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# NARRATIVE RELATIONS

## Resources for meaning-making and person-centred practices in geriatric care

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# Narrative relations

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Thesis for Doctoral Degree (Ph.D.)

By

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# Popular science summary of the thesis

The key topic of this thesis is narrativity in healthcare. Simply put, narratives – or stories – play a powerful part in shaping human experiences and actions. As humans, we organize and create meaning around our experiences and actions by means of stories. Consequently, we can learn a lot about human experience and action by attending to peoples' stories. In terms of healthcare, listening to patients' stories has long been seen as an important part of compassionate healthcare practices, as it gives health professionals insights into patients' unique situations, needs and illness experiences. Stories give clues about what matters to people. But is there really room for stories and narrative meaning-making in healthcare today?

In recent decades, medical and technical advances have made it possible to treat diseases more effectively, which together with overall societal development enables people to live longer. A flipside of this progress is that healthcare has become more specialized and fragmented, but also that a growing number of people live with long-term health conditions. This has been widely recognized and thoroughly problematized in relation to the future healthcare needs of societies, and there is a global call for change in how healthcare is organized and delivered. When focusing on treatment of medical issues, an unforeseen side effect is that healthcare has become somewhat distanced from the experiences of human beings affected by disease or other health conditions. As human beings, diagnoses or health issues are not something separate from our lives at large. We are rooted in physical, social, and cultural circumstances, where health and disease have meanings and consequences for us and for others. To obtain holistic and compassionate understandings of people seeking healthcare, healthcare workers should be capable, and supported, to unify different types of knowledge and skills in their everyday practices and be responsive to the meanings people make around their health and life situations more broadly. Lately, this has been increasingly acknowledged, and there is an ongoing movement calling for so-called person-centred care. While some theoretical frameworks and models already exist to translate these ideas into practice, there is still a lack of knowledge about how this cultural transformation of healthcare can be realized by healthcare workers in their everyday work practices. So, what do stories have to do with this?

Long-lasting academic work from various research fields suggests that stories – in this thesis often called narratives – have much to offer when aiming for holistic understandings of people. Some models for person-centred practices strongly emphasize the necessity of eliciting patient stories about their illness and using them in partnership with the person to guide all healthcare activities and decisions. Other models promote the use of stories and art to develop healthcare professionals' sensibility to patient stories in their work. But is listening to patients' stories enough?

How do the circumstances for everyday practices allow for attending to patient stories? And how can stories be integrated and useful in healthcare practices? There is still little knowledge about how this may take place in everyday healthcare practices and how stories, narration, and narrative ways of reasoning may offer practical resources in this context. This thesis contributes to shedding light on such matters. It is based on ethnographic fieldwork on an inpatient geriatric ward, focus group discussions with healthcare professionals working on that ward, and theoretical resources from narrative theory.

The research site had a mission to provide medical care and rehabilitation to older people with recently deteriorated health situations or multiple health issues that required a multiprofessional team. During fieldwork, I closely engaged with and examined the everyday working practices and interaction where healthcare was enacted, and talked to the people directly involved. Observations and informal interviews were recorded in extensive written fieldnotes. These data were analysed using an interpretative narrative method with the aim to understand how narrative meaning-making took place and unfolded in the everyday practices (**paper 1**). Through focus group discussions prompted by vignettes developed from the ethnographic fieldwork, healthcare professionals shared their practice-based knowledge about working on the ward, which was analysed through a qualitative constant comparative method to better understand how the use of narration was reflected in their accounts of everyday practices (**papers 2 & 3**). These two data sets were finally analysed together, through an interpretative narrative method, to deepen the understanding of conditions for staff to engage with stories and narration in their work (**paper IV**).

The findings of this thesis imply that there are reasons to broaden the understanding of how narrativity might contribute to compassionate and person-centred healthcare practices, beyond merely attending to patient stories in terms of somewhat fixed accounts of illness experiences and life situations. The findings show how people's stories are constantly created and reshaped in interactions with other people. Such co-creation of stories often takes place as joint explorations in everyday situations while doing seemingly mundane things. Both patients and staff invited other people in their ongoing quest for making sense of current situations and possible futures, which in turn shaped their actions and decisions. However, due to habitual and task-oriented ways of working, and what was seen as accredited parts of healthcare work, staff often overlooked such invitations from patients, thus missing opportunities for valuable insight into patients' ongoing meaning-making around their health situation. In the ward areas off-limit to patients, staff engaged in co-creation of stories to a somewhat greater extent, mostly inside professional groups, but also interprofessionally. This suggests that such practices of '*engaging in narrative relations*' could support various foundational qualities of healthcare work: building trustful relationships between patients and staff,

and in the interprofessional team; learning from coworkers; preventing simplistic understandings of people and situations; and supporting continuity and coherence in the health services. However, if obliviously engaging in narrative relations, the findings also indicate a risk of disseminating harmful understandings and stereotypes, or of reinforcing power structures. Finally, the findings show how the conditions for engaging in narrative relations were influenced by broader social stories and conflicting understandings about what healthcare practice is, and how it should be delivered.

The implications of these findings are that mundane situations in inpatient care may offer hidden resources for understanding what matters to patients and should not be undervalued in terms of creating person-centred care cultures. Another implication is that it is not only patient stories that matter in terms of person-centred practices, but staff's stories and interpretations of others' stories also shape how their practices transpire. Therefore, it is important to raise awareness of the ongoing narration in everyday care practices, to be reflective about what stories are told and disseminated in these contexts and about whose stories are acknowledged.

# Populärvetenskaplig sammanfattning

Berättelser och berättande fyller en viktig funktion för hur vi människor förstår och ger mening åt våra erfarenheter och handlingar. Vi är ständigt omgivna av berättelser, både i form av de större kulturella berättelser som säger något om vad som anses vara rätt och fel, eller gott och ont, i olika sammanhang, men också i form av det berättande som vi ägnar oss åt för att förstå och förmedla det vi är med om i vårt vardagliga liv. Genom att organisera våra erfarenheter narrativt, det vill säga som berättelser, knyts enskilda händelser och upplevelser ihop och blir begripliga utifrån det större sammanhang som berättelserna skapar.

Den här avhandlingen handlar om berättande och berättelsers roll i hälso- och sjukvård för äldre personer.

Inom hälso- och sjukvård har patientberättelsen lyfts fram som en resurs som kan hjälpa medarbetare i vården att bättre förstå och bemöta patienter. Dessa berättelser kan ge ledtrådar om vad som är betydelsefullt och viktigt för personen i fråga, så att vården kan anpassas med respekt och medkänsla för varje individ. Men finns det utrymme och förutsättningar för berättande och meningsskapande i det sätt som hälso- och sjukvård bedrivs på idag?

De senaste decenniernas medicinska och tekniska framsteg har gjort det möjligt att framgångsrikt behandla sjukdomar som tidigare varit dödliga, vilket tillsammans med samhällsutvecklingen i stort bidrar till att människor lever längre. Samtidigt innebär denna utveckling att vården har blivit mer specialiserad och därmed också fragmenterad, samtidigt som en större andel människor lever med långvarig sjukdom eller ohälsa. Detta medför förändrade krav på hur framtidens hälso- och sjukvård behöver organiseras och bedrivas. Ett dilemma i relation till den alltmer specialiserade hälso- och sjukvårdens fokus på diagnoser och medicinsk behandling av specifika hälsoproblem, är att människors upplevelser av sjukdom och ohälsa inte är isolerade från det levda livet i stort. Vi människor är i grunden del av större sociala, fysiska och kulturella helheter där hälsa och sjukdom har betydelser och konsekvenser både för oss själva och för andra. För att kunna bemöta personer utifrån en helhetssyn behöver vårdpersonal sammanföra och dra nytta av olika kunskapsformer och förmågor i sitt vardagliga arbete. De senaste åren har detta framhållits allt mer, i form av en önskvärd omställning mot det som ofta benämns som personcentrerad vård. Även om det redan finns forskning och modeller som beskriver teoretiska grunder och komponenter för att stödja omställningen mot personcentrering, så saknas det fortfarande kunskap om hur denna genomgripande förändring av vårdkultur kan omsättas och förstås i det vardagliga arbete som utförs av hälso- och sjukvårdens medarbetare. Så vad har berättande med detta att göra?

Forskning om berättande har utvecklats under decennier, spänner över flera olika forskningsfält och har lagt en teoretisk grund till att förstå berättandets funktion och betydelse för mänskligt meningsskapande. Baserat på det finns det teoretiska modeller för personcentrerad vård där berättande utgör en central del. Vissa modeller har patientberättelsen som utgångspunkt för såväl vårdplan som partnerskap mellan personen och vårdpersonalen. Andra förespråkar att vårdpersonal tar del av, och reflekterar över, litterära berättelser eller andra konstformer för att utveckla sin förmåga att empatiskt ta in och tolka patienters berättelser. Men är detta tillräckligt? Hur påverkar de vardagliga villkoren för vårdarbete möjligheten att låta patienters berättelser få inflytande i vården? Hur kan sådana berättelser systematiskt integreras och användas i vårdarbetet? Det saknas fortfarande kunskap om hur berättande kan komma till uttryck och användas som en praktisk resurs i vårdarbete. Syftet med den här avhandlingen är att bidra till en fördjupad kunskap och förståelse för hur berättande kan ta sig uttryck och utgöra en möjlig resurs för personcentrering och meningsskapande i dagligt arbete inom geriatrisk vård.

Avhandlingen består av fyra delarbeten. Den bygger på etnografiskt fältarbete på en geriatrisk vårdavdelning, fokusgruppsdiskussioner med medarbetare på avdelningen och teoretiska resurser från narrativ teori. Vårdavdelningens verksamhet omfattade sjukvård och rehabilitering för målgruppen äldre personer med flera samtidiga hälsoproblem eller med behov av stöd från andra för att klara sitt dagliga liv. Fältarbetet på avdelningen innebar deltagande observationer i det vardagliga vårdarbetet för att få insyn i arbetssätten, processerna, rutinerna och interaktionerna mellan personer på avdelningen, samt informella intervjuer med patienter och medarbetare på avdelningen. Data i form av fältanteckningar analyserades med en tolkande narrativ metod i syfte att förstå hur narrativt meningsskapande kunde ta sig uttryck i de vardagliga situationerna och aktiviteterna på avdelningen **(delarbete I)**. I fokusgrupperna fick medarbetare från de olika professionerna på avdelningen reflektera över sina erfarenheter från det kliniska arbetet, med utgångspunkt i vinjetter – korta berättelser som gestaltade vardagliga situationer på avdelningen. Data analyserades med en kvalitativ, konstant jämförande metod med syfte att förstå hur deltagarna använde berättande i sitt arbete och vilka möjliga funktioner det fyllde **(delarbete II & III)**. Slutligen analyserades de båda dataseten som en helhet med tolkande narrativ metod för att fördjupa förståelsen om medarbetarnas möjlighet att använda sig av berättande som en resurs i vårdarbetet **(delarbete IV)**.

Resultaten från studierna tyder på att det finns anledning att i högre grad använda berättande som resurs för personcentrering och meningsskapande i vårdarbete, utöver att enbart fokusera på patienters berättelser. Möjligheterna att låta patienters berättelser integreras i vården visade sig vara knutet till andra personers pågående berättande och narrativa meningsskapande. Detta tyder på att olika personers

berättelser och meningsskapande påverkas och omformas i ständig interaktion med andras berättelser. Genom att introducera begreppet *narrativa relationer* bidrar avhandlingen till att begreppsliggöra det ömsesidiga, pågående berättande som inkluderar flera olika personer.

Resultaten visar också hur vardagliga situationer och interaktioner i vårdarbetet på en geriatrisk avdelning ger möjlighet till narrativt meningsskapande där både patienter, medarbetare och andra kan mötas i ett samskapande berättande. Detta samspel uppstod ofta under gemensamma, vardagliga aktiviteter som inte sällan passerade som en obemärkt och trivial del av verksamheten på avdelningen och därmed inte gavs status som en erkänd del av arbetet. Situationer som exempelvis en gemensam fikastund, eller att gå och hämta ett par strumpor tillsammans med en patient visade sig öppna upp möjligheter för personal att få ytterligare pusselbitar för att öka sin förståelse för patientens behov, resurser, önskningar och förutsättningar. Detta kunde bidra till att skapa tryggare relationer mellan patienterna och vårdpersonalen och till att vägleda personalens handlande och bemötande.

Det samskapande berättandet i de narrativa relationerna skedde inte bara mellan patienter och vårdpersonal utan även vårdpersonal sinsemellan. I avhandlingen används metaforen av en teaterscen där interaktionerna mellan personal och patienter sker *på den kliniska scenen (clinic frontstage)*, medan personalens arbete som görs bortom de direkta interaktionerna med patienter sker *bakom kulisserna (clinic backstage)*. En stor del av arbetet på vårdavdelningen skedde bakom kulisserna. Samtidigt påverkade detta emellanåt dolda arbete vad som kunde ske i de direkta interaktionerna med patienter. När personal engagerade sig i narrativa relationer bakom kulisserna, kunde de bilda sig bättre uppfattningar om patienternas personliga situationer genom att sammanfoga olika berättelsefragment till en större helhet. Det här sättet att resonera narrativt kunde också bidra till att personal uppnådde en ökad förståelse för varandra över professionsgränserna genom att i berättandet ge och få insyn i varandras vardagliga erfarenheter, dilemman och villkor. Detta kunde i sin tur bidra till ökad samhörighet och förståelse för kollegorna som personer, och underlätta kollegialt och interprofessionellt stöd och lärande. Samtidigt belystes en risk att de narrativa relationerna kunde medföra spridning av negativa eller stereotypa förståelser eller vidmakthålla hierarkier och outtalade maktförhållanden, grundat i en omedvetenhet kring potentialen i de narrativa relationerna. Eftersom de narrativa relationerna ofta inte utgjorde en medveten eller erkänd del av arbetet utan tenderade ske som en osynliggjord praktik, pekar resultaten mot ett etiskt ansvar att skapa förutsättningar för reflektion och ökad medvetenhet kring vilka berättelser som får spridning i vårdarbetet, vilket kan innefatta såväl personliga som organisatoriska narrativ. Även då de narrativa relationerna verkade ha betydelse för att föra vidare en viss typ av kunskap och information som främjade

grundläggande kvaliteter och värden i vårdarbetet, så uppnådde förhållningssättet inte alltid status som en erkänd del av arbetet.

Sammantaget kan resultaten från avhandlingen utgöra argument för att om- och uppvärdera det vardagliga, osynliggjorda och relationella arbetet som värdefulla delar av vårdarbetet, vilka alltså snarare kan ses som potentiellt viktiga arenor för att realisera en personcentrad vårdkultur. Genom att skifta fokus från att se berättelser som färdiga produkter som patienter har och ombeds redogöra för i vården, till att istället förstå berättande som ett möjligt tolkande förhållningssätt som är ständigt tillgängligt att använda, erbjuder avhandlingen en utvecklad förståelse av berättandets potential i vardagligt vårdarbete. Här ingår ett ökat fokus på vårdpersonalens berättande som en väsentlig del av de narrativa relationerna, samt ett etiskt ansvar att reflektera över vilka berättelser som upprätthålls. Kunskapen kan utgöra en utgångspunkt för fortsatt forskning i syfte att utveckla arbetssätt som stödjer omställningen mot personcentrerad vårdkultur i praktiken.

# Abstract

Narrative approaches in healthcare have attracted a lot of academic attention, suggesting a strong potential in narrativity to help shift healthcare towards more compassionate and person-centred practices. Yet, there is still a need to better understand how narrativity might be understood, made relevant, and realized by healthcare staff in their everyday practices. Drawing on ethnographic fieldwork, healthcare professionals' practice-based experiences shared in focus groups discussions, and narrative theory, this thesis puts everyday healthcare practices at the centre of inquiry, with the overall aim to develop a deepened understanding of narrativity as a potential resource for person-centredness and meaning-making in inpatient geriatric care practice. This compilation thesis includes four academic papers, each contributing to illuminating different aspects of narrativity in everyday practices. The initial studies shaped the design of the latter, thus building cumulative knowledge pertaining to the overall aim. Drawing on ethnographic fieldwork, **Paper I** explores how narrative meaning-making takes place and unfolds on a geriatric ward and discusses that in relation to contextual conditions and person-centred care. The findings render a multifaceted portrayal of the relational and intersubjective character of narrative meaning-making in healthcare practices and show how mundane events and activities of everyday life on a ward were often undervalued in terms of offering opportunities for exploring and co-creating possible understanding of patient situations between them and staff. **Papers II & III** are based on a constructivist grounded theory methodology. Vignettes developed from the previous ethnographic fieldwork were used to prompt focus group discussions with healthcare professionals. **Paper II** explores healthcare professionals' experiences and reflections about the use of narration in their everyday work. The findings reflect narration as an ongoing practice of mutual narrative interchange between multiple narrators, including patients, significant others, and staff, and thus introduce the notion of engaging in *narrative relations*. Moreover, the findings suggest potential consequences for clinical practice of people's engagement in narrative relations. **Paper III** expands understanding about the notion of narrative relations by exploring how and where narrative relations are adopted and enacted in everyday practice on a geriatric ward. A main finding was the existence of a twofold practice whereby some activities and actions were generally approved as authorized tasks or routines, i.e. *acknowledged practice*, while other activities were not assigned this status, and thus took place as *underground practices*. Together with the concepts of clinical frontstage and backstage, the analysis constructed four distinct arenas for engaging in narrative relations. The findings discuss the transboundary function of narrative relations to interconnect these arenas and contribute to continuity in everyday practices. Finally, **Paper IV** explores conditions for engaging in narrative relations on a geriatric ward by delving into how healthcare staff interpret conditions for their practices. The findings from a hermeneutic analysis contribute to a deepening

understanding of how everyday healthcare practices unfold not only governed by predefined organizational conditions, but that these conditions are continuously interpreted by people, which affect how practices are enacted. Whilst some interpretations were aligned with attitudes and activities enhancing narrative relations, others simultaneously thwarted narrative relations by enacting task-orientation, division, and a focus on measurable biomedical or functional improvements and outcomes.

In summary, this thesis suggests a broadened understanding of narrativity that expands the focus beyond eliciting verbal narratives and coherent stories when aiming for fostering person-centredness, to entail a relational approach of continuously tapping into the ongoing narrative meaning-making that people – both staff and patients – engage in. This approach builds on the notion that multiple narratives continuously communicate through narrative relations. When consciously and ethically cultivated, staff practices of engaging in narrative relations may contribute to uphold foundational relational qualities in healthcare.

# List of scientific papers

I. Scholander, L. H., Vikström, S., Mondaca, M., & Josephsson, S. (2021). Stories under construction: Exploring meaning-making on a geriatric ward. *Journal of Aging Studies, 58*, 100940. doi.org/10.1016/j.jaging.2021.100940

II. Scholander, L. H., Boström, A-M, Josephsson, S., & Vikström, S. (2023). Engaging in narrative relations in everyday work on a geriatric ward: A qualitative study with healthcare professionals. *Journal of Clinical Nursing*, 32, 3954–3966. doi.org/10.1111/jocn.16480

III. Scholander, L. H., Boström, A.-M., Josephsson, S., & Vikström, S. (2023). Hidden or approved? Exploring arenas for narrative relations in geriatric care. [Manuscript submitted for publication].

IV. Scholander, L. H., Vikström, S., Boström, A.-M., & Josephsson, S. (2023). Inquiring into the conditions for engaging in narrative relations on a geriatric ward – how interpretation matters in everyday practices. [In manuscript].

# Contents

# List of abbreviations

| | |
|---|---|
| ADL | Activities of daily living |
| CGT | Constructivist grounded theory |
| GPCC | Gothenburg Centre for Person-centred Care |
| PCC | Person-centred care |
| PCP | Person-centred practice |

# Prologue

Shortly after I began my doctoral research in the field of geriatric care, I remember talking to my dad who said: "So you are now fulfilling what you set out to do at the age of nineteen." I did not understand what he meant, and he told me this story:

"I remember the day you came home from your summer job in the nursing home", he said. "You were truly affected by what you had experienced and so upset about how the staff appeared to be quite indifferent to older people they met, and perhaps mostly by the fact that they were not adequately supported by the organization to be able to do a better job. You said: 'I will commit myself to make sure you and mum will never have to experience that.'"

Although slightly embarrassed to recall this spur of youth pathos based on limited insight into the everyday realities of healthcare work, a piece of it admittedly persisted and made its way into this thesis. In hindsight, this experience of somewhat empty and desensitizing practices was significant to my growing interest in understanding everyday healthcare practices. This interest was augmented when I later started working as a physiotherapist, experiencing firsthand how different conditions may affect what relationships and practices become possible for healthcare professionals to engage in.

Through my own practice as a physiotherapist in primary and geriatric care, I have experienced how the complexity of healthcare work requires integration of a broad range of knowledge forms, methods, and skills, some of which may be better supported by healthcare organization and culture than others. For me, this complexity called for resources to help me manage the distress of not always being able to do what I believed in, or finding meaning in what I did. Without knowing it, this was when my interest in narrativity began. However, at that point, narrativity as a theoretical concept was not included in my professional vocabulary, which is probably still the case for many healthcare professionals. In similarity to my experiences, I have met participants during my research who have clearly been capable and innate users of narration for the purpose of everyday meaning-making. At the same time, I could identify with their confusion when being introduced to the theoretical realm of narrativity. Similarly, my first professional relation to narrativity was essentially a non-conceptualized, practical experience of absorbing stories of patients and colleagues, and of writing down or telling colleagues about my own clinical experiences as a means of interpreting and trying to make sense of the everyday complexities. Yet, not until my academic work did it occur to me that those activities were related to narrativity and meaning-making.

Basically, the events and situations calling for meaning-making are all found in everyday healthcare practices – the arena this thesis seeks to better understand. Since narrativity is still not a clearly identified or generally acknowledged resource in healthcare practice

and education, an important contribution of this thesis is that it offers insights into the opportunities and potential role of narration as a resource for meaning-making and person-centredness in everyday geriatric care. Moreover, the thesis also verbalizes some of the tacit knowledge and activities healthcare professionals often already engage in but don't always accredit as valuable parts of their work.

# 1 Introduction

This thesis is situated in a time when healthcare systems globally are facing challenges related to demographic development and population ageing, calling for a radical shift in how healthcare services are funded, managed, and delivered (World Health Organization, 2015a). One contemporary challenge, conspicuously displayed and gaining public awareness during the Covid-19 pandemic, is linked to competence provision, retention of staff, and work environment in healthcare (World Health Organization, 2016). The required shift towards person-centred and integrated healthcare requires that healthcare workers are adequately supported to implement the changes needed, and knowledgeable about what that shift could mean in practice. While person-centred practices are widely requested and acknowledged in contemporary healthcare discourse, there is a need for more knowledge about how person-centeredness can translate into everyday healthcare practices, and how different forms of knowledge can be integrated to realize holistic and meaningful healthcare practices for people (Karolinska Institutet, 2023).

Partly as a response to this development, partly as a movement on its own, narrative approaches in healthcare have attracted much academic attention, generally sharing the idea that a focus on narrative holds strong potential to help shift healthcare towards more person-centred, humane, and compassionate practices (Blix et al., 2019; Charon, 2001; Ekman et al., 2011). Research from a broad range of disciplines has enhanced our understanding of the role of narrativity in human life and theorized it as a key means for meaning-making and a resource for person-centredness. However, existing knowledge is not sufficient to explain the particularities of everyday practices, where existing frameworks and theories are to be realized, which is the arena to which this thesis seeks to contribute a better understanding.

In the growing yet heterogeneous population of older adults, person-centredness and narrative practices have been suggested as particularly valuable (Berendonk et al., 2017; World Health Organization, 2015b). Among people admitted to inpatient geriatric care, complex and multifaceted health issues are common, demanding that staff bring together various types of knowledge and skills to recognize the whole person (Welsh et al., 2014). Consequently, inpatient geriatric care is one specific area of healthcare that could benefit from a better understanding of how narrativity is recognized, made relevant and realized by staff in their everyday practices. However, there is limited research on how narrativity is expressed and understood in everyday inpatient geriatric care, as well as the conditions and opportunities for using narrativity as a resource within these settings.

To address these gaps, this thesis aims to explore the evolving processes of everyday practices in inpatient geriatric care to deepen the understanding of narrativity as a potential resource for person-centred healthcare practices.

# 2 Theoretical framework

This chapter accounts for the theoretical foundation underpinning the thesis and explains how I understand and use key terms.

Narrative approaches may pertain both to healthcare practices and to a field of research. Although this thesis is concerned with both, the theoretical underpinnings in narrative theory are consistently the same. However, based on the epistemological and methodological approaches of this thesis, and the emerging findings from earlier studies, the theoretical framework developed during the process. In the latter studies, my progressing understanding of narrativity in everyday practices made it pertinent to put a greater emphasis on the relations and transactions between individuals and their environment than I did in the early phase of the research process. Moreover, while making use of additional theoretical resources in the individual papers to discuss and develop the understanding about narrativity in everyday practices, I focus the theoretical framework specifically on central theoretical ideas and concepts used throughout the entire thesis.

## 2.1 Situating the thesis in narrative theory

As my background is in the practical field of healthcare, my first professional encounter with narrativity was experiential and practical, lacking adequate theoretical justifications. My interest in the activities of everyday practices has naturally shaped my understanding of narrativity and influenced my choices in terms of theory. Theories linking narrativity to human experience and action are central to my understanding and application of narrativity in this thesis, while narrative theories and methodologies concerned with, for instance, linguistic analyses of narratives in terms of structure or content, was never the focus. Instead, I have been particularly interested in narrative in relation to human meaning-making around everyday experiences and actions, and the function of the ongoing creation and interpretation of narratives in everyday practices. In relation to this interest, Ricoeur's writings on narrative, action and interpretation (1984; 1991a; 1991b) contributes with a philosophical foundation in hermeneutics, while scholars who have drawn on Ricoeur's philosophy to develop theory and methodologies tied to everyday healthcare practices have particularly influenced my methodological choices, including Mattingly (1998a), Alsaker et al. (2009; 2013) and Josephsson and Alsaker (2015). I have also found Kristensson Uggla's (1994) interpretation of Ricoeur's work valuable when chiselling out my theoretical position. Moreover, I draw on Bruner's (1986) writings on meaning-making and a narrative mode of thought. Together, these theoretical resources as elaborated below, support the assumption underpinning the thesis, i.e., that meaning is not something fixed, but people consistently engage in meaning-making processes tied to their experiences and actions.

### 2.1.1 Narrativity in human action and experience

A central element of the chosen theoretical resources that makes them relevant to studying everyday practices is the acknowledgement of a narrative structure of human action and experience. Actions, events, and experiences are fundamental in narratives (Mattingly, 1998a; Ricoeur, 1984, 1991b), which is easily recognized when trying to tell a story without any of those elements. Mattingly (1998a, p. 7) states that "stories are about someone trying to do something, and what happens to her and to others as a result", while also arguing that stories are not only verbal accounts presented in talk, but also "serve as an aesthetic and moral form underlying clinical action. That is, therapists and patients not only tell stories, sometimes they create story-like structures through their interactions" (1998a, p. 2). This quote highlights narratives as a means for the organization of action rather than for retrospective representation, shifting the focus away from narratives as finalized verbal accounts with a beginning, middle and end, towards open-ended narrative processes embedded in the actions of everyday lives. Hence, studying human action in the context of everyday situations and activities can give insight into how meaning-making takes place in people's everyday lives (Alsaker et al., 2009). Action, if understood as something that someone does, is always embedded in meanings (Ricoeur, 1984); actions have implicit or explicit motives, explaining why someone does or did something, and they are embedded in a shared social system of meaning. Actions originate from previous experiences and preunderstandings, and they have consequences. Hence, actions link past, present, and future in the same vein as narratives. A basic assumption in my theoretical position underpinned by Ricoeur's narrative theory is that people's narrative constructions are ongoing and developing in constant interchange with pre-existing systems of meaning (Kristensson Uggla, 1994; Ricoeur, 1984). In people's everyday lives, individuals' narratives are constantly evolving in communication with their surroundings and with other people as they mutually respond and react to their actions. Individuals continuously act, reason, and reshape their narrative understandings as a response to that. Consequently, individuals' understanding and action is always developing as a result of ongoing communication with their environment, as opposed to being an isolated or fixed condition preceding communication (Kristensson Uggla, 1994). This also means a shift towards understanding narrativity as something ongoing and forward-looking in human lives, instead of merely recollecting and organizing past events (Josephsson et al., 2006; Mattingly, 1998a).

Two interlinked concepts central to Ricoeur's narrative theory are *emplotment* and *mimesis*; emplotment takes a central position in my conceptualization of narrativity. These concepts can be traced back to Aristotle's concepts *mimesis* and *mythos*, the latter another word for *emplotment*. Emplotment refers to the action of organizing events in a plot (Ricoeur, 1984). While mimesis originally referred to imitation, Ricoeur advances the concept by developing a theory about a *threefold mimesis*, which more clearly presents the process character of the mimetic activity (Kristensson Uggla, 1994;

Ricoeur, 1984). Following Ricoeur's interpretation, Aristotle's mimesis concept should not be understood in terms of copy or identical replica, but as structuration rather than structure – an act of creation rather than reproduction. Moreover, action, rather than characters, is the object that mimesis imitates (Kristensson Uggla, 1994; Ricoeur, 1984). Mimesis and emplotment are thus interconnected in the sense that imitating is an activity because it produces something, namely the organization of events – the plot. Narrative is linked to emplotment since the narrative itself is the organization of the events.

When setting out to study narrativity in everyday practices, the notion of a threefold mimesis offered a useful theoretical underpinning to the study of situated processes and was particularly applied in the last study. The concept recognizes that any narrative activity requires a preunderstanding, or *prefiguration*, of everyday practices and the world of action – an already achieved insight regarding possible goals, motives, and meanings of actions, referred to by Ricoeur (1984) as *mimesis*$_1$. Shared social and cultural understandings, as well as previous experiences, shape this prefiguration and offer various materials for individuals to draw on in their creation of narratives. However, as mimesis$_1$ offers not only one possible meaning of an action, actions and narratives call for interpretation. The next phase of the threefold mimesis process, *mimesis*$_2$, is the configuration of a narrative, i.e., the creative activity of organizing separate actions, intentions, actors, etcetera into a coherent course of events by means of emplotment (Kristensson Uggla, 1994; Ricoeur, 1984). The emplotment creates meaning by putting those elements in relation to each other, not merely adding them one after another. This is, at the same time, an act of interpretation, as it is possible to create different plots from the same story elements. However, it also offers a means to explore new interpretative possibilities. Bruner (1986, p. 26) has referred to this as "trafficking in human possibilities rather than in settled certainties", using the term *subjunctivizing reality*. To resist ending up in a fixed product, the third phase of the mimesis process opens the narrative activity to ongoing refiguration, by the reception of the narrative in *mimesis*$_3$. If no one takes in the narrative, if it is not communicated and absorbed by someone, the process becomes inhibited and cannot be fulfilled (Kristensson Uggla, 1994). Mimesis$_3$, then, provides an opportunity to refigure mimesis$_1$ through mimesis$_2$. Someone takes in a narrative, shapes how that narrative is understood by refiguration in relation to their own preunderstandings. Still, the narrative simultaneously has capacity to shape and refigure the understanding of the one who takes in the narrative. Hence, there is a dialectic mediation in the process. This theoretical understanding has been important in my work to allow for a more dynamic understanding of narrativity when studying processes of everyday action.

### 2.1.2 Two modes of organizing reality

Bruner (1986) argued that there are two distinct modes of ordering human experiences and constructing reality. One is the paradigmatic mode, organizing experiences through categorization, classification, and conceptualization. The other is the narrative mode, locating human experiences and actions in time and space through a plot, thus opening for process reasoning. Although coming from the field of psychology, Bruner's project has been concerned with culture and meaning, locating the quest for meaning not merely in the human mind or in biological processes, but in culture (Bruner, 1990; Mattingly et al., 2008). In similarity with Ricoeur's viewpoint, Bruner argues that humans draw on already existing symbolic systems and preunderstandings embedded in culture in their meaning-making of everyday practices. So when Bruner writes about the two modes of thought, he refers to two modes of organizing reality, which are not processes restricted to human thought but in continuous communication with culture and social systems. However, for humans to be able to engage in such communication they need abilities in terms of a processual, narrative mode of thinking. The distinction between two modes of organizing experiences has been a useful theoretical lens for understanding different ways of reasoning in everyday practices.

## 2.2 Situating key terms

The key terms I use in this thesis may have different meanings in different contexts. In this section, I present definitions and conceptualizations that pertain to how I understand and use the key terms in this thesis.

### 2.2.1 Narrative, narrativity and narration

Narrative is a broad concept that can be understood differently in various academic traditions and there is not one generally accepted definition. My conceptualization of narrative is underpinned and shaped by a few different definitions and claims put forward by other scholars here accounted for. At the end of the section, I summarize my understanding of the key terms more concisely.

I generally use the terms *narrative* and *story*, as well as *narration* and *storytelling*, synonymously. This is essentially because the Swedish words, *berättelse (story, narrative)* and *berättande (storytelling, narration),* used in information material about the research and in conversations with participants, may refer to both. In Swedish, the terms *narrativ (narrative)* and *narrativitet (narrativity)* generally have somewhat theoretical connotations and are generally not used in everyday discourse.

Given that I situate the thesis theoretically as presented above, my conceptualization of narrative includes both verbal stories and non-verbal narratives embedded in action. Central in my conceptualization of narrative is the notion of *emplotment* – the organizations of the events or actions into a plot (Ricoeur, 1984). Ricoeur equates

narrative with emplotment and defines the operation of emplotment as "a synthesis of heterogeneous elements" (Ricoeur, 1991b, p. 21). This means that emplotment is the activity of drawing together a succession of events to a unity that is meaningful, as it shows how events are related and belong to a larger whole (Mattingly, 1998a). Also Polkinghorne highlights plot and action as central in his definition, declaring that in a story "events and actions are drawn together into an organized whole by means of a plot" (Polkinghorne, 1995, p. 7). Hence, emplotment may pertain to *big stories* such as life stories, novels, or even historic accounts, but also includes the *small stories* through which people create meaning around the matters of everyday life (Bamberg, 2006), which is at the centre of interest in this thesis. At the same time, it excludes the broadest understandings of narrative as any prosaic discourse, i.e., "any text that consists of complete sentences linked into a coherent and integrated statement" (Polkinghorne, 1995, p. 6).

To summarize my understanding of the basic features of what counts as narrative: narrative creates meaning of human action and experiences by configuring heterogeneous elements into a temporally meaningful whole by means of emplotment. Thus, narrative goes beyond reporting mere facts or information, but may make facts and information meaningful when configured into parts of a plot. Narrativity is an inherent quality in narrative, and refers to the extent to which something is characterized by emplotment. Narration refers to the activity of emplotment, whether in action or words.

### 2.2.2 Narrative-in-action

The concept of narrative-in-action is closely linked to the overall theoretical perspective of the thesis. It refers to a methodology and a theoretical resource articulated by Alsaker et al. (2009; 2013) yet grounded in Ricoeur's (1984; 1991b) narrative theory and Mattingly's (1998a) anthropological work. Aligned with these foundations, narrative-in-action refers to the notion that narrative meaning is embedded in everyday activities and actions; thus it is possible to study meaning-making by paying attention to everyday action and activities, and not only to verbal storytelling. When people engage in everyday activities, they create images which they connect to previous experiences and to future events (Alsaker et al., 2013). Thus, everyday actions are embedded in a narrative structure, while the enacted narrative is closely tied to the social and contextual circumstances. Actions arise from previous experiences and shared cultural or symbolic understandings, and they contribute to shape the imagined future.

### 2.2.3 Meaning and meaning-making

I refer to *meaning* and *meaning-making* in this thesis in a narrative sense; hence, it is closely interconnected to the concepts presented above. First, meaning is not

understood as a pre-existing product or phenomenon, but as an activity (Polkinghorne, 1988). Narrative creates meaning by connecting diachronic events into reasonable courses of events, thus creating relations between heterogeneous elements (Ricoeur, 1984). Narrative meaning is created by "noting that something is *part* of some whole and that something is the *cause* of something else" (Polkinghorne, 1988). When one event is linked to another, meaning is created out of an otherwise meaningless chronological order. When something happens *because of* something else, not just after something else, meaning is created around those events. In other words, meaning occurs when scattered events over time are connected by being interrelated through emplotment. A basic assumption is that people try to make sense of situations they are in by means of narrative. Narrative is the very means by which succession of events are ascribed with meaning, and, following Ricoeur's understanding of a threefold mimesis, this is an ongoing process that includes imaginative elements of the future, not only something that is done retrospectively. Moreover, narratives are selective and involve events that are somehow significant to the story someone is producing (Mattingly, 1998a). What people include and emphasize in their narratives says something about what they perceive as meaningful and significant. Paying attention to the events and actions made significant in people's narratives may offer insight into what people assign meaning to, which then allows for exploring meaning-making processes. However, as narratives always have several possible meanings, they call for interpretation (Kristensson Uggla, 1994; Ricoeur, 1984).

### 2.2.4 Everyday action, activities, practices, and situations

When using the terms *everyday activities* and *everyday practices*, I refer to the understanding presented by Alsaker et al. (2013, pp. 68-69) in terms of "the everyday doings of people in their local cultures, which includes both situational performance and the natural occurring conversations that take place in the context". This understanding implies that everyday life is an arena where cultural acts take place and where individuals' actions are situated in and continuously related to the cultural world, integrating individuals with and within their local culture. Hence, the term *action* denotes the intentionally based counterpart to behaviour (Bruner, 1990), while *situated action* refers to action that is "situated in a cultural setting, and in the mutually interacting intentional states of the participants" (Bruner, 1990, p. 19). This implies that action always takes place in a pre-existing cultural system of shared meanings and, consequently, action is interpretable. When using the term everyday *situations*, I understand it based on the argument put forward by Clarke et al. (2018), as a demarcation towards *context* as something separated from individuals, while *situations* instead implies a relational understanding of individuals as part of their context – an assumption consistent with the narrative-in-action theory.

### 2.2.5 Interpretation

Abandoning the view of narratives as fixed representations of underlying meaning and moving to an understanding of narratives as ongoing co-constructions which may have multiple meanings, requires an epistemic and methodological shift towards interpretation. Accordingly, the meanings that interpretation construct are not reproductions of some underlying, subjective meaning that could be disclosed, but should rather be recognized as one possible understanding, presuming an abundance of meaning in the interpreted text or action as an ontological condition for the interpretation (Kristensson Uggla, 1994; Ricoeur, 1991a). According to Josephsson and Alsaker (2015, p. 12) interpretation can be defined as "the assignment of possible meanings to situations or language". Interpretation involves inquiring into the conditions and context of the actions or statements that are to be interpreted, in order to gain insight into the origination for those actions or statements (Gustavsson, 2000b). Hence, interpretations take place by connecting someone's actions or statements to their everyday life and culture, to understand the action or statement in the light of that contextual situation (Alsaker et al., 2009). This understanding of interpretation is applicable both to the ongoing interpretation that people undertake in their everyday lives, and to interpretation as an analytical approach in qualitative research. In such hermeneutic approaches, interpretation refers to an iterative communicative movement between parts and whole, i.e., between the emerging interpretations and the material that the interpretations draw on (Josephsson & Alsaker, 2015), based on the main assumption in hermeneutics, namely that parts can only be understood if viewed in light of the whole (Alvesson & Sköldberg, 2017). How hermeneutics is applied as a research method is described further in chapter 5.

### 2.2.6 Person-centred practice

While referring to the concept of *person-centred care* (PCC) in the earlier papers of this thesis, my conceptual understanding has developed over time, and I have become more convinced of using term *person-centred practice* (PCP). My reasons align with what has been argued by McCormack et al. (2021): PCC privileges the personhood of the patient over that of the healthcare professionals, instead of being equally valued for all persons. Accordingly, my current understanding of PCP is reflected in their definition of person-centredness as "… an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development" (McCormack & McCance., 2016, p. 39). The emphasis on *all* relationships and not only on dyadic patient-professional relationships constitutes an important argument. So does the inclusion of practice and culture in the definition, coming from an intentional wish to

be inclusive to all healthcare professionals (McCormack & McCance., 2016). Moreover, this definition was developed from and deliberate attempt to move away from the discourse of *care* that may imply an understanding of something that is delivered to patients from staff, and instead to focus on culture, inclusive of all persons (McCormack et al., 2021).

# 3 Literature review

The following chapter gives an overview of previous research on narrativity in relation to healthcare practices. The ambition is not to make a complete review of this immense field but to provide sufficient background to the studies I have conducted. While chapter 2 provided a more specific positioning of the thesis in narrative theory, this overview is more inclusive to demonstrate the polysemy and conceptual breadth tied to narrativity in healthcare. Towards the end, this section also briefly explains the Swedish healthcare context, specifically narrowed down to inpatient geriatric care, which was the setting for the studies included in the thesis.

## 3.1 Why pay attention to narratives in healthcare?

Starting this literature review by contextualizing the thesis in the broadest sense, there are widely recognized challenges facing healthcare systems today. These are related to, yet not exclusively depending on, demographic development and population ageing, and include challenges in healthcare workforce provision (World Health Organization, 2015a; 2016). In recent decades, medical and technical advances have made it possible to treat diseases more effectively, which, together with overall societal development, enable people to live longer. A flipside of this progress is that healthcare has become more specialized and fragmented, and a growing number of people live with long-term health conditions (WHO, 2015a; Kristensson Uggla, 2014). As human beings, health or diagnoses are not something separate from our lives at large. We are rooted in physical, social, and cultural circumstances where health and disease have meanings and consequences for us and for others. If healthcare should systematically and ethically deal with all aspects of what it is to be a human suffering from health issues, fundamentally new approaches in terms of how healthcare is managed and delivered are required.

To meet the demands raised by this development, there is an ongoing, global movement on multiple levels towards radically changing healthcare systems typically built to handle acute diseases towards healthcare systems with capacity to handle the increase of long-term health conditions in an ageing population; systems organized around the health needs of people rather than around diseases (World Health Organization, 2015a). This shift requires that healthcare systematically acknowledges people as having a variation of needs and resources, and supports people to be participants in their own care rather than merely passive recipients (Nolte et al., 2020). Consequently, this requires changes in how everyday healthcare practices are organized and delivered, in the roles and relationships between people needing healthcare and healthcare professionals, and ultimately a shift in the care cultures of organizations where healthcare takes place (McCormack & McCance., 2016). The term person-centredness is often used to describe this approach. However, while the notion of PCC has been

around for more than a decade now, changing healthcare culture and ways of working toward systematically enacting PCP, instead of occasionally attaining person-centred moments, has proved a complex and tenacious endeavour, necessitating person-centredness values to pervade all levels of healthcare systems (McCormack et al., 2021). Refocusing professionals' ways of working from longstanding, medically oriented and task-driven practices, towards emphasizing and integrating other forms of knowledge essential for holistic, meaningful, and person-centred practices, caring for people in the context of their life situations, requires resources that support acknowledgement and integration of different types of knowledge, including the experiential knowledge from people's lives (Kristensson Uggla, 2022; Naldemirci et al., 2021). This is where narrativity comes in as a potential resource.

## 3.2 Approaching narratives in healthcare practices – what is already known?

For some decades, there has been an increasing number of studies sharing the overall idea that a focus on narratives holds strong potential to help shift healthcare towards more compassionate and person-centred practices. Some researchers have even suggested an understanding of care to be of a narrative nature (Berendonk et al., 2017). However, the scientific literature presents a variation of terms regarding narratives and narrativity in healthcare. A few examples are narrative medicine, narrative-based approaches, narrative care, and narrative practices, all with somewhat different meanings and sometimes unclear definitions. As this review aims to give a wide-ranging overview of the field, it avoids any deeper conceptual analysis of these different terms. Moreover, although I mainly use the term 'healthcare' in this thesis, studies in the narrative field sometimes refer to healthcare practices as 'medicine', especially the earlier studies, while others refer to 'care'. This dissimilar use of terms is often based on professional perspectives where research relating to the practices of physicians is commonly referred to as medicine, while research referring to nursing practices more often refers to care or nursing. For the purposes of this overview, I deliberately take an inclusive stance, and aim to give a broad and general background regarding the turn towards narrativity in healthcare practices over time. However, the multiple terms and meanings make visible the need for research contributing to a better understanding of how narrativity can contribute as a practical resource in everyday practices.

### 3.2.1 Narrativity in human experience and meaning-making

The idea of narrativity as something deeply human is far from new. Humans' creation of meaning around their experiences has been conceptualized by several scholars as a fundamentally narrative endeavour (Polkinghorne, 1988; Ricoeur, 1984, 1991b). Humans create stories to bestow meaning to their experiences of themselves and of the world they live in. Broader cultural narratives suggest how life should be lived, what is good or

bad, forbidden or permitted, and through those shared stories people create their cultural, national, and organizational identities (Spector-Mersel, 2010). By creating and sharing narratives, people interpret past and present experiences, and shape the imagined futures by connecting different experiences into meaningful wholes (Mattingly, 1998a; Polkinghorne, 1988). Considering this power of narratives, it is easy to understand why they have gained so much attention as a subject for research, and why various methods for inquiring into narratives have been developed.

A broad range of academic disciplines have taken an interest in the study of narrativity, beginning as early as with Aristotle. However, the epistemological shift, often called 'the narrative turn' in humanistic and social sciences, emerged somewhere in the late half of the 20th century, as researchers from a broad range of disciplines increasingly attended to narrative-based approaches to gain insights into social phenomena (Sarah, 2013). Although narratives had previously been studied by literary scholars, narrativity now gradually became a field of inquiry in its own right, based on assumptions that narratives, and how individuals relate to them, play an important role in how they understand themselves and their experiences of the world (Hyvärinen, 2010). These ideas challenged the positivist modes of inquiry and the realist epistemology that had become dominant in research at that time; the development of narrative theory and methods appeared broadly across the social and humanistic disciplines (Riessman, 2008). Since then, narrativity in various ways has been studied in anthropology, gerontology, psychology, narratology, linguistics, philosophy, sociology, healthcare sciences and more. Today, the concept is also frequently referred to in popular discourse. Evidently, too much has been written to enable a full account of the narrative field, and there is not one generally accepted definition of the concept. Hence, the intention with this review is not to cover every aspect of narrativity, but to locate the position of this thesis within this vast field. The research I present in this thesis is restricted to narrativity in the realms of human meaning-making, interpretation, and everyday action, thus demarcating it from other structure-oriented interests in narrative, such as in linguistics or narratology.

### 3.2.2 The narrative turn in medicine and healthcare sciences

At the time of the narrative turn, scholars also took an interest in the role and meanings of narratives in relation to medicine, illness, and human suffering (Riessman, 2008). Hence, there has been a widespread academic interest over the decades in illness narratives, and in the relationship between narratives and illness (Hydén, 1997). Simultaneously, the successful scientific progression in terms of medical and technical development has informed healthcare practices strongly towards focusing on diagnoses and biomedical issues, whereas the experiential and subjective aspects of illness have often been set aside (Kristensson Uggla, 2014). As facing illness has been conceptualized as a biographical disruption (Bury, 1982), narratives are put forward as a human means

for creating new coherence and meaning when experiencing such disruptions of narrative continuity in life (Frank, 1995). As argued by Frank (1995), this understanding has ethical implications for everyone who engages with people facing illness, implying a responsibility among healthcare professionals, family members and society to pay attention to and validate the stories people tell in order to create new meanings around their illness experiences.

Scholars have, in various ways over the years, theorized healthcare practices as twofold, dealing with two types of knowledge, cultures, or discourse, and discussed the tensions occurring when such contrasting aspects are brought together in healthcare encounters. For instance, Mishler *(1984)* distinguished between two different 'voices' present in medical encounters: *the voice of medicine*, representing professionals' scientific, medical discourse and *the voice of the lifeworld*, representing patients' experiences of illness and the consequences on their lives, often expressed by means of narrative. In a similar vein, Kleinman (1988) distinguished between illness and disease, where illness refers to the subjective experiences and meanings related to the symptoms or suffering, whilst disease refers to the biomedical or functional problem. To get insights into the meanings of illness, Kleinman argued for the need to pay attention to the narratives people use to make sense of their illness experiences. Similar distinctions have been suggested in relation to other healthcare disciplines, such as occupational therapy, where the notion of a two-body practice was presented by Mattingly and Fleming (1994), referring to the position of occupational therapy as a profession between two cultures, dealing not only with biomedical problems but also social, cultural, and psychological issues that concern the meaning of illness. According to these authors, storytelling and narrative forms of reasoning are crucial for making sense of the experiences that healthcare professionals deal with in their everyday practice, and for helping to create strategies for clinical actions, treatment plans and relationships (Mattingly, 1991; Mattingly, 1998a; Mattingly & Fleming, 1994). However, ideas about narrative approaches in healthcare have not been unchallenged, and conceptions of narrative have been discussed both as too broad and too narrow (Walker et al., 2020). In terms of being too broad, narrative has been questioned since it may refer to most anything related to subjective meaning and experience, while in terms of being too narrow, concerns have been raised around that if narratives promote some ways of interpreting human experience over others, they risk inhibiting other possible forms of self-understanding or experiences (Walker et al., 2020). Strawson (2004) has extended this as far as saying that there are deeply non-narrative humans who do not view themselves or their lives in terms of narrative, while Woods (2011) argues that although narrativity may play an important role in human self-understanding, illness experiences and healthcare, it might not be the only possible form, hence diversity of perspectives should be thoughtfully preserved.

Despite the two dimensions of healthcare practice having been discussed for decades, the challenge of unifying diverse aspects and forms of knowledge remains in everyday healthcare practices of today (Kristensson Uggla, 2014). The following sections present more recent attempts, where narrativity holds a central position, to deal with this challenge.

### 3.2.3 Narrativity and person-centred practices

As the notion of PCC has become increasingly acknowledged in contemporary healthcare discourse, one stream of research on PCC has turned particularly towards the role of narrativity in person-centred practices. This section mainly reviews how narrativity has been used and theorized in relation to PCC, and presents frameworks for PCC that more specifically emphasize narrativity as a key feature. I will exemplify a few frameworks, demonstrating a range of applications in the field. However, there are other studies that link narrativity to PCC to some extent, yet not all will be reported in the scope of this review.

Aspiring to PCC challenges traditional ideas of how healthcare should be practiced, which often is expressed in task-oriented and diagnosis-centred practices, or medical labelling of people instead of seeing the whole person in their bigger context (McCormack et al., 2021). As concluded in a synthesis of review studies looking into the concepts of person- and patient-centred care (Håkansson Eklund et al., 2019), there is a considerable overlap between these concepts. However, the authors suggest that the concepts differ fundamentally in their goals: while patient-centred care strives towards a functional life, person-centred care aims for a meaningful life. This focus on the relation between PCC and meaning may be connected to the idea of human meaning-making as a health resource (Knizek et al., 2021), which is one aspect contributing to justify the focus on narrativity due to its meaning-making function.

However, the attention paid to narrativity in relation to PCC theory varies. Some frameworks place narrativity at its very centre (e.g. Buckley et al., 2014; Ekman et al., 2011), while other sources do not explicitly attach any importance to it (e.g. McCormack & McCance, 2016; Santana et al., 2018; American Geriatrics Society Expert Panel on Person-Centered Care, 2016).

#### *3.2.3.1 The GPCC-framework*

In a Swedish context, the connection between PCC and narrativity has been acknowledged due to a framework developed at the Centre for Person-Centred Care (GPCC) at Gothenburg university (Ekman et al., 2011), which has been influential in the Swedish discourse around PCC. The GPCC-framework highlights elicitation of patient narratives as a key practice (Britten et al., 2020; Ekman et al., 2011). Narratives are emphasized as crucial to redirect attention from the physiological perspective of the

patient to the person situated in a weave of relations and experiences (Kristensson Uggla, 2014). The model offers a practical guideline for practicing PCC as it contains three routines to "initiate, integrate and safeguard PCC in daily clinical practice" (Ekman et al., 2011, p. 250), where the patient narrative holds a central position as a prerequisite for PCC. The first routine is based on elicitation of the patient narrative, aiming to initiate a partnership. The second aims to develop the partnership and create a common understanding of the patient's situation by sharing information and decision-making regarding care plan and goals. The third routine serves to document the narrative, including patient preferences, beliefs, values, and the commonly-agreed care plan. Several studies have shown a broad range of positive outcomes from implementing the model in various care contexts (Britten et al., 2020). Its influence is noticeable in documents and guidelines published by the healthcare professional associations, e.g. The Swedish Society of Nursing, The Swedish Society of Medicine & The Swedish Association of Clinical Dietitians (2019)[1] and The Swedish Association of Health Professionals (2020)[2], where eliciting patient narratives is highlighted as a prerequisite for PCC in practice. However, that does not necessarily mean that it has been implemented in healthcare practices more broadly.

Although partnership is central in this framework, one possible limitation is that the focus lies mainly on *patient* narratives, and the framework does not pay any particular attention to other narratives that may influence the partnership, or staff competency in terms of engaging with patients' narratives. The use of narrative may risk being understood as quite instrumental when restricted to the patient narrative, not taking other beneficial aspects of narratives and narration into account. Moreover, as argued by Naldemirci et al. (2018) it builds on an assumption that all persons are capable and willing to provide a verbal narrative to share with healthcare professionals, thus neglecting both non-verbal forms of narratives and other actors who could contribute to the narrative. Additionally, Naldemirci et al. (2020, p. 245) have suggested that "narrative elicitation is neither a simple transition from traditional medical history taking nor a type of structured interview". Hence, it takes skills and strategies to succeed in narrative elicitation, but due to different settings, situations, and contexts there might not be a set of strategies that always work.

Lastly, as concluded by Britten et al. (2017), who have studied professionals' understanding of the routines as they implement the GPCC framework in practice, healthcare staff are governed by different logics in their everyday work. The conflict between logics of, for instance, medicine, economic management and PCC, might make it burdensome to implement a change towards a practice that is able to cherish the

[1] Svensk sjuksköterskeförening, Svenska läkaresällskapet & Dietisternas riksförbund
[2] Vårdförbundet

manifold particularities of individual experiences embedded in personal narratives. To enable that would require a shift in clinical mindset and care culture, which is as important as the clinical routines. Similarly, McCormack & McCance (2016) have called attention to a need to focus more on person-centred *culture* rather that the frequent focus on *care* in strategies and frameworks.

#### *3.2.3.2 The Framework of Narrative Practice*

The Framework of Narrative Practice (Buckley et al., 2014) provides a broader understanding of how a narrative-based approach to practice might be useful for obtaining person-centred practices. The framework was created in residential care settings for older persons and integrates elements of the *Person-centred Nursing Framework* developed by McCormack and McCance (2006) which in its original form had no explicit link to narrative theory. Buckley et al. (2014) note that since narrative understanding deals with meaning, contexts, and perspectives it has similarities with the antecedent framework, which also allowed for these aspects. However, before the development of the Framework of Narrative Practice the relationship between the Person-centred Nursing Framework and narrative was not explicit.

In short, the Framework of Narrative Practice consists of two main components (Buckley et al., 2014). The first component includes the "pillars", i.e., the foundational underpinnings of the framework including a pillar labelled *narrative aspects of care*. This component could be understood as recognizing both the meso- and micro-level, focusing as well on prerequisites and attributes of the staff as the need for supportive organizational systems or culture development. The pillar about narrative emphasizes the use of knowing the biographical details or life history of the patient and to incorporate it into the care plan, thereby showing similarities with the GPCC-framework, but also adding the benefits of knowing oneself as a healthcare professional.

The second component contains the operational elements, i.e. aspects of the framework's implementation in practice, which includes three interlinked elements of narrativity, namely *narrative being, narrative knowing* and *narrative doing*. In short, *narrative being* refers to existential aspects of always acknowledging and interpreting persons and their activities as parts of the larger context in which they exist, including the past, the present, and the possible future. *Narrative knowing* is described as a mode of perceiving and understanding a person's narrative and identity, taking into consideration both salient aspects of their present story while also acknowledging how this is rooted in the past and how it shapes the creation of future stories. *Narrative doing* is about safeguarding that activities are meaningful for individuals, that activities have a purpose and leads to relevant outcomes. While this part gives more nuances to the different aspects of narrative beyond just recalling biographical information, it is not fully apparent how the framework might be translated into everyday healthcare practices.

However, a subsequent study using action research methodology have provided more situated insights into how the framework might be understood and used in a residential care setting (Buckley et al., 2018).

#### *3.2.3.3 Life Story work*

*Life story work* is an intervention mainly used in long term care settings and involves recording a biographical account of a person's past and present life, aiming to inform the care they receive and helping healthcare staff to better understand the person beyond their diagnosis (McKeown et al., 2006; McKeown et al., 2010; McKinney, 2017). The intervention often results in a life story document or a book which may also include photos. The making of this document can include both the person, significant others, and staff. Life story work has been suggested to have the potential to enhance PCC in long-term care facilities (Doran et al, 2019) and when used with people with dementia it may contribute to 'maintenance of the person with dementia as a whole person rather than a demented patient' (Grondahl et al., 2017, p. 4). Studies on life story work report mostly positive effects for both patients, family members and staff regarding outcomes ranging from individual benefits on psychological well-bring and empowerment, to improved relationships between the person and staff, or between staff and family members (Parker et al., 2020). However, the number of high-quality studies is limited (Grondahl et al., 2017). Moreover, the positive outcomes depend on the time and resources available for staff to engage in this activity together with families and residents, and staff need education and training before engaging in life story work (Doran et al., 2019). A recognized risk is that the life story document becomes a onetime task resulting in a product that does not fulfil its purpose to be integrated in care practices (McKinney, 2017).

### 3.2.4 Narrative and hermeneutical competence among healthcare professionals

Another area of research is particularly concerned with how narrative forms of knowledge may be valuable for healthcare professionals in their work, and consequently potentially beneficial for the people they meet as patients in their practice. Acting from such knowledge is assumed to contribute to creating a more compassionate and person-centred healthcare culture overall. Ultimately, for patient narratives to be useful in practice, professionals must have the competencies and sensitivity to engage with them.

The field of narrative medicine emerged at the beginning of the century in the United States as a reaction to biomedically oriented, fragmented and reductionist medical practices, and places narrativity at the centre of clinical practice (Charon, 2001; Charon et al., 2016). It builds on a foundation encompassing several academic disciplines, such as literary theory, philosophy, narratology, aesthetic theory, and cultural studies. Narrative medicine could be used as an educational intervention offering a consistent

and replicable set of pedagogical strategies and tools (Milota et al., 2019). By means of reading, reflective writing and sharing with others about experiences of art and literature, the intention is to help healthcare professionals widening the clinical gaze; becoming more reflective in terms of the meanings of others' stories, as well as their own emotions and actions; and appreciating the relational aspects of practice (Charon et al., 2016). Studies evaluating participation in narrative medicine programmes shows high participant satisfaction and positive outcomes on various competencies e.g. relationship-building, empathy, confidence, and pedagogical and clinical skills (Remein et al., 2020). However, whilst research suggests that narrative medicine offers effective pedagogical tools for developing competencies among healthcare professionals (Milota et al., 2019), fewer studies evaluate whether narrative medicine training leads to compassionate care in clinical encounters (Barber & Moreno-Leguizamon, 2017), or the effects on patients' experiences of illness, although some positive outcomes in terms of patient well-being related to illness has been shown (Fioretti et al., 2016). Moreover, narrative medicine has been criticized for overlooking other non-narrative forms of human experience and art forms, and some philosophers have questioned the underlying idea that meaning in human experience and self-understanding is reached by means of narrative (Ahlzen, 2019; Morrison, 2023; Strawson, 2004). Still, narrative medicine may include non-narrative art forms such as reflecting on poetry or visual art and referring to aesthetic experiences more broadly (Charon et al., 2016). This contributes to a vagueness about how competencies referred to as narrative are linked to non-narrative experiences in narrative medicine training.

In narrative medicine, the term *narrative competence* is often used for the notion of professionals' skills in interpreting and engaging with the meanings of patients' stories as well as with their own processes of meaning-making relating to their practice (Charon, 2001; Charon et al., 2016). A similar concept is 'existential literacy', referring to healthcare professionals' sensitivity to the existential aspects and meanings tied to human life and suffering when caring for patients in life-decisive phases (Arman et al., 2013). Here, patients' narratives are seen as much more than just verbal narratives. Thus, various manifestations and signs that can be expressed and 'read' also in bodily interactions and caring situations require the professional to put their own presuppositions aside. Another related concept is *hermeneutic competence*, which has been suggested to support PCC practices in residential care settings (Vrerink et al., 2022). This concept entails abilities to respectfully explore and interpret the meanings of people's stories, expressions, or doings instead of merely focusing on facts and tasks.

### 3.2.5 Narrativity and everyday action

Another stream of research has attended to narrativity as something that goes beyond merely verbal accounts by considering the narrative structure of action and

experiences. The theoretical underpinnings for this have already been more thoroughly described in section 2.1.1.

Shifting the focus towards enacted narratives offers new opportunities to obtain insights into the meanings embedded in everyday healthcare practices (Josephsson et al., 2022), while also requiring other research methodologies to enable insights into how meaning is created in the ongoing stream of everyday action (Alsaker et al., 2009).

In relation to healthcare practices, this conceptualization of narrative plays a significant role. Mattingly (1998a) showed how occupational therapists interacted with their patients in the form of enacted narratives or unfolding drama, where the clinical actions were embedded in relation to people's past, the current circumstances for why they may have sought healthcare, and images of what they desired or were moving towards in the future. By creating story-like structures through the interaction between patients and healthcare professionals, the clinical actions become meaningful as part of a greater whole that is the person's life context (Mattingly, 1991). A person's illness experience is not an isolated phenomenon, but part of a larger context, thus likely affecting other people such as family members or friends. If this is not recognized in the unfolding clinical story-making, healthcare activities are more likely to be perceived by the patient as meaningless.

Other researchers, primarily in the field of occupational science and occupational therapy, have developed new research methodologies to enable insights into enacted narratives in everyday life (Alsaker et al., 2009; 2013) while others have studied meaning-making in everyday activities in various contexts (e.g. Alsaker and Josephsson, 2010; Alsaker & Ulfseth, 2017; Reed et al., 2018; 2020). These studies provide situated insights into how processes of meaning-making are closely linked to everyday action for people with chronic conditions (Alsaker & Josephsson, 2010), how relationships and collective activities have potential to support meaning-making and mental health recovery (Reed et al., 2018, 2020), and how staff engagement in narrative imagination with patients can change the way situations are interpreted and enact new possible stories (Alsaker & Ulfseth, 2017). Altogether, these studies point at the potential of everyday activities and relations as an important arena for PCP to evolve.

However, when narrativity linked to everyday action is considered in the light of the previous section about hermeneutical competence among professionals, questions emerge about how such competencies are connected to and enacted in everyday actions of their practice. If interpretative skills are foundational for what people actually do in healthcare, whether consciously or intuitively, there is a need to better understand how interpretation and meaning-making takes place and unfolds in relation to everyday actions in healthcare. Hence, although the connection between narrative and action is theoretically well-founded, several questions remain about how to understand the

relation between narrativity and the activities and interactions people undertake in everyday healthcare practices.

### 3.2.6 Research on narrative care for older adults

Older adults have been described as a priority target group for whom PCC and narrative practices may be particularly valuable (Berendonk et al., 2017; World Health Organization, 2015b), partly due to the often increasingly complex health needs in older age, partly due to the variable health status, needs and resources among people in this population. While some older people have excellent health and function, others experience multiple health issues and need extensive help from others. Nevertheless, attitudes and assumptions about older people based on outdated stereotypes are persistent (World Health Organization, 2015b).

Research specifically focusing on narrativity in care for older adults is often underpinned by assumptions from narrative gerontology, according to which human lives are conceptualized as storied (Kenyon & Randall, 1999), i.e. individuals give meaning to their lives through narrative. A central assumption in narrative gerontology is that narrative meaning-making and identity formation is ongoing throughout our whole lives, which have implications for healthcare for people in later life (Berendonk et al., 2017). Moreover, previous research has suggested that dominant understandings about aging and the current structures of care settings construct beliefs about storied meaning-making as ending in later life, which systematically obstructs possibilities for narrative development for older adults (Bohlmeijer et al., 2011). This has been referred to as 'narrative foreclosure' which is defined as 'the conviction that no new experiences, interpretations, and commitments are possible that can substantially change one's life-story and the meaning of one's life as it is told now' (Bohlmeijer et al., 2011, p. 367). In similarity with Frank's (1995) argument about the ethical implication following the recognition of narrative disruptions caused by illness, this makes up the argument that quality care for older adults must involve narrative practices where older people's narrative identities are acknowledged and supported in care practices. Since significant life events such as illness, moving to a residential home or loss of life companions are more prevalent in later life and may present disruptions in life stories and challenge narrative identity (Villar & Serrat, 2017), maintaining engagement with older people's narrative development and meaning-making is especially important.

Most research on narrativity in relation to care for older people has been conducted in long term care settings. A less investigated healthcare setting in terms of narrativity is short term inpatient geriatric care, a field where it is particularly important to integrate different forms of knowledge and skills (Åberg & Ehrenberg, 2017). In addition to specialist competence in geriatric care and medicine, and skills in how to encounter people with complex health needs, professionals working in these settings must be able

to work efficiently in interprofessional teams including collaboration with external health- and social care services, and engagement with individual's meaning-making related to illness and ageing is often pressured by restricted timespans. However, as noted by Clark (2015), health- and social care professionals often have been socialized into different profession-specific ways of approaching patients and their stories, and they have different understandings of older people's needs in healthcare, which makes it crucial to appreciate and integrate different views, thereby contributing to a more multifaceted understanding of the individual person. That would require insights by professionals in the different narratives they create and means for putting together the different professional understandings with the patient's own views to a co-constructed narrative where no professional version becomes systematically dominant. Little is still known about the everyday conditions and context for teams to engage in such practices in inpatient geriatric care.

## 3.3 The Swedish healthcare context

The research presented in this thesis is conducted in the context of inpatient geriatric care in Sweden, which is here described to give a background to the empirical studies in the thesis, as healthcare for older adults may be understood and organized differently in other parts of the world.

Sweden has a universal yet decentralized health- and social care system (Socialstyrelsen, 2023), where 21 regions and 290 municipalities are responsible for managing and providing health and social care (Sveriges Kommuner och regioner, 2023). While regulated by national legislation, regions and municipalities have far-reaching constitutional rights of local self-government, limiting the mandate of the national government to direct their organization or goals (Janlöv et al., 2023), although recently the current government has appointed a commission to investigate changes in responsible authority towards increased centralized governance (Dir. 2023:73). The regions are responsible for most of the primary care services and specialized healthcare, including inpatient geriatric care, while municipalities provide home and social care, including residential care for older people. Health and social care are mainly publicly financed and accessible to citizens based on assessments of people's needs rather than financial capacity (Janlöv et al., 2023), yet services can be delivered both by public providers and private companies under contract with the regions or municipalities (Socialstyrelsen, 2023). Recent years have seen an ongoing reform of the Swedish healthcare system towards *Good quality, local health care*[3] – a more sustainable, integrated and person-centred healthcare system, aiming to be accessible, coherent and proximate to people. This broad-based reform, based on the investigation

[3] In Swedish: God och nära vård

*Coordinated development for good quality, local health care* (SOU 2020:19), aims for a new way of managing and conducting healthcare, where primary care attains a strengthened position and a broadened responsibility as the hub for healthcare. Yet, different levels of healthcare and divided responsibilities will remain, requiring structures and resources for continuous collaboration and coordination between healthcare professionals and service providers. For older people with multiple care needs, this may become especially pertinent.

### 3.3.1 Inpatient geriatric care

Older people admitted to inpatient geriatric care often have multiple and complex health issues, requiring a holistic perspective and specific competence regarding the needs of this patient group (Ellis et al., 2011). Approximately half of all hospital inpatients aged ≥65 years have been reported as frail[4], and approximately another 25% as pre-frail (Doody et al., 2022). The complex health states commonly known as geriatric syndromes do not fall into distinct disease categories and necessitates healthcare that is specialized in facing these complex and multidimensional problems (World Health Organization, 2015b). For older people with multimorbidity, a multiperspective view of health and social care management is important to prevent fragmentation of care services, which involves components on various levels including political steering, leadership, and interorganizational cooperation, but also including the level of competence among all professionals involved (Meranius & Josefsson, 2017).

In Sweden, geriatric medicine is a hospital specialty offering specialized care for older people requiring this competency (Svensk Geriatrisk Förening, 2023). As the often-complex health situations of people in need of inpatient geriatric care require interprofessional teamwork and coordination of follow-up care with other healthcare providers upon discharge, the shared responsibilities between regions and municipalities have rendered enduring challenges to the integration of different levels of care in the Swedish healthcare context (Spangler et al., 2023). In 2018, Sweden adopted the *Law (2017:616) on coordination upon discharge from in-patient healthcare* (SFS 2017:612) to increase the degree of care integration between regional health services and municipal social services. Recent analyses indicate that this has resulted in reduced length-of-stay for discharge-ready patients, while showing less impact on post-discharge outcomes, such as lowered re-admissions or increased post-discharge care planning (Spangler et al., 2023). Although it is essential with supportive structures and incentives for integrated healthcare services, an important aspect is related to

[4] The authors defined frailty as 'a state of increased vulnerability, resulting from age-associated declines in reserve and function across multiple physiologic systems such that the ability to cope with every day or acute stressors is compromised' (Doody et al., 2022).

healthcare professionals' everyday resources to carry through changes to fulfil new requirements, such as engaging in effective interprofessional teamwork as well as cooperating with other service providers. In relation to inpatient geriatric care, there is still a limited number of studies on interprofessional teamwork, collaboration, or changes in care culture in this specific setting. The few studies found investigate, for instance, characteristics of importance for the quality of inpatient geriatric care from an interdisciplinary team perspective (Åberg & Ehrenberg, 2017), suggesting interactive assessment processes, a holistic care approach, and proactive non-hierarchical interaction to be important factors. Another study investigated the relation between self-assessed interprofessional teamwork, quality of care and turnover in acute geriatric care units and found an association between quality of the teamwork and quality of care (Piers et al., 2019). To the best of my knowledge, only one study related to narrative practices in inpatient geriatric has previously been conducted, using life story work as an educational intervention to enhance PCC competency among healthcare trainees from various professions (Nathan et al., 2022). Hence, the limited number of studies merits more research to better understand the everyday particularities for healthcare teams and patients in these settings, which is important to support development of inpatient geriatric care services with a capacity to realize values such as dignity, participation, and continuous learning in everyday practices.

## 3.4 Summary and rationale for the thesis

Person-centred and integrated health services are increasingly requested as demographic development, including population ageing and expansion, requires a radical shift in how healthcare services are funded, managed, and delivered (World Health Organization, 2015a). As part of realizing this shift, healthcare workers must be knowledgeable about what the shift means in practice and adequately supported to carry through these changes. Today, there is still a lack of knowledge about how person-centeredness can translate to systematically permeate everyday healthcare practices, and how different forms of knowledge can be integrated in practice to actualize holistic and meaningful healthcare for people in different settings. However, previous research has come up with several arguments for the potential of narrative approaches to obtain person-centred and holistic healthcare practices.

At a time when it is increasingly stressed that if PCP is to be systematically realized, person-centredness must influence all relationships and levels of healthcare (McCormack et al., 2021), questions arise whether there might be more to gain from narrativity in healthcare practices when striving for transforming practices towards person-centredness including *all* persons. Today there is limited research addressing how narrative practices evolve in the context of everyday healthcare practices. To better understand the particularities of such everyday practices where existing frameworks and theories are to be realized, more research involving practice-based

experiences of healthcare professionals is needed. In terms of PCP, Liberati et al. (2015) have suggested that studies focusing exclusively on the individual or dyadic level of healthcare may obscure the awareness of a bigger picture, while organizational studies on a meso or macro level might risk missing the specificities and perspectives of patients and professionals in their local contexts. None of these approaches fully seize the interaction of practices and relationships that make up patients' and professionals' everyday experiences within healthcare, which would require methods engaging with everyday practices. The same argument may be used when studying narrative practices. Focusing only on individual level narratives may obscure the awareness of how the organization supports or thwarts narrative practices, and organizational studies might risk missing the specificities and perspectives of patients and professionals in their local contexts. Addressing the potentially problematic division between individual level and organizational level research, Liberati et al. (2015) have suggested that a practice-based research approach that encourages close examination of mundane, everyday working practices, may offer a useful methodological approach to generate knowledge of everyday interaction and practices.

While most research on narrative approaches in healthcare for older adults has been conducted in long-term care settings, the specific conditions of inpatient geriatric care are less explored. There is a shortage of studies on narrativity putting engagement with the everyday healthcare practices at the centre of inquiry in these settings. To address the above-mentioned gaps, this thesis aims to explore narrativity in the evolving processes of everyday practices in inpatient geriatric care, with the ambition to deepen the understanding of narrativity as a potential resource for person-centred healthcare practices.

# 4 Research aims

The overall aim of this research project has been to explore narrativity in the context of inpatient geriatric care, to develop a deepening understanding of narrativity as a potential resource for person-centredness and meaning-making in everyday healthcare practices.

The specific aims of the included papers are:

I. To explore how narrative meaning-making takes place and unfolds on a geriatric ward, and to discuss the matter in relation to contextual conditions and person-centred care.

II. To explore healthcare professionals' experiences and reflections about narration in their everyday work.

III. To explore and develop knowledge on how and where narrative relations are adopted and enacted in everyday practice on a geriatric ward.

IV. To explore and understand conditions for engaging in narrative relations on a geriatric ward.

# 5 Epistemology, methodology and methods

In this chapter, I describe the epistemological and methodological underpinnings of the research and the methods I have used for generating and analysing data. An exploratory approach was central in the overall project design. Hence, the early studies shaped the design of the latter, resulting in cumulative knowledge and continuously deepened understanding about narrativity as a resource in the everyday practices of inpatient geriatric care.

| | Study 1 | Study 2 | | Study 3 |
|---|---|---|---|---|
| | *INTERPRETATIVE, CONSTRUCTIVIST EPISTEMOLOGY* | | | |
| **Aim** | ***Paper I***<br>To explore how narrative meaning-making takes place and unfolds on a geriatric ward, and to discuss the matter in relation to contextual conditions and person-centred care. | ***Paper II***<br>To explore healthcare professionals' experiences and reflections about narration in their everyday work. | ***Paper III***<br>To explore and develop knowledge on how and where narrative relations are adopted and enacted in everyday practice on a geriatric ward. | ***Paper IV***<br>To explore and understand conditions for engaging in narrative relations on a geriatric ward. |
| **Methods** | Ethnographic fieldwork: participant observation, informal interviews<br>Interpretative/hermeneutic narrative analysis | Constructivist Grounded Theory<br>Focus group discussions, constant comparative analysis | | Interpretative/hermeneutic narrative analysis of previously generated data |
| **Data** | Ethnographic fieldnotes | Transcribed audio-recordings | | Ethnographic fieldnotes<br>Transcribed audio-recordings |

***Figure 1*** *Overview of the studies included in the thesis.*

## 5.1 Epistemological position

The thesis is grounded in an interpretative, constructivist epistemology, and on the assumption that social reality is fluid, constructed and multifaceted. Based on this understanding, social reality is not something fixed, but continuously evolving and interpreted. I use the term constructivist in the same vein as Charmaz (2014), to acknowledge the researcher's involvement in interpretation and construction of data, and to highlight knowing and learning as always embedded in social context, thus taking a stand against individualistic assumptions. Accordingly, narratives are viewed as social constructions negotiated and interpreted towards the social and cultural contexts where they are expressed or enacted (Josephsson & Alsaker, 2015). Thus, meanings of

individual experiences and actions are constantly shaped and reshaped by social forces, and individuals are in constant, inseparable communication with their environments (Alsaker et al., 2013). The interpretative character of narratives and human experience, and the reinterpretation of narratives made in interpretative research make the notion of a *triple hermeneutics* (Meretoja, 2016) appropriate as it emphasizes the interlaced layers of interpretation: researchers interpret a social reality that is "always already constituted by interpretations, and researchers' interpretations may feed back into this reality" (Brinkmann, 2017), showing similarities with the concept of a threefold mimesis (Ricoeur, 1984). As this epistemic position pervades the whole research process, it informed the choices of methodologies and how I have combined them, as well as how data and findings are valued and understood. In keeping with this position, I was part of the social situations in which data were generated. Hence, the knowledge this thesis presents is evidently a product of the situated interactions between the participants, me and my co-workers involved in the research process (Carter & Little, 2007); it is with this position in mind that the work should be read and evaluated.

## 5.2 Methodologies – justifying methods

I draw on a few different methodologies to explain and justify the methods I have used. The methodologies overall share common epistemological ground, and there are links between them which I explain to rationalize how I have used them together. Moreover, they insist on iterative research processes where data generation and analysis are not separate processes. Another commonality in these methodologies is that they offer means to generate theoretical ideas grounded in empirical research.

### 5.2.1 Ethnography, narrative-in-action, and interpretative narrative inquiry

Ethnography is concerned with understanding social groups or cultures. Choosing to engage in ethnographic fieldwork helped me to gain situated insights into the social interactions and the ongoing everyday practices in the setting I sought to understand (Hammersley & Atkinson, 2007). Immersion in the field allowed me to come closer to the social and cultural conditions and the everyday actions as they took place in their natural context. This links ethnography as a methodological resource to the narrative-in-action methodology, which requires precisely that kind of immediate presence in the processes of everyday life and action (Alsaker et al., 2009; Alsaker et al., 2013). The narrative-in-action methodology (papers I and IV) acknowledges a connection between narrative and action, and recognizes how social aspects influence individual construction of experiences by emphasizing the individual-structural interconnectedness. Moreover, this methodology offered resources for investigating the processes of how personal and cultural narratives communicate, distinguishing it from methodologies for narrative inquiry focusing on individualistic interpretations of personal narratives. As ethnography does not prescribe a single possible type of

analysis, introducing an interpretative narrative methodology together with the narrative-in-action approach (papers I and IV) offered justifications for narrative as an analytic, interpretative mode of reasoning (Josephsson & Alsaker, 2015; Polkinghorne, 1995). Hence, this methodology contributed a resource to work analytically to identify storylines in the data through a hermeneutic process of articulating tentative interpretations, checking those against data or generating additional data, and refining interpretations, in a continuous back-and-forth movement (Gustavsson, 2000a). This is how the methodology justifies gaining access to the unfolding and multifaceted processes of everyday life instead of identifying components and general characteristics (Josephsson & Alsaker, 2015).

### 5.2.2 Constructivist Grounded Theory

The Constructivist Grounded Theory (CGT) approach (papers II and III) was guided both by the CGT principles suggested by Charmaz (2014), and by scholars who have more strongly emphasized the abductive logic as part of the methodology (Clarke et al., 2018; Timmermans & Tavory, 2012). As previously mentioned, this methodology is also based on an iterative research process where data generation and analysis are conducted in parallel, and the emerging analytic ideas dictate how to proceed with the data generation. However, papers II and III are more distinctly focused on the experiences and reflection on everyday practice from the viewpoint of staff on the ward, necessitating a means of inquiring into this other than participant observation. The focus group methodology offered an additional methodological resource to acquire insight into the collective and interactive processes of reasoning assumed to shape the understandings of everyday practices among staff. Aligned with the notion that knowing and learning are collective processes embedded in social interactions (Charmaz, 2014), the focus groups were arranged with the intention to create arenas where participants could collectively inquire into the conditions and experiences of their everyday clinical practices (Kamberelis et al., 2018). Another assumption was that interactions in the focus groups encouraged participants to jointly explore, clarify and reflect on their individual and shared experiences and understandings of their everyday practice (Morgan & Spanish, 1984). Thus, the focus groups offered insights into how staff co-created, negotiated and developed their understandings of the everyday practices on the ward.

## 5.3 Methods – research actions

In this section I present the methods I used for data generation and analysis, and describe in more detail the different research actions I engaged in. A common feature of the interpretive narrative methodology (Alsaker et al., 2009; Josephsson & Alsaker, 2015) and the CGT methodology (Charmaz, 2014) (paper II & III) is that data generation and analysis are iterative and parallel processes. However, for reasons of readability I address them separately here. When writing “we” in this section, I refer to the co-

researchers involved in the different studies, whose names are presented in the list of co-authors in the papers.

### 5.3.1 Data generation

I used multiple sources and methods to generate data to approach the subjects of interest from different angles. This is justified by the need for rich and versatile data in interpretative studies, rather than proving accuracy in terms of agreement between data sources (Carter & Little, 2007; Josephsson & Alsaker, 2015). I have mainly drawn on two sets of data in the analyses: the first generated from ethnographic fieldwork and the second from focus group discussions. The two data sets offered different types of opportunities to inquire into the practices on the ward. Paper I builds on the ethnographic data. Paper II and III are based on data generated from the focus groups. In paper IV, I used material from both datasets.

#### *5.3.1.1 Ethnographic fieldwork*

I conducted ethnographic fieldwork from March to June 2019, engaging in participant observation and informal conversations with people being and acting on the ward. Through these methods, I wanted to obtain insights into everyday situations, actions, interactions, and priorities encompassing various perspectives, depending on the people's different roles and functions on the ward. As the interest of the study was social situations and interactions in staff's everyday practice, most observations were focused on situations involving staff in some way. However, patients, their families, or the managers were often part of those situations. Moreover, their reflections on various situations of everyday practice were valuable contributions to obtaining a more versatile understanding of such situations.

Before being granted formal access to the field, my main supervisor, Staffan Josephsson, and I met with gatekeepers, including the operations manager for the whole geriatric clinic, and the unit managers on the different geriatric wards, to present the project. The unit managers were positive about giving us access to the wards. Due to the available resources for the project, we decided to focus on one ward with the purpose of obtaining a deeper understanding of one site instead of splitting focus between two sites and possibly gaining a broader but more superficial understanding. However, obtaining gatekeepers' formal approval for the research was just a first step of gaining access to the everyday activities on the ward. More important for being able to generate rich and adequate data was to establish relations and a sense of security among participants regarding my role and the purpose of my observations. To do this, I had to continually consider how I positioned myself, how and when to best present the reasons for why I was there, or what I observed and wrote about. I discuss such ethical considerations more thoroughly in chapter 8. We also presented the research project to staff at their regular staff meetings and provided information letters distributed via email

to all staff members before entering the field. To become familiar with the procedures on the ward before initiating participant observation, I gathered and read various documents, checklists, and guidelines. These included descriptions of processes and routines for the different professional groups, and various information brochures for patients and their families or significant others.

I visited the ward twice a week on average during the fieldwork period. Visits ranged from 45 minutes to 7.5 hours, most frequently around three hours. As noted by Hammersley and Atkinson (2007), longer periods of observation easily become unmanageable, and normally, they argue, a selective approach results in better data. The purpose of longer observations was to obtain a comprehensive view covering a full work shift, while shorter observations had a more specific focus, such as participating in a particular meeting. Moreover, the selective approach encouraged by Hammersley and Atkinson (2007) implies that decisions must be made regarding what, when and where to observe, as well as what to record, since in most cases it is not possible to observe and record everything going on. Hence, for adequate coverage I tried to identify times and activities of the day that I perceived as salient for my research focus, i.e. times and activities including lots of human interaction and communication. After the two initial observations when the unit manager had arranged for me to accompany members of the nursing staff, I purposefully asked different people if I could go with them during parts of their day. I wanted to get insights into the routines of each professional group, observe as many routines, activities, interactions, and meetings on the ward as possible, including both formal and informal situations. I also wanted to observe what was going on in the common areas of the ward at different times of the day. As I learned more about the setting, I conducted more focused observations of situations of interest, such as meetings, coffee breaks or certain procedures.

Together with a group of three other researchers, co-authors of paper I, I planned and discussed possible approaches and areas of interest for participant observation throughout the fieldwork period. In the group we regularly followed up on the fieldnotes I had written and discussed how tentative analytic ideas and emerging questions could best guide the subsequent observations.

#### *5.3.1.2 Writing ethnographic fieldnotes*

After each participant observation session, I immediately wrote fieldnotes (Emerson et al., 2011; Hammersley & Atkinson, 2007). These were naturally more detailed after shorter visits and I found that, in general, about three hours of observation was optimal for balancing between being able to write extensive descriptions and obtaining adequate overview of chains of events to prevent fragmentation. Fieldnotes included descriptive information about what I observed – what happened, what people did, conversations, and interactions (Emerson et al., 2011; Hammersley & Atkinson, 2007). When possible, in

terms of practical, social, or ethical circumstances, I wrote preliminary notes during the observations to remember details and significant events, and sometimes I took short breaks for writing during the session. Afterwards, I elaborated on these notes and added descriptions of all the other matters I could recall. Additionally, I wrote reflective notes about my own thoughts and feelings, ethical issues, and emerging questions to follow up on. As argued by Hammersley and Atkinson (2007), I deliberately tried to stay open to and describe the everyday events taking place without any discriminatory lens in terms of letting a too limiting focus prematurely decide on what would be of interest in the analysis. This choice was also of significance to the interpretative narrative analyses (papers I and IV), which require rich and vivid data which offer a multitude of interpretative possibilities (Josephsson & Alsaker, 2015).

#### *5.3.1.3 Interprofessional focus group discussions*

Between October 2020 to August 2021, my co-supervisor, Sofia Vikström, and I conducted seven focus groups discussions with healthcare professionals and managers on the ward (n=31). Based on our epistemic position, we assumed the focus groups to be dialogical events rather than interviews (Kamberelis et al., 2018). Thus, the 'interview guide' was used as a help to cover broad topics of interest and keep the discussion around the topic, and not to ensure strict alignment to specific questions. Neither was this document static; as advocated by CGT methodology (2014), it was developed when analytic ideas or questions of interest for the aim of the research emerged.

All staff on the ward received written information about the study and an invitation to participate. This was distributed via email and on noticeboards. I also presented the research at a regular staff meeting. As I was familiar with the ward from the previous period of participant observation, several participants were likewise familiar with the research project and with me. However, due to the rather high turnover among junior physicians and registered nurses, several people were also new. Interprofessional representation in the focus groups was a way to obtain heterogeneity in terms of professional perspectives. Based on previous observations of how different professions worked together on this ward, we assumed that the groups were 1) homogeneous enough since people shared common ground and in general felt comfortable together having a fruitful discussion about their everyday practices, and 2) heterogeneous enough based on the interprofessional composition (Dahlin-Ivanoff, 2017). However, in the initial focus groups, only registered nurses and nursing assistants signed up. Thus, we purposefully invited participants with other professions to the latter focus groups in line with the CGT principle of theoretical sampling (Charmaz, 2014). The latter groups eventually became more diverse and represented most professionals on the ward.

Focus group duration averaged 77 minutes, and discussions were audio-recorded and then transcribed.

***Table 1*** *Focus group composition.*

| Focus group # | Duration | Participants, profession* n =31** | Gender, Female/Male | Work experience in current profession. Range, years (median) | Employment duration on the ward Range, years (median) |
|---|---|---|---|---|---|
| **1** | 66 min | 3 RN<br>6 NA | 8/1 | 0.25–34 (5)<br>*** | 1–12 (3) |
| **2** | 60 min | 1 RN<br>2 NA | 3/0 | 0.6–2 (2) | 0.4–2.5 (0.6) |
| **3** | 63 min | 3 RN<br>2 NA | 5/0 | *2.5–23* (4.5) | 0.8–5 (3.5) |
| **4** | 111 min | 2 OT<br>1 PT<br>1 MD | 4/0 | *1–27* (12.5) | 0.75–5 (3) |
| **5** | 69 min | 2 RN<br>2 MD | 2/2 | *1–14* (2.5) | 0.7–1 (0.9) |
| **6** | 83 min | 1 OT<br>1 PT<br>1 NA<br>1 MD | 3/1 | 0.7–10.5 (3.25) | 0.5–5 (1.9) |
| **7** | 88 min | 1 unit manager<br>2 deputy unit managers | 3/0 | *5–6* (5.5)<br>*** | 3–5 (4) |

*Abbreviations: RN – Registered Nurse, NA – Nursing Assistant, OT – Occupational Therapist, PT – Physiotherapist, MD – Medical Doctor
**31 unique individuals. One participant attended two focus groups: first as a health professional, and later in a new position as unit manager.
***Imputed one missing datum.

#### *5.3.1.4 Using vignettes*

The choice to use vignettes as prompts for discussion (Barter & Renold, 1999; Wilks, 2004) was made based on an issue I encountered during the research process. During my ethnographic fieldwork, several participants had expressed feelings of uncertainty in terms of the concepts of narration[5] and person-centredness, which they expressed were abstract or theoretical. As we primarily wanted to inquire into the everyday situations of healthcare practice and assumed that staff reflections around those were more worthwhile for our purposes than their theoretical knowledge about narration and PCP, we consequently wanted them to provide rich descriptions and reflections of their everyday practices and reasoning. Hence, we deliberately chose to start the discussions by asking them to reflect on a vignette portraying an everyday situation on a geriatric

[5] The Swedish word 'berättande' could be translated to both storytelling and narration, yet none of the words fully correspond to the meanings likely ascribed to the Swedish word. 'Berättande' is a word that may be used both in everyday language and in research but could have a broader meaning or being less precise than the English word 'storytelling'.

ward. I developed the first and main vignette from the ethnographic material (paper I), while I wrote a second vignette during the research process to portray features of the emerging findings. Both vignettes were intentionally layered and open for several interpretational opportunities and perspectives to facilitate reflection and discussion. Moreover, they avoided any predefined explanation of how narration or PCP should be understood. In all groups, the vignettes sparked vivid discussions among the participants and proved to be a good resource for generating rich data relevant for our purposes.

### 5.3.2 Analysis

I analyzed the data using various methods based on the aims of the four different papers. However, the analyses and writing processes for papers II and III partly overlapped.

#### *5.3.2.1 Interpretative/hermeneutic, narrative analysis*

The analytic process in papers I and IV share the hermeneutic foundation, and the use of narrative as an analytic mode of reasoning (Josephsson & Alsaker, 2015; Polkinghorne, 1995). In paper I, the analysis was guided by an interpretive narrative analysis (Josephsson & Alsaker, 2015), thus the analytic task was to identify plots and storylines in the data. In practice, this meant writing analytic texts that I shared with a group of three co-researchers involved in the analysis and co-authors of paper I. I wrote those first analytic texts from situations in the data that raised questions, provoked emotions, or stood out as interesting to explore further. Moreover, I wrote second analytic texts with additional ideas and reflections. I discussed this material with my co-authors during repeated analytic meetings, and we came up with new questions and areas of interest for subsequent data generation. Towards the end of the period for participant observation, when I had generated a rich set of data, I read the whole body of fieldnotes to get a cohesive overview. Soon after that naïve reading I read the text again with a more reflective approach, adding new analytical ideas. At this stage I worked closer to the text and did not generate more data, but went back and forth between data, tentative interpretations, and theory that could contribute to enrich the understandings of the material (Josephsson & Alsaker, 2015). I articulated different emerging plots and refined them after discussions in the research group. Finally, I presented the findings as three interconnected narrative vignettes, representing situations from the data that reflected our interpretations and that contributed to meet the aim of the study. I put the vignettes in dialogue with theory to make visible the interpreted meaning of the situations portrayed.

In paper IV, both data sets formed the 'text' for the hermeneutic analysis. The hermeneutic process involved articulating tentative understandings that contributed to answer the research questions, while continuously checking if these interpretations

were supported by the data, re-articulating analytic ideas, checking them with data and so on (Gustavsson, 2000a). Through the analytic process, fragments from the data could be developed to plots grounded in the empirical material. As the assumption about a dynamic interplay between individual narratives and shared social or cultural narratives had ascended to centre of interest at this stage of the research project, Ricoeur's (1984) threefold mimesis concept was used as a theoretical resource to keep ourselves constantly mindful of the continuous transactions between culturally shared preunderstandings of the conditions for everyday practices, individuals' interpretations made towards these preunderstandings, and the communication between those (Alsaker et al., 2013). This was an important analytical tool for capturing the processual and transactional movements shaping the conditions, instead of merely mapping out conditions or prerequisites for practice, without gaining a deeper understanding of how such conditions were interpreted and given significance by people, how that influenced the activities they engaged in on the ward, and how the practice was enacted.

#### *5.3.2.2 Constant comparative analysis*

Analyses in papers II and III built on principles from CGT (Charmaz, 2014), a version of grounded theory aligned with the epistemological stance of the thesis by its flexibility and resistance of mechanical application of the method. Hence, in accordance with Charmaz (2014), these principles are flexible guidelines underpinning the analytic process rather than strict rules or requirements, and the findings are an interpretative portrayal of the studied setting, emerging under specific conditions. The principles of CGT include drawing on empirical data to develop codes and themes; an iterative and comparative method of data generation, coding, memo writing, theme development, and theoretical sampling. During this process I worked in close cooperation with my co-supervisor, Sofia Vikström, whom I sent codes and interpretations to and engaged in ongoing analytical discussions with. My other supervisors were also part of the research team and involved in analytical discussion meetings throughout the process. Although my preunderstanding in narrative theory naturally influenced my understanding of the data, I deliberately tried to stay close to the data when developing codes and themes to emphasize theorizing, rather than applying current theory.

A few different principles guided the coding process. Initial codes should stay open to different possible theoretical directions, connote action, and be kept close to the data (Charmaz, 2014). Acknowledging that data could imply multiple meanings, we also used simultaneous coding, which justified overlapping codes of the same text segment (Saldaña, 2009). At a later stage we applied structural coding to organize initial codes around the research questions. So far, the analytic processes for papers II and III overlapped. Emphasizing the abductive logic in paper III (Clarke et al., 2018; Timmermans & Tavory, 2012), a final stage of the analysis process allowed for putting the emerging themes in dialogue with theoretical resources, helping us to position and integrate our

new findings from the empirical data in relation to relevant existing knowledge. The process overall facilitated conceptual development grounded in empirical data.

#### *5.3.2.3 Writing as part of analysis*

As seen above, writing and rewriting were important parts of the analytical processes. Awareness of how I used writing and what it does is important both for understanding what fieldnotes, vignettes or reports of findings are, and how they can be understood. Although writing was a central activity and method throughout the research process of this thesis, ethnographic writing in particular is closely connected to analysis (Hammersley & Atkinson, 2007). However, writing was also fundamental for developing vignettes, as part of the iterative method where data generation and analysis were intertwined as the vignettes built on previous data and analysis, for prompting discussions for data generation, and in memo-writing. Writing was also central in communicating analytic ideas with my co-researchers, and in the hermeneutical analysis processes. My co-researchers' reception of my written texts was an important part of the joint analytic work. As they read the texts based on their preunderstandings and knowledge, other perspectives evolved and opened new interpretative possibilities. This required awareness, reflexivity, and choices in terms of style and purpose of the developed texts. In terms of vignettes, I was inspired by basic literary techniques such as 'show don't tell' (Zwicky, 2021) in order to avoid developing factual or summarizing accounts or presenting a predefined meaning of the situation portrayed. Still, a basic epistemological condition in this kind of research is that I am writing from a particular position at a specific time, which makes both the vignettes used in data generation, and the findings, something other than neutral and generalizable texts (Richardson & St Pierre, 2000). Instead, the findings represent contextual and partial knowledge, yet contribute to adding new insights, facets, and nuances to understand the multidimensionality of social life. In turn, this should be reflected in the reports, offering accounts of the research context and the researcher's positionality.

# 6 Situating the research in a local context

In this chapter I present the local research setting, after which I portray how a day on the ward might proceed. The purpose is to offer insight into the specific context of the studies for readers to be able to contextualize and appraise the findings.

## 6.1 The local research site

The studies were conducted on an inpatient geriatric care ward at a hospital in Stockholm, Sweden. The choice of site was partly based on the opportunities for gaining access to conduct ethnographic fieldwork, and partly on the active attempts that had been made to organize the selected ward to better facilitate interprofessional cooperation and prevent uniprofessional silos; my co-researchers and I viewed this as an important condition for obtaining insights into interprofessional communication, central to the overall aims of the research.

On a ward like this, a multitude of people, roles and professions are gathered and in various ways come to interact, cooperate, and make decisions that affect one another, where some have more power or influence than others. People gathered here have different responsibilities, backgrounds, understandings, knowledge, and authority in regards of the activities and interactions carried out on the ward, depending on their position. Some are patients, often in vulnerable situations due to disease, and some are professionals. Additionally, a ward is not altogether detached from broader societal and cultural norms or political decisions. Hence, everyday practices on these kinds of wards are inescapably complex.

### 6.1.1 Mission and patient group characteristics

According to its mission statement, the ward should provide medical care and rehabilitation to older people with impaired functioning, multiple health issues, and dependence on others in their daily lives. Formally, there was no age limit, but patients were reported to be 65 years and older. To be admitted to the ward, one should have a recently deteriorated health situation that required medical intervention and rehabilitation by a multiprofessional team, or need further medical care after emergency admittance. Purely social issues or need of care did not qualify for admittance. However, at times people were admitted based on mainly social rather than medical reasons, for instance when a home situation suddenly became unsustainable, and family or home care services could no longer manage. Hence, part of the ward's mission was to interact and cooperate with other health and social care agencies in the vicinity. People in need of palliative care were generally not admitted to this ward; however, for a few patients,[6]

[6] n=15 out of a total of 1,686 patients during 2020.

an end-of-life care plan was initiated during their stay.[7] The stipulated length of stay on the ward was five days, yet the reported length of stay was 7.8 days on average. However, at the end of the data generation period, staff reported that the stipulated length of stay had become shorter and shorter, with even five days considered too much. The gender distribution among patients were 60 % female and 40 % male. Heart disease, infections, fractures, and obstructive pulmonary disease were the most common reasons for admission, and co-morbidity was common. Around 15 % of patients were diagnosed with dementia. However, staff reported experiences of a higher frequency of cognitive impairment among patients. During the period of the focus groups, one floor was periodically committed only to Covid-19 care.

The management explicitly attempted to organize the ward to facilitate interprofessional collaboration. Additionally, there were high ambitions for development both from the management and from many of the co-workers, who initiated various smaller and larger projects, such as information campaigns, meetings for improving communication and cooperation, new technology, and regular in-service training. There was an ongoing conversation, often initiated by the managers, about enhancing person-centredness in practice, but at this time there was no formal framework or model for implementing PCP or narrative practices, and several staff members expressed hesitance about what those concepts really meant when translated into clinical practice. However, some routines aimed to enhance person-centredness and interprofessional cooperation. One was a web-based 'coordinated individual plan'[8] for patients in need of further care from multiple actors, such as social services, primary care or rehabilitation – i.e. most of the patients. The plan should be created together with the person after a meeting, and clarified the responsibilities of different caregivers, as well as the decided time plan. However, this was not specific for this ward, but rather mandated by Swedish law (SFS 2017:612). Another routine was the daily team rounds. Further, each professional group had daily handover meetings where information about patients were transferred verbally, e.g. between shifts. In terms of interprofessional and interpersonal relationships, various staff meetings for discussing ethical issues or cooperation were found on the agenda. However, not all staff members systematically participated in such meetings.

### 6.1.2 Premises

Divided over three nearly identical floors, the ward had a capacity of 42 hospital beds; just over half of them in single rooms, the rest in double rooms. The entrance on each

[7] A care plan based on a decision of initiating palliative, end-of-life care, after conversation between responsible physician and patient, in Swedish called 'brytpunktssamtal'.
[8] In Swedish: Samordnad individuell plan (SIP).

floor was located at the centre leading to a foyer. Straight ahead was a glass wall towards the adjoining dining room, while corridors with patient rooms, dispensary rooms and repositories extended both to the left and the right sides of the foyer. Two rooms used by staff were also immediately accessed from the foyer: one a shared, interprofessional office for administration duties on each floor, the other used for various purposes on different floors, e.g. a workplace for care coordinators. Next to the dining room was a day room and these contiguous rooms, together with a large balcony, made up the shared spaces for patients and their visitors. Joint activities such as group exercise were also arranged in the day room. Occasionally, when most patients were in their rooms, staff also used these areas for meetings, handovers, or informal gatherings. At the end of the left corridors were meeting rooms, often used for the team rounds or other meetings. The staff rooms were also found here, with kitchens, dining tables, sofas, noticeboards for information, and pigeon-holes for all staff members. At the end of the righthand corridors were the unit managers' offices. The shared offices next to the foyer were intended for all professions. The rooms had three computers on each side. In the furthermost section of the room, behind a low room-dividing screen, were three additional computers, mainly used by the physicians.

The hospital had an explicit ambition to integrate art and aesthetics into the care environments. Overall, my impression was that the physical environment was pleasant, and seemed to be prioritized both by the organization and the staff who looked after it to create an aesthetically appealing place. The premises were airy and modern, in terms of colours, tapestry, and furniture. Artworks such as paintings, sculptures and photographs looked carefully curated and an important part of the interior design. The patient rooms were also spacious and modern. The only exception to spaciousness was some of the clinic backstage areas; registered nurses often criticized the cramped size of the dispensary room, and staff also talked about the shared interprofessional office as somewhat under-sized for the administrative needs during parts of the day.

### 6.1.3 Staffing

The unit manager and two deputy unit managers were responsible for the registered nurse and nursing assistant staff, and the day-to-day running of the ward. The physicians had an external manager, physically stationed elsewhere, and a separate budgetary allocation. The same pertained to the allied health personnel. The healthcare professions represented on the ward daily included registered nurses, nursing assistants, occupational therapists, physiotherapists, and physicians, including senior physicians with specialist competence in geriatric medicine and junior physicians who had often graduated recently and not yet started their residencies. When needed, a speech and language therapist and a dietitian could also be consulted, and they were present on the wards a couple of days a week. One registered nurse and one nursing assistant had full-time positions as care coordinators, and were thus responsible for

establishing contact with other health and social care providers, as well as coordinating activities involving the patients and their families or significant others. There were also nursing assistants working mainly in the kitchen and dining area. The staff turnover among registered nurses and junior physicians was high. Around 70 % of the registered nurses had zero to two years of professional experience, and junior physicians often stayed a shorter time before moving on to do their internship. The staffing was steadier regarding nursing assistants, allied health professionals and senior physicians.

### 6.1.4 A day on the ward

Any attempt at a fair portrayal of everyday life on the ward would require at least a novel, probably several. A synopsis like this cannot possibly do justice to the multitude of perspectives and activities taking place. Hence, this sketchy description should be understood for what it is: it accounts mainly for the professional activities observed from morning to evening on a regular day. Weekends had lower staffing, which was frequently discussed and problematized by staff perceiving that they did not have time for more than keeping up with the very basics, even though the patients' needs were the same, no matter the day, and there were usually more visitors asking for staff attention.

During day shifts, nursing staff worked in pairs of one registered nurse and one nursing assistant responsible for around four to five patients. Starting the shift at 7 am, early activities included handover from the night shift staff, reading up on the records, taking notes on each patient, after which they had a morning meeting together, sharing patient information, often following a specific checklist. At this time of the day, most patients remained in their beds. After their meeting registered nurses typically joined in the dispensary room to prepare the morning medications, to subsequently deliver them to the patients. Nursing assistants started the morning routines with the patients, e.g. assisting with activities of daily living (ADL) and breakfast, conducting blood specimen collections, and measuring vitals. Physicians started around 8 am with a short uniprofessional morning meeting to get reports from the night shift and decide on staffing. Via a digital meeting solution, physicians from a geriatric ward on another hospital site also participated in those meetings in case staffing resources needed to be reallocated between wards. After the meeting they split up over the three floors. Three senior physicians were overall responsible for one floor each, i.e. 14 patients, with each senior physician having practical help from two junior physicians. Senior physicians received the referrals and decided who was eligible for admittance. They also kept the general overview of the patients' medical status, had a supervising function, and delegated specific tasks and assessments to the junior physicians, who usually interacted more immediately with the patients. Senior physicians worked on the same floor over longer periods of time. Junior physicians alternated between floors, yet often had better continuity in terms of responsibility for the same patients than the registered nurses and nursing assistants. Occupational therapists and physiotherapists also

started around 8 am with reading up the records and planning. One occupational therapist and one physiotherapist cooperated on each floor, typically the same pair staffed the same floor for a longer period. They made most assessments together, conducted rehabilitation training, and informed and delegated everyday rehabilitation activities to nursing assistants. They also had many administrative duties and frequent contact with other health and social care actors and family, and ordered self-help devices. At 9 am they had a morning meeting in the staff room where they both discussed work-related issues and matters of a more informal character.

Interprofessional team rounds on each floor started in the meeting rooms around 9:30 and nursing staff appeared keen to accomplish the morning chores before that. Physicians, physiotherapists, and occupational therapists participated during the whole meeting while registered nurses and nursing assistants circulated depending on which part of the ward was being discussed, hence only participating in discussions regarding patients they were responsible for that day. Patients did not participate. Junior physicians generally went for a bedside round afterwards, when they talked to each patient, followed up on the night, how patients felt, and current medical issues that needed attention. The team rounds were typically led by a physician and followed a certain structure, written on a card, covering reasons for admittance, the objectives for the stay, including patient expectations, planned date for discharge, medical status, nursing status, rehabilitation status and forward planning. However, the structure was often influenced by the meeting leader; some physicians stayed closer to the checklist than others. Several participants expressed that the senior physicians strongly influenced the focus of the conversation, making the rounds slightly different across floors. Participants in the rounds were invited to share what they knew about each patient from their professional perspective, based on their own experiences or from the records. This information was often focused around the topics on the standard checklist.

Much activity took place before noon, which was also reflected in how staff described their practice. After the team rounds, and during the rest of the day, various activities occurred. Staff made assessments or admission interviews, followed up on issues with patients, worked with administration, record keeping or other documentation in the office, or made phone calls. Care coordinators followed-up with physicians regarding the team rounds and planned discharges, and engaged in intense communication with various service providers and significant others through phone calls and web-based systems. Some patients were discharged, and rooms cleaned out. New patients arrived producing a chain of activities, including various professions according to stipulated processes. During lunch hours, the patients who could manage were encouraged to eat in the dining room. Sometimes they shared tables, sometimes not. Staff seldom joined in the meals, but could come and go in the dining area, sometimes sitting down for a while.

As registered nurses and nursing assistants were expected to always cover the ward, they went for lunch at different times, often eating in the staff room on the ward. Physicians and allied health professionals more frequently seemed to leave the ward to have lunch elsewhere. At 1 pm the registered nurses and nursing assistants working the evening shift arrived and started to read up on the records. One physician on stand-by duty covered all three floors during evening and night shifts. Handover meetings took place around 2 pm. During my period of participant observations, the day shift staff, including all professions, intended to meet every day at 2.30 pm for a checkout meeting to discuss what had been good during the day, what could have worked out better, and how they perceived the collaboration. However, these meetings were often missed or deliberately discarded due to other chores. Generally, staff talked appreciatively about the checkout, but did not prioritize it by habit. Thus, it had transformed into a somewhat irregular occurrence. Up until about 3 pm, the day and evening shift nursing staff overlapped. During this time, joint activities or group training sessions for patients were sometimes arranged. Staff meetings or competence development activities were also sometimes scheduled during this time slot. After that, the staffing was reduced during the evening shift, thus more vulnerable to unexpected events. The main focus for staff was on administrating medicines, talking to patients' visitors during visiting hours, registering new patients, making arrangements around dinner, helping patient to go to bed for the night and handing over to the night shift staff. The afternoons and evenings seemed generally less hectic, both according to what I observed and to registered nurses and physicians' descriptions.

Naturally, there was a large variety of needs and desires among patients admitted onto the ward. Some wanted to spend time in the shared areas, while others preferred to stay in their rooms. Some requested intense rehabilitation training, while others expressed a need for rest and relaxation. Several of the patients used wheelchairs and needed assistance or supervision with ambulation. Some preferred staying in bed, although encouraged to sit up in armchairs or move to the shared areas, some were bedbound due to their condition. Some used walkers and patients often needed assistance with mobilization or ADL, while others were independent. Although this variety of needs was generally acknowledged by staff, it seemed that patients mostly had to adapt and put up with the ward's procedures and timetables. The staff also seemed to be governed quite strictly by routines and checklists, which was also reflected in their discussions. The organization promoted certain practices and timeframes, such as morning routines, administration of medicines, mealtimes, and team rounds. Yet, several unplanned situations emerged during the days, as people had needs that did not align with the timetable and which thus interfered with the structured schedules. Sometimes there was room for that, sometimes not.

# 7 Findings

This chapter summarizes the main findings of the thesis. Subsequently, it accounts for the findings of each individual paper.

## 7.1 Main findings

Overall, the findings contribute to broadening the scope for narrativity as a resource for PCP and enacted respect for human experiences in everyday practices of inpatient geriatric care. The findings offer an argument for reconsidering everyday healthcare situations as opportunities for joint meaning-making, which may contribute to translate values linked to PCP into practice, and thus worthy of approval as valuable parts of healthcare work. Moreover, a conceptual contribution of this thesis is the concept of narrative relations. The findings show how practices of engaging in narrative relations are not restricted to elicitation of patients' verbal narratives as a separate task to accomplish. Rather, instead of being detached from the everyday action and communication between people, practices of engaging in narrative relations present an approach that is possible to engage in continuously. The findings portray narrative relations as an ongoing, mutual process of meaning-making involving multiple people. This process is potentially available for healthcare professionals to tap into during everyday situations and interactions. By tapping into such processes, healthcare staff can obtain valuable insights about what matters to patients and to colleagues. Furthermore, engagement in narrative relations is suggested to have the potential to support foundational qualities of care work, such as building trustful relationships, supporting continuity and coherence, contributing to work-based learning among colleagues and offering healthcare staff better understanding of other people's perspectives and situations. Nevertheless, ignorance about which meanings are conveyed through narrative relations could also promote negative, limiting, or desensitizing narratives and discourses, or reproduce traditional biomedical or task-oriented practices, pointing at an ethical call to raise awareness of the narratives of which people are a part.

## 7.2 Paper I

The first paper contributes with perspectives on how narrative meaning-making takes place and unfolds in everyday healthcare practices, discussed in relation to person-centred practices and contextual conditions. Moreover, the study presents new perspectives, and raises questions regarding possibly undervalued activities, situations, and approaches in geriatric care – opportunities that may be overlooked in terms of fostering person-centred cultures.

The findings are presented as a triptych of interconnected vignettes together rendering a multifaceted portrayal of the relational and intersubjective character of narrative

meaning-making in everyday healthcare practices. The findings show how seemingly mundane situations, such as when staff and patients fetch a pair of socks together, or sit down for a coffee, offer arenas for exploring and creating meaning around queries of patients' situations. Moreover, they show how both patients and staff on the ward invited others to join them in co-creative narrative meaning-making through which they tried out possible understandings and interpretations to give meaning to everyday situations and events. Such invitations could sometimes be expressed in subtle comments, ordinary talk, or a request for facts to see how the invited person responded before more openly delving into the matter or moving towards the search for the meaning of facts. Thus, being invited to join someone's meaning-making requires sensibility, willingness to accept the call, and social and organizational conditions that allow for joining such undertakings, which the analysis showed was not always the case in this study setting. The findings suggest that stepping into such intersubjective spaces of meaning-making may help both staff and patients to make sense of situations, reach shared understandings, and figure out how to move forward from those insights. Likewise, missing out on such opportunities may obstruct meaning-making processes, suspend valuable insights, and thwart partnerships.

Through the analysis it became visible how narrative forms of reasoning were often pushed aside in favour of fact-oriented and paradigmatic forms of reasoning, both between patients and staff, and among staff. More specifically, the findings portrayed through the first vignette show how patients in everyday situations invite staff into their search for meaning and understanding of their own current situation and possible future situations. When staff fail to notice those invitations or respond to them with a mismatched form of reasoning, it may affect or obstruct the patient's ongoing meaning-making and hinder people from finding common ground in their relations. At the same time, staff might miss important insights about the patient from what the patients are trying to tell them. The second vignette concerns staff's backstage narration and portrays findings suggesting that staff often invited each other into their own efforts to make sense of their clinical experiences. They told colleagues about puzzling situations, trying to understand situations better and find out how to respond. This in turn was suggested to affect how they could act together with patients. The last vignette addresses the patient perspective. It portrays a patient's underlying reasoning about why they may have reasonable explanations for not telling staff everything, motivated by the staff's own actions, mismatched reasoning, or inadequacy in building trust that they can manage what is disclosed, which may create distance between people and obstruct partnerships. This links the third vignette to the others, where the consequences of such withholding are illustrated.

## 7.3 Paper II

Paper II concerns healthcare professionals' situated experiences and reflections about their everyday work and the use of narration in their practice. Through the analysis, narration was reflected as an ongoing process of mutual narrative interchange between multiple narrators, including patients, their significant others, and staff. The paper suggests a term for this process by introducing the notion of *engaging in narrative relations*. Thus, healthcare professionals' use of narration showed to be a resource much more extensive than is often discussed in terms of eliciting patient stories. The findings suggest that engaging in narrative relations may contribute to upholding various foundational qualities of healthcare practices, as specified in figure 2.

The analysis showed how practices of engaging in narrative relations could help prevent overly-simplistic understandings of people and situations. Bringing together narratives from various perspectives created a more comprehensive understanding of the multilayered proceedings on the ward. This enabled better understandings of people, their roles, responsibilities, and activities, but also made it easier to see the bigger picture and obtain a broader grasp of the conditions of healthcare practice. Moreover, engaging in narrative relations helped support trustful relations. When staff were genuinely responsive to patients' needs and requests, instead of just providing facts or acting according to predefined protocols, they could create a sense of security and trust in the relationship with the patient. Being able to reason beyond facts and imagine plausible stories that gave a comprehensible context to patients' actions and requests, was suggested to help staff empathize with, and relate to, the person more easily. Furthermore, relations between staff seemed to benefit from sharing stories about clinical situations and challenges, since recognizing and responding to shared experiences was proposed to foster affinity and peer support.

Continuity and coherence in healthcare activities were also shown to benefit from engaging in narrative relations, as healthcare actions could be related to, and informed by, a wider context. By connecting various professional perspectives and the patients' own stories, a bigger and less fragmented picture was conveyed and this guided actions and decisions.

Finally, the analysis indicated that engaging in narrative relations supported learning from coworkers and helped transferring tacit knowledge reached from experiencing various situations. Narratives portraying everyday situations gave insights into other people's situations and made visible similarities or differences between different positions. Moreover, such narratives could illustrate how responsibilities and tasks may overlap or contradict each other. Thus, sharing those narratives with one another enabled people to support each other or even to take over some activities beyond

professional boundaries, eliminate double-work or counter-productive actions arising from ignorance about other professional groups' habits and ways of working.

However, despite the suggested benefits of engaging in narrative relations, a potentially harmful side was identified. As narrative relations helped building interpersonal relations around jointly constructed meanings, this practice could also convey negative interpretations or reinforce stereotypes or dominant narratives not necessarily beneficial to people or activities on the ward.

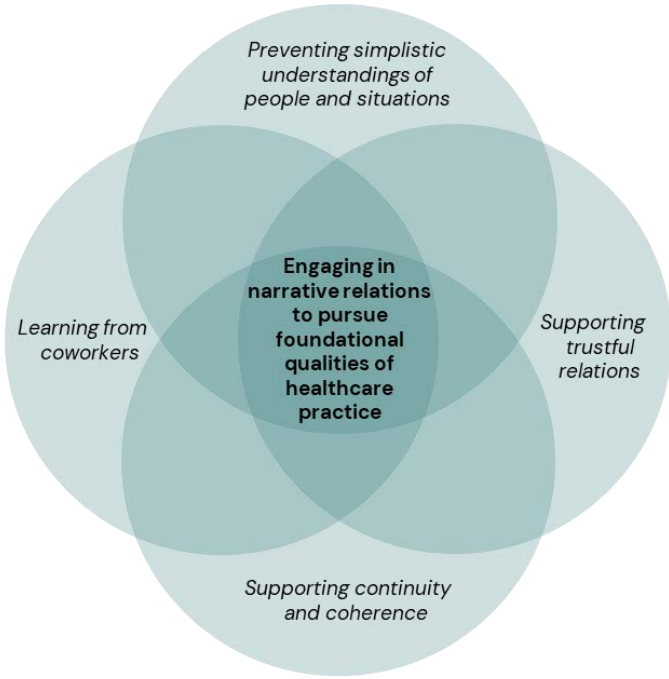


***Figure 2*** *The findings reported in paper II consist of one core theme and four subthemes.*

## 7.4 Paper III

The third paper furthers the understanding about the notion of narrative relations by exploring how and where these are adopted and enacted in everyday practice on a geriatric ward. A main finding emerging through the analysis was a twofold practice where some activities and actions were generally approved as authorized tasks or routines, referred to in the paper as *acknowledged practice*, while other activities were not assigned this status, and thus labelled *underground practice*. These two practices are understood as positioned on a continuum, without firm boundaries separating them.

Although the foundational qualities suggested to be supported by engaging in narrative relations in paper II were generally highly valued by staff, the practice of engaging in narrative relations was often part of the underground practice. When an activity was not part of the acknowledged practice it risked not being given sufficient time and approval. Likewise, relational activities risked being outmanoeuvred in favour of tasks that were more easily defined and measured. However, the analysis implied that the tacit activities of the underground practice had crucial value in terms of the quality of healthcare. While tempting to think that the solution would be to upgrade underground activities to acknowledged practice, the findings also indicated that this may not be reasonable, since some activities might not be suitable to transform into routines or schedules. However, a more viable solution would be to acknowledge the underground practice and professional discernment, thus creating margins for the unexpected and relational to take place.

Lastly, the analysis indicated that the practice of engaging in narrative relations seemed to differ somewhat, depending on who was involved. An observed tendency was that narration including staff and patients seemed to differ from narration between colleagues. Hence, the already established theoretical division between clinic frontstage, and clinic backstage was a useful resource for placing narrative relations on yet another continuum; the first refers to interactions between patients and staff members while the latter refers to the staff interactions and activities off-limit to the patients. By considering these continuums together, as shown in figure 3, the analysis constructed four distinct arenas for engaging in narrative relations, that were not irreducible to one another. Although boundaries between arenas were understood as constructed, the findings show how practices of engaging in narrative relations took place in all the arenas; however, the interconnections between the arenas could be weak, thus still resulting in a fragmented practice. Nevertheless, the analysis identified that narrative relations also offered a means for bridging boundaries between arenas, although organizational and cultural aspects seemed crucial to what extent this was possible. Such aspects were beyond the scope of the paper, yet were explored further in paper IV. The notion of arenas and boundaries between them was applicable to other somewhat bounded relational contexts in this setting, for instance professional groups,

so although this paper did not report all possible relational contexts or arenas represented in the data, the function of narrative relations may still be applicable to other arenas and the boundaries between them.

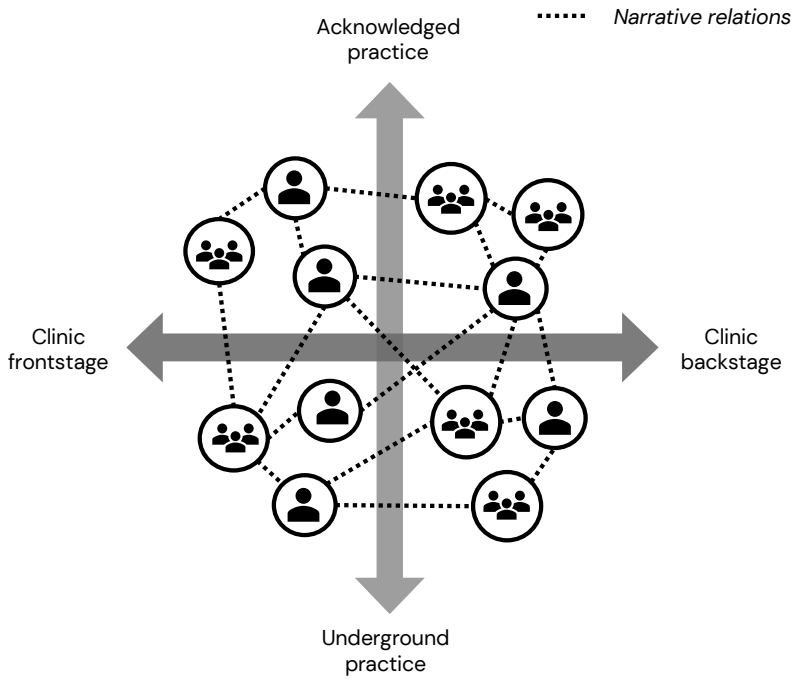


***Figure 3*** *The findings in paper III identified four arenas of practice, and implied that staff on a geriatric ward may engage in narrative relations in all arenas. While strongly established boundaries between arenas may result in fragmentated practices, narrative relations offered a means for bridging those boundaries, thus protecting continuity.*

## 7.5 Paper IV

The findings in this paper provide insights into conditions for engaging in narrative relations on a geriatric ward, by analysing how healthcare staff on a ward interpret everyday conditions for their practices, how they act based on such interpretations, and the consequences those actions and practices have for the opportunities to engage in narrative relations.

Overall, the findings portray how healthcare staff acted in front of various *backdrops*, a term used for the continuously reflected preunderstandings of central features broadly affecting how healthcare practice can be carried out. Backdrops such as presumed moral responsibilities in healthcare, accepted scope and purpose of healthcare, or available time and resources, sparked multiple interpretations that influence how people acted, see figure 4. Hence, the findings offer a situated understanding of how conditions for everyday practice are not static but in continuous communication with people and interpreted differently with different consequences in terms of the clinical actions they set in motion. People responded to backdrops in their everyday practice, discussed them, and acted in relation to them. The findings show how different interpretations rendered different meanings from those backdrops, consequently leading clinical actions in different directions.

Altogether, the findings illustrate the layers and complexities of everyday healthcare practice on a geriatric ward, abandoning assumptions about everyday conditions as something linear. Moreover, the findings consider how these various everyday interpretations have consequences on the conditions for engaging in narrative relations; whilst some interpretations were aligned with attitudes and activities supporting narrative relations, others simultaneously thwarted narrative relations by enacting task-orientation, professional division, a focus on measurable improvements and outcomes relating to biomedical aspects or an individualistic evaluation of people's actions instead of considering organizational prerequisites. Morals accepting unruliness and ambiguity as basic conditions for healthcare practice, openness to new ways of working, affirming the intrinsic value of healthcare relationships and accepting that as part of the scope and purpose of healthcare, all seemed to prompt actions and choices favouring engagement in narrative relations. Checklist-based routines promoting easily definable tasks, focusing on functional or medical improvements while diminishing the more vague and ambiguous aspect of healthcare work, more likely contributed to discourage engagement in narrative relations.

These findings contribute to a deepening understanding of how everyday healthcare practices unfold, not only governed by predefined organizational conditions, but that these conditions are continuously interpreted by people, which affect how everyday practices are enacted. This in turn has implications for how to change practices in

desired directions; expecting fixed organizational structures to foster practices allowing for narrative relations may not be sufficient due to the tensions that were shown to exist between the different interpretations that people make, which in turn calls for new approaches and methods.

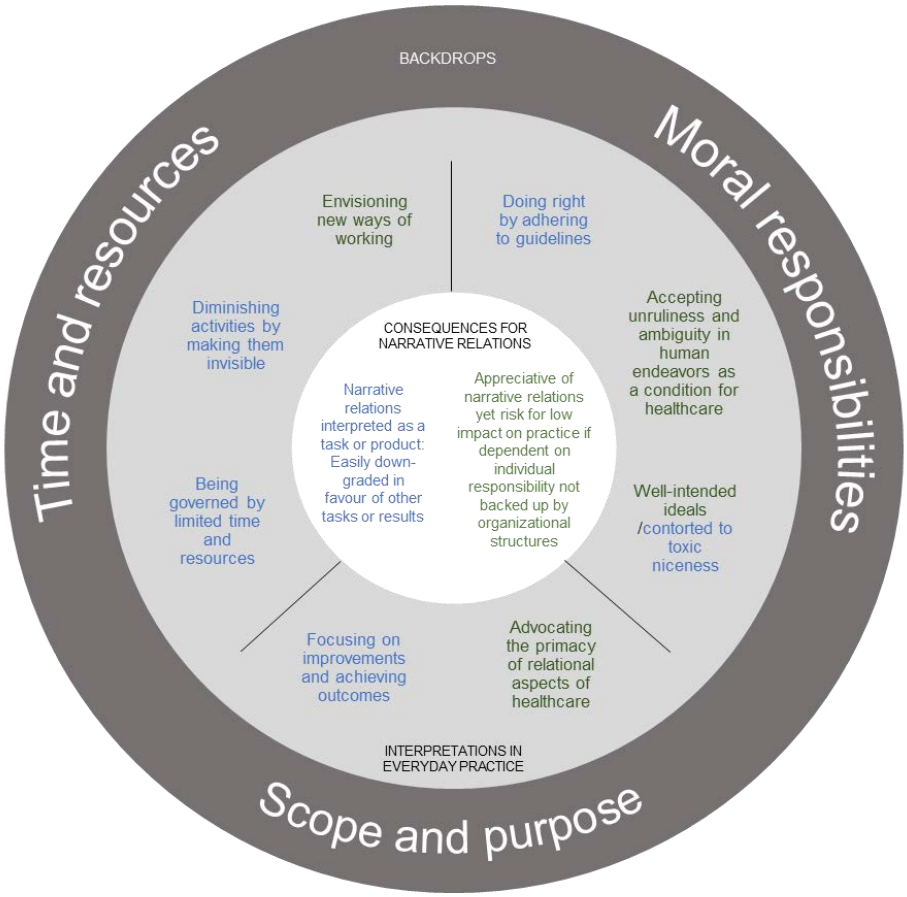


***Figure 4*** *Overview of the findings presented in paper IV. The colours indicate contradicting interpretations within the same backdrop and the core consequences they withhold.*

# 8 Discussion

In this chapter, I reflect on the findings from the individual papers in relation to one another, and discuss contributions to healthcare practices and to theoretical development. Subsequently, challenges and opportunities are discussed in relation to the methodological and theoretical choices I made. This is followed by ethical considerations.

## 8.1 General discussion of the findings

### 8.1.1 Reflections on the findings in the light of each other

What insights about narrativity as a potential resource for person-centredness and meaning-making in inpatient geriatric can be obtained from this thesis? By considering the contributions of the separate papers in the light of each other, this section gives a synthesized overview of the insights generated from this research project and suggest possibilities for how this knowledge might be useful in everyday healthcare practices. While the findings and questions emerging from the first studies came to inform the aims and designs of the subsequent ones, the latter studies contribute to expand the understandings reached through the earlier studies. When looking at the findings together, one possibility is that the term narrative relations, emerging in paper II and evolving throughout the subsequent studies, could be used to retrospectively give a term to a notion already portrayed in paper I. Hence, in hindsight, paper I could be read as a situated depiction of the evolving concept of narrative relations.

#### *8.1.1.1 From task to process - a relational narrative approach to everyday care situations*

Overall, the findings in papers I-IV are concerned with how narrativity may be expressed and productive in everyday practices of inpatient geriatric care. Throughout the four papers, narrativity is characterized as relational and intersubjective. One way to understand this is that it opens for seeing individual narratives, such as patients' illness narratives, as something more than just accounts of their illness and its impact on their life, namely as 'living stories'[9] (Boje, 2007), communicated and continuously reformed together with others. Here, the practice of engaging in narrative relations might offer an approach apt to engage with such living stories. Furthermore, this could be understood as a shift away from seeing narratives as products or outcomes, to emphasizing narration as an ongoing, mutual process, potentially available for healthcare

[9] A concept used by Boje (2007), described as follows: "Living story has many authors and as a collective force has a life of its own. Living story is a collective social process and has no existence apart from, and is indeed inseparable from, the event during which the story is performed."

professionals to tap into during other activities, thus, not a separate task itself. If accepting this, it expands the understanding of narrativity in the creation of healthcare partnerships by 1) emphasizing the reciprocity between multiple narrators, narratives, and everyday practices, and 2) broadening the opportunities for healthcare partnerships to become established through relational webs of narration rather than in dyadic relationships. The findings thus offer an empirically grounded argument for the potential in reconsidering everyday interactions, including mundane situations that at first may seem insignificant, as arenas for joint meaning-making (paper I) and narrative relations (papers II and III) valuable for upholding foundational qualities in healthcare practices (paper II). However, as shown in papers III and IV, everyday interactions and situations often fell outside what was interpreted by staff as acknowledged practice, i.e. activities that people generally considered legitimate to grant time and resources to.

#### *8.1.1.2 Conflicts between approved and repressed practices*

The findings altogether imply that opportunities for engaging in narrative relations were easily obstructed due to the kind of tasks and practices that were generally approved and made legitimate by staff and managers. Whether activities and practices were granted the status of acknowledged practice or not seemed influenced by a complex interplay between social and organizational structures, dominant narratives and individual interpretations and actions responding to those (papers III and IV). Hence, the findings indicate that the conditions for everyday practice were not statically prescriptive but continually interpreted and negotiated by people, reflected in the choice to introduce the term *backdrop* in paper IV. The findings portray how backdrops were interpreted differently, and that some interpretations took precedence over others, thus influencing whether or not narrative relations became part of acknowledged practice. When looked at together with paper III, this sheds new light on the findings in that paper; if conditions are not static prerequisites but always interpreted, then it might be of less use to merely identify specific actions or processes that are thought to support narrative relations, if not following up how these prerequisites are played out and negotiated in practice. This may add an important perspective to the discussion about how to change healthcare culture and bridge professional divides, widely known to be a challenging endeavour (Braithwaite, 2015; Malik, et al., 2020). As shown in paper III, various fora for establishing new practices to facilitate joint reflection and interprofessional cooperation had been trialled in the study setting. Yet such efforts had, to a large extent, fallen short, and different explanations for why that happened were suggested by participants. Paper IV offers a possible way to understand why this linear way of reasoning may not be enough. If not considering how such 'good conditions' are interpreted and used by people in everyday practice, even satisfactory organizational conditions for a certain practice may prove inadequate to obtain the intended change. Paper III, moreover, portrays arenas in practice and shows how bounded relational

contexts may obstruct communication between arenas. A possible consequence of this is that if people create narratives without finding ways to share them with others, or adjust and negotiate their plots to build common ground, they risk being distanced from each other, thus inhibiting partnership and resulting in fragmented practices. This may happen in dyadic relationships as shown in paper I, as well as between bounded relational contexts, such as professional groups, discussed in paper II, or in different arenas of practice, as portrayed in paper III.

Overall, the findings imply that relational aspects of healthcare practice seemed to be frequently repressed to an underground practice, as they could neither be eliminated due to their contribution to uphold foundational qualities in healthcare work, nor were they given the status of acknowledged practice (papers III and IV). Consequently, sufficient time and resources were not allocated to cover for the underground practices, while still taking up time and resources when acknowledged practice was not always enough to cater for the human needs inevitably encountered in everyday healthcare practices.

#### *8.1.1.3 Resources hidden in plain sight*

What would happen if the underground practices were recognized as equally important parts of the work as medically oriented tasks? And how could these presumably pre-existing resources be extracted and utilized? One contribution of this thesis is that the findings may offer an argument to why the activities carried out as underground practices may not just be trivialities of everyday life, but relational resources hidden in plain sight. The findings demonstrate how the mundane and seemingly trivial stories people share in everyday situations have much to offer in healthcare work if staff became more aware of their potential and were supported to actively employ them. Hence, a possible suggestion based on the findings is that broadly acknowledging and encouraging these underestimated resources might offer a beneficial way forward in the strive towards realizing PCP. How this can systematically be supported across professional groups would be a productive area for further research and development.

Despite the underground practices identified, the findings also showed how staff already reflected on the usefulness of relational work and portrayed a tacit narrative competence that supported narrative relations, although they did not explicitly frame their practice in terms of narrativity. Professionals' ability to engage in narrative relations was particularly apparent in their clinic backstage relationships and interactions, especially within professional groups, while less consistently noticeable in their interactions with patients in the clinic frontstage. As the findings show how backstage engagement in narrative relations could benefit clinic frontstage practices by preventing simplistic understandings of people and situations and helping staff see a fuller picture of patients' situations (papers II and III), they offer yet another argument for the

usefulness of not only focusing on patient-professional narration. This resonates with findings from previous studies from the field of communication research on clinic backstage teamwork (Ellingson, 2003; Fox & Brummans, 2019). Nevertheless, backstage narrative relations are not enough to fully understand patient situations if they are not also being responsive to patient stories in the clinic frontstage.

#### *8.1.1.4 Contributions to everyday healthcare practices*

What consequences for everyday healthcare practices come with shifting focus from narratives as outcomes to accepting a relational understanding? How can this knowledge support person-centredness and meaning-making in everyday practices in geriatric care? One possible implication is that staff can deliberately draw on narration, not only in dyadic relations with patients, but by extending it to also become a practical resource in their collegial and interprofessional relationships and interactions, which resonates with arguments advocating that realizing PCP requires person-centred cultures which must include *all* persons on all levels in the healthcare system (McCormack et al., 2021). The findings highlight the significance of creating mutual emplotments and meanings around everyday experiences, offering an argument for why such practices should not be understood as mundane and insignificant, but as possibly having potential as a resource for supporting transformation of care cultures towards PCP. Engaging in narrative relations may offer a means for staff to support patients in their ongoing narrative meaning-making around their situation, while also allowing for transmitting those patient narratives in the team to inform the healthcare activities and decisions more broadly. In other words, narrative relations may offer a vehicle for jointly created meanings around what is important to patients. In the same vein, they may offer a means for shared understanding and mutual respect between staff members regarding what is important for them in their different professional roles to be able to do a good and meaningful job, thus ensuring that no single professional perspective overrules other perspectives necessary for holistically oriented healthcare. However, questions remain about how narrative relations can be systematically supported to bridge professional boundaries in healthcare organizations that might still be characterized by profession-based silos and hierarchies (Braithwaite, 2010). Previous research has suggested core factors for promoting more connected and networked healthcare, including identifying gaps and boundaries in social and physical spaces, using 'boundary spanners', i.e. people who facilitate intergroup connections, and facilitating interactive relationships between groups (Braithwaite, 2015). Engaging in narrative relations is aligned with these suggestions yet may additionally offer a practical means accessible in everyday healthcare work if the value of such practices becomes generally acknowledged. The findings of this thesis present an argument to support such claims.

#### *8.1.1.5 Raising awareness of narrative relations to prevent unfavourable consequences*

Whilst the findings primarily imply beneficial consequences of engaging in narrative relations, they also shed light on some potentially harmful aspects, inferring an ethical issue for discussion. If practices of engaging in narrative relations are normative and hold the power to disseminate certain meanings, interpretations, or understanding, they may also contribute to uphold negative, limiting, or dehumanizing narratives and discourses or to reproduce and maintain traditional biomedical or task-oriented practices, as noticed in papers II and IV. In these cases, this effect was often not deliberately intended, but rather the result of oblivious or perfunctory practices of disseminating narratives without insight about the possible consequences. Such oblivious practices may not become visible until challenged by alternative narratives. Consequently, this entails an ethical argument to deliberately engage with, and to raise awareness around, the narratives that are taken for granted, and to allow for alternative or challenging understandings to come forward. Since this in turn may uncover power relations, thus potentially even present a perceived threat to those who may benefit from maintaining the dominant narratives and practices, it calls for establishing supportive structures for safe and respectful interaction where different voices and understandings are encouraged. This, too, aligns with contemporary discourse on PCP, which strongly emphasize that PCP must come from person-centred cultures involving all levels and relationships in the healthcare system (Karolinska Institutet, 2023; McCormack et al., 2021). Nevertheless, how to create such spaces where alternative narratives and various voices are equally represented and valued is an important area for future research.

### 8.1.2 Insights into the particularities of inpatient geriatric care practices

The findings of this thesis contribute to a better understanding of the contextual particularities of inpatient geriatric care. This setting typically differs from long-term residential care for older people in terms of length of stay, which may affect how relationships are understood, built, and maintained in relation to a specific context. Inpatient geriatric care may also present specific conditions in terms of the need for efficient integration and collaboration between multiple professional groups, health services and family members that often are included in the healthcare activities involving people admitted to these settings. This entails fundamentally different prerequisites for establishing adequate, multilateral relationships compared to long-term care settings where people stay for longer periods of time. Nevertheless, most previous research on narrative approaches in healthcare for older people has been conducted in long-term care settings.

In the study setting, engagement in narrative relations was suggested to support foundational qualities of the care work, such as building trusting relationships, supporting continuity and coherence, contributing to work-based learning among

colleagues and offering healthcare staff better understandings of other people's perspectives and situations. Moreover, as engagement in narrative relations is understood as a relational process that may be available for staff to tap into in their everyday interactions, instead of a task that should be completed, it is rather about cultivating an approach or culture that may offer multiple benefits without necessarily taking up more time. As shown in paper III, seeds to such approaches were already to be found in the underground practices. Yet, as seen in paper IV, available time, both in terms of length of stay and to keep up with the schedule during the day, was a backdrop that was frequently suggested to determine what practices were possible and what was explicitly valued in practice. Due to the tendency towards even shorter timeframes sanctioned for inpatient geriatric care services, this is a pertinent area for more research to understand the specific conditions in this context. However, when considered in a larger context, such as in relation to the desired shift towards people-centred healthcare systems or the current transformation of the healthcare system in Sweden towards *Good quality, local healthcare*, one may wonder whether a narrative relations perspective could also be useful in a larger sense to influence care cultures more broadly. Ultimately, the quite short time span for inpatient geriatric care is often just a part of a chain of health and social care measures, and intra-organizational continuity is not enough for patients' experiences of continuity. Questions arise around the potential role of narrative relations as a means for bridging organizational boundaries, thus creating better continuity between different service providers involved in the follow-up care around older adults admitted to inpatient geriatric care. As this thesis is limited to intra-organizational relations, such conclusions cannot be drawn. However, future research may find a narrative relations perspective useful to further explore its possible potential for interorganizational continuity.

### 8.1.3 Theoretical contributions

#### *8.1.3.1 The notion of narrative relations*

One conceptual contribution of this thesis is that it introduces the notion of narrative relations and presents insights into how narrativity has more to offer in terms of PCP than what may be achieved by merely focusing on eliciting patients' verbal narratives. The findings resonate with social understandings of narratives, implying that people's stories are in constant communication with other people's narratives, with broader cultural narratives, and even with narratives expressed in action or practices (e.g. Boje, 2007; Rudman & Aldrich, 2017). Coining the term *narrative relations* has been an attempt to conceptualize this broader application by also acknowledging that narratives of people other than patients are important for how everyday healthcare practices and relations evolve. Importantly, this is not to discount the importance of patient narratives or to reinforce professional-centred practices, but to acknowledge the impact of

professionals' narratives on how everyday healthcare practices are played out, including the possibility for patients to be supported in their ongoing narrative meaning-making.

The concept of narrative relations was first proposed in paper II, where narration, when reflected in healthcare professionals' experiences of their everyday work, was construed as a "relational process that people engage in to pursue and uphold several foundational qualities" of healthcare practice, and a phenomenon "characterised by a mutual narrative interchange between multiple narrators including patients, their relatives and staff" (Scholander et al., 2023, p. 3958). However, the ensuing analyses in papers III and IV made visible some limitations of this first conceptual description. Firstly, there was a lack of clarity in the status of the concept in terms of whether it should be understood as a definitive or a sensitizing concept according to Blumer's distinction: "Whereas definitive concepts provide prescriptions of what to see, sensitizing concepts merely suggest directions along which to look./.../ They lack precise reference and have no benchmarks which allow a clean-cut identification of a specific instance and of its content. Instead, they rest on a general sense of what is relevant." (1954, p. 7). In paper II, narrative relations might be read as a definitive concept. As I came to reconsider this in the subsequent studies, my understanding of narrative relations as a sensitizing, evolving concept is more clearly stated in paper III. Secondly, the first descriptions of narrative relations acknowledge the mutual narration between *people*, hence, the transactions with other available materials that may shape people's narrative interpretations are overlooked. Cultural narratives may as well be expressed through established practices (Alsaker et al., 2013). By using the narrative-in-action framework (Alsaker et al., 2009; Alsaker et al., 2013) and the threefold mimesis theory (Ricoeur, 1984) as analytical resources in paper IV, the concept of narrative relations was opened to be less restricted to relations between individuals.

A key contribution of the concept of narrative relations is that it offers a term that acknowledges the relational and transactional qualities of people's narratives, thus making such tacit practices and processes visible and possible to talk about, which is important in terms of raising awareness about how individual narratives do not occur in isolation but are continuously shaped in relation to others. The concept resonates with previous research oriented towards relational understandings of narrativity in healthcare practices, recognizing both patients and staff as narrative beings, and that their interactions are narratively shaped (Berendonk et al., 2017; Blix et al., 2019), thus moving focus from individual narratives to the ongoing co-constructive processes and transactions that shape and reshape people's narratives. Fox and Brummans (2019) have suggested that *joint emplotment* in backstage team meetings helps healthcare teams to collectively construct and negotiate a joint understanding of patients' situations by co-creating plots based on their different perspectives. Similarly, Clark (2015) has argued that interprofessional teams' insights into patients' narratives requires

knowledge about both patients' and professionals' narratives, since professionals' understandings of patients are largely shaped by their professional background and which understandings they have been socialized into. The concept of narrative relations adds to this knowledge by going beyond verbal communication and allowing for reconsidering everyday activities, situations, and interactions as promising arenas for joint narrative meaning-making where PCP can potentially be realized. As this understanding was not fully obtained when explaining the term narrative relations as suggested in paper II, an updated version might now be appropriate, acknowledging not only verbal transactions between people, but also that transactions with broader social narratives and practices shape people's narrative interpretations and constructions. Hence, narrative relations could more accurately be understood as an ongoing, communicative process of narrative interpretation, including multiple people and their social environments. Healthcare professionals' reflective engagement in narrative relations may contribute to pursue and uphold foundational qualities of healthcare practice, while oblivious narrative relations may as well disseminate and reinforce undesired or harmful understandings or practices. The ethical consequences of this are further discussed in section 8.3.

#### *8.1.3.2 Contrasting individualistic narratives to a relational, communicative understanding of narrativity*

The thesis contributes to theory development by linking existing theories about relational and communicative aspects of narrativity to how it might be played out in an inpatient care context. The currently strong emphasis on individual patient narratives may possibly have arisen from good intentions to see the whole person as a response to the tendency of medicine becoming too generic and biomedically oriented in its focus on treating diseases. For instance, while the GPCC-framework focuses on eliciting patient narratives (Ekman et al., 2011), it also strongly emphasizes partnership. However, it does not go as far as recognizing patient narratives as transactionally shaped and reshaped, thus having no motive for acknowledging the potential influence of professionals' narratives. The thesis contributes with an argument, developed through the dialectic between theory and empirical data, for the need to take a broader grasp of narratives in healthcare, beyond the patient narratives, as these are embedded in narrative relations. If accepting that people's narratives are embedded in shared cultural narratives, this implies that healthcare professionals must be supported to engage with those broader meanings to prevent dehumanizing practices of ascribing fixed single stories or stereotypes to people. This aligns with previous research suggesting a broader view of how narrative elicitation according to the GPCC-model can be understood, for instance by embracing non-verbal means and co-construction of narratives with other people, and by highlighting professional skills and strategies (e.g. Naldemirci et al., 2018; 2020). This also resonates with previous research from long-term care settings, suggesting that healthcare practices with older people could benefit from recognizing

and working with embodied narratives in a systematic way (Berendonk et al., 2017). This so called '*small story approach*' acknowledges the fluid conversational co-creations of narratives closely connected to the context in which they appear when people engage and interact in the present (Berendonk et al., 2017; Villar & Westerhof, 2023).

## 8.2 Methodological considerations

In this section, I discuss some key methodological considerations regarding the studies in the thesis. Positioning the thesis in an interpretative, constructivist tradition and choosing methodologies that offered flexible guidelines for data generation and analysis, instead of being prescriptive, entails both advantages and risks. In this section, I discuss such strengths and limitations among others, and reflect on how I have worked to safeguard academic quality and trustworthiness.

As narrativity is not tied to a particular research field, and narrative healthcare practices can be approached with various research methods, positioning the thesis in the vast and inclusive field of healthcare sciences requires clarity and consideration in terms of methodological choices. In this thesis, I have combined theoretical and methodological resources with roots in various scientific disciplines and drawn on experiential knowledge reported by healthcare professionals. Some methodologies originate from other scientific disciplines, such as the anthropological roots of ethnography or the philosophical roots of narrative theory. A strength with research located in the borderland of disciplines is that it offers possibilities in terms of letting different perspectives inform each other in dialogue instead of reinforcing disciplinary division and fragmented views of phenomena (Berner, 2011). While being aware that I do not have my basic education in philosophy or anthropology, and that I cannot possibly have reached the same depth as someone who has, I also see the benefits in what Berner (2011) calls intellectual integration, i.e. using methodological resources and traditions of thought from various disciplines, when aiming to understand practicalities of everyday life, which cannot be restricted to a particular discipline. However, although those perspectives and methods have enriched my data and my understanding, unifying different disciplinary perspectives also brings risks in terms of safeguarding internal consistency.

As argued by Carter and Little (2007), internal consistency between epistemology, methodologies, and methods is a key marker of quality in qualitative research, which I have consciously used as an overall guiding principle throughout the research process and in writing the thesis. In the exploratory process of this research, not all choices were settled at the onset, but they developed through careful consideration along the way. Reflecting together with experienced researchers on the methodological choices has been a way to facilitate my learning and development as a researcher, but also a means for chiselling out and locating my theoretical position and to understand consequences

of the choices. Some key points of this process include striving for congruity between philosophical perspective and research methodologies, between methodology and articulation of research aims, between methodology and methods for data generation, and analysis (Carter & Little, 2007; Joanna Briggs Institute, 2017), which are not one-time events but require ongoing monitoring of steps taken in the research process. Continuous reflexivity has also included my potential influence on the social situations of data generation and interpretation. Endeavouring towards sincerity, argued by Tracy (2010) as another quality marker of qualitative inquiry, I have engaged in writing reflective notes including my own experiences, convictions, weaknesses, or feelings that may have influenced the research. I have shared and discussed those reflections with peers and received valuable feedback and questions, both from the co-researchers involved in the studies and from a larger network of scholars experienced in qualitative methods, including but not exclusively narrative theory and methodology. Moreover, I have strived towards transparency in papers about the reports being interpretative products.

The exploratory design of the project and its overall aim required methodologies that allowed for close examination and engagement with the everyday situations and working practices in the setting I wanted to understand. Hence, I made methodological choices that allowed me to generate rich empirical data close to the everyday practices. As I wanted to achieve a thorough and contextualized understanding of the social and cultural particularities of such practices, I chose to generate data on only one site. This allowed for in-depth insights, and rich, accumulative data, as required in interpretative research. Yet, based on this it is neither possible nor intended to make broad claims in terms of generalizability. Instead, to enable transferability, rich descriptions of the research context and the assumptions underlying this research may invite readers to make connections and comparisons between the findings of this thesis and other settings and experiences.

A strength of the overall research approach was that I started off with ethnographic fieldwork to acquire intimate familiarity with the setting in terms of its working procedures, activities, and interactions. Ethnographic immersion in the field allowed me to observe everyday actions as they took place in their natural context, hence, offering a situated insight into the social and cultural conditions and the tacit knowledge expressed in practices, contributing to attain credibility in the research. These insights would have been harder to acquire if splitting my attention over different sites or if using methods based on retrospectively recounted experiences, such as in a decontextualized interview situation (Josephsson & Alsaker, 2015). Accounts of everyday action in an interview situation may take another focus, firstly because they are adapted to the context of that situation, and secondly, our everyday actions often unconsciously pass by, sometimes without ever being verbalized. However, as interviews

may offer insights into the experiences, reasoning, or interpretations of other people, which cannot be obtained by merely observing actions, I also engaged in informal interviews and conversations immediately linked to the real-time situatedness of the actions and situations I observed (Alsaker et al., 2009). Later, interprofessional focus group discussions added another type of data generated from participants' reflections on their everyday practices, allowing for a richer understanding of the activities and interactions on the ward based on professionals' experience-based expertise. Overall, the combination of these different data provided rich material for analysis, including thick descriptions of situations and interactions with concrete detail about the context in which they took place, supporting credibility (Tracy, 2010). Moreover, the different types of data, and inclusion of multiple voices from patients and people from different professional groups, together with theoretical resources, helped deepen the understanding by showing different facets of everyday practices in the study setting. Based on my epistemological position, I view this as a process of crystallization, which is a way to enhance trustworthiness by gaining richer data rather than a means for proving accuracy or validation (Carter & Little, 2007; Tracy, 2010). However, a possible risk with including multiple voices and perspectives is that breadth is prioritized at the expense of depth. Nevertheless, as the aim of the research was not tied to individual meanings, but to understand how social processes of everyday practice unfolded, this inclusiveness was a deliberate choice.

Ethnographic fieldwork also comes with other risks; one is that the researcher's presence affects the observed situations so that participants act differently or adjust to the researcher in different ways, which may result in misrepresentational data of the situations portrayed. Also, how the researcher responds to situations, or what type of questions one asks, may shape how situations unfold. To gain access to social situations and to minimise people acting differently due to my presence, I had to establish relationships over time with people, which in turn sheds light on another precondition: observations are not neutral and objective but affected by the researcher's preunderstandings and relationships in the field. As this risk is an epistemological precondition if accepting an interpretative position, it can never be fully eliminated. Instead, it requires awareness together with active attempts to mitigate these risks by being transparent and reflective about one's presuppositions and choices, and engagement in careful planning during the whole research process (Hammersley & Atkinson, 2007). Another issue is that ethnographic data generation is necessarily selective. As acknowledged by Hammersley and Atkinson (2007), it is not possible or desirable to observe everything that is going on in a complex social setting like the study site, and as an observer one must make strategic choices, both to include different perspectives and situations, and to generate rich, contextual data. To attain this, I tried to conduct participant observation at times of the day when most interactions and activities took place, and to join people from different professional

groups during a variety of activities and interactions. In terms of inclusion of participants, my intention was to involve a multitude of perspectives and activities to gain multifaceted insight into the everyday practices, at this point without prioritizing any viewpoint. As PCP and narrativity are not tied to any certain professional perspective, I was interested in this social setting as a whole; how different perspectives represented in the everyday practices on the site communicated, clashed, or cooperated, and the consequences of that. This ambition was beneficial to gaining a holistic understanding of the site, yet a consequence was that it gave more limited insights into different professional perspectives. As the findings, together with similar suggestions from previous research (e.g. Clark, 2015), implied that deeply rooted understandings held by different professional groups offer various views of what healthcare is and how it should be practiced, it would be valuable to gain more specific insights into the dominant narratives of different professional groups to be able to fully understand such professional differences, to compare them, and better understand how to bridge them. However, that would have required a longer period of ethnographic fieldwork with each professional group. For the same purpose it might have been beneficial to arrange uniprofessional focus groups. However, as the resources allocated to this doctoral project did not allow for either of these, it would be of interest to explore this further in future research.

A methodological challenge encountered early in the research process was that several staff members, who were not previously used to thinking about their work in terms of narrative, told me they perceived the notions of narration and storytelling[10] as theoretical and abstract. As this was thought to have implications both for the fieldwork and for the focus group discussions, my supervisors and I discussed the possible ethical and methodological consequences if the knowledge healthcare professionals have on this area might, to a large extent, be of tacit nature, meaning it could be difficult for them to verbalize if encountered with the topic for the first time in an interview situation. More broadly, it raised questions about how different forms of knowledge can be integrated in an ethically sound way, and how can it be justified to put theoretical labels on people's tacit knowledge. One way of dealing with this was to engage in a continuous dialogue between the actions I observed, participants' own reflections on their everyday practices, the theoretical resources, and tentative analytic ideas. The theoretical framework provided a means for interpreting the phenomenon and putting the empirical insights in dialogue with well-established theory about narrative and action. As the research progressed, it became possible to try out our analytical ideas of the phenomenon with the participants, chiselling out a language for their practices, which they could reflect on in the latter focus groups. Hence, a possible justification is that if

[10] In Swedish: "berättande".

the theoretical knowledge is believed to give a language to something that is valuable to the participants themselves, yet hard to make visible, it may be ethically motivated to suggest a language for it, and reflect on its *resonance* among participants and other audiences, described by Tracy (2010, p. 844) as a quality criteria referring to the 'research's ability to meaningfully reverberate and affect an audience'. As suggested by Gustavsson (2000a), the process of coming to *see something as something* is how interpretative research can make important contributions, because it implies seeing something as something *significant*. It contributes to translate one thing into another and to link experiences to meaningful wholes. While experiences may not be perceived in terms of theoretical concepts, the assumption that concepts about reality and the experiences of that reality are inextricably linked together, makes interpretation a means for creating theory and understanding a phenomenon. However, such theorizing insists on conscious ethical engagement to not become ignorant assumptions reinforcing other agendas. Although it was beyond the scope and resources available for this project, this displays a limitation regarding the fact that the project did not continue to involve participants in a more participatory phase and utilize these new theoretical insights to collaboratively develop new practical resources tied to their work. Yet, the knowledge produced so far has shed light on the already existing use of narration among staff in their practices in inpatient geriatric care, the possible benefits of engaging in narrative relations, as well as the pitfalls of oblivious use of narration. Such insights may be used as a knowledge base to reflect on in future participatory research projects to develop practices supportive and aware of narrative relations in similar settings.

The idea of using vignettes was another deliberate attempt to manage the issue of the uncertainties expressed by participants in terms of narration as a theoretical concept. Instead of starting off by asking questions about narration and PCP, the vignettes were used to prompt discussion and reflection about participants' everyday clinical experiences and practices in this setting, thus generating rich data about their everyday experiences and actions. When constructing the vignettes, I purposefully used situations that were reflected in the empirical data and the analytic insights from the first studies. Obviously, there is always a risk that the choice of vignette leads the discussion in a certain direction. Thus, I had the ambition to portray situations and interactions without implying any predefined explanations, values, or clues about how the situations should be understood. Thus, it was possible to reflect on the chain of events from the various positions of the different characters involved. An advantage with these vignettes was that they sparked vivid discussions about everyday practices on the ward, by first helping participants get started to reflect around the situation in the vignette, which soon enough was connected to their own everyday practices. However, a potential limitation was the use of only two different vignettes, and therefore it is not possible to say if other vignettes would have spurred other types of discussions. Nevertheless, as the vignette was mainly used for prompting discussion about everyday practices, the

larger portion of the focus group discussion was directed on their own practices, not on the vignettes. Although the interpretations made from bringing together various empirical data with theoretical resources may entail abstractions that would not exactly reflect what staff would report if asked how they use narration in their work, the contribution lies rather in the process of theorizing and generating new understandings of tacit phenomena. In this sense, an important part of the research process was to tease out methodological means to be able to understand something new about narrativity in everyday care practices. This is also why I gradually came to view the CGT process in terms of an abductive analysis, where the writings of Clarke et al. (2018) and Timmermans and Tavory (2012) helped me develop my understanding and justify why I came to recognize this kind of theory generation as not being purely inductive. Abduction offers a back-and-forth looping between the concrete specificities of empirical data and more theoretical ways of thinking about them (Clarke et al., 2018). Timmermans and Tavory (2012) have argued that abduction as the guiding principle of empirically grounded theory construction may be more accurate than purely inductive approaches when aiming for conceptual innovation, as it allows for an interplay between existing theories and empirical data. Hence, empirical data may contribute to seeing existing theory in a new way, while theory likewise may contribute to understanding the empirical data. According to my epistemological position, interpretation is not possible without preunderstanding, and the use of theoretical resources was necessary to better understand narrativity in healthcare practices by putting empirical data in dialogue with theory.

Generally, an advantage of the iterative processes advocated by the chosen methodologies made it possible to follow leads that emerged and to adjust the focus of the data generation as analysis evolved. This approach was suitable due to the explorative nature of the research project and allowed for new insights to evolve while learning from participants as the studies progressed (Morse, 2018). In the hermeneutic studies, the back-and-forth comparisons between data and tentative interpretations was one way to safeguard rigor and make sure there was enough data to support analytical claims. The constant comparative method used to analyse the focus group data was similar in that sense; constant comparison of data, codes, memos, and categories allowed for new decisions in consideration of preceding data and previously analytical ideas (Charmaz, 2014; Morse, 2018). One risk in this process, in terms of the researcher being the instrument for both data generation and interpretation, is that what a researcher notices in the data is shaped by prior understandings, and represents one view among many possible (Charmaz, 2014). While the knowledge claims are not to provide universal truths but to give deeper understanding of complex social phenomena, we still used some approaches to handle this risk in a scholarly sound way, for instance, to involve other researchers in reflective and critical discussion during the whole research process to include different perspectives. Also, the iterative progression

allowed for participant reflection on tentative analytic ideas during the process, giving insight into how the analytic ideas resonated with the participants. However, in the hermeneutical analysis of paper IV, no new data were generated, and new questions could not be further explored. To some extent, this was a limitation of that paper, while simultaneously pointing out a basic precondition for hermeneutic interpretation to be consciously aware of, namely that the 'whole' analysed in relation to its parts, is always a constructed whole, eventually part of an always larger whole, and somewhere lines must be drawn to be able to manage the amount of data. The methodological approach to handling this was to make continuous assessments about whether the data one works with is assumed to have substance and relevance for the research questions (Gustavsson, 2000a). The data, including both fieldnotes from participant observations and focus group transcripts, offered material that my colleagues and I deemed rich enough to adequately contribute to the aim of the study. Similarly, the ward as a research setting was somewhat treated as a bounded entity, while in fact, the activities and conditions on the ward were part of an even larger context, affected by political decisions and societal discourses – aspects not included in the analysis. Hence, while the findings of paper IV contribute to insights into how conditions for everyday practices in inpatient geriatric care were given various meanings, affecting how practices turned out, these insights must be considered as partial.

## 8.3 Ethical considerations

The studies in this thesis were approved by The Regional Ethical Review Board in Stockholm (reference number 2019-00248, paper I-III) and The Swedish Ethical Review Authority (reference number 2022-05463-02, paper IV). The application to attain ethical approval requires that research is planned and conducted in accordance with the Declaration of Helsinki (World Medical Association, 2013), taking into consideration that the potential benefits outweigh the burdens or risks, and the ethical principles of respect for people's autonomy and confidentiality, beneficence, non-maleficence, and justice. All presumptive participants received written and oral information about the research, data management and their right to withdraw at any time. Participants in the focus groups gave their written informed consent before participating in the discussions. The ethnographic fieldwork within everyday healthcare practices mandated another approach to safeguard ethical conduct and required that informed consent was repeatedly given throughout the data generation process.

Ethnographic fieldwork requires constant ethical awareness and reflexivity as it may include people in vulnerable situations. Avoiding such exposed situations would have distorted the data as such situations are part of the practices I wanted to understand. Hence, I needed to be persistently mindful about the integrity, privacy, and potential discomfort of participants, including both staff and patients, and therefore applied an ethics-in-practice approach (Huot, 2015) instead of just settling for one-time written

informed consent. This approach promotes ongoing and careful considerations regarding possibly problematic situations and the potential influence of my presence, which includes both aspects of 'relational ethics', i.e. being constantly thoughtful of my actions, words, whom I engaged with, and the possible consequences this may have on others, and 'situational ethics', referring to ethical practices that emerge from consciously considering a context's specific circumstances (Tracy, 2010). I repeatedly asked participants to give their consent to be observed in their practices. Nevertheless, a particularly challenging aspect was that, during participant observation, I often found myself entering ongoing situations and interactions. Since I was mostly going along with someone from the staff, we sometimes entered meetings or patient consultations involving others in the team as they had already started to interact. The ethical dilemma occurring in such situations was that if I interrupted the interactions to tell everyone why I was there, the natural interaction was considerably affected, while not asking for permission might be unethical in terms of informed consent. I reflected on this together with experienced colleagues in the research group, and over time, as staff on the ward became more used to my presence and I too had a better knowledge of them, these situations became easier to read. I also made sure to introduce myself to the patients when starting my observational session to prevent entering ongoing situations involving patients who had not previously agreed to my presence. However, it happened that difficult situations occurred, requiring instantaneous discernment whether it was most appropriate to stay or to leave, and I had to interpret the situation, gestures, and body language to make a decision.

During the participant observations I positioned myself as a learner, there to understand the everyday practices on the ward and to explore how narrativity was used and expressed in practices and interaction of this particular social and organizational setting. As I was not there to evaluate individuals' actions, I actively addressed this with participants, to make sure they were informed and comfortable with the focus of my observation, which was aiming at understanding activities, interaction and processes as occurring in their social context. In terms of observing staff, I was mostly kindly welcomed; people let me join them and were willing to share their reflections and explain what they did. Some people were more hesitant yet curiously inquiring into what they wanted to know before letting me join them. Others were more openly reluctant, and although only a few explicitly declined, I sometimes chose to not ask people who clearly gave non-verbal signals of not wanting to participate. Being perceptive and responding adequately to the ambiguity and potential discomfort that some people displayed, without becoming overly decisive on someone else's behalf, was an ongoing ethical challenge. However, as time went by, I experienced that people seemed more confident with my role, and I also learnt who was comfortable and positive to my presence and who was less so, which made it easier to find suitable situations to observe with more subtle cues from participants that they approved of my presence.

To safeguard participants' anonymity and integrity during participant observations, data was only recorded through fieldnotes instead of audio or video recording. As fieldnotes are always selective and affected by my perception and understanding of what is relevant, they are not neutral. However, I determinedly tried to separate my own reflections and early interpretations from more descriptive accounts of what I observed or heard. I strived towards not deciding beforehand what would be valuable to record or not, and instead write about everything I could recall. I also wrote the fieldnotes immediately after each observation session. Sometimes there was room for jotting down memos immediately after an observed situation and sometimes, such as during meetings, it was even appropriate to take notes. Such situations allowed for more precise renderings of conversations or quotes, yet it can never be as precise as an audio recording. As memo writing could also feel intrusive, I avoided it deliberately in several situations. However, the benefit of gaining access to situations that would not be ethically sound to audio or video record justifies the less precise renderings, and may nevertheless give sufficient insight into situations. I acquired support in these issues and decisions by reading methodological literature, and through continuous discussions with supervisors and researchers experienced in ethnographic methods. Audio-recorded data from focus groups were handled and stored to protect privacy of participants. Moreover, pseudonyms were used, and if personal information or attributes jeopardized anonymity, such information was altered in reports in a way that was thought to preserve the meaning.

The outbreak of the Covid-19 pandemic caused some ethical and methodological consequences in terms of the arrangement of focus group discussions. The ward was converted to Covid-19 care during spring 2020, and thus closed to all visitors. Neither did we consider it ethical to add to the staff's current workload and potentially perceived pressure in the new situation, by suggesting focus groups via digital communication channels. The methodological issues concerned the iterative research process given by the methodology, which we had to handle pragmatically. While the postponing of the initial groups did not matter significantly per se, we had to adapt data generation during and between the second and third waves, and arrange the focus groups when the staff on the ward had the capacity to participate. Hence, some of the groups had to be conducted more closely to one another than desired if wanting to complete initial coding between each session. We handled that by conducting preliminary analyses of the recorded discussions between the sessions, and the emerging questions and tentative analytic ideas from these discussions guided the next focus group. However, as those clusters of focus groups were separated by longer periods of time, coding and analysis could still iteratively guide the subsequent data generation. Thus, theoretical sampling was still possible. Participants were also given the opportunity to reflect on the tentative analytic ideas emerging through the process, as means to enshrine trustworthiness in the process.

On a final note, the findings presented in this thesis call for a discussion of their ethical implications. While practices of engaging in narrative relations have the potential to systematically support beneficial qualities of healthcare, their potential may also entail a risk of reinforcing negative beliefs, stereotypes or power structures if practiced obliviously. Even when not practiced systematically and consciously, there are reasons to assume that narrative relations exist to some extent in any social system. The shared meanings embedded in cultures are taking the form of narratives (Bruner, 1990). Moreover, narratives take a moral stance, implying something about what is good, bad, right or wrong, or what a certain action is assumed to achieve (Bruner, 1990; Mattingly, 1998b). Raising awareness about the narratives that are passed on or enacted by jointly reflecting on stories in everyday practices then becomes a necessity for an ethically engaged healthcare. Brody and Clark (2014) argue in terms of narrative ethics, that it is critical to train oneself to ask a few different questions related to whether a certain story makes it possible for people or groups of people to *hold their own,*[11] and whether there are other people for whom the story makes it harder to hold their own. If that is the case, how could the story be constructed differently from the others' perspective? And how could a situation be understood if both stories were compared side by side, instead of only accepting the first version? This might extend to healthcare organizations in the sense of an obligation to train and support co-workers to ask such questions – to ask for additional stories. A similar argument is put forward by Baldwin (2015), namely that if accepting that humans make sense of the world, themselves and others by means of narrative, then human action must be seen as narratively based and narratively contextual, which necessitates that we have insight into the narratives of which we are a part in order to act ethically. Conscious and facilitated engagement in narrative relations might offer a means for this, although there is more research to be done to sculpt possible ways of conducting and supporting such practices and awareness.

[11] In the sense of maintaining one's position and resisting giving in to pressure or opposition.

# 9 Conclusions

This thesis contributes to a deepening understanding of narrativity as a resource for person-centredness and meaning-making by showing how narrativity can be reflected in everyday practices and interactions of inpatient geriatric care. The findings show how interaction around everyday activities and actions creates relational opportunities for staff to better understand patients' unique situations, beyond merely eliciting their stories during more formalized consultations or interviews. The findings indicate that there are reasons to adopt a more inclusive view of narrative, moving beyond eliciting patient narratives, when acknowledging the potential use of narratives to achieve PCP. In the following, I outline some possible conclusions from the findings.

The thesis suggests a broadened understanding of narrativity that expands the focus beyond verbal narration and coherent stories, to rather entail an approach where it is possible to continuously tap into the ongoing narrative meaning-making that people engage in. This involves multiple people in transactional and open-ended processes of narrative interpretation. The thesis offers a term for this mutual narration involving multiple people in their social environment by introducing the notion of 'narrative relations'.

Healthcare staff's engagement in narrative relations may contribute to realizing and upholding foundational qualities in healthcare practice. These can include preventing simplistic understandings of people and situations; building trustful relationships with patients and each other across professional boundaries; and creating coherence in healthcare interactions that facilitates interprofessional learning, affinity and cooperation in the team. Yet, ignorant engagement in narrative relations may as well disseminate and reinforce undesired or harmful understandings and practices, which has ethical implications.

Mundane, everyday situations in inpatient geriatric care offer opportunities for staff to support patients' meaning-making around their situation. Yet, those opportunities might often be trivialized, overlooked by staff, or repressed to undervalued, invisible practices that are not commonly acknowledged as important parts of healthcare work. Similarly, everyday situations and activities between staff members offer opportunities for joint meaning-making around work-related concerns. Hence, there are reasons to reconsider the value of mundane, everyday situations in healthcare as a venue where meaningful stories can unfold and be co-created. This may open for a wider understanding of the use of narratives when aiming for PCP that goes beyond the often-promoted elicitation of patients' verbal stories.

To unlock this potential to support patients' meaning-making in everyday situations, it might be helpful to develop awareness around the staff members' ongoing narrative

meaning-making and narrative interpretations, as they influence how the joint construction of meanings together with patients can unfold. The impact of patient stories on healthcare activities seems highly contingent on how staff succeed in co-constructing and circulating the patient narrative in the team, thus making it significant in practice, instead of, for instance, merely co-creating diagnosis-centred or facts-based understandings of patients.

Practices of narrative relations may already take place in everyday healthcare practices, yet sometimes in invisible, oblivious ways not acknowledged as part of healthcare work. Research and development work that helps making use of this hidden resource may be a worthwhile path for future academic undertakings, and synergistic in terms of fostering person-centred care cultures.

# 10 Future perspectives

In this final chapter, I envisage potential implications for clinical practices, and suggest possible directions for future research.

A contribution to clinical practices is that the thesis acknowledges the significance of everyday situations and activities in inpatient geriatric care as arenas for joint narrative meaning-making. The thesis provides a theoretical, yet empirically grounded, argument for the need to reflect on the potential benefits gained from mundane situations and interactions in inpatient care. Granting these aspects of healthcare practices status of accredited parts of healthcare may have important implications for transforming healthcare culture towards person-centeredness, since these situations offer concrete arenas where relationships can be furthered and meaning created and negotiated for both patients and staff. Moreover, as such meaning-making practices already seemed to take place, often as hidden, underground practices, there may be an already-existing resource to mobilize instead of only adding new ways of working. Practices of engaging in narrative relations may similarly offer an already available social resource in everyday healthcare practices, yet they need to be consciously and ethically cultivated and employed by healthcare organizations. Methods for supporting such endeavours still need to be developed, calling for more research to articulate how mobilization of existing, yet tacit and possibly repressed, knowledge may be promoted in everyday practices. Other remaining questions are related to how healthcare organizations can create awareness among staff and managers about their narrative relations, in terms of their content, the arenas where they are played out, and the boundaries or communication between arenas. There is also a need for more research about how everyday clinical practices can give room for equal representation of different people's narratives, and for deliberately and actively facilitating communication between them.

The thesis also raises awareness about people's stories as relational and multifaceted co-constructions, which has implications for how to engage with stories in healthcare work. Adopting a relational understanding of narration in healthcare practices has implications for how to understand patient narratives, as it acknowledges that those communicate with other people's narratives and actions. Shifting the focus away from task-oriented practices of eliciting patient narratives, towards looking at how staff narratives shape the opportunities for how patient narratives can be understood and integrated in care work, may offer a means for truly making it possible for staff to listen to, respect, and support patients in their ongoing meaning-making. Embracing this perspective and acknowledging the ongoing transactions of everyday practices, may be fruitful in future research when aiming to advance the understandings of how to support change towards person-centred cultures in everyday practices. However, methods for

how to broadly foster relational understandings of narratives among healthcare staff are yet to be developed and researched.

Additionally, accepting a relational understanding of narrativity has consequences for how it can be approached and studied. If accepting that narratives and meaning-making are not merely individual issues, epistemological and methodological consequences follow: the research focus must shift from the individual to tap into the relational and collective processes, including the transactions between individuals and their social, cultural and material environment. To understand a person based on these assumptions, one must acknowledge that the person is not a fixed and isolated entity, but continuously evolving in communication with others and with their environment, which also affects what an individual narrative is.

Based on the above, the thesis could serve as a theory base for at least two possible purposes. Firstly, it could provide a theoretical justification for involving healthcare professionals in participatory research and development in terms of how narrative relations in healthcare work could be supported and fostered. Secondly, if initiating such research to develop practical methods and ways of working with narrative relations, the thesis could provide clarifications to make the notion of narrativity in healthcare, the relational perspective, and the benefits of it, more concrete for healthcare workers from different professional groups. Moreover, the knowledge presented in the thesis could be used as a rationale for why engaging in narrative relations would be potentially beneficial for *all* people – patients, families, and members of various professional groups. How this could be designed and employed is still to be uncovered in future research.

Whilst recognizing the potential of narrative relations in regard to supporting aspects such as continuity, workplace learning or building relationships, no conclusions can be drawn concerning potential outcomes for patients and healthcare systems more broadly. Neither is it possible to draw any conclusions about outcomes related to, for instance, staff job satisfaction, turnover rates, patients' experiences, length of stay, or readmission rates. To enable evaluation of such measures would first require that methods for systematic engagement in narrative relations are designed and implemented. As this thesis highlights that staff's different interpretations of everyday conditions affect how practices turns out not always following a linear logic, it is likely that participatory inclusion of healthcare professionals from different professional groups is needed to locate the tensions occurring in everyday practices as they are enacted. This could allow for a dialogue between these dynamics and structural facilitators or organization theories. Hence, there is much more to learn about how engagement in narrative relations can be systematically supported, about profession specific attitudes towards such practices, how organizations and management can facilitate these practices. Overall, an interdisciplinary and dialectic approach to knowledge generation in this area might be fruitful to future research when aiming to

transform everyday practices, thus taking into consideration the experience-based knowledge of healthcare workers, together with the existing knowledge base and perspectives from different academic fields.

# Epilogue

Returning to the optimistic plans of my younger self, I am now aware how little I knew about the complexities of everyday healthcare practices. Transforming everyday conditions and culture in geriatric care is not an easy endeavour that one takes on alone. Yet, the knowledge generated through this thesis adds a little piece to the puzzle of understanding of how meaningful and person-centred healthcare practices may come about for and with people, whether their role is as patients, families, significant others, or professionals.

Speaking of endeavours that one cannot accomplish alone, I now proceed to the last, most delightfully written part of this book.

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