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4TH INTERNATIONAL IN SICKNESS & IN HEALTH CONFERENCE

CHANGING PROFESSIONAL PRACTICES AND NEW NOTIONS OF HEALTH AND ILLNESS

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WELCOME

Dear Conference Participants,

Welcome to the 4th In Sickness and Health Conference!

And welcome also to Odense, this beautiful city right in the middle of Denmark. Odense was founded more than 1000 years ago, and I hope you will have time to walk or cycle around in the city centre or follow the winding river through green parks. Odense's claim to fame is probably as the native town of the poet Hans Christian Andersen, before his urge for travel sent him off to Copenhagen and to explore large parts of Europe.

I am so pleased that you have decided to join us in critical debate and discussion at this 4th In Sickness and Health Conference. If this is the first time you've been able to attend the conference, I hope that you will find colleagues here with interesting questions and ways of thinking about the issues that both trouble us in health care – but also offer us such rich ground in which to explore. If you have attended some of our previous conferences, I hope that you will enjoy a comparable experience, this time with a Scandinavian twist to it!

The 4th In Sickness and Health Conference awoke a lot of interest from scholars around the world, but the tightening of travel budgets meant that many scholars had to cancel their participation. We have deliberately decided to view these changes as reinvigorated opportunities to engage in closer discussions, which are reflected in the programme. Previous conferences have been characterised by open and informal intellectual discussions and networking, and it is our hope that these qualities will be central at this conference too.

Although the conference is concerned with classic social-anthropological conceptions of health, individual and society, motives for research and methods described in the abstracts are not *comme il faut*. Those of us hosting this conference hope you will find a 'home' at this conference and that you will join us in expanding the community of scholars who ask and seek answers to questions about how it is that things come to be the way they are currently in health care – and what it would take for things to be different?

I want to express my thanks to my planning colleague, Lotte Huniche (University of Southern Denmark) for her great support and assistance to me in organising this conference. I also want to thank my colleagues, Sioban Nelson, David Holmes, Trudy Rudge, Denise Gastaldo, Kristin Björnsdóttir, Christine Ceci, Mary Ellen Purkis and Anthony Pryce for their tremendous contributions to developing the programme for the conference.

We started out as the "Helsinki Seven" and we're growing! Which bodes well for what we all hope will emerge from our time together over the next few days.

Niels Buus,

Conference Chair

PROGRAMME AT-A-GLANCE

WEDNESDAY MAY 4TH		
9.00-15.00	Daytrip to Kolding: Trapholt Museum for art, and The Danish Nursing History Museum.	
16.00-18.30	Registration open	
17.00-17.15	Opening comments	Professor Helle Johannessen
17.15-18.30	1. Plenary	Professor Lorna Rhodes
18.30-20.00	Reception	
THURSDAY MAY 5TH		
8.30-17.00	Registration open	
9.00-10.15	2. Plenary	Professor Davina Allen
10.15-10.45	1. Coffee break	
10.45-12.30	1. Concurrent sessions	
12.30-13.30	1. Lunch	
13.30-15.15	Round table discussions	
15.15-15.45	2. Coffee break	
15.45-17.00	3. Plenary	Professor Ole Dreier
17.15-18.15	Social event	
18.30-	Conference dinner at SDU	
FRIDAY MAY 6TH		
9.00-10.15	4. Plenary	Senior Lecturer John Paley
10.15-10.45	3. Coffee break	
10.45-12.30	2. Concurrent sessions	
12.30-13.30	2. Lunch	
13.30-15.15	3. Concurrent sessions	
15.15-15.45	4. Coffee break	
15.45-17.00	5. Plenary	Professor Mats Alvesson
17.00-17.15	Closing comments	

DETAILED PROGRAMME

WEDNESDAY MAY 4TH:

17.00-17.15: OPENING COMMENTS

Professor Helle Johannessen

17.15-18.30: 1. PLENARY SESSION. Auditorium O 100.

Chair: Niels Buus

Professor Lorna Rhodes: *Ethnography of and in supermax prisons*

18.30-20.00: WELCOME RECEPTION

THURSDAY MAY 5TH:

9.00-10.15: 2. PLENARY SESSION. Auditorium O 100.

Chair: Lotte Huniche

Professor Davina Allen: *"Just a typical teenager" – normalization, self and other in mothers' accounts of parenting young people with diabetes*

10.15-10.45: COFFEE BREAK

10.45-12.30: 1. CONCURRENT SESSIONS

Auditorium O 100. Home care

Chair: Mark Avis

1. Christine Ceci, Mary Ellen Purkis and Kristin Bjornsdottir. *Aging and accommodation: contemporary practices of justification*
2. L. M. Funk. *Home health care and family responsibility: a critical analysis of the accounts of managers and leaders*
3. K Kuluski, A. P. Williams, W. Berta and A. Laporte. *Waiting for Long-term care: the role of home and community based care capacity in shaping risk of placement in Northwestern Ontario*

Room O 94. Technology

Chair: Lotte Huniche

1. E. M. Borycki and M. Alford. *Effects of hybrid paper-electronic environments upon nursing practice*
2. Ingunn Moser and H. Thygesen. *Telecare for the elderly living at home: new arrangements, practices and relations*
3. S. Van Droogenbroeck. *VERO: innovative equipment. Let's see what we can do with it*

Room O 95. Standardization

Chair: Christina Foss

1. Miriam Grotowski, S. Taylor, J. Ward and Anne Croker. *"It's ok for some": what happens when patients don't fit the directed model of care?*
2. Lorelei Newton, S. A. Kimpson, M. M. Alford and Mary Ellen Purkis. *Translating practice(s): promises and perils for nurses adopting best practice guidelines*
3. Kristin Bjornsdottir. *The place of standardization in home care practice*

Room O 96. Professionals

Chair: Niels Buus

1. M. Hall and Trudy Rudge. *Professionalising agenda or hidden agenda*
2. Fang-Tzu Yen. *An analysis of the effects of gender, culture and power relations on the doctor-patient communication between Taiwanese doctors and immigrants from Southeast Asia.*
3. B. Croker, Anne Croker, Miriam Grotowski and J. Charles. *Unsettling a medical student's biomedical socialisation*

Room O 97. Institutional ethnography

Chair: Lorna Rhodes

1. Catherine O'Neill. *Bioethics and Dorothy Smith: How institutional ethnography can extend and enrich the bioethical discourse... perhaps?*
2. Britt Mari Olsen. *Collaboration across organizational border: in the consumer's best interest*
3. Janet M. Rankin and Marie L. Campbell. *Knowledge and gender relations at the intersection of nursing work and technology*

Room O 98. Professional practice

Chair: John Paley

1. Thomas Foth. *Understanding nursing as dispositif: healing and devastation in the age of biopower*
2. K. A. Kristensen. *Qualifying pedagogical practices of health promotion in educational support for people with developmental disabilities*
3. Trudy Rudge, Amelie Perron and Dave Holmes. *Domesticating research: practice development and its organisational agenda*

Room O 99. Normalization

Chair: Andreu Bover

1. Carl R. May, F. S. Mair and T.L. Finch. *A political sociology of translational gaps: actor-networks, normalisation processes, and the configuration of patients as a distance in telemedicine and telecare*
2. Christine Øye. *Care as boundary work – a study of protection and normalization work in a psychiatric hospital in Norway*
3. Ruth Desouza. *Civilising mothers: health professional discourses of migrant maternity in Aotearoa/New Zealand*

12.30-13.30: LUNCH

13.30-15.15: ROUND TABLE DISCUSSIONS

Room O 94. *Theory driven qualitative research*

Chair: Denise Gastaldo and Lorna Rhodes

How do qualitative researchers incorporate theoretical concepts into their work? Or, put differently, how does empirical research engage theory in such a way that analysis emerges organically from and illuminates the practices of everyday social life? In this session participants will discuss the opportunities and dangers of organising research using well-defined theoretical frameworks and concepts.

Room O 95. *Professional practice and change in health care delivery*

Chair: Mary Ellen Purkis, Christine Ceci and Kristin Bjornsdottir

Senior leaders responsible for the delivery of health care often portray the knowledge claims of professional practitioners as problematic and self-serving. These knowledge claims can be rejected on a number of different levels: they reflect a failure to engage in interprofessional team work, they reflect an attachment to a distant, historical past, they reflect an attempt to professionalize and valorize what is simply resistance to change. In this session, participants will discuss methods and models of organizational change with an aim of exploring the tensions between professional knowledge and organizational change and a desire to unearth opportunities for one to be achieved through the other

Room O 96. *Critical research in the 21st Century*

Chair: Lotte Huniche and Ole Dreier

We both work from a theoretical background in critical psychology that places emphasis on critique as an indispensable part of driving theoretical as well as practical development forward. We would like to share thoughts on what needs we have for critical research today. We would also like to discuss the conditions, opportunities and limitations for conducting research with a critical angle in various national/local context. What are the current challenges for criticality within academia and with respect to conducting research on intervention, developmental work and practice research?

Room O 97. *Health care reform - governmentality and control*

Chair: Trudy Rudge and Dave Holmes

Foucault offers a position to explore how thinking and practices of government changed with the rise of liberal government in the 18th Century. Governments since this time were concerned with how to govern through more refined and diffuse means and political technologies. Hence governmentality (strategies and ways of thinking about governing) used biopower (anatomopolitics and biopolitics) to govern health of individuals and of populations to bring about healthcare reform. Discussions and questions about 'governing' health/health work (in various settings) will be the focus of this section.

Room O 98. *Publication*

Chair: Michael Traynor and Niels Buus

Michael and Niels are co-editors of the medical sociology journal *Health*; and Michael is also European editor of *Nursing Inquiry*. We plan to introduce or remind those attending about the stages of the decision-making process that occur when you submit papers to journals such as *Health* and *Nursing Inquiry*. We will talk about ways of maximising the chances of getting your paper accepted and issues like authorship and what colour paper to use.

15.15-15.45: *COFFEE BREAK*

15.45-17.00: 3. *PLENARY SESSION*. Auditorium O 100.

Chair: Lotte Huniche

Professor Ole Dreier: *Illness and treatment in everyday lives*

17.15-18.15: *SOCIAL EVENT*

18.30: *CONFERENCE DINNER* at University of Southern Denmark

FRIDAY MAY 6TH:

9.00-10.15: 4. PLENARY SESSION. Auditorium O 100.

Chair: Niels Buus

Senior lecturer John Paley: *Lies, damned lies, and stories. The romanticisation of narrative in health care*

10.15-10.45: COFFEE BREAK

10.45-12.30: 2. CONCURRENT SESSIONS.

Auditorium O 100. Categorizing deviancy

Chair: Helle Johannessen

1. Dave Holmes. *Civilising the "barbarian": a critical analysis of behavior modification programmes in forensic psychiatry settings*
2. E. Walsh and Dawn Freshwater. *Dominant discourses as technologies of identity in offender health care*
3. Amelie Perron and Trudy Rudge. *Exploring violence in a forensic hospital: a theoretical experimentation*

Room O 94. Care

Chair: Ingunn Moser

1. Catherine Ward-Griffin, J. Keefe, A. Martin-Matthews, J. Belle Brown, M. Kerr and O. St-Amant. *Nurses caring for elderly relatives: examining the care work of double duty caregivers*
2. G. Ottmann, C. Laragy and J. Allen. *Risk, risk management and duty of care in self-directed social aged care: exploration of an enabling risk management model*
3. J. P. Ronan. *The onus of self-care and self-management: a treatise on resisting neoliberal realities while caring for the self*

Room O 96. Medication

Chair: Mary Ellen Purkis

1. Christina Foss. *Patient participation revisited: contextualizing elderly respondent's experiences and reflections on participation*
2. K Fahnøe. *Enacting medication in in-patient rehabilitation for alcoholics*
3. Niels Buus. *Explaining adherence to antidepressants*

Room O 98. Body

Chair: Marie Campbell

1. Jo Gilmartin. *A critical literature review: the impact of reconstructive surgery following massive weight loss on patients' quality of life*
2. I.R. Knutsen, Christina Foss and L. Terragni. *Weight-loss treatment as empowerment or as a new form of dependency*
3. Jo Gilmartin. *Contemporary cosmetic surgery: the potential risks and relevance for practice*

Room O 99. Unhealthy categories

Chair: Carl May

1. A. M. Evans. *The place of madness: from banishment outside to banishment within*
2. O. Petrovskaya. *The difficult patient: a new spin of an old tale*
3. S. Donovan. *Older people and falls: constructions of care.*

Room O 77. Illness experiences

Chair: Christine Ceci

1. V Jayde, M Boughton and P Blomfield. *"She is a jewel": the link between professional practice and the experience of ovarian cancer*
2. Elisabeth Assing Hvidt, Helle Ploug Hansen and H. R. Iversen. *Meaning making among Danish cancer patients in rehabilitation: a taylorian perspective*
3. M. A. Boughton. *The fragile nature of health: suddenly and unexpectedly confronted with a life threatening illness and its aftermath*

Room O 78. Health

Chair: Bridget Hamilton

1. H. Haslund-Thomsen. *Establishing family after birth of light preterm infant*
2. Beverly L. Edwards. *African American women's perceptions of health, treatment and illness and its relationship with professional practice* (virtual presentation)
3. Ignaas Devisch. *The style of our life: a health issue?*

Room O 79. Globalisation

Chair: Nina Nissen

1. S Horghagen and S Josephsson. *Theatre as collaboration, liberation and relationship for asylum seekers*
2. Denise Gastaldo, L. Magalhaes, C. Carrasco. *Web of solidarity and exploitation: entangled individual and social responses for global economic problems*
3. Andreu Bover, Denise Gastaldo, M. Miró and E. Peter. *The power of home (un) care: caregivers' discourses in the Spanish context*

12.30-13.30: LUNCH

13.30-15.15: 3. CONCURRENT SESSIONS

Auditorium O 100. Participation and empowerment

Chair: Denise Gastaldo

1. Betina Dybbroe. *Empowerment as concept and new professional tool in health promotion?*
2. S. Chaudhary, Mark Avis and C. Munn-Giddings. *Early findings from a study of UK self help groups. Can Habermas' model of the public sphere be a useful tool for understanding self help groups' civic role? And what does the case of self-help groups tell us about the relevance of Habermas' theory?*

Room O 94. Professions and practice

Chair: Amelie Perron

1. P. Fisher and R. Deery. *Emotionally engaged practice and the pursuit of excellence in midwifery*
2. Mary Ellen Purkis, M. Alford, L. Newton and S. Kimpson. *Clearing a space for nursing practice: boundary work in ambulatory cancer care*
3. Anne Croker, F. Trede and J Higgs. *Down under collaboration: embracing the complexity of interprofessional care*

Room O 96. Ethics

Chair: Mats Alvesson

1. H. Lausund. *What does the context of home nursing care consist of and how does this context affect the ethical approach of practice?*
2. Michael Traynor, A. Evans and C. Leliopoulou. *Masochism in nursing: ethics after Lacan and Zizek*
3. G. B. Nielsen and Katie Eriksson. *Caring ethics as presence: a pivotal view on ethics in caring relationships*

Room O 98. Qualitative methodology

Chair: Janet Rankin

1. Bridget E. Hamilton. *What can we gain from ethnographic research? A review of strong and weak analyses of everyday nursing practice*
2. Elise B. Bukhave, Mette Rothmann and Lotte Huniche. *Doing qualitative interviews facilitated by the use of photographs*
3. A. Ostenfeld-Rosenthal. *General practitioners and spiritual healers compared. An anthropological comparative analysis of MUS patients' experience of respectively GP consultation rituals and spiritual health rituals*

Room O 99. Young people

Chair: Dave Holmes

1. C. Janzen and D. Jefferey. *Prescriptions for practice: Children, psychopharmaceuticals and the governance of difference*
2. R Einboden, Trudy Rudge and C Varcoe. *Producing children: healthy development, risk & human capital*
3. Maureen Ryan. *Performing health: a genealogy of nurses' adolescent health promotion practices*

Room O 77. Health

Chair: Ole Dreier

1. S. L. Moore. *A place called home: the social and cultural context of health*
2. A. Greene and D. Martin. *Changing lenses: from illness to wellness*
3. C. van Mossel. *Policy as technology in health/care*

Room O 79. Gender and groups

Chair: Davina Allen

1. C. McDonald, M. McIntyre and P. Brown & O. Petrovskaya. *A critical analysis of institutional heterosexism and its effects on citizenship*
2. L. Gibson and Nina Nissen. *Making visible gendered processes in complementary and alternative medicine*
3. K. K. Roessler. *The responding relationship*

15.15-15.45: COFFEE BREAK

15.45-17.00: 5. PLENARY SESSION. Auditorium O 100

Chair: Niels Buus

Professor Mats Alvesson: *The Triumph of Emptiness*

17.00-17.15: CLOSING COMMENTS

POSTERS

1. LISBETH HYBHOLT:

How to study the impact of patient education on the chronic patient's everyday life?

2. LOUISE HYLDBORG LUNDSTRØM:

Junior doctors in general medicine: the concept of power

3. LENE MOESTRUP:

Existential needs of dying cancer patients and their relatives during the terminal phase in a Danish hospice

4. CAMILLA BLACH ROSSEN, NIELS BUUS AND ELSEBETH STENAGER:

Ethnic minorities' use of the community mental health services: an interview study of illness models among mentally ill minority groups and their relatives

5. CHRISTINA PRINDS RASMUSSEN:

Faith, existence and motherhood with premature babies

6. S GONZÁLEZ, P SEGUÍ, J PERICÀS, M BENNÀSSAR:

The vision of nursing students about the work in primary care

7. P SEGUÍ, M BENNÀSSAR, J PERICÀS, A AGUILÓ, S GONZÁLEZ, J DE PEDRO:

Health promotion in university curriculums from the university of Balearic Islands

8. BRITT MARI OLSEN:

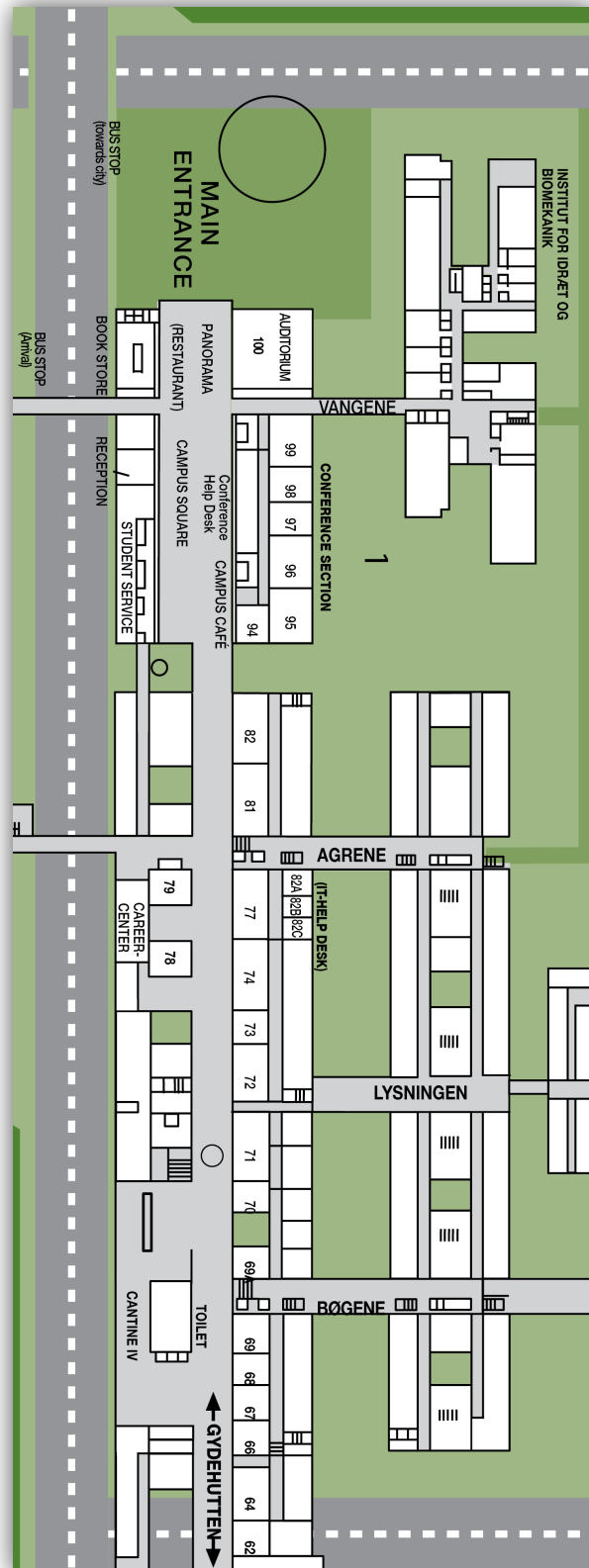
Collaboration across organizational border: in the consumer's best interest

BUS SCHEDULE

- CENTRAL STATION TO CAMPUS

Bus #	Bus Station Section B	Departure	Hans Mølle Gade	Georgsgade	Nansensgade	Ejbygade	L. A. Rings Vej	Rosengårdcentret	Blåka	Campus
41	05.21	05.25	05.27	05.29	05.31	05.32	05.34	05.35	05.37	05.41
41	06.19	06.23	06.25	06.27	06.29	06.30	06.32	06.33	06.35	06.39
41	06.53									
40U		07.23	07.25	07.27	07.29	07.31	07.33	07.35	07.40	07.45
41	07.26	07.30	07.33	07.35	07.38	07.39	07.42	07.44	07.47	07.52
40U		07.37	07.39	07.41	07.43	07.45	07.47	07.49	07.54	07.59
41	07.41	07.45	07.48	07.50	07.53	07.54	07.57	07.59	08.02	08.07
40		07.53	07.55	07.57	07.59	08.01	08.03	08.05	08.10	08.15
40U		08.10	08.12	08.14	08.16	08.18	08.20	08.22	08.27	08.32
41	08.16	08.20	08.22	08.24	08.26	08.28	08.30	08.32	08.37	08.42
40U		08.30	08.32	08.34	08.36	08.38	08.40	08.42	08.47	08.52
41	08.36	08.40	08.42	08.44	08.46	08.48	08.50	08.52	08.57	09.02
40U		08.50	08.52	08.54	08.56	08.58	09.00	09.02	09.07	09.12
40		09.00	09.02	09.04	09.06	09.08	09.10	09.12	09.17	09.22
40U		10	12	14	16	18	20	22	27	32
41	16	20	22	24	26	28	30	32	37	42
40U		30	32	34	36	38	40	42	47	52
41	36	40	42	44	46	48	50	52	57	02
40U		50	52	54	56	58	00	02	07	12
40		00	02	04	06	08	10	12	17	22
41	12.36	12.40	12.42	12.44	12.46	12.48	12.50	12.52	12.57	13.02
40U		12.50	12.52	12.54	12.56	12.58	13.00	13.02	13.07	13.12
40		13.00	13.02	13.04	13.06	13.08	13.10	13.12	13.17	13.22
40U		13.10	13.12	13.14	13.17	13.20	13.22	13.24	13.30	13.34
41	13.16	13.20	13.22	13.24	13.27	13.30	13.32	13.34	13.40	13.44
40U		13.30	13.32	13.34	13.37	13.40	13.42	13.44	13.50	13.54
41	13.36	13.40	13.42	13.44	13.47	13.50	13.52	13.54	14.00	14.04
40U		13.50	13.52	13.54	13.57	14.00	14.02	14.04	14.10	14.14
40		14.00	14.02	14.04	14.07	14.10	14.12	14.14	14.20	14.24
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40U		30	32	34	37	40	42	44	50	54
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40U		50	52	54	57	00	02	04	10	14
40		00	02	04	07	10	12	14	20	24
40U		10	12	14	17	20	22	24	30	34
41	16.36	16.40	16.42	16.44	16.47	16.50	16.52	16.54	17.00	17.04
40U		16.50	16.52	16.54	16.57	17.00	17.02	17.04	17.10	17.14
40		17.00	17.02	17.04	17.07	17.10	17.12	17.14	17.20	17.24
40U		17.10	17.12	17.14	17.17	17.20	17.22	17.24	17.30	17.34
41	17.21	17.25	17.27	17.29	17.32	17.35	17.37	17.39	17.45	17.49
41	17.51	17.55	17.57	17.59	18.02	18.04	18.06	18.08	18.13	18.17
41	18.21	18.25	18.27	18.28	18.30	18.31	18.33	18.35	18.38	18.44
41	18.51	18.55	18.57	18.58	19.00	19.01	19.03	19.05	19.08	19.14
41	19.21	19.25	19.27	19.28	19.30	19.31	19.33	19.35	19.38	19.44
41	19.51	19.55	19.57	19.58	20.00	20.01	20.03	20.05	20.08	20.14
41	20.21	20.25	20.27	20.28	20.30	20.31	20.33	20.35	20.38	20.44
41	20.51	20.55	20.57	20.58	21.00	21.01	21.03	21.05	21.08	21.14
41	21.51	21.55	21.57	21.58	22.00	22.01	22.03	22.05	22.08	22.14
41	22.51	22.55	22.57	22.58	23.00	23.01	23.03	23.05	23.08	23.14
41	23.51									

MAP OF CAMPUS - CONFERENCE SECTION



ABSTRACTS, PLENARY SESSIONS

“JUST A TYPICAL TEENAGER” – NORMALIZATION, SELF AND OTHER IN MOTHERS’ ACCOUNTS OF PARENTING YOUNG PEOPLE WITH DIABETES

D Allen (allenda@cf.ac.uk)

Cardiff University, Wales

A discourse of ‘normal adolescence’ dominates the space in which young people with diabetes, parents and clinicians make sense of health behaviours. Adolescence is widely understood as a universal transient phase driven by biological impulses and characterized by emotional turmoil and risk-taking. This view, which has its origins in developmental psychology, has been largely discredited within the academic literature, but persists both in formal theory and everyday use. It is suggested that this anomaly can be understood in part because ‘normal adolescence’ provides a framework of understanding and vocabularies of motive with which to negotiate the other conflicting discourses which shape the moral order at this stage of the life-course: normalization, teenage autonomy and adult responsibility. In the diabetes field, these tensions are expressed most powerfully by mothers, reflecting the ambiguity of their status whereby they are expected to encourage their child’s independence on the one hand, but feel held to account for their actions on the other. Drawing on qualitative interviews generated in a wider study of the transition from child to adult diabetes services, in this paper I will consider how mothers evoke discourses of ‘normal adolescence’ to do two kinds of interactional work: management of their own moral credentials and management of the moral credentials of their child. Part of the power of a psychological discourse of ‘normal adolescence’ is that it furnishes an interpretative frame and discursive resources through which present difficulties can be accounted for and contained and more optimistic futures constituted.

THE TRIUMPH OF EMPTINESS

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University of Lund, Sweden

Grandiosity and illusionary acts in contemporary organizations. The talk argues that we, in particular in the West, live in an age of grandiosity, putting imprints on contemporary organizations. The mundane and trivial are, whenever possible, being transformed into something much more aesthetic and appealing. Value is seemingly increased or enhanced with minimal cost – just through adding a more desirable label or image. There is a boosting of claims of progress, achievements and extraordinary qualities of individuals, occupations, organizations and societies. This has frequently less to do with substance – ‘real’ improvements or practices/material reality living up to fantastic claims are rare. Contemporary grandiosity is not like older forms, intended to celebrate elite superiority and easily identified as symbolism enhancing, but is more subtle, democratic and is intended to conceal through claims to illuminate the truth. There is a symbolic pollution of the world through the extensive production and distribution of images loosely connected to, or contradicted by, material reality – a reality becoming more and more ambiguous. In organizations we have leadership, ethics, competence development, strategies, knowledge-intensiveness, professionalism, visions and values, gender equality, diversity, quality, knowledge management ... Or perhaps not?

ILLNESS AND TREATMENT IN EVERYDAY LIVES

O Dreier (ole.dreier@psy.ku.dk)

University of Copenhagen, Denmark

Changes in health care policies and practices in recent decades have increased the reliance on patients' everyday activities to supplement, follow-up, and maintain treatments. They have led to new, precarious relations between professional practices and regimens, on the one hand, and patients' everyday experiences of health and illness, on the other.

Nonetheless, there is a trend in research to zoom in on isolated causal mechanisms studied under special conditions. This broadens the gap between the gaze of research and the new, everyday-dependent arrangements of health care practices. In research patients are mainly visible at a pragmatic level concerned with patient choice, consumer perspectives and satisfaction, patient responsibility and adherence. In other words, patients are seen in relation to the health care delivery while the new reliance on patients' everyday lives is not captured. This leaves professionals with little research basis for their boundary crossing work with patients.

A critical corrective to this situation is needed. After all, illness, treatment, and health are, first of all, part of people's ongoing everyday lives. Centering on everyday lives in health care research raises other topics and issues and leads to other empirical findings and conceptual expansions. I shall present Examples of how to do such research from the research group on Personal Conduct of Everyday Life and Intervention where we have used various designs and methods to study the everyday lives of persons in relation to various medical and psycho-social treatments.

LIES, DAMNED LIES, AND STORIES THE ROMANTICISATION OF NARRATIVE IN HEALTH CARE

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University of Stirling, Scotland

Consider the following claims that have been made about statistics:

- “The secret language of statistics is employed to sensationalize, inflate, confuse, and oversimplify.”
- “Statistics primarily function as part of a persuasive argument.”
- “Sometimes statistical methods and terms are unwittingly misused, especially in the media. On other occasions, statistics are consciously used to baffle, deceive, legitimize decisions, and bolster authority and power.”
- “In the modern world quantification has a prestige and power which was unparalleled in medieval Europe.”
- “Numbers convey information in a familiar, standardized, and reassuring form. At the same time, the very power and persuasion of statistics obscures the fact that numbers are social and historical artefacts.”
- “There is a great irony in our eagerness to use statistics and believe them. Quantification appears to make knowledge uniform and universal, but its seductive force makes it an ideological instrument of oppression, homogeneity and deception.”

The thesis of this paper can most effectively be conveyed by substituting ‘story’ or ‘stories’ for every occurrence of ‘statistics’, ‘numbers’ and ‘quantification’ in the above excerpts. The currently dominant ideology in health-related epistemology emphasises the limits of quantification but romanticises narrative, making it difficult to recognise that the abuse-capacity of statistics is rivalled, and very often outstripped, by the abuse-capacity of stories. Stories inflate, confuse, baffle, oversimplify, seduce, and deceive. They are social and historical artefacts whose primary function is persuasion, and whose unparalleled prestige masks their ideological power. The paper will justify these claims, and reflect briefly on the implications for health care.

ETHNOGRAPHY OF AND IN SUPERMAX PRISONS

L Rhodes (lrhodes@u.washington.edu)

University of Washington, USA

How do we conduct ethnography in "closed" and difficult environments? And how do we address the even more challenging problem of finding our theoretical way in the midst of such intense ethnographic practice?

This talk describes research in the supermax prisons of Washington state (USA), facilities where prisoners are held in long-term solitary confinement and where a framing of crime in terms of "choice" dominates local discourse. The process of research, the internal dynamics of these institutions, and the potential for theoretically informed understanding will be addressed.

ABSTRACTS, PAPER PRESENTATIONS

EFFECTS OF HYBRID PAPER-ELECTRONIC ENVIRONMENTS UPON NURSING PRACTICE

EM Borycki & M Alford (malford@bccancer.bc.ca)

University of Victoria, Canada

Purpose: The authors will present on the preliminary results of a qualitative study that captures the impact of hybrid paper-electronic health care environments (i.e. where web-based guidelines and paper/electronic patient records are used as sources of information) upon nurses' work practices.

Background: Electronic patient records (EPRs) have promised to revolutionize nursing practice globally by making patient information more accessible to nurses. EPRs are electronic representations of a patient's health data. They are held by healthcare organizations (e.g. hospitals) and are used by nurses to provide patient care. EPRs are also cognitive artifacts that support aspects of nurses' work. Many EPRs have been designed around the premise that paper patient records would no longer be used in healthcare and that full EPRs would replace them. However, hybrid (i.e. electronic-paper) environments predominate world-wide in Europe, Canada and the US. Some experts have begun to conclude that no hospital will be "fully paperless" and as a result "there will always be some form of paper even in the most" (Pizzi, 2007, p. 1). Other researchers have identified that EPRs cannot effectively support nurses' cognitive and physical work. This makes it difficult if not impossible to eliminate paper patient records (Borycki et al., 2009).

Methods Used: A laboratory based, clinical simulation study (Borycki et al., 2010) is undertaken where nurses are asked to participate in simulations of representative, real world situations involving artificial or simulated patients. Nurses are observed interacting with the simulated patients and the electronic and paper components of their practice environment. The research will present on how such hybrid environments alter the nature of nurses' work and the implications of these changes upon how organizations (i.e. hospitals and universities) educate, train and support nurses.

STANDARDIZATION AND FLEXIBILITY IN HOME CARE PRACTICE

K Bjornsdottir (kristbj@hi.is)

University of Iceland, Iceland

Universality through standardization is increasingly seen as the hallmark of high quality health care services. Standards aim at making actions comparable over time and space. They are based on the idea that a best way of providing health care, the most effective and efficient way, can be identified and applied universally across cultures. The emphasis on standardization has received considerable criticism in the literature, for example in nursing which will be the focus of this paper. It has been argued that by strictly or uncritically adhering to standardized work methods such as clinical pathways or best practice guidelines, important contextual issues are ignored. A number of authors have pointed out that, in their practice, nurses tend to rely on local or situated knowledge that may not have received legitimization but is nevertheless of key importance to the people being served.

The aim of this paper is to clarify the tension between the reliance on standardized knowledge and work methods and the relevance of tacit or localized knowledge in home care nursing practice. There has been considerable pressure on nurses working in home care in Iceland to adopt standardized work methods such as RAI, which is a universal assessment form, which has become widely used. Home care nurses describe its use as time consuming and fail to see the relevance of the information gained to their practice.

By drawing on authors (from feminism and Actor Network Theory) who have theorized the relationship between different technologies and practice and findings from my ethnographic study of home care, I plan to examine the place that standardized knowledge has in home care practice that attempt to foster flexibility and respect for patient's wishes and preferences.

THE FRAGILE NATURE OF HEALTH: SUDDENLY AND UNEXPECTEDLY CONFRONTED WITH A LIFE THREATENING ILLNESS AND ITS AFTERMATH

MA Boughton (maureen.boughton@sydney.edu.au)

University of Sydney, Australia

Introduction: This paper will commence with articulating the experience of a 22 year old woman, (Christie) who was serendipitously diagnosed with Acute Lymphoblastic Leukaemia (ALL). She subsequently was found to be Philadelphia Chromosome positive and underwent a Stem Cell Transplant (STC). The focus of this presentation will be on a reflective critique of the changing nature of health in this scenario and the role (and (re)actions) of key players as experienced by Christie's mother – a registered nurse.

Method: The experience will be critiqued in relation to the extant literature on understandings of health and what it means to be sick. Literature on the sick role and how it affects (or becomes incorporated by) individuals and their family will be utilized in interpreting and articulating meaning for this experience of being diagnosed with ALL.

Findings: The findings to be discussed in this presentation are related to Christie's experience. They are: 1) the impact of the diagnosis, hospitalization and becoming a "sick" person 2) the impact of being paralysed with fear and shock on the communication process 3) the effect of uncertainty and new understandings of health for the patient and family.

Conclusions: Population statistics can have a negative effect on the individual while the importance of maintaining a positive attitude "in sickness" has a significant role in survivorship.

Communication that is person and family focused is desirable and should be the focus of encounters. The patient and their existence in the world (their frame of reference) is a key factor in the way they experience illness and health in their life (after).

THE POWER OF HOME (UN)CARE: CAREGIVERS DISCOURSES IN THE SPANISH CONTEXT

A Bover (andreu.bover@uib.es), D Gastaldo, M Miró & E Peter

University of Balearic Islands, Spain

Caregiving, Spanish context: In Spain in the last decade many socially vulnerable groups, particularly dependent persons and their family caregivers, have suffered as result of dramatic changes in social protection policies. Neoliberal policies that have been created to solve the current economic crisis have damaged the welfare state considerably.

A Critical Qualitative Approach: Using a critical and post-feminist perspective, we will present the experiences, perceptions and expectations of caregivers in the home between 2000 to 2004 in Mallorca (Spain). Women and men from three generations who were taking care of children, chronic and elderly dependents were interviewed individually and in focus groups.

An Intersection of Discourses of Caregiving: Micro and Macro policy. The complexity of power relations developed in the family care practice at home will be presented. These are based on an intersection of multiple dominant and emerging discourses about private and public responsibility of care for dependents, which are shaped by discourses of gender roles, generational values and roles of family, health system and state. Ethical issues will be discussed showing the sensitive connection between the micro policy of everyday practice of care in the home and changes in the macro policy of social protection in Spain. This work represents that within a decade in Spain hope has turned to frustration in the search for health equity and social justice for family caregivers.

DOING QUALITATIVE INTERVIEWS FACILITATED BY THE USE OF PHOTOGRAPHS

EB Bukhave (ebukhave@health.sdu.dk), M Rothmann & L Huniche

University of Southern Denmark, Denmark

Background: Interviews are often used for data collection in qualitative health research. The methodology differs according to type of interview but the purpose is commonly to describe personal experiences, perspectives and understandings. Conducting health research is a challenging process which has inspired the use of other methods to supplement interviews depending on the subject matter under investigation.

Purpose: To critically compare and discuss the use of photographs in connection with qualitative interviewing in two ongoing research projects.

Methods: In the osteoporosis study focus group interviews were facilitated by photos, statements and participants' comments. In the study on the conduct of everyday life with rheumatism photos were participant generated and discussed in a following in-depth interview.

Results: The use of photos, statements and participant comments encouraged the discussion in the focus groups on osteoporosis. The approaches made it possible to get insight at both individual and group level and enabled a high level of participation in the discussions. Participant generated photos showed great potentials in making interviews meaningful and relevant for the participants in the study on rheumatism. The photos are in themselves also rich sources of data on cultural and social constructions. The language of images is powerful and restricted at the same time and therefore needs investigation to know what they represent for the participants.

Conclusion: We argue that insights gained from interview studies may be broadened and deepened by using other research methods. Different research questions call for different methodological approaches in order to provide detailed data.

EXPLAINING ADHERENCE TO ANTIDEPRESSANTS

N Buus (nbuus@health.sdu.dk)

University of Southern Denmark, Denmark

Purpose and background: This paper reports on a prospective interview study of Danish depressed patients' view on taking anti-depressant medication. Medicine taking is controversial because it often indicates a fundamental mismatch between clinicians' therapeutic advice and patients' illness behaviour. 30-60% of patients discontinue taking their prescribed antidepressants within the first 12 weeks of treatment. The purpose of the study was to gain insight into depressed persons' explanations of their illness and antidepressant treatment and examine how these explanations were related to their self-reported level of adherence

Methods and results: In-depth, semi-structured interviews were conducted of 16 respondents one and four months after discharge from a hospital admission for depression. The 32 qualitative interviews were supplemented by a diagnostic interview and self-report measures. Arthur Kleinman's concept "explanatory model" was used to be sensitive to and explore the respondents' explanations of illness and treatment. The findings indicated, that most respondents took their antidepressants as prescribed, but that there was a conspicuous 'explanatory gap' in the respondents' accounts of their medication use. There were no strong, meaningful links between the respondents' use of antidepressants and their accounts of the reasons for their illness.

Conclusion: Personal "explanatory models" did not explain the respondents' adherence to antidepressants. The presentation will include a discussion of the scientific value of using user-perspectives in adherence research.

AGING AND ACCOMMODATION: CONTEMPORARY PRACTICES OF JUSTIFICATION

*C Ceci*¹ (christine.ceci@ualberta.ca), *ME Purkis*² & *K Bjornsdottir*³

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Demographic and epidemiological changes mean that frail older people have come to be seen as an expensive problem for health care systems. One challenge for professionals and policy-makers has been to find ways to respond to what is often perceived as a coming crisis by delivering high quality care in the home. For the past several years then, we have been investigating the discursive and practice contexts that shape home care in Canada and considered these in relation to the situation in Nordic countries. These analyses have been useful for placing what is local, particular and concrete in the constitution of good care for those who are older and frail in a dialogical relationship with more global discourses and importantly, with the distinct responses of diverse national contexts. This work draws attention to the ambiguities of home care practices, and in particular to the weakness of the justifications available to support the provision of home care for those who are older and frail in Canada.

This paper considers the nature of the conditions of possibility where the frailties of older people would matter and would make a difference in decisions about how our lives would work and how resources ought to be distributed. We address the characteristics of contemporary practices of justification (c.f. Boltanski & Thevenot, 1991/2006) in the context of home care then turn to the work of Giorgio Agamben (1993/2003) for assistance in understanding the forms of community that enable the displacement of appeals to justice and end with consideration of what it might mean for us to accommodate frail elders now and in the future.

EARLY FINDINGS FROM A STUDY OF UK SELF HELP GROUPS. CAN HABERMAS' MODEL OF THE PUBLIC SPHERE BE A USEFUL TOOL FOR UNDERSTANDING SELF HELP GROUPS' CIVIC ROLE? AND WHAT DOES THE CASE OF SELF HELP GROUPS TELL US ABOUT THE RELEVANCE OF HABERMAS' THEORY?

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Purpose and background: Self help groups are believed to be a widespread phenomenon in the UK (Elsdon 2000) and to play an important civic role. However evidence about this aspect of groups remains scarce. This paper reports on a study of self help groups' lifecycles, and using a Habermasian framework, considers their role within the 'public sphere.'

Methods and results: The study involved group observations and 40 group member interviews. The data were analysed against those criteria that are central to Habermas' theory; groups' aims and topics of conversation were examined in order to ascertain whether they engaged with questions about the common good and how far their discourse expressed political, as opposed to purely personal concerns; groups' structure, in order to illustrate how far they operated democratically; and their relationship with public services, in order to gauge their independence from the state and the importance members placed on independence.

The findings indicate a wide variety in the extent of self help groups' public sphere efficacy. Many groups exhibited characteristics such as an egalitarian structure, unconstrained dialogue and self-conscious independence that would be conducive to a civic role. In others however, group leaders' dominance or groups self-identification as part of the spectrum of public services indicate a less civic nature.

Conclusions: We suggest that Habermas' framework provides a useful starting point for the analysis of this aspect of self help groups. However, his emphasis on communicative processes does not fully account for groups' role in community network formation that will also affect their civic potential.

DOWN UNDER COLLABORATION: EMBRACING THE COMPLEXITY OF INTERPROFESSIONAL PRACTICE

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Purpose and background: Despite increasing interest in health professionals working together, collaboration in health care continues to pose challenges. Integral to these challenges are stakeholders' differing interests, motivations and drivers, and the resultant lack of clarity about 'what is sought and why'. The purpose of this Australian study was to more deeply understand the complexity of collaboration with the ultimate aim of facilitating critical support for patient-centred collaborative practice.

Method and results: Hermeneutic research strategies were used to explore (i) conceptualisations of collaboration in the literature (including organisational, educational, research and health care literature) and (ii) team members' experiences of collaborating in Australian rehabilitation teams (including observations of 13 team meetings and semi-structured interviews with 66 team members). Data were analysed to identify *domains of collaboration* and *dimensions of interpersonal endeavour*. The model developed from the findings highlights tensions between technical-rational and human-organic approaches to collaboration in relation to:

- delineated teams versus evolving networks;
- interchangeable discipline representation versus awareness of particular individuals;
- expected measurable aims versus synergistically evolving outcomes ; and
- structured communication processes versus informal interactions and developing relationships.

Conclusion: This model can inform support through critical reflection in relation to: policy-makers' funding and structural support; discipline bodies' facilitation of collaboration; educational institutions' preparation of health professionals for teamwork; managements' provision of resources for teams; and individuals' capabilities for collaborative practice. Reflection and action on new insights are important to ensure management-centred technical-rational approaches to collaboration do not overshadow the importance of *people* in health care collaboration.

UNSETTLING A MEDICAL STUDENT'S BIOMEDICAL SOCIALISATION

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Background and introduction: Despite the predominantly biomedical focus of medical education in Australia, students have opportunities to challenge the sufficiency of this socialised perspective for complex professional practice, for example during clinical placements focusing on health equity issues. This presentation explores the unsettling influence of women's collective wisdom on a medical student's biomedical socialisation in relation to the 'ordinariness' of breastfeeding in a remote Australian Aboriginal community.

Methods and findings: This critical reflection, informed by hermeneutic principles, was instigated by a medical student's experiences during her Health Equity Selective (HES) placement, and facilitated by her invited mentors' experiences with Aboriginal health issues, breastfeeding support and promotion, and medical education. The project involved reflecting on, and interpreting, a set of texts compiled from: the student's assignments submitted during her HES placement in a remote Aboriginal community; literature definitions of health and illness; breastfeeding literature and narratives; and mentor reflections on biomedical socialisation. Evolving insights related to the relationship between 'health equity' and 'illness inequity' and the importance of differentiating between these two notions. A set of questions was developed from these insights to encourage students and health professionals to critically reflect on (i) meanings of health and illness, and (ii) understandings of 'health equity' in relation to the structural embeddedness of biomedical dominance.

Conclusion: The insights developed through this critical reflection challenge the sufficiency of the notion of health equity as providing adequate and accessible biomedical services, and introduced the concept of nurtured reciprocity and responsiveness in health care that is underpinned by humility and wonder.

CIVILISING MOTHERS: HEALTH PROFESSIONAL DISCOURSES OF MIGRANT MATERNITY IN AOTEAROA/NEW ZEALAND

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The empirical study of migrant maternities offers a theoretical vantage point for considering wider issues such as imperialism, nation building and reproduction. Using the white settler context of Aotearoa/New Zealand, I detail an empirical study that explored the discourses used by well child nurses to represent their work with migrant mothers. Migrant mothers pose a threat to the liberal feminist conception of the maternal subject as autonomous and self-determining. Well child nurses articulate a gap between their capacity to provide care and services to migrant mothers. The barriers to providing care and support represented by the gap are due in part to language and communication barriers and the presence of extended family in the form of maternal authority figures and involved fathers. The migrant mother's inter-dependence with other women means that she does not carry the burden of mothering solely and therefore is not autonomous and her perceived subordination to the men in her life prevents her from being self-actualised and free. The gap presents the child health nurse with a number of subject positions, such as the benevolent benefactress which enhances the performance of goodness that is fundamental to nursing subjectivity and is influenced by Christianity and liberal feminism. The migrant mother is disciplined to take up normalising practices that enforce adaptation to dominant cultural norms such as autonomy and independence.

These discursive practices or normalising strategies of power are colonising because they involve the re-ordering of space and the surveillance and control of mothers. I argue that health professionals discipline and regulate gendered bodies in racialised ways that reinforce and reproduce colonial power relations and that this has the potential to contribute to health inequalities and ethically and socially unacceptable outcomes. Further development and refinement of cultural safety, an indigenous ethical form of nursing practice is advocated.

THE STYLE OF OUR LIFE: A HEALTH ISSUE?

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More than ever, the way we live our lives has become subject to our own decision-making. Our whole way of living has become the expression of personal lifestyle choices and the result of individual and voluntary decisions. In many countries the pursuit of a healthy lifestyle has or is expected to become a criterion in the allocation of healthcare services. One of the crucial questions is what could be the consequences of this evolution for health care policy for individuals and for society in general?

If we consider the individual as autonomous and regard the way he lives as largely a matter of his own free choice, would it then not be ? logical? to hold the patient personally responsible for making (un)healthy life style choices, when he tries to obtain insurance or when monitoring entrance to training programs or healthcare facilities? And if the individual is unwilling to change his risky behavior, could he then also no longer obtain health care services?

Consequently, there are increasing discussions in healthcare about lifestyle, the autonomy of the individual and its responsibility for its own health. Lifestyle is also an issue in debates on the ethics of current health policy and health insurance: private insurance companies increasingly promote the values of mass sports, fitness and a healthy way of living. In many countries the pursuit of a healthy lifestyle has or is expected to become a criterion in the allocation of healthcare services. One of the crucial questions is what could be the consequences of this evolution for health care policy for individuals and for society in general?

A crucial point in this discussion deals with the way we understand the concept of lifestyle: is it fair to hold obese patients fully responsible for their condition, because it is simply the result of their lifestyle choices? Considering the fact that the means for health care are principally limited, what are the ethical and philosophical options and arguments to distribute these means, given the fact that today, a healthy lifestyle is an important factor for health? What are the philosophical and ethical options if this would be the starting point of future health care?

OLDER PEOPLE AND FALLS: CONSTRUCTIONS OF CARE

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Purpose and background: Care pathways, which provide practitioners with an overall schema of what should happen to a patient, are presented as devices for promoting quality of care. However, it has been argued that within care pathways the condition is reified, and that as a consequence patients become defined by their impairment and the complexities of their lives are disregarded. Over the last decade in the United Kingdom, people aged 65 years and over have been the target of a concerted falls prevention policy drive, articulated in national care standards and operationalised through integrated falls care pathways. In this doctoral study (in progress) I focus on the new condition of 'falls' which has emerged, and investigate older people's experiences of care in the context of falls prevention services.

Methods and results: Depth interviews were carried out with 15 older people recruited from different sites of care across the falls care pathway and focused on individuals' falls story and the care they had received. Drawing on a Foucauldian discourse analytical approach, I examine how care is constructed in participants' accounts and identify the associated subject positions offered by these constructions.

Conclusion: This study brings to the fore different, as in unfamiliar, discursive constructions of care, and highlights care as a situated practice. I consider what these constructions mean for an older person's patienthood, that is, the ways in which they can participate in and experience care, and how these discursive constructions articulate with policy and professional discourses of care.

EMPOWERMENT AS CONCEPT AND NEW PROFESSIONAL TOOL IN HEALTH PROMOTION?

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The core in the concept of empowerment following the cultural and experience based learning theory of Paolo Freire is to change asymmetric power relations by enhancing collective and individual cultural, social and life historical capacities to act. The development of community based and work-place based health promotion strategies today in Denmark include empowerment as goal and as tool of health promotion, at one and the same time.

Recent research in health promotion based on an empowerment angle within the development of local communities is founded on the understanding that a range of psycho-societal components and relations can contribute to mobilising vulnerable individuals and groups by strengthening their competences and life orientations and increasing their influence on health in relation to social, economic and cultural conditions (Nutbeam, Kruikschank, DeMayo, Andersen). In relation to working life, the empowerment approach has been enriched by learning research with focus on participation and theory about the relationships between adjustment learning and transformative learning (Ellström, Mezirow), and new attempts have been made to install health promotion as empowerment through learning in combined development and research projects (Arneson, Ekberg, Gustavsson).

The articulation is that “training” citizens for a holistic health promotion strategy and practice involves a change to existing power relations in the field so that free spaces or sustainable development and learning areas can be provided, and this will then give room for empowerment and democratisation. This is in the form of mobilising and involving of the resources of citizens and civil society both through different forms of citizen participation, but also through social partnerships and grassroots initiatives in clubs and associations, in neighbourhoods and in the workplace. The study into the health strategies of various civil societies from healthy construction, organic communities to the health promoting campaigns of Danish NGOs shows that parts of the population currently have an increasing interest in re-embedding parts of the health efforts in civil society. The challenge is to develop the capacity and ability to work with action strategies for health in all society’s arenas (workplace, urban space etc.) and across the traditional sectors in the public administration. Empowerment enhancing approaches thus becomes included into professionalization and municipal strategies for health promotion.

The paper intends to explore the concept of empowerment as it is represented in municipal programmes on health promotion, and its relation to forms of user-involvement and participation in present Danish policies in health. The paper will furthermore discuss these understandings in relation to the theoretical development and discussion of the concept (Andersen et. Al.) looking at it from the perspective of power and of space for and enabling of action. Lastly the consequences for professionalization in health will be drawn in, including a professionalization perspective (Dybbroe, Hjort, Dahl).

AFRICAN AMERICAN WOMEN'S PERCEPTIONS OF HEALTH, TREATMENT AND ILLNESS AND ITS RELATIONSHIP WITH PROFESSIONAL PRACTICE

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Purpose and Background of the Study: The purpose of this study was to explore African American women's perceptions of health, treatment, and illness and its relationship with professional practice. Despite many recent improvements in the health of Americans, substantial differences still exist among racial and ethnic groups. The frequently cited explanation for the disparity in health care for African Americans is lack of access to quality health care. The incidence of breast cancer illness in African American women continues to increase with no decrease in mortality trends. African American women have the highest breast cancer death rates. Despite all the gains that have been made in clinical, basic, and behavioral research, African American women continue to lag behind disproportionately affected by this disease.

Summary of the Methods Used and the Results: In this qualitative pilot study, factors that promote breast cancer illness and health in African American women were explored and the professional practices utilized by their physicians were examined. Data were collected in four focus group sessions, where the study's participants were asked questions related to their perceptions of health and the professional practices utilized by their physician. Cultural values had a major impact relating to health and seeking health care.

Conclusion: These women's narratives provide much insight into the issues they have regarding their breast cancer illnesses, professional practices utilized by their physician and directions for future research.

PRODUCING CHILDREN: HEALTHY DEVELOPMENT, RISK & HUMAN CAPITAL

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The purpose of this paper is to critically analyse the implications of commonly held ideologies of development, and more specifically, examine how these organize nursing practices with children. Moving beyond traditional staged maturation, recent studies of human development appreciate context as significant and identify facilitative environments and resources. Most however, remain anchored in ageist assumptions.

These assumptions structure nurses' understandings of children, create 'developmentally appropriate' expectations for both children and nursing practice, and organize interactions with children within concepts such as dependence, protection, safety and discipline. Children's bodies are assumed to be natural, material bodies, independent of their social context and meanings. Motivated by intentions to protect and facilitate healthy development of these bodies, nurses engage in seemingly benign surveillance of children and populations. 'Risks' to 'normal' development can then be captured early, offering the opportunity to intervene and optimize the production of a child as a subject of social value.

Drawing on a cost analysis, some contemporary developmental researchers conceptualize children as 'human capital' and call for an 'investment into our future', in effort to secure funding for quality child-care and social programs, often targeted toward children and families who are considered 'high risk'. The results of this analysis will clarify how these multiple developmental discourses obscure social and political interests that shape children's bodies, and the practices of nurses who work with them.

THE PLACE OF MADNESS: FROM BANISHMENT OUTSIDE TO BANISHMENT WITHIN

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Purpose and background: A few centuries ago, based on a foundation of silence, madness became conceptualized as 'mental illness'. Those deemed mad were silenced both via their physical exclusion and psychiatry's reasoning (Foucault, 1961). The purpose of this paper is to analyze a current mental health policy in order to consider how madness is conceptualized and the implications of this.

Methods and results: Theoretically framed by Foucault's (1961) work, a discourse analysis was conducted on a policy document outlining the mental health reform strategy for 2009-2019 of an Australian government department. The analysis focused on how madness was conceptualized and the consequences of this. The analysis included the political implications of this conceptualization on the funding of acute mental health services in this jurisdiction.

Findings include government reluctance to recognize service system deficits or make commitments to action, cost-shifting to other levels of government and a movement away from increased funding toward co-ordination, redesign and monitoring. These movements are achieved via the broadening of the concept of madness until it disappears. In this way responsibility for service response and funding can be shifted both to other government departments and other levels of government entirely.

Conclusion: Recent policies of 'deinstitutionalization' apparently addressed the physical exclusion of those deemed mad, yet another form of exclusion now arises. Madness becomes so far integrated that it disappears from within, silenced via a lack of recognition produced by discourses of commerce and capital. Yet while disappearing for funding purposes, madness remains firmly confined within the construct of 'mental illness'.

Foucault, M. (1961). *Madness and civilization: a history of insanity in the age of reason*. New York: Routledge.

ENACTING MEDICATION IN IN-PATIENT REHABILITATION FOR ALCOHOLICS

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Background: In this paper I analyze the interaction that constitutes the medication in an in-patient rehabilitation institution for alcoholics. This is a part of my PHD thesis on social work within in-patient institutions. My analyses depart from a re-conceptualization of Foucault's concept of governmentality based on Goffman's dramaturgy. This entails that governmentality is understood as interaction between individuals. From this perspective the aim is to analyze governmentality in situ by studying how knowledge, subjectivity and power is constituted and negotiated in the interaction between professionals and clients.

The approach and some results: The primary method has been observation this has been supplemented by group interviews and document analysis. My observations have been guided by Foucault's notion of techniques as the material manifestation of power. This has led me to focus on the relations between acts of the individuals which I understand as performing different roles in the Goffmanian sense. Thereby I elucidate the different specific acts that form the medication as a complex situation that besides medically addressing the lack of self-management also allows clients to show their will and progress while the professionals are able to examine the client's in order to assess the recovery of the client and at show support and solicitude.

Conclusion: The analysis points towards the medication as a governmental technique which is both a technique of domination and a technique of the self that in multiple ways addresses the will of the client in order to transform him into a self-managed citizen.

EMOTIONALLY ENGAGED PRACTICE AND THE PURSUIT OF EXCELLENCE IN MIDWIFERY

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Purpose and background: This paper is based on a study of midwifery practice that investigated transitions in professional practice taking place in 2008, a time when maternity services were working towards improve the rate of normal births and decrease interventions associated with the medicalisation of childbirth.

Methods and results : Using an ethnographic approach, this sociologically based study sought to explore similarities and differences between obstetric-led and midwife-led cultures through observations, interviews and focus groups carried out at three sites: a newly established midwife-led unit working alongside an obstetric site; a well established midwife-led unit working alongside an obstetric unit; and, an obstetric led unit that was exploring the feasibility of midwife-led care. It was found that understandings of practice at all the sites were culturally embedded in hierarchies that emphasised risk over other concerns, thereby obstructing the development of 'ecologies of practice' necessary for the confident and responsive approaches required for 'woman-centred' approaches.

Conclusions: While employment in the public sphere has traditionally been associated with a rational mindset that should remain uncontaminated by emotion, there is a growing body of research that suggests that engaged practice in human service work is not generated solely through cognition and rational processes but also involves philanthropic emotional engagement that engenders a commitment to excellence and a genuine concern for people. Drawing on MacIntyre's *After Virtue*, we argue that organisational cultures should be supportive of committed midwives who reflect on organisational policies and have the courage to question them, in order to promote the wellbeing of women service-users.

PATIENT PARTICIPATION REVISITED – CONTEXTUALIZING ELDERLY RESPONDENT'S EXPERIENCES AND REFLECTIONS ON PARTICIPATION.

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The purpose of this study was to identify how different discourses that operate in shaping the elderly persons notions - and practices of patient participation.

Qualitative data were collected from individual in-depth interviews 18 elderly persons 1-2 weeks after discharge from hospital. The analysis is based on a discursive approach, inspired by Foucaultian theories on power and subjectivity. The understanding of how patients are constituted within the central discourses on participation in acute hospital care are obtained by studying how elderly patients accept, resists and negotiate the contemporary discourses of participation.

Analysis revealed that elderly persons' notions of participation are based on values that are dissimilar from contemporary values embedded in discourses of efficiency, individualism and competence. Elderly patients are actively constituting themselves within the existing discourses by processes of both adapting to- and resisting these discourses through a number of diverge and sophisticated strategies aimed at getting influence. Elderly patients did not portray participation as an explicit and outspoken right. Patient participation as exercised by the elderly could rather be described as a subtle invitation given through choosing a good strategy where the elderly patients' balanced their needs against the needs of other patients.

The subtle and diverse practice of participation might be a reason why the elderly patients' interest in participation is quite 'invisible', both to researchers and to the professionals.

UNDERSTANDING NURSING AS A DISPOSITIF: HEALING AND DEVASTATION IN THE AGE OF BIOPOWER

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Under the Nazi regime a well-calculated program aiming at killing chronically mentally 'ill' patients took place in Germany, which was part of a broad biopolitical program based on well established scientific and eugenic standards. Nurses were part of that program in their everyday practice. However, there are suspicions that psychiatric patients were already assassinated way before and long after the Nazi regime. These findings imply that the rationales for these executions must be investigated within the "psychiatric practice" itself. This presentation aims at exploring the mechanisms that enabled nurses to radically change their mental representations of mentally ill patients under their care. The working hypothesis is that dominant scientific discourses influenced nurses' mental representations which portray the mentally ill patients as "lives not worth living". The analysis, based on 140 patient records obtained from psychiatric hospitals, shows that nurses played a decisive role in such biopolitical programs and were instrumental in the extermination of "lives not worth living".

HOME HEALTH CARE AND FAMILY RESPONSIBILITY: A CRITICAL ANALYSIS OF THE ACCOUNTS OF MANAGERS AND LEADERS

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Purpose and Background: Changes in health service delivery in Canada in recent decades have involved the transfer of some tasks once performed by professionals, to family caregivers. This research addresses the question: how are families' roles and responsibility in care constructed among home health leaders and managers, in contrast to the constructed roles and responsibility of home health?

Methods and Results: Drawing on critical discourse analysis, interviews with 13 individuals in management and leadership positions in home health in British Columbia, Canada were examined, supplemented by relevant home and community care policy and practice documents. Responding to questions about family involvement, participants commonly expressed the ideal of ill persons remaining at home (including chronic disease self-management and self-care). Family involvement was seen as essential to support this choice, and family members were defined as the primary providers, with home health as supplementary. Family responsibility was described as a structural imperative given the resource context of home health; in other cases, it was constructed as a moral imperative. Some participants introduced contrasting ideas about the need for flexibility, client-driven care, not 'forcing' family members to provide care, and acknowledging that not everyone can provide care. Both interviews and documents generated examples of how responsibility expectations manifest in practice and policy.

Conclusion: Findings will be discussed in relation to broader contexts shaping home health care practice, policy and 'philosophy.' Recommendations for promoting reflexivity and critical thinking in the training and education of home health administrators will be proposed.

WEB OF SOLIDARITY AND EXPLOITATION: ENTANGLED INDIVIDUAL AND SOCIAL RESPONSES FOR GLOBAL ECONOMIC PROBLEMS

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Background and Purpose: It is estimated that there are 30 to 40 million undocumented workers worldwide, half a million of them living in Canada alone. In our qualitative study with undocumented Latin American workers residing in the Greater Toronto Area, we explore the intersection of migration, gender, and other social determinants of health that impact the wellbeing of this population.

Methods and Results: Guided by postcolonial feminist theory, we ground our work on principles of advocacy for a hidden and vulnerable population and community participation. In collaboration with 2 community organizations and several advisors, 25 undocumented workers were recruited to participate in 3 interviews and body mapping sessions on their migration journey, work experience, and social life.

We have found that the production and maintenance of undocumented migration is extremely complex. International (in)formal markets, private businesses, and employers, among many others, benefit lucratively by worker migration. Yet, some participate concomitantly in the exploitation of and solidarity with undocumented workers. The precarious nature and temporariness of undocumented work causes workplace vulnerabilities by limiting workers' ability to negotiate working conditions, improve their earning potential, or establish social ties. However, within these same spaces workers also encounter co-workers and managers who support them through hardship, creating hybrid spaces that are difficult to resist.

Conclusion: Canada, a high-income country, has several work places that are the "new south" – where human beings who are not citizens live in a hiatus of rights. Despite individuals' agency, it is very difficult to resist oppression in such spaces because they are entangled in solidarity and social support.

A CRITICAL LITERATURE REVIEW: THE IMPACT OF RECONSTRUCTIVE SURGERY FOLLOWING MASSIVE WEIGHT LOSS ON PATIENTS QUALITY OF LIFE

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Aim: To critically review published papers on the impact of reconstructive surgery following weight loss on patient's quality of life.

Background: The global obesity epidemic is a major health problem and a growing number of morbidly obese patients are seeking surgical solutions such as bariatric surgery. Massive weight loss often leads to excess of lax, overstretched skin causing physical dysfunction and psychosocial problems which impacts on patients' Quality of Life (QoL). Reconstructive surgery is a major growth intervention for body improvement and beautification following massive weight loss. However little collective evidence exists regarding the impact of body contouring on patients QoL and psychosocial function.

Methods: Database searches of CINAHL, Psychinfo, EMBASE and the Cochrane library using various key word combinations related to reconstructive surgery following bariatric surgery, body contouring following massive weight loss, reconstructive surgery and psychosocial outcomes. Abstracts and articles were analysed to identify quality of life outcomes.

Results: A total of ten papers matching the inclusion criteria were identified. The literature revealed that many patients reported an improved QoL following reconstructive surgery such as freedom from dependence or disability, a better sex life and a good self-image, improved mental well-being and confidence and improved self-efficacy towards eating. A number of variables influencing QoL outcomes were identified too including dissatisfaction with the occurrence of dog ears in the scar and complications such as serous fluid collections, wound dehiscence and anemia because of blood loss.

Conclusion: Massive weight loss results in an excess redundant skin creating physical, functional and psychosocial problems that impact on QoL. There is ground for believing that possible long-term change in massive weight loss patient management will make its sustained appearance when national guidelines and policy recommend an 'ideal' care pathway for patients following reconstructive surgery is avowed. Moreover inequalities in terms of availability and accessibility of NHS body contouring provision need to be addressed by the DoH. The massive weight population continues to grow, globally. Therefore it is crucial that health professionals make critical use of evidence, engage with outcomes research, innovative practice, and challenge idealistic 'media expectations'. The multidisciplinary team approach is essential in furthering the evolution of novel ideas and offering first class individualised, long-term care.

Key words: Reconstructive surgery following massive weight loss, body image, psychosocial outcomes, QoL, lack of health policy

CONTEMPORARY COSMETIC SURGERY: THE POTENTIAL RISKS AND RELEVANCE FOR PRACTICE

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Study aim: To examine and critique the risks of cosmetic surgery and consider implications for practice.

Background: Cosmetic surgery is a growing industry with a significant global phenomenon. Feminists have been critical of aesthetic surgery practice, offering a range of representations in regard to 'identity', 'normality', 'cultural and social pressures', 'agency' and 'self-enhancement'. Discourses around minimizing risk information acknowledge deficits in not supplying patients with full risk information. The results are usually devastating, and lead to serious health complications that incisively diminish well-being for patients, and increase health costs.

Design: Critical review.

Method: This paper represents a critical review of risks associated with cosmetic surgery. A Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature Analysis and Retrieval System on line (Medline) and British Nursing Index (BNI) search with relevant key words was undertaken and selected exemplary articles and research describing and/or evaluating cosmetic surgery risk. Only papers in the English language from 1982 to 2009 were reviewed. The papers examined were mainly empirical studies; some opinion papers, policy documents, textbooks and websites were examined too.

Results: The literature revealed that several factors influence consumer risks including regulation vagaries, medicalization processes, fear of aging discrimination, wanting to avoid ethnic prejudice and media pressure. Government strategies in the United Kingdom (UK) have attempted to improve clinical standards; however, little attempt has been made globally to raise institutional and professional awareness of the huge impact of cultural and social pressures on consumers.

Conclusion: Avoiding shattering complications by improving the provision of risk information for patients is a worthwhile goal. Therefore health professionals need to consider consumer rights and autonomy more carefully, facilitate rigorous screening and develop knowledge in regard to relational autonomy and alternative interventions.

Key words: cosmetic surgery, regulation risks, medicalization risks, patient autonomy, and relational autonomy

CHANGING LENSES: FROM ILLNESS TO WELLNESS

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Purpose and background: A clash of cultures is playing out in Canadian communities. For too long mainstream Mental Health and Addiction Services have been delivered through a western medical lens, viewing mental disorders and health as disconnected to broader issues of spirituality, culture, and social conditions. Indigenous perspectives being holistic in nature, consider the balance of physical, mental, emotional and spiritual realms, suggesting when there is imbalance, adjustments must occur. Data informs that aboriginal populations on Vancouver Island have significant mental health or addiction issues yet do not access mainstream services. Unrealistic expectations based on western worldview and ways of knowing create a downloading of responsibility on to the “patient”, interfering with ability to access services. Incongruent with the profile of the aboriginal population, is the notion that there is a self-directed pursuit of healthcare requiring an individual, family and community to be educated, assertive and empowered.

Summary of results: This paper describes the journey of one health authority to better meet the mental health/addiction needs of aboriginal people and reduce the disparities in mental health/addiction outcomes through refocusing services and resources through a cultural and client-centered lens. The authors share their experience of creating opportunities to enhance access with emphasis on values based in mutual respect, cultural safety and sensitivity, equal partnership and connection to traditional territory.

Conclusion: The process demonstrates an emerging shift in areas of mental health/addiction practice after two years of development. The authors share their experience and successes to date.

“IT’S OK FOR SOME”: WHAT HAPPENS WHEN PATIENTS DON’T FIT THE DIRECTED MODEL OF CARE

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Purpose and background: Health professionals are often required to work within directed guidelines and expected parameters. However not all patients and situations ‘fit’ such constraints, and working with these cases can be challenging. This presentation explores two situations involving Aboriginal people in rural Australia, including issues related to diagnosis and risks of onward transmission of HIV. These cases raised three important questions: How can health professionals respond appropriately for people who fall outside of the expected parameters and for those situations beyond the scope of clinical guidelines? What is it like to not know the answer? And how do we ‘first do no harm’?

Method: This critical reflection undertaken to explore these questions involved a dialogue with these two cases, and a critique of policy directives guidelines and journal articles.

Results: Two tensions were raised in relation to HIV health care for Australian Aboriginal people resident in rural areas: firstly tensions between health care directives guiding health professionals’ practice and what is possible; and secondly, tensions relating to understandings of permission giving, urgency and connecting with Aboriginal people in such cases. In recognising that these tensions are not necessarily readily resolved, a *model of situated uncertainty for HIV health care* was developed that articulates some (perhaps) insolvable but (definitely) informative issues requiring openness for both action and learning.

Conclusion: Providing health care for people with HIV in rural and remote Australia offers many opportunities for health professionals to develop personal understandings and strategies for dealing with, and learning from, situational uncertainties, and the (often associated) personal discomfort and disquiet.

PROFESSIONALISING AGENDA OR HIDDEN AGENDA?

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Background: At the beginning of the 20th century, when the Australasian Trained Nurses Association (ATNA) was formed as a professional association for Trained Nurses in Australia, the preferred position of the founding members was that a federal government system for nurses' registration be established. More than 100 years after that sentiment was expressed, a national registration scheme and accreditation scheme has been established to regulate health practitioners and students

Methodology: Historiography methods of oral history and analysis of empirical sources have been applied to examine the social and political contexts in which changes to nursing regulation in South Australia have occurred. South Australia, an Australian state, has a unique history of settlement, which has shaped nursing regulation within its borders. Archival materials included oral histories, government reports, newspapers, all of which were available in the public domain. Four major themes emerged from this study. This paper focuses on the 4th theme:

The regulation of nursing work by way of State Registration and the nurse registering authority as an instrument of the South Australian government, to provide nursing care while at the same time minimising costs associated with the provision of that care.

Conclusion: State Registration has in nursing has strong associations with recognition as a legitimate profession. However it is shown that the gains achieved by the nursing owe more to the agenda of the government in relation to health care provision than the efforts of the profession

ESTABLISHING FAMILY AFTER BIRTH OF LIGHT PRETERM INFANT

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This PhD. project focuses on the process of becoming a family after birth of a light preterm infant (born 3-8 weeks before expected delivery). The background is that parents to children born extremely premature (more than 8 weeks before expected delivery) express a strong feeling of lack of normalcy compared to families with full term babies. They furthermore express a need for support from health professionals, even though some of them get some help from hospital-consultations. The light preterm children's families are not offered these consultations. It is in this border zone of normalcy with hospitalization through weeks as the start point also for the light preterm infant's family; I examine how construction of everyday life, parental identity and social roles and practice are negotiated, contested and accepted.

Could this open up to new ways of being a family? Are underlying cultural ideas of what a normal family is activated through the process? Does preterm birth influence family discourse?

My fieldwork will be carried out over a period of 1, 5 year, among families in their homes and within professional health settings. It will consist of a mixture of participant observation, interviews with parents, focus group discussions with parents and interviews with health professionals as well. It is a multisite fieldwork about families with their first born light preterm child in Denmark.

WHAT CAN WE GAIN FROM ETHNOGRAPHIC RESEARCH? A REVIEW OF STRONG AND WEAK ANALYSES OF EVERYDAY NURSING PRACTICE

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Ideologies in nursing practice – such as the nurse-patient relationship, care, sacrifice and deference to doctor's work - are durable and dominant. A steady stream of nursing research employs ethnographic fieldwork, to answer questions about the particulars of nursing settings and of practice in contexts. This paper seeks to show how unexamined ideologies and discourses can limit the value of ethnographies. In comparison, some fieldwork and analysis is theoretically informed, variously employing theories from philosophy, sociology and psychology. Theoretical analyses are often considerate or critical of nursing ideologies. This paper aims to tease out the impact of common-sense approaches to analysis of everyday nursing work, and compare these studies and their findings with studies that employ an explicit theoretical frame.

Several contemporary published ethnographies in mental health settings are used to argue the potential merits and pitfalls of different approaches. I highlight the outcomes of such research, in terms of their contribution to understandings of everyday nursing practices. Discussion illustrates the potential of strong analyses to inform distinctive nursing curricula and designs of senior practice roles. I consider implications for the standing of the discipline, for education and for patient care, in this era of tight competition for healthcare resources.

CIVILISING THE “BARBARIAN”: A CRITICAL ANALYSIS OF BEHAVIOUR MODIFICATION PROGRAMMES IN FORENSIC PSYCHIATRY SETTINGS

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Drawing on the works of Erving Goffman and Michel Foucault, this article presents part of the results of a qualitative study conducted in a forensic psychiatric setting. For many years, behaviour modification programmes (BMPs) have been subjected to scrutiny and harsh criticism on the part of researchers, clinicians, and professional organisations. Nevertheless, BMPs continue to be in vogue in some “total” institutions, such as psychiatric hospitals and prisons. Discourse analysis of mute evidence available *in situ* was used to critically look at behaviour modifications programmes. Compelling examples of behaviour modification care plans are used to illustrate our critical analysis and to support our claim that BMPs violate both scientific and ethical norms in the name of doing “what is best” for the patients. We argue that the continued use of BMPs is not only flawed from a scientific perspective, but constitutes an unethical approach to the management of nursing care for mentally ill offenders. Nurse managers need understand aware that BMPs violate ethical standards in nursing. As a consequence, they should overtly question the use of these approaches in psychiatric nursing.

THEATRE AS COLLABORATION, LIBERATION AND RELATIONSHIP FOR ASYLUM SEEKERS

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Purpose and background : This presentation is based on a published article that focuses on theatre as an occupation for asylum seekers living in immigration centres. The aim was to describe the engagement of asylum seekers in a theatre production that presented their narratives and experiences. The participants (n=11) came from a Norwegian reception centre for people seeking asylum and they originated from Asia and Africa.

Summary of results: The study had an ethnographic design and used participatory observations. Data was analysed using an interpretative method. The findings identified themes of waiting for a future, making narrative turning points, becoming visible through participation and creating meeting places with possibilities through theatre.

Conclusion: The discussion and conclusion addresses how engagement in theatre activities might serve to liberate people in locked situations, how participants in such occupations creates relational aesthetics that can construct collaboration and social relations, and how stories of life experts can create art expressions in the context of applied theatre without being a professional artist.

MEANING MAKING AMONG DANISH CANCER PATIENTS IN REHABILITATION: A TAYLORIAN PERSPECTIVE

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Purpose: The purpose of this paper is being twofold: 1) to analyze empirical data from a project on Danish cancer patients' self-reported secular-existential, religious and spiritual orientations by using Charles Taylor's main concepts as analytical tools and 2) to contribute to a sociological enterprise: the theorizing about secularization on the basis of the study's analytical findings.

Background: This paper relies mainly on research from two fields: 1) That of religious/spiritual coping and illness, specifically research on the relation between existential, religious and spiritual meaning-making and illness adjustment and 2) the past thirty years' reevaluation of the secularization theories in the sociology of religion. Charles Taylor's secularization theory and key concepts as presented in *A Secular Age* (2007) are used as primary analytical framework.

Methods: Data have been generated through ethnographic fieldwork comprising 1) participant observation during 9 residential rehabilitation week courses at RehabiliteringsCenter Dallund, a Danish Rehabilitation Center 2) semi-structured interviews in the homes of 11 rehabilitation patients and 3) 5 focus group interviews conducted at RC Dallund with 3-7 participants in each group.

Results: The paper shall demonstrate how concepts that lie at the heart of Taylor's secularization analyses, such as "fullness," "the immanent frame," "cross pressures" and "porous and buffered selves" have proven helpful to the analytical work of Danish cancer rehabilitation patients' self-reported secular-existential, religious and/or spiritual meaning making orientations.

Keywords: Secularization, Modernity, Meaning-making, Cancer

PREScriptions FOR PRACTICE: CHILDREN, PSYCHOPHARMAEUTICALS AND THE GOVERNANCE OF DIFFERENCE

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Purpose and Background of Study: This paper is part of a larger project intended to rouse imaginings of social work as a profession accountable to the larger world– a more worldly profession of future-oriented theorization and pedagogy. The purpose of this particular paper is to expand the discussion on practice with psychopharmacaceutically- medicated children beyond best practices and medication compliance. Instead we reframe the issue as inextricable from power as it surges from the state to professional ‘experts’ and through the bodies of individual children.

Summary of methods: In this qualitative study we ask: what do social workers do at the hub of psychopharmaceuticals and practice with children? We argue, using Foucault’s notion of governmentality, that pharmaceuticals and neoliberalism form an ideal site of convergence to explore how social workers function as both the implementers and embodiments of political rationalities. The ‘messy actualities’ (Larner, 2000) of these rationalities are explored through two case studies from the presenter’s practice. These cases illustrate how bio-power in its most intimate expressions, is enacted differentially upon bodies marked by social difference.

Conclusion: Under neoliberal governmentality the good professional subject is one who exercises fiscal responsibility and ‘evidence-based’ practices. This paper illustrates how psychopharmaceutical use with children coheres with this rationality. Practice at the hub of psychopharmaceuticals and children is always a political and intersubjective exercise situated within the web of conduct. Failing to recognize ties between governmental discourses, subjective formation and professional practice threatens to conflate good social work with effective compliance management.

“SHE IS A JEWEL” – THE LINK BETWEEN PROFESSIONAL PRACTICE AND THE EXPERIENCE OF OVARIAN CANCER

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Research conducted by V Jayde as a student at The University of Sydney, Australia

Study purpose and background: Ovarian cancer is the most lethal form of gynaecological cancer. A comprehensive literature review was unable to locate any articles, which explored the experience of ovarian cancer for children, nor any literature specifically pertaining to the Australian experience of ovarian cancer for women and/or partners. This study aims to address these identified gaps by describing and interpreting the (Australian) experience of ovarian cancer for women, as well as partners and adult children of women with the disease.

Methods used and results obtained: Phenomenological philosophy informs this research in which data were collected via digitally recorded unstructured interviews with thirty participants (13 women, 11 children and 6 partners). The transcribed interviews were analysed based on van Manen's (1990) method for data interpretation.

The diverse ovarian cancer experiences of women, adult children and partners will be explored and presented. In particular, the relationships between healthcare professionals and the client experience of ovarian cancer, and client preferences for relationships with healthcare providers, will be discussed with an emphasis on implications for practice.

Conclusion: This study is aimed at addressing identified gaps in knowledge. It provides a unique glimpse into the illness experiences of women, adult children and partners affected by ovarian cancer. Issues identified in this study have important implications for professional practice and are critical to the provision of optimal healthcare to people affected by ovarian cancer.

Reference: van Manen (1990) *Researching lived experience: Human science for an action sensitive pedagogy*. Albany: State University of New York Press

WEIGHT-LOSS TREATMENT AS EMPOWERMENT OR AS A NEW FORM OF DEPENDENCY?

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The purpose of this study was to shed light on and discuss treatment of patients diagnosed as morbidly obese in contemporary societies. Background for the study is establishment of a Norwegian treatment programme intending to empower morbidly obese patients towards lifestyle changes. The programme is extensive and includes a preparation stage with a course in lifestyle change, a treatment stage with bariatric surgery and an aftercare stage with self-help groups.

Longitudinal interviews were performed with nine participants in the programme at five different stages in their treatment process. Data were analyzed by discourse analysis to look for how the respondents constructed identity through talk at different stages in the treatment process. The findings revealed how the respondents dreamt of turning into “normal” bodies and a “normal” life, and they considered the operation to be a “new start” in life. The respondents lost much weight after surgery, but continued to struggle for normality and constructed themselves with fragile control. They constructed themselves as dependent on “stomach-control”, with less confidence in own ability to take over control. Uncertainty regarding the future and stigmatization represented identity challenges also long time after bariatric surgery. The study concludes that treatment of morbidly obese patients in contemporary societies seem to represent a normative and disciplining process based on medical power and dependency, in contrast to ideals of control and autonomy in health promoting initiatives.

QUALIFYING PEDAGOGICAL PRACTICES OF HEALTH PROMOTION IN EDUCATIONAL SUPPORT FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

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The paper presents preliminary results of a research project originating in a partnership between Roskilde University, Region Sjælland and 3 special educational institutions for developmentally impaired people. The research project aims to identify 'best practices' of health promotion in the everyday culture of the institutions; to help qualify the practices of professionals and the participating institutions.

Generally, support of people with developmental disabilities educates and assists individuals in mastering their individual lives to achieve high degrees of autonomy and life quality. This type of support is what, following the Ottawa Charter of WHO, conceptually could be described as practices of 'health promotion' under a broad environmental and psycho-social model of health.

However, a terminology of health promotion is generally distant from a Danish pedagogical debate and practice. What is often explicitly articulated and systematized in this type of support are educational perspectives that focus on the individual's capacities and skills alongside medical treatment practices and technologies that deals with diagnosing and monitoring particular symptoms of illness. This is potentially problematic for a group that is highly dependant on support to function well in most aspects of their daily social lives. The important tasks of supporting communities and everyday social and physical environments in which people with disabilities can live, work, love and play, are at the risk of being suppressed or simply tacitly presupposed in practice and policy decisions.

The paper will particularly analyse notions of health and well-being in the experience and practices of the participating special educational institutions.

WAITING FOR LONG-TERM CARE: THE ROLE OF HOME AND COMMUNITY BASED CARE CAPACITY IN SHAPING RISK OF PLACEMENT IN NORTHWESTERN ONTARIO

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Purpose of Study and Background: While some individuals can successfully age at home, others with similar levels of need may require facility based long-term care. The purpose of this paper is to examine the factors that determine whether or not older persons age at home. We argue that in addition to the characteristics and care needs of individuals (the demand side); access to home and community care at the local level (the supply side) determines whether or not older people receive care at home relative to other settings.

Methods and Results: In conducting the analysis we draw on the Balance of Care framework to analyze the characteristics of individuals waiting for long-term care placement in Thunder Bay (urban community) and the surrounding Region (rural communities) of Northwestern Ontario ($n = 858$). This framework provides the means to estimate the extent to which their needs could potentially be met in the community if homecare services were available.

The results show that individuals waiting for long-term care in Thunder Bay experienced higher levels of impairment than those in the Region. However in both areas, most individuals required assistance with instrumental activities of daily living (e.g. housekeeping, meal preparation, etc). In both areas there was limited access to informal caregivers. If a homecare package were to be made available, 8% of those waiting for facility based long-term care in Thunder Bay could potentially be supported safely and cost-effectively at home (lower than the cost of long-term care) compared to 50% in the surrounding Region.

Conclusion: The results confirm that the supply side matters. When homecare cannot be accessed, long-term care may become the default option, particularly in rural and remote areas. If given access to homecare (including health and social care services), a significant proportion of individuals can potentially age at home.

“WHAT DOES THE CONTEXT OF HOME NURSING CARE CONSIST OF AND HOW DOES THIS CONTEX AFFECT THE ETHICAL APPROACH OF PRACTICE?”

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Purpose and background: Current political health priorities focus on providing health services at the so called lowest level of care. In Norway, this is increasingly accompanied by discussion of the quality and ethics of public health services provided by the local authorities.

Good professional care does not exist by virtue of itself. The professionals' approach to challenges constitutes their practice. In addition, when elaborating ethically on the quality of good care, the context of practice should also be taken into consideration. Professional care in private homes challenges the professional caregivers in ways other than professional institutional care. But how and why is this so, and what does it mean and imply?

The project includes both a structural and a hermeneutic approach in order to deepen our understanding of home nursing care as a complex challenge. Through such a focus, this study discusses ethical aspects related to structural and professional elements relevant for home nursing care. Thus, the aim is to study and reflect upon the normativity of home care practices and how this is handled by home care nurses.

Methods and results: The study links up with an empirical ethical approach and has an ethnographical design including both participant observation of home care nurse interventions and qualitative interviews of the observed nurses. The qualitative interviews are based on the observations and invite the respondents (nurses) to reflect on their day-to-day challenges as ethical challenges.

Conclusion: Data and analysis will be based on pilot study and the presentation will presents work in progress.

A POLITICAL SOCIOLOGY OF TRANSLATIONAL GAPS: ACTOR-NETWORKS, NORMALIZATION PROCESSES, AND THE CONFIGURATION OF PATIENTS AT A DISTANCE IN TELEMEDICINE AND TELECARE

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Purpose and background: Work to understand the dynamics of socio-technical change in healthcare has typically rested on case studies that provide relational analyses of specific innovations and the networks of actors and practices in which they are implicated. Large scale, longitudinal, studies of innovation processes are rare. This paper draws on a series of studies undertaken in the UK between 1997 and 2009 to develop a longitudinal qualitative analysis of the design, evaluation, and operationalization of telemedicine and telecare services.

Methods: Reconsideration of qualitative data collected and previously analyzed in seven sequential but overlapping studies undertaken between 1997-2009. Data was collected by means of ethnographic fieldwork; interview; focus groups; workshops; and web-enabled data collection instruments – leading to around 400 formal and informal interviews with patients and carers, health and social care professionals, healthcare managers and policy-makers, and system manufacturers and suppliers.

Conclusions: The paper traces a series of shifts through three ‘translational gaps’ that lead from ‘digital delivery’ of healthcare for acute healthcare needs, to telecare for the management of chronicity: (i) building a justification on an innovation – through the application of telemedicine to micro-level problems of professional practice, specialist service delivery, and the production of evidence; (ii) attempting to modernize recalcitrant professionals through incorporating technological innovations in meso-level shifts in the organization of healthcare services; (iii) placing expensive problems of chronic illness and cognitive impairment at a distance by deploying telecare systems to manage macro-level reconfigurations of problematic populations.

A CRITICAL ANALYSIS OF INSTITUTIONAL HETEROSEXISM AND ITS EFFECTS ON CITIZENSHIP

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Statement of purpose : This paper analyzes and critiques the disjuncture between the legal reality and the lived reality of queer people relying on health care institutions.

Summary of methods and results: The tension between legal rights conferred for non-heterosexual people in Canada and continued prevalence of heteronormative policy and practice emerged in qualitative interviews with lesbian women, aged 60 to 84. Having already faced considerable exclusionary institutional practices in their lives to date, these women expressed anticipatory dread of the erasure of their lives in residential or long term care.

Informed by feminist historical scholars, our analysis draws on the notion of sexual citizenship and extends the work of Richardson, who makes a case for the institutionalization of heterosexism in Western public discourse. In this sense sexual citizenship reflects the degree to which a person's sexual status constrains access to citizenship in terms of legal, social and political rights.

Conclusion: The notion that citizenship is conferred on multiple levels - the legal, political and social- helps us to respond to the issue of why legal rights do not go far enough to ensure full citizenship. And so while non-heterosexual women may have the protection and rights of citizenship in the legal realm the terms on which they are conferred are those of what Richardson calls 'partial citizenship'. Partial citizenship suggests, for example, that while a woman may not be denied admission to a residential care center based on non-heterosexual status, the social or political rights of full citizenship remain tenuous or absent in residential care settings.

A PLACE CALLED HOME: THE SOCIAL AND CULTURAL CONTEXT OF HEALTH

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Background: Arts in healthcare is an emerging movement that links the expressive arts with the healing arts and brings these into the mainstream of traditional healthcare to promote well-being. Dr. Gene Cohen, who was an internationally renowned gerontologist lead the way with cutting-edge neuroscience and groundbreaking psychology to describe the emotional growth and wisdom that many older adults acquire through creative expression as they age. His research in this area demonstrated the significance of creativity in relation to aging such that it not only enables older people to have access to their own potential in later life, but it challenges younger age groups to think about what is possible in their later years in a different way.

Summary of methods and results: A photographic project was conducted in which data were collected at a Home for the Destitute Elderly and Children in Northern India. This visual arts project started as an endeavour to expand the scope of research, bringing together emerging fields of art, research and aging in an effort to capture the “spirit of aging” in different cultures. However, through being immersed in the culture of the Home, it became clear that the spirit of aging did not just exist in the elderly themselves, but in the rhythms of life reflected through the activities of the home. The results of the project are portrayed through an exhibit of photographs and a multimedia presentation that reflects the spirit of place.

Conclusion: Throughout the project, what became evident was the power of image to “bridge the chasm created by differences of language and alphabet” and reveal itself as a means for “universal communication” (Feinenger in Phillips, 2000, p. 25).

TELECARE FOR THE ELDERLY LIVING AT HOME: NEW CARE ARRANGEMENTS, PRACTICES AND RELATIONS

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Purpose and background : This research addresses the introduction of new telecare technologies for elderly people living at home in four European countries. It investigates how these technologies change care arrangements, practices and relations; analyses how care is redefined and redistributed in these new configurations; and traces the framing of normative patienthood, health and illness.

Summary of methods used: The research is based on ethnographic studies as well as citizen panels, and analyses the data according to script-analyses.

Results and conclusion : The results show that telecare is no simple solution to aging populations, care crises, and rising care costs. Telecare does not replace care networks; telecare depends upon, brings along and or mobilizes care collectives. It also introduces and assigns tasks, skills and responsibilities to a range of new actors. Further, telecare requires a lot of work of relating, negotiating, and adjusting in order for them to work well. Telecare also makes patients aware of their bodies, needs, relations and limits, in new ways. They learn to know and examine themselves in ways that used to be taken care of by others. Telecare also gives the patients the task of being more active, self-aware, responsible and self-managed. This implies a new definition of care as looking after yourself and being independent – rather than being cared for by others. Accordingly, telecare users have to be relatively fit and able. At the same time, telecare makes visible that patients are *not* independent individuals, independency is at best an achievement, depending on networks and collectives.

TRANSLATING PRACTICE(S): PROMISES AND PERILS FOR NURSES ADOPTING BEST PRACTICE GUIDELINES

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Currently, expert nurses in cancer care settings are being enlisted in the organizational project of instituting symptom management guidelines (SMGs), designed as “best practices,” which operate as a set of standards by which nurses can both practice and assess their practice.

Our interview-based qualitative research into nursing practice in a “nurse-run” ambulatory patient support clinic in a western Canadian cancer agency, both previous to and during the implementation of SMGs, reveals the unintended consequences of introducing knowledge translation processes into expert practice contexts. Nurses find themselves balancing both the “promises”—information readily at hand, being more thorough, with the “perils”—using detailed standards within time constraints, considering the complexity of cancer patients’ lives beyond symptoms, exposing nurses’ practice to increased surveillance—produced by the introduction of SMGs.

In this paper, we describe some of the detail (and consequent difficulty) inherent in the adoption of the SMGs into practice. We also discuss what is at stake for nurses to incorporate SMGs into their practice in this setting, as they balance existing expertise with the “expert knowledge” of the guidelines, revealing the promises and perils of doing so.

CARING ETHICS AS CARING PRESENCE A PIVOTAL VIEW ON ETHICS IN CARING RELATIONSHIPS

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Purpose and background: The paper is about caring ethics in theory and practice. 'Caring ethics' is conceived as a theoretical position with obligations to nursing practice. The purpose of the study is to explore the ethical relationships between nurses and patients in a psychiatric context. The research questions are: *What conceptions of caring ethics do psychiatric nurses have? What ethical situations do they experience? How do they deliberate and make decisions about their actions?*

Methods and results: The study is a pilot study with two psychiatric nurses as participants. The research paradigm is qualitative using a phenomenological methodological approach. Firstly a conception of caring ethics is presented grounded in traditional ethical and contemporary feminist and caring theories. Secondly data from qualitative interviews about daily work experiences of caring ethics and ethical choice situations are presented. The analysis reveal five essences of caring ethics, namely 'ethics and morals', 'a good nurse', 'caring', 'ethical choice' and 'suffering and co-suffering'. Thirdly the findings are elaborated and discussed. The findings indicate that conceptions of caring ethics are twofold and that moral actions are grounded in multiple ethical traditions and theories. Outstanding moral components which situate the essences are found to be the 'dignity' of the human being, the 'being-with' in caring presence, the 'responsibility' in the caring relation, the impact of 'ethical conscience' and the use of 'practical reason'.

Conclusion: The findings are preliminary and demand further investigation in similar and other contexts to strengthen the knowledge base of caring ethics.

MAKING VISIBLE GENDERED PROCESSES IN COMPLEMENTARY AND ALTERNATIVE MEDICINE

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Social science research in complementary and alternative medicine (CAM) has, over the last two decades, focused on the emergence, content and evidence base of CAM. Debates about CAM professionalisation, integration and multiple medical realities have also been prominent. Whilst it has been consistently noted that women consume and practise alternative therapies more widely than men there has been little analyses of these processes. In particular, there has been a noticeable absence of engaging with feminist thinking in examining these issues, and little research has explored the influence of new social movements and identity relating to the work and use of alternative therapies.

This paper explores this lack and argues that feminist analyses are necessary for an analysis of the less visible gendered processes that operate in CAM. We suggest that considerations of gender allow us to more fully understand issues of power relations in the clinical encounter and processes of personal and social change engendered through CAM. In addition, adopting a feminist perspective permits a different discourse about professionalisation, integration and multiple medical realities to emerge.

COLLABORATION ACROSS ORGANIZATIONAL BORDER – IN THE CONSUMERS BEST INTEREST

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Continuity in the follow-up and treatment of consumers in the community mental health services – after the Norwegian National Programme for Mental Health (1995-2008).

This ongoing phd-project explores how professionals collaborate within the mental health system in order to provide services that ensure that the consumers receive the most appropriate services. A lot of people with mental illnesses are in use of services from different specialties or sectors. Continuity of care is a primary goal in the mental health services set out from the Government.

The aim of this study is to explore what create or inhibit continuity within the care of mentally ill who are in need of such complexes services.

This phd-project is based on a sociological method called Institutional Ethnography (IE), a qualitative study. Different methods are used to gather data: focus groups, individual interviews, observations and some text reading. As a starting point I have carried out 7 focus group interviews with professionals from municipalities and institutions. I am working on my analysis. Almost simultaneously I am carrying out 20 individual interviews with consumers, to get their experiences with institutionalizing. Later on 7 out of the 20 consumers will be followed in their transitions from community-care to institutional-based care and back to community care. To get an overall knowledge of what doings is required during these transitions, professionals who are involved with the consumers will be interviewed individually as well. In addition to this, the researcher will be an observer in meetings and read relevant documents.

The presentation will focus on gathering data from focusgroups. Both ethical and professional questions will be discussed in relation to the aim of the study.

BIOETHICS AND DOROTHY SMITH: HOW INSTITUTIONAL ETNOGRAPHY CAN EXTEND AND ENRICH THE BIOETHICAL DISCOURSE...PERHAPS?

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In contemporary modern health care systems, sophisticated technological and medical advances generate treatment dilemmas especially at the end of life. A problem in acute hospitals is that treatment decisions in care of older patients are complex, particularly when the patient at the centre of care is unable to be part of the decision making process. The bioethical ideal of patient autonomy in these situations become opaque and decisions are made by others for example, family members and health care practitioners (Beauchamp & Childress, 2009). This decision making process is negotiated in acute hospitals where the everyday work of patient care is organized to ensure maximum efficiencies (Rankin & Campbell 2006).

The purpose of my paper is to show how decisions concerning the treatments of older patients in hospitals are shaped by the discourses used; discourses that are ruled by both local and extra local interests (Smith, 2005; 2006).

My argument is based on the findings of an ethnographic study of treatment decisions in the care of older patients in two university hospitals in Dublin, Ireland.

My findings showed that when older patients were unable be part of decision making, decisions were left to family members and or the health care practitioners. The various players involved drew on different discourses to negotiate their way through the uncertainties of possible outcomes. Practitioners drew on thin scientific technical discourses while families drew on thick social discourses.

Good patient care in acute hospitals requires both thin scientific technical discourses, and thick social discourses. Practitioners however need to be aware that the dominance of thin discourses may delegitimize the thicker social discourses. This may result in unintended consequences in that thin discourses produced lead to practice that is removed from the human aspects of care.

GENERAL PRACTITIONERS AND SPIRITUAL HEALERS COMPARED - AN ANTHROPOLOGICAL COMPARATIVE ANALYSIS OF MUS PATIENTS' EXPERIENCES OF RESPECTIVELY GP CONSULTATION RITUALS AND SPIRITUAL HEALING RITUALS.

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Purpose: The purpose of the research project was to compare MUS patients' experience of respectively GP consultation rituals and spiritual healing rituals.

Background: Medically unexplained symptoms (MUS) are defined as: physical symptoms for which no adequate physiological basis can be found. Consequently, the reality of patients' subjectively experienced symptoms (illness) is often misbelieved and unrecognized. Because of this non-existence of the disease the GP as well is left in a grey area without tools for treatment.

Methods: There was conducted 6 months fieldwork and qualitative interviews with 20 informants: 10 on GP consultations and 10 on spiritual healing.

Results: The patients appreciate their GP especially if she moves beyond her biomedical competences. Generally, the informants experience the GP as 'closed', ie. she mainly has her bio-medical skills and symbols to draw on, while a healer is experienced as 'open', i.e. she is not subject to the same limitations and in principle has an endless array of symbols to draw on, for example, symbols concerning the existential and the spiritual. Especially the existential and spiritual dimensions of the illness are something many patients – especially 'religious sceptics' - call for.

Conclusion: Drawing on anthropologist Levi-Strauss' concepts of 'ingenieur' - 'bricoleur' and anthropologist Tambiah's (Lévy-Bruhl's) concepts of 'participation' – 'causality' it is argued that from a patient experienced perspective the biomedical scientific paradigm constitutes an obstacle for the GP to offer the MUS patients the best treatment and support. The paper concludes with some reflections on what constitutes 'the good healer'.

RISK, RISK MANAGEMENT AND DUTY OF CARE IN SELF-DIRECTED SOCIAL AGED CARE: EXPLORATION OF AN ENABLING RISK MANAGEMENT MODEL

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Background: Potential risks to clients and risk management issues faced by care providers are at the forefront of issues raised when exploring Self-Directed Home Care options with older people with more complex needs. The notion of consumer choice potentially challenges conceptions of 'risk' and 'duty of care' forcing social care practitioners and managers to re-visit how risk is appropriately managed.

Summary of Methods and Results: This paper reports on how the issue of risk is being addressed by three Australian social care agencies involved in a multi-method Self-Directed Care research project. The paper draws on phase one, the action research-based development phase, phase two, a formative and iterative evaluation of phase one, and the first 8 months of phase 3, a 18 months cohort study involving one intervention and one comparator arm (n=168), as well as participant observation and semi-structured interviews with staff and management. The paper highlights the key challenges of an 'enabling' risk management approach. This enabling risk management approach helped to identify ways for older people with complex needs to self direct their social care safely. However, more traditional risk management approaches underpinning government policies and guidelines, gate keeping by staff without adequate knowledge of the process as well as a more paternalistic conceptualization of duty of care represented ongoing problems.

Conclusion: Enabling risk management strategies provide one possible avenue to mitigate potential conflicting of interest between choice and client risk. However, such approaches need to be bound up with a holistic change management strategy to be successful.

EXPLORING VIOLENCE IN A FORENSIC HOSPITAL: A THEORETICAL EXPERIMENTATION

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This presentation is a theoretical experimentation that seeks to introduce the work of French philosopher Bruno Latour in the health sciences, specifically in nursing. A well known philosopher of science, his work is seldom used to explain various phenomena that are relevant to health and nursing work. Although he did not explicitly address the issue of violence (in any sense of the term), theoretical tools such as *Actor-Network Theory* may provide insights that make them relevant to the examination of violence in health settings. This presentation critically examines the violence experienced by psychiatric nurses in an Australian forensic hospital as an exemplar and seeks to explore and integrate new theoretical constructs to understand the issue of violence in this particular context.

THE DIFFICULT PATIENT: A NEW SPIN OF AN OLD TALE

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Purpose and method: This presentation focuses on aspects of a larger, in-progress project. In a larger project I seek to write a genealogy of the *difficult patient*. This current paper brings together nursing literature on the topic of the difficult patient and reads it through the lens of the philosophical assumptions of Nietzschean-Foucauldian genealogy.

Results: Nurses have always encountered difficult patients. From the time the *difficult patient* was first mentioned in nursing journals in the UK and US in the early 20th century, this phrase has been taken up in an essentializing way as conveying a particular meaning about the phenomenon of difficulty. Over the last 40 years, a number of nursing scholars have studied this phenomenon. Viewed collectively, these studies comprise what appears to be a progressivist history of the phenomenon of the difficult patient. This history reveals a deepening insight of the discipline of nursing into the nature of this phenomenon, an insight that carries a promise of a potential resolution of the issue of difficulty. In contrast, considered in light of Nietzsche and Foucault's anti-essentialism and historicity, the seemingly upward story of this phenomenon is transformed into an *effective history* of the difficult patient.

Conclusion: In this alternative, effective history, the difficult patient is a product and an object of nurses' knowledge, and is inseparable from and contingent upon the history of nursing and a shifting ethos of the health care system. Movements within the health care system and nursing create *grids of visibility*, to use the phrase of a Foucauldian scholar Nicolas Rose, through which the phenomenon of difficulty emerges and takes shape.

CLEARING A SPACE FOR NURSING PRACTICE: BOUNDARY WORK IN AMBULATORY CANCER CARE

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The dynamics of contemporary ambulatory cancer care are investigated as they condition the possibilities for nurses to direct and alter their practice to meet emerging population health needs. A number of factors are at work in this site of contested professional practice: rising incidence of cancers within the Canadian population; shifting funding models for cancer research; debate about the value of an interprofessional agenda in health care delivery; traditional power and gender relations; traditional discourses of autonomy and professionalism among others.

The paper offers evidence of the range of strategies employed by organizational actors in an attempt achieve one of two forms of practice that may be understood as ends of a spectrum. Those in favour of a 'modern,' interdependent form of autonomous professional practice advocate for the creation of a nurse run clinic where patients may consult with nurses on many aspects of their experience of living with cancer and its treatment. At the other end of the spectrum are those who would advocate for a return to a 'pre-modern' form of practice where nurses were assigned to oncologists and provided ancillary support to patients through direction from the oncologist. The co-occurrence of these distinct versions of professional nursing practice have a tendency to generate conflict within the organization and to create an *impasse* for those interested in focusing on the experience of the person living with cancer.

We will draw on Bruno Latour's work that challenges historical claims on the advancement of practice and outcomes over time. Having set out the ethnographic context of practice in one particular ambulatory cancer centre, we will explore the possibilities of resolving current conflicts in that setting through reference to Latour's notion of the "non-modern" (http://www.bruno-latour.fr/presse/presse_art/GB-01%20DOMUS%2001%2004.html). In the non-modern, Latour argues, matters of fact are transformed into matters of concern and science is practiced such that it "absorbs the many impure languages that allow real sciences to be empirical for good" (Latour, 2004).

Our paper will explore the opportunities of conceiving of non-modern cancer care in an effort to generate productive models of practice that incorporate and move beyond the current *impasse*.

KNOWLEDGE AND GENDER RELATIONS AT THE INTERSECTION OF NURSING WORK AND TECHNOLOGY

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Background and purpose of the study: Our research focuses on nursing and health reform. (Rankin and Campbell, 2006). Nurses work within a variety of objective, technologically generated modes of knowledge. These new forms of knowledge “eclipse” (Smith, 1987) critical components of nursing knowledge and organize nurses to unwittingly activate practices that are deleterious for patients. Nurses’ work, organized and oriented towards improving efficiencies, produces taken-for-granted activities that have troubling consequences. The purpose of our research is to describe and map how this happens.

Summary of methods used and results: Using Dorothy Smith’s (1987, 2005) institutional ethnography (IE), and drawing on its feminist origins, we explore how gendered forms of knowledge feature in the social organization of contemporary nursing. IE was developed using Smith’s standpoint as a woman. She noted that women’s knowledge generated through experiences in the home, were absorbed into objectified ruling practices controlled by men. Historically, knowledge developed through daily particularities is downgraded within gendered regimes of knowledge.

When a historical line of thinking about authorized modes of knowing is applied to changes in nursing we are brought face to face with technologies organizing health care. Despite that nursing work is no longer exclusively female, gendered regimes of knowledge continue to subordinate experiential knowledge. Our research reveals that experiential knowing is critically important for nursing and its “eclipsing” needs to be problematized.

Conclusion: This paper offers a conceptual/analytic framing of instances of the new technologies at work in nursing and of nurses’ everyday use of objectified knowledge. Our paper proposes how these data can be treated a basis for “seeing gender”.

THE RESPONDING RELATIONSHIP

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Purpose of the study: The objective is to present the *Odense Group Approach* (OGA). The aim of this approach is to examine psychological aspects of group processes especially for patients with somatic diseases.

Background: Intervention projects normally take as their starting point some specific context such as the organization or the duration of a project and use this to examine the outcomes of the intervention such as reduced weight, freedom from drug dependency etc. The processes that patients or participants thereby experience and interpersonally create appear to remain in a behaviouristic 'black box'.

Methods and results: OGA attempts to make a closer analysis of this 'black box' and in so doing has come upon five relevant themes that exert an influence upon the outcomes of the intervention: feed-back given, group cohesion, corrective emotional experience, universality of suffering and group climate. These five themes have their roots in the tradition of psychoanalysis. The corrective emotional experience has its origin in the work of Alexander & French (1946), while the terms group climate, universality of suffering and group cohesion have been dealt with in research by the psychoanalyst Irwing Yalom (2005, 6ff., 133ff.). The particular significance of the responding relationship, whereby the psychologist reveals his or her own experience in a selective and purposeful way, has its origins in the work of the Göttinger school (Heigl & Heigl-Evers, 1978, Streeck & Leichsenring, 2009, 96). Using these five aspects the aim is now to explain how with the assistance of one specific health intervention a change of behaviour was brought about, and how, for example, the desired behaviour was not achieved.

Conclusion: The focus is on communication between people and the aim is on the one hand to help to explain psychological and social processes and mechanisms and on the other to assist the analysis and evaluation of interventions.

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THE ONUS OF SELF-CARE AND SELF-MANAGEMENT: A TREATISE ON RESISTING NEOLIBERAL REALITIES WHILE CARING FOR THE SELF

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Background and Purpose: A growing impetus for health and illness care in the new millennium emphasizes self-management of health protection, disease prevention, and chronic illness experiences of individuals. While there is a logical idealism to this approach, there are extreme inadequacies in the contexts of the worlds where these behaviors are to be performed. Increasingly, there is substantive neglect to the issues of what really matters in sustaining the health of a nation's population. The empirical research is clear—macro or social determinants have the most impact on the health and wellbeing of individuals and communities. These determinants are the sum total of *effects* of the complex interactions of governance that relate to how well infrastructure such as material necessities of security, food and water safety, housing, education, economic security, and access to primary health care are enacted by sovereign governments. The net effects of these interactions result in micro-determinants of health—or *symptoms* expressed as behavioral patterns, genetic predispositions, local social circumstances, and environmental factors. This is not a dialogue about macro opposed to micro determinants of health but rather how the *capacities for knowledge* are suppressed, constraining a more advantageous individual wellbeing in our neoliberal world.

Methods and Outcome: Utilizing discourse analysis, I will present a schema of practices that optimize self-care and self-management following Foucault's description of four types of technologies that are relevant in understanding the evolution of "care-of-the-self": technologies of production, of sign systems, of power, and of the self.

Conclusion: Reconceptualizing resistance shifts the onus of "care-of-the-self" to positive ethical actions.

DOMESTICATING RESEARCH: PRACTICE DEVELOPMENT AND ITS ORGANISATIONAL AGENDA

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Purposes of the study and background: Practice development has been put forward as a response to the need to professionalise the nursing workforce. One of its aims is to provide nurses with the means to promote change and flexibility in nursing practices through the application of emancipatory research to problems identified in practice. This paper aims to expose how research undertaken within the rubric of practice development is limited and contained.

A summary of the methods uses and the results: Using a neo-Foucauldian approach, a collection of practice development texts on research were analysed for the forms and limits of research promulgated in them. The analysis shows that the defining of 'problems' suitable for researching by the 'clinical' nurse were limited in their scope and impact – largely within organisational imperatives for quality and efficiencies. Moreover, while these projects were deemed as emancipatory in their effects, the consequence was to domesticate, rather than to add or contribute to genuine change or development of nursing knowledge.

Conclusion: The professionalising dogma associated with practice development, while providing a format for ward based nursing research does not contribute to significant research based change in nursing practice. Instead it domesticates nurses' research sequestering such efforts away from bringing 'development' to the profession and re-locates such research back with the organisations in which nurses work.

PERFORMING HEALTH: A GENEALOGY OF NURSES' ADOLESCENT HEALTH PROMOTION PRACTICES

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Purpose of the study: The purpose of this paper is to examine current nursing approaches to adolescent health promotion research and practice employing a Foucauldian perspective on knowledge development within human sciences. The intent is to critically appraise the ethics of nursing scholarly endeavors directed toward understanding notions of adolescent health including practices directed toward promoting adolescent health. The central question guiding this work asks, how do the 'regimes of practices' (Foucault) that shape contemporary nursing approaches to adolescent health promotion practice influence nurse and adolescent agency within the context of health promotion practice.

Summary of methods and results: Foucault (1984d) suggested three domains of genealogy—the domains of science, politics, and ethics. I explore these three domains as they apply to a genealogy of nursing practices directed toward adolescent health promotion. A process of problematization allows for the questioning of how the formation of health promotion as a scientific endeavor within the human sciences, the limitations of its field and the definition of the health promotion subject implicated a political structure and a moral practice for nurses. Results include the influence of a discourse describing adolescent risk, irrespective of adolescent social contexts, particularly in sexual health promotion practices.

Conclusion: I propose that an understanding of the political, social, economic and contextual factors influencing adolescent health is important in order to successfully challenge the idea that risk to adolescent health is a naturally occurring phenomenon. I suggest the performative effect of an adolescent risk discourse.

MASOCHISM IN NURSING: ETHICS AFTER LACAN AND ZIZEK

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Purpose and Background: Academic nurses can still be found publicly mourning the loss of the profession's Christian, ethical duty foundation promoted in the 19th century (Bradshaw 2010) despite arguments to the contrary (Nelson and Gordon 2006). This paper recontextualises talk of ethical duty within a Marxist and Lacanian psychoanalytic framework revealing a structural masochism characteristic of the profession.

Methods and results: Starting with a critique of a recent paper from Bradshaw, and moving on to present focus group data from on-going PhD work, this paper looks to the writing of Slavoj Zizek—who blends Marxist and psychoanalytic theories—to trace within nursing a move from an ethic of duty, through a stance of self-sacrifice, to the enjoyment (jouissance) of masochism. In the process, the notion of ethics itself will be problematised.

Conclusion: In an era where health professionals are said to be experiencing proletarianisation, the reinstatement of Victorian Christian ideology functions, in Marxist terms, to control and pacify the workforce. However, from a psychoanalytic viewpoint, the self-sacrifice of Christian duty promoted by the traditionalists provides a source of jouissance for nurses. This jouissance can be experienced in the repetition of talk enacting the abuse and powerlessness that many nurses find a core part of their working experience and identity.

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VERO: INNOVATIVE EQUIPMENT. LET'S SEE WHAT WE CAN DO WITH IT

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Technology far ahead of practice: Last century the question has been raised if medical drugs are designed to cure diseases or if diseases are designed to get a proper purpose for a newly invented drug. (e.g. Rein Vos on Beta-Blockers)
We can translate this question to “is medical equipment designed to diagnose/ cure diseases or are diagnostics/ curing diseases designed to be a proper purpose for a newly invented machine?”.

Media and a similar problem: We will take a closer look at the radiotherapy machine Vero, a unique kind of equipment located at a Belgian hospital. The Belgian media hype was gigantic for just being some medical equipment. Moreover it is not clear what the advantages and disadvantages exactly are of this radiotherapy machine. By analysing articles of the belgian media and comparing the Vero problem with the beta-blockers problem, we notice that science and the practice of it are a social construct.

Let's be aware of the Einstein problem: This reminds us at the the theoretical research of Albert Einstein which had no direct purposes in real life, but has been used to invent an atomic bomb.

My purpose is not to claim that Vero will not be useful in the future. But we must contemplate on the fact that technology grows faster than the appliance of it in clinical practice. Or in other words, the social construct of the practice of science is behind on the booming technology.

POLICY AS TECHNOLOGY IN HEALTH/CARE

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The role of policy-making in the construction of health and disease is worthy of attention. This paper will examine approaches to policy-making and their role in shaping understandings of health/care and policy responses to those understandings. An analysis of policy-making literature reveals key debates that contextualise the explosion of evidence-based policy-making in health/care. Borrowing from its predecessor evidence-based practice, initiated and lauded in medicine, evidence-based policy-making purports a very particular approach to and use of knowledge production. The scientism and its rationalist foundation in modern epistemology that dominates ways of seeing and understanding much of life and the world in the global north also dominates health/care policy and, in turn, constructions of health and disease. The technical, individualising, and responsibilising discourses that dominate an evidence-based approach to policy-making contribute to a biomedical construction of health/care that denies space for consideration of everyday life. The principles of evidence-based policy-making have an affinity with neo-liberalism, however, and thus make sense in contexts with increasingly neo-liberal orientations.

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NURSES CARING FOR ELDERLY RELATIVES: EXAMINING THE CARE WORK OF DOUBLE DUTY CAREGIVERS

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Background: Double duty caregivers (DDCs) are those individuals who provide care both at home and at work. Current conceptualizations of paid and unpaid care work tend to assume that these two domains are distinct, subsequently little is known about the health effects of the blurring of boundaries between familial and professional caregiving.

Purpose: Guided by a critical feminist perspective, the purpose of this sequential mixed-methods study was to examine how and to what degree double duty caregiving (DDC) affects the health of Canadian, female and male nurses caring for elderly relatives.

Methods: Phase I: Using a cross-sectional survey design, 1424 RNs were randomly selected from provincial college memberships who completed mailed or web surveys. Phase II: Using grounded theory, repeat in-depth telephone interviews were conducted with a purposeful sample of 50 male and female DDCs.

Results: DDCs reported lower health outcomes compared to non-DDCs. Further, female DDCs experience higher levels of exhaustion compared to male DDCs. Qualitative findings also suggest that DDCs professionalize their familial care, especially those with high expectations and limited resources, taking a toll on their health.

Conclusion: Study findings revealed that the provision of care at home and at work tended to result in negative health effects for nurses, which warrants further investigation. Developing a more comprehensive understanding of DDC and how it influences the health and well-being of health professionals, is particularly urgent given the aging population, an aging health care workforce, and an increasing shortage of health care professionals.

DOMINANT DISCOURSES AS TECHNOLOGIES OF IDENTITY IN OFFENDER HEALTH CARE

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In this paper we explore the way in which dominant discourses construct professional practice and professional identities, both internally and externally, in the world of offender health care. We suggest that the dominant discourses that prevail on the stage of offender health are determined predominantly by public and professional media. These discourses are influenced by the political mood of the day, which in these times of austerity, is significant as both health and the criminal justice systems are scrutinised both financially and professionally to ensure economic care delivery, see Department of Health (2010).

In this paper we reflect on our practice development work in offender health, and note two key discourses to explore regarding how they construct the professional identity of offender health professionals, and impact on care delivery: Caring and Custody. Commonly reported in the professional literature as *competing* philosophies, they are now at the fore as partnership working between health care and non health care professionals is promoted, see Bradley (2009). The impact of partnership working on the workforce is significant as roles and boundaries are defined, working practices are revised and educational opportunities developed. Through this paper we utilise our own experiences to deconstruct the discourses of caring and custody and explore how they are portrayed and how they construct the professional identities of those caring for prisoners from the perspective of nurse and prison officer. We conclude by reflecting on the purpose served by the construction of professional identity through dominant discourse, promoted by the media.

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AN ANALYSIS OF THE EFFECTS OF GENDER, CULTURE AND POWER RELATIONS ON THE DOCTOR-PATIENT COMMUNICATION BETWEEN TAIWANESE DOCTORS AND IMMIGRANTS FROM SOUTHEAST ASIA

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As more Southeast Asian immigrants arrive, Taiwanese doctors confront challenges in providing treatment for patients from diverse cultures who speak different languages from the host society. This paper explores the unequal gender, cultural, and power relations between these immigrants and Taiwanese doctors, in order to examine if such relations affect their communication and damage immigrants' health.

Based on an ethnographic assessment of 21 immigrants and 11 medical interpreters, my analysis presents the perspectives of immigrants who use the health care system and communicators between doctors and immigrants.

Vietnamese and Indonesian non-ethnic Chinese, married to Taiwanese via marriage agencies, are the most disadvantaged. The findings demonstrate that due to intersectional and systematic oppressions, these immigrants encounter transnational reproduction and compliance—doctors communicate mainly with their husband's families. If not aware that their husband's families often filter information so as to control wives' action and bodies, doctors do not consult consents from immigrants, but from their husband's family. Thus, doctors collaborate with patriarchy; furthermore, doctors may reproduce the host society's pervasive cultural hegemony. Some doctors decline the queries of Southeast Asian immigrants and treat them ruthlessly, which differ greatly from their attitude toward immigrants who speak English fluently. My research subjects are more likely to receive silent treatment and encounter gender disempowerment.

This paper concludes that unequal gender, cultural and power relations in communication greatly damage immigrants' health in such a way that they lose reproductive rights and undergo amniocentesis, sterilization or abortion, yet are neither fully informed, nor consent to such treatments.

CARE AS BOUNDARY WORK

- A STUDY OF PROTECTION AND NORMALIZATION WORK IN A PSYCHIATRIC HOSPITAL IN NORWAY

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Topic area: Scope of practice and professional boundary work in health care teams. The paper will illuminate the tension between protection work and normalization work in a psychiatric hospital.

The empiric material is based on a nine months ethnographic field research on daily life and milieu therapy in a psychiatric hospital in Norway. The Norwegian government is concerned about risk factors and engages in protective efforts to minimize danger for the well-being of its citizens, while at the same time they organize mental health programmes and services to work for normalisation through goals such as independence and coping.

Such paradoxical claims create tensions and difficult dilemmas for the professional staff. On the one hand the staff will have to protect patients from injury, and on the other hand the staff will prepare patients to take responsibility for themselves as independent citizens. To protect patients from harm and injury imply deprivation of liberty, while working for independence and coping imply giving patients freedom thorough self-determination while hospitalized. The empiric material will be illuminated by Mary Douglas` theory on containment and boundary work.

ABSTRACTS,
POSTER PRESENTATIONS

HOW TO STUDY THE IMPACT OF PATIENT EDUCATION ON THE CHRONIC PATIENT'S EVERYDAY LIFE?

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Purposes of the study and background: This paper is a part of the PhD. project “Educating adults with a chronic disease to live their everyday life” where the overall aim is to develop a model illustrating factors that facilitate, limit or obstruct the transfer from patient education in clinical practice into the persons everyday life after discharge. The aim in this paper is to discuss how it is possible to study the impact of patient education while hospitalised, on the chronic patient's everyday life after discharge. Education is understood as everything in the hospitalisation which has a learning potential e.g. the milieu, conversations with health professionals and group sessions.

Summary of methods used and the results: The method is a critical comparative analysis of the concept ‘transfer’ seen from different learning theories. Preliminary findings showed transfer is a concept, which associates to a narrow understanding of learning and learning processes. It may be problematic in a study where I want to reach a deeper understanding of difficulties encountered by persons with chronic diseases when they try to learn to live their everyday life as prescribed by health professionals.

Conclusion: At this point it seems as an approach involving situated learning theory will make it possible to explore the impact of patient education in the person's everyday life after discharge.

JUNIOR DOCTORS IN GENERAL MEDICINE: THE CONCEPT OF POWER

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Background: Postgraduate medical education (PGME) relies on supervision and a focus on physician competencies in clinical training. In Denmark, each trainee (junior doctor) is usually employed in several consecutive places, and in each department or practice he/she is attached to a trainer (senior doctor) responsible for documenting the obtained competencies during the stay. Former studies have shown oppressive power relations inside the medical profession and these can cause counter-productive efforts in medical education.

Purposes: To examine the power structure of the PGME in general medicine in Denmark as it is experienced by the trainees, especially in case of problematic circumstances of their education or their personal life.

Methods: A critical discourse analysis of the official documents describing PGME from the National Health Board and other authorities involved, focusing on the language of requirements and potential sanctions. Subsequently, an interview guide regarding the learning environment and daily clinical training practice will be developed. Semi-structured interviews with 3-6 trainees will be conducted and analysed in an attempt to generate a theory of internal oppressing forces inside the PGME. Foucault's concept of power and other relevant perspectives will be applied, as will considerations of the researcher's own position as a doctor in the field.

Conclusion: The study is anticipated to broaden the knowledge about how junior doctors in general medicine experience the structure and dynamics of power in their educational course. The results are likely to have impact on the evaluation of medical education and the future recruitment to the specialty.

EXISTENTIAL NEEDS OF DYING CANCER PATIENTS AND THEIR RELATIVES DURING THE TERMINAL PHASE IN A DANISH HOSPICE

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Background: International research suggests that life-threatening diseases lead to intensification of existential considerations and that such intensification increases with the threat of dying. Furthermore the research suggests that support of the existential considerations can help cancer patients and their relatives to improve the quality of life in the palliative phase.

However the research is mainly based on North American studies. Preliminary research from the Scandinavian region suggests that it may be difficult to transfer research findings generated in a religious community as the North American to a society like the Danish because of the extent of secularism. Thus it seems necessary to do research in a Danish secular context. This will be of international relevance, especially in countries where secularism is on rise and performed religious traditions deteriorate.

Aim: The aim is to provide research-based knowledge about the complexity of existential reflections and needs among terminal cancer patients and their relatives in Denmark.

Method: The key research questions are formulated as:

1. What kind of existential considerations and needs are central to cancer patients and their relatives during the terminal phase in a Danish hospice?
2. How are the existential needs being fulfilled at the hospice?
3. How management of existential needs can be optimized in a hospice according to terminal cancer patients, relatives and relevant resource persons?

Empirical data are generated through three qualitative sub-surveys: 1) Participant observation in tree hospices 2) Semi structured interviews with 15 dying cancer patients and 15 corresponding relatives 3) Focus group interviews with staff at the hospice.

COLLABORATION ACROSS ORGANIZATIONAL BORDER – IN THE CONSUMERS BEST INTEREST

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Continuity in the follow-up and treatment of consumers in the community mental health services – after the Norwegian National Programme for Mental Health (1995-2008).

This ongoing phd-project explores how professionals collaborate within the mental health system in order to provide services that ensure that the consumers receive the most appropriate services. A lot of people with mental illnesses are in use of services from different specialties or sectors. Continuity of care is a primary goal in the mental health services set out from the Government.

The aim of this study is to explore what create or inhibit continuity within the care of mentally ill who are in need of such complexes services.

This phd-project is based on a sociological method called Institutional Ethnography (IE), a qualitative study. Different methods are used to gather data: focus groups, individual interviews, observations and some text reading. As a starting point I have carried out 7 focus group interviews with professionals from municipalities and institutions. I am working on my analysis. Almost simultaneously I am carrying out 20 individual interviews with consumers, to get their experiences with institutionalizing. Later on 7 out of the 20 consumers will be followed in their transitions from community-care to institutional-based care and back to community care. To get an overall knowledge of what doings is required during these transitions, professionals who are involved with the consumers will be interviewed individually as well. In addition to this, the researcher will be an observer in meetings and read relevant documents.

The presentation will focus on gathering data from focusgroups. Both ethical and professional questions will be discussed in relation to the aim of the study.

FAITH, EXISTENCE AND MOTHERHOOD WITH PREMATURE BABIES

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Background: Giving birth to a premature baby raises at least two issues for a woman. First, her pregnancy is interrupted preterm and second, she becomes a mother of a vulnerable and premature child. Therefore mothers of premature babies are in a position characterized by experiences of loss, crisis and unpredictability similar to cancer patients. Do these women as well consider existential and religious issues? And if so, how do these issues affect their way of coping?

Aim: The aim of the study has two dimensions:

- To explore the independent influence of pregnancy and childbirth related to an intensification of existential and religious issues among Danish mothers of babies born either around due date or prematurely.
- To explore the impact of existential and religious issues on the way of coping, among mothers of premature babies, who have or have not, respectively, an integrated religiosity.

Methods: The project follows a mixed methods approach. It is initiated by a nationwide quantitative questionnaire (Part one) among two groups: Mothers of premature babies born before 32nd week of gestation, and mothers of full term babies. Part one also functions as a filter for participants needed for part two. Part two consists of qualitative interviews with two groups (10 interviews in each group) of mothers who had a premature baby, selected from the survey: One group of these mothers who experienced that the existential and religious issues had big impact on their way of coping, and one group who did not attach importance to these issues.

ETHNIC MINORITIES' USE OF THE COMMUNITY MENTAL HEALTH SERVICES: AN INTERVIEW STUDY OF ILLNESS MODELS AMONG MENTALLY ILL MINORITY GROUPS AND THEIR RELATIVES

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Background and purposes of the study: Research indicates that ethnic minority outpatients at psychiatric community centre in Odense, Denmark (DPC) do not receive care and treatment to the same extent as ethnic Danish outpatients. In particular they choose not to participate in psychoeducation and supportive counseling. The difference between the groups is not caused by differences in the mental illness but perhaps by differences in their understanding of mental illness.

It can have great personal, economical and social consequences if the mentally ill person and their families don't receive sufficient professional support. Research indicates that a psychosocial intervention in which the family is included is of great importance for experience of support, stress in the family, medicine adherence and relapse.

The project will give concrete proposals of improvements to the existing psychosocial offers in DPC which are tailored to the needs of ethnic minority groups.

Methods: The aim of the project was to gain knowledge about how ethnic minority groups understand mental illness and what needs for psychosocial support they have. Since the understanding of mental illness is to some extent culturally defined, and clinical experience indicates that it is difficult to recruit and interview this vulnerable group, we have chosen to interview relatives. Semi-structured interviews with 25 relatives will be carried out. All interviews will be analysed on the basis of acknowledged principles of thematic analysis.

The Project started up in October 2010 and is expected to have ended in September 2011. In May 2011 the provisional findings will be presented.

HEALTH PROMOTION IN UNIVERSITY CURRICULUMS FROM THE UNIVERSITY OF BALEARIC ISLANDS

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Purpose of the study and background: Universities must be able to contribute to promoting healthy lifestyles. As promoters of health, they should integrate physical, psychological, social and training activities to improve the life quality at the university community. A university that advances health is one that joins health promotion with its purpose, aiming to foster human development and improve quality of life for its students and employees, thus impacting both the labour and social circles. The aim of this study is to evaluate the incorporation of healthy lifestyles in different degrees and postgraduate curriculums at the University of the Balearic Islands.

Methodology and results: An electronic questionnaire was sent by mail to all the teachers from the University of the Balearic Islands that were not members of studies directly related to health. Furthermore a total of 5 semi-structured interviews to teachers outside studies related directly to health were carried out. The main results of the study suggest that teachers don't do activities related to healthy lifestyles and, most of them, don't know how to connect their subjects with these lifestyles.

Conclusions: Teachers of degrees and postgraduate courses that are not directly related to health do not usually engage in activities that promote healthy lifestyles among their students as they find it difficult to establish the connection between their subjects and health. Although they understand the impact of these activities on the future of their students, they think that they are not able to implement these activities because they have not the adequate tools.

THE VISION OF NURSING STUDENTS ABOUT THE WORK IN PRIMARY CARE

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Purpose of the study and background: The aim of this study is to show the opinions that nursing students express on the organisation and competences of Primary Care (PC) nursing, and on inter-professional relations. The students who took part in this study had no previous contact with the work in PC, so we think that their vision of the culture of the institution could provide an interesting perspective.

Methodology and results: Qualitative research study based on the group discussion technique – using four discussion groups among 10 and 12 nursing students after six weeks of practices in a health center. We asked two major questions: what did they like most about PC and what the least?. These practices had been their first contact with PC, although some practices had previously been done in hospitals.

As a result, we can highlight the continual reference to the autonomy of the nurse PC regarding hospital nurse, and the possibility of undertaking activities to promote health that directly affects the population. One negative aspect was the futility of emergency triage by nurses in PC. About inter-professional relations the opinion was very different depending on the health Center.

Conclusion: One of the main conclusions from the study is that students believe that PC nurses have a higher level of autonomy than hospital nurses. They think that this level of autonomy allow nurses in PC to have a more close relation to the patient, to carry out more Health Promotion activities, to make training sessions, etc. Most of the students have a positive view of the work that nurses do in PC.

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