



## Raising the question of dignity through knowledge about tacit practices and politics: sharing learning from the Norwegian welfare state

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Received for publication: 2017 Accepted for  
publication: 10<sup>th</sup> September 2017 Published:  
20<sup>th</sup> September 2017

<https://doi.org/10.19043/ipdj.7SP.001>

### Abstract

The focus of this special issue is some of the main tacit policies and practices in the Norwegian welfare state. By looking at what is tacit, mute, unarticulated and neglected we will contribute to raising and presenting knowledge about the social and ethical question of dignity in welfare. This introductory article will first give a short overview of the historical background of the Norwegian welfare state and some of its current features. This will be followed by our positioning of the Norwegian welfare state as situated within complex practices, political discourses and dimensions that might be characterised as tacit, implicit or unarticulated. The article aims to discuss the concept of dignity in welfare services, at the individual and structural level, by asking '*what kind of practices and structural conditions preserve dignity and where might dignity be violated, ignored or left out?*'

The various articles in this special issue of the *International Practice Development Journal* illuminate what can be said and what is mute and tacit in different ways, and consider a range of practice-based responses. By revealing tacit dimensions in the Norwegian welfare this issue offers important insight into practices and discourses where dignity is at stake. It is a requirement of us all that we revisit dignity and its location and representation in our health systems to ensure it is not left behind as the state and other systems within it evolve.

**Keywords:** Tacit knowledge, welfare state, Norway, dignity, practice

## Introduction

This special issue of the *International Practice Development Journal* considers the tacit practices and politics in the Norwegian welfare state. The collection of articles have been presented at several seminars on this specific topic arranged by a Norwegian research group focusing on *Omsorgens grunnlag, fenomener og vilkår* [The foundations, phenomena and conditions of care]. The group comprises researchers from universities and university colleges across Western Norway. It has been meeting for several years, connected by a common interest in exploring the foundations of care from theoretical as well as empirical perspectives. Currently, the group is shedding light on the Norwegian welfare state and its tacit dimensions, doing so in the belief that the setting and the context of this welfare state – as well as a critical perspective on it – will be of interest to an international audience. The Nordic welfare states have traditionally placed a strong emphasis on universal rights and through this developed a high level of trust among their citizens. However, the welfare state is changing under the influence of various factors: demographical, economical and global challenges, as well as challenges to the way the welfare state is run. These factors include New Public Management, the rise of private sector bringing increasing privatisation in healthcare, and also a small but increasing influence from for-profit organisations. Thus, it feels timely to reconsider the issue of dignity and how it might be affected by these changes.

## The Norwegian and wider Nordic welfare state context

The benefits of the Norwegian welfare state are offered to all – they are universal. The state provides its citizens with economic and social security (Raphael, 2014). The government distributes resources to allow all inhabitants access to basic goods like housing, education, health and social care services. However, in the past couple of decades there has been a growing concern that the welfare state is inefficient, unable to achieve its objectives consistently and unsustainable in financial terms (Jann and Lægreid, 2015). Health and welfare services in Norway are facing challenges due to demographic changes, increasing chronic health problems, marginalisation and poverty (Eide et al., 2017). This means a substantial and growing level of dependency among citizens on services such as health and social care and rehabilitation. It is claimed that the traditional Norwegian and wider Nordic values of universalism and solidarity are under threat (Jann and Lægreid, 2015), leading to a ‘welfare state fatigue’ (Raphael, 2014, p 14). Consequently, the welfare state has moved in a direction where new political solutions are sought; for example, the issues of an ageing population are being tackled by arranging for citizens to become active and participating citizens, whether as health service users or as volunteers (Eide et al., 2017). Furthermore, healthcare service models are increasingly being reframed by marketisation in Nordic countries (Anttonen and Meagher, 2013). For example, home-based care and care home services are increasingly offered by for-profit providers in Norway (Vabø et al., 2013). However, in comparison with the other Nordic nations, Norway has the lowest level for-profit healthcare service deliveries; only 2% of nursing homes in Norway in 2012 were run by for-profit companies (Vabø et al., 2013, p 181). This can be explained by the fact that Norway is a rich country, it is not densely populated and has wide variety of municipalities, including a lot of smaller ones. Just as importantly, the country has a strong consensus culture and well-organised resistance through strong trade unions, with unions forming alliances to campaign for maintaining the welfare state.

Nevertheless, market and neoliberal ideas in relation to the right of individual choice are prominent in Norwegian and Nordic healthcare services and practices (Glasdam et al., 2015; Vitsø and Vik, 2017). Despite the introduction of some market-driven changes and related new ideas, citizens retain a high degree of trust in the state and its healthcare services (Vike, 2004.). This is in no small measure because the welfare state has largely continued to safeguard the collective and personal dignity of its citizens (Vike, 2004). Nevertheless, as some of the contributions in this special issue show, this is not always the case, as persons receiving care services might also be victims of violations and offences to their dignity. Therefore, this issue considers: *What kind of practices and structural conditions preserve dignity and where might dignity be violated, ignored or left out?* The answer to such a question is often left unarticulated, mute or tacit. A further aim is to consider the position of the Norwegian model in

relation to the concept of dignity in healthcare, both at the individual and structural level. Also, the authors in this special issue will look into some of the consequences of 'newer' welfare state politics and how policies shape, reshape or influence to a certain degree tacit care practices.

### **The tacit dimensions in the welfare state**

The concept of tacit knowledge or tacit knowing stems from scientist and philosopher of science, Michael Polanyi, who famously stated that 'we can know more than we can tell' (1966/2009). The use of the term 'tacit dimensions' here in relation to the Norwegian welfare state is not an attempt to enter the philosophical and general debate on tacit knowledge. Instead this article will highlight how different ways of understanding tacit dimensions, as set out by the authors in this special issue, can help us illuminate the various practices and policies in our welfare system. Swedish philosopher Bengt Molander (1992; 1996) argues that tacit knowledge is located in the body, in practice, in culture and even in language. He also argues that tacit knowledge not only concerns what is difficult to articulate in terms of embodied, implied or unconscious knowledge, but also knowledge that is silenced – that is, made voiceless by being restricted or disempowered. Within healthcare services these are crucial issues that include what we can say are silenced practices.

The Norwegian sociologist Kari Wærness (1978) made an important contribution to putting this issue on the social sciences agenda when she introduced the concept of the 'invisible welfare state'. This concept concerns silenced female knowledge and practices of housework and care work, and represents one central historical forerunner of today's healthcare services, including its tacit dimensions. In sum, this conceptual background gives rise to questions for this special issue, including:

- Are there medical or healthcare practices or practitioners that are silenced?
- Are some practices forced into the background by other dominant practices?
- Are the voices and knowledge of persons using services recognised and honoured?
- Are there vulnerable groups that are silenced through practices?
- Are some vulnerable groups marginalised by a focus on the suffering of other vulnerable groups?
- Are there languages, discourses and practices contributing to hidden power relations, contested and contrasting claims, and privileged positions?

These questions and challenges are thematised and problematised in different ways by the authors of the articles that follow.

### **Dignity in practice and politics**

The concept of dignity has been the subject of considerable international debate in healthcare in recent years (Tranvåg and McSherry, 2016). In the context of the Norwegian welfare state, the importance of dignified care and seeing each patient as a person have been emphasised and problematised (for example, Frost and Husebø, 2016). Dignity has a philosophical and political history dating back to antiquity and has been promoted by philosophers such as Pico della Mirandola and Immanuel Kant. It has been prominent as a fundamental human right since the *Universal Declaration of Human Rights* (United Nations, 1948), which states that all human beings have an inherent dignity. This has been extended to patients' rights, where the dignity of the patient is fundamental – for instance, in the *Declaration on the Promotion of Patients' Rights in Europe* (World Health Organization, 1994) and in the international *Code of Ethics for Nurses* (International Council for Nurses, 2012). In Norway the debate around the importance of dignity and dignified care for frail older people resulted in a *Verdighetsgarantien* [dignity guarantee] that was put into law (Ministry of Health and Care Services, 2010). However, research has shown that this guarantee is sometimes little more than empty words and is violated on a daily basis – it is claimed, due to a lack of resources (Haukelien, 2013). Furthermore, Norwegian philosopher Inga Bostad (2016) criticises the dignity guarantee, arguing that its underpinning premise is fundamentally flawed: dignity is fundamentally unique to each human being and not something that can be guaranteed; it can only be strived for and facilitated. The individual nature of the concept is something that has been stressed in various research; among

others, Chochinov (2008, p 674) concludes that dignity 'means different things to different people' since human beings differ from each other, having different status, cognitive abilities and resources. And this subjective kind of dignity can be maintained or diminished, for instance, by the acts of others, or depending on a person's self-esteem. According to Swedish philosopher Lennart Nordenfelt (2004, p 74), the subjective dimension of dignity is tied to a 'dignity of identity' that incorporates a sense of ourselves as integrated 'persons with a history and persons with a future', and is particularly vulnerable to illness and old age, and to the acts of other people.

Despite dignity's vagueness and particularity, this special issue has been situated within the concept of dignity, because of the belief that it is of utmost importance in healthcare in general, and in the Norwegian welfare state in particular. Frank and Synnes (2016) argue that dignity is an abstract claim that needs stories in order to be articulated. In addressing the tacit dimension in the Norwegian welfare state, this special issue sought different perspectives and other narratives to illuminate dignity-preserving practices as well as deficiencies, in the interaction between persons offering and receiving care, as well as in governmental policies and in large-scale societal trends.

### **A short overview of the articles**

The articles by Jacobsen and Fagertun present analyses of governmental White Papers illuminating how official discourses emphasise some factors of health while neglecting others. Jacobsen's article *Active ageing* explains how this concept has gained prominence in the Nordic countries over recent years, and how this is reflected in Norwegian and other Nordic policy documents. In his analysis of Norwegian White Papers Jacobsen demonstrates the implicit and taken-for-granted aspects of the concept of active ageing, showing how these might exclude other activities that are meaningful for many older people, in particular the working class and the very frail.

Anette Fagertun's *The anti-politics of healthcare policy and its blurring effects on care work in Norway* presents a discourse analysis of White Papers for Norwegian healthcare. In her analysis, Fagertun traces the emergence of person-centred care to a transformation of the public sector influenced by neoliberal tendencies, for instance an ideological emphasis on individualisation. She argues this implies a depoliticisation of care work that might render it invisible and also hinder gender equality.

Moving from the tacit dimension of discourses, there are articles emphasising innovative practices that are still on the margins of the welfare state. The article *It's good to be useful: activity provision for people living with dementia on green care farms in Norway* by Tobba Therkildsen Sudmann and Ingebjørg Træland Børsheim, relates how an innovative practice of farm-based adult day care for people living with dementia can enhance wellbeing and joy by allowing them to get away from regular day care, and become involved in activities that are meaningful and empowering and also reduce cognitive pressures. The authors argue that green care is a liminal experience, during which interaction creates a sense of community and a situated identity that diminishes the significance of dementia. The article points towards positive outcomes but also stresses the need for more research to avoid a naive positivity and enthusiasm that might accompany such innovative and exciting practices.

A related project on persons living with cognitive impairment and involvement is presented in Anita Gjermestad's article, *Narrative competence in caring encounters with persons with profound intellectual and multiple disabilities*. Here Gjermestad argues for the need for narrative competence among staff in caring encounters with persons with profound disabilities living in residential homes. Narrative competence is crucial in facilitating person-centred care in such encounters and can be developed and supported through providing arenas for discussion and reflection among staff. Sharing various interpretations of the non-verbal and bodily utterances of persons with profound intellectual and multiple disabilities can contribute to a richer understanding of these persons.

Several of the articles emphasise tacit dimensions among healthcare workers and in their practices. In Ellen Ramvi and Birgitta Haga Gripsrud's article *Silence about encounters with dying among healthcare*

*professionals in a society that 'de-tabooises' death*, a psychosocial approach is applied to unwrap an apparent paradox: on the one hand there is an ongoing de-tabooisation of death in Norwegian society, whilst on the other, studies on healthcare personnel indicate that professionals' experiences with dying and death become silenced and unspeakable within care services. The question the authors pursue theoretically is, how can we understand silence about encounters with death among healthcare professionals in this societal context?

Based on an ethnographic study, Anne Marie Sandvoll's article *Tacit practice in nursing homes* describes various tacit and unspoken practices among staff in nursing homes. Staff are committed to daily work routines, and have to deal with several unexpected events daily, some of them challenging. Close contact with some residents' behaviours has the potential to evoke difficult emotions among staff, which they find hard to admit to. The findings suggest that greater awareness, communication and reflection about these tacit aspects of care could be beneficial to current and future nursing staff.

In *Developing a culture of pride, confidence and trust: enhanced collaboration in an interdisciplinary team*, Kristin Ådnøy Eriksen and Sølvi Heimestøl take as a starting point the Norwegian 'collaboration reform' in healthcare and argue that collaboration in terms of evolving processes and reciprocal engagement has not been given sufficient attention. In the article the authors present findings from facilitated processes in an interdisciplinary team that works with pregnant women and parents at risk of substance abuse and/or mental illness. The authors show that taking part in facilitated processes improved the team members' awareness about their work, and gave them confidence in their own and colleagues' competence, and in their ability to handle complex situations.

Finally, in *The tacit care knowledge in reflective writing – a practical wisdom*, Linda Rykkje examines how care for older people is represented in students' reflective writing assignments. Rykkje argues that the situational dilemmas that the students retell illustrate traces of tacit care knowledge or practical wisdom. She says recognising the practical wisdom of healthcare personnel, especially for the benefit of future generations of nurses, is an important focus for person-centred and evidence-based practice in higher education.

Together, the different articles in this special issue give important insight into current tacit, mute or unarticulated practices, discourses and developments in the Norwegian welfare state. Examples from the Norwegian context have the potential to bring fruitful perspectives to this journal's international readership, and to be instrumental in the ongoing debate on dignity within healthcare. Finally, this special issue can contribute to (re-)establishing the research agenda on the topic of dignity for nursing and healthcare research; something arguably in need of continuous revisiting as welfare systems evolve.

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