encompass. However, scholars seem to agree that care is linked to relational aspects with and a holistic understanding of patients but it has become increasingly difficult for nurses to incorporate these normative values of care amid a socio-political discourse driven by neoliberal rationality that prioritizes market forces and economic efficiency in public services (Newman et al., 2008; Duncan et al., 2015; Blasdell, 2017; Pajnkihar et al., 2017). The technical-economic rationality guiding healthcare not only disregards compassionate and humanist moral values, often construed as essential components of nursing caring, but also induces inequality through austerity measures (Faith, 2013; Latimer, 2014; Nairn, 2019). In the absence of a critical theoretical foundation of what care actually comprises in order to inform "critical" nursing practice, nurses are unable to question the management ideology of efficiency used as justification for the profound transformation of healthcare services (Clarke, 1999; Karnick, 2014). In this context, nurses are engulfed by a public agenda that shifts nursing attention from providing care based on caring values to providing care based on efficiency standards, which creates dissonance for nurses about the ethics of their practice (Rankin & Campbell, 2006). In order to challenge this ideology and to provide nurses with tools that would enable them to challenge these societal developments, this study adopted a critical approach (Thomas, 1995; Sumner, 2010; Wall, 2010; Rudge, 2011; Friesacher, 2017).

The overall aim of this critical study was to analyse the nursing action of professional nurses working in the home care setting in Ontario to identify the ethical dimensions of what

participants perceived as “good” care. Based on these normative assumptions, the study aimed to develop the first elements for a critical theory of nursing actions. I wanted to gain a deeper understanding of what the economization of healthcare actually means for the nurses working at the bedside, how these nurses actually care for their patients in their everyday work, and how they perceive and define good care in the Ontario privatized home care sector. According to many authors this form of privatized healthcare is increasingly determined through market-based regulations and the systematic implementation of economic processes that structure nurses’ work (Randall & Williams, 2006; England et al., 2007; Yakerson, 2018). Based on my analysis of empirical data gained through semi-structured interviews, I was able to reconstruct normative dimensions of care that I later used to define the ethical dimension of care. I used these ethical dimensions as the foundation for a critical theoretical framework that enabled me to interrogate the current politics of home health care in Ontario. Hopefully, these considerations will provide nurses with the theoretical tools to criticize these transformations that are shaping nursing care reality through managerial rationality that focuses solely on economic efficiency.

A critical theory of nursing actions must be based on normative dimensions that can be derived from the immanent ethical values of nursing practice and that are already, yet tacitly, embedded in real work settings (Honneth, 2015; Friesacher, 2017). Accordingly, nursing actions constitute the building block of this study, which demonstrated that nurses’ perception of good care cannot be subsumed under a technical or evidence-based perspective. Care, as implicitly understood by the participants in this study, cannot be conceptualized as the implementation of specific guidelines and cannot be realized in a task-oriented environment. The care participants described as good necessitates a form of “knowing on a deeper level” that understands the patient as a whole person. Participants also described care as a specific form of communicative

action in which the patient and the nurse discuss and negotiate caring options and reach an agreement or consensus on how they want to proceed. This form of communicative action was not limited to linguistic rational argument, as in Habermas' conceptualization of communicative action, but comprises very complex forms of knowing and interactions that require an intimate and trusting relationship. Care can only be "good" if the nurse is able to connect with the lifeworld of the patient and uncover the personal concerns and needs that are not just related to the medical diagnosis of the patient. Communication in nursing comprises non-verbal communication, particularly when patients are not able to verbally communicate. In these cases, the nurse's ability to use touch, engage with emotions, and "be with" the patient establishes another form of communication that demands a broad panoply of skills. I called this dimension of nursing care the hermeneutic-phenomenological case understanding, which explores hidden and sensitive information in order to arrive at a deeper understanding of the patient's personal experience within a specific situation.

In addition to identifying communicative action and corporality as normative dimensions of good care, the study also revealed that nursing actions, understood as a specific form of communicative action, must be based on recognition of the patient. Using Honneth's theory of recognition, I was able to conceptualize nursing care as based on the three dimensions of recognition: love, respect of legal rights, and solidarity. These three dimensions are considered necessary normative preconditions for nursing care as defined in this study. Unless the personal identity of the patient is respected and recognized in concert with an empathetic engagement and the protection of patients' rights to access adequate care and enjoy self-determination, good care, as defined in this study, cannot be realized.

Using the normative dimensions explicated through the analysis of the interviews, I demonstrated in the discussion of the results that efficiency measures violate not only the three dimensions of recognition but also make it impossible to actually realize the normative ideal of communicative action. The reality of the transformations in healthcare allows only forms of care that systematically deny patients' recognition and obstruct any chance for patients' self-realization and self-determination. The measures implemented to increase productivity condensed nurses' workloads and was a major barrier for the participants in trying to realize their idea of good care. Providing care in a rush made it impossible to establish a "caring conversation" with patients, provide them with emotional support, or to connect to their lifeworld. Standardization of care, clinical guidelines, and evidence-based protocols implemented in home care were criticized as being prescriptive, treating all patients based on a universal formula and thereby neglecting patients' lived experiences and depriving them of adequate care based on individual needs (Wernet et al., 2017). Moreover, the rigidity of guidelines did not give an opportunity for the nurses to advocate for their patients and show solidarity. The systematic violation of the normative dimensions of recognition in nursing care represents an assault to the identity of patients and was identified in this study as a form of reification. The results clearly highlighted that nurses in the Ontario home care sector are left in an ethical tension between their vision of good care and the instrumental rationality of the system to which they are accountable. Nurses are trapped between responding to the demands of the healthcare system oriented toward efficiency and based on means-end analyses, and the demands of the lifeworld of their patients that require understanding and interpretation of different situations.

The discussion highlighted that nursing must integrate different and often opposed forms of knowledge based on competing research interests that are not easily compatible. Following Friesacher (2017), I proposed to conceptualize nursing action as based on a "double logic action" in that the nurse must master a hermeneutic-phenomenological case understanding and combine it with a biomedical, technical approach of EBN aimed to provide explanations and predictions (Friesacher, 2017). Following Habermas (1987a), I proposed that this double logic must be extended by a critical theoretical approach based on an emancipatory interest. Therefore, this study provides a comprehensive framework that integrates analytical-empirical, hermeneutic-phenomenological, and critical theoretical knowledge to arrive at a definition of nursing actions and nursing care.

This combination of knowledge in nursing is compatible with Chinn and Kramer's (2011) emancipatory approach that challenges existing patterns of knowing by adding a critical pattern of knowing to analyze social and political conditions that interfere with nursing practice and induce injustice in care. I broadened this emancipatory approach by introducing the three dimensions of recognition as necessary conditions for successful communicative nursing actions. Because understanding the corporal dimension is prioritized in recognition, I introduced the "double logic of action" that combines hermeneutic knowledge with technical knowledge in caring actions. I prefer the notion of "double logic of action" to "patterns of knowing" because it emphasizes the difficulties in combining competing logics in one form of action and it underlines the complexity of nursing actions. Finally, a critical emancipatory approach to nursing actions that provides a critical perspective on the social praxis of nursing care is proposed to protect the identity of patients and prevent reification by emphasizing the need to implement caring

relationships that respect autonomy, dignity, and the right for patients to receive equitable, fair, and equal treatment (Ray & Turkel, 2014; 2015; Friesacher, 2017).

Therefore, this study pleads for a new ontological foundation of nursing care by focusing on what nurses actually do and conceptualizing nursing action based on Honneth's theory of recognition. A critical theory of nursing actions based on recognition can provide nurses with the philosophical and theoretical tools to reconstruct their practice based on a caring approach that opposes the dominant managerial discourse, which is mainly technical and economic in its orientation (Rudge & Thorne, 2013; Goodman, 2014). The theoretical foundation of care provided in this study enables nurses to define good nursing practice and to use these normative foundations for a critique of healthcare systems in which nursing is at risk of changing into a set of commodified services used to promote efficiency and productivity of the healthcare "market" without enough attention to caring relationships (Hussey, 2013; Rudge, 2013).

A critical theory of nursing actions also addresses the way capitalism and the economization of social life negatively influence relationships and reproduce reification concealed in nursing interactions (Friesacher, 2017). It alerts nurses to inappropriate forms of care that have infiltrated their daily practices without them being aware of the pathologic nature of the behaviours requested by the system. These pathological forms of care dehumanize the patient by neglecting emotional needs and personal concerns and deny them recognition. The elements of a critical theory of nursing actions as proposed in this study direct nurses towards caring activities that recognize the identity of the patient by promoting self-confidence through emotional and loving caring relations, strengthening of self-respect through protecting patients' legal right to receive adequate and accessible healthcare, and enhancing social esteem through activities of support and solidarity that appreciate the patient as a valuable member of the

community. Care based on recognition as used in this study enhances a patient's ability for self-realization and self-determination.

The suggested elements for a critical theory of nursing acknowledge the centrality of the nurse-patient relationship that has been emphasized in many nursing theories (Leininger, 1988; Watson, 1985; Swanson, 1991; Boykin & Schoenhofer, 2013). However, the framework posed in this study conceptualizes the relational aspect as an intersubjective, communicative interaction that can only be realized if every participant in the interaction is recognized on all dimensions of recognition. A critical theory of nursing actions also includes a political dimension and emphasizes the practice of social advocacy to promote justice, equity and equality in care, especially when vulnerable patients are not able to engage in a dialogue (Friesacher, 2017). Social advocacy entails focusing on factors that create equity in healthcare and assists patients who need help by acting on their behalf to exercise their right of self-determination and resume well-being (Hanks, 2013). Thus, the fight for rights, equity, and equality is not limited to actions of sympathy at the individual level nor is it limited to organizational change within the work setting. It crosses the borders of the work setting to the public sphere where nurses engage in social and political actions to address contextual factors and political ideology, shaping the provision of care and impeding ethical nursing practice (Rudge, 2011). Although the political dimension may not be easy to enact and carries the risk of complicating the role of nurses amid the bureaucratic and managerial system, nurses have a social mandate to protect their patients from health inequities and pathologic forms of care that insult their identity. Acting as patient advocates and getting involved in public health issues promise success in fulfilling expected social roles and regaining public trust (Des Jardin, 2001).

In conclusion, using Honneth's theory of recognition as a cornerstone for a normative definition of nursing care constitutes an essential element for the foundation of a critical theory of nursing actions. Only if the patient is recognized on the three dimensions will nursing care become an ethical endeavor. Care based on recognition must be established on a hermeneutic-phenomenological case understanding that prioritizes the lived experience of the patient with recognition for the right for self-determination. Only then will a patient be able to be heard and able to participate on an equal footing with the nurse in a communicative action that results in consensus. Ignoring the corporal-phenomenological dimension of nursing action is understood as the denial of a patient's right to ascribe meaning to personal experience, which is in itself an act of neglect of the personhood of the patient (Schmitz et al., 2011). This theoretical approach not only provides a philosophical and normative foundation for nursing actions but also provides an emancipatory approach that urges nurses to advocate for their patients at the meso and macro levels and to fight against barriers that may interfere with the enactment of good care. Thus, the struggle for recognition requires nurses to intervene in the public domain and advocate for their patients in the social and political spheres to regain rights and achieve equity and equality in healthcare whenever any of the three dimensions of recognition is violated.

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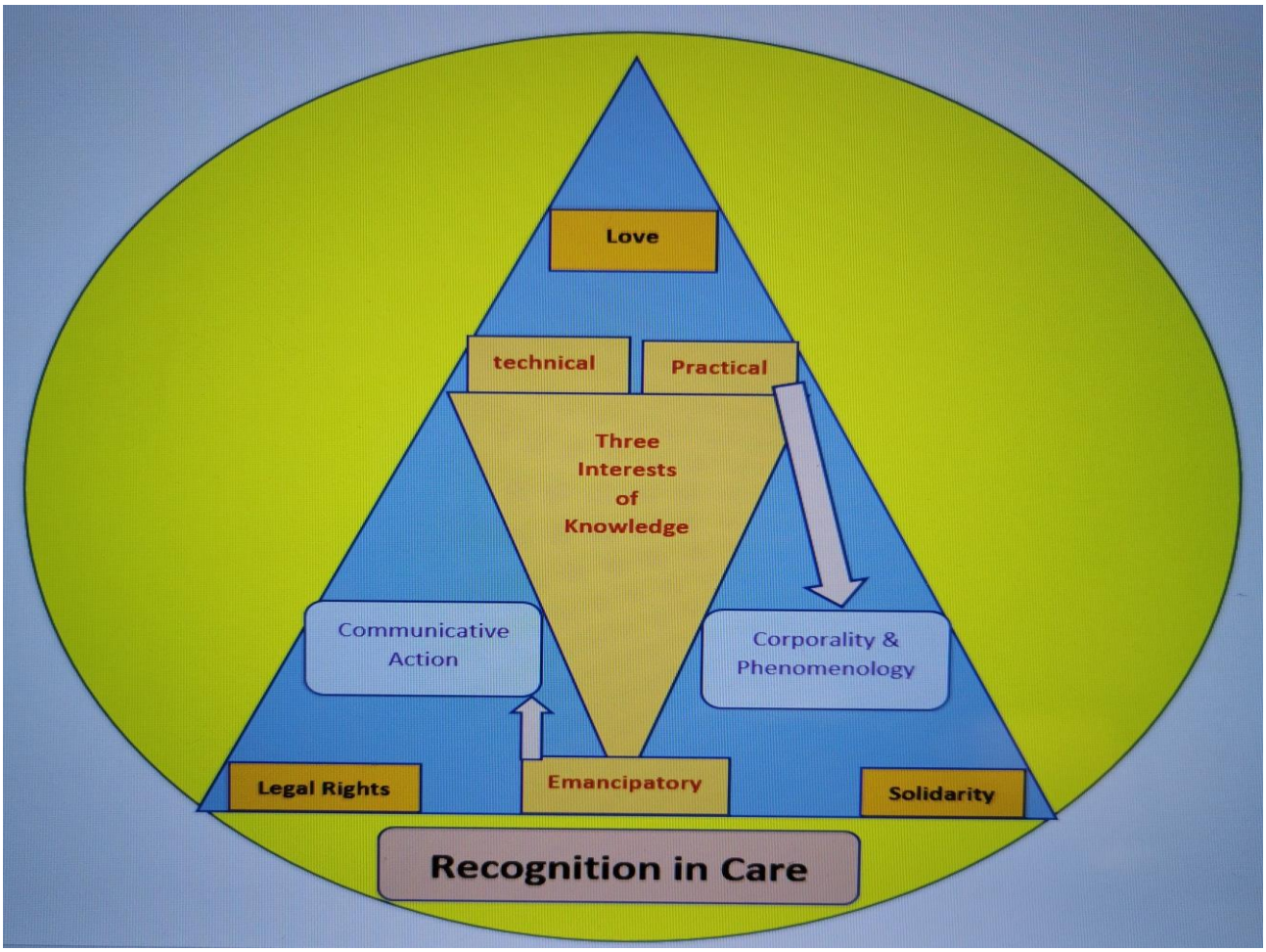
Appendices

Appendix A: Theoretical Framework Diagram

RECOGNITION IN CARE



Appendix B: Ethics Approval

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-04-19-3139
Titre du projet / Project Title	Economization of Nursing Care in Ontario: A Critical Ethnography of Nursing Action
Type de projet / Project Type	Thèse de doctorat / Doctoral thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	13/05/2019
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	12/05/2020

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Mohamad Hamze AL CHAMI	École des sciences infirmières / School of Nursing	Chercheur Principal / Principal Investigator
THOMAS FOTH	Ecole des sciences infirmières / School of Nursing	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments

Le Comité d'éthique de la recherche (CÉR) de l'Université d'Ottawa, opérant conformément à l'*Énoncé de politique des Trois conseils* (2014) et toutes autres lois et tous règlements applicables, a examiné et approuvé la demande d'éthique du projet de recherche ci-nommé.

L'approbation est valide pour la durée indiquée plus haut et est sujette aux conditions énumérées dans la section intitulée "Conditions Spéciales ou Commentaires". Le formulaire « Renouvellement ou Fermeture de Projet » doit être complété quatre semaines avant la date d'échéance indiquée ci-haut afin de demander un renouvellement de cette approbation éthique ou afin de fermer le dossier.

Toutes modifications apportées au projet doivent être approuvées par le CÉR avant leur mise en place, sauf si le participant doit être retiré en raison d'un danger immédiat ou s'il s'agit d'un changement ayant trait à des éléments administratifs ou logistiques du projet. Les chercheurs doivent aviser le CÉR dans les plus brefs délais de tout changement pouvant augmenter le niveau de risque aux participants ou pouvant affecter considérablement le déroulement du projet, rapporter tout évènement imprévu ou indésirable et soumettre toute nouvelle information pouvant nuire à la conduite du projet ou à la sécurité des participants.

The University of Ottawa Research Ethics Board, which operates in accordance with the *Tri-Council Policy Statement* (2014) and other applicable laws and regulations, has examined and approved the ethics application for the above-named research project.

Ethics approval is valid for the period indicated above and is subject to the conditions listed in the section entitled "Special Conditions or Comments". The "Renewal/Project Closure" form must be completed four weeks before the above-referenced expiry date to request a renewal of this ethics approval or closure of the file.

Any changes made to the project must be approved by the REB before being implemented, except when necessary to remove participants from immediate endangerment or when the modification(s) only pertain to administrative or logistical components of the project. Investigators must also promptly alert the REB of any changes that increase the risk to participant(s), any changes that considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project or the safety of the participant

Kim THOMPSON

Responsable d'éthique en recherche / Protocol Officer Pour/For **Daniel LAGAREC** Président(e) du/ Chair of the **Comité d'éthique de la recherche en sciences sociales et humanités / Social Sciences and Humanities Research Ethics Board**

Appendix C: Study Information Sheet

Study Information Sheet

Study Title: Economization of Nursing Care in Ontario: A Critical Study of the Daily Actions of Nursing.

Primary Researcher: Mohamad Hamze AL Chami, PhD Candidate, School of Nursing, Faculty of Health Sciences, University of Ottawa. Cell: xxx-xxx-xxxx. Email: xxxxxxxx@uottawa.ca

Research Supervisor: Dr. Thomas Foth, Associate Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa. Phone: xxx-xxx-xxxx. Ext: xxxx. Email: xxxxx@uottawa.ca

Introduction

This is an invitation to take part in a research study that is taken to fulfill the primary researcher's requirements for the PhD in Nursing at Ottawa University. Please take your time to read this information about the study before making your decision to take part. This study is conducted independently from your workplace administration. Thus, to participate (or not) will not be known by your employer nor would it in any way affect your professional involvement and/or employment.

Background and Research Purpose

Economization of healthcare services and the focus on efficiency and productivity measures in healthcare reforms in Canada, and more specifically in Ontario, diverted the attention of nurses away from the 'humanistic' focus of patient care towards quantifiable and other economic measures. This shift reconfigured the perceptions of professional nurses about what constitutes 'good' nursing care.

The purpose of this study is to analyze what nurses do in their everyday clinical work in home care, what they perceive as 'good' nursing care and how contextual factors (like economical, time constraints, political context, etc.) influence nursing practice. Based data analysis, the study will critique the influence of economization on nursing care from the perspective of nurses working at the bedside and managers of nursing care. It will also provide reflection on the ethical values and meaning of nursing care derived from the verbatim account of participants.

Study Design and Process

You are asked to participate in this study because you are a professional nurse providing home care to patients in Ottawa. To participate in the study, you must be a Registered Nurse or a Registered Practical Nurses who can speak English. Formal interviewing will be conducted during the data collection period between May 2019 and September 2019.

Participation consists of answering a set of open-ended questions structured to encourage talking and providing illustrations about desired topics. Questions will be conducted in a one-to-one interview that will be audio-taped and then transcribed by the researcher himself for analysis. If

you wish to participate in this study, you will be required to sign a consent form at the beginning of the interview. Each participant will be interviewed once for about one hour. Interviews will take place at times and locations convenient for participants inside or outside workplace.

Confidentiality
All data obtained is considered confidential and results will be used anonymously through the use of pseudonyms that prevent identification of participants or the selected institutions in any report of the study. Only anonymous data of the interviews will be shared with thesis committee members or used in future presentations or publications.

Risks and Benefits
Your enrolment will not threaten your employment or have any negative impact on your future career. Participation in this study is entirely voluntary and you may withdraw at any time with no negative consequences on your side. Moreover, you have the full right to refrain from answering any question during the interview.

Participation will give you opportunity to reflect what nurses do, what they consider as 'good' care and how contextual factors influence the practice of nursing care. Each participant will receive$ 20 cash as a token of appreciation of her/his contribution to the study just before the start of the interview. A summarized copy of the research findings will be offered to participants who request to be informed about the study results.

Questions about the Study
Should you have any question or concern about the study or your participation please feel free to contact the primary investigator or the supervisor of this research study. If you have any question regarding the ethical conduct of this study, you may contact the office of Research Ethics and Integrity, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5. Tel.: (613) 562-5387. Email: ethics@uottawa.ca

Primary Researcher,

Mohamad Hamze Al Chami, RN, MA (Ed), PhD Candidate
School of Nursing / Ecole des sciences infirmieres
Faculty of Health Sciences/Faculte des Sciences de la Sante
University of Ottawa/Universite d'Ottawa
451 Smyth Road
Ottawa, ON K1H 8M5
Email: xxxxxxxx@uottawa.ca
Cell: xxx-xxx-xxxx

Appendix D: Recruitment Flyer

We are Recruiting Research Participants

Are you a professional nurse who provides home care nursing services in Ontario?

Are you interested in a reflective interview that seeks understanding of what nurses do in their daily clinical work, how they wish to care for their patients and how such caring actions and values are influenced by the broader context?

To participate in the study, you must be a Registered Nurse or a Registered Practical Nurses who can speak English.

This study consists of an audiotaped interview that will take approximately 60 minutes to finish.

Interviews will be conducted at time and place convenient for participants.

Participants will receive$ 20 cash as a token of appreciation of their contribution to the study.

To sign up for the study, simply email the primary researcher, Mohamad H. Al Chami at: xxxxxxxx@uottawa.ca

Primary Researcher: Mohamad Hamze AL Chami, PhD Candidate, School of Nursing, Faculty of Health Sciences, University of Ottawa. Cell: xxx-xxx-xxxx.

Appendix E: Email Sent to Selected Respondents

Dear participant (name),

Thank you for expressing your interest to participate in the study. Your participation will contribute to the knowledge base of the study. I appreciate the time you will allocate for the interview. What would be a time and place that is convenient for you to conduct the audio-taped interview?

If you want to discuss this issue on phone, please don't hesitate to call me at: xxx-xxx-xxxx.

Sincerely yours,

Mohamad Hamze Al Chami, RN, MA (Ed), PhD Candidate
School of Nursing / Ecole des sciences infirmieres
Faculty of Health Sciences/Faculte des Sciences de la Sante
University of Ottawa/Universite d'Ottawa
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Appendix F: Interview Guide for Nurses and Managers

Interview Guide: Sample of Questions for Nurses

In order to establish rapport and collect demographic data about participants, the following questions were chosen to start each interview with every participant:

1. What is your initial? (RN or RPN).
2. How long have you been working as a professional nurse? (Total years of experience).
3. When did you choose to join home care nursing? (Home care experience).
4. Why did you choose home care nursing?

To generate knowledge related to the stated objectives of the study, the following preliminary questions will be addressed to help and guide the interview process:

1. How do you describe your everyday work?
    a. Could you describe a visit for a patient that you see for the first time?
    b. What do you do when you start your care?
    c. How do you determine the needs of your patient?
    d. What are the most important things you start with when you want to provide care for your patient? What are the priorities of care?

2. What do you see as the most important characteristics of 'good' nursing care when interacting with patients?
    a. Describe a situation when you felt happy and satisfied with the care you provided to a patient? What made you happy that you did well in caring for the patient?
    b. What are the goals of the care you provide? What motivates you to provide caring?

c. How do you perceive good nursing care? What do you value in nursing as a profession?

d. In your opinion what core values differentiate nursing care from care provided by other health professionals?

3. In your opinion, what factors do influence nursing care? how do contextual factors (organizational, managerial and political) influence the provision of nursing care?

    a. Describe an experience when you were not satisfied with the care you provided to patient? What happened? What were the consequences?

    b. What caring activities you want to do but you find them difficult to apply?

    c. What are the challenges that constrain or interfere with your enactment of good care?

    d. What factors do you think are guiding or shaping patient care?

Interview Guide: Sample of Questions for Managers

In order to establish rapport and collect demographic data about participants, the following questions were chosen to start each interview with every participant:

1. What is your initial? (RN or RPN).
2. How long have you been working as a professional nurse? (Total years of experience).
3. When did you choose to join home care nursing? (Home care experience).
4. Why did you choose home care sector as a working place?

To generate knowledge related to the three first stated objectives of the study, the following preliminary questions will be addressed to help and guide the interview process:

Describing nursing action:

1. Tell me about the everyday experience of your nurses. What do nurses do when they visit their patients?
2. How do nurses determine the needs of their patients?
3. What are the priorities of caring that you want your nurses to do when caring for patients?

Describing nursing values and ideals:

1. Would you please describe a situation when you felt satisfied with the care provided by nurses? What made you feel happy that your nurses did well in caring for the patient?
2. What are the ideals and values of good nursing care that you think are of greatest importance?
3. In your opinion how is nursing care different from care provided by other health professionals?
4. What constitutes the core of professional nursing care? What is peculiar about nursing care?
5. What do you do as a nurse manager to ensure the implementation of nursing values and standards in nursing practice?

Influence of context on nursing action:

1. What caring activities you want your nurses to do do but you find them difficult to apply?
2. What changes have occurred to home care services since you have started?
3. What factors do you think are guiding and shaping nursing care?

4. What relation do you see between the broader economic/political transformations in healthcare sector and the practice of good nursing care?
5. How do you see the influence of transformations on nursing care?

Appendix G: Consent Form

uOttawa

Université d'Ottawa
Faculté des sciences de la santé
École des sciences infirmières
University of Ottawa
Faculty of Health Sciences
School of Nursing

Consent Form

Study Title: Economization of Nursing Care in Ontario: A Critical Study of the Daily Actions of Nursing.

Primary Researcher: Mohamad Hamze AL Chami, PhD Candidate, School of Nursing, Faculty of Health Sciences, University of Ottawa. Cell: xxx-xxx-xxxx. Email: xxxxxxxx@uottawa.ca

Research Supervisor: Dr. Thomas Foth, Associate Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa. Phone: xxx-xxx-xxxx. Ext: xxxx. Email: xxxxx@uottawa.ca

Invitation to Participate: I am invited to participate in the above mentioned research study conducted by Mohamad Hamze AL-Chami as a fulfillment for his PhD requirements. This study is conducted independently from the organization where I am employed and my decision to participate (or not) will in no way affect my professional involvement and/or employment.

Purpose of the Study

The purpose of this study is to analyze what nurses do in their daily clinical work in home care, what they perceive as 'good' nursing care and how contextual factors (like economical, time constraints, political context, etc.) influence nursing practice. Based on data analysis, the study will critique the influence of economization on nursing care from the perspective of nurses working at the bedside and managers of nursing care. It will also provide reflection on the ethical values and meaning of nursing care derived from the verbatim account of participants.

Participation

My participation will consist of answering a set of open-ended questions structured to encourage talking and providing illustrations about desired topics. Questions will be asked in a one-to-one interview that will be audio-taped and then transcribed by the researcher himself for coding and analysis. I will be interviewed once for about one hour in a place and at a time convenient for me.

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Benefits

My participation will give me opportunity to reflect on what nurses do, what they consider as 'good' and ethical action when caring for patients and how contextual factors influence the practice of nursing care. I will receive$ 20 cash as a token of appreciation of my contribution to the study just before the start of the interview. At the completion of the study, a summary of the research results can be provided upon my request.

Risks

My participation in this study will entail sharing behaviors, beliefs and feelings incorporated during personal clinical experience. I have received assurance from the researcher that every effort will be made to minimize any unexpected risk that may negatively impact my employment or future career. Any personal information will be kept confidential and my identity will not be revealed or identified in any report of the study.

Confidentiality and Anonymity

I understand that my verbatim accounts will be used only for coding and analysis purposes. Only the researcher and the supervisor will have access to the list of participants and other related research data. Moreover, results will be used anonymously through the use of pseudonyms that prevent identification of participants and institution in any report of the study. Only summarized anonymous data of interviews will be shared with thesis committee members and used in future publications or presentations.

Conservation of data

I was made aware that during data collection and analysis, original electronic data will be stored in a secured computer while hard copies will be kept in a locked cabinet in the locked office of the supervisor in Ottawa University. After data analysis period, hard copies will be shredded and all electronic data will be securely deleted from computer after 5 years of data collection. During retention period, only the researcher and the supervisor will have access to the collected data and the list of participants.

Voluntary Participation

I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any question without suffering any negative

consequence. If I choose to withdraw, all data gathered until the time of withdrawal will be destroyed unless I give permission to use it.

Acceptance: I, ---------- agree to participate in the above research study conducted by Mohamad Hamze AL Chami from the School of the School of Nursing, in Ottawa University, under the supervision of Dr. Thomas Foth.

If I have any question about the study, I may contact the researcher or his supervisor.

If I have any question regarding the ethical conduct of this study, I may contact the office of Research Ethics and Integrity, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5. Tel.: (613) 562-5387. Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: Date:

Researcher's signature: Date:

Appendix H: Thematic analysis chart: Moving from open codes to major themes.

Research questions	Sample of Open Codes	Subthemes	Major themes
How do nurses describe their daily actions? /What do nurses do in real clinical fields?	Deep knowing, intimate relationship, understanding personal issues, exploring primary concerns, relationship of trust, honest conversation, knowing what's going on, going beyond technical work.	a-Knowing the very personal dimensions of life	**" Knowing on a deeper level"** A very specific kind of nurse-patient relationship
	Knowing everything, looking at bigger picture, checking on home environment, understanding the whole person, patient as part of family, self-care of patient, utilizing academic knowledge in holistic care.	b-Understanding the "whole" person	
	Discussing care with patient, checking what is pertinent to patient, include patient in care, interactive process, agree on a plan, patient empowerment, ownership of healthcare.	c-Involving patient in care	
	Direct body touching, providing catheter care, underwear changing in bed, assistance in taking off clothes, bathing the patient.	d-Providing intimate bodily care	
What are the most important characteristics of 'good' nursing care? /What subjective values motivate nurses in their work?	Empathy and compassion, genuine concern, being with, showing interest, showing presence, nurturing relationship, care for the human person	a-Demonstrating genuine concern and emotions	**" Treating patients as human beings"** Values guiding good nursing care
	Respect for patient, respect for all needs, respect for values, respect for environment and place, respect for property, respect for faith and religion, respect through signing consent.	b-Showing respect	
	Helping people, making them feel they matter, enhancing well-being, acting on their behalf, assist to resume autonomy.	c-Providing help and advocacy	

Appendix H (continued): Thematic analysis chart: Moving from open codes to major themes.

Research questions	Sample of Open Codes	Subthemes	Major themes
How do contextual factors influence how nurses actually provide care? /What are the barriers of 'good' nursing care?	Underfunding and service cuts, statistical matrix of care, care is based funding, limited PSW, shortage of staff, low payment of staff.	a-Funding as the determinant of quality care	**" Do a lot more with less"** Impact of underfunding and cutbacks on quality care
	More work but less time, Rush in care, no caring conversation, inadequate time for care, care as delivery of service, neglect in care, patient feels insulted, increased anxiety of nurses,	b-Time pressure and inappropriate care	
	Early discharge from hospital, dumping of patient without home preparation, lack of coordination, supplies not ready at home, readmission, inability to access care, no family member to help, inability to pay for care, patient left alone	c-Premature hospital discharge and inadequate access to care	
	Evidence-based care, calculable performance indicators, standardized care steps, following rigid guidelines and protocols, standard timing for care, care is not patient-centered	a-Bureaucracy and Standardized Care	**" Challenged and frustrated"** Policies and work environment not conducive to good care
	Nurses are uninformed about transformations, Patient forgotten in transformation, inefficient healthcare, broken community link.	b-Discontent with healthcare policy	
	Seeing too many patients per day, dealing with difficult patients, providing services beyond responsibilities, inability to provide good care, moral crisis,	c-Caring within difficult work conditions	

Appendix I: Performance Indicators

Indicator	Definition
Referral Acceptance Rate	Measures the number of requests to provide visit and/or hourly service to new clients (referrals) accepted by the service provider within the specified response timeframe. Numerator: Number of visit referrals accepted in a month (both urgent and non-urgent), multiplied by 100 OR Number of hourly referrals accepted in a month (both urgent and non-urgent), multiplied by 100. Denominator: Number of visit referrals offered in the same month (both urgent and non-urgent) OR Number of hourly referrals offered in the same month (both urgent and non-urgent).
Overall Satisfaction	% of respondents who rate the services provided by their service provider as very good or excellent Numerator: Number of respondents who rated 4 or 5 (Very Good or Excellent) when asked the question: Overall how would you rate the [Service Provider Name] provided by [Service Provider Org]? Denominator: Total number of respondents for whom a response was reported on the question: Overall how would you rate the [Service Provider Name] provided by [Service Provider Org]?
Satisfaction with Continuity	Total score as a percentage of total possible score on the question: Has receiving [SERVICE NAME] from different [PROFESSIONAL NAMES] caused any problems for the quality of care [YOU RECEIVE/YOU RECEIVED/NAME RECEIVES/ NAME RECEIVED]? Numerator: Number of respondents who rated "Never", "Sometimes", "Often" or "Always" (where Never = 4, Sometimes = 3, Often = 2 and Always = 1) when asked the question: Has receiving [SERVICE NAME] from different [PROFESSIONAL NAMES] caused any problems for the quality of care [YOU RECEIVE/YOU RECEIVED/NAME RECEIVES/ NAME RECEIVED]? Denominator: Total possible score (4 times the number of respondents answering the question)

Indicator	Definition
Patient Centred Care Appointments (KPI 3)	Number of respondents who rated "Always" in response to each of the following three questions: i) Were visits from [SERVICE PROVIDER] arranged at a convenient time? Ii) In the last two months of care, how often did [SERVICE PROVIDER] arrive on time? iii) How often did this agency or [SERVICE PROVIDER] keep you informed about when [SERVICE PROVIDER] would arrive? Numerator: Number of respondents who rated "Always" in response to each of the following three questions: : i) Were visits from [SERVICE PROVIDER] arranged at a convenient time? Ii) In the last two months of care, how often did [SERVICE PROVIDER] arrive on time? iii) How often did this agency or [SERVICE PROVIDER] keep you informed about when [SERVICE PROVIDER] would arrive? Denominator: Total number of respondents answering all three questions.
30 Day Readmission Rate	Readmission rates within 30 days for the same condition Numerator: number of clients on the pathway who were discharged and then readmitted within 30 days Denominator: number of clients on the pathway who were discharged
Final Outcomes Achieved	% of final outcomes achieved according to the pathway Numerator: number of clients on the pathway who have reached the final interval and have achieved all outcomes on the final pathway interval Denominator: number of clients on the pathway who have reached the final pathway interval
Outcomes Achieved by Day X	% of final outcomes achieved by day x threshold Numerator: number of clients on the pathway who have reached the day X threshold and have achieved all outcomes on the final pathway interval Denominator: number of clients on the pathway who have reached the day X threshold

Indicator	Definition
Discharge Reports	Measures the rate of discharge reports received by the CCAC Calculation: (# times that the service provider has submitted a discharge report on or before the applicable deadline in a month/# of discharge reports that should have been submitted in that month) X 100
Missed Care	"**Missed Care**" means any scheduled Fixed Period Visit or Hourly Visit to a Patient, authorized by the CCAC as part of the Patient Care Plan, that has been accepted by the Service Provider but that the Service Provider fails to attend and fails to reschedule the visit time to the satisfaction of the Patient in accordance with the Patient Care Plan and includes a Fixed Period Visit or Hourly Visit required by the Patient Care Plan that the Service Provider originally accepts and then subsequently informs the CCAC that it is unable to carry out;" "For clarity, for the purposes of the definition of Missed Care, a Fixed Period Visit or Hourly Visit requested by the CCAC for a specific time represents a requirement of the Patient Care Plan and if such time specific Fixed Period Visit or Hourly Visit is not delivered at the specified time, it shall be considered Missed Care for the purposes of this Agreement, regardless of whether a Patient has accepted the delivery of Services at a different time as an alternative to the specified time." Numerator: Any visit (fixed period or hourly visit) to a client, authorized by the CCAC as part of the Patient Care Plan, that the Service Provider fails to attend and is unable to reschedule in accordance with the Patient Care Plan. Denominator: All visits (fixed period visits or hourly visits) delivered plus the number of visits (fixed period visits or hourly visits) that are not delivered in accordance with the Patient Care Plan.

Indicator	Definition
5 Day Wait Time – Personal Support – by Patient Available Date	% of complex patients who received their first personal support service within 5 days of the date the patient is available to receive service. Numerator: # of complex Patients (as designated by the CCAC) who receive their first Fixed Period Visit or Hourly Visit of Personal Support and Homemaking Services for the first Referral for Personal Support and Homemaking Services no later than 5 days following the Patient Available Date in a month. Denominator: # of complex Patients (as designated by the CCAC) for whom a first Referral for Personal Support and Homemaking Service is made within the same month.
5 Day Wait Time – Nursing – by Patient Available Date	% of all patients who received their first nursing service within 5 days of the date the patient is available to receive service. Numerator: # of Patients who receive their first Fixed Period Visit or Hourly Visit of Nursing Services for the first Referral for Nursing Services no later than 5 days following the Patient Available Date in a month. Denominator: # of Patients for whom a first Referral for Nursing Services is made in the same month.

Appendix J: Full Demographic Data for Participants

Demographic data of Participants at settings A and B

Participant's Code	Male (M) /Female (F)	Category	Position Of work	Total Years of Nursing Experience	Home Care Years of Experience	Duration
*PA 1	(M)	RN	Home care nurse	4	2.5	50m: 27s
PA 2	(F)	RPN	Home care nurse	23	19	44m:37s
PA 3	(F)	RPN	Home care nurse	30	11	41m:37s
PA 4	(F)	RN	Home care nurse	19	17	49m:34s
PA 5	(F)	RPN	Clinic nurse	14	14	44m:22s
PA 6	(F)	RN	Home care nurse	22	17	44m:36s
PA 7	(F)	RN	Home care nurse	18.5	7	32m:11s
PA 8	(M)	RPN	Home care nurse	8	6	36m:14s
PA 9	(F)	RN	Nurse Manager	15	15	46m:42s
PA 10	(F)	RPN	Nurse Manager	20	16	31m:57s
*PB 1	(F)	RPN	Home care nurse	5	3	40m: 32 sec
PB 2	(F)	RPN	Home care nurse	14	3	27m: 39 sec
PB 3	(F)	RPN	Home care nurse	34	28	46m: 55 sec
PB 4	(F)	RN	Home care nurse	14	10	50m: 56 sec
PB 5	(F)	RN	Nurse Manager	10	6 months	53m: 11sec
PB 6	(F)	RN	Clinic Nurse	7	5	47m: 09 sec
PB 7	(F)	RN	Nurse Manager	20	3	55m: 21 sec
PB 8	(F)	RN	Home care nurse	28	13	40m: 20 sec
	Sum	Sum	Sum	Average	Average	Average
Average/Sum	2 Males & 16 Females	8 PNs &10 RNs	12 Home care nurse 2 Clinic nurses 4 Nurse Managers	16.97 (17) years	10.56 (10.6) years	44m: 00sec

*PA#: Participant from setting A. *PB#: Participant from setting B.