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Title: The epistemological complexity of ideal care : long-term care professionals' perspectives

Year: 2022

Version: Accepted version (Final draft)

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Please cite the original version:

Hämäläinen, A. (2022). The epistemological complexity of ideal care : long-term care professionals' perspectives. *International Journal of Care and Caring*, 6(4), 493-509.
<https://doi.org/10.1332/239788221x16382572220893>

article

The epistemological complexity of ideal care: long-term care professionals' perspectives

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The article elaborates what aspects of knowledge eldercare workers describe concerning everyday long-term care practices. The article utilises a thematic analysis of Finnish long-term care workers' semi-structured interviews ($n = 25$), and in doing so, it contributes to the discussion concerning the epistemological basis of care. The analysis specifies four aspects of knowledge in long-term care work: objective/objectifying, particular, corporeal and tacit. In line with existing literature on knowledge and care, the findings indicate that rational-technical epistemological approaches are insufficient when complex and fluid care relations are concerned. Moreover, cognitive impairments and other particularities of eldercare provide previously under-researched epistemological perspectives for consideration.

Key words care of older people • epistemology • corporeality • qualitative methods

To cite this article: Hämäläinen, A. (2021) The epistemological complexity of ideal care:
long-term care professionals' perspectives, XX(XX): 1–17, *International Journal of Care
and Caring*, DOI: 10.1332/239788221X16382572220893

Introduction

Beneath any established view and practice related to care lie a mixture of ontological, epistemological and ethical assumptions, which are contested and constantly defined in political discourse, policies and practices. Care work has historically been underpinned by rational-technical thinking, increasingly leading in Finland as well as other Western societies to corresponding care policies, such as marketisation or market-derived solutions, governance based on accountability, and productivity-driven digitalisation. Studies elaborating the insufficiencies of such policies for the complex characteristics of care have been carried out for decades, but the rational-technical paradigm continues to determine current care policies (Woods, 2011; Lupton, 2012: 3).

To elaborate the everyday dimensions of such epistemological underpinnings, the present article will carry out an empirical analysis concerning what eldercare professionals working in round-the-clock residential care settings view as the important aspects of knowledge in care work. Along with the empirical analysis, the article will also contribute to the theoretical discussion on what the rational-technical paradigm means in terms of good care. In the existing literature on care and knowledge, the rational-technical paradigm – which refers to an epistemology based on biomedical

and decontextualised health information rather than holistic, embodied, intuitive and contextualised insights – has been seen to undermine the core ideals of care (see, for example, Benner et al, 1996; Twigg, 2000; Barnes and Henwood, 2015).

The life-world of eldercare is the main focus of this article, which means bringing into the discussion eldercare professionals' views on what kind of knowledge is needed in eldercare work. The article will do so by utilising semi-structured interviews ($n = 25$) with Finnish round-the-clock care workers carried out in 2018. The interviews involved thick descriptions of different aspects of knowledge required in long-term care (LTC) practices. Care workers themselves are the true professionals in what constitutes good care, which is why it is both crucial and interesting to see how knowledge appears in their spoken accounts of everyday care settings. Borrowing from Twigg (2000: 1): 'It is at the front line where the true character of care reveals itself. It is there that it is created; and only there can it be judged.' Round-the-clock residential eldercare is as dense a milieu of care as it gets. It includes continuous and multilateral examples of the situational vulnerabilities, as well as the multitude of epistemological and ethical complexities, that reside at the heart of caring.

In light of the concerns presented earlier, the present article asks: what aspects of knowledge appear in LTC workers' speech concerning their everyday experiences of care work? The findings will show that to care is to deal with 'truths' that manifest on many different levels and in partly conflicting ways. Along with *objective/objectifying knowledge*, there are examples of more ambiguous ways of knowing – *particular knowledge, corporeal knowledge* and *tacit knowledge* – which seem to be concerned with *insight* rather than *information*. Based on these findings, the broader aim of the article is to locate the findings as part of the discussion concerning the suitability of the rational-technical paradigm as an epistemological basis of care.

The article will proceed as follows. First, the theoretical assumptions and key past literature will be introduced. Second, the context of the empirical study – Finnish intensive service housing (ISH) – will be clarified. Third, the data and method of the study will be presented. After that will follow a section including empirical analysis of the different aspects of knowledge in LTC work. Lastly, a discussion section will compile the theoretical yield and the broader implications of the article.

Tensions between care and rational-technical knowledge in the existing literature

The foundation of the rational-technical thinking that the present article assumes to underline Western care policies lies in modernist philosophy stemming from the Enlightenment's ideas of essentialist mind–body dualism, reason as the highest form of human understanding and societal progress as connected to advances in science and technology (Lupton, 2012: 24, 82). Roughly outlined, from the 18th century onwards, such tenets have constituted a *biomedical* view of the body as a clinical object of Western medical sciences, which has also had profound implications for the ontological, epistemological and ethical assumptions concerning human being (Gordon, 1988; Foucault, 2012 [1976]; Lupton, 2012). In the social sciences, such reductionist naturalism has already been challenged by late 20th-century post-structuralists, starting from Foucault's genealogies on the linguistic power structures of Western medicine in his *Madness and Civilization* (Foucault, 2003 [1967]) and *Birth of the Clinic* (Foucault, 2012 [1976]). However, as Lupton (2012: 3) argues,

the biomedical paradigm still impacts medical sociology, and one of the underlying arguments of this article is that such a paradigm still impacts our societies to a great extent – and therefore also our conceptions of care. While biomedical thought has been connected especially with medicalisation and objectification of the human body, knowledge being reduced to information is another perspective of rational-technical thought. As [Tsoukas \(1997\)](#): 827 writes:

Contrary to how knowledge was viewed in pre-modern societies, knowledge now tends to be understood as information, that is as consisting of objectified, commodified, abstract, decontextualized representations. The overabundance of information in late modernity makes the information society full of temptations. It tempts us into thinking that knowledge-as-information is objective and exists independently of human beings; that everything can be reduced into information; and that generating ever more amounts of information will increase the transparency of society and, thus, lead to the rational management of social problems.

Due to the fluid and relational nature of care, many nursing and care researchers view reducing care knowledge to information concerning the body-object as having resulted in an overemphasis on empirical experiments and numeric measurements, as well as a high demand for universalisable knowledge in care settings. For the sake of consistency, this article will follow the critical stance of [Benner et al \(1996](#): 27) in naming such an epistemic care paradigm generally as *rational-technical*. Rational-technical knowledge presupposes generalisation and decontextualisation, in that it is seen to precede everyday caring situations and be applicable to other or all imaginable contexts. Along with such a *prefabricated* nature of knowledge ([Lykkeslet and Gjengedal, 2006](#): 79), critical attention has also been directed to the idea of the *propositional* nature of language ([Walker, 2007](#): 7–8; [Pols, 2012](#)), as rational-technical thought has a tendency to consider language as consisting of factual statements concerning the objective world that resides, *ipso facto*, ‘out there’, ideally as something to be neutrally analysed and described.

Finding the rational-technical paradigm insufficient for explaining the experiences and practices of care has resulted in a rich literature on alternative approaches. For example, Benner’s ([1984](#); [Benner et al, 1996](#)) influential work argues that nursing work is essentially about intuitive action, affirming nurses’ experiences of their situational expertise worldwide ([Purkis and Björnsdóttir, 2006](#): 250). Other critics have suggested that knowledge required in care work should be considered as reflective practice involving practical competence and artistry ([Schön, 1987](#); [Kinsella, 2010](#)), *phronesis* (as in know-how) ([Tyreman, 2000](#); [Sellman, 2009](#); [Pols, 2012](#)), craftsmanship ([Coeckelbergh, 2013](#)) or tacit knowledge ([Kontos and Naglie, 2009](#); [Börjesson et al, 2014](#)). All of these perspectives view knowledge as inherently situated, meaning that whether the cumulatively established health information or a more ambiguous aspect of knowledge is in focus, ‘a view from somewhere’ rather than ‘nowhere’ is always at stake, to borrow [Haraway’s \(1991\)](#) words. As care ethicists have tirelessly argued, care constitutes a relational rather than a strictly rational world ([Tronto, 1993](#)).

Furthermore, corporeality as a central aspect of care has inspired literature aiming to fill the gaps in modernist epistemology ([Benner, 1994](#); [Lawler, 1997](#); [Twigg, 2000](#); [Hamington, 2004](#), [James and Hockey, 2007](#); [Hämäläinen, 2020](#)). The rationalist

epistemology conceptually separates the mind and the body, thereby reducing the care receivers' bodies to objects to be understood and examined, and also diminishing the importance of the corporeality of the caregivers themselves. Whereas the focus ought to be on *embodiment* as a lived, situational experience, the body(-object) has become the locus of knowledge (Draper, 2014: 2237), which Twigg et al (2011: 175) have called 'bleaching out of the corporeal'.

However, dichotomous demarcation into the rational-technical paradigm versus intuitive, embodied or contextual epistemologies has also received criticism. Relying purely on intuition, for example, may risk overemphasising the caregivers' insight, thereby diminishing the care receivers' voice and needs (Björk, 1995). It is clear that good care also requires evidence and generalisations, for example, regarding the repetitive nature of many care tasks or ensuring the equity of care provision, which may become neglected by concentrating on contextual ideals. Purkis and Björnsdóttir (2006: 250) have suggested that caregivers 'operate in two knowledge spaces, the decontextualised space of evidence-based practice and the personal space of the patient'. Here, the epistemological complexity, or even paradoxicality, of care and knowledge starts to reveal itself. The unique ambiguity of care as human action is that it deals with intertwining epistemologies in spontaneous situations: it has to combine knowledge as technical information and knowledge about the person's life-world. Another perspective aiming to transcend the rational–intuitive dichotomy in care is that of Galvin and Todres (2011), who write about 'embodied relational understanding' as knowledge that combines the head (as in technical evidence and propositional knowledge), the hand (as in situational and embodied knowledge) and the heart (as in the capability to imagine the inner world of the care receiver), leading towards a more holistic understanding of care.

Why, then, is this epistemological deliberation important in terms of the care of older persons? The answer lies in the practical bearings of rational-technical thinking on eldercare policies. For example, its widely criticised connections to too decontextualised and rigid ethical principles (Gilligan, 1982; Tronto, 1993; Sen, 1999; Nussbaum, 2000) have been linked with the surge of neoliberal care reforms in the Western world (Woods, 2011). In brief, the reasoning behind the neoliberal reforms has been that it would not be possible to assess the relations and rights between market(ised) care service providers without some kind of accountability for and commodification of care services, for instance, sorting out and putting price tags on care tasks. Resembling Tsoukas's (1997) notion of informatisation as the epitome of late modernity, Barnes and Henwood (2015) have argued that rational-technical thought has contributed to the hegemony of an 'informatisation of care', which is seen to have undermined the holistic character of caring. Expert knowledge presented as 'health information' has been elevated above other forms of knowledge that might emphasise the care receivers' experience. This is one reason why the authors have stressed the importance of regarding all health information as also situated forms of knowledge (Barnes and Henwood, 2015: 152).

A fitting example of informatisation in the field of eldercare is the implementation of new digital technologies. The systematic gathering, arranging and preserving of information is emphasised to ensure the rights of both workers and care recipients, and to make sure that care needs and therefore care work can be predicted, planned and performed as efficiently as possible. To provide a Finnish example, an official quality recommendation concerning eldercare given by the Ministry of Social Affairs and

Health (2017: 27) in Finland argues that as much as a fifth of eldercare work could be replaced with automation and robotics ‘in a couple of years’. However, while ensuring rights, accountability and efficiency, informatisation also slowly changes the essence and content of care, examples of which have been provided concerning the health information systems used in the LTC of older people (Hämäläinen and Hirvonen, 2020) and telecare technologies in homecare (Pols and Willems, 2011). These examples show how the informatisation underpinning care practices should not be thought of merely as the technical accumulation of knowledge, but rather as something that fundamentally transforms the epistemological possibilities, and therefore also the practical processes, of eldercare work.

ISH for older people in finland

Round-the-clock residential eldercare provides a valuable context for analysing the contents of interpersonal caring. As in many other European countries, Finnish ISH has become the most common form of residential eldercare, replacing nursing homes and hospital wards. The ISH facilities have care staff working around the clock, usually divided into morning, evening and night shifts. The personnel are relatively highly educated, including: nurses, physiotherapists and occupational therapists (secondary degree in health and social work); practical nurses (tertiary degree); and activity instructors, kitchen staff and cleaning staff (tertiary or no degree). The facilities are often divided into group homes of 10–20 residents for whom living at home with the help of homecare services has become challenging due to physical or mental impairments. ISH facilities are often described as homelike living arrangements, but they range from small homelike units to former nursing homes and other settings that are, in fact, rather institutional in nature. In 2018 in Finland, 7.6 per cent of over 75-year-olds and 16.3 per cent of over 85-year-olds were ISH residents. In 2015, 53 per cent of all ISH residents had been diagnosed with dementia (Finnish Institute of Health and Welfare, 2021).

At the beginning of 2019, the circumstances in private ISH providers’ facilities caused a stir in the Finnish media, with revelations of poor-quality services (Jolanki, 2019). Compared to workers in other sites of health and social care work, and the workforce in general, significant levels of mental and physical strain have recently been reported by care professionals working in Finnish LTC for older people. As reasons for this, they reported insufficient support from managers, few opportunities to influence one’s work and a poor worker-client ratio (Kröger et al, 2018). Along with relatively low wages, these factors partly explain the high turnover rate and high intentions to quit one’s job among care workers in LTC (Kröger et al, 2018).

In ISH, one will find a multitude of care needs, among others: hourly bodily functions that require immediate attention; medical assessments; constant help with bed positions; help with transitions from beds to toilets, from apartments to general areas and from general areas to outside; constant social needs; help with eating; understanding psychological conditions; and existential vulnerabilities. Such needs are also addressed in hospitals, but Finnish ISH can be argued to be an even more ‘dense’ site of caring, in that it is not considered a temporary phase, but rather the last living location. The idea of a group home with round-the-clock caring attention is what defines ISH as a site of care where, ideally, everything about the person is potentially a matter of care.

Therefore, ISH is also interesting in terms of its specific knowledge practices. Due to the work being carried out in three shifts, passing knowledge interpersonally and continually around the clock is essential. Care professionals have traditionally transferred knowledge by engaging in oral group reports between and during the shifts, where they discuss whether the residents' medical conditions, moods or other issues have changed in the group home. While oral reporting is still common, there has been a shift towards the structured, electronic recording of health information in eldercare services. This means that knowledge needed for daily care work ought to be obtained by recording and reading electronic health records on mobile devices and personal computers, which is expected to reduce errors and ambiguities related to care practices, and to improve coordination between healthcare actors ([Hämäläinen and Hirvonen, 2020](#)). Such a shift has profound epistemological and ethical implications, which often seem to be presented as technical in nature in policy formation but with which care professionals end up engaging and struggling every day ([Hämäläinen and Hirvonen, 2020](#)).

Data and method

The qualitative, semi-structured interview data ($n = 25$) were collected in 2018 by the author and a colleague from care workers and nurses working in ISH in two Finnish cities. The informants represented the typical ISH workforce: practical nurses ($n = 14$); registered nurses ($n = 8$), some of whom had a managerial role in their unit; activity instructors ($n = 2$); and an occupational therapist ($n = 1$). The gender distribution (23 women; two men) resembled the situation in health and social care in Finland. Their ages varied between 24 and 57 years.

In addition to research permits from the cities' housing services departments, approval from the Ethical Committee of the University of Jyväskylä was acquired before carrying out the data collection. The informants were recruited either directly through care unit managers or by distributing a call on staff emailing lists. Especially in the former case, it is clear that the sampling method may have provided the author with informants whose participation was not entirely voluntary. Some of the informants were familiar to one of the two interviewers due to their work experience in the field. The majority of the interviews were carried out at the informants' workplaces, with one on the premises of the University of Jyväskylä and one in the interviewer's home. The interviews were recorded and manually transcribed. Their durations ranged from 60 to 90 minutes. Specific themes concerning daily work practices and habits, emotions, technologies used, responsibilities, and so on were addressed using key questions and prompts when necessary.

The data were analysed using thematic content analysis ([Boyatzis, 1998](#)). The interview frame included a distinct theme covering experiences of and views on what is included in good care, which helped in carrying out the analysis. However, given that notions of good care practices and the types of knowledge related to the notions were scattered throughout the data, the first stage of the analysis consisted of reading the data thoroughly while making preliminary notes and highlighting words, sentences and sections where the informants spoke of practical interaction with residents and the factors and ideals that they associated with good care interactions in the LTC of older people. These parts were then moved to another file, resulting in 38 pages of interview excerpts, which were once again read through several times,

paying attention to how explicit and implicit perspectives of knowledge appeared in the interview data. This was done by colour-coding the words and sentences where the informants spoke about attending to the residents' care needs in terms of decision-making, information use, knowledge, truths, intuition or empathy. After several reading cycles of the narrowed-down data corpus and a reaffirming reading cycle regarding the whole body of data, four aspects of knowledge required in LTC work were revealed: objective/objectifying knowledge, particular knowledge, corporeal knowledge and tacit knowledge.

Findings: the LTC of older people requires at least four different perspectives of knowledge

Objective/objectifying knowledge

First, the analysis identified some rational-technical aspects of eldercare work. Rather unsurprisingly, knowledge related to the medical examination of residents' bodies steers care professionals' decisions in the LTC of older people. The history of eldercare work is connected to nursing expertise, in the sense of supporting doctors' clinical work, meaning that it requires numeric measurements, symptom assessments, probability calculations related to the acquired information and the resulting decisions on medication. To an extent, this history is visible in Finnish residential eldercare as well. The findings show that nursing practices related to finding and assessing medical bodily symptoms were often the first things that care professionals talked about when asked how they approached care situations. This was especially the case if they were not yet familiar with the resident.

'So, of course, we start by checking whether there's something like a rise in body temperature, or whether there hasn't been bowel movements, or whether there's pain or, for example, weeping since it could indicate an infection, urinary tract infection. So, then, we somehow assess and, for example, take measurements. We take body temperatures, urine samples and such basic vitals.' (Informant 15)

In these perspectives, caring actions concentrate on examining bodily fluids, taking samples, looking at numeric values and so forth, in a manner that regards the body of the care recipient as an object-like entity, something about which information is instrumentally gathered and biomedically assessed. In the preceding quote, the informant also talks about pain and weeping, but such embodied events are primarily depicted as evidence of an infection. LTC work inevitably includes a rational-technical aspect of nursing: taking a caring stance that is based on pre-contextual knowledge. Such knowledge deals with health-related facts or at least regards health information as something that has become very stable in the course of the history of nursing work:

'If someone is in pain, then I check whether the skin is damp, what colour the skin is, if they look nauseated, if they look tired, sleepy, their vitality, are they restless, moving or staying calm, what kind of noises they are making, or whether they're silent, whether they are warm.' (Informant 15)

While clinical information is based on physiological measurements and probability assessments, it is not necessarily only gathered by technical measurements, but rather also by palpating, assessing skin tones or other visuals that require hands-on assessment. However, the knowledge at hand is based on biomedical information, in that the actions taken, be they quantitative measurements, assessments of bodily changes (including moods) or sensory recognition of pain, are carried out in order to discover the *cause* of such *symptoms*. Therefore, as empirical measurements, interpretations of numeric information or sensory symptom assessments, objective knowledge of care events also *objectifies* the body of the care recipient, framing the epistemological interest concerning the body as that of finding the symptoms of diseases or conditions. Of course, the underlying premise of such action is to give good care to a person in need, which is why caring does not succeed without biomedical knowledge. In the data, this was especially the case when the informants talked about residents unfamiliar to them, which, to an extent, resembles hospital settings, where there is a higher demand for quick judgement and action. However, the next categories show that objective knowledge constitutes only a part of good care, specifically as everyday care needs in LTC settings are of unlimited duration and more holistic in nature, and therefore also that objectification may have its downsides.

Particular knowledge

The informants' notions of the importance of individual preferences, personal histories and the particular needs of the care recipients are repeatedly evident in the data. It seems that a significant part of LTC work is about such particular insight into what the entirety of the person's being is about: what is unique instead of general, and what a resident as a historical being requires in the very moment. The following quote presents this quite explicitly, as the informant, using the analogy of caring for a baby who cannot yet express needs in detailed language, contrasts technical actions based on general knowledge to knowing what to do due to knowing the detailed gestures of a particular and familiar LTC resident:

‘Time brings a lot of knowledge of the person. Just one glance might be enough, and I already know what she or he means or wants or needs. So, knowing the person [is important]. But if there are new [residents], then it might need a bit of adjusting and searching. Like, when a baby cries, you first offer them the nappy change, then the baby bottle and then something else. So [laughs], first it goes like that, but when you already know the person, you already know from the posture of their head where we are at.’ (Informant 24)

A quick glance or gesture may be enough to prompt a particular caring attitude and action if there has been time to get to know the resident's personality. The initial understanding and the cumulative growth of such particular knowledge – the beginning and development of a unique, interpersonal care relation – impacts all aspects of such a relation, including biomedical assessments, as it is also easier to assess health information by considering the contextual and person-specific aspects. As one informant put it: “A good caregiver is like a chameleon, able to mirror and adapt to what a resident is about.” Another informant talks about the difference between medical information and “live situations”:

‘Usually, we start by simply checking the facts, seeing what illnesses there are and whether there are clear diagnoses, what is the medical information at hand. But, often, they can be in total conflict with meeting the human being. A person can be extremely care-heavy on paper, but here comes a smiling, physically rather capable person equipped with good interaction skills and humour, an enchanting person. On paper, a person is completely different than in live situations.’ (Informant 15)

Along with other Western societies, during the 2000s, Finland saw a discursive turn towards person-centred care, where particular needs were seen as an important part of arranging eldercare ([Moisanen, 2018](#)). However, unfortunately, such views seem to reside mostly at the level of policy documents and less so in practice ([Moisanen, 2018](#)). The informant in the preceding quote also gives a hint of this tension, in that the primary type of action may have to do with illnesses, physical capabilities and other, more technical aspects of care needs, but the truly important part of a caring relationship begins when seemingly less important matters, such as life histories, interests that are or have been close to their heart, and so forth, are discussed. Being attentive to such particularities is what [Purkis and Bjornsdottir \(2006\)](#) refer to as nurses operating between the knowledge of personal space and evidence-based knowledge. LTC professionals need to constantly combine these sometimes logically conflicting knowledge spaces in their daily work, which is highlighted in their versatile speech on the importance of putting themselves in the residents’ shoes.

As in other countries, Finnish LTC is greatly affected by residents’ cognitive impairments. While suitable treatment for dementia requires objective knowledge, it is also an area where particularity can come to define care situations almost completely, to the extent that the concept of objectivity becomes almost redundant. Similar findings emerge when corporeality is addressed in the following section, but LTC professionals negotiating the epistemological aspects of care when their understanding of the world collides with residents’ understanding, impacted by cognitive impairments, yields important questions concerning particularity as well. The informants provide concrete examples of operating between the ‘decontextualised space of evidence’ and ‘the personal space’ of the resident ([Purkis and Bjornsdottir, 2006](#)). LTC work entails constant uncertainty concerning what is true to each person:

‘Truth is to be used very carefully because it feels bad when you don’t know that you don’t remember.... But many, let’s say 15 per cent, of the nurses cling to the truth all the time, which creates conflicts. For example, “Your mother is dead, has been dead for a long time already.” Well, how would you feel when you suddenly heard your mother is dead?’ (Informant 14)

The informants use different methods to work through epistemological conflicts. The informant in the preceding quote resolves such situations with the help of what she calls ‘truth therapy’, where instead of ‘clinging to the truth’, she ‘leads’ a resident with dementia away from longing for their parents. This is usually done communicatively by searching for the emotions behind the propositions and spending time with the resident to talk about why they long for their relatives, which eventually leads to an emotional connection instead of detachment. Instead of objective truths, such

communicative ‘truth therapy’ underscores that the particularity of the care receiver is regarded as the basis of care.

Corporeal knowledge

When care professionals describe ideal caring actions, they seem to eventually end up describing their own bodies or the bodies of residents. The descriptions may start with notions of the objective knowledge that is needed when there is not yet enough particular knowledge about the person, but once they contemplate what is most important in good care relations, their speech begins to concern gestures, expressions, presence, postures and the changes and unfamiliarities regarding such corporeal events.

Here, we can also turn our attention towards cognitive impairments, which open up a whole new corporeal aspect of knowledge and its particular essence. For a conversation with a person with severe dementia, the propositional aspects of language may not matter at all anymore, and in earlier phases of dementia, objective truths also lose a lot of their explanatory power. As one informant put it: “What is the truth anyway? For the person with dementia, it’s totally different than for us, even though we know what the true situation is.” The data are full of reports where the care professionals point to cognitive impairments as something that forces them to find an alternative solution in the moment: “People’s gestures tell a lot about them. Even if the answer is ‘yes’ but the facial expression indicates ‘There is no way you can come and do anything’, something she or he doesn’t want. You read it on someone’s face rather than accept the ‘yes’” (informant 24).

In such examples, the propositional nature of language often presumed in the rational-technical paradigm – what is noted, wished or argued explicitly in words – has lost its importance. Care professionals ‘have to read between the lines’. The ‘betweenness’ is everything that is non-propositional, thus corporeal, in the situation – in the preceding quote, spoken of as ‘face’. Importantly, in such a situation, there can be no distinction between the will of ‘the mind’ and the will of ‘the body’ existing separately. In Maurice Hamington’s (2004: 33) words: ‘The embodied and habitual nature of care should not be confused with mere instrumentality: the physicality of care helps to shape the content and direction of ethical considerations.’

Propositional and corporeal knowledge can be in stark contrast and, ultimately, in outright conflict. An example of this is provided by an informant talking about a situation they had while working in a place they had not worked at before:

‘[In a bed in a group home unfamiliar to me] lay an incredibly sweet old lady. I told her what I would do, she smiled, and when I gave her an injection she said “F*** you” to me. Later, the other nurses informed me, when I told them she smiled and said it almost joyfully, that she doesn’t mean what she says. She smiled at me and showed no aggression. They said she just says “F*** you” a lot. I don’t know if it was her way of thanking me because she said it with a smile and didn’t resist at all.’ (Informant 13)

Such situations can be perplexing because we are so used to thinking about interaction in propositional terms. Cognitive impairments force us to consider interpersonal communication in a completely different way. The particular aspects of knowledge manifest as the unique embodied characteristics of each resident, to which the unique

embodied characteristics and capabilities of LTC professionals align (or fail to align). When embodiedness is taken seriously and the mind–body dichotomy is discarded, a propositional, linguistic insult may appear as an expression of affection. Here, we can return to Draper (2014) and other proponents of the practical corporeality of nursing and caring, who claim that the traditional epistemology based on bodies as objects makes it impossible to take the holistic aspects of corporeality sufficiently into account, which has been further reaffirmed by the examples presented in this section.

Tacit knowledge

The data are also full of captivating examples of care professionals relying on their instinct without being able to fully explain why and how the right decisions are sometimes based on ‘gut feeling’ or ‘just somehow appear’. This reveals an important perspective to knowledge and truth in LTC work, showing how hard they are to capture by decontextualised knowledge or, more generally, by other means than being present in the actual situations. However, the interviewees’ expressions include at least some clues of what tacit knowledge in care is about. It is perhaps best to attempt to understand the inexplicable by paying attention to care situations including persons with dementia; once cognitive and linguistic capabilities are diminished or gone, decontextualised and propositional ways of producing knowledge seem to give way to instinct-based care actions:

‘The experience you have as a nurse and by having worked with a diversity of older persons ... you get a feeling of the big picture. You also have to rely on intuition: the feeling that what’s on paper doesn’t tell you anything and maybe not even the interaction itself. You get a sixth sense; you feel that there’s something more to it still.’ (Informant 15)

The ‘sixth sense’ mentioned by this informant is referred to in many ways in the data. The informants often spoke of this with the help of metaphors, such as ‘reading the situation’, ‘wordless reading’, ‘keeping antennas up’ and ‘navigating’, or by saying that they ‘just somehow see’, ‘know’, ‘feel’ or ‘read’ what is the proper way to attend to the residents’ needs. These ways of speaking are here called ‘tacit’, based on Polanyi’s (2009 [1967]) distinction between ‘tacit’ and ‘propositional’ knowledge, whereby he coined the phrase ‘we can know more than we can tell’. Tacit knowledge happens for the knower in the moment, cannot be articulated (Polanyi, 2009 [1967]) and presumes that the body knows what to do without rational deliberation (Benner, 1984).

In line with the aforementioned thoughts of Polanyi and Benner, as well as the analysis of the present article, Lykkeslet and Gjengedal (2006), with the help of observation and interviews, describe hospital nurses’ work by emphasising that while scientific knowledge is, by definition, knowledge that is ‘pre-fabricated, produced in a different location than the location where it is to be used’, nursing inevitably *happens*. Therefore, the character of the action and the knowledge required is always flexible, involving situational being and action instead of applying ready-made information. Such a view on caring has been connected with *know-how* and *insight* (Tyreman, 2000; Sellman, 2009; Kinsella, 2010; Pols, 2012), originating in the Greek term ‘*phronesis*’ and referring to knowledge or wisdom manifest in practical action. The data at hand show not only many implicit examples of practical knowledge, but also explications

of it: "You always have to think that there is never just one answer, and each time it is good to meet the person and stay there for a while. You can't make assumptions, but rather obtain the information right there when something, like a change, happens. You cannot assume" (Informant 15).

In line with the preceding quote, [Pols \(2012\)](#) has developed the idea of know-how and tacit knowledge by writing about 'know-now', which refers to a set of tacitly and automatically applied skills. According to Pols, the verb *knowing* becomes more important therefore than the noun *knowledge*. Earlier, the informant points to the insufficiency of pre-reflexive knowledge in comparison to obtaining the information when something happens. Therefore, the happening in the life-world, the reflexive aspect of care presented here as tacit knowledge, adds to and essentially combines the particular and corporeal components of LTC care, thereby fulfilling the argument on the importance of pointing out the deficiencies in the rational-technical care paradigm. This is in line with the aptly worded findings of [Kontos and Naglie \(2009: 689, emphasis in original\)](#) concerning the particular and embodied dimensions of tacit knowledge in dementia care: 'social and cultural habits, movements, and other physical cues disclose significant information about the individuality of care recipients, which brings their personhood into focus for practitioners. In addition, practitioners use their *own* bodily dispositions to make meaningful connections with their care recipients in the course of providing dementia care.'

Discussion

The explicit research question of the article was: what aspects of knowledge appear in LTC workers' speech concerning their everyday experiences of care work? The previous section specified four different aspects that arose from the informants' speech on care: objective/objectifying, particular, corporeal and tacit knowledge. The concluding implications of these aspects for the epistemology of care will be elaborated in this final section of the article by comparing the findings to the existing literature that has concerned itself with the implications of the rational-technical paradigm for caring.

The epistemological outlook produced by the findings supports many perspectives acquired in nursing research previously carried out mostly in hospitals, which suggests that nursing and care work in the LTC of older people are still firmly rooted in biomedical practices. This is visible in how decontextualised knowledge sometimes defines nurses' responses: especially with new residents, and more so if something unexpected happens in a resident's condition, objective knowledge seems to be applied. Revisiting the metaphoric categorisation of 'embodied relational understanding' by [Galvin and Todres \(2011\)](#), 'the head' (along with 'the hand' and 'the heart') is required in nursing as 'technical evidence and propositional knowledge'. In this sense, the rational-technical paradigm can provide an epistemology on which to base care actions. Objective knowledge is needed to make probability assessments based on generalised, empirical results because the scope of diseases and conditions that a person may be subjected to is so vast and complex. Problematising vulnerabilities in health in this way calls for a solid epistemological foundation based on decontextualisation.

Importantly, however, by definition, LTC is underpinned by a different ethos than a hospital ward, the point of which is, in most cases, to treat diseases as efficiently and quickly as possible. This perspective has not been given sufficient academic attention.

In contrast with hospitals, round-the-clock residential care in Finland exists to provide an elderly person with their last home and to address any care needs that come about in the remaining time. In this way, its ontology – its distinct embodied rhythms in its distinctive spaces – is unique among health and social services, which is why its ways of knowing are idiosyncratic as well. This is a probable reason why the informants discussed many other requirements of knowledge than ‘the head’: particularity, as in understanding otherness; corporeality, as in understanding embodiedness; and tacitness, as in understanding the inexplicable.

The findings referring to the more ambiguous perspectives on knowledge are in line with existing voices challenging the hegemony of the rational-technical epistemology. First, [Purkis and Bjornsdottir's \(2006\)](#) idea that hospital nurses operate in both a ‘decontextualised space of evidence’ and ‘the personal space of the patient’ applies well to the aspect of particular knowledge found in the LTC of older people (excluding the word ‘patient’). Every care event is epistemologically contextual, meaning that to holistically know how to act requires seriously adapting to the foreignness of another person’s life-world. In [Haraway's \(1991\)](#) terms, the rational-technical mind attempts, and sometimes succeeds in, ‘viewing from nowhere’, but what these settings of dealing with constant care needs especially show is that life-worlds are messy and unpredictable. They are combinations and amalgamations of differing and sometimes foreign ‘views from somewhere’. As one informant put it when asked what good care is: “It all starts from the perspective of the resident.” Care professionals possess a lot of specific, objective knowledge, but their professionalism is also, to a great extent, about shifting between knowledge spaces and knowing which script to play by in specific and constantly changing circumstances.

The aforementioned, fluid understanding of professionalism (and of knowledge) is also highlighted by how corporeality appeared in the data and how it often appears in the existing literature as well. As responses to questions on how care professionals navigate good care in LTC practices, the speech often turned towards bodies: moods, glances, altered habits and so on. As [Maurice Hamington \(2004: 48\)](#) writes:

The information my body garners when confronting others – knowledge of their expressions, mannerisms, gestures, smells, and sounds – far exceeds what is available to my consciousness and allows me to know others as perceptual wholes. Our perceptions are rich and complex, providing an enormous amount of information and making it possible for us to care.

Keeping in mind the aspect of particularity, important is not only the resident’s body as an object to be solved, but also an understanding of holistic *embodiedness*, that is, the intertwinement of the expressional ability of two or more bodies in a situation. The informants talked about not only the residents’ bodies, but also their own. They mentioned the positive impacts of touching, simple presence or caring tones of voice on the residents. The holistic picture regarding corporeality and care provided by the findings is in line with kindred studies that have often worried about how the rational-technical paradigm impacts these aspects of caring ([Twigg et al, 2011; Draper, 2014](#)).

Along with particularity and corporeality, the prevalence and multitude of the almost inexplicable ways of knowing require serious attention when care work is assessed and planned. Intuitive and tacit ways of knowing seem to be important everyday experiences of professional caring. The requirement of attuning to the personal space

of the other becomes especially challenging in the many appearances of dementia in LTC. Interpreting the particular expressions of residents, not to mention utilising decontextualised knowledge, becomes more and more ambiguous when propositional communication becomes non-factual or withers away.

Therefore, the more general position that this article has attempted is that while the descriptive notions that ‘the head’ is needed alongside ‘the hand’ and ‘the heart’ are obviously true, and their epistemological intertwinement is an important position regarding care, considering the direction to which the rational-technical paradigm seems to yet be steering eldercare in Western societies – digitalisation, marketisation, accountability, efficiency, care poverty and so on – suggests that it might be time to better emphasise the core ethical assumptions behind the descriptive epistemological frameworks. Of course, no empirical scrutiny of the development of care policies has been carried out in this article, so that has to be left for future work to tackle.

The findings of this article cover only the experiences found in the LTC of older people in Finland, possibly leaving out aspects of knowledge required in caring that research carried out in other fields might reveal. Nevertheless, the empirical work of this article seems to be in line with the existing research on the epistemological aspects of caring. While strengthening the voices articulating the downsides of the excessively technical underpinnings of care policies, it also reveals what specific epistemological perspectives are entailed by round-the-clock residential eldercare as a particular and thus greatly under-researched field of care. The incessant disregard of these perspectives is akin to the ‘invisibility of care’ in all levels of Western societies (DeVault, 2014; Harman, 2021). As Harman (2021: 11) argues when writing about the plethora of sensory ways of knowing in homecare work, care workers ought to be recognised as ‘active subjects of knowledge production’. Bearing in mind that LTC professionals possess complex skills of attending to other people’s vulnerability, such a shift would require an explicit emphasis on *insight* as an equally important epistemological dimension of care as *information*, to borrow Polanyi’s (2009 [1967]) terms.

Finally, the key aspect of the LTC of older people is the fact that cognitive impairments continue to become more and more common, and to define the work practices, relations and required epistemological and ethical thinking in eldercare services. Therefore, if the voices emphasising the more ambiguous aspects of knowledge are unheard or misunderstood even when something as clearly *irrational* as dementia is concerned, applying flawed epistemological and ethical premises will continue to lead to poor working conditions, ethical dissonance and the overall bad quality of care.

Note

¹ <https://twitter.com/anttihamalainen>

Funding

The study was supported by the Strategic Research Council at the Academy of Finland (projects 327145 and 327149) and the Academy of Finland’s Centre of Excellence in Research on Ageing and Care (projects 312367 and 336671).

Acknowledgements

I would like to thank Dr Helena Hirvonen for gathering half of the data used in the analysis of the present article. I am also grateful for the invaluable feedback of the supervisors of

my PhD dissertation research, Dr Sakari Taipale and Dr Lina van Aerschot, and also for all the insightful comments provided by the anonymous reviewers, *IJCC* editorial office and members of Centre of Excellence in Research on Ageing and Care research project and Hidas research collective.

Conflicts of interest

The author declares that there are no conflicts of interest.

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