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Antti Hämäläinen

Encountering the Other

Care Ethics and the Technologisation of Care of Older Persons

UNIVERSITY OF JYVÄSKYLÄ
FACULTY OF HUMANITIES AND
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ABSTRACT

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Care policy in Finland is facing a triple crisis: care costs are threatening the public economy, professionals are fleeing the sector and the quality of care is low, especially the care of older persons. As a cure for the crisis, technologisation is promised to deliver a "triple win" in the form of structural efficiency, improved working conditions and better health.

In this study, I explore care as a lived encounter and contrast it with its recent technologisation, arguing that the root cause of the crisis is a gradual disconnection with the essence of care and its impact on our lives. I delve into three overlapping domains: the theoretical debate on the essence and ideals of care within the framework of feminist care ethics; care professionals' encounters with vulnerability in care of older persons; and the reconfigurative influence of the technologisation of care on the other two domains.

I explore these domains through the results of four research articles, including both theoretical arguments based on feminist care ethics and phenomenology, and empirical results derived from qualitative data consisting of interviews with care professionals (n=25) working in Finnish intensive service housing (ISH) of older persons.

My research setting is based on a theoretical argument on care. I suggest that care ethics should consider care either using a phenomenological conception, as a lived encounter with the vulnerable Other, or using a poststructural conception, as a relational structure emanating from the distribution of care and neglect in a broader social context.

Building on the theoretical argument, I elaborate on what care professionals view as crucial in lived care encounters with older persons. First, understanding alterity – the radical uniqueness encountered in the Other – is crucial for ideal care, which is reinforced by literature in critical disability studies and phenomenology. Second, care is constituted by embodiment. Ideal care of older persons, particularly concerning dementia, requires comprehending the Other's body as lived intercorporeality rather than an object of care. Third, I show that care encounters necessitate ethical action in the form of active attunement to the Other's vulnerable situation. This is evident when care professionals attune to the alter-temporalities of ISH residents with dementia.

Finally, I contrast these aspects of care with the technologisation of care of older persons. Care professionals' interviews depict the sociomaterial, reconfigurative impacts of electronic health records (EHRs) on ideal care practices in ISH, as well as the impacts of safety alarm systems (SASs) on dementia encounters. EHRs instrumentalise care through structured, digital recording of care events, and SASs disrupt attunement to residents' needs, being at odds with the nuanced, embodied alterity in lived care encounters.

The ethico-ontological significance of lived encounters with vulnerability, which lies at the heart of feminist care ethics, provides a critical framework for evaluating any care policy and practice. I conclude that although the technologisation of care may yield the "triple win" in some areas, an unquestioning application of technology to the care of older persons may risk reinforcing the instrumental conception of the human being, rooted in a neoliberal ethos. To reduce the care of older persons to technological units or instrumental tasks is to misinterpret the social and embodied foundation of existence itself.

Keywords: Care, care ethics, care of older persons, long-term care, dementia, care technology, phenomenology, embodiment, sociomateriality, qualitative methods.

TIIVISTELMÄ (ABSTRACT IN FINNISH)

Hämäläinen, Antti
Toiseuden kohtaamisesta – hoivaetiikka ja iäkkäiden ihmisten hoivan teknologisoituminen
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Hoivapolitiikka on Suomessa ja muissa länsimaissa kolmoiskriisissä kasvavien kustannusten uhatessa julkista taloutta, ammattilaisten paetessa alalta ja hoivan laadun heiketessä erityisesti vanhustenhoidossa. Teknologisaation luvataan vastaavan kriiseihin ”kolmoisvoitolla”: tehostumisena, parantuneina työoloina ja kasvavana hyvinvointina.

Tässä tutkimuksessa tarkastelen hoivaa elettynä kohtaamisena ja pohdin sen merkitystä iäkkäiden ihmisten hoivan teknologisoitumiselle. Väitän hoivan kriisien kumpuavan siitä, että olemme kadottamassa ymmärryksen elämämme ytimessä olevan hoivan olemuksesta. Tutkin rinnakkain feministisen hoivaetiikan teoreettista keskustelua, hoivatyöntekijöiden puhetta hoivakohtaamisista tehostetussa palveluasumisessa sekä hoivan teknologisoitumisen sosiomateriaalisia vaikutuksia hyvälle hoivalle.

Tarkastelen näitä osa-alueita esittelemällä neljän tutkimusartikkelin antia, sisältäen sekä hoivaetiikan ja fenomenologian teoretisointia että empiirisiä tuloksia perustuen iäkkäiden ihmisten tehostetussa palveluasumisessa työskentelevien hoiva-ammattilaisten (n=25) haastatteluista koostuvaan laadulliseen aineistoon.

Tutkimustani ohjaa hoivan käsitteeseen kohdentuva teoreettinen argumentti. Ehdotan aluksi, että hoiva tulisi ymmärtää joko fenomenologisessa merkityksessä, elettynä kohtaamisena toiseuden kanssa, tai jälkistrukturalistisessa merkityksessä, rakenteena, joka ilmenee sekä hoivan että hoivan puutteen laajempina sosiaalisina konteksteina.

Jatkan kohdentamalla huomion hoivaan elettynä kohtaamisena, ja erittelen haastateltujen hoivatyöntekijöiden hyvässä hoivassa keskeisinä pitämiä tekijöitä. Hoivassa oleellista on ensinnä ymmärtää toisen kokemus radikaalilla tavalla ainutlaatuisena olemisena. Tämän myötä hyvä hoiva edellyttää myös, että toisen keho ymmärretään elettynä, kokonaisvaltaisena ja yksilöllisenä hoivatoimenpiteiden kohteen sijaan, erityisesti muistisairauden ollessa kyseessä. Näiden huomioiminen edellyttää myös eettistä konkretiaa, eli aktiivista virittymistä omasta kokemuksesta poikkeavaan kokemukseen ja siitä kumpuavaa toimintaa, siis hoivaa. Tämä ilmenee esimerkiksi hoiva-ammattilaisten kykynä virittyä muistisairaiden asukkaiden ajallisuuteen.

Pohdin myös iäkkäiden ihmisten hoivan teknologisoitumista näiden hoivan perustekijöiden valossa. Haastatteluissa ilmenee, miten hoivan järjestelmällistä kirjaamista edellyttävät asiakastietojärjestelmät uudelleenmuovaavat ja välineellistävät hoivaa sekä miten turvahälytysjärjestelmät häiritsevät asukkaiden kohtaamista, erityisesti muistisairauden ollessa kyseessä. Tehostetun palveluasumisen teknologisoitumisessa on työtä helpottavat puolensa, mutta sen ilmentymät myös uhkaavat hoivan kokemuksellista ja hienovaraista ydinaluetta.

Feministisen hoivaetiikan ytimessä oleva eettis-ontologinen toisen haavoittuvuuden ruumiillinen kohtaaminen tarjoaa kriittisen kehyksen hoivapolitiikan ja -käytäntöjen arvioinnille. Johtopäätökseni on, että vaikka hoivan teknologisoituminen saattaa tuottaa jossakin mielessä ”kolmoisvoiton”, kyseenalaistamaton iäkkäiden ihmisten hoivan teknologisoiminen aiheuttaa myös hoivan ja ylipäätään olemisymmärryksemme välineellistymistä. Hoivan pelkistäminen osatekijöihin ja välineellisiksi tehtäviksi viittaa siten olemassaolon sosiaalisen ja ruumiillisen perustan lähtökohtaiseen väärintulkintaan.

Asiasanat: Hoiva, hoivaetiikka, iäkkäiden ihmisten hoiva, muistisairaudet, hoivateknologia, fenomenologia, ruumiillisuus, sosiomateriaalisuus, laadulliset menetelmät.

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I have heard someone say that family carries you to a certain point and friends take care of the rest, to which I can fully relate. Thank you Tiina and Lasse for carrying me to that certain point in an exemplary, thoughtful and secure way, and thank you for continuing to do so. Anna and Jenni, you are simply the most important persons in the world to me.

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Jyväskylä 24.4.2024

Antti Hämäläinen

TABLE

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ORIGINAL PAPERS

1 INTRODUCTION

Care policy in Finland is facing a triple crisis: care costs are threatening the stability of the public economy, professionals are leaving the sector and the quality of care is decreasing. The last notion is true especially in care of older persons where unmet, extensive care needs are increasingly common (Aaltonen and Van Aerschot, 2021). As a cure for the crisis, technologisation and digitalisation are promised to deliver a "triple win" leading to improved structural efficiency, technological innovation and better care (Neven and Peine, 2017; Jaakola, 2023).

In this study, I explore what kind of essential aspects constitute ideal care encounters in round-the-clock care of older persons, and elaborate the recent technologisation of the field in light of the essential aspects. I argue that the root cause of the ongoing care crises is a gradual disconnection with the essence of care and its profound impact on our lives. To investigate the tension between such essence and technologisation, I delve into three overlapping domains: the theoretical debate surrounding the essence and ideals of care within the framework of feminist care ethics; care professionals' experiences of practical encounters with vulnerability in round-the-clock care of older persons; and the reconfigurative influence of the technologisation of care of older persons on the other two domains. To accomplish this, I present the results of four research articles that form the basis of this study:

Article I	Hämäläinen, A. (2020). Care ethics and the technologisation of eldercare. *International Journal of Care and Caring*, *4*(2), 167–182.
Article II	Hämäläinen, A. (2022). The epistemological complexity of ideal care: Long-term care professionals' perspectives. *International Journal of Care and Caring, 6*(4), 493–509.
Article III	Hämäläinen, A., Leinonen, E. and Era, S. (2024). Attunement as a practice of encountering dementia time in long-term eldercare work. *Time and Society, 33*(2), 170–190.

Article IV	Hämäläinen, A. and Hirvonen, H. (2020). Electronic Health Records reshaping the socio-technical practices in Long-Term Care of older persons. *Technology in Society, 62*, 101316.

The articles explore theoretical concepts rooted in feminist care ethics, phenomenology and social studies of science and technology (STS). Additionally, they draw on results from thematic content analyses of qualitative data obtained through interviews with care professionals (n=25) working in intensive service housing (ISH) of older persons in Finland. The authors' roles concerning the gathering and analyses of the data are outlined in *Appendix 1*.

The theoretical output of this study concerns its elucidation of the conceptual tension between two strands that underlie care theory and that pull in different directions (Conradi, 2020). On one hand, care is a momentary, concrete recognition of and response to the vulnerability of the Other that spans across time and space through lived, embodied encounters. We enter the world in a state of absolute vulnerability, and this vulnerability continues to make unanticipated appearances throughout the rest of our lives, shifting us in and out of care encounters. Through this profound understanding of vulnerability, care has an existential, somewhat stable essence over time. At the heart of responding to vulnerability – be it a child's whimper, a hidden concern, or any dissonance we seem to recognise in the Other almost instinctively – a certain inherent and embodied understanding endures.

On the other hand, along with our inherent awareness of the beating, vulnerable heart of care, care also takes on different forms across different spaces and times. How we enact and think about care is reconfigured by policies, coffee room conversations, devices, spaces, internet videos, wars, academic texts, information systems and so forth. Caring is also dictated by structures of unequal redistribution of vulnerability and neglect, in that the capability to overlook or remain distant to others' vulnerabilities is always endorsed by a social context.

While a dichotomy between the ethical and political underpinnings of care has been at least implicit throughout the history of care theory, I suggest that care theory should explicate care either in a phenomenological conception, as an ideal, lived encounter with the vulnerable Other, or in a poststructural conception, as a relational structure referring to broader phenomena emanating from how care needs are being met with caring, indifference, neglect, violence and so forth.

While my approach to the dichotomy at the heart of care is a distinct theoretical outcome of the study, it also delineates my empirical focus on what care understood as a lived encounter entails, whereby I present the first research question:

RQ1. What kind of essential aspects of lived care encounters emerge in the speech of care professionals working with older persons?

Drawing from interviews where care professionals talk about encountering ISH residents, the data first reveals that understanding *alterity*, i.e. the radical and singular uniqueness encountered in the Other, is crucial to the provision of ideal care. Critical disability studies (Kafer, 2013; Yoshizaki-Gibbons, 2020) and philosophical approaches to alterity (Daly, 2022; Hamington, 2004, 2020; Lévinas, 1979; Merleau-Ponty, 1962, 1968; Weiss, 1999) further reinforce these findings. Secondly, care is constituted by *embodiment*. Successful care of older persons, especially when dementia is concerned, requires a profound comprehension of the body as lived intercorporeality rather than a generalised object of care. Thirdly, I show that an ideal care encounter necessitates ethical action in the form of active *attunement* to the vulnerable and embodied situation of the Other. This is evident in the speech of care professionals regarding attunement to the alter-temporalities of ISH residents with dementia, and these results are reinforced by ethico-ontological understandings found in phenomenology.

After this, I contrast the essential aspects of lived care encounters arrived at in RQ1 with instances of care technologisation by presenting the second research question:

RQ2. How do care professionals' views of central digital technologies of round-the-clock care work relate to these essential aspects of care?

The results demonstrate the sociomaterial, reconfigurative impacts of electronic health records (EHRs) on ideal care practices in ISH, as well as the impacts of safety alarm systems (SASs) on encounters with persons with dementia. The results show how EHRs enforce generalisation through structured, digital recording of care events, and SASs disrupt holistic attunement to residents' needs, which are at odds with the nuanced, embodied alterity of lived care encounters.

The empirical context of this study is ISH, which is a form of long-term care (LTC) of older persons. ISH involves round-the-clock care provided by highly educated professionals, including registered nurses with tertiary level degrees and practical nurses with secondary-level degrees. Residents in ISH commonly require extensive care, including help with bodily functions such as eating, drinking, showering, toileting and transitioning from the bed to the toilet, moving from their apartments to communal areas and outdoors, along with social, psychological and existential needs. ISH facilities typically consist of common areas and small studio apartments for residents, but the environments can feel rather institutional (Hämäläinen, 2022.)

In early 2015, while working as an activity instructor in ISH, I found myself filling the gaps in the social and existential aspects of care due to staff shortages in nursing work. While closely observing the everyday vulnerabilities caused by dementia, I became aware of the immense challenges in determining the appropriate responses to such vulnerabilities. Interacting with residents who had dementia and whose words and sentences clearly did not always convey the same meaning as mine highlighted a concern: is it appropriate to decide what is best for another person and if so, when and how? For instance, when facing residents whose dementia had progressed past its early stage, it became evident that there are certain moments in life where co-thinking, co-action and co-being, even to the extent of making decisions on behalf of another person, are necessary.

This notion appeared as disconcerting in a Western context founded on values of individual freedom and rationality. The downsides of the rational-technical ethos were also evident in the ISH context, which was and is going through increasing systematisation and digitalisation along with other care services for older persons (Hämäläinen and Hirvonen, 2020; Hirvonen et al., 2021; Jaakola, 2023; Pekkarinen and Melkas, 2019; Sjögren et al., 2023). I witnessed and took part in situations where digital technologies penetrated, disturbed and transformed care settings, for example, constantly buzzing alarms on smartphones, electronic recording of care tasks and tablets used for social and entertainment purposes.

Whether impacting overtly or covertly, some ethos, as in some ethico-ontological understanding of the world, founds any political context. The current state and future direction of care of older persons could be considered as a matter of mere policy formation. However, if we fail to address the most basic needs of certain persons in society, there may be something wrong not in our methods, i.e. policy "design", but rather in the undercurrents of our thinking. By examining the idealities and shortcomings in responding to the vulnerability of older persons, we may perhaps gain insights into responses to vulnerability, or the absence thereof, more broadly. The realms of vulnerability and care needs that emerge with old age await each one of us. Therefore, along with engaging in ethical and phenomenological theorisation on care, the aim of this study is to look at the essentials of care *in situ*, to uncover the lost meanings of care, obscured by the modern, instrumentalised ethos.

In this summary of my PhD study, next, I introduce the theoretical foundations of the study, beginning with feminist care ethics as the theoretical departure point of the study, followed by my own theoretical arguments concerning care. After that, I describe how sociomateriality and instrumentality are required for assessing the relation between care and technologisation. Then, Chapter 3 presents the sociomaterial context of the study, ISH of older persons, and provides a brief overview of the historical context of Finnish LTC of older persons. In Chapter 4, I explain the data and methodology used in the empirical analyses and explain the methodological and ethical underpinnings of the data gathering and analyses. After that, Chapter 5 includes a summary of the articles on which this study is based. In Chapter 6, I introduce the main arguments of the study, answering each research question by returning to the results of the four articles and with the help of literature on care ethics, phenomenology and sociomateriality. Finally, in Chapter 7, I conclude the main results of the study and discuss their contribution to care research and policy.

2 THEORETICAL FOUNDATIONS AND ARGUMENTS OF THE STUDY

2.1 Feminist care ethics as the theoretical basis of the study

In this section, I will explore how the concept of care has been approached in the existing literature. Conceptual accounts of care have been most extensively presented by feminist philosophers, particularly in the field of feminist care ethics[1], which forms the basis of this study's perspectives on care. Care ethics does not refer to a collection of ethical guidelines of caring; it is not a theory that applies only to care work or persons who otherwise tend to give care in society. Rather, it is a moral and political theory that argues the significance of care for being, ethics, knowledge, sociality and politics, making it a theory that applies to everyone in every society (Collins, 2015, p. 8). Although the history of care ethics is relatively recent, it is beyond the limitations of this study to describe its entire scope. Rather, I will focus on perspectives that are relevant in terms of this study's objective of investigating care professionals' views on lived care relations and the technologisation of care of older persons. In this chapter, first, I will elaborate the historical point of departure of care ethics, followed by an exploration of the ethico-ontological and politico-structural underpinnings found within the tradition. Later in the chapter, I will present my own, phenomenology-inspired conceptual approach to care, which will function also as an analytical framing for presenting this study's results in Chapter 6.

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[1] In the field of nursing science, there is also a wide-ranging tradition of nursing ethics that has produced important perspectives resembling and intersecting with those of care ethics (Benner, 1994, 2000; Benner et al., 2009; Draper, 2014; Galvin & Todres, 2013; James & Hockey, 2017; Kinsella, 2010; Purkis & Bjornsdottir, 2006; Watson, 2008). Despite the partially evident similarities in philosophical approaches, this study cites nursing ethicists narrowly and selectively (mainly in the theory section of *Article II*), due to nursing ethicists' predominant concern with traditional occupational nursing and notable emphasis on clinical work performed in hospitals.

2.1.1 The conceptual origins of care ethics as a moral and political theory

Understanding the contents of ideal care encounters requires a brief overview of the origins of the recent ontological, epistemological, ethical and political accounts of care as they are presented in the tradition of care ethics. Focusing on these aspects through the lens of care in academic and other societal thought is a relatively recent pursuit. First of all, care ethics originates explicitly in feminist philosophical and political thought. While the epistemological gender bias and women's role in Western societies attracted attention during the feminist movements of the 1960s, it was not until the late 1970s that academics began to recognise the conceptual significance of care in shaping the foundations of societies. The early 1980s saw the release of seminal works on care ethics by Ruddick (1980), Gilligan (1982) and Noddings (1984), followed by Tronto's (1993) pivotal contribution in the 1990s. A unifying theme throughout the history of care ethics has been to criticise and present an alternative framework to mainstream moral philosophy based on justice. For example, Walker (2007, p. 7) bundles the mainstream moral philosophies into "the theoretical-juridical model", where morality is understood through "compact, propositionally codifiable, impersonally action-guiding code within an agent, or as a compact set of law-like propositions that 'explain' the moral behaviour of a well-formed moral agent". Instead of justice, the early proponents of care ethics highlighted vulnerability, needs and concrete relations as intrinsic ethical conditions of human being (Keller and Kittay, 2017).

Sara Ruddick's pioneering assertion of "maternal thinking" (1980) as a distinct yet disregarded basis for philosophical thought can be considered as one starting point of care ethics (Held, 2006, p. 26). Ruddick distinguishes an ethical disposition that "arises out of maternal practices organised by the interests of preservation, growth and acceptability" of the well-being of another being, typically exemplified as the child in her essay (ibid, p. 357). While essentialising gender is discernible in her essay, in that Ruddick highlights the distinctive being and thinking most evidently found in mothers' ways of attending to children, she believes that the maternal disposition is not dictated by social or biological categories. Thus, Ruddick was the first to advocate a conception of maternity as an "intellectual capacity" worthy of recognition (ibid, p. 358). Ruddick emphasises maternity's capacity of openness towards another being over traditional scientific foundations of clarity, certainty and conceptually closed structures. In her view, the latter have imposed fixed notions of autonomy and individuality, resulting in overemphasised separations between the inner and the outer, between the self and the other (ibid, p. 352).

A significant contribution to the understanding of the relationship between care and justice-based approaches to ethics was made by the psychologist Carole Gilligan. With *In a Different Voice* (1982), Gilligan highlights the moral conceptions in interviewees' responses to moral dilemmas that mainstream academic thought has ignored. Gilligan does not support her mentor Lawrence Kohlberg's interpretation of the empirical results that underpin his famous psychological theory of stages of moral development. Gilligan questions

Kohlberg's results, where moral competency is portrayed as a progression through stages of moral reasoning, leading Kohlberg to conclude, among other things, that girls are slower to mature in their morality. Kohlberg arrives at his conclusions by analysing participants' responses to moral dilemmas; boys tended to prioritise abstract ethical principles while girls focused more on context and relationships. Gilligan further examines the moral perspectives of girls and identifies a "different moral voice" solely expressed by women in Kohlberg's data. In this different voice, the interviewees paid attention to the relations between the characters described in ethical dilemmas, simultaneously weighing the perspectives and interests of all the characters (ibid).

While Gilligan's argument also rightly faced criticism for being gender essentialist, it sparked a discussion on the foundations of justice and care in moral philosophy, which prevails in academic discussions on ethics (Barnes, 2015; Bubeck, 1995; Conradi, 2020; Engster, 2007; Held, 2006; Kittay, 1999; Robinson, 2013; Tronto, 2013). Gilligan argues that the relationships we find ourselves in have consequences for moral thought no less significant than abstract universalisations, upon which the malestream, Western, modernist moral philosophy has been based since Immanuel Kant's moral philosophy.[2]

Therefore, Gilligan's work, along with Nel Noddings's *Caring* (1984), established the foundation for feminist care ethics as a relational moral philosophy. Taking relationality as an ethical point of departure meant focusing on how actual, context-specific relations between persons can be maintained and repaired (Hekman, 1995; Held, 2006; Sevenhuijsen, 1998; Tronto, 1993, 2013). Gilligan's theory proved influential, as it managed to explicate what had bothered many feminist philosophers regarding mainstream moral theories, revealing the conceptual potency of the experiences traditionally marginalised in mainstream academic thought. Virginia Held (2006) sums up the ethos of care ethics in terms of relationality:

> Dominant moral theories tend to interpret moral problems as if they were conflicts between egoistic individual interests on the one hand, and universal moral principles on the other. The extremes of "selfish individual" and "humanity" are recognized, but what lies between these is often overlooked. The ethics of care, in contrast, focuses especially on the area between these extremes. Those who conscientiously care for others are not seeking primarily to further their own individual interests; their interests are intertwined with the persons they care for. Neither are they acting for the sake of all others or humanity in general; they seek instead to preserve or promote an actual human relation between themselves and particular others. Persons in caring relations are acting for self-and-other together. Their characteristic stance is neither egoistic nor altruistic; these are the options in a conflictual situation, but the well-being

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[2] Although Kant's moral philosophy cannot be explained in any meaningful scope in this work, the core of Kantian *deontology* is the "categorical imperative" according to which we should act in every situation in a way that can be willed a universal moral law, elevating reason as a source of morality above contextual or emotional circumstances (Tronto 1993, p. 9). Along with utilitarianism and virtue ethics, deontology has been the cornerstone of Western moral philosophy for over two centuries.

> of a caring relation involves the cooperative well-being of those in the relation and the well-being of the relation itself. (Held, 2006, p. 12.)

Focusing on the transformative power of ethics arising from concrete relationships has led to explorations of care both as an ethical and political ideal, especially due to Joan Tronto's *Moral Boundaries: A Political Argument for an Ethic of Care* (1993), where she pushed the moral philosophical arguments of care ethics towards a political theory of care. Although care ethics before Tronto was not devoid of political perspectives (quite the contrary) nor has it been clearly a political theory after her, *Moral Boundaries* marked a shift in the tradition in that it argued against ethical essentialisations of care and instead called on care ethicists to pay attention to how cultural and political boundaries leave care (ethics) out of the centres of power. Tronto's claim was that only by shifting the boundaries could care ethics become a moral theory to be reckoned with alongside other moral theories. Due to her extensive influence, *Moral Boundaries*, along with Tronto's other works, will rightfully appear as a reference point throughout this study. Her combination of the ethical and the political has also resulted in a conceptual dichotomy underlying care ethics, which I will begin addressing next.

2.1.2 The dichotomous conceptual undercurrents in care ethics

Growing from small academic circles in the 1980s into an influential moral and political theory in the 21st century, care ethics has developed through difficult and profound debates concerning issues such as, but not limited to, justice, essentiality, dyadicity, gender, intersectionality, subjectivity and democracy. These debates seem to stem from its very departure point of amalgamating ethical and political theorisation into a distinct field of study. Despite the multifacetedness and internal disputes, at the very least everyone under the banner of care ethics seems to criticise instrumental moral understandings and the hegemony of neoliberal epistemology and politics. This study recognises this fruitful internal movement within the theory and is motivated by questions on what the disputes mean and inflict upon the concept of care itself, and how they can be applied in criticism of how instrumental, neoliberal governmentality neglects care.

I particularly lean on the work of Elisabeth Conradi (2020), who identifies two distinct strands in the care ethics literature, the *ethico-political* and the *welfare-resourcing* ones, which arise from different "underlying assumptions" and "normative claims" (ibid, pp. 27–28). According to her, the "philosophy" based ethico-political strand posits that one-to-one care relations prompt a moral philosophical argument on how to better perform supportive interactions in a world where human vulnerability is unavoidable. This results in an emphasis on communication in social situations and on how everyday practices can lead to successful caring relations. The "sociology" based welfare-resourcing strand focuses on the social groups that are engaged in such supportive acts and how the distribution of responsibility aligns with society's unjust structures. This results in analysing the societal conditions of the aforementioned supportive acts and the social statuses of those performing the supportive acts (ibid, p. 32). In a similar vein, Sophie Bourgault (2017, p. 2) identifies care theorists' interests in both ethical concerns related to the concrete actions between caregivers and care receivers, and analyses of socio-institutional conditions, claiming also that the concept of care refers to both of these perspectives at the same time. Daniel Engster (2018, p. 11) also takes the view that since Tronto's (1993) political theory of care, some care ethicists have adopted a "morality first" approach while others have argued in a more critical and democratic vein. The initial division and the recent blurring between ethical and political theory in care ethics is also noted by Mercer E. Gary (2022), who argues that "care ethics" has evolved into "care theory" in the course of broadening its scope towards political analysis. Many of the tensions at the heart of developing relational ethics into a political theory derive from criticisms of parochialism concerning care ethics, namely the problem of how normative arguments on close relationships and attachment as ethical motivation could be expanded into a broader normative framework (Tronto, 1993, pp. 170–171). As Hamington (2020, p. 108) explains, to cover more diverse phenomena, most of care ethics' history has been devoted to extending the concept of care beyond close relationships.

Therefore, positions concerning the *care dyad* – whether it is ethically and politically relevant to focus on what happens in a care relation between two persons – are key to understanding how the history of care ethics has progressed. This has also resulted in some conceptual ambiguity, an issue on which I will elaborate later. Importantly, the suspicion of the dyad is rooted in the progression of feminist theory, in that the moral theorisation of care ethics originated as an expansion of the attachment found in the dyad between mother and child (Noddings, 1984; Ruddick, 1980, 1989) into an ethical theory, which was later deemed as essentialist and distanced from care ethicists' analytical focus.

Many care ethicists from the 1990s onwards have explicitly challenged the dyadic understandings of care, most influentially Joan Tronto, emphasising that care has no well-defined beginning or end (Tronto, 1993, p. 103). Along with abandoning the gender essentialist ethical perspective of mothering, overcoming the dyad highlights that the boundaries between numerous actors within networks of care in any given care context are unclear and constantly evolving. For instance, Barnes (2015) explores the issues associated with dyadic notions of care and points out that along with intimate face-to-face interactions, more spatially and temporally distant actions also constitute care. This means that apart from, for instance, the dyad between a home care worker and an older person with care needs, many other social (and material) relations constitute the meanings of care for both participants. Therefore, through criticising dyadicity, some care ethicists have been able to broaden the conceptual scope of care and highlight its explanatory power for broader issues, such as global inequality (Held, 2006; Robinson, 1999; Vaittinen, 2015, 2017) and democracy (Tronto, 2013).

While the criticism of dyadicity originates in the gender issue, the conceptual tension between dyadicity and plurality also has a more profound connection with justice. As I write in *Article I* (Hämäläinen, 2020), Diedrich et al. (2006) have identified the wider issue concerning the *second-person relations* and *third-person relations* for care. The authors highlight, based on Emmanuel Lévinas's philosophy (1979), that our immediate second-person relationship to another person (the dyad) cannot monopolise all our caring attention, as we find ourselves engaged in other relationships as well. The dangers of the dyadic focus are evident concerning the concrete agency of caregiving as in any care context, there are also other potential receivers of care beyond the immediate care dyad. Therefore, other, practically unlimited and therefore endlessly complex third-person relations constitute the political phenomena addressed, for example, when care ethicists explore the social and structural implications of responding to vulnerability (Diedrich et al., 2006; Lévinas, 1979). In other words, the dyadic attentiveness to the needs of the Other is always restricted by other relations, meaning that focusing on one person in a particular situation inevitably leads to the disregard of someone else's needs at the same time (see also Vaittinen 2022, p. 19). Following from this basic fact concerning relationality, the concept of care is beginning to manifest (also) as a structure.

As I state in *Article I*, Lévinas's differentiation of second- and third-person relations incorporates a notion concerning the *origin of justice*:

> The interpersonal relation I establish with the Other, I must also establish with other men [sic]; there is thus a necessity to moderate this privilege of the Other; from whence comes justice. (Lévinas and Nemo, 1985, p. 90.)

The shift in care ethics from a moral theory based on close relationships towards a broader political theory is a direct analogy with the transition from second- to third-person relations, leading also to different approaches to justice. Justice has been a persistent theme in care ethics, originating from Gilligan's *In a Different Voice (1982)*, where she questioned the place of justice at the heart of Western moral philosophy. Thereafter, differing normative claims on justice have been present in two "strands" of care, which Conradi (2020) claims arise from "philosophical" and "sociological" arguments. The "philosophical", or ethical, views concentrating on normative ideals such as attachment, attentiveness or listening found in one-to-one care relations aim to *replace* justice at the centre of societal power. The "sociological" arguments that investigate structural injustices aim to *broaden the scope* of justice to include care ideals (Conradi, 2020, p. 33). Tronto (1993) illustrates this problem through the dichotomy of "difference" and "sameness". In terms of difference, referring to care as meta-ethically distinct from mainstream justice-based approaches is an attempt to argue against justice, seeking to overthrow it from the centres of power. On the contrary, advocating sameness strives for access to the centres of power by arguing that care and justice possess similar normative notions pertaining to universal humanity.

Shifting the analytical focus between dyadic and plural perspectives to care is evident in how care ethics is usually defined as "moral *and* political theory". Although the dichotomy seems to underpin, or as Conradi (2020, p. 26) argues, hinder, the development of care ethics, connecting the two perspectives may also be the strength of the theory in the first place (Barnes, 2015, p. 34; Bourgault, 2017,

p. 3). However, as I will argue in Chapter 2.2, this requires that the dichotomous foundation is explicitly elaborated in analyses related to care. This study benefits from Conradi's (2020) analytical clarity, as the theoretical understanding of care I ultimately arrive at moves around a dichotomy that communicates with hers. In this study, I propose an approach that shares her departure point but explores it from a slightly different perspective. First, in the following subchapters, I propose that Conradi's "ethico-political strand" is rooted in an ethico-*ontological* understanding of care, while what Conradi refers to as the "welfare-resourcing strand" derives from a *politico-structural* understanding of the term. Following Conradi, ultimately, the ethico-ontological strand relates to vulnerability and the politico-structural strand to the distribution of responsibility in a society, both of which I will examine in the next two subchapters in more detail. Later on, in my analysis of care professionals' speech of care encounters and technologisation in round-the-clock care of older persons, I divert further from Conradi's terminology by exploring the ethico-ontological and politico-structural emphases through differences in phenomenological and poststructural philosophy.

2.1.3 Embodied vulnerability as the ethico-ontological basis of care ethics

The relational understanding of human being, interaction and society is the foundation of care ethicists' basic arguments, whereby care ethics partly rests on notions that are in essence ontological (Daly, 2022; Hamington, 2022; Mortari, 2021; Vosman and Nortvedt, 2020, p. 2). By ontology, I refer to the philosophical study of being, where the fundamental categories of reality and the relationships between them are under scrutiny. Ontology derives from the Greek words "ontos" (*όντως),* meaning "being", and "logos" (*λόγος*), meaning "word" or "reason". Fundamental questions concerning being are constantly before us in our everyday lives although, paradoxically, they easily escape our notice and remain obscure (Heidegger, 2010, pp. 69–70). With a focus on care, however, it is possible to force questions of being into visibility, as to care is to engage first-hand with fundamental existential matters. Our possibility to contemplate being in the first place is enabled by care, in that we all result from someone's prioritising of our life over their own (Mortari, 2021, p. 145). The world is presented to us through our inescapable embodiment and the care or neglect our contextual, bodily matters enact (Vaittinen, 2015, 2022; Zechner et al. 2022). Care relations – relations that in an ideal sense produce attachment, other-centredness and solidarity by default – ontologically stand out in relation to other systems of social relations, in that they are led by other-centredness in a way that contractual-led political or cultural relations, for example, market relations, do not (Lynch et al., 2021, p. 6). Due to care's potential to reveal such fundamental aspects of being, care ethicists have put forward ontological arguments on the idiosyncratic essence of care, for example, its distinct *attitude* (Noddings, 1984), *rationality* (Wærness, 1984), *species activity* (Fisher & Tronto, 1990) or *logic* (Mol, 2008). As I show later, our inherent relationality can be developed into an argument for the ontological primacy of ethics (Lévinas, 1979), which is why I use the term *ethico-ontology* in this study.

Next, I will elaborate on vulnerability and embodiment as the ethico-ontological premises of care ethics.

Vulnerability

Perspectives on the idiosyncrasy of care have consistently arisen from the notion that human life is inherently vulnerable (Engster, 2005, 2019; Ferrarese, 2016; Held, 2006; Kittay, 1999; Laugier, 2016; Miller, 2020; Tronto, 1993; Vaittinen, 2015; Zechner et al., 2022). The ethical argument in favour of care ethics stems from the fact that vulnerability persists throughout our lives and manifests, for example, as illness, disability and frailty, and should therefore be recognised much better in our conceptions of the world itself. Ethics is, then, transformed from normative assumptions of "good life" or making "right choices" towards the ordinary experience of everyday life (Laugier, 2016; Pols, 2023). These views also lead to a normative emphasis on interdependency over autonomy or independency. As Virginia Held (2006, p. 14) writes: ″that we can think and act as if we were independent depends on a network of social relations making it possible for us to do so".

However, arguing for the importance of dependency and vulnerability is not without problems (Engster, 2019; Miller, 2020). For example, Miller (2020) argues that vulnerability is insufficient as the source of moral responsibility due to being a universally shared human condition, which can be too easily disregarded. She argues instead that dependency, also ontologically shared in Miller's view, is not a matter of identification with others but rather always requires a response to distinctiveness, to contextual and distinct needs.

In an opposite stance to that of Miller, Fineman (2010, pp. 167–168), although outside care ethics, believes that vulnerability relates not only to interdependency, in the sense of being located within a web of dependency relations defined by social relationships, but more profoundly to the constant *potentiality* of dependency, which in her view ought to be the centre of any political and theoretical endeavour. Building on Fineman's work, along with care ethicists' preceding texts on vulnerability and care (see Ferrarese, 2016; Laugier, 2016; Vaittinen, 2015), Engster (2019) notes the ambiguity when dependency and vulnerability are used interchangeably in care ethics. Furthermore, he claims that care ethicists have predominantly based care ethics on dependency, where care needs emanate from a person’s inability to improve their own circumstances, thus making them dependent on others' caring actions. Similarly to Fineman, Engster argues that overemphasising dependency directs too much analytical attention towards care as a private activity, risking a disconnection between care and the human condition. He advocates a broader comprehension of vulnerability as a fundamental concept within the scope of care ethics:

> First, good caregiving generally involves more than merely attending to the inevitable dependencies of individuals – the frailty of older people, for example. It also means attending to their worries and concerns and emotional and social well-being. Although a focus on dependency need not lead to a narrow biological approach to caring, it can

> easily do so. [...] A vulnerability perspective also brings to light the temporal dimension of good care. Good caregivers generally do more than just attend and respond to the needs of individuals as they arise. They work at a step before needs or harms manifest themselves – anticipating individuals' vulnerability to unmet needs and harms so that real threats to their well-being never arise. (Engster, 2019, pp. 8–9.)

Engster suggests here that care is also about the contextual recognition of the potentiality of dependency, not only about recognised, distinct dependency to which care then responds with distinct actions. Such a technical perspective risks instrumentalising both caring and human being. Therefore, Engster defines care as a response to vulnerability, that is, "to susceptibility or exposure to harm, needs, loss, coercion, domination and other unwanted conditions or events" (ibid, p. 7). As is revealed by Engster's wording, this understanding of vulnerability also extends beyond the possibility or need to fully address such susceptibilities, meaning that vulnerability may also be connected with positive meanings, for example, becoming vulnerable by opening ourselves towards others in our relationships (ibid).

Luigina Mortari (2021) describes a similar notion to those of Fineman and Engster but argues for the connection between vulnerability and care in existential terms. I argue that she therefore explicates the core of care ethicists' normative notions related to the shared human condition of vulnerability but at the same time points to how this condition always necessarily manifests as a singular experience. Mortari asserts that vulnerability (and therefore care) arises from our inherent *infiniteness*. We all die, but before that we have also arrived in this world from nothingness without choosing our birth, completely shapeless yet with a duty to find a unique shape for our existence, and, ultimately, to die (Mortari, 2021, p. 155). Care, then, responds to a progress of actualisation of another person's own possible being (ibid, p. 159). Vulnerability in this sense is a very singular problem concerning the source of one's own existence. However, the fact that this source also remains inevitably *unknown* to every one of us is a strong argument for valuing connections with other beings who share this confusion. Therefore, as Mortari (ibid, p. 157) writes, "care is an ontological action, necessary because human life is uncertain and incomplete". The active, temporal and other-oriented nature of care involves responding to another person's situation holistically and before dependence even occurs, rather than merely reacting to clear-cut, predetermined needs. For example, caring for an infant consists not only of satisfying expressed and externalised needs but also of offering experiences that help the infant to flourish in life (ibid, p. 156). Due to vulnerability, then, care is (also) about connection on the level of ontological questions, which, ideally, results not only in tackling or diminishing concrete needs but also in holistic action aimed at helping others to flourish.

Embodiment

Although the views on vulnerability capture the ethico-ontological underpinnings of care, with existential perspectives there is a risk of overly abstract theorisation that loses the focus of concrete lifeworlds. Therefore, care as a response to vulnerability is better informed by incorporating *embodiment* as the practical basis for comprehending vulnerability and needs. Care is to a considerable extent about meeting inevitable bodily needs (Tedre, 2004; Vaittinen, 2015), and is conducted in accordance with bodily rhythms rather than predetermined temporalities (Twigg, 2000, pp. 93–98) and culturally determined as dirty work due to its closeness to the body, bodily fluids and excrement (ibid, pp. 143–145). The focus on bodies in care settings has evolved to a more extensive emphasis on embodiment as part of care ethics, where the focus is not merely on bodies as ethico-epistemological subjects and objects of care (see for example Hamington 2004, 2020; Vaittinen, 2015, 2017, 2022). Apart from concerning care tasks carried out on the body, the relational ontology of care stems from a more profound comprehension of the fluid and expressive *co-presence* of living bodies in interaction with other living bodies (Beasley and Bacchi, 2007; Fuchs and De Jaegher, 2009; Hamington, 2004; Mol, 2008). This is in line with other aspects of care ethicists' criticism of Western moral theory, which has also greatly overlooked the ethical potential of the body, reducing it to something we merely possess rather than primarily experience (Miller, 2020, p. 11).

A significant contribution to the topic of embodiment in care ethics can be found in Maurice Hamington's *Embodied Care* (2004). In it, Hamington offers a noteworthy definition of care through a conception of embodiment:

> Care is an approach to individual and social morality that shifts ethical consideration to context, relationships, and affective knowledge in a manner that can be fully understood only if its embodied dimension is recognized. Embodied care centers not on theoretical or abstract understandings of right and wrong but on affective, embodied, and connected notions of morality. (Hamington, 2004, p. 32.)

Hamington has consistently advocated the idea that arguing for the relational and vulnerable aspects of care is, or should be, deeply rooted in embodied epistemology and ontology. According to Hamington, care "flows from the knowledge manifested in the body" (ibid, p. 39), based on the corporeal-epistemological phenomenology of Maurice Merleau-Ponty (1962, 1968). Hamington argues that the body's role in creating, maintaining and expressing knowledge is fundamental for comprehending and defining care. This is because, first, our bodies mediate our perception of the world before we are even aware of it and, second, successful caring for someone requires already knowing something about them. The conception conveyed here is that the body, or rather embodiment, plays an active and fundamental role in acquiring knowledge (ibid, pp. 44–45). Essentially, the idea of embodied care is that comprehending and responding to vulnerability can take place through infinitesimal gestures, smells, tones etc. that surpass our conscious and logical capacities. The embodied lifeworld of care affects all human interaction and is thus a necessary aspect of caring and analyses of care relations (ibid, p. 48). This embodied necessity has also recently been connected with ontologies of vulnerability to argue against neoliberal societal and existential understandings (Hamington, 2020; Hoppania and Vaittinen, 2015; Vaittinen, 2022; Zechner et al., 2022).

Further on, I will revisit these and other perspectives on the meaning of vulnerability and embodiment for care and argue that embodiment is very much at the heart of the ethico-ontological and politico-structural dilemma of care. Next, I will elaborate on the aspects underlying care ethics' development from its ethical basis of relationality and vulnerability into a political theory.

2.1.4 The distribution of responsibility as the politico-structural basis of care ethics

Keeping in mind the shift in emphasis from the ethical concern stemming from the contents and actions within the care dyad towards plural applications of care ethics, I will now elaborate on how the latter perspectives have developed care into a political theory of care. While care connects with existential matters that arise from our inherent vulnerability and embodiment, it is also a laborious activity. Care ethics is also rooted in the observation that, in direct connection with how some moral dispositions have been hegemonised while others have been marginalised as Carole Gilligan (1982) shows, some actions in society are deemed productive and receive formal recognition in the form of wages, whereas others are left on the margins to be dealt with informally and in domestic settings. All care encounters are always-already influenced by power structures, resulting in complex networks of addressing and declining others' needs. The unequal allocation of reproductive labour within any society can be comprehended as a phenomenon that generates and is influenced by networks of care relations, and rightly so, as the history of care is evidently gendered and racist and has consistently been overlooked in Western moral philosophy. This academic marginalisation comes as no surprise because patriarchy has socially marginalised those engaged in caring – mainly women and ethnic minorities – resulting in care being an invisible form of labour (Gilligan, 1982; Tronto, 1993). In other words, along with being an ethico-ontology connected with ideals that stem from addressing situational vulnerabilities, care is also a precarious activity rooted in cultural and political histories (Miller, 2020).

In *Moral Boundaries* (1993), Joan Tronto describes the potential neglect that challenges any account of care as "privileged irresponsibility" (ibid, p. 121). In Tronto's view, care has remained an ″outsider's'" claim, outsiders traditionally being women or ethnic minorities, i.e. people who are left to do societally unappreciated care labour, in contrast with social strata closer to the centre of societal power who define policy and do not have to engage in care labour (ibid, pp. 15, 62, 91). Therefore, she puts forward a politico-structural argument concerning care, emphasising that care ethics' arguments of relationality and vulnerability ought to be considered in a political context, in that no moral theory or a situation can be detached from its inherent power relations (hence the ″boundaries″ of moral thought in her book).

Furthermore, Tronto (ibid, pp. 77–84) argues against Gilligan's (1982) notion of care as a "different voice" in contrast with justice and posits that the pursuit of access to societal power structures cannot happen by appealing to either ”difference” or ”sameness” by the outsiders.[3] On the one hand, appealing to difference would mean (and has meant) that outsiders will also stay outsiders exactly due to difference itself, for example, due to being viewed as good caregivers by virtue of being women. Descriptive of this was the discussion (or lack thereof) on care worker unions’ demands for better pay in Finland in 2022, where the entirety of the workforce in the health and social care sector were denied societal power by prohibiting their strikes through legislation (Ojala et al., 2022). As I am writing this, the current Finnish government is attempting to also prohibit by legislation the Finnish care sector's possibility of negotiating higher rises in salary compared to the male-dominated export sectors (Valtioneuvosto, 2023, p. 61). On the other hand, appealing to sameness in seeking access to the centres of power creates difficulties in terms of (the lack of) intersectionality. Intersectionality is linked to the transition from second-wave feminism, which focused on gender differences (within a white, educated population) to third-wave feminism, which addressed how ethnicity, sexual orientation and class impact societal positions (Tronto, 1993, pp. 15–16). The issue with appealing to sameness, then, is that with such a stance it becomes impossible to bring about substantial change in the distribution of care between different groups with different subject positions, and also that pleading to sameness cannot yield enough political power to shift the standpoint of the powerful groups in society (ibid).

Instead, Tronto (ibid) amalgamates the ethico-ontological arguments of care ethics with politico-structural ones by arguing that care ethicists should pay attention to ”moral boundaries”, i.e. the cultural preconditions that uphold the distribution of care between different groups in a society. She believes the first such boundary is the division between morality and politics, whereby moral arguments connected to caring are left on the margins as secondary to political(-rational) ones, thus lacking proper political influence. The second boundary is the hegemony of the "Kantian moral point of view”, requiring that moral judgements be based on distant, impartial and rational perspectives. Such a mindset has relegated ethics to the fringes of philosophical and societal discourse, thus eroding the explanatory power of care as underpinning not only ethics but human essence. The third boundary in Tronto’s view lies between public and private life. Politics as a public sphere has come to be defined in terms of rational decision-making whereas the private sphere of home is deemed as the realm of close, emotional relationships. This boundary results in care being seen as a non-political issue (ibid, pp. 6–11).

While *Moral Boundaries* of course rests partly on the perspective of ethical significance stemming from vulnerability and needs as constitutive for our being, Tronto's primary call is for a *discursive* analysis of how societal power structures precede and determine any ethics; the very idea of "moral boundaries" entails looking at the conditions by which morality is *produced*. Following Tronto's approach, which develops the ethical basis of care ethics into a political theory of

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[3] Fraser (1995, pp. 80–82) poses a similar notion framing the issue in terms of recognition and redistribution.

care, care ethicists have implemented the concepts of vulnerability and relationality in terms of structures of ignorance (Casalini, 2020, pp. 61–62). It is also clear that this shift necessitates replacing the dyadic understanding of care with a plural one. For example, Selma Sevenhuijsen (1998) argues that the ethical analyses of vulnerability should lead to a shift towards analysing care as a social practice within institutional care arrangements instead of ethical ideals found in one-to-one encounters. Indeed, amalgamating the ethical arguments with political theory has allowed development of the all-encompassing issues of vulnerability and relationality to include analyses of institutions (see for example Koggel and Orme, 2019). These interpretations of care ethics have allowed political analyses concerning areas such as democracy (Tronto, 2013) or global division of labour (Robinson, 2013; Vaittinen, 2017). Over the past 40 years, feminist philosophy has progressed from its second wave, concentrating on the implications of gender dichotomy, towards the third wave of intersectionality and then further towards posthuman philosophies, such as the recent and influential *Matters of Care* by María Puig de la Bellacasa (2017). With this progress, care ethics has increasingly emphasised how care (and vulnerability) manifests in the confines of discursive, political and material networks, therefore progressing from care ethics towards a more encompassing care theory (Gary, 2022, pp. 2–4).

2.2 The theoretical arguments concerning care in this study

My theoretical contribution to care ethics is to explore the conceptual outcomes of the dichotomous underpinnings of care, so I can later elaborate the essential aspects of care professionals' lived care encounters with older persons in ISH. This exploration does not result in dividing care ethicists bluntly into "ethico-ontologists" and "politico-structuralists", as both conceptual tendencies seem to exist in any work within care ethics, although they may differ in both intensity and explicitness. For example, Tronto's account is of course not solely based on the politico-structural aspect of care, as much of the influence of *Moral Boundaries* stems from presenting the "four stages" as the general requirements of successful care – caring about, taking care of, caregiving and care receiving (Fisher and Tronto, 1990; Tronto, 1993, pp. 105–108) – with a later addition of a fifth stage, "caring with", emphasising the collective and political dimensions needed in care (Tronto, 2017). After all, Tronto writes: "[w]hat is definitive about care... seems to be a perspective of taking the other's needs as the starting point for what must be done' (1993, p. 105). Therefore, Elisabeth Conradi (2020, p. 29) places Tronto's care ethics within both the "vulnerability" and "distribution" strands of her framework. Due to their rootedness in feminist critique of both moral philosophy and societal structures, all care accounts include ontological and political aspects. Therefore, my aim is rather an analytical one, to explore where the different directions in thinking about care can lead and to make use of these directions in exploring the meanings of practical, everyday care relations.

In this section I will present my own perspective on care, which also frames my analytical approach in Chapter 6, where I present the results of this study. First, I will return to the meanings related to dyadic care encounters. I borrow from phenomenology the concepts of *alterity*, to focus on the situational experience of vulnerability to which care responds, and *embodiment*, through which the Other's vulnerability is revealed to us. After that, I will present Zechner et al.'s (2022) concept of *ailment* and Vaittinen's (2022) notion of the *ethics of needs*, which build a political account of care based on the enactive potential of embodied needs that comes close to my departure point of embodiment. Finally, I will elaborate on how phenomenology and poststructuralism underpin the ethico-ontological and politico-structural tendencies of care ethics, leading to the usage of the concept of care on two different levels. I argue that explicating this dichotomy may result in better future analyses of care.

2.2.1 Understanding vulnerability and care through phenomenology

I will now momentarily shift back from care understood in the plural sense towards the "care dyad" and see whether an explicit connection with vulnerability and dyadicity could clarify the ethical and ontological (and therefore, ultimately, the political) arguments on which care ethics is based. Why revert to exploring the dyad? In reading care ethics literature over the years, along with my deepening fascination related to its depth and scope in exploring human being, sociality and morality, I have at times ended up longing for a more analytical and philosophical emphasis on the care receiver's position, that is, meanings related to the concrete experience of vulnerability and the actions taken to address it (see also Vaittinen, 2015, 2017, 2022). Although I also fall short empirically in this regard in this study, I will now explore how perspectives of phenomenology, namely alterity and embodiment, can be used in making an argument for how the dyadic view of vulnerability might still be useful.

The lifeworld of the Other

In *Article I*, I have attempted a dyadic approach to vulnerability and care by emphasising the "dyadic mutuality" of immediate care relations (Hämäläinen, 2020). Rather than focusing on relationality in the sense of a network or a structure of care, in the article I explored what specific aspects of care are crucial when examining it as an idiosyncratic, contextual event. In this view, care encounters are understood as *momentary co-creation of meaning* rather than relations between individual actions of separate subjectivities on one hand or as dictated by a social structure on the other. Therefore, the primary focus of the article is on the "inter" aspect of the word "intersubjective". In the article, this was depicted as dyadic mutuality wherein the eventuality of care can be traced back to two individuals sharing a moment defined by vulnerability and the attentiveness that responds to it (Hämäläinen, 2020, pp. 171–173). While further examination has shown both the take on relationality and the concept of dyadic mutuality to be too ambiguous, I will now look closer into whether the dyad as the ethico-ontological departure point of care could still be applied usefully. However, in this summary of the PhD study, I proceed to use the term *lived encounter* instead of dyadic mutuality, shifting towards a more phenomenological perspective.

In the term “lived encounter”, the word "lived" establishes the phenomenological foundations of care as situated in a reflexive and embodied *lifeworld* (Husserl, 1970). The word "encounter" emphasises the situationally and temporally particular character of the dyadic relation that manifests as a moment of care between two persons. Elaborating what I mean by the lived care encounter can be supported by some perspectives of phenomenology, which addresses the basis of human understanding by investigating human experience and how phenomena appear in human experience (Nortvedt and Vosman, 2020, p. 3). In this study, I will apply phenomenology merely as a collection of philosophical perspectives forming the basis of the exploration of the conceptual issues related to care ethics and care, not in the sense of a methodology, such as "phenomenological reduction" in the Husserlian sense (for example, Husserl, 2012).

One of the phenomenological core concepts, lifeworld (Lebenswelt), finds its roots in Edmund Husserl's (1970) text *The Crisis of European Sciences and Transcendental Phenomenology,* and has been further developed by phenomenologists following Husserl, especially Edith Stein (1988), Martin Heidegger (2010) and Maurice Merleau-Ponty (1962, 1968). Husserl defines lifeworld as the "world of immediate experience", as "already there" or "pregiven". World, therefore, does not pertain to an objective "world out there" nor a subjective "world within", but to the world as a holistic, relational experience that transcends such subject–object divisions. Lifeworld refers to the significance of our sensory, embodied, intricately textured and *meaningful* experiences. Think here of the ineffable depth of experience when witnessing the hues of autumn leaves, yearning for a distant loved one, being bewildered, being bored, savouring fresh bread after prolonged hunger, being in the same room with somebody, experiencing how fever or pain finally leave the body, taking a detour through a nicer landscape or feeling sorrow for someone's hardship. Such matters do not exist in the world out there or within us; they *come about* in a pre-theoretical process of world-to-consciousness which we tend to call experience. As Alcoff (2000, p. 40) interprets Heidegger, a lifeworld is "a world whose reference points all point to us, a lived world, and not a world in itself, or a world indifferent to human projects and concerns". A holistic, qualitative and interpretative comprehension of the world shows how things and events are inescapably *relevant* for us as human beings at all times, even as the alienating influences of technology or postmodern life attempt to distance us from moments of significance and intimacy.

Phenomenology can be fruitfully directed towards care encounters due to their inherent concern of vulnerability, as has been highlighted by some care ethicists (Hamington, 2020; Mortari, 2021; Noddings, 2003; Nortvedt and Vosman, 2020) and researchers in the field of nursing studies (for example, Galvin and Todres, 2013). Because the lived and situational manifestation of vulnerability calls for caring responses in the form of at least some kind of dyadicity – an experience or hope that *somebody* responds with caring actions to a need arising in *your* experience – the concept of *otherness* at the heart of many phenomenological ontologies reveals its analytical value.

First, it is important to explore the conceptual origins of otherness, especially to eliminate any connotations related to other*ing*. Othering, understood as political practices and discourses of unequal identification of persons of groups in social contexts, has been extensively investigated across various areas of critical social theory (Brons, 2015; Crang, 2013, p. 61). Othering entails actions that use categories of the self and the Other to distance individuals or groups from centres of power in a society. For example, care is partly manifest in its current forms due to the influence of languages and philosophies of othering, such as malestream moral philosophies that have historically considered close relationships as peripheral and irrelevant for ethical analyses.

Although many social theories view otherness as a derogatory category, approaching the Other through phenomenology and social ontology can lead to an opposite, emancipatory argument. If other*ing* denotes which *types of persons or groups* are identified as others in political settings, the concept of other*ness*, or *alterity*, raises an ethico-ontological question about *who* this person before me is in their otherness, *what is the meaning* of this encounter for my own being and, subsequently, for my ontological and ethical relation to them. In phenomenological literature, otherness and *alterity* are used synonymously; from here onwards, I will utilise the term "alterity" instead of "otherness" to distance my approach from the negative and coercive uses and implications of the Other. In particular, this distinction aims to dissociate this work from a connotation of othering older persons.

The category of the Other (often written with a capital O in phenomenological literature to highlight its pre-theoretical, existential significance) is rooted in G. W. F. Hegel's dialectic on the self and the Other in his *Master-Slave Dialectic* (Hegel, 2018). In the dialectic, on which many later philosophical accounts of the Other build[4], encountering the Other is fundamental to the (re)construction of self-consciousness. The Other is in a radical sense *not-similar-to-self;* however, its function as other*ing* is hindered by the fact that self-consciousness at the same time also recognises its own way of being in the Other, acknowledging in them a similar intrinsic dilemma (Brons, 2015), which "always refers back to alienness in ourselves" (Klaver, 2020, p. 22). Thus, the Other as "not same" is not reduced to a suspicious alien but instead is perceived as something that exposes the foundation of existence itself. The self as an ethical, ontological and political experience necessitates encountering another self-consciousness in the world. This means that experiencing need and desire in the first place is only possible through the recognition of and by another

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[4] Such as Beauvoir's (2015) feminist philosophy, Sartre's (2003) existentialism, Lévinas's (1979) or Merleau-Ponty's (1962) phenomenology or Lacan's (2001) psychoanalysis.

self-consciousness, which is reciprocally possible by recognising the Other's similar need for recognition (Honneth, 1996, p. 37).[5] Rather than a means to an end (i.e. an object), another sentient being becomes a radical Other, an end in itself.

Alterity is crucial in terms of care ethics' tendency to draw its ethical arguments from vulnerability and relationships, which can be further explored through the work of Emmanuel Lévinas, who presents alterity as the pre-ontological starting point of ethics (1979). For Lévinas, ethics derives from encountering the face of the Other, as one can encounter something that absolutely escapes one's control and will solely in the presence of the Other. The Other is not simply a fraction of the plurality of persons, but rather represents otherness as such, remaining beyond our cognitive or practical grasp. The gaze of the Other is straightforwardly ethical, as it opens up an infinite unknown, given that we face the Other's gaze holistically, *as such*, or as Lévinas says, "without even observing the colour of his eyes" (Lévinas and Nemo, 1985, p. 85). Encountering the Other preconditions ethics in that, ultimately, it is the naked vulnerability in the Other’s face that impels us to refrain from causing harm to them. As Vanlaere and Burggraeve interpret Lévinas:

> The suffering of the other disturbs and disrupts us, it throws us off-balance, disrupts our agenda, invades our emotional world and disturbs our mood, whereby we lose our equanimity. We no longer have everything under control. The suffering of the other is the concrete, poignant heteronomy of the other that breaks into our existence unannounced and unabashed. (Vanlaere and Burggraeve, 2020, p. 95.)

Therefore, the radically ethical experience of alterity is important for care ethics' ethico-ontological basis as responding to vulnerability. In the results section of this study, I will proceed to explore what the practical contents of lived care encounters are in terms of alterity.

The Other as an inevitably embodied being

A further phenomenological exploration of vulnerability and/as alterity shows how they in fact manifest inevitably through embodiment. Phenomenological perspectives tend to approach the body as *embodiment*, serving as a reflexive foundation of experience instead of simply being a node in a world of detached subjects and objects. According to Galvin and Todres (2013, pp. 28–29), embodiment refers to "the concrete *here* of ourselves". Although our bodies can sometimes appear to us as objects, they are not best described through their physiological or chemical construction. The body is not merely something that I and others *possess*. Rather, embodiment is constructed in relation to our experiences, in a state of constant becoming and in co-presence with the world and with other lifeworlds. The lifeworld is always-already experienced situationally, never as a view "from above" or "from nowhere" (Haraway, 1988,

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[5] For connections between recognition theory and care of older persons, see Pirhonen, 2017; Laitinen and Pirhonen, 2019.

p. 589), but always "from the midst of itself", from within a body, in a certain situation, context, direction and posture, occupying a certain space in a particular manner (Merleau-Ponty, 1968, p. 113). We can understand both space and others that also inhabit it from the singular perspective our bodies give us by being *here*. Our bodies inhabit a constant, emotional *feeling*. Embodiment does not calculate brainwaves and neural paths and arrive at conclusions but rather is in a constant state of becoming, in an emotional flux (Galvin and Todres, 2013, p. 25). Intentions, then, are not inherently hidden within us until they are verbalised; instead, they are expressed through embodied action (even if infinitesimally subtle) perceptible to others and are thus constantly changing in response to our interactions with others (Fuchs and De Jaegher, 2009, p. 469).

Encountering the Other is embodied, in that comprehending the Other's vulnerability partly takes shape through infinitesimal bodily gestures that *underlie* our relations (Hamington, 2004). Phenomenology-derived ethical perspectives that depart from embodiment are often based on the corporeal phenomenology of Maurice Merleau-Ponty (for example, Daly, 2019, 2022; Diprose, 2012; Hamington, 2004, 2020; Weiss, 1999). Merleau-Ponty, building on previous phenomenological insights, such as Husserl's (1970) lifeworld and Heidegger's (2010) fundamental ontology and hermeneutics, argued that the world is always perceived as the body-subject (Merleau-Ponty, 1962, p. 206), putting the primary emphasis in phenomenological analyses on perception. Arguing against a detached understanding between the one who perceives and the one who is perceived, the subject and the object, Merleau-Ponty asserts that embodied, bidirectional perception is the "background from which all acts stand out" (Merleau-Ponty, 1962, pp. x–xi; Hamington, 2004, pp. 47–48). This is evident regarding knowledge required in encountering alterity, as it exceeds what is available to our rational understanding and allows for an understanding of alterity as a perceptual whole (Hamington, 2004, p. 48).

In this vein, Weiss (1999), arguing against the Kantian categorical imperative and rational ethics, puts forward an idea of a *bodily imperative*, where moral significance emerges out of a constantly enacted embodied exchange with the Other which in turn constantly transforms us and our moral significance. Embodiment entails being affected by the Other's body, which I will also show to be evident in care professionals' views on ideal manifestations of care when presenting the results of the study. Weiss's argument points to the inherent problem with ethics understood as a rational, non-relational process, in that moral significance understood as arising from embodied encounters can never be any kind of static expression of morality. In such a reflexive view of embodiment, we can also witness a resemblance to the ethico-ontological basis of care ethics and its criticism aimed at mainstream moral philosophy.

Furthermore, Daly (2019; 2022, pp. 145, 150) searches for "the ontological structures that can support care ethics" with the help of Merleau-Ponty, asserting that an embodied encounter is an ethical event *in itself*. Daly's position departs from Merleau-Ponty's analyses of perception and attention (Merleau-Ponty, 1962). Perception is embodied in that we are always "on this side of our bodies"

(Daly, 2019, p. 9); things always appear in our experience in a field, be it visual, auditory, tactile, etc., meaning that there can be no bodiless or world-less experience (Daly, 2022, p. 148; Merleau-Ponty, 1962, p. 62). Perception takes place in the lifeworld, which means that it is in a constant hermeneutic motion between an object and its environment, and between the self and the Other. Merleau-Ponty's embodied ontology is crucial for analysing care, in that instead of crude, unidirectional concern directed towards needs, attentiveness in care becomes transformative of both participants, allowing for "mutuality in understanding each other's affectivity, situatedness and historicity" (ibid, p. 150). According to Merleau-Ponty (1968), and as pointed out by Hamington (2020) in relation to care, this *reversibility* (réversibilité) transcends subject–object divisions as it refers to how we can at the same time both experience touching (something or someone) and being touched (by something and someone). Touching and being touched are distinct perceptual experiences, meaning that experiencing perception is not the same as experiencing being an object of perception, yet both of these experiences intersect in our bodily perception. This leads to the ethico-ontological basis of care, or in Hamington's words: "caring is embedded in learning not for the sake of accumulating disjointed facts, but emerges from the reversibility between self and other in the flesh: the fundamental connection we have with others in our perceptual experience" (ibid, p. 122).

These perspectives on caring attention for the Other also lead to a calibrated situational responsibility, protecting from attention becoming a totalising agenda of the one giving care, in that through reversibility the ethical relation is constantly kept in check by embodied co-presence (Daly, 2022, p. 150). This is also depicted by Fisher and Tronto's (1990; Tronto, 1993, pp. 107–108) fourth stage of care, care receiving; without some kind of receptiveness the attentiveness is not fulfilled. The shifting attention between self and the Other means that perception is inevitably relational and therefore ethical as such (Daly, 2022, p. 150), much as in Lévinas's phenomenological analysis of ethics emanating from the face of the Other (Lévinas, 1979). Of course, these notions situate ethics on the very primordial level of embodiment. In terms of everyday care encounters, shifting between the self and the Other shows exactly the ethically demanding nature of, for example, professional care of older persons. This is due to the premise of vulnerability itself: there can be no general rules for checking whether vulnerability is/was addressed sufficiently; however, I argue this is exactly where the depth and explanatory power of care ethics as relational ethico-ontology lies. As I will also show in the results section of this study, especially when propositional language has lost its rational meaning-making ability due to dementia, care professionals' acts of "reading embodiment" necessitate a lived and bidirectional understanding of the care encounter.

2.2.2 Exploring the care dichotomy through phenomenology and poststructuralism

Having explored the phenomenological underpinnings related to the ethical arguments of care ethics – alterity and embodiment – I will now return to the dichotomy within care ethics and explore what situating the phenomenological basis of care might mean for understanding care as both ethico-ontological and politico-structural theory. I argue that the differences between them can be explained by the ontological differences between phenomenology and poststructuralism. Phenomenology departs primarily from a reflective description of intentional, lived human experience, and the search for the truth or essence of that intentionality, while poststructuralism emphasises an understanding of the nature of language as radically incomplete, leading to suspicion of any essentiality and holistic subjectivity. Poststructuralist philosophy has therefore argued that innate experience cannot be detached from its social, discursive conditioning and much wider external relations (Alcoff, 2000; Stoller, 2009; Williams, 2014, p. 8). Any kind of wholesome engagement with the differences between poststructuralism and phenomenology is of course completely beyond the scope of this study; however, I claim these differences are visible in care ethics and can help explicate its approaches.

In this task, first, a recent collection of works by Viva Collective of Finnish care researchers, on *ailment* (Zechner et al., 2022) and *ethics of needs* (Vaittinen, 2022), which combine vulnerability and embodiment into a political theory of care, is of great help as they come close to how I have approached embodied vulnerability as the ethical departure point of care in this study. By exploring ailment and ethics of needs alongside the phenomenological perspectives on embodied vulnerability, I aim to show how the phenomenology-driven ethico-ontological and the poststructural (and postmaterialist) politico-structural undercurrents of care ethics meet and diverge ultimately in how they consider the vulnerable body.

With ailment (Zechner et al., 2022), the authors seek to explore a more reflexive argument concerning the socio-political implications of viewing embodied vulnerability as the ontological point of departure of care. Ailment relates to the social aspects of embodied vulnerability, akin to *affects* which have garnered increasing academic interest since the release of *The Cultural Politics of Emotion* by Sara Ahmed (2013). Affects are emotional forces that reside neither within nor outside individuals but rather in the relations between actors, creating relational webs of affectionality. Affects are cultural-material phenomena rather than psychological states; they both stick to individuals and flow through them, determined by historically-specific, cultural settings (ibid). In a similar vein, the authors argue that ailment is an embodied, relational force that always necessitates *some kind of* disposition or action from us (such as attentive care, indifferent care, neglection, fear, disgust), reconfiguring both individuals and collectives in partly unexpected ways. Furthermore, caring as practice is tied to ailment:

> Attending to ailment as a practice is dynamic and open-ended. Ailing is an active process that draws attention to the rapidly and sometimes unexpectedly changing nature of the human condition. An ailing body requires attention, but what the body requires today might change tomorrow – also depending on the attention that it receives today. In intimate family relations, a first sign of a care need may be a sense

> that something is not quite right, especially in the case of dementia or other illnesses without significant physical symptoms. (Zechner et al., 2022, pp. 68–69.)

Thus, the affectual character of ailment seems to result in a reflexive notion of what is at stake concerning embodied vulnerability and how it also impacts the world as social and political (re)configurations.

One of the Viva collective writers on ailment, Tiina Vaittinen, has also discussed care ethics on the basis of embodied vulnerability, developing it towards a complementary theory of "ethics of needs" (Vaittinen, 2015, 2017, 2022). Vaittinen offers a novel and intriguing view on the vulnerable body's *enactive* potentiality (much akin to ailment in Zechner et al., 2022), building on Giorgio Agamben's view of modern biopolitics as delineation between life understood as *zoē,* where life is depicted as "bare life", a simple fact of existence that can be sacrificed, and *bios*, ethically and politically valuable and meaningful life within a community (Agamben, 1998). While Agambenian readings of biopower typically view bare life as the forced absence of political agency, Vaittinen holds that exactly this "bareness" of the body can be viewed as the "constant opening of the political" (2015, p. 100), tracing the political enactment-ability to the bodily functions themselves. In her view, vulnerability is inevitably at the core of any ethics or politics due to the fact of the mundane material needs – eating, moving, sleeping, defecating and so on – and the reactions (be they care or neglect) they enact. In terms of vulnerability, this refers to bodies' vulnerability to *life itself,* as they age, decay and ultimately perish (ibid, p. 104).

I read Vaittinen's ethics of needs as a poststructuralist take on vulnerability and care, which in a fascinating and novel way describes the political inclinations of taking embodied vulnerability as the departure point of care ethics. The poststructural underpinnings lie in her Derridean analysis of how the bare needs of the body are *muted* on the level of discursive possibilities (2022, pp. 7–8). Even though our needy bodies demand reactions from us all the time – some with better capabilities to enact reactions than others – these demands are constantly being written out in neoliberal epistemologies and politics. Vaittinen's analytical focus on embodiment is therefore on the "*weave of relatedness* that the body both *carries and produces* simply through the processes of living" (ibid, p. 16, emphases by AH) and the corporeal relation of care "not just a linear, singular trajectory that connects the caregiver with care-receiver, but *a vehicle through which needs shape entire political economies*" (Vaittinen, 2017, p. 142, emphasis by AH).

I consider that both my phenomenology-derived ethico-ontological premises of care ethics and Vaittinen's ethics of needs as approaches to vulnerability stand on the shoulders of past care ethicists' work and both end up face-to-face with the vulnerable body. Vaittinen asserts that care ethics has traditionally emphasised practices of care-*giving* (as in care as either work or the moral disposition of the one who cares) and that this perspective has proved insufficient in resisting neoliberal governmentality due to providing agency primarily to subjects that have the capacity to care (Vaittinen 2015, p. 100; 2022, p. 3). In a similar vein but with slightly different outcomes, this study explores the ethical importance of the lived encounter of embodied alterity, which inevitably also starts with vulnerability instead of care actions.

However, the directions through which these paths towards the essential role of body at the heart of care have been cleared differ. This is not a matter of either direction being right or wrong but rather indicative of the broader tendency of care ethics being underpinned by differences in phenomenological and poststructuralist analytical foci (see Alcoff, 2000; Stoller, 2009). For example, in this chapter I have elaborated on how the ethico-ontological underpinnings of care can be understood through a phenomenological understanding of our shared vulnerability, leading to ethics that is rooted in ontological essentialisations of alterity and embodiment. I argue that these essentialisations, to a minimal extent, are needed to confirm that *a particular caring action* in relation to a *particular experience of vulnerability* is truly care instead of indifference or neglect – in other words, that Fisher and Tronto's fourth stage of care, care receiving, is fulfilled (Fisher and Tronto, 1990; Tronto, 1993, pp. 107–108). Concentrating on radical alterity and embodied vulnerability (in its holistic, existential sense) is of ultimate importance when considering reactions to the needs of persons who cannot express their will in propositional language (Hämäläinen, 2022; Hämäläinen et al., 2024), as I will show in the results section of this study.

On the other hand, as I have already explained, the politico-structural perspective departs from emphasising plurality, as it seeks to understand care on a more comprehensive level in terms of which histories and structures have resulted in experiences of vulnerability, and how vulnerabilities and the responses also reconfigure what we understand as care. These reconfigurations emanate from the discursive boundaries that frame care, vulnerability, the body, care work, gender and so on, in specific ways that are beneficial for some groups within society and detrimental for others. This is evident, for example, in Tronto's *Moral Boundaries* (1993) as it shifts from an analytical focus on ethics concerning the care receiver's vulnerability to a political and discursive analysis of the relational vulnerabilities of the one(s) giving care (Vaittinen, 2015, pp. 110–111). Or in Vaittinen's (2022) work, where she concentrates on the bare neediness of the body as the "lowest common denominator of embodiment" (ibid, 12). While referring to material needs shared by everybody through physiological facts, the bareness elucidates the power differentials between bodies' capacities to enact care in relation to governmentalities that are differently inscribed on bodies (ibid, 12–13). The fact that differing bodies in differing contexts have differing capacities for such infliction would inevitably be missed with a strictly analytical focus on dyads or, in particular, existential vulnerability. In other words, a plural and discursive understanding of care is needed in order to resist structures of neglect, or in Tronto's words, "privileged irresponsibilities" (Tronto, 1993, p. 121)

These differing analytical levels are also visible in how vulnerability as the source of care can be understood in two ways. As I wrote in the previous chapter, the ethico-ontological perspective to care connects with existential vulnerability, the origin of which *remains unknown to us*, as it is "given to us as a basic condition of our being, not as the result of human effort" (E. H. Martinsen, 2020, p. 55). This makes vulnerability (also) an existential issue and ultimately a question on the ontological primacy of ethics through alterity. The Other remains, and will remain, a radical mystery to us, yet one we cannot but try and approach with care and understanding. The mystery can be faced only by facing the Other, that is, by engaging a particular person holistically in a lived care encounter. For this aspect of vulnerability, we need a phenomenological approach. In the poststructurally grounded politico-structural emphases on care, vulnerabilities are (also) always-already culturally and historically *produced* in complex, structure-forming relations of care and neglect, which are inevitably mediated by limitations of language. This means that approaches to care as a response to vulnerability also need to focus on discourses and phenomena that *enact* vulnerabilities, such as gender, ethnicity or class. That care ethics refers to these two levels of analysis at the same time shows its intriguing potential. Once again, there are no pure "ethico-ontologists" and "politico-structuralists" to be found in care ethics, but rather the differing conceptual undercurrents are always visible at differing amplitudes, sometimes more implicitly and sometimes more explicitly.

However, that the concept of "care" itself refers to these two levels is problematic, unless the underlying meanings are explicitly addressed. I propose, then, that "care" ought to be explicitly understood as a *lived encounter* with vulnerability experienced in concrete, embodied alterity on the one hand, and as a *relational structure* that creates the contexts for the responses to vulnerabilities on the other. Both of these are true in any instance of care, as one aspect does not work without the other. On the one hand, care as a lived encounter with the Other also requires an understanding of the contexts that have influenced their particular history. On the other hand, any relational structure of care is devoid of ethical content without an understanding of the radical meaning of alterity and embodiment for our existence. However, *the analytical focus in each inevitably lies on different levels*: on particular experience or on structural phenomena. They can of course be combined, as care ethicists have in creative ways, but I argue that analyses of care gain a lot of clarity if the foci are presented in a more explicated manner. For example, when presenting the results of this study, I view "care" as a lived encounter, since I am interested in how vulnerabilities are being responded to in round-the-clock care of older persons, where dementia and other impairments prompt profound questions related to issues such as vulnerability, embodiment and subjectivity. However, when concluding what these aspects mean as part of broader contexts, I cannot forget "care" as a relational structure, because without care it would be impossible to discuss how the vulnerabilities explored are situated in relation to other manifestations of vulnerabilities or ways of arranging care (and neglect) in society.

Later in Chapter 6, I will apply the above theoretical argument and elaborate on the essential aspects of care, understood as a lived encounter, in care professionals' views on ideal care in their interaction with older residents in ISH settings. Next, because this study also examines the influence of non-human actors on encounters with vulnerability in ISH of older persons, in the subsequent section I will elaborate on both instrumentality and sociomaterial ontology, which are needed to consider the recent trend of the technologisation of care of older persons.

2.3 Instrumentality and sociomateriality as theoretical perspectives on the technologisation of care

In this study, in addition to exploring the essential aspects of lived care encounters in ISH, my interest also lies in the ongoing trend towards the technologisation of care of older persons and how this trend relates to those essential aspects. I use the broad term *technologisation* interchangeably with the narrower term *digitalisation*, although the explicit empirical focus in this study is on ISH technologies that are very much digital: EHRs and SASs. As I elucidate in Chapter 3.3, the technological spectrum of care of older persons of course ranges from simple mechanical aids to complex digital interfaces, and today also includes artificial intelligence, and a range of solutions from client-centred welfare technologies to systems that primarily mediate care work. Therefore, it is worth noting that when referring to "technologisation" I do not mean technology in its broadest material sense (such as traditional assistive devices, beds, doors, pharmaceuticals, buildings and so forth, without which any care of older persons in any meaningful sense would not be possible) but rather refer to the recent developments of technologisation of care, where it is portrayed as a major policy influence in tackling societal care crises. Furthermore, by writing about 'technologisation of care' I wish to keep on board the connotation that care of older persons is something that is reconfigured by a technologised way of thinking, briefly defined in the next section as instrumentality, which would be lost with a systematic use of the narrower concept of digitalisation. Therefore, with the risk of some ambiguity, I switch between using the technologisation and digitalisation of care depending on the context.

In this section, I will discuss the theoretical perspectives that inform this study's approach to the technologisation of care of older persons. This also calls for a turn towards a politico-structural understanding, in that technologisation and other broad phenomena impacting care require theoretical perspectives which can connect with the discourses, epistemologies and politics that underlie them. First, I will briefly distance my position from instrumental conceptions of technology. Second, I will elucidate the importance of sociomaterial theories, found in social studies of science and technology (STS), for explaining the influence of EHRs and SASs on the ideal contents of care. Furthermore, I will explore the tension in ontological approaches between care ethics and sociomateriality along with its repercussions for the arguments and conclusions of this study.

2.3.1 Technology, instrumentality and neoliberalism

First, a holistic understanding of the recent tendencies in the technologisation of care of older persons necessitates a detachment from a conception of technology as *instrumentality*. In *The Question Concerning Technology,* Heidegger (1977, p. 288) discards the instrumental conception of technology as a neutral means to an end functionality. Instead, he asserts that technology should be understood more comprehensively, as related to human existence – as a "mode of truth" rather than "a mere collection of things and activities" (Heidegger, 1977, pp. 294–295; Ihde, 2022, pp. 31–32). Further engagement in the Heideggerian phenomenology of technology is well beyond the limits of the analyses in this study. However, Heideggerian anti-instrumentality, which reveals the *reflexive* essence of technology understood not only as an arrangement of "devices and gadgets" but as constitutive to the possibilities of experience, is the broad departure point for how I approach technology in this study.

Understanding technology as constitutive of the possibilities of experience implies that its boundaries as a category are never fixed, which is in contrast with instrumentality as a means to an end conception of the world, rooted in and evidenced by values such as utility, information, efficiency and quantisation. My view of instrumentality is akin to Adorno and Horkheimer's (1997) view of "instrumental reason" at the heart of modernity's progression, which, much like Weber's (2001) concept of rationality, marks a shift in social and political thought from ends to means and from larger meanings and purposes behind goals to an emphasis on efficiency concerning their achievement (Buchanan, 2018). With instrumentality, I refer to an ethos which manifests not only as phenomena such as "digitalisation" or "automatisation" but also as discursive acts. This is also evident in Foucault's (2008) concept of governmentality, which "defines a discursive field in which power is 'rationalised'" (Lemke, 2001, p. 191). Therefore, technologisation of care, for example, is not only about the increasing prevalence of technical entities in care contexts but also about the underlying instrumental discourses that reconfigure care as a relational structure. Haridimos Tsoukas provides an example of instrumental reduction in knowledge through his view of informalisation:

> 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. (Tsoukas, 1997, p. 827.)

Instrumentality is present in care policies, political agendas on care and practical care contexts including both humans and non-humans. In Finnish policy documents on care of older persons, the trend of technologisation is formulated as an inevitable, self-evident fact (Jaakola, 2022). For example, an official quality recommendation concerning care of older persons given by the Ministry of Social Affairs and Health (STM, 2017, p. 27) in Finland suggests that one-fifth of work related to care of older persons could potentially be substituted by automation and robotics "in a couple of years".

I suggest that the instrumentality and technologisation of care of older persons also share a common ground with neoliberal epistemology that influences the current political contexts in the Western world. While neoliberalism has been rightfully denoted as an overly ambiguous concept (Thorsen and Lie, 2006), some of its connotations are easy to connect with values of instrumental character, such as utility and efficiency. Neoliberalism forms a political-economic governance that shifts the role of the state towards enabling and preserving the possibilities of individual entrepreneurial freedoms and skills, which are considered fundamental to human well-being, leading to policies that extend markets to areas of social life where they have not traditionally existed (Dahl and Hansen, 2021, pp. 5–6; Harvey, 2005, p. 2). This trend has become increasingly evident in care of older persons during the 21st century (Anttonen and Häikiö, 2011; Hoppania, 2019; Hoppania et al., 2022; Hoppania and Vaittinen, 2015; Karsio, 2024). Although free market values do not categorically presuppose instrumentalisation, or vice versa, the inclination to introduce markets into new areas of society increasingly requires that these areas also operate under market legislation. As a result, neoliberalism leads to the "re-commodification" of public sector functions (Pierson, 2001). Based on these principles, care of older persons must be dissected into commodities that can be assessed, bought and sold. For example, as I show in the results section of the study, EHRs, used by over four-fifths of Finnish ISH professionals (Karhinen et al., 2019), are based on strict, predetermined categories into which care professionals force nuanced care events (Hämäläinen and Hirvonen, 2020).

Next, I explore the conceptual basis of the technologisation of care in more detail by focusing on its sociomaterial meanings.

2.3.2 STS and sociomateriality

Contrary to the instrumental understanding of technology, I examine the influence of EHRs and SASs on care settings by concentrating on how they also *reconfigure* what we understand as good care. This perspective necessitates comprehension of *sociomateriality,* meaning that artefacts are understood to enact our lifeworld alongside, and intertwined with, human actors (Gherardi, 2016). The analytical focus in this study on lived care relations prioritises relations between beings capable of experiencing vulnerability over more-than-human assemblages. However, it does not mean that I would reduce technology to a tool-like, passive element within care environments. Such a stance would, and often does, lead to blunt descriptions of the "benefits and drawbacks" of care technologisation, as technologisation devoid of ethical content risks diminishing the ideals and quality of care. As I wrote in the previous section, how we understand vulnerability or care in the first place is produced by complex, structure-forming phenomena, an impactful example of which is technologisation.

Therefore, I build my approach to technology on the work carried out in (STS), with actor-network theory (ANT) as its central approach, where the social elements of any technological or scientific entity are emphasised. Technological artefacts are thereby given an active, performative role. This grants human and non-human actors an equal, preanalytical role when scrutinising lifeworld phenomena. Bruno Latour and Steve Woolgar (1979) famously demonstrated how social factors impact even the results of clinical laboratory work, emphasising how much laboratory work is about informal speech, selective use of data and so forth. Therefore, the foundation of ANT is the "ruthless application of semiotics", which holds that all entities are formed through their relations with other entities (Law, 1999, p. 3). These relations, which bring together the "socio" and the "material" to form an oxymoron, are regarded as separate but inherently interconnected aspects, leading to "material relationality" (ibid, p. 4). In sociomateriality, things are *performed* by and through the material relations they are tangled up in, meaning that the analytical focus is on how things get performed and perform themselves into relatively stable relations and entities (ibid).

Active performativity of material entities is difficult to detect in everyday routine without a sociomaterial outlook. For example, Latour's famous illustration of performativity, written under the pseudonym "Jim Johnson" (1988), is that of an automatic door-closer. The primary purpose, i.e. the *script*, of a door-closer, a technology we now take for granted, is to minimise the amount of cold air entering a building. It has technologised a function previously reserved for humans – people opening and closing doors themselves or for each other when entering and leaving buildings. Latour used this simple little technology as an example of sociomaterial complexity in action in any given setting. The design and engineering of our door-closers and other technologies rarely accounts for all their social, ethical or political impacts; even though the door-closer was fulfilling its script, its mechanical function also presented difficulties for older persons or persons using a wheelchair. In these groups' lives, the door-closer was not a mechanical instrument but rather something that very actively performed change in their daily lives.

The performative aspect of technology means that STS focuses on scripts enforced by non-human artefacts on sociomaterial settings (Akrich and Latour, 1992). As a result of the aforementioned issues, the prescription of an automatic door-closer has evolved into that of an electric door, which prescribes both retention of warm air and accessibility for all groups. Consequently, the prescription of an electric automatic door involves a subtle but noteworthy alteration in social behaviour: we participate less in the customary actions of holding a door open for somebody else. To illustrate non-human performativity in institutionalised care, smart devices with in-built instant messaging applications have gradually emerged as impactful, actor-like entities alongside care workers (Hirvonen et al., 2022). Both top-down applications designed for care work and bottom-up work-related and off-work group chats contribute to determining when, how and by whom care work is performed. Hence, a crucial question arises: is there a *performative* difference between how a human manager and a technological system impact events in a care institution? The sociomaterial perspective requires that materiality inevitably, in overt and covert ways, steers the social and vice versa. Therefore, a nuanced understanding of materiality is crucial to appreciating the complex dynamics at play, for example regarding the technologisation of care of older persons.

Sociomaterial analyses have proven fruitful across many research fields, such as organisational studies (Orlikowski, 2007), hospital settings (Mol, 2002, 2008), as well as various aspects of care. For example, in a volume edited by Mol et al. (2010), *Care in practice: On tinkering in clinics, homes and farms,* the sociomaterial perspectives of care range from veterinary practice to dementia care. Along with clinical hospital care, research on care of older persons has witnessed sociomaterial research initiatives, such as telecare (López and Domènech, 2008; López–Gómez, 2019; Mossfeldt Nickelsen, 2019; Pols and Willems, 2011), dementia care (Driessen, 2018; Moser, 2011; Thygesen, 2009) or home care (Ertner, 2019; Stokke, 2017), which highlight the drawbacks of simplistic perceptions pertaining to technology implementation in care of older persons. In this study, I do not aim to engage in a methodological competition with these studies that frequently adopt extensive ethnographical methodologies and actor-network analyses. Instead, I aim at a selective utilisation of sociomaterial concepts when contrasting ideals of care of older persons with specific technological examples found in ISH work.

2.3.3 Prescription, subscription, taming and unleashing

In this study, *Article IV* offers a sociomaterial perspective on the role of EHRs in ISH work (Hämäläinen and Hirvonen, 2020). We employ Akrich and Latour’s (1992) concept of *prescription,* to depict what EHRs forbid and allow in ISH work, and *subscription,* to depict ISH professionals' reactions to those prescriptions. According to the authors, and Latour's terminology elsewhere (1992, p. 236), prescription exemplifies how any technology follows a predetermined script that informs its design and anticipated usage. An engineer–designer anticipates an *inscribed* user who comprehends and internalises the script as an actor would a screenplay. Therefore, the prescription of a technology also prescribes certain properties and behaviours to users. In reality, the implementation of technology never operates precisely as prescribed, which is why Latour and his followers have introduced the concept of subscription to describe the response of the anticipated users. Subscription occurs when the design encounters a messy and unpredictable everyday life. What is prescribed in the technology may be underwritten, neglected, reformed and rejected by human actors (Akrich and Latour, 1992).

To examine how prescription and subscription occur in the context of EHRs and ISH work, we apply the concepts of Pols and Willems (2011) who expand script theory to illustrate how telecare technologies can either *tame* and *unleash,* or *be tamed* and *unleashed* by, their users in care contexts. These concepts demonstrate how technologies both affect and are affected by care practices. Care technologies tame care workers, as technological prescription may prohibit certain actions in care work, such as the increasing use of telecare, which diminishes embodied presence. Alternatively, care technologies can unleash care work to function in new ways, such as incorporating telecare video calls, unleashing care workers to pay full attention to the content and meanings in the speech of the one receiving care. These are instances of the performative role of technology in care work. Vice versa, human actors also tame the technologies, for example, by bending the prescription of a safety alarm system to reduce the frequency of alarm calls if a care receiver triggers too many alarms. Human actors also unleash technologies, such as engineers designing the safety alarm system technologies which are then sent out as performative actants into the world. I will provide a closer look at these meanings in Chapter 6.2, which describes this study's results on technologisation of care in ISH settings.

2.3.4 The ontological tension between lived encounters and sociomateriality

Next, I admit a certain degree of instrumental attitude on my part in terms of the theoretical choices concerning technologisation in the study. While the previous sections portray how sociomateriality informs the results and arguments related to care technologies in this study as a methodological approach, I admit that its use is narrow and selective, which goes against the grain of the basis of STS and ANT onto-epistemology, where distinguishing between ontological levels of analysis is fundamentally avoided (López-Gómez, 2019, p. 6). My analyses on lived care encounters focus on vulnerable human lifeworlds emerging from intercorporeality, while the sociomaterial analyses on technologies' impacts on those encounters requires selectively extending the focus to more heterogeneous onto-epistemology. Here, the previously presented difference concerning essentiality in phenomenology and poststructuralism is evident, which now requires some clarification also in terms of sociomateriality.

Jeannette Pols (2015) highlights the onto-epistemological difference between STS and care ethics. Pols criticises care ethics by contending that despite its advocacy of relational ethics, care ethicists still often endeavour to establish essentialist definitions of good care, much like I argue in this study. A key theoretical guideline in STS and ANT is ontological *agnosticism* (see for example Callon and Latour, 1992), denying "the intersubjective" or "social" as distinctive reality and favouring sociomaterially heterogeneous entanglements (López-Gómez, 2019, p. 10). The actor-network is, as described by Law (1999, p. 7), "a semiotic machine for waging a war on essential differences" or, according to Latour (1999, p. 20) "a theory that says that by following circulations we can get more than by defining entities, essence or provinces". As a poststructuralist theory, ANT rejects any form of essentiality leading, among other notions, to a demand that non-human actors are granted an equal preanalytical role alongside human actors. Of course, this anti-essentiality also concerns the source of normativity, whereby Pols substitutes care ethics with an "empirical ethics of care":

> Different from care ethics, what care is and if it is good is not defined beforehand [in empirical ethics of care]. A care practice may be contested by comparing it to alternative practices with different notions of good care. By contrasting practices as different ways of living together that are normatively oriented, suggestions for the best possible care may be argued for. Whether these suggestions will actually be put to practice is, however, again a relational question; new actors need to re-localize suggestions, to make them work in new practices and fit them in with local intra-normativities with their particular routines, material infrastructures, know-how and strivings. (Pols, 2015, p. 81.)

In essence, Pols takes an empirical stance on defining care normativity by posing questions of where, by whom and how good care should be defined. Pols calls for careful ethnographical exploration of how giving and receiving care manifest in everyday care contexts. As a methodological perspective, her argument is robust, given that care ethicists may overlook significant practical considerations that are central to how care is enacted, such as the influence of material entities. According to her, the empirical ethics of care cannot lead to prescriptive normativity but rather "suggestions" on what normativities are to be chosen and what are to be discarded. The "re-scriptive intra-normativities" that follow from such analysis can be useful in comprehending the varying ethical aspects that arise from sociomaterial assemblages. (ibid, p. 88; see also Pols, 2023).

While my empirical approach of searching for the essential aspects of care in care professionals' interviews borrows from Pols's ideal of the empirical ethics of care, my theoretical argument and the conclusions of the study do not meet holistically the requirements of analytical agnosticism and sociomaterial heterogeneity of care relations. I share the disconcertment of López-Gómez (2019) concerning the analytical agnosticism of ANT in care contexts, as it may also jeopardise vital aspects of care for the sake of heterogeneity. His view is that instead of the preanalytically agnostic, "almost aseptic" repertoire of ANT, care settings require "political/ethical commitment to the becoming of the persons with whom we become entangled during our inquiries", that is, for whom the experience of care or neglect is primary (ibid, p. 9). This call for a certain degree of non-agnosticism when care is concerned is in line with the ethico-ontological view of care based on phenomenology, whereby our inherent existential vulnerability poses a challenge for analytical heterogeneity. I argue that a preanalytical ontological focus on sociomaterial heterogeneity instead of the phenomenology of vulnerability involves a risk of producing descriptive analyses that miss the point of departure in caring: how experientially fundamental it is to either receive good care, indifferent care, bad care or be left without care, which are ethically vital experiences that can only be appreciated through an existential comprehension of vulnerability. The underpinnings differ not only epistemologically but also ontologically between an agnostic focus on a network of human and non-human entities and care encounters arising between beings who are capable of vulnerability and affection. In line with the circular, two-way movement in the hermeneutical approach, I contend that the re-scription advocated by Pols can be achieved precisely by posing the question "What is care?" at the intersection of theoretical contemplation and empirical material. Contemplating care through the lenses of care ethics and phenomenology, as well as interpreting care practitioners' views of ideal care, bring these two worlds into a dialogue.

Therefore, in this study the sociomaterial reconfigurations of care are secondary to lived care relations, emphasising the ethico-ontological essentiality (in as minimal a sense as possible) that derives from existential vulnerability and embodiment. My view is that the increasing negligence of our most fundamental vulnerabilities in the current neoliberal context needs to be confronted with an understanding that is rooted in ethico-ontological questions concerning the human condition. Emphasising care instead of agnosticism implies "taking sides, participating, acting, making a choice, taking a position" (López-Gómez, 2019, p. 10). In spite of this tension on the level of ontological core arguments in relation to care ethics, in this study I do utilise sociomateriality and empirical ethics, albeit selectively. This choice is simply due to the need to emphasise material performativity instead of instrumentality when exploring how care professionals view the impacts of technologisation on care encounters in ISH. However, this will not mean prioritising the ontological heterogeneity of sociomaterial analysis at the cost of phenomenological meanings found in lived encounters between beings capable of experiencing vulnerability, co-presence and, in an ideal situation, care.

3 SOCIETAL CONTEXT

Empirically, this study focuses on the ideals and materialities found in care professionals' speech on encounters with older persons living in ISH in Finland. In this chapter, I will explain the historical, societal and material surroundings that have shaped the current ISH of older persons.

3.1 A brief history of LTC of older persons in Finland

The origins of care of older persons in late 20th and early 21st century Finland can be traced back to "poorhouses" (*köyhäintalo*), which were introduced in the 14th century and granted official status in the late 19th century following the enactment of a law in 1879 mandating their establishment. These institutions were intended to provide accommodation for parentless children, disabled individuals, older adults lacking familial support and others lacking the means to provide for their basic living requirements. However, these institutions were heavily paternalistic and disciplinary in nature, resulting in work duties, poor working conditions and very marginal rights (Topo, 2011, pp. 879–880.) The general attitudes towards care started to change from punishment to protection in the first decades of the 20th century, partly due to the devastating Finnish civil war in 1918 which had vast psychological, societal and economic impacts. This resulted in a gradual shift from poorhouses with a disciplinary approach to more institutionalised nursing homes, known as municipal homes (*kunnalliskoti*) at the time. Legislation on social protection in 1922 provided the options of institutionalised care in a nursing home, community care given in homes and fees paid for accommodating a person in need (resembling the later separation of care into formal care in nursing homes, formal home care and paid informal care), although the realities of these forms of care varied significantly between municipalities (ibid, p. 881).

However, a definite shift towards recognising older persons as a distinct group with specific care needs only occurred with the 1937 legislation on the national pension system. Though this initial measure granted rights for older persons as a collective for the first time, it was not until the period spanning from the 1950s to the 1970s that care of older persons was truly institutionalised in the form of both benefits and services covering age-related needs. A 1956 legislation granted universal pensions to all citizens aged 65 or above in Finland. Subsidies for healthcare expenses and medicines for individuals in need were provided under legislation passed in 1963. In 1972, healthcare services were made freely accessible in all municipalities (ibid, p. 882). These measures are significant components of the emerging welfare state in Finland and are consistent with developments in other European countries, particularly in the Nordic region (Anttonen and Sipilä, 2000). For older persons with care needs, this resulted in greater use of institutionalised care options, including both home care and care provided in nursing homes. Paasivaara (2002, p. 86) has called the period between 1940 and 1970 in Finland "the great transformation in care of older persons", characterised especially by the systematic building of institutionalised nursing homes. On the one hand, the institutionalisation increased subjective rights in terms of receiving care, larger social benefits and more extensive networks of care, i.e. receiving more extensive and better care either at home or in a nursing home with staff specialising in care of older persons. On the other hand, nursing home care could still be condescending and disciplinary, and the circumstances remained relatively poor (ibid).

In Paasivaara's terminology, institutionalisation gradually led to the era of the expanding welfare state (1970–1990), which emphasised service-centredness and individualistic and humanistic values (ibid, pp. 87–88, 138), and moved away from only providing ″upkeep″ of older persons as well as the bleak realities of nursing home facilities. This change decreased rigid hierarchies within nursing home work and was supported by a more holistic ethos regarding care. This meant that both emotional and more mundane interactions with the residents began to be embraced and promoted. During the emerging welfare state era, work duties within and outside the facilities along with church service were deemed sufficient as residents' activities. However, in the growing welfare state era, a more holistic approach was adopted. This included the introduction of televisions, radios, hobby crafts, facilitated group activities, libraries and so forth to the daily lives of those residing in nursing homes (ibid, p. 139). The change also affected care tasks, where individual needs began to take precedence over rigid structural ideals. This resulted in flexible scheduling for activities such as bathing, feeding and other daily or weekly matters (ibid, p. 140).

The era of welfare state expansion has been defined as one of "de-commodification" of social protection (Esping-Andersen, 1990), where receiving care was viewed as a right to be protected from the private sphere of market mechanisms and, to some extent, family conditions as well. However, a neoliberal shift in governance ethos in the 1990s, described as the "re-commodification" of public sector functions (Pierson, 2001), marked an extensive shift in Finnish care policy. The 1990s recession in Finland, along with an ideological shift denouncing the welfare state as rigid, ineffective and expensive, led to a period named ”renewal” (Paasivaara, 2002), or ”retrenchment” (Julkunen, 2001), of the Finnish welfare state. The shift resulted in care of older persons, along with the rest of the public sector, being subject to an ethos of cost-effectiveness, leading to experiences of increased pressure to work quickly on the part of the care workers (Paasivaara, 2002, pp. 146–147). Although non-public third sector institutions had played a substantial role in the development of the welfare state, their actions serving as a blueprint for expanding public services to new social policy areas, Finnish care policy has shifted its focus towards marketisation, market-like governance and rationalisation measures in order to reduce expenditure during the first decades of the 21st century (Karsio and Anttonen, 2013, p. 87). Similar developments have occurred to varying degrees across Northern Europe (Anttonen and Meagher, 2013).

Care of older persons has experienced a great impact in terms of the restructuring of public social and health services in Finland (Anttonen and Karsio, 2016; Henriksson and Wrede, 2012). In the course of the first decades of the 21st century, care has been increasingly reconfigured by marketisation (Anttonen and Häikiö, 2011; Karsio, 2024; Karsio and Anttonen, 2013; Puthenparambil, 2019), refamilisation (Kröger, 2019, pp. 9–10), managerialism (Hoppania et al., 2021) and financialisation (Hoppania et al., 2022). Legislative reforms have resulted in the displacement of previous partnerships between the public sector and welfare associations, as well as the eradication of universal, rights-based care services for older persons in favour of for-profit providers. From 1990 to 2009, the proportion of social service personnel employed in public services in Finland decreased from 88% to 68%. During the brief period from 2000 to 2009, the number of for-profit service units more than doubled, while the number of non-profit units decreased slightly. The most significant growth of for-profit provision occurred in ISH (Karsio and Anttonen, 2013, p. 87). In 2018, about 40 % of Finnish eldercare services were provided by non-public actors, within which the for-profit share tripled between 2007 and 2018 (Karsio, 2024, p. 35).

Neoliberalism has been understood both in the sense of an ideology, discourse or governmentality and a logic of reorganising the state (Dahl, 2012, pp. 283–284), which has repercussions not only for how states are organised but also for subjectivity, sociality and ideals. The neoliberal shift, connected with ideals of liberalisation, internationalisation and globalisation, included at least the marketisation of public services, New Public Management, an increase of individuals' and families' care responsibilities, quasi-marketisation and managerialism, although the boundaries between these are ambiguous (Streeck and Thelen, 2009). Importantly, since all the empirical data for this study was collected from public service housing units, care given in the public sector has also been impacted by the major shifts in ethos of governance and care policy. Due to the neoliberal ethos of managerialism, extending the private sector ideals of detailed accountability and self-governance to public care, the public sector has also seen the treatment of care as a commodity, as an entity to be dissected, quantified and compartmentalised. These tendencies have been deemed as failed care policy in light of the complexity and depth that sufficient care requires

(Hoppania et al., 2021; Hoppania and Vaittinen, 2015). The increase in control through use of managerialist methods includes a plethora of technologised care practices, such as electronic recording of care tasks, the impacts of which will be demonstrated in the results section of this study.

3.2 ISH as a common site of care of older persons in Finland

From the 1980s until the present day, there has been a significant shift in the contents of residential care services for older persons in Finland, as part of the trend of rationalisation of public services. Traditional institutional nursing home care has been replaced by home care or home-like residential care. ISH (*tehostettu palveluasuminen*) has become the prevailing form of LTC of older persons, rendering traditional nursing homes *(vanhainkoti*) and hospital wards marginal sites of care of older persons. In 2019, 7.3 % of persons aged 75 and above and 15.8 % of persons aged 85 and above in Finland were ISH residents (Finnish Institute of Health and Welfare, 2021a). However, the facilities and living arrangements in ISH may not always vary significantly from those of nursing homes. The key difference lies in the fact that apartments in ISH (which are often quite small rooms by the corridors of rather institutional-like facilities with sometimes hundreds of other residents) must include bathrooms to legally qualify as private apartments. The policy emphasis has shifted from institutionalism towards home care and service housing for two main reasons: connotations of poor quality of care in nursing homes and increasing demands for cost-efficiency (Vilkko, 2000).

ISH provides an invaluable context for analysing care relations. As the name suggests, ISH residents have intensive care needs related to old age, ranging from a constant need for help with bodily functions such as eating and drinking, toileting and transitioning from bed to toilet, to moving from apartments to communal areas and outdoors. According to a 2015 statistic, more than half of ISH's residents have been diagnosed with Alzheimer's or some other form of dementia (Finnish Institute of Health and Welfare, 2021b); however, the current proportion is probably considerably higher. The staff at ISH specialise in addressing the social needs of the residents and have a profound understanding of their psychological conditions, and overall provide the residents with ongoing caring attention. ISH is often the last place of living for older persons with significant care needs, making it a site where every aspect of the resident's life is potentially a matter of care.

The care personnel at ISH work round-the-clock, typically in morning, evening, or night shifts. Finnish ISH professionals possess comparatively high levels of education, with nurses, physiotherapists and occupational therapists holding tertiary level degrees in health and social work, while practical nurses have secondary-level degrees. The secondary-level degree holders include activity instructors, kitchen staff and cleaning staff—with some holding no degree. The housing facilities are typically divided into group homes with 10–20 occupants per unit. The size of the facilities varies by service provider and may include dozens of group homes. ISH as a living arrangement is commonly characterised as a home-like environment, but the facilities range from small home-like units to former nursing homes and other settings that have a more institutional atmosphere (Hämäläinen and Hirvonen, 2020).

Working in ISH is demanding, both physically and emotionally, requiring highly specialised skills. The pursuit of cost-effectiveness has resulted in limited resources being allocated to the LTC of older persons in Finland (Van Aerschot et al., 2022). Shortages in staff and limited time for optimal care have been prevailing issues in Finnish care of older persons for several years. At the beginning of 2019, the deficiencies in the service quality of numerous private ISH facilities broke into the news cycle, triggering a commotion in the Finnish media (Jolanki, 2019). Previous research has demonstrated that experiencing time pressure in care work has risen, acting as one of the main stressors of care workers and a significant cause of their high turnover rate (Kröger et al., 2018; Van Aerschot et al., 2022). As many as 85 % of Finnish ISH professionals report that they cannot do their job as well as they would like to (Karhinen et al., 2019). Compared to workers in other health and social care workplaces and the general workforce, care professionals working in Finnish LTC of older persons have reported significant levels of mental and physical strain, such as poor work-related health, stress and burnout (Van Aerschot et al., 2022), along with being exposed to violence (Vaittinen, 2019). The negative experiences have been reported to result from a lack of support from managers, too few opportunities to influence the way work is done, experiences of inadequacy, feelings of time pressure and a weak worker-client ratio (Kröger et al., 2018; Van Aerschot et al., 2022). The high turnover rate and propensity to quit among LTC professionals, especially younger care workers, can be attributed to a combination of relatively low income and a significant number of temporary work contracts (Kröger et al., 2018; Van Aerschot et al., 2022).

3.3 The current state of technologisation of ISH in Finland

Several policy initiatives have been implemented in Finland to enhance digitalisation in the public health and care service structure, with the goal of reducing costs (Sjögren et al., 2023). Although digitalisation has been widely discussed in Finland, Pekkarinen and Melkas (2019, p. 13) have suggested the need for a clearer state-level steering system. The intrinsic market-drivenness of technologisation has resulted in the proliferation of various systems in the field and among public actors. Recent policies on the technologisation of care of older persons in Finland have notably emphasised technology-aided means of enabling older persons to live at home for as long as possible (Karsio and Anttonen, 2013).

The 21st century has seen a surge in technologisation and digitalisation in ISH as well. Currently, Finnish ISH is a highly technologised field, where care professionals work with a variety of different digital devices and systems. *Table 1* presents the findings of a recent study by Karhinen et al. (2019), which shows the frequencies of technology usage among Finnish ISH professionals:

Table 1 Percentages of ISH professionals reporting use of different technologies (Karhinen et al., 2019).

email	86 %	digital movement sensors	22 %
electronic health records	84 %	electronic access control for residents	22 %
desktop computers	79 %	instant messaging applications	18 %
electric patient lifts	70 %	entertainment technology (video games etc.)	14 %
safety alarm bracelet systems	60 %	video communication technology (Skype etc.)	13 %
smart phones	52 %	digital tablets	9 %
laptop computers	40 %	rehabilitation technology	5 %
safety phone systems	39 %	social robots	0.9 %
non-smart mobile phones	38 %	medication dispensers	0.7 %
enterprise resource planning systems	27 %	video telecare equipment	0.4 %

The two technologies under scrutiny in this study, EHRs and SASs, along with electric patient lifts, are the most commonly used digital technologies in ISH work if common technologies such as phones and computers are excluded (ibid).

Karhinen et al.'s (ibid, p. 37) study also highlights how technologies are generally integrated into daily ISH work. Out of all respondents, 21% use digital technologies for half or more of their work time, while 76% report using them for less than 25% of their work time. Only 3% of care professionals report not using digital technologies in their work.

The study also reports on how ISH professionals view the impact of technology on different dimensions of ISH work (ibid, pp. 41-47). Technologisation is seen to cause a burden, as 73% report an increase in workload due to technologisation, 13% report experiencing constant discontinuities in work caused by technology, while 28% report experiencing them daily and 26% report experiencing them weekly. Out of all respondents, 56% feel that a lack of technological skills hinders their work in ISH, although 48% report only moderate hindrances. Reports of insufficient technological support on the part of the employer are given by 52% of ISH professionals.

Additionally, the study reports the impacts of technology on the quality of ISH work and care relations (ibid, pp. 41–47). The results are somewhat ambiguous, as 45% of ISH professionals believe that technology has improved their ability to perform their job well, while 50% disagree. In terms of interaction with residents, 38% report that technology has reduced face-to-face interaction, while 43% report that it has not. Out of all respondents, 49% believe that technology has improved the safety of residents, while 27% disagree.

A closer look at how especially EHRs and SASs impact ISH care practices and relations will be provided in Chapter 6.2. Next, I will present the data gathered by interviewing Finnish ISH professionals, along with the methodology and ethical considerations of the study.

4 DATA AND METHODOLOGY

In this chapter I present the data and methodology forming the basis of the empirical analyses of the study, along with theoretical and ethical considerations related to the methodological choices. The following subchapters will concentrate on *Articles II, III* and *IV* that present results drawn from empirical data. The analyses, methods and authors' roles have been elucidated in *Appendix 1*. *Article I,* however, is a theoretical exploration of the essential aspects related to the concept of care. It does not include explicit methodology in the form of, for example, conceptual analysis, which is sometimes utilised in philosophy. Rather, it engages in a theoretical discussion on the literature of care ethics, social ontology and phenomenology to establish a re-conceptualisation of care relations, and uses the re-conceptualisation to scrutinise how technology is adopted in practices of care for older persons.

4.1 Interviews with Finnish ISH professionals

Three articles that form the basis of this PhD summary (*Articles II, III* and *IV*) report empirical results drawn from qualitative, semi-structured interviews conducted in autumn 2018. The data corpus, referred to as *ICTCare data*, was gathered in collaboration with my colleague, Dr. Helena Hirvonen. Approval was acquired from the Ethical Committee of the University of Jyväskylä before the data collection (18.6.2018, see *Appendix 2*). The interviews (n=25) were conducted with care professionals employed in sites of ISH units in two cities in central and southern Finland. The study participants consisted of 14 practical nurses (with a secondary-level degree), eight registered nurses (with tertiary level degrees; two of whom held executive positions in their workplace), two activity instructors (with either a secondary or no degree) and one occupational therapist (with a tertiary level degree). Of these, 23 were women and two were men, and their ages ranged from 24 to 57 years, reflecting the gender distribution and age range typically found in the Finnish workforce engaged in care of older persons.

The work of care professionals in Finnish ISH is primarily hands-on. All the participants, except for one manager, performed practical daily care duties such as bathing, testing, assisting residents in and out of bed, feeding, escorting to social events and providing company. They also completed additional tasks such as documenting information in EHRs and quality assessment systems, responding to SASs' call-button alarms, ordering supplies and accessories and communicating with residents' relatives and those close to them.

The interviews were planned by discussing prevalent themes in ISH work with Dr. Hirvonen, namely technologisation, high levels of mental and physical burden, ideals of care, marketisation, diversification, responsibility, gender issues, ethnicities and work control. This led to a semi-structured interview framework (see *Appendix 3*), which consisted of loosely constructed themes that guided the interviews. Background content, experiences of previous workdays, mental abilities, emotions, workplace safety, issues regarding ethnicities and gender, distinctive features of care, meanings and specific examples of ideal care relationships and events, as well as responsibilities and the capacity to manage work in ISH were all considered during the interviews. An overarching aim was to systematically explore the impacts of various technologies on all of the above topics. Additionally, the informants were asked what technologies they used in their work and how they viewed the technologisation of ISH care settings and care of older persons in general.

The participants were primarily recruited through care unit managers and by sending out a call through email lists of the units. The majority of the interviews took place at the workplaces of the informants, with one being conducted at the premises of the University of Jyväskylä and another at my own residence, as per the informant's request. Despite the extensive interview framework, the overall length of the interviews was acceptable, ranging from 50 to 130 minutes, and the interviews offered an insightful overview of the dominant aspects of ISH work. The interviews were recorded on-site and subsequently transcribed by a transcription service.

4.2 Three separate thematic content analyses

Articles II, *III* and *IV* included in this dissertation all employed the ICTCare data. Moreover, all three studies were conducted according to a similar research methodology, adhering to the tenets of thematic content analysis (Boyatzis, 1998; Braun and Clarke, 2006). Thematic content analysis is a flexible analytical tool for interpreting qualitative text data, as it is not tied to any particular theory or epistemology (Braun and Clarke, 2006, pp. 4–5). It is based on identifying, analysing and reporting patterns in data, thereby providing rich and complex interpretations of the given subject. A *theme* captures something significant in the data in relation to the research question and elucidates patterned meanings within the data set. Furthermore, quantity regarding the patterns is not necessarily prioritised, as qualitative interpretation is based on a holistic interpretation of a text (ibid, p. 10).

In this study, *data corpus* refers to the entirety of the transcribed interview data, whereas *data set* refers to the combination of extracted parts of the data corpus, encompassing all individual and coded chunks of data, i.e. *data extracts*, related to the topic at hand (ibid, pp. 5–6). Both the data corpus and the data set must be read repeatedly to avoid missing something crucial in terms of the thematisation and in relation to the research agenda.

The approaches in all three analyses conducted in this study were inductive rather than theoretical (ibid, p. 12). Of course, the analyses were all impacted already by how the interviews were thematised using a loose interview frame (*Appendix 2*), resulting from our preliminary theoretical insight concerning, for example, care, technologisation, socio-political milieu and so forth. However, it was possible to freely drift towards any subject in the interviews, which provided a rich data corpus for the analyses.

In each of the analyses, the process of thematisation involved several stages: two to three rounds of reading through the entire data corpus, preliminary thematisations by highlighting and colour-coding relevant paragraphs, sentences and words, rereading the entire data with the highlights, narrowing down the corpus to data sets including relevant content according to the research settings, thorough reading of the data sets, thematisation of the data sets, rereading the data corpus with the thematisations in mind (with an emphasis on what might be missing or misinterpreted), rereading and rethematising the new dataset and producing a report using the contents of the final thematic structure.

Although the methodological approach itself was similar in each case, the themes and the researchers' responsibilities varied between analyses (reported fully in *Appendix 1)*. In *Article II,* I conducted the thematic content analysis to explore what aspects of knowledge emerge in ISH workers' talk about their everyday experiences of care work. This analysis was conducted by me alone. The interview frame included a specific theme that covered questions of what is included in good care, which helped in conducting the analysis. However, as talk about good care practices and related knowledge were dispersed throughout the data corpus, the first phase of the analysis involved careful reading, notetaking and identification of terms, sentences and segments where the respondents discussed interaction with residents, as well as the factors and principles associated with ideal care interactions in the ISH of older persons. These excerpts led to a separate data set consisting of 38 pages of interviews. They were then carefully scrutinised several times to identify any explicit or implicit insights on how knowledge in care settings was perceived by the respondents. This process involved identifying and colour-coding specific words and phrases used by the informants in relation to decision-making, information use, knowledge, truth, intuition, or empathy when addressing the care needs of residents. After multiple readings of the data set, along with a reaffirming read-through of the entire data corpus, four thematisations of knowledge necessary in ISH care encounters were identified: objective/objectifying knowledge, particular knowledge, corporeal knowledge and tacit knowledge. (Hämäläinen, 2022, pp. 6–7.)

Article III engages in a thematic content analysis of ISH professionals' talk about what kind of temporal practices are at play in ISH professionals' care interactions with older persons with dementia. All three authors participated in the analysis process. First, I read all of the data corpus in full and extracted words, sentences and segments related to temporality (excluding work career reports, temporalities outside work and interviews with service managers not involved in hands-on care work) into a separate data set. This data set consisted of 52 pages of data. A further round of analysis was then conducted by the third author, who omitted sections unrelated to temporalities associated with ISH professionals' care interactions with residents (for instance, speech about work schedules). This resulted in a data set of 28 pages. All three of us then independently analysed the data set, searching for evidence of temporal attunement with regard to dementia in the informants' first-hand experiences of care of older persons. The resulting analyses were then compared and thematised together in a structure that presents ISH professionals' practices of attuning to the alter-temporalities of residents with dementia as three distinct but intersecting aspects: understanding temporal alterity followed by receptive and expressive practices of temporal attunement (Hämäläinen et al., 2024, p. 8.)

In *Article IV*, we conducted a thematic content analysis to explore the views of care professionals regarding EHRs used in ISH work. The analysis was primarily conducted by me, with the second author providing support and analytical insight during the later phases of the analysis. First, I highlighted and extracted the segments in the data corpus related to EHRs, which were then reread to identify preliminary views on EHRs as part of ISH work. Finally, the analysis generated a data set including 14 empirically closed codes that covered various issues, including the different typifications of systemic information and experiences of the different ways in which EHRs affect ISH work. This final stage of the analysis was conducted by discussing the themes with the other author. Utilising the theoretical frameworks of prescription and subscription (Akrich and Latour, 1992) and taming and unleashing (Pols and Willems, 2011), the analysis condensed the 14 codes into six and divided them into two categories demonstrating the meanings of EHRs as part of the sociomaterial landscape of ISH work (Hämäläinen and Hirvonen, 2020, p. 3.)

4.3 The methodological underpinnings of the study

Qualitative analysis never follows a linear process of reduction, clustering and abstraction, although all these different perspectives and analytical actions are necessary for a thorough analysis of any subject. This is also evident when reviewing the analyses of the articles, which were conducted separately and at different times, resulting in a cumulated insight into meanings of care, whereby the contents and the possibilities of the data were shown in a different light.

While the four articles are mentioned in this summary in a sequential manner, in reality the path is akin to that of a winding road or, in a hermeneutic view, perhaps a carousel with irregular rotational speed. The arrangement of the articles from *I* to *IV* in this study assists in the presentation of this summary text, however, their chronological order differs from it. In reality, the articles were written and published in the following order: *Article I, Article IV, Article II* and *Article III.* I followed the structure outlined in this summary in order to present my arguments on the contents of lived care encounters first, and then to contrast them with the technologisation of care. However, in terms of the analyses, the approach has not of course been as straightforward as it appears. The analytical foci and results of earlier analyses, such as sociomateriality in *Article IV* or epistemology in *Article II,* have influenced the ideas and the analytical focus of the subsequent articles' analyses of care.

These examples illustrate that qualitative analyses are never driven by content alone, but rather by hermeneutic interpretation, where the understanding of the whole derives from grasping each individual part, which in turn must refer back to the whole (Gadamer, 2004, pp. 293–294; see also Heidegger, 2010). In isolation from the whole text, a word, sentence, or segment is not meaningful. Without the word, sentence or segment, the meaning of the whole text also changes. Hermeneutics therefore refers to a means of *interpreting* the world. According to Gadamer (2004), this is achieved through the hermeneutic experience of the world, which involves expanding our experience through prejudice, familiarity and common understanding. This experience in turn repositions itself as a new part of the whole, transforming a previously structured and ordered world. Therefore, interpretation resembles a conversation that takes place in a dialectic form of question and answer (ibid, p. 391). Hermeneutic interpretation is applicable to any expressive act or setting, be it a text, an utterance, a situation, a work of art, an institutional milieu and so on.

Therefore, understanding the meaning present in an interview, a transcription of the interview and the resulting analysis requires a hermeneutical perspective. None of these include "pure meanings", rather, as manifestations of expression they open up possibilities of interpretation. For example, the use of thematic interviews with a particular group means that a number of perspectives on the research outcomes are decided beforehand by the researcher. It is important to note that the hermeneutical perspective should not be considered closed (as in prefixed) or open (as in relativist), but rather as a projection between the "fore-projection" and the "what is there", as presented by the existence of the text itself:

> A person who is trying to understand a text is always projecting. He projects a meaning for the text as a whole as soon as some initial meaning emerges in the text. Again, the initial meaning emerges only because he is reading the text with particular expectations in regard to a certain meaning. Working out this fore-projection, which is constantly revised in terms of what emerges as he penetrates into the meaning, is understanding what is there. (Gadamer, 2004, p. 269).

However, the obvious shortcomings of this thesis are methodological, in that the study's extensive claims concerning the nature of ideal care relations could benefit from a more thorough empirical examination of the lived relations themselves, or at least including also ISH residents' interviews. The choice of a methodological approach such as participatory observation of ISH could have provided opportunities for interpreting lifeworld care relations. However, the analysis of interviews with care professionals offers distinct opportunities for exploring the contents of ideal care encounters. The interview context, in which care professionals discuss the contents and meanings associated with care through an interview framework that enables, for example, ethical considerations of care, has a potential to generate different insightful perspectives and avenues of inquiry. Providing round-the-clock residential care of older persons is closely related to a plethora of aspects of care – the physical, emotional, social and existential questions are faced day by day, night by night, minute by minute – which means that ISH professionals are experts in ensuring holistic attentiveness to another person's daily needs. Of course, with this study's approach of interviewing ISH professionals only, the perspective of older persons' experiences of ideal care is completely missing from this study, which can be read as a major methodological shortcoming. Although the understanding of care in this study emanates from vulnerability, the empirical context itself stays on the level of exploring aspects of car*ing* on part of the caregivers. This tendency in care ethics has been criticised at least by Vaittinen (2015, 2022), and future research endeavours on lived care encounters should have a more encompassing methodology.

4.4 Ethical considerations

When conducting qualitative data gathering and analysis in delicate work settings, research ethics need to be carefully considered. Therefore, before conducting the interviews, we applied for a pre-evaluation of the research setting from the Ethical Committee of the University of Jyväskylä, which resulted in approval after minor clarifications (18.6.2018, see *Appendix 2*).

Before conducting the interviews, the interviewees read and signed an information and consent document (ICD, see *Appendix 4*), informing the informants about how and for what reasons the study would be carried out. The ICD included background information on the study and explained the significance of elaborating ISH professionals' views on care of older persons due to the current structural transformation and technologisation of care work. The ICD also informed the interviewees that the data would be collected only for the use of the project *New technologies, ageing and care* -research group of the *Centre of Excellence in Research on Ageing and Care* -research project and could only be used with the permission of the responsible collaborator (Prof. Sakari Taipale, who led the research group) during the project period (2018–2025). Additionally, the ICD stressed that participating in the interviews was voluntary, that the interviews would be conducted outside working hours and that the interviewees could withdraw their participation at any point during the interview or afterwards during the project period without stating a reason for the withdrawal.

Furthermore, the ICD included information on confidentiality, anonymity and means of storing the data. The privacy of the informants was carefully attended to throughout the process. The digital recorders used in conducting the interviews were set to carry out live encryption of the voice data. After each interview, the recordings were instantly transferred to a password-protected folder within an online data storage provided by the University of Jyväskylä, which ensured the privacy of the data storage. All audio data was then removed from the recorders. When conducting the analyses, data sets acquired from the data corpus were all anonymised in terms of all recognisable pieces of information including names, places, specific histories and so on. The datasets and the final analyses used coded information signifiers to distinguish the informants from each other. A password-protected document connecting the coded signifiers and the data corpus was kept in a protected online data storage provided by the University of Jyväskylä. The interviewees were informed that the data would be transferred to The Finnish Social Science Data Archive for long-term storage after the project period (2018–2025) and that at that point the data corpus would be anonymised, and all aforementioned signifiers would be destroyed.

Before the study, we also acquired research permits from the two cities' housing services departments. The participants were primarily recruited through care unit managers and by making an appeal using the email lists of the units. I acknowledge the possibility that this sampling method may have provided us with a select and slightly biased group of informants. Additionally, my prior work experience may have impacted the interview situations and thus contents in some way, but probably it helped to relax the interview situations, as I had some prior understanding of what the informants were talking about. On the other hand, it may also have hindered my ability to take an outsider's perspective on their work. A mixture of two researchers conducting the interviews, one of whom had occupational experience and one who did not, was probably fruitful, resulting in a rich data corpus.

I, or any co-author to my knowledge, did not use artificial intelligence in this study, with the exception of language correction (DeepL Write) prior to the pre-evaluation of the study. The very final version of the study underwent language correction by a human proofreader (Anchor English).

5 SUMMARY OF ARTICLES

Article I, Hämäläinen (2020) 'Responses to vulnerability – care ethics and the technologisation of eldercare', published in *International Journal of Care and Caring,* argues for a re-conceptualisation of care relations. The re-conceptualisation is then utilised to examine the way technology is implemented in care of older persons. The article begins by defining care as attentiveness to vulnerability, as it is understood in the tradition of care ethics. After that, the article outlines four key aspects of care relations: relationality, dyadic mutuality, corporeality and devotion. It then contrasts these aspects with the idea of the sociomaterial intertwinement of technological and human actors in care practices. Finally, this article uses two examples of telecare to demonstrate how the essential aspects of care can help in understanding the technologisation of care of older persons.

Article II, Hämäläinen (2022) 'The epistemological complexity of ideal care – ISH professionals' perspectives', published in *International Journal of Care and Caring,* explores what aspects of knowledge ISH professionals emphasise in relation to everyday ISH practices. The article draws on the ICTCare interview data and contributes to discussions concerning the epistemological basis of care. The analysis identifies four epistemological dimensions in ISH work: objective/objectifying, particular, corporeal and tacit. Consistent with existing literature on knowledge and care, the results suggest that rational-technical epistemological approaches are inadequate when dealing with fluid and nuanced care relations. Additionally, dementia and other epistemologically idiosyncratic aspects of care of older persons showcase previously under-researched perspectives on both care and epistemology.

Article III, Hämäläinen, Leinonen and Era (2024) 'Attunement as a practice of encountering dementia time in long-term eldercare work', explores the temporalities of care work in the societal context of increasing proportions of older persons with care needs and demands of cost-effectivity. Allocating care work into units and subtasks requires that time is understood as linear clock-time. Through the use of ICTCare data and thematic content analysis, we examine how care professionals themselves talk about their temporal experiences and practices concerning care interactions in long-term dementia care. Our analysis reveals how achieving ideal dementia care cannot be solely based on a quantitative understanding of time. Rather, we showcase the importance of a qualitative temporal perspective. By utilising the concepts of temporal duration (Bergson, 2014), crip time (Kafer, 2013) and dementia time (Yoshizaki-Gibbons, 2020), we argue for an understanding of alter-temporal experience, towards which care is ideally directed. We argue that a concept of attunement is necessary to fully comprehend the ideality within temporal practices of dementia care. Our analysis distinguishes practices of temporal attunement into three different aspects: an understanding of dementia time, receptive practices and expressive practices. Additionally, the analysis describes the institutional limitations of attunement, such as a lack of staff and technological disruptions.

Article IV, Hämäläinen and Hirvonen (2020) 'Electronic Health Records reshaping the socio-technical practices in Long-Term Care of older persons', published in *Technology in Society*, presents an analysis of Electronic Health Records (EHRs) in ISH based on sociomaterial core assumptions. The aim of EHRs is to improve resident-centred care by enhancing information clarity and coordination between ISH workers and organisations. Research has produced ambivalent results regarding these intended outcomes. Our article analyses the potential unintended consequences of using EHRs in ISH. The article argues that to scrutinise EHRs in ISH, one must understand their implementation as sociomaterial processes. EHRs are regarded as performative artefacts rather than passive technological instruments. Although EHRs have been analysed in healthcare contexts, the context of care of older persons has previously been under-researched. We draw from a qualitative interview study (n=25) conducted in 2018 with Finnish ISH professionals (ICTCare data). Through thematic content analysis, we show how ISH professionals negotiate and interpret sociomaterial practices of EHR use in their workplace. Our results indicate that while EHRs may improve accountability, they are also perceived as disorganised, unrefined and burdensome. The results indicate that the intended effects of EHRs may disrupt the nuanced characteristics of caring.

6 RESULTS FROM THE ARTICLES

In this chapter, first, I present this study's results on what kind of aspects care professionals speak of as crucial in lived care encounters, followed by an analysis of the relevance of these aspects in relation to central technologies in current ISH settings in Finland. The results are presented according to two research questions (RQs):

> RQ1: "What kind of essential aspects of lived care encounters emerge in the speech of care professionals working with older persons?"
>
> RQ2: "How do care professionals' views of central digital technologies of round-the-clock care work relate to these essential aspects of care?"

These RQs function on the level of the PhD summary, meaning that they derive from the differing research settings, questions and results of the four research articles on which this study is based. Therefore, the following results combine care professionals' views on topics such as knowledge or temporality required in care work into essential aspects of lived care encounters. As expected by the hermeneutical methodological underpinnings of this study, the following results have impacted the formation of the theoretical arguments presented earlier in this study, which in turn have affected how the results on the level of the PhD summary are presented. This means that the results are delineated in terms of the analytical foci arrived at in the theoretical section of this study: care ethics understood in terms of both ethico-ontological and politico-structural conceptions constituting our understanding of care, resulting in two separate concepts of care that function together: care as a lived encounter and care as a relational structure. The following results will concentrate on the former perspective on care, without forgetting the relational structures when considering what the results mean within/for broader policy contexts. Similarly, the results concerning the digital care technologies examined are in accordance with sociomaterial theoretical perspectives on technology.

My answer to RQ1 will elaborate what care as a lived encounter entails in ISH professionals' interview speech. Therefore, it will have an empirical emphasis, while also building on the departure point of the theoretical *Article I*, where the content of lived (in the article referred to as "immediate") care relations is initially described in terms of relationality, dyadic mutuality, corporeality and devotion (Hämäläinen, 2020). These essentialisations will be revisited with the help of the empirical results of *Article II*, which investigates the meanings related to knowledge and insight in care professionals' talk about ideal care relations and encounters (Hämäläinen, 2022), and *Article III*, which investigates the meanings of temporality and alterity in care professionals' talk about ideal care (Hämäläinen et al., 2024).

While a comprehensive argument on the technologisation of care in terms of the lived aspects of care is not possible with the empirical results at hand, my answer to RQ2 begins with *Article IV,* providing results on the sociomaterial impact of a central technology on the ISH of older persons and on EHRs, highlighting some tensions in how the technologies are situated in relation to ideal, lived care encounters (Hämäläinen and Hirvonen, 2020). Furthermore, *Article III* highlights the impact of safety alarm systems (SASs) on care professionals' practices of temporal attunement to dementia (Hämäläinen et al., 2024). Finally, these results are contrasted with the previous arguments concerning lived care encounters.

6.1 The essential aspects of care as a lived encounter

Having narrowed the analytical focus of the study down to care understood as a lived encounter, in this section I outline how the essential aspects of such encounters emerge in care professionals’ talk about encountering older residents in ISH settings. In *Article I,* I theoretically elaborate on the essential aspects of ideal, immediate care relations, including relationality, dyadic mutuality, corporeality and devotion (Hämäläinen, 2020). In the article, through the first three aspects, I argue that care is ideally about addressing the needs of a particular person by another particular person, which always happens in terms of corporeally manifest gestures, whereas devotion refers to the concrete response needed for the other aspects to be actualised. Further examination of care ethics, phenomenology and care professionals' interviews has shown this framework to be too ambiguous, which is why this PhD summary can be read as a theoretical and empirical broadening and improvement of the arguments presented in *Article I.* I will reconfigure the aforementioned framework with the help of empirical results acquired in *Article II* (Hämäläinen, 2022) and *Article III* (Hämäläinen et al., 2024), along with perspectives on alterity and embodiment as portrayed earlier in the theoretical arguments of the study.

I will detail *alterity*, *embodiment* and *attunement* as the ethico-ontological foundation for comprehending vulnerability within lived care encounters. As we will discover, these aspects are not mutually exclusive but rather interconnect and complement each other when encountering the vulnerability of the Other.

6.1.1 Navigating from objectivity to alterity is key when encountering vulnerability

As I elaborated earlier, care is an idiosyncratic human activity that ideally originates in an experience of encountering vulnerability manifest as embodied alterity. This argument is evidenced by qualitative results drawn from *Article II* (Hämäläinen, 2022), which investigates aspects of knowledge that care professionals working in ISH deemed crucial for ideal care encounters.

In this section I describe the aspects of encountering the resident ideally as a particular person; however, it is first important to note that the results also showcase how care is partly about objective knowledge derived from general means of acquiring care knowledge (Hämäläinen, 2022, pp. 7–8). This means biomedical assessment of the body(-object), as in examining symptoms and samples and interpretation of the resulting numeric values in the light of general medical information and knowledge about their relations to diseases and conditions. In these cases, the epistemological interest is in finding the *cause of the symptoms*. This is no surprise in light of the extensive, physical care needs connected with the residents' old age in ISH. Attending to needs in ISH partly requires pre-contextual knowledge detailing health-related information; however, according to the results this is the case particularly when the care professionals are not yet familiar with the person in need of care, resembling the onto-epistemology found in hospital settings, where quick medical judgement and action is key (ibid).

However, compared to hospitals, everyday care needs in ISH are more holistic in character and of unclear and sometimes unlimited duration, meaning that objectifications may undermine practices of attending to ISH residents' needs. ISH professionals have to navigate within both the "decontextualised space of evidence" (whether medical or otherwise instrumental) and "the personal space" of the resident (Purkis and Bjornsdottir, 2006). When discussing what constitutes ideal ISH care encounters, care professionals talk extensively about the importance of recognising the individual preferences, personal histories and particular needs of the care recipients, showing how a significant part of ISH work involves empathetic and holistic insight on alterity (ibid, pp. 8–10). The focus in these views is on uniqueness instead of generalisations and on interpreting what a resident as a historical being needs at a particular moment, i.e. as a historical, holistic subjectivity that inevitably differs from that of the caregiver. Thus, according to the results, if there has been ample time to acquaint oneself with the resident's uniqueness, a simple look or gesture may elicit a caring attitude and action (ibid, p. 8). In other words, understanding the *momentary manifestation of alterity* in the encounter is crucial. ISH professionals must constantly integrate sometimes logically conflicting knowledge domains into their daily work, as emphasised in their eloquent speech on the significance of trying to put themselves in the residents' shoes.

In *Article II,* lived care encounters in round-the-clock care of older persons are also situated in a particular vulnerability context related to old age: care of older persons in ISH is to a great extent about encountering dementia, whereby the demands of alterity are revealed in their full scope (Hämäläinen, 2022). The informants use various methods to navigate epistemological conflicts inherent in dealing with dementia and to manage the ongoing uncertainty concerning what is true for each person. This was demonstrated, for instance, through the use of "truth therapy", in which the care professional gently guides a resident with dementia away from longing for their parents, instead of "insisting on the truth" (ibid, p. 9). This is typically achieved through communication, by exploring the emotions behind statements and spending time with the resident to discuss *why* they miss their family, ultimately resulting in emotional connection rather than detachment. Such a communicative practice emphasises the alterity of the care recipient as the foundation of care, rather than relying on objective, instrumental truth evaluations (ibid, p. 9). Lindholm (2015) has presented similar results on care professionals' skilled responses to "confabulations" of persons with dementia:

> Confabulations should not be regarded as disoriented, unrealistic contributions, but rather important openings into the life history of the person with dementia. We can access this life history if we just listen sensitively, wait quietly, provide nonverbal attention, and allow time for what persons with dementia have to say. (Ibid, p. 196.)

This careful navigation is also in line with Driessen's (2018) notion of *will-work*. By will-work, Driessen draws attention to how managing attention and sculpting moods and emotions are inevitable aspects of good care, residing in "the space between doing nothing and exerting force" (ibid, p. 125). The notion that both neglect and coercion will lead to poor care emphasises the epistemological complexity and ambiguousness of care practices, where interpretation and alignment with care needs in unique contexts are at the core of action.

Furthermore, understanding alter-vulnerability as an important part of lived care encounters can be examined through the lens of temporality, as we show in *Article III* (Hämäläinen et al., 2024). In the article, we contend that ideal dementia care necessitates a comprehensive grasp of *temporal alterity*, enabling a comprehension of another person's alter-temporal experience, which care can strive to enter, align itself with and influence (ibid). In the article, and in concert with the notion of *lifeworld* in Chapter 2.2, we consider time as a lived and qualitative experience, following Henri Bergson's philosophy, where time is understood as *duration (durée*) (Bergson, 2014, pp. 100–106). According to Bergson, time occurs within/as duration, rather than as quantitative, instrumental change as we have perceived it since the invention of clocks (Guerlac, 2006, p. 1). In this shift in focus, the immeasurable and subjective temporal experience takes analytical precedence over the objectively acclaimed knowledge of time. The issue with symbolic temporality is that it suspends and restricts what we experience as an immediate occurrence in our temporal flow (Guerlac, 2006, p. 19).

For temporal duration to be of significance regarding care relations, i.e. to combine qualitative temporality and alter-vulnerability, an understanding of the idiosyncratic essence of care needs related to dementia is needed. First, we utilise concepts borrowed from critical disability studies – *crip time* and *dementia time* – which highlight the alter-temporal dimensions of disability and dementia:

> Crip time is flex time not just expanded but exploded: it requires reimagining our notions of what can and should happen in time, or recognising how expectations of "how long things take" are based on very particular minds and bodies. [...] Rather than bend disabled bodies and minds to meet the clock, crip time bends the clock to meet disabled bodies and minds. (Kafer, 2013, p. 27.)

> Dementia time, as an extension of crip time and queer time, is a temporal dis/orientation that challenges and disrupts normative and dominant forms of time. Dementia time involves focusing on a particular moment in time and space and embracing that individual moments may be self-contained, nonlinear, intermittent, irrational, and idiosyncratic, yet are no less meaningful or valuable. (Yoshizaki-Gibbons, 2020, p. 103.)

Following these perspectives on care and temporality, our qualitative analysis of care professionals' speech on ideal care encounters presents *attunement* as a temporal attitude and action directed towards the vulnerability of the Other, with a focus on the care of older persons with dementia in ISH settings. When asked about ideal care and practices of meeting the needs of persons with dementia, the informants commonly discussed the need to understand the alter-temporalities of dementia to ensure adequate care (Hämäläinen et al., 2024, p. 8). These descriptions of temporal alterity pertain to dementia time (Yoshizaki-Gibbons, 2020). For instance, the informants discussed the importance of approaching the residents with "sensitive antennas" and "recognising their moods", in order to attune to their lived, temporal experience. As one informant said, it is important to make temporal adaptations by "slowing down the pace". According to another informant, "the residents don't have to hurry anywhere and can't perhaps do things quickly, so why require quickness from them?" (ibid, p. 8).

Therefore, attunement represents a fundamental aspect of relating to alterity. Recognising vulnerability in the Other and adopting an empathetic position towards their situation *happens* through the process of shifting and negotiating temporal perspectives. Attunement includes a careful movement between understanding the situation from the alter-temporal perspective of the other person and helping this alter-temporal perspective align with, for example, an intimidating event such as bathing, lifting or another intricate bodily action by careful commentary or embodied steering of the events. Our results on temporal attunement evidence what Merleau-Ponty and his academic followers call *intercorporeality* (Merleau-Ponty, 1968, p. 143; Diprose, 2012; Hamington, 2004; Weiss, 1999; Fuchs and De Jaegher, 2009), where interaction is seen to arise as co-presence that exceeds the sum of its parts. For example, an audience listening to a speaker, or musicians playing together, coordinate their movements according to the other's infinitesimal movements, in however minimal and unnoticeable ways, participating in each other's sense-making (Fuchs and De Jaegher, 2009, p. 470). The results above show that care professionals' dispositions depart to a great extent from an understanding of intercorporeality, especially when dementia is concerned. Later in this chapter, regarding the topic of attunement as a moral *action* that derives from understanding intercorporeality, I will showcase attunement practices that follow from this understanding of alterity as practices of receptivity and expressivity. However, first I will engage in further exploration of embodiment's place in the lived care encounter in ISH.

6.1.2 Embodiment constitutes encountering alterity

To continue from the above notions on intercorporeality, the articles' results further indicate that embodiment in its holistic, meaning-making, phenomenological sense, that is, not simply as the body-object, is at the heart of care professionals' understanding of the residents' alter-vulnerability. Care professionals are skilled in interpreting situational needs through gestures, postures and expressions, as presence and touch can facilitate understanding of experiences, intentions, wishes, emotions and general well-being (Twigg, 2000). Embodiment, an often overlooked area in Western mainstream philosophy as well as in gerontology, provides an antithesis to the rationalism of the Enlightenment that has reduced the significance of the body and emotions in human definition through logical reasoning, control and abstraction (ibid). This trend of disregarding the body and its sensations is prominent also in contemporary neoliberal and managerialist care practices where embodiment has no place (ibid, pp. 8–9; Hoppania and Vaittinen, 2015; Vaittinen, 2015, 2017, 2022).

Understanding embodiment is especially important in terms of ageing since physical and cognitive capacities tend to deteriorate towards the end of life. *Article II* (Hämäläinen, 2022) displays how when care professionals describe alterity in ideal care events, they eventually end up giving intricate descriptions of embodiment. The descriptions may also encompass decontextualised knowledge of the body (as a general body-object), including medical information, sensory recognition of pain or other means of discerning physical changes in the body, which are required when there is insufficient particular knowledge about the person (Hämäläinen, 2022, pp. 7–8). However, as they contemplate the most important aspects of care relations within long-term care environments, their speech shifts towards gestures, expressions, tones, presence, postures and the changes and unfamiliarities related to such embodied events (ibid, pp. 10–11).

When encountering a person with dementia that has developed past its early stages, the propositional[6] aspects of language may become irrelevant, as indicated by an informant who stated: “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” (ibid, p. 10). The results of *Article II* include many reports where

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[6] Language understood as patterns of symbols, marks and sounds that make up meaningful declarative statements that can be regarded as true of false.

the care professionals talk about dementia as something that pushes them to find alternative solutions in the moment. These notions are repeatedly connected with bodily expression: "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'" (ibid, p. 10). In such cases, differentiating between the will of "the mind" and the will of "the body" becomes obsolete. Dementia necessitates a completely different approach to interpersonal communication, and, I would argue, therefore presents a significant challenge to any systematic moral or epistemological theory. The alterity at the heart of care manifests as the unique embodied characteristics of each resident, to which the unique embodied characteristics and capabilities of ISH professionals align as care (or fail to align as indifference, neglect or coercion).

In *Article II,* the informants' speech on ideal dementia care emphasises the diminished importance of language as declarative, propositional information, i.e. what is noted, wished or argued explicitly in words. A serious approach to embodiment and the rejection of mind-body dualism means that what may seem like a straightforward insult can, in fact, be an expression of affection. This is well portrayed in an example given by an informant, where a resident uttered to them "fuck you" straightforwardly while receiving an injection but with a warm and caring attitude and composure (Hämäläinen, 2022, p. 10). Care professionals "have to read between the lines", as one informant said (ibid, p. 10), referring to how crucial the skill of "reading" embodiment is for successful caring. The data is full of captivating examples of care professionals relying on their instincts without being able to fully explain the reasoning behind their decisions. Sometimes, the decisions are based on "gut feeling" or "just somehow appear" (ibid, p. 11).

This highlights a significant viewpoint regarding knowledge and truth in care encounters, demonstrating the difficulty in capturing care in terms of decontextualised knowledge or other means that neglect embodied insight. The informants frequently used metaphors to describe their approach to attending to residents' needs, including "reading the situation", "wordless reading", "keeping antennas up" and "navigating". Additionally, they said they could "just somehow "see", "know", "feel" or "read"" what was the most appropriate way to attend to the residents' needs (ibid, p. 11). *Article II* presents these experiences as tacit knowledge (ibid, pp. 11–12), drawing on Polanyi's (1966) differentiation between "tacit" and "propositional" knowledge, wherein he argued that "we can know more than we can tell". Tacit knowledge occurs spontaneously for the knower in the moment, cannot be articulated and assumes that the body knows what to do without rational deliberation (Benner, 2000; Hämäläinen, 2022, pp. 11–12). In this vein, Pols (2012) explores the concepts of tacit knowledge and know-how through the term *know-now,* referring to skills that are tacitly and automatically applied, suggesting that "the verb *knowing* becomes more important therefore than the noun *knowledge*" (ibid, p. 85).

When propositional language has lost (some of) its meaning-making ability due to dementia, care professionals' practices of "reading embodiment" necessitate a lived and bidirectional understanding of the care encounter, in the sense of intercorporeality as portrayed in the previous section. This is in relation to Merleau-Ponty's notion of embodied reversibility as argued by Hamington (2020, p. 122): "caring is embedded in learning not for the sake of accumulating disjointed facts, but emerges from the reversibility between self and other in the flesh: the fundamental connection we have with others in our perceptual experience". I maintain that the above results on lived care encounters emphasise the importance of embodiment for ethical understanding in the first place, suggesting that any analysis of care must somehow connect to the ontological implications of care as an idiosyncratic encounter. Interpreting our inherent relationality solely in the psycho-social sense of standing in relation to each other and "impacting" each other's lives is trivial and fails to capture the unique essence of our interconnectedness through care (Hamington, 2020, pp. 115–116). Keeping in mind the phenomenological understanding of intercorporeality, and the embodied nature of perception in the first place, this study's results portray intriguing views on how care professionals use such understanding to pursue good care. In an ideal care encounter, the radical difference manifested through the Other's embodiment automatically prompts an understanding of manners, needs, affects and dispositions that fundamentally differ from our own, as well as an understanding of how the feeling of radical alterity, and therefore vulnerability, is always something we deeply share in the encounter. This alterity and similarity can only be enacted meaningfully if the encounter is understood in the profound sense of embodiment.

6.1.3 Attunement to embodied alterity as active moral agency

I have now explored lived care encounters in terms of alterity and embodiment; however, issues remain regarding the relation between these aspects and practical moral action. In other words, *understanding* alterity and embodiment in a profound way is not the same as *acting* accordingly. The idea that both recognition of vulnerability (care as a disposition) and responding to it with care (care as action) are required for care to be considered successful is of course not novel in care ethics. For example, according to Fisher and Tronto's (1990) influential presentation of the four stages of care, recognising vulnerability (caring about), also requires an ethical shift (willingness to respond) and practical action (caregiving) followed by responsiveness to its impact (attentiveness to how care is received) for caring to be considered successful. Or in the words of Marian Barnes (2012, pp. 21–23): "without action to follow the awareness of need, care cannot be complete", referring to the "responsibility" or "obligation" to care (see also Engster, 2007; Tronto, 1993).

Other accounts of the ontological primacy of ethics tend to share a similar problem. For example, although the previously showcased views of Lévinas, Merleau-Ponty, Daly and Hamington propose that the understanding of the ontology of the self and the Other is pre-theoretically ethical, alterity and embodiment as the ontological metastructure of lived care encounters still seem to be preliminary facts of being – representing a starting point of sorts (see Miller, 2020). It is necessary to consider whether merely highlighting the embodied alterity is sufficient to justify why we ought to respond to others' vulnerabilities with practical action.

Through exploring care professionals' speech about care encounters it is possible to search for the movement from disposition to action. It is imperative to acknowledge the potency of an empirical perspective on the issue, which may also differ from the theoretical viewpoints. The methodology of asking the question "Why should I care?" can also be reversed, as Jeannette Pols (2015) has suggested. Pols's "empirical ethics" sets out to discover ethical meaning-making in care practices themselves, rather than through deduction by care ethicists in ivory towers. (I am currently writing these sentences in one of these towers with a nice, snowy view.) Although I maintain that the theoretical understanding of care ethics and phenomenology is crucial in the context of alterity and embodiment due to existential vulnerability, when it comes to care practice as moral action, it is beneficial to also adopt the ideal of empirical ethics.

In my prior discussion of alterity as fundamental for lived care encounters, the results of *Article III* showcased how encountering alterity in dementia care is initially about the recognition and understanding of alter-temporality as attunement (Hämäläinen et al., 2024). However, the care professionals not only referred to mere recognition and understanding of it, but also described what sort of caring actions such understanding leads to. These views reveal the (ideally) practical ethical agency at the heart of professional care work.

In our analysis, first, the informants talk about temporal attunement as practices of *reception*, involving an active, embodied attunement to align with the lived temporal experience of persons with dementia. This is described as practices such as slowing down the pace to better fit the rhythm of the resident, remaining present and “simply being there”. We refer to these practices as *listening*, symbolising the holistic capacity and willingness to practically attune one's embodied experience with another person's alter-temporality. This also involves both breaking away from the confines of care home time and reducing the priority of one’s own temporal experience (ibid, pp. 9–10).

Second, attunement manifests as practices of *expression*. For instance, the care professionals guide the residents' experiences towards ongoing or upcoming events by carefully describing the events with an understanding of alterity (acquired by practices of listening). Using a bed-lift, changing a diaper, showering and other bodily events can be a frightening experience for a person whose sense of time and place is lost if the task is executed quickly without an explanation of what is being done and why, by whom and in what manner. We referred to these practices as *speaking*, symbolising the care professionals' holistic capability of bringing the residents into the shared moment by means of expression (ibid, pp. 10–11). These examples are akin to the previously presented notion of "will-work" proposed by Driessen (2018), in that according to this study's results, ISH professionals' attunement to the residents' alter-temporality as expression seems to function exactly as movement between the event, near future and the resident's temporal-existential point of experience, connecting them through an embodied and emotional attitude.

If listening is about a temporal-positional adjustment towards the Other's alterity, speaking is about steering the alter-temporality towards a certain attitude or action, referring to the other side of the bidirectional movement of intercorporeality. Anya Daly's (2019) and Maurice Hamington's (2004, 2020) previously presented Merleau-Pontyan views of care based on the ethical primacy of embodiment are in direct connection with how care professionals speak of attunement practices in ISH. Merleau-Ponty's notion of reversibility refers to our perceptive ability to experience both touching and being touched intersecting in the same moment, and our perception's shift of attention between the self and the Other. These intercorporeal foundations of care are elucidated by care professionals' depictions of expressive practices of attunement when encountering residents with dementia. These practices are both psychologically and ethically demanding, as there are no ethico-ontological guidelines for caring that apply to all encounters. On the contrary, care is exactly about the challenging ability to navigate (as in, recognise alter-vulnerability and shift the recognition to caring actions) through any context and manifestation of vulnerability and need.

As the examples of listening and speaking suggest, in practices of attunement the ideals of embodied alterity manifest as practical aspirations of ethical action. These aspirations can be understood as reciprocal *trust* that inevitably comes with the lived, caring encounter. *Article I* (Hämäläinen, 2020) highlights the ethical obligation within the ethico-ontological premises of care from a perspective of trust, rooted in Knud Ejler Løgstrup's (2020) notion of *ethical demand*. Løgstrup's ethical phenomenology is based on the fact that we always-already find ourselves in the world, intertwined in relations and exposed to other people's will and mercy. From this it follows that we find ourselves in relationships of trust with others. Thus, relational ethics demands that we prioritise trust over mistrust since we cannot act in the world without, at least minimally, exposing ourselves to the power of others (ibid, pp. 8–9).

Attunement to the alter-vulnerability of the residents manifests as practices of listening and speaking, and shows how the ethico-ontological demand (to care) emanates from basic trust, as it compels us to choose between honouring the Other's trust by taking responsibility for their life or disregarding it by placing our own self-interest first (Søndergaard Christensen, 2015, pp. 27–28). Søndergaard Christensen (ibid, p. 30, emphasis in original) contends that the ethical demand results from an essential interpersonal commitment: "When I am faced with the ethical demand, it returns me to the particular relation that exists between the other and me; it simply points out that *I hold his or her particular life in my hand*." By listening and speaking, the one giving care momentarily and practically holds in their hand the particular life of the one in need of care. Care always requires some aspects of pre-contextual knowledge; however, the results show that without bidirectional attunement there is a risk of care being shifted to neglectful carrying out of given tasks or, at worst, coercion.

As a result of the trust that comes with our inevitable relationality, care understood as a lived encounter is also ideally non-contractual; it does not involve an expectation of receiving care in return. It also means that care can only be given and received, not demanded, because having to demand care is already a manifestation of someone's failure to respond to the ethical demand set by the Other's existence. The introduction of contractuality in a lived care encounter necessarily results in the diminished ethical value of the care provided; when vulnerability is met with the expectation of a reciprocating benefit, the irreplaceably valuable lifeworld of care and existential vulnerability is sacrificed. In other words, a selfless and attentive response to the vulnerabilities of another similar (that is, similar in alterity) being is needed.

The underlying question of "why should I care?" is persistent regardless of how much effort is invested in contending that ethics precedes epistemology, that we are inherently ethical beings shaped by our embodied interconnectedness, that our innermost existence is reliant on the Other both in an ontological and a psycho-social sense and that we are vulnerable in a manner that is both profoundly personal and unavoidably shared. While Daly, for example, presents a strong ethico-ontological argument based on intercorporeality when facing the problem of "the amoralist" (Daly, 2022), following Jeannette Pols's idea of "empirical ethics" (Pols, 2015), moral action constituting lived care encounters can perhaps be best explored empirically, or at least by combining the ethico-ontological essential aspects with the empirical assessment of care. By observing or interviewing those who engage in daily care practices, we can witness how the ethico-ontology of care emanates from practical encounters with vulnerability. In this way, ethics is presented to us in a manner that is perhaps more difficult to overlook compared to care ethical or phenomenological theory-construction. Care professionals' practical attunement to alter-temporality is the phenomenology of vulnerability *in situ;* lifeworlds of care as moral action following from profound and complex understandings of embodiment and alterity are revealed to us in full scope in ISH practices of encountering dementia.

6.2 Technologies reconfiguring lived care encounters

I have identified alterity, embodiment and attunement as the essential aspects of care understood as a lived encounter. Next, it is time to consider these aspects alongside technologised care practices prevalent in our time, where the frameworks of care are increasingly guided by instrumentality instead of care ethics (Hämäläinen, 2022). Based on the PhD articles underlying this study, it is feasible to explore how technology reconfigures care given in ISH in general, as well as to reveal its influence on the (im)possibilities of addressing residents' vulnerability.

In this section, first, I will present results demonstrating the sociomaterial impacts of EHRs on ISH work and care ideals. After that, I will explore SASs' impacts on care encounters with ISH residents who have dementia. I will conclude by comparing the results for EHRs and SASs with the essential aspects of lived care encounters.

6.2.1 A sociomaterial analysis of EHRs in ISH

Article IV presents an analysis of the sociomaterial (although in the article we use the term "socio-technical") influence of EHRs on the ISH of older persons in Finland (Hämäläinen and Hirvonen, 2020). Professional care faces increasing accountability requirements facilitated by information and communications technology. In recent years, the development of documentation and communication practices in care work has focused on EHRs. These systems have been extended from healthcare to ISH and the home care of older persons. EHRs facilitate the electronic recording of clinical treatment, daily care activities, residents' moods and other information, with the aim of reducing errors and ambiguities related to care work and improving the coordination of information exchange between healthcare organisations (ibid, p. 1).

However, our research indicates that EHRs have far-reaching impacts on healthcare practices beyond accountability. We utilise Akrich and Latour's (1992) script theory, which is built around concepts of *prescription,* to outline the constraints and liberties that EHRs impose on ISH work, and *subscription,* to refer to the reactions of ISH actors to those prescriptions. Furthermore, we draw upon the sociomaterial analysis of telecare technologies by Pols and Willems (2011) who expand the script theory by showing how technologies may *tame* and *unleash,* or *be tamed* and *unleashed* by, their users in care settings.

Our analysis presented the ways in which EHRs prescribe ISH work, revealing how they shape care practices in a top-down manner (Hämäläinen and Hirvonen, 2020, p. 3). The policy ideals of digital accountability are hampered by inconsistencies resulting from changing software, updates, general technical unreliability and malfunctions. According to care professionals' interviews, this leads to wait times and frustration, requiring the search for alternative ways of documenting their work and the experience of time being wasted on technical tasks thus reducing the time spent with residents (ibid, pp. 3–4). The information contained in EHRs is also viewed as too unrefined when compared to the nuanced characteristics of real-life care encounters (ibid, p. 4). ISH workers are expected to record the nuanced care events under fixed, organisationally appointed themes, in a practice known as "structured recording". Here, the strong, top-down prescription of EHRs is visible: a strict framework of digital information concerning predefined care events is laid out. Care professionals criticise EHRs, for example, because while EHRs may be suitable for hospital settings based on efficiency, they may not align well with care of older persons. The results also show how ISH professionals detect a significant disparity between care presented "on paper" and the rich nuances of care found in "a live situation" (ibid, p. 4).

While *Article IV* primarily explores the sociomaterial impacts of EHRs on the work practices of care professionals in general, the results also highlight the impact of EHRs on the lived care encounters with ISH residents. For instance, while EHR incoherencies or dysfunctions can disrupt the flow of work, they also cause ethical concerns (ibid, p. 3). While the informants view EHRs as beneficial in terms of factuality and being able to track and demonstrate accomplished care tasks, the digital images of care that are produced are seen to lead to grossly inadequate depictions of what happens in the actual encounters. However, the fact that the EHR prescription does not allow sufficient expressions of care does not prevent care workers from attempting such expressions by other means, which is evident in the results as means of "tinkering" EHRs (ibid, p. 3; Mol et al., 2010). ISH professionals find alternative ways to exercise their caring mind by writing paper notes and by means of oral reporting between colleagues. Care entails an emotional morality that influences actions since emotion and action are difficult to separate (Hope, 2019). Yet digitalisation has left care professionals with difficulties in expressing their ethics of care, as processes of rationalisation pose a risk of depersonalisation of care. As our results suggest, ISH workers are aware of this risk and employ various strategies to mitigate it.

Another disadvantage of EHRs discussed by ISH professionals is that EHRs enforce physical distance from care encounters. The results suggest that EHRs are perceived as an external and burdening aspect of care work (Hämäläinen and Hirvonen, 2020, p. 4). The informants often described providing care without devices as "normal" and "slow", while the use of technologies was associated with "speed" or "coldness". The heart of care work is considered to reside somewhere outside EHRs, which are deemed bureaucratic and "of no real value for the residents" (ibid, p. 4).

Even though EHRs tame ISH workers, the results also reveal how EHRs include the potential to unleash ISH workers to undertake care tasks in ways that would be impossible otherwise, for instance, exchanging information between different care facilities (ibid, pp. 5–6). Importantly, instead of unleashing ideal encounters with vulnerability, these unleashed potentials mostly function on the level of factuality, accountability and information use (ibid, p. 6), not care relations. Overall, EHRs appeared to have been unleashed in ISH settings without consulting the end-users: once brought into use, it is difficult for ISH professionals to manage the numerous positive and negative impacts that are not prescribed in their design (ibid, p. 6).

6.2.2 The impacts of SASs on encounters with dementia in ISH

Expanding on how the technologisation of care of older persons affects ideal care encounters, care professionals in *Article III* speak about disturbances with regard to attunement to the alter-temporalities of residents with dementia (Hämäläinen et al., 2024). In addition to shortages in staff, the results indicate that another central ISH technology, SASs, contribute to decreased opportunities for attunement. These systems refer to bracelets or pendants worn by ISH residents that send signals to care professionals’ smart phones either when a resident presses a button on the device, or the device automatically registers something unusual in the resident’s health data. Although SASs are also reported to reassure

ISH professionals of the residents’ safety and well-being, they frequently reduce the opportunities for holistic and meaningful interactions with persons with dementia. This is evidenced by how the "beeps", "clanks", "tinkles" and "buzzes" related to SASs disrupt delicate moments of co-presence (ibid, p. 13). The sounding of the alarm disrupts the caregiver's attunement to the resident's ongoing situation, dictating that they are expected to be elsewhere. Reports indicate that such disturbances occur extensively and suggest that the systems are a significant cause of temporal discordance in dementia care in the ISH of older persons (ibid, p. 13; see also Lydahl, 2023).

A comprehensive sociomaterial analysis would be necessary to fully comprehend the impact of SASs on care relations in the ISH of older persons. However, the above results on temporality indicate that the prescription of SASs may not be as straightforward as it may appear. Social alarms address particular vulnerabilities, such as the lack of care, which is becoming increasingly common due to the decreasing number of care workers available for older persons with care requirements. However, the technologised expressions of care needs via the use of SASs undermines the recognition of situational vulnerability: if an individual does not press the button, it may be assumed that they do not require attention (Hämäläinen, 2020, pp. 178–179). The recent trend of connecting SASs to live health data potentially ensures security in terms of health and that no-one is left on their own in dangerous situations, but at the same time it replaces lived care encounters determined by embodiment using technologised images of care recipients' bodies. This may increasingly be the case, as currently the night shifts in Finnish ISH work include care professionals monitoring all residents' live health data presented simultaneously on a computer screen.

6.2.3 Conclusion on the impacts of EHRs and SASs on lived care encounters in ISH

While the sociomaterial analysis of EHRs reveals the inescapable intertwining of various care agents, both human and non-human, a comprehensive view on my PhD articles' results also indicates how care professionals' sociomaterial approaches towards the adoption, resistance, or tinkering of technological prescriptions are means to *a care ethical* end.

Given the presented framework of essential aspects of lived care encounters in this study, it is clear that reserving a central place for EHRs in determining successful care runs a risk of neglecting alterity and embodiment as the basis of ideal care of older persons. Based on strict prescription in the form of precodified headings under which care professionals must present both their own and the residents’ experiences, the policy ideal of "structured recording" of care tasks ultimately suppresses embodied alterity. As detailed in Chapter 6.1, ideal care encounters are to a great extent defined by embodied and tacit insight as opposed to objective knowledge. The most important aspects of the care of older persons are soft tones of voice, careful approaches, a holistic presence, a nuanced understanding of the resident's particular ways of being, needs and so forth (Hämäläinen, 2022). These results can be read through Martinsen's (K.

Martinsen, 2006; according to E. H. Martinsen, 2020) phenomenology-derived distinction between the "perceiving eye" and the "recording eye", portrayed as different attitudes towards patients in hospital settings. The perceiving eye refers to openness and receptivity both towards the Other and towards one's own emotional response to the Other's response, much like Merleau-Ponty's bidirectional perception or care professionals' practices of attunement. The recording eye, on the other hand, shifts to an outside position of classification, systematisation and differentiation, to arrive at a diagnosis based on a pre-contextual epistemological framework, much like how objective knowledge was presented earlier in the results. Martinsen (2020, p. 69) explicitly connects this with EHRs, in that their form and the style of the recording gaze, written in an impersonal manner, that is, EHRs' prescription, do not leave room for the experience of the perceiving eye.

Therefore, one key message concerning EHRs in this study borrows from our informant's view, stating that while EHRs digitally ensure the accountability of ISH, they do not necessarily suit the long-term care of older persons as well as they suit clinical settings (ibid, p. 4). Hospitals are (ideally) temporary sites for *curing* health abnormalities, where clinical efficiency is key, but the ISH is a site of holistic *caring*, planned as a site for the remaining years of a person's life, which is not an apt setting for unquestioned rationalisation or generalisation.

Reports on the inability to provide care of sufficient quality are extensive (Hämäläinen et al., 2024, p. 10), which at least partly explains the frustration of having to tend to devices instead of persons in need of care. The ethical stress of care workers resulting from having to perform care tasks as "machine-like conveyor belt work" against their own care ideals is repeatedly associated with understaffing (ibid, p. 12). Up to 85 % of Finnish ISH professionals and up to 80 % of Finnish care professionals in general report that they cannot do their work as well as they would like to (Karhinen et al., 2019, 2021). Feelings of hurriedness have been among the main reasons for the rapidly increasing turnover rate in care work (Kröger et al., 2018; Van Aerschot et al., 2022). Other contributing factors are insufficient support from managers, few opportunities to influence the way work is done, a sense of inadequacy, feelings of time pressure and a poor worker-to-client ratio (Van Aerschot et al., 2022). This study indicates that ethical stress is exacerbated by the inability to meet ideal care standards, and this is partly due to the increasing focus on using systems and devices that reinforce the instrumental nature of care work.

As shown in answering RQ1, listening and speaking as practices of temporal attunement to dementia elucidate the extremely delicate nature of lived care encounters (Hämäläinen et al., 2024, pp. 9–11). While the results on SASs in this study are narrow, they indicate that, along with EHRs as the other central technology in ISH, SASs contribute to the instrumentalisation, rationalisation and quantisation of care. Time efficiency has been neatly technologised by SASs that binarise care needs and explicate the increasing hurriedness of ISH work by buzzing and beeping (ibid, p. 13). Furthermore, the constant alarms may become normalised and not be taken as seriously as they should be. As a result, attentiveness to alterity is transformed into more binarised and generalised care practices, potentially restricting the alter-embodiment at the core of care. Some older persons may also be stigmatised by having to wear items that clearly indicate their dependence on care, may struggle to comprehend the meaning behind pressing a button on a bracelet or may be unable or reluctant to address their needs through pressing a button (Cook et al., 2016; Lydahl, 2023).

SASs have impacts on the contents of care encounters, in that the resulting digital images of bodies risk replacing lived encounters, leading to further detachment of the lived aspects at the heart of care (see also Lydahl, 2023). Developments resulting in increasingly technologised body-images as premises for the care of older persons, for example, forms of telecare based on live monitoring of health data interpreted by artificial intelligence, await us in the near future. In light of these views, perhaps we should look back at Agamben's view of modern biopolitics as a delineation between life understood as *zoē*, "bare life", a simple fact of existence that can be sacrificed, and *bios*, an ethically and politically valuable and meaningful life within a community (Agamben, 1998). A future where the scope of vulnerability that comes with old age is addressed by monitoring health data on screens or by artificial intelligence sounds to me a lot like approaching bare, ethically meaningless existence. Contrary to such views of instrumentality, encountering alter-vulnerability in a holistic manner necessitates cautious and sometimes slow attunement to the idiosyncratic temporalities of persons with significant care needs, which are also inevitably embodied.

How, then, can we avoid solely descriptive accounts of the pros and cons of the technologisation of care that do not consider the ideals of care ethics? Alterity, embodiment and attentiveness are not arbitrary ontological aspects; the ethico-ontology of care ethics rests on vulnerability as an inherent fact of our existence. By focusing on vulnerability, it is possible to move from descriptive accounts of technology to prescriptive ones. This means that technology can be thought of as something that reconfigures and obscures the ontology and ethics of vulnerability. Not only do we use technologies as tool-like extensions in interpersonal relations, but our use (and non-use) of technologies also shapes our experiences, habits and therefore our care relations, depending on how the vulnerabilities are met. In addressing certain vulnerabilities, technology always creates new vulnerabilities in other directions (Coeckelbergh, 2013; Hämäläinen, 2020). Therefore, technology should be understood as something that *transforms vulnerability*, instead of instruments that can reduce or rid us of vulnerabilities as modern scientific and technological praxis suggests (Coeckelbergh, 2013, pp. 4–5). Considering technology as an agency that transforms vulnerability emphasises its intrinsic ethical nature, as it provides "material answers to ethical questions" by shaping human practices (Verbeek, 2006, p. 361). The essential aspects of lived care encounters become important when considering which vulnerabilities technology can address with regard to old age and, in doing so, what other vulnerabilities it creates.

7 CONCLUSIONS AND DISCUSSION

In this PhD summary, I set out to explore what essential aspects constitute ideal care encounters in ISH and to elaborate on the recent technologisation of care of older persons in light of these essential aspects. To achieve this, I first proposed that the ethical and political theory of care ethics would benefit from explicitly separating its phenomenological and poststructuralist conceptions, leading to an understanding of care as both a lived encounter and a relational structure. While presenting this critical argument concerning care ethics, explicating the distinction also served an analytical purpose regarding the entire study, allowing for a focus on the ideal foundations of care as a lived encounter with vulnerability. By answering two RQs formed around the main initiatives of the study, I have arrived at an ethico-ontological framework that can be applied when elaborating care theory, care policy and care practices.

First, by answering the first research question – "What kind of essential aspects of lived care encounters emerge in the speech of care professionals working with older persons?" – I incorporated empirical results and literature on phenomenology and care ethics and established that ideal care encounters derive from an understanding of alterity and embodiment, followed by attunement as practical, moral action.

After that, I answered the second research question – “How do care professionals' views of central digital technologies of round-the-clock care work relate to these essential aspects of care?” – by using alterity, embodiment and attunement to assess results that represent the impacts of two key technologies, EHRs and SASs, on lived care encounters and practices. I proposed that these technologies include a tendency to instrumentalise care relations, which is at odds with the ideals emerging in lived encounters with the Other's vulnerability.

In this final section of the study, I briefly discuss the academic and societal implications of these results.

7.1 Concluding theoretical remarks on care

In the vast history of Western philosophy and sociology, feminist care ethicists have been the few to ask the question "What is care?". Resulting from the question, care ethics has shifted between the ethical and political dimensions at the heart of the concept of care (Bourgault, 2017, pp. 2–3; Conradi, 2020; Gary, 2022, pp. 2–4). In this study, I have suggested how this divide might be explicated more fruitfully: care understood both as a *lived encounter* and a *relational structure.* Key in exploring these are their underlying philosophical differences: elaborating the divide through differences in phenomenological and poststructuralist ontology (Alcoff, 2000; Stoller, 2009) builds on previous approaches to the ethical and political dimensions of care in a novel way. The significance of phenomenology in terms of the ontological basis of care is evident, but studies reporting connections between care ethics and phenomenology have been rather few, some recent exceptions aside (Daly, 2019, 2022; Hamington, 2004, 2020; Mortari, 2021; Nortvedt and Vosman, 2020). Therefore, with alterity, embodiment and attunement as all-encompassing facts that intertwine the self, the Other and vulnerability in our existence, I have aimed to find a firmer ground on which the ethico-ontological arguments of care can be laid, alongside the politico-structural facts of the prevalence of inequalities in the distribution of vulnerability and care in our societies.

I believe that at the heart of the dichotomous underpinnings lie questions concerning essentiality. Poststructuralism, based on the repercussions of the always-already open nature of language for the social conditioning of any object of analysis, by default resists any notions of essentiality, while phenomenology tries to reflect on the essence and truth in the holistic, lived experience (Alcoff, 2000; Stoller, 2009). Essential notions of care were discarded early in the history of care ethics due to their rootedness in essentialising the care relations between mothers and children (for example, Ruddick, 1980; Noddings, 1984), leading to a risk of building the whole theory on gender differences. Such forms of gender essentiality belong in the bin; however, essentiality in terms of the existential meanings of care need not be disposed of. As I elaborated in Chapter 2.1.2, the history of care ethics has seen ethico-ontological claims connected to the inherent nature of vulnerability as fundamental to our being and relations with others. As I argued, the ethico-ontological and politico-structural views can be understood through different perspectives to vulnerability. Our vulnerability is existential, in that its source remains unknown to us, which manifests both in our own experience and in encountering the Other. Vulnerabilities are also contextual, in that they also always emanate from cultural contexts. However, care ethicists have seldom incorporated alterity in its phenomenological-existential sense with vulnerability, and embodiment has too often been regarded as a bodily *dimension* of care rather than its ethico-ontological *premise* (with exceptions such as Hamington, 2004, 2020; Daly, 2022; Vaittinen, 2015, 2022). I argue that these essential perspectives on care and being human should be addressed more explicitly.

Furthermore, suspicion of essential arguments also explains care ethicists' uneasy relationship with dyadic notions of care. Essentialising the mother–child -dyad was a mistake, no matter how powerful and tempting its normative content was. However, this also should not lead to discounting the explanatory ethical and political power of the concrete, lived experience of having one's vulnerability holistically addressed by another person, or in other words, encountering the Other. I believe that this dyadic aspect at the heart of care as ethical action, along with the plural, politico-structural aspect needed in order to assess from what kind of circumstances the vulnerability emerges, still holds considerable explanatory power when resisting the instrumental, neoliberal hegemony detrimental to care.

Once more, my claim is not that these ontological premises have not previously been used in arguments for the ethical and political importance of care ethics, nor that lived encounters are somehow more important than relational structures. My claim is that the inconsistent and ambiguous intertwinement of ethico-ontological and politico-structural notions in relation to care has muddied the waters, also in terms of the political claims of the place of care in society. For example, in accounts that address the coercive or otherwise negative manifestations of care (for example, Kelly, 2017; Sihto and Vasara, 2023; Simplican, 2015; Vaittinen, 2019), it is immediately clear that care is used in a plural, descriptive sense. Examples of coercion, indifference or neglect in the name of care unavoidably emanate from relational, unjust or structures distorting care rather than the ethical premises. Care as a lived, ideal encounter cannot, for instance, be paternalistic because it must somehow be affirmed as care by the one who receives it, as portrayed also in the fourth stage or "care receiving" in Tronto's argument of the basic requirements of care (Kittay, 1999, pp. 200–202; Tronto, 1993).

Paying attention to embodiment, alterity and attunement at the heart of concrete responses to vulnerability also shows how the difference between the lived, dyadic care encounters and the structured, plural understandings is ultimately *temporal*. Care in the former sense necessitates an understanding of temporal *duration* (Bergson, 2014, p. 100–106), time as a qualitative co-presence, whereas the latter meaning requires at least some broadening of the temporal perspective in order to grasp broader-level phenomena. With this in mind, I suggest that the analytical focus on lived encounters treats the term "care" more as an active *verb* and resists its use as a *noun*. The ethico-ontological complexity related to the bidirectional attunement as constant shifting between the perspectives of the self and the Other, as portrayed by the care professionals' interviews, depicts "care" in reflexive flux. This does not mean that care understood as a relational structure would not be reflexive in some sense as well. Constantly reconfigured by policies, technologies, everyday conversations, academic texts, political speeches, natural disasters and so on, "care" also takes on constantly differing *forms* which change with time. However, what is in flux in "care" as a relational structure is more in the sense of a noun. We need care as a noun to grasp how responses (or lack thereof) to vulnerabilities form as care phenomena: discussing care of older persons, global care chains, care policy, care crises, care deficit, the technologisation of care, dementia care and so forth, all require some kind of stability of the concept. At the same time, we need the verb to confirm that someone has in fact experienced care instead of indifference, neglect or coercion. Perhaps the ambiguity in care ethics can also be clarified through an understanding of what we mean exactly when we utter the word "care".

Finally, I have begun to pay attention to how care understood as a verb alters other concepts it touches. For example, viewing "time", "body" or "knowledge" through the lens of care seems to require more reflexive meanings of them as well. If we consider time in relation to care, it seems that the care encounter itself demands a verb-like understanding of time: as if care would automatically require alter-temporality instead of linear time when facing vulnerability, such as dementia (Hämäläinen et al., 2024). In terms of the body, care "reads between the lines", indicating that the body needs to be understood as embodi*ment*, as a constantly shifting and indefinable reflexivity that requires embodied temporal attunement. Or, in terms of knowledge, as Pols (2012, p. 85, emphasis in original) writes, in care "the verb *knowing* becomes more important therefore than the noun *knowledge*". It seems that the care encounter itself starts to demand a verb-like understanding of knowledge: as if care would ultimately adjust our understanding of knowledge towards embodied, situational insight instead of decontextualised knowledge, such as medical generalisations (Hämäläinen, 2022). Of course, linear temporality and quantitative, medical, general knowledge of the body are also needed as part of successful care, as elaborated by care professional's talk about objective/objectifying knowledge (Hämäläinen, 2022, pp. 7–8). For example, propositional knowledge about what happens as dementia progresses over time supports embodied insight in the lived encounters. To some extent, care requires such instrumental means. However, the noun must be kept in check by the verb to acknowledge the unknown origins of our vulnerability and the depth of care as a response to vulnerabilities experienced situationally by unique persons. Distancing from the lifeworld of vulnerability – what attentiveness, indifference, neglect or coercion feel like in one's experience – may lead to instrumentality as the departure point of care policy, as increasingly seems to be the case in the current neoliberal contexts of care.

7.2 Technologisation of care reflecting neoliberal instrumentality

The utilisation of technology and digitalisation in the care sector has been suggested to provide a "triple win" leading to improved structural efficiency, technological innovation and better care (Neven and Peine, 2017), and Finland is no different in this regard (Jaakola, 2023). In Finnish policy documents on care of older persons, the trend towards technologisation is also formulated as an inevitable, self-evident fact (Jaakola, 2022). An official quality recommendation concerning care of older persons given by the Ministry of Social Affairs and Health (STM, 2017, p. 27) in Finland suggests that one-fifth of work related to care of older persons could potentially be substituted by automation and robotics "in a couple of years".

However, any care policy is underpinned by a set of ontological, epistemological and ethical assumptions. The promotion of the "triple win" regarding the technologisation of care seems to be a component of a more extensive shift in our thinking, referred to as “instrumentality” in this study. The underpinnings of care work are increasingly being shaped by "rational-technical" thinking (Benner et al., 2009), which has also led to related care policies in Finland and other Western countries. These policies encompass marketisation, governance based on accountability and productivity-focused digitalisation (Anttonen and Karsio, 2016). Despite the decades of research exploring the inadequacy of such policies towards the holistic, embodied, intuitive and contextualised nature of care, the rational-technical paradigm, based on biomedical research and decontextualised health information continues to dictate care policies (Barnes and Henwood, 2015; Benner et al., 2009; Lupton, 2012).

Where does all this instrumentality originate? When something seems ambiguously justified, it may be best to follow the money. Neoliberalism's confidence in the free market mechanism as the best way to allocate resources prioritises the "private" over the "public", which has led to the privatisation of care services, installing quasi-market mechanisms in the public care sector and shifting the responsibilities of care onto persons in need of care and those close to them (Karsio and Anttonen, 2013; Pierson, 2001; Ward, 2015). Consequently, this has led to the financialisation of care, as large, multinational for-profit companies are gradually taking over care sectors (Hoppania et al., 2022; Karsio, 2024). With old age being heavily emphasised in future demographics all around the world, there is a lot of money to be made. Therefore, the instrumentalisation and technologisation of care are not an arbitrary shift in ethos, but rather connected with commercial interests (Hoppania et al., 2022; Parviainen, 2023; Zechner et al., 2022, p. 54). For care to be bought and sold on the market, it needs to be instrumentalised into commodities, that is, distinct tasks counted in minutes and euros; bodies need to become objects and vulnerabilities need to become predetermined needs. Care needs to become a noun we can control.

Successful care requires a certain degree of instrumentality. Probability assessments based on generalised, empirical evidence are sometimes helpful in addressing the wide and complex range of illnesses and health conditions that an individual may encounter (Hämäläinen, 2022, pp. 7–8). While an element of decontextualisation and rationalisation is necessary for successful caring (or at least curing), if these become too dominant, they risk imposing top-down measures that do not fit particular care settings and therefore silence the values of ordinary care experiences (Harman, 2021, p. 11; Laugier, 2016; Pols, 2023, p.

115). In this study, care professionals have spoken about both the profound ideals of care and the overly instrumental nature of technologisation in relation to these ideals. Given the ability of ISH professionals to be intricately attuned to the Other's vulnerability, it is imperative to emphasise the crucial role of insight alongside information as an equally important dimension of care. This is in line with Pols's (2015) "empirical ethics of care", where prescriptive ethical contemplation is substituted by witnessing how ethics arises from care practices themselves. The ethical content emanating from care practices needs to be emphasised much more in both care policy and care ethics, as care professionals in ISH and home care settings encounter vulnerabilities in an all-encompassing sense.

Finally, I would like to stress that, by definition, "long-term care" of older persons is guided by an ethos distinct from that of a hospital ward, which prioritises the effective cure of diseases and conditions. In contrast to a clinical hospital setting, ISH is older persons' final residence and addresses their holistic care needs for the rest of their lives. It concerns particular and embodied daily rhythms, existentially challenging relationalities arising from dementia and other cognitive issues, inevitably declining physical capabilities, as well as social relationships culminating in death. In other words, its *ontology* is different from that of a clinical setting, which means that it also necessitates a different *ethics*, which has been thoroughly explored in the empirical results of this study. When considering technologisation as part of such an ethico-ontology, we should always start from an ethic of care and be wary of top-down solutions.

7.3 Vulnerability and care as the bases of society

Since the beginning of 2017, I have been contemplating and investigating the concept of care. During this period, I have sadly lost three of my grandparents, Liisa and Liisa, as well as Niilo, who passed away on the day of writing the first sketch of this paragraph. There is no denying that witnessing the low quality of their care at the end of their lives has had some influence on the thoughts I have presented in the articles and in this summary. These unsettling experiences arise from the national aim to facilitate independent living of individuals in their own homes for as long as possible with the aid of technology (Karsio and Anttonen, 2013; STM, 2017). I have seen this policy goal of "ageing in place" transforming into "ageing in a cage", as both physical and existential security have been neglected through the denial of access to ISH care. Within the triple crisis of care – involving service costs, professionals' exiting the sector and the quality of care – the crisis in quality of care has haunted me for years. Moreover, its direction seems to be the opposite of where it should be, given the severe vulnerabilities related to old age. As a result of the austerity policy of the present government in Finland, some areas have recently devised plans to radically reduce the number of ISH beds in response to severe budgetary constraints, apparently sending older persons with significant care needs back to private homes (Pohjois-Pohjanmaan hyvinvointialue, 2022).

A sense of a lack of responsibility on the part of the service system pervades my experiences. What I perceive is a lack of care, understood as the relational structure of an unequal distribution of resources. However, the structure itself (the noun 'care') has certainly not been the main focus of my worry, or the worry of my late grandparents, but rather the situated and temporal lifeworlds of vulnerability of each person. Their lives have gravely lacked dyadic, lived encounters (in both frequency and duration) where their needs, worries and other vulnerabilities would have been holistically met, as we all would want in such situations. Then again, my mind shifts back towards the structures as I realise that the worry I encountered while engaging with the vulnerable lifeworlds of my grandparents and older residents at my former workplace in ISH, can be multiplied at least tens of thousands of times in Finland alone, as I write this. Ultimately, my mind shifts back once again as it considers the radical Other in each of them – each of us – which reveals the ethico-ontological purpose at the heart of all care structures. This is the hermeneutical, shifting motion needed for "repairing our world" (Fisher and Tronto, 1990, p. 40) – but with the temporally and situationally unique, embodied manifestation of vulnerability as the Other as its centrifugal, ethico-ontological force that repels an ethos of instrumentality.

The final conclusion of this study concerns dementia. Around 200 000 persons with dementia in Finland alone (Viramo and Sulkava, 2015) reside quite silently, or as Vaittinen (2022) would put it, "muted" in their embodiment, amid instrumentalised care structures. They are addressed primarily in terms of instrumentality: objects that consume public resources in structures of care. However, dementia inflicts upon us a philosophical tension that concerns life itself, as it reveals the practical, existential, emotional and embodied ways in which we are all vulnerable. In relation to dementia, we are compelled to confront the Other in a radical way. Once a person with significant physical or cognitive challenges is abandoned in their vulnerability under the banners of ageing in place policies or hollow promises of digitalisation, the ideals of embodied alterity at the heart of care and human existence have been completely disregarded. Failure to recognise the shared ethico-ontological foundation of existence is to radically diminish the humanity of the Other. Therefore, the state of care reveals the state of a society at large.

SUMMARY IN FINNISH

Toiseuden kohtaamisesta – hoivaetiikka ja iäkkäiden ihmisten hoivan teknologisoituminen

Hoiva on Suomessa tätä nykyä kolmoiskriisissä: hoivan kustannukset uhkaavat julkisen talouden tasapainoa, kuormittuneet hoivatyöntekijät siirtyvät muille aloille ja hoivan laatu heikkenee. Jälkimmäisin kriisi ilmenee erityisesti iäkkäiden ihmisten hoivassa, jossa hoivatarpeet jäävät enenevässä määrin vaille huomiota (Aaltonen ja Van Aerschot, 2021). Samaan aikaan yleistyvät äänet, jotka tarjoavat kriiseihin ratkaisuksi teknologian ja digitalisaation suomaa "kolmoisvoittoa" rakenteellisen tehokkuuden, parantuneiden työolojen sekä paremman terveyden ja hyvinvoinnin myötä (Neven ja Peine, 2017; Jaakola, 2023). Vaikuttaa kuitenkin siltä, että hoivaa teknologisoidaan ensisijaisesti vastauksena taloudellisiin haasteisiin, jolloin kysymykset kehityksen syvemmistä vaikutuksista ovat vaarassa jäädä vähemmälle huomiolle.

Väitöstutkimukseni peräänkuuluttaa noiden syvempien vaikutusten parempaa huomiointia. Tähdennän tutkimuksessa hoivan olemuksellista perustaa, ja pohdin, mitä teknologisoituminen hoivan olemuksen näkökulmasta merkitsee. Tarkennan huomioni iäkkäiden ihmisten ympärivuorokautiseen hoivaan ja sen teknologisoitumiseen. Tutkin suomalaisten, iäkkäitä ihmisiä hoivaavien hoivatyöntekijöiden (n=25) haastattelupuhetta hoivakohtaamisista ja teknologisoitumisesta tehostetun palveluasumisen maailmoissa. Analyysimenetelmänä käytän laadullista sisällönanalyysiä. Analyysin pohjalta esitän, että yllä mainittujen kriisien juurisyynä on se, että olemme hiljalleen kadottaneet hoivan keskeisen merkityksen olemisellemme.

Väitöstutkimukseni teoreettisena lähtökohtana on feministisen hoivaetiikan teoriaperinteessä ilmenevä hoivan kahtalaisuus yhtäältä eettis- ja toisaalta poliittisluonteisena käsitteenä (Conradi, 2020). Kaksijakoisuus on tarkoittanut käytännössä sitä, että hoivatutkijoiden lausuessa sanan "hoiva" on epäselvää, mihin se oikeastaan milloinkin viittaa. Kehitän Elisabeth Conradin teoriaa erittelemällä ensin hoivaetiikan kaksijakoisuuden eettis-ontologiseksi ja poliittis-rakenteelliseksi painotuksiksi, ja jäljittämällä niiden poikkeavuudet eroihin fenomenologisessa ja jälkistrukturalistisessa ajatteluperinteissä (ks. Alcoff, 2000; Stoller, 2009).

Tutkimuksen teoreettinen argumentti on, että "hoiva" pitää määritellä aiempaa selkeämmin: joko *elettynä kohtaamisena*, eli tietyn ihmisen konkreettisena kokemuksena siitä, että joku vastaa hänen tarpeeseensa hoivalla, tai *suhteisena rakenteena*, joka kumpuaa siitä, millaisiin muotoihin hoivan tapahtumat yhteiskunnassa ovat hiljalleen järjestyneet.

Hoivan ymmärtäminen tuossa ensimmäisessä merkityksessä, elettynä kohtaamisena, edellyttää tuen ottamista fenomenologisesta ajattelusta. "Eletyllä" viittaan fenomenologian tapaan painottaa olemisen elämismaailmaa (Lebenswelt) (Husserl, 1970), jolloin maailma ymmärretään välittömänä kokemuksena, aina jo olemassa olevana tuntemusten ja havaintojen tapahtumisen kokonaisuutena. ”Kohtaaminen” taas kohdentaa ymmärryksen hoivan tapahtuman ainutlaatuisuuteen, tapahtumiseen nimen omaan hoivatarpeita omaavien ja niihin vastaavien ihmisten välillä. Fenomenologian eksistentiaalinen vire johtaa myös ajattelemaan haavoittuvuutta olemisen perustana. Haavoittuvuus juontuu siitä tosiasiasta, että olemme auttamatta keskeneräisiä olentoja – meidät on heitetty tähän maailmaan ilman, että olemme valinneet tänne syntyä, mutta kuitenkin velvoitettuina tulemaan omaksi itseksemme (Mortari, 2021, 155). Olemisen haavoittuvuuden kohtaamme viimeistään perustarpeidemme vaarantuessa, eli kun kohdallemme osuu onnettomuus, sairaus, tai muu tila, jossa oma olemisemme ei jaksa yksin meitä kannatella. Tiedämme oikein hyvin, oikeastaan automaattisesti, onko joltakulta saamamme kohtelu haavoittuvuuden koetellessa meitä tavalla tai toisella hoivaa vai ei, koska kysymys on pohjimmiltaan eksistentiaalinen. Hoiva elettynä kohtaamisena kumpuaa siitä, että tämä haavoittuvuus ei myöskään ole vain itseämme koskeva ongelma, vaan meillä on kyky tuntea myös toisen kohdalle osuva vaiva omissa kehoissamme.

Hoivan ymmärtäminen sen toisessa merkityksessä, hoivasuhteiden rakenteina, viittaa siihen, mitä esimerkiksi yhteiskuntapolitiikan oppiaineessa usein tutkitaan tai mistä A-studioissa iltaisin puhutaan. On kyse hoivavastuiden jäsentymisestä yhteisössä, siitä mitkä ryhmät muita yhteisössä hoivaavat ynnä muista hoivan tapahtumiin tai vajeisiin liittyvistä, politiikkatason ilmiöistä (ks. esim. Tronto, 1993; Sevenhuijsen, 1998). Tällöin hoivaetiikan perinteessä ”hoiva” on viitannut siihen kontekstuaaliseen tapaan, jolla haavoittuvuus ja hoiva kulloinkin jakautuvat epätasaisesti yhteisössä. Vaikka hoiva kumpuaisi meitä kaikkia yhdistävästä, eksistentiaalisesta haavoittuvuudesta, on se myös työtä, fyysisesti ja henkisesti raskasta sellaista. Tätä hoivan ilmiöitymisen ja epätasaisen jakautumisen huomiointia tukee fenomenologian sijaan paremmin jälkistrukturalistinen ajattelu, jonka myötä on mahdollista päästä käsiksi yhteisön (hoiva)rakenteina ilmenevien valtasuhteiden kielelliseen konstruoitumiseen.

Sanottaessa ”hoiva” voidaan viitata, ja toistuvasti viitataan, kumpaankin edellä mainituista merkityksistä, mikä aiheuttaa epäselvyyksiä hoivatutkimukselle ja luultavasti myös yhteiskunnallisella tasolla tehdyille päätöksille hoivan suhteen. Jaon tekeminen selväksi selventäisi myös hoivaan liittyviä feministisen politiikan keinoja ja tavoitteita.

Eriteltyäni hoivan kaksi merkitystä keskityn tarkastelemaan hoivan perustekijöitä sikäli kuin hoiva ymmärretään ensin mainitsemassani merkityksessä, elettynä kohtaamisena. Hyödynnän tässä neljän tutkimusartikkelin empiirisiä tuloksia sekä valikoituja fenomenologian ja hoivaetiikan kirjallisuuden näkökulmia. Väitän eletyn hoivakohtaamisen rakentuvan kolmelle perustekijälle, jotka ovat *toiseus*, *ruumiillisuus* ja *virittyminen*.

Toiseus ei tarkoita sitä itsestään selvää huomiota, että ”lisäkseni on olemassa muita ihmisiä tai olioita”, vaan sitä että kohdatessamme toisen kohtaamme jotakin radikaalilla tavalla ainutlaatuista maailmassa. Lainaan Emmanuel Lévinasilta (1979) ajatuksen siitä, että toisen ihmisen katse (tai kasvot, tai laajemmin ottaen ilmaisu) riisuu meidät aseista. Toisen katseen äärellä oleminen on meille radikaali ja loputon *kysymys*, joka auttamatta myös jää ilman selkeää vastausta. Toisin sanoen toiseutta ei voi milloinkaan täysin ottaa haltuun ja siten määritellä yksipuolisesti. Eletyssä maailmassa toisen kohtaaminen on siten myös oman olemisen eksistentiaalisen perustan rakentava hetki.

Toiseuden huomioimisen merkitys ilmenee hoivatyöntekijöiden haastatteluissa puheena siitä, miten asukkaiden ainutkertaiset historiat, taipumukset, tavat ja eleet sekä niihin kytkeytyvät tarpeet on huomioitava hoivassa. Työntekijät puhuvat myös yleistasoisen tiedon merkityksestä hoivalle, erityisesti tilanteissa, joissa iäkästä ihmistä ei entuudestaan tunneta. Kysyttäessä mikä on oleellisinta hyvässä hoivassa, vastaukset kuitenkin käsittelevät sitä, miten keskeistä on oppia tuntemaan asukkaan olemisen tapaa kokonaisvaltaisesti (Hämäläinen, 2022). Hoivatyöntekijät puhuvatkin palveluasumisen hoivasuhteiden vaativan erilaista ymmärrystä verrattuna sairaalaympäristöihin, joissa luonteeltaan yleistettävällä, esimerkiksi lääketieteellisellä tiedolla on suurempi merkitys. Hyvä hoiva edellyttää, että asukkaan toiseus – ainutkertaisuus – pääsee eletyssä kohtaamisessa esiin. Tämä on erityisen oleellista muistisairauksien tai muiden kognitiivisten tai fyysisten vaivojen määrittäessä toisen olemista. Haastatteluiden perusteella tällöin on keskeistä ymmärtää esimerkiksi radikaalilla tavalla poikkeavaa ajallista kokemusta. Jos esimerkiksi 90-vuotias muistisairas ihminen odottaa äitiään vierailulle, johtaa ymmärrys toiseudesta kysymään valloillaan oleviin tunteisiin liittyviä kysymyksiä ennemmin kuin vetoamaan objektiiviseen totuuteen sen suhteen, onko moinen vierailu mahdollinen.

Myöskään *ruumiillisuus* eletyn hoivakohtaamisen perustekijänä ei tarkoita ainoastaan itsestään selvää ymmärrystä ruumiin osatekijöistä, sitä että hoiva kohdistuu sangen usein ruumiin tarpeisiin, kuten syömiseen, ruumiineritteisiin tai siirtymiseen. Ruumiillisuuden fenomenologia viittaa siihen, että koemme maailman aina sisäisesti; havaitsemme maailman koko ajan auttamatta jostakin käsin, sillä maailmaa ei voi mielekkäästi havaita minään irrallisena tai yleisenä kokemuksena. Tämä "jostakin", josta käsin kaikki koetaan, on aina jokin ruumis. Ruumiillisuuden perinpohjainen merkitys avautuu Maurice Merleau-Pontyn (1962, 1968) ruumiinfenologiassa koko maailman havaitsemisemme ja ymmärryskykymme mahdollistajana. Hänen *käännettävyyden* (réversibilité) käsitteensä on eletyn hoivakohtaamisen ytimessä, sillä se viittaa siihen, miten olemme kokemuksessamme paradoksaalisesti yhtä aikaa sekä havaitsevia että havaittuja olentoja. Ruumiillisessa kokemuksessamme koskettaminen on mielekäs kokemus siinä missä kosketetuksi tuleminen. Se, että nämä kaksi lähtökohtaisesti erilaista kokemusta voivat yhdistyä yhdeksi kokemukseksi yhdellä hetkellä, paljastaa koko olemissuhteemme maailmaan nähden. Tapahdumme ruumiimme kautta omituisesti kahteen suuntaan yhdessä yhtenäisessä kokemuksessa.

Näkökulma ei ole helpoin ymmärtää, sillä otamme ruumiillisuutemme helposti itsestään selvänä – emmehän oikein muuta mahda, koska meillä on lähtökohtaisesti vain ruumiillisuudestamme kumpuava näkökulma. Käännettävyys on kuitenkin aivan eletyn hoivasuhteen ytimessä: jos mietimme aiemmin huomion kohteena ollutta toiseutta, tapahtuu toiseuden kohtaaminen nimenomaan kaksisuuntaisena kokemuksena toisen ruumiista (ks. myös Hamington, 2004, 2020; Daly, 2022). Lévinas puhuu kasvoista, koska tismalleen kasvoissa ruumiillisuuden ilmentyminen toiseutena on intensiivisimmillään. Meillä on kyky havaita toisen kasvoilta, ruumiin asennosta tai äänen sävystä erittäin hienovaraisesti hätää, iloa, levottomuutta, seksuaalista virittymistä, rauhaa ja niin edespäin. Hoiva elettynä kohtaamisena on juuri tuota ainutlaatuista, miltei automaattisen tuntuista kykyä vastata toisen ruumiissa havaittuihin, mitättömimmillään häviävän pieniin nyansseihin ja tarpeisiin – niiden ilmiselvien ruumiillisten hoitotarpeiden ohella.

Ruumiillisuuden perinpohjaisuus ilmenee haastatteluaineistossa erityisesti kysyessämme, miten hoivatyöntekijät tunnistavat muistisairaiden ihmisten tarpeita. Puhe hyvästä hoivasta koskee toki paikoin ilmiselvää ruumiintoimintoihin reagoimista, mutta puhuessaan hyvästä hoivasta haastateltujen puhe kääntyy usein ruumiin hienovaraisiin eleisiin, asentoihin, äänenpainoihin ja katseisiin (Hämäläinen, 2022). Eräs haastateltava sanoi huomaavansa ”pelkästä nenän asennosta, jos jokin on vialla”. Nämä huomiot osoittavat, että hoivassa on informaation ja yleisen tiedon sijasta ensisijaista niin sanottu hiljainen tieto. Hoitajat kertoivat ”vain jotenkin” tietävänsä, ”lukevansa” tai ”tuntevansa” mitä tehdä, käyttävänsä ”tuntosarvia” tai ”kuudetta aistia”, ”luovivansa” ja niin edelleen. Tämä kaikki selittämätön mutta kuitenkin keskeisessä osassa oleva tapahtuu juuri ruumiillisuutena, huomaamattomassa mutta ilmiselvässä maailmassa käyttämiemme sanojen tavoittamattomissa.

On tärkeää ymmärtää, että toiseus ja ruumiillisuus voivat näivettyä umpifilosofiseksi olemisen perustan puimiseksi, eräänlaisiksi neutraaleiksi tosiasioiksi, joiden äärellä saattaa silti olla liian helppo sanoa ”näin näyttää tosiaankin asian laita olevan, mutta miksi minun pitäisi alkaa hoivata muita?”. Tämän vuoksi tarvitaan vielä näistä tosiasioista kumpuavaa eettistä toimintaa. Kolmantena eletyn hoivakohtaamisen perustekijänä on siten *virittyminen*. Fenomenologi Knud Ejler Løgstrup (2020) kirjoittaa Lévinasin tapaan ”eettisestä velvoitteesta”, joka kumpuaa toiseudesta. Olemisemme haavoittuvuus tarkoittaa, että olemme aina lopulta auttamatta toisten ihmisten valintojen armoilla. Tämä tarkoittaa, että ihmisten välisiä suhteita määrittää perustavalla tavalla luottamus. Jokaisessa kohtaamisessamme toisen kanssa pidämme joko oman olemisemme kurssin tai sitten liikumme toisen suuntaan; toimimme joko toisen luottamuksesta käsin tai omista tarpeistamme käsin. Løgstrupin velvoite laittaa toiseuden ja ruumiillisuuden toimimaan konkreettisemmin välillämme. Oleminen toisen äärellä on siten lähtökohtaisesti ja jatkuvasti eettistä.

Jotta eettinen velvoite ei jäisi julistukseksi liitutaululla ja liian liki tuota umpifilosofisointia, on sen sisältöjä parempi tarkastella konkreettisia hoivan maailmasta kumpuavia esimerkkejä analysoiden (ks. myös Pols, 2015, 2023). Hoivatyöntekijöiden puhuessa hyvistä hoivakohtaamisista muistisairaiden ihmisten kanssa käy ilmi toisen kokemusmaailmaan virittymisen oleellisuus (Hämäläinen ym., 2024). Muistisairauden kohtaamisessa tämä on erityisesti ajallista virittymistä, jossa aikaa ei ymmärretä lineaarisena vaan laadullisena ilmiönä, *kestona* (durée) (Bergson, 2014). Hoiva on virittymistä toiseuteen ensinnäkin kuuntelemisena, mikä näkyy aineistossa puheena ”pysähtymisestä”, ”hidastamisesta” tai ”aidosta läsnäolosta”. Toisen olemista kuunnellaan nimenomaan siten, että toisen kokemus-maailma painottuu oman jäädessä taustalle. Muistisairauksien äärellä tämä on tietenkin aivan keskeistä, sillä muutoin hoivan sijaan kohtaamista määrittäisi toisen puolesta joko oma, ei-muistisairauden määrittämä kokemus tai institutionaaliset raamit, kuten tietojärjestelmät tai hoivakodin seinällä olevan kellon viisarit. Kuuntelemisen lisäksi virittyminen on myös ilmaisemista, eli esimerkiksi tietynlaista puhetta hoivatoimien yhteydessä. Tehostetun palveluasumisen maailma on täynnä muistisairaan ihmisen kokemuksesta käsin vieraita tai pelottavia, ruumiillisesti intensiivisiä kokemuksia, kuten pestyksi, syötetyksi tai sängystä nostolaitteilla nostetuksi tulemista. Näissä tapahtumissa on keskeistä se, että hoivaa antava ihminen virittää muistisairaan maailmaa ilmaisullaan kohti tapahtuvaa tai tulevaa tilannetta. Konkreettisesti tämä tarkoittaa esimerkiksi pehmeää äänensävyä ja erityisesti muistisairaan ajallisuutena tapahtuvan toiseuden näkökulmasta puhumista.

Eriteltyäni elettyjen hoivakohtaamisten kolme perustekijää, käännän katseeni kohti tämänhetkisiä, yhteiskunnallisia hoivailmiöitä. Tarkastelen myös iäkkäiden ihmisten ympärivuorokautisen hoivan teknologisoitumista ja sitä, miten se suhteutuu aiemmin erittelemiini hoivan ihanteisiin. Erittelen kahden artikkelin tulosten perusteella asiakas- ja potilastietojärjestelmien sekä rannekehälytysjärjestelmien vaikutusta hoivatyöhön ja hoivakohtaamisiin. Näiden tulosten tulkintaa ohjaa teoreettinen lähtökohta, joka ammentaa tieteen ja teknologian tutkimuksen (social studies of science and technology tai STS) perinteen sosiomateriaalisuuden ajatuksesta. Tällöin ihmisen luomien esineiden, laitteiden, järjestelmien, tai laajemmin ymmärrettynä materian ylipäätään, ajatellaan muovaavan sosiaalista kokemusmaailmaa merkityksineen ihmistoimijoiden rinnalla (ks. esim. Gherardi, 2016; Akrich ja Latour, 1992; Mol ym., 2010).

Tätä nykyä laajasti iäkkäiden ihmisten hoivatyössä käytettävät asiakastietojärjestelmät ovat sovelluksia, joihin kirjataan päivittäin hoivatoimenpiteitä, tutkimustuloksia ja muita asukkaan hoivan kannalta oleellisia tietoja ja huomioita (Hämäläinen ja Hirvonen, 2020). Ne toimivat osittain käsikirjoituksensa mukaisesti, eli selkeyttävät informaation kulkua organisaatioiden välillä ja parantavat tiedon tarkastettavuutta, mutta hoivatyöntekijöiden puheessa ne kuitenkin myös muovaavat monisyistä hoivaa ennalta määrättyyn muottiin. Asiakastietojärjestelmiin liitetty ”rakenteellisen kirjaamisen” ihanne tai velvoite, eli ennalta määritellyt kategoriat hoivatoimenpiteille, koetaan karkeina elettyihin hoivakohtaamisiin nähden. Hoivatyöntekijät ovat myös turhautuneita kasvaviin vaatimuksiin hallita järjestelmiä varsinaisen asukkaiden kanssa tapahtuvan läsnäolon kustannuksella.

Hälytysjärjestelmissä on kyse asukkaan mukana olevasta painikkeesta tai elintoimintoja mittaavista sensoreista hoivatyöntekijöiden työpuhelimiin lähtevistä hälytyksistä, joiden koetaan luovan omaisille, työntekijöille ja kognitiivisesti kyvykkäille iäkkäille ihmisille turvallisuuden tunnetta. Hoivatyöntekijöiden puhuessa hyvistä hoivakohtaamista muistisairaiden asukkaiden kanssa hälytysten koettiin kuitenkin myös häiritsevän merkittävästi kohtaamisia tehostetun palveluasumisen arjessa (Hämäläinen ym., 2024). Erityisesti muistisairaan ihmisen maailmaan virittymisen kannalta piippaavat ja kilahtelevat hälytykset koettiin ärsyttävinä (ks. myös Lydahl, 2023).

Siinä missä hoivan teknologisoitumisen ”kolmoisvoitto” pitää paikkansa joillakin osa-alueilla, näyttää se perustuvan enenevässä määrin ajattelun välineellistymiseen, jolloin hoivan käytäntöjä määrää informaatio, hyöty, järjestelmällisyys tai laskennallinen vaikuttavuus. Tällöin hoivan sisällöt näyttävät typistyvän suorituksiksi, tekniikoiksi tai minuuteiksi. Teknologioistumisen luonne tulisi kuitenkin ajatella välineellisen ongelmiin vastaamisen sijaan haavoittuvuuden kautta: vastatessaan tiettyyn haavoittuvuuteen teknologia luo aina uusia haavoittuvuuksia toisaalle (Coeckelbergh, 2013). Välineellistyminen lienee yhteydessä myös uusliberaaliin eetokseen, jossa markkinaihanteita istutetaan yhteiskunnan alueille, jotka ovat tavanneet perustua johonkin muuhun kuin markkinoiden logiikkaan (Dahl ja Hansen, 2021; Harvey, 2005; Anttonen ja Häikiö, 2011; Hoppania, 2019; Hoppania et al., 2022; Karsio, 2024). Jotta hoivaa voidaan sysätä markkinoille, se täytyy ensin paloitella ja määritellä hoivatuotteiksi.

Hoivan välineellinen teknologisoiminen uhkaa hämärtää hoivan perustekijöiden merkitystä. Tutkielman johtopäätöksenä esitän, että hoivan teknologisoiminen tulee ajatella uudelleen, aloittaen ajattelu hoivan eletystä maailmasta ja sen ihanteista käsin. Olemisemme lähtökohtaiseen haavoittuvuuteen vastaaminen edellyttää ymmärrystä olemisemme eettis-ontologisesta perustasta. Hoivan ihanteiden, toiseuden, ruumiillisuuden ja virittymisen merkityksistä katsottuna välineellistyminen murentaa hoivan, ja siten koko inhimillisen, haavoittuvan olemisemme perustaa.

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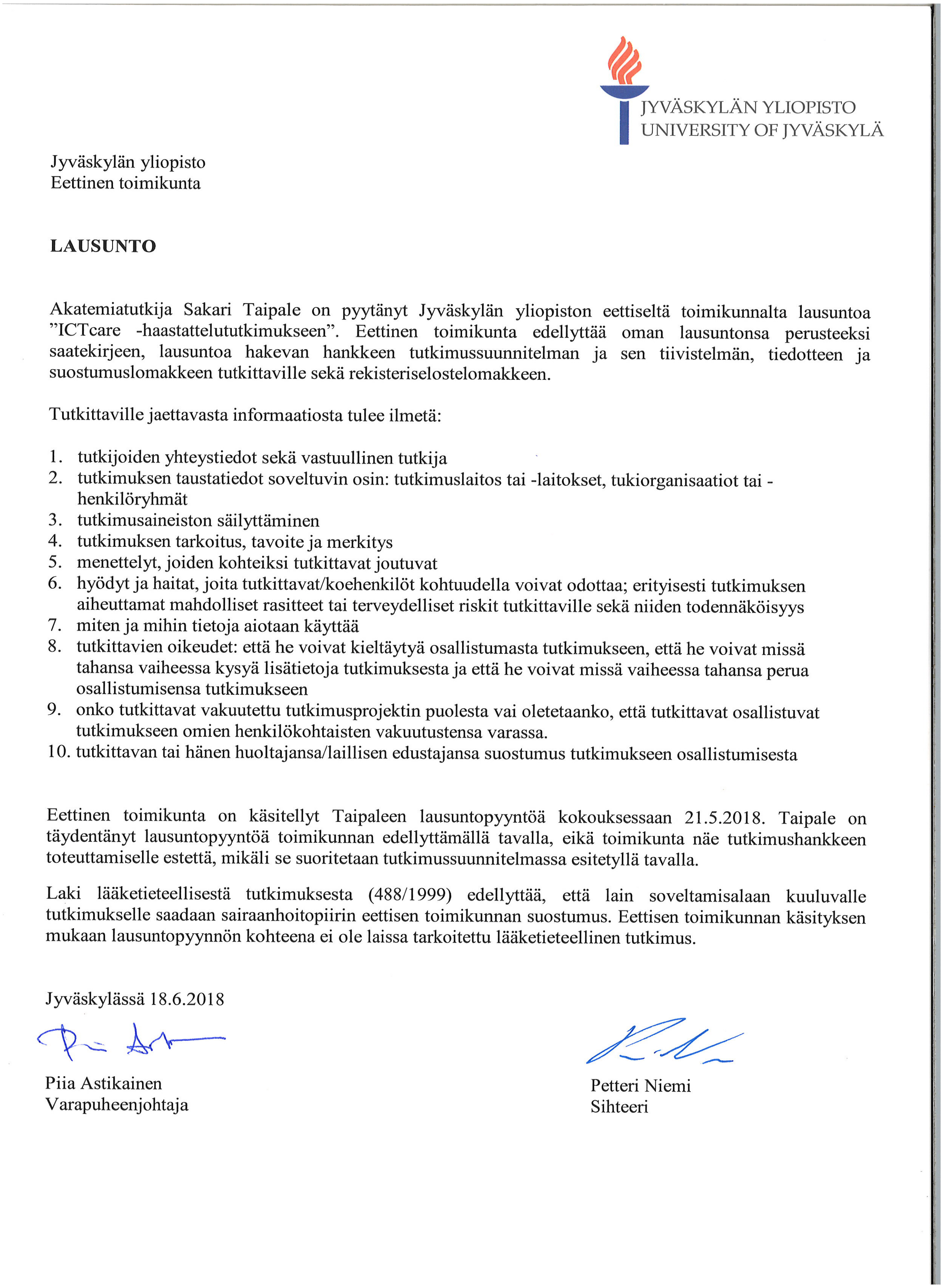
APPENDICES

APPENDIX 1: DATA, METHODS AND ROLES IN THE ARTICLES BASING THE STUDY

Article no.	**Article I**	**Article II**	**Article III**	**Article IV**
Reference	Hämäläinen, A. (2020). Responses to vulnerability: Care ethics and the technologisation of eldercare. *International Journal of Care and Caring*, *4*(2), 167–182.	Hämäläinen, A. (2022). The epistemological complexity of ideal care: Long-term care professionals' perspectives. *International Journal of Care and Caring, 6*(4), 493–509.	Hämäläinen, A., Leinonen, E., and Era, S. (2024). Attunement as a practice of encountering dementia time in long-term eldercare work. *Time and Society, 33*(2), 170–190.	Hämäläinen, A., and Hirvonen, H. (2020). Electronic Health Records reshaping the socio-technical practices in Long-Term Care of older persons. *Technology in Society, 62*, 101316.
Data	-	Qualitative interview data (ICTCare data, n=25)	Qualitative interview data (ICTCare data, n=25)	Qualitative interview data (ICTCare data, n=25)
Data gathering roles	-	50 % Hämäläinen 50 % Hirvonen	50 % Hämäläinen 50 % Hirvonen	50 % Hämäläinen 50 % Hirvonen
Analysis method	-	Thematic content analysis	Thematic content analysis	Thematic content analysis
Analysis roles	-	100 % Hämäläinen	50 % Hämäläinen 25 % Leinonen 25 % Era	75 % Hämäläinen 25 % Hirvonen

APPENDIX 2: APPROVAL OF THE ICTCARE DATA GATHERING BY THE ETHICAL COMMITTEE OF THE UNIVERSITY OF JYVÄSKYLÄ



JYVÄSKYLÄN YLIOPISTO
UNIVERSITY OF JYVÄSKYLÄ

Jyväskylän yliopisto
Eettinen toimikunta

LAUSUNTO

Akatemiatutkija Sakari Taipale on pyytänyt Jyväskylän yliopiston eettiseltä toimikunnalta lausuntoa "ICTcare -haastattelututkimukseen". Eettinen toimikunta edellyttää oman lausuntonsa perusteeksi saatekirjeen, lausuntoa hakevan hankkeen tutkimussuunnitelman ja sen tiivistelmän, tiedotteen ja suostumuslomakkeen tutkittaville sekä rekisteriselostelomakkeen.

Tutkittaville jaettavasta informaatiosta tulee ilmetä:

1. tutkijoiden yhteystiedot sekä vastuullinen tutkija
2. tutkimuksen taustatiedot soveltuvin osin: tutkimuslaitos tai -laitokset, tukiorganisaatiot tai -henkilöryhmät
3. tutkimusaineiston säilyttäminen
4. tutkimuksen tarkoitus, tavoite ja merkitys
5. menettelyt, joiden kohteiksi tutkittavat joutuvat
6. hyödyt ja haitat, joita tutkittavat/koehenkilöt kohtuudella voivat odottaa; erityisesti tutkimuksen aiheuttamat mahdolliset rasitteet tai terveydelliset riskit tutkittaville sekä niiden todennäköisyys
7. miten ja mihin tietoja aiotaan käyttää
8. tutkittavien oikeudet: että he voivat kieltäytyä osallistumasta tutkimukseen, että he voivat missä tahansa vaiheessa kysyä lisätietoja tutkimuksesta ja että he voivat missä vaiheessa tahansa perua osallistumisensa tutkimukseen
9. onko tutkittavat vakuutettu tutkimusprojektin puolesta vai oletetaanko, että tutkittavat osallistuvat tutkimukseen omien henkilökohtaisten vakuutustensa varassa.
10. tutkittavan tai hänen huoltajansa/laillisen edustajansa suostumus tutkimukseen osallistumisesta

Eettinen toimikunta on käsitellyt Taipaleen lausuntopyyntöä kokouksessaan 21.5.2018. Taipale on täydentänyt lausuntopyyntöä toimikunnan edellyttämällä tavalla, eikä toimikunta näe tutkimushankkeen toteuttamiselle estettä, mikäli se suoritetaan tutkimussuunnitelmassa esitetyllä tavalla.

Laki lääketieteellisestä tutkimuksesta (488/1999) edellyttää, että lain soveltamisalaan kuuluvalle tutkimukselle saadaan sairaanhoitopiirin eettisen toimikunnan suostumus. Eettisen toimikunnan käsityksen mukaan lausuntopyynnön kohteena ei ole laissa tarkoitettu lääketieteellinen tutkimus.

Jyväskylässä 18.6.2018

Piia Astikainen
Varapuheenjohtaja

Petteri Niemi
Sihteeri

APPENDIX 3: THE ICTCARE INTERVIEW FRAME

Thematic interview framework for the ICTcare interviews (translated by AH)

Preliminary questions

Background questions: occupation, age, place of birth, work history, life situation.

How did you originally become involved in the care sector?

What was your previous working day like? (Follow-up question: What were the good or bad moments of the day for you? Were there any memorable moments in your day?)

Was the day particularly busy or difficult? If yes/no, describe a busy day or a good day?

Mental resources and security

Can you think of any situations in your work recently that would have brought you joy, happiness and pleasure? How have you expressed these feelings?

Can you think of any recent situations where you have felt irritated, angry or frustrated? How have you expressed these feelings?

What kind of conflicts or disagreements between people have you encountered in your work? How have you dealt with these situations?

Have any devices or applications caused any incidents at work? What kind of incidents?

Do the devices or apps affect the safety of the residents?

What does the gender of the caregiver matter or does it matter at all? Can you recall situations where your own femininity/masculinity felt important or meaningful or where you were reminded of your femininity/masculinity? In what ways is your own femininity/masculinity a strength or weakness in caregiving?

The essence of caring in care work

In what ways does care work feel different from other jobs? Is it easy or difficult to get people who work in other fields to understand the contents and specific nature of your work?
What do you think about the responsibility (being responsible for the life or basic needs of another person) in care work? When do you feel burdened by responsibility? What helps with this?

Is it easy to limit responsibility and caring to workplace situations?

What do you think about the statement that at work you have to be both sensitive and strong at the same time? What do the demands of sensitivity and strength mean? In what situations have your own sensitivity and strengths come to the fore?

Technology is seen as making care work easier and more effective in the future. What do you think about technologies used in care work? Do devices and applications make your work easier? In what ways?

Do you think the technology used in care work is good for the residents?

Tell us about a situation where a device or app has particularly helped you to care for a resident?

Please describe a situation where the device or app has particularly hindered the care of a resident?

Interaction and responding to needs

Describe how you meet clients in your daily work. Has this changed during your career?

Please describe an ideal interaction situation with a client.

What are the factors that enable a good interaction with a client? What are the obstacles to a good relationship?

How can you influence the quality of the relationship?

What are the things that help you identify the needs of the person you are caring for?

How does the carer's limited expressive capacity affect your practice?

Please tell me about a situation in which you have interpreted the needs of a person with a memory impairment from a gesture other than a request?

What aspects of the person you are caring for are in the focus of your attention if they do not express their needs verbally a) at all b) very limitedly c) somewhat limitedly?

In what ways do devices or applications affect the well-being of the resident?

Do the devices or apps affect the interaction with the carer? What about the person with memory loss? If so, how?

Control of work and life outside work

Do you sometimes feel that caring for others conflicts with living your own life or taking care of your own needs? Please tell me about a situation where you have been flexible with your own needs/life. How did this feel?

The three wishes: what would you change in your work if you could? What would you like to keep?

If you had a choice, what would you like to do in your life right now?

What would have been worth asking? Was there anything essential you didn't ask or something else you would like to add or clarify?

APPENDIX 4: THE INFORMATION AND CONSENT DOCUMENT WITH REGARD TO ICTCARE DATA GATHERING

Jyväskylän yliopiston ICTcare -haastattelututkimus

TIEDOTE TUTKITTAVILLE JA SUOSTUMUS TUTKIMUKSEEN OSALLISTUMISESTA

(Researcher's contact information omitted.)

Tutkimuksen taustatiedot

Tämä haastattelututkimus on osa Jyväskylän yliopiston Teknologiat, ikääntyminen ja hoiva –tutkimusprojektia, joka kuuluu Suomen Akatemian rahoittamaan Ikääntymisen ja hoivan tutkimuksen huippuyksikköön. Yksikössä tutkitaan vuosina 2018–2025 laajasti ikääntyneiden hoivaan liittyviä ajankohtaisia kysymyksiä. Jyväskylän tutkimusryhmämme kiinnostus kohdistuu erityisesti teknologioiden rooliin hoivan järjestämisessä. Keräämme aineistoa kahdesta Suomessa sijaitsevasta kaupungista, jotta saamme hoivatyöstä mahdollisimman kattavaa tutkimustietoa. Tutkimushaastattelut (N=30) tullaan toteuttamaan tehostetun palveluasumisen yksiköissä työskentelevän henkilöstön piirissä syksyn 2018 ja kevään 2019 aikana.

Ikääntyneiden parissa toimivien hoivatyöntekijöiden haastatteleminen on nyt ajankohtaista, sillä hoivatyö on muutoksessa erityisesti teknologioiden hyödyntämisen osalta. Tahdomme haastatteluiden avulla selvittää ikääntyneiden hoivaan liittyvän työn sisältöä ja ajankäyttö teknologioiden käytön näkökulmasta. Lisäksi olemme kiinnostuneet siitä, miten hoivatyöntekijät kokevat hoivan arkisen kanssakäymisen ja millaisia haasteita, päätöksiä ja näkemyksiä ikääntyneiden hoivaamiseen ja teknologioiden käyttöön hoivatyössä liittyy. Tutkimuksen merkitys on siten yhtäältä tuottaa ajankohtaista tieteellistä tutkimustietoa ikääntyneiden hoivan käytännöistä ja toisaalta tuoda hoivatyöntekijöiden ääntä esiin ja osaksi yhteiskunnallista keskustelua, joka määrittää hoivatyön tulevaisuutta.

Tutkimusaineiston käyttötarkoitus, käsittely ja säilyttäminen

Haastatteluissa kerätty tieto on täysin luottamuksellista. Luottamuksen säilyminen varmistetaan anonymisoimalla eli koodaamalla piiloon kaikki sellainen tieto, josta haastateltava on mahdollista tunnistaa. Käytännössä tämä tarkoittaa sitä, että haastateltaviin viitataan äänitteissä summittaisella tunnistenumerolla ja että haastatteluteksteistä häivytetään esimerkiksi paikkoihin ja henkilöihin liittyvä tieto, josta haastateltava tai haastattelun aikana mainitut kolmannet osapuolet kuten potilaat tai toiset työntekijät voitaisiin tunnistaa. Aineistoa, jota ei voida näin toimien anonymisoida, ei anneta jatkokäyttöön. Tutkijat pitävät yllä salassa pidettävää avainlistausta haastateltavien tunnistenumeroista sekä henkilötiedoista. Salasanasuojattuja aineistoja säilytetään Jyväskylän yliopiston verkkolevyllä, jolle on pääsy vain tutkimusryhmän jäsenillä.

Aineistoa tullaan käyttämään ensisijaisesti Ikääntymisen ja hoivan tutkimuksen huippuyksikön tutkimustarpeisiin. Tutkimusryhmämme laajat verkostot mahdollistavat sen, että tutkimustuloksia tullaan esittelemään sekä kansallisesti että kansainvälisesti yhteiskuntatieteisiin kytkeytyvissä tieteellisissä aikakauslehdissä, konferensseissa, opinnäytetöissä ja opetuskäytössä. Voimme raportoida julkaisuistamme haastateltavien niin toivoessa heille myös suoraan esimerkiksi sähköpostitse.

Pääsy aineistoon on Hirvosen ja Hämäläisen lisäksi tutkimusryhmän ICTcare vastuullisella johtajalla (Sakari Taipale), jonka suostumusta edellytetään anonymisoidun aineiston jatkokäyttöön. Aineiston pitkäaikaissäilytys tapahtuu Tampereen tietoarkistossa hankkeen päätyttyä vuonna 2025, jolloin salassa pidetyt ja haastateltavien tunnistenumerot sekä henkilötiedot yhdistävät avainlistaukset hävitetään tutkittavien yksityisyyden suojaamiseksi myös hankkeen päättymisen jälkeen. Tutkittavalla on haastattelun yhteydessä ja hankkeen aikana (2018–2025) mahdollisuus kieltää häntä koskevan aineiston luovuttaminen jatkokäyttöön. Tunnistenumeroiden hävittämisen jälkeen tämä ei ole enää mahdollista, sillä henkilötietoja ja anonymisoitua haastatteluaineistoa ei silloin ole enää mahdollista yhdistää toisiinsa.

Menettelyt, joiden kohteeksi tutkittavat joutuvat

Haastateltavaksi kutsutaan tehostetun palveluasumisen yksiköissä työskenteleviä täysi-ikäisiä työntekijöitä n. 1-1.,5 tunnin mittaiseen yksilöhaastatteluun. Haastatteluun osallistumisesta kiinnostuneita pyydetään ottamaan suoraa yhteyttä haastattelut toteuttaviin tutkijoihin (Helena Hirvonen tai Antti Hämäläinen) puhelimitse tai sähköpostitse sopiakseen haastattelun ajankohdasta ja paikasta. Haastattelu nauhoitetaan ja myöhemmin litteroidaan eli kirjoitetaan auki nauhoitteen pohjalta. Haastateltavalta pyydetään lupa haastattelun jälkeiseen jatkoyhteydenottoon tarvittaessa haastattelussa esiin tulleiden seikkojen tarkentamiseksi.

Haastattelun teemat koskevat ikääntyneiden asiakkaiden ja potilaiden parissa tehtävää ammatillista hoiva- ja hoitotyötä: haastattelussa keskustellaan aiheesta hyvin vapaamuotoisesti. Haastateltavaa pyydetään kuvailemaan omin sanoin mm. työtään, sen arkisia rutiineja, kokemuksia asiakastyön haasteista ja työn palkitsevuudesta sekä omassa työssä koetuista muutoksista viime vuosien ajalta. Kysymykset on suunniteltu siten, etteivät ne loukkaa haastateltavan yksityisyyttä eivätkä koske yksittäisiä potilas- tai asiakastapauksia. Ennen haastattelun alkua haastateltavan kanssa keskustellaan lyhyesti pyrkimyksestä kolmansien osapuolten (asiakkaat, potilaat, kollegat) yksityisyyden varjelemiseen haastattelun aikana.

Tutkimuksen hyödyt ja haitat tutkittaville

Tutkimukseen osallistuvat antavat tutkijoille arvokasta tietoa jota tutkijat voivat edelleen jakaa laajalle yleisölle: politiikan ja julkisen hallinnon päätöksentekijöille, lehdistölle, ammattijärjestöille sekä koti- ja ulkomaiselle tutkimusyhteisölle. Tutkimustieto voi parantaa tutkijoiden ja päättäjien tietoutta ja ymmärrystä myös sellaisista seikoista, jotka aiemmassa vanhustyön tutkimuksessa ovat jääneet vähälle huomiolle.

Tutkittavien oikeudet ja vakuutukset

Haastateltavan työnantaja on antanut suostumuksensa haastattelukutsun levittämiseen sen henkilöstösähköpostilistojen kautta. Tutkimukseen osallistuminen ei edellytä tämän lisäksi erillistä suostumusta haastateltavan esimieheltä tai työnantajalta. Osallistuminen tutkimukseen on täysin vapaaehtoista. Haastattelu on täysin luottamuksellinen ja se toteutetaan haastateltavan työajan ulkopuolella. Tutkittavilla on tutkimuksen aikana oikeus kieltäytyä tutkimuksesta ja keskeyttää tai perua osallistumisensa syytä ilmoittamatta missä vaiheessa tahansa ilman, että siitä aiheutuu heille mitään seuraamuksia.

Tutkimuksen järjestelyt ja tulosten raportointi ovat luottamuksellisia. Tutkimuksen tulokset julkaistaan tutkimusraporteissa siten, ettei yksittäistä tutkittavaa voida tunnistaa. Tutkittavilla on oikeus saada lisätietoa tutkimuksesta tutkijaryhmän jäseniltä missä vaiheessa tahansa. Tutkimuksesta on täytetty henkilötietolain edellyttämä rekisteriseloste, jonka tutkittava halutessaan saa tutkijoilta nähtäväkseen.

Jyväskylän yliopiston henkilökunta ja toiminta on vakuutettu. Vakuutus on voimassa tutkimuksissa ja niihin välittömästi liittyvillä matkoilla. Vakuutus sisältää henkilökunnan (tutkijan) potilasvakuutuksen, toiminnanvastuuvakuutuksen ja vapaaehtoisen tapaturmavakuutuksen. Tutkittavalla olisi hyvä olla oma henkilökohtainen tapaturma/sairaus-ja henkivakuutus, koska tutkimusprojekteja varten vakuutusyhtiöt eivät myönnä täysin kattavaa vakuutusturvaa. esim. sairauskohtauksien varalta.

Tutkittavan suostumus tutkimukseen osallistumisesta

Olen tutustunut yllä kuvattuun selosteeseen ja täten annan suostumukseni

☐ haastattelun nauhoittamiseen ja nauhoitteen litterointiin sekä anonymisointiin,

☐ henkilötietojeni (nimi, yhteystieto, ammatti, työkokemus vuosissa) säilyttämiseen tutkimusryhmän ylläpitämässä rekisterissä,

☐ haastattelun suorittaneen tutkijan jatkoyhteydenottoon tarvittaessa haastattelua koskevan tiedon tarkentamiseksi,

☐ anonymisoidun aineiston käyttöön tutkimus- ja opetustarkoituksessa (esim. tieteelliset julkaisut ja esitelmät konferensseissa ja seminaareissa),

☐ anonymisoidun aineiston pitkäaikaissäilytykseen ja jatkokäyttöön opetus- ja tutkimustarkoituksessa varsinaisen tutkimushankkeen päätyttyä.

Olen perehtynyt tämän tutkimuksen tarkoitukseen ja sisältöön, kerättävän tutkimusaineiston käyttöön, tutkittaville aiheutuviin mahdollisiin haittoihin sekä tutkittavien oikeuksiin ja vakuutusturvaan. Suostun osallistumaan tutkimukseen annettujen ohjeiden mukaisesti. Voin halutessani peruuttaa tai keskeyttää osallistumiseni tai kieltäytyä tutkimukseen osallistumisesta missä vaiheessa tahansa. Tutkimustuloksiani ja kerättyä aineistoa saa käyttää ja hyödyntää sellaisessa muodossa, jossa yksittäistä tutkittavaa ei voi tunnistaa.

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Päiväys Tutkittavan allekirjoitus

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Päiväys Tutkijan allekirjoitus

ORIGINAL PAPERS

I

RESPONSES TO VULNERABILITY: CARE ETHICS AND THE TECHNOLOGISATION OF ELDERCARE

by

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Responses to vulnerability – care ethics and the technologisation of eldercare

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Abstract

This article argues for a reconceptualisation of care relations and uses the reconceptualisation to scrutinise the way technology is adopted in eldercare practices. First, it draws on the definition of care as attentiveness to vulnerability, used in the tradition of care ethics. Second, it specifies four essential aspects of care relations: relationality, dyadic mutuality, corporeality and devotion. Third, using socio-technical and phenomenological perspectives, care relations are contrasted with the idea of intertwining technological and human actors in care practices. Finally, using two adaptations of telecare as examples, the essential aspects of care relations are shown to be crucial for a thorough socio-technical understanding of eldercare and technology.

Keywords: care ethics, eldercare technologisation, phenomenology, STS

Introduction

A first stage in considering the role of new technologies in care practices requires thorough work to clarify some essential aspects of care relations. Instead of aiming for an exhaustive definition of caring, I identify certain elements of its immediate interpersonality, with the help of care ethics, social ontology and phenomenology. These conceptual moves are made to strengthen the argument that the special characteristics of care should be emphasised over more technocratic and economic views concerning care policy (Wærness, 1984b; Gilligan, 1982; Tronto, 2013).

After exploring essential aspects of care relations, I look at the role of technologies in eldercare arrangements using also ideas related to Social Studies of Science and Technology (STS), where the equivocality with regard to what is human and what is technological in a given practice is brought to the fore (eg. Latour and Woolgar, 1986). This approach offers an understanding of technology as an integral part of care arrangements (and vice versa).

Eldercare provides an important context in which to consider these assumptions. New technologies have played a pioneering role in eldercare in Western societies, yet older people as end-users have been neglected in design processes (Östlund et al, 2015). While central reasons for the technologisation of eldercare seem to revolve around challenges involving the economic resourcing of ageing populations, the impacts of technologisation on the characteristics of care also require serious attention. Eldercare is also contextually important on account of vulnerability. Old age increases the probability of requiring care, which, at the same time, exposes the vulnerability we face regarding our existence. Ageing forces us to consider the boundaries of our being, the fact that none of us can escape harm, and therefore that we all rely on other people's help.

This article seeks answers to two conceptual questions: (1) *what is specific to interpersonal care relations,* and (2) *what does this specificity mean when adopting new technologies in eldercare practices*? In the first section, the tradition of care ethics is briefly introduced and care is framed around the concept of vulnerability. The second section scrutinises the four essential aspects of interpersonal care relations, the first of which is *relationality,* a concept found in the literature on care ethics. The second aspect is *dyadic mutuality*, which is considered crucial in terms of the relational stance. In a third aspect, care relations are considered in terms of *corporeality*, whereby caring is tied to concrete, embodied interactions. The fourth aspect explores the ethical obligation of care relations in terms of *devotion*. In order to analyse how technology is situated in care relations, the third section of the article contrasts care ethics with perspectives of socio-technicality and explores the impacts of two telecare technologies on eldercare practices, ultimately clarifying the analytical potential of the theoretical framework established in the second section of the article. The final section presents the article's concluding remarks on the technologisation of eldercare.

Care ethics as a philosophy of vulnerability

In the 1970s and 1980s, "second-wave feminism" established with it a relational moral philosophy called *care ethics,* which has recently undergone a growth in popularity (Hamington, 2018: 312). Care ethicists contrast their thinking with Western, liberal moral philosophy by criticising its foundation in abstract formulations resulting in symmetrical actions made by atomistic rational actors (Gilligan, 1982; Noddings, 1984). According to Stephanie Collins' (2015) reading of the history of care ethics, care ethicists maintain that moral responsibility is situational in that moral deliberation is tied to the relations between particular people with unique histories rather than to abstract principles. In her summary, care ethics also holds that the particular needs of vulnerable individuals need to be the focus of moral attention rather than the universal rights of rational agents. Care ethics also views moral deliberation as an ongoing process, rather than as detached acts or reciprocal calculations, and considers that the actions and attitudes involved in active caring for another being are needed rather than, or at least in addition to, mere non-interference (Collins, 2015: 5). Therefore, while 'care' has been multifacetedly used as a philosophical concept also before care ethics, I view and develop it in concert with the perspectives of care ethics introduced in the past four decades – in broad terms, as a response to the need of another being.

Care ethicists have argued that dependency is an essential aspect of care, in that becoming a person inexorably involves receiving some sort of care. Sarah Clark Miller (2005) writes:

> [...] persons are not fundamentally independent. Rather, they are mutually dependent. Our unavoidable dependency means that if we are to survive, let alone thrive in leading lives that are recognizably human, others must respond to our dependent selves by meeting our needs through their caring actions. During certain life moments, failure on the part of others to do so could amount to our demise. But I am not solely a dependent being who needs others to bolster my well-being; others, in their inevitable dependence, also need my assistance, hence solidifying the mutuality of the relation. (Miller, 2005: 140–141).

In this vein, the mutuality and reciprocity involved in relating to the interdependence between oneself and another similar being form the ethical basis of care. Every human being has entered the world completely helpless and will experience periods of helplessness during their life course, during which being human is considered to be conditioned by a dependence on others (Kittay, 1999; Held, 2006; Tronto, 2013).

Daniel Engster (2018) has recently argued that care ethics should view dependency as subordinate to *vulnerability*. While care constitutes the addressing of explicit human dependency *par excellence*, a broader concept of vulnerability is fruitful in emphasising the fact that we are all vulnerable to unwanted ailments, injuries, diseases, and so forth – and therefore to a potential dependence on others – throughout our life course. An emphasis on "unwanted" is crucial, in that vulnerability does not always appear in negative forms. Sometimes choosing to make oneself vulnerable is necessary in order to build close relationships with others, or in terms of other enriching aspects of our lives (Engster, 2018: 7).

While there is a broad discussion on vulnerability and care (see MacKenzie et al, 2013), at this point it suffices to support Engster's view with some notions of phenomenology, where vulnerability is thought to stem from the tacit understanding of our existence as something limited by death. Being human is always *being-at-risk*, due to the possibility of being violated. This may involve violation by the other, in terms of neglect or violence, or may involve one's own suffering and death (Coeckelbergh, 2013). Vulnerability of this magnitude bases care ethics better than (only) the situational dependence on others. Therefore, human vulnerability is not a stable concept. It resides in neither the subject nor the object – neither within us nor 'out there'. It is defined instead by the fluid relations between the subject and the object. Humans become vulnerable by acting in relation to others and the world around them (Coeckelbergh, 2013: 43–45).

Based on the above, one of the core arguments of care ethics would seem to be that care relations are very special existential loci, because they are precisely where vulnerability is addressed (or left unaddressed). I take this as the point of departure for the further exploration of interpersonal care relations.

What are the essential aspects of care relations?

This section explores the aspects which can be considered to condition caring in terms of responding to vulnerability. It does not claim to cover everything involved in caring, but rather seeks what should be regarded as, at the very least, the essential aspects of immediate care relations. These features are presented as *relationality, dyadic mutuality, corporeality* and *devotion*.

First, however, it is necessary to clarify what is meant here by 'essentiality', especially as its gendered definition was explicitly abandoned in care ethics a long time ago (Tronto, 1993; Kittay, 1999). While essentiality will be clarified in the process of exploring the different aspects of care, at this point it is best defined as something that refers to ontology. Examples of ontological assumptions in care ethics are, for example, that dependency and relationality are fundamental to the human condition. Here, the ontological in terms of care relations refers to the culturally stable aspects of human inter-relatedness – to the way we have come to *exist in relation to one another and to the world* through care. Importantly, the essentiality of the characteristics of care relations does not mean metaphysical essentiality, but rather the conceptual stability resulting from the historical depth of these characteristics. For instance, technology has been part of our being since stones were made into tools and fire was mastered, meaning that it has been embedded into our experience and our traditions for so long that being itself cannot be construed without it (Stiegler, 1998). Similarly, our immediate relationship to another sentient and vulnerable being, distinguished from other forms of being, has been built into the way we relate to the world for at least as long as technology in the aforementioned sense. This interpretation of essentiality is important in that the exploration of care phenomena, such as different forms of technologisation, also requires some emphasis on the depth of the relations at the core of caring.

The *relationality* of vulnerability

The first essential aspect of interpersonal care relations is *relationality*, one of the conceptual cornerstones in the tradition of care ethics. Joan Tronto writes:

> To care well requires the recognition that care is relational: no judgment about whether care is good can be accomplished from a singular perspective, not that of caregivers or care receivers. (Tronto, 2013: 140)

This relational stance is thought to be in conflict with modernist moral philosophies that seek universal moral guidelines in order to overcome the relational aspects of morality (Wilshire, 1992; Hekman, 1995). In care ethics, interdependency is morally emphasised over independency in that caring is situated within the relational co-existence between people, not only as the deliberation of self-sufficient individuals (Held, 2006). Presenting agency as fluid means that ongoing and situational relationships can transcend dull categorisations such as 'consumers', 'care receivers' or 'older people', and seek instead the moral essence in the *particularities* of each interaction (Hill and Thomson, 2017: 179). Care interactions draw attention to vulnerabilities we all share, but which are manifested in unique ways, for they always involve different people with differing histories.

In the aforementioned sense, situationality and temporality are at the core of the relational, ethico-ontological understanding of care ethics. Care ethicists' views on relationality have partly referred to the complex social, economic and political relations that organise, facilitate and hinder caring. The focus has therefore often been on culturally constructed phenomena, for example on the perspectives of gender and labour, and rightly so, for caring is historically gendered and has remained on the margins of Western moral philosophy. This academic marginalisation is no surprise, as those involved in caring, predominantly women, have also been socially marginalised by patriarchy, rendering care an invisible form of labour (Gilligan, 1982; Tronto, 1993). In short, along with exploring the essential "nature" of caring, it is also important to regard the dangers of essentialisations, in that they can (and evidently have) lead to unequal caring responsibilities. These perspectives provide a good definition of the historically polarised aspects of care, and have been explored thoroughly for example in Tronto's *Caring Democracy* (2013).

While each caring event is inevitably affected by the aforementioned cultural relationalities, my aim is to explore the more immediate life-world of particular caring events. This approach benefits from a more narrow definition of relationality, the repercussions of which are further explicated in the next subsection concerning dyadicity. Generally, however, this means steering away from political theorisations of care towards a more phenomenological perspective. I agree with the view that the explanatory force of care ethics in many cases resides exactly in combining these two perspectives (Barnes, 2012: 33–34; Tronto, 2013), however, discussing the impacts of the current and future use of technology on care relations at the end of this article proves more powerful if the phenomenological aspects are emphasised. Of course, this perspective does not neglect the political theorisations altogether, in that they include views, such as vulnerability, relationality and corporeality, that are central for this article's purpose of exploring the impact of technology on care relations.

Thus in this article, the narrower definition of relationality points to the situational and temporal character of the experiences of particular persons – to *their* life history, habits, needs and so forth – which require caring attention, rather than to broader interrelations consisting of, for example, social, political and economic networks. The focus is thus on each event of caring, *each relation at hand*, not on the abundance of relations that facilitate or structure it. To further focus this view, the article next considers dyadicity as the second essential aspect of care relations, one which has been extensively discussed in care theories over recent decades but still seems to require attention in discussions of care.

Dyadic mutuality frames care as relating to the vulnerability of a self-reflecting other

In care ethics, dyadic relations have often been transcended in order to broaden the scope to cover institutions, for instance (Tronto, 2013; Robinson 1999). I agree with Marian

Barnes (2015) who explores the problems with regard to dyadicity by pointing out that, along with intimate face-to-face interactions, more spatially and temporally distant actions also constitute care. For example, to some extent, one can be attentive to another person's need from a distance by, for instance, helping someone with an application crucial for receiving a particular care service, or comforting someone over the internet.

First, however, spatial or temporal distance does not really change the dyadic characteristic of such care settings, in that ultimately all manifestations of care can be traced to *someone's* situational attentiveness to a particular vulnerability. Along with relations in their networked sense, ultimately *someone's* attentiveness to particularity is required. Second, Diedrich et al (2006) have highlighted the broader problem with regard to how caring is situated in the immediate second-person relations and politico-structural third-person relations. Based on Emmanuel Lévinas' work, the authors note that our immediate, *second-person* relation to another person cannot take all our caring attention, as it is not the only relation we find ourselves in. Other, practically unlimited and therefore endlessly complex *third-person* relations constitute the political phenomena addressed, for example when care ethicists explore relationality in its broader definition (Diedrich et al, 2006: 45–50; Lévinas, 1969). The attentiveness to another's need is always limited by other relations. However, and importantly for the argument on dyadicity, this does not mean that the specific essence of second-person attentiveness should not be regarded as the primary departure point of caring, which is why it is regarded here as an aspect without which caring would not be caring. As Lévinas says:

> The interpersonal relation I establish with the Other, I must also establish with other men; there is thus a necessity to moderate this privilege of the Other; from whence comes justice. Justice, exercised through institutions, which are inevitable, must always be held in check by the initial interpersonal relation. (Lévinas & Nemo, 1985: 90).

Of course, dyadicity in itself does not suffice, which is why the perspectives on corporeality and devotion are needed (discussed later), but if the dyadic aspect were left out, the aforementioned examples of caring would make little sense. Concerning the example of comforting someone over the Internet, we would then have to accept that an online algorithm would suffice as a caregiver. If caring was not defined as a distinctive relation to a certain, concrete other, from someone to someone, the scrutiny of what is immediate in care relations would become abstract. Therefore, in the centre of the argument on dyadicity is that, ideally, one cannot care attentively for an imaginary other, or a number of people at the same time (or vice versa), because the ability to relate to the situational vulnerability of the other will be fragmented and diminished, at the very least.

For a reader who is yet not certain that an algorithm could not provide care, I will further clarify the interpersonal basis of dyadicity. This dyadic interpretation of care not only involves attentiveness towards particular personal features and situations – i.e. relationality as it is defined in this article – but also the definitively mutual aspect of it. Here, the intertwinement of the uniqueness and the similarity of the other is presented as an aspect of *dyadic mutuality*. While the next subsection will further explore the corporeal aspects and the fourth one the ethical obligation related to care, first, relationality is connected to dyadicity by theories of *recognition*. Here, recognition does not mean colloquial "acknowledgement of" or "distinguishing" an entity, but rather the intersubjective basis for human self-relations. Based on G. W. F. Hegel, theories of recognition define self-consciousness as fundamentally social, as recognition takes place only within a recognition-relationship to another self-consciousness (Hegel, 1977). A person can thus experience her/himself as needy and desiring only within a recognition-relationship to another person which, reciprocally, is possible by recognising another being with similar needs (Honneth, 1995: 37). Through recognition, people exist in relation to themselves and their environment partly from the viewpoint of another being (Laitinen, Särkelä and Ikäheimo, 2015: 3). Rather than a means to an end (an object), then, through recognition the other becomes an end in itself.

Axel Honneth (1995) has steered away from Hegel's metaphysical theorisation by connecting recognition to the beginning of human life. The first steps towards recognition are taken when an infant separates her/himself from her/his mother ontologically and becomes self-relational (Honneth, 1995: 98–100). Later on in life, this relationality defines friendship, love and the ability to care. In this way, recognition provides a foundation for the desire to merge with the other by experiencing the other as another consciousness who re-establishes her/his ontological boundary, leading to a "mutual dissolution of boundaries" (Honneth, 1995: 104–105). The gendered presumptions of the mother-child dyad as the basis of care are well known and belong in the past, and I do not attempt to revive this sort of dyadicity as a fundamental argument for caring. Rather, the ontological and socio-psychological arguments of recognition theory work together here in systematising human relationality and vulnerability on a general level. In theories of recognition, *the ability of self-relation is tied to mutual similarity, thus also making it possible to recognise the unique individuality of the other*.

By arguing "beyond dyadicity", some care ethicists have broadened the conceptual scope of care and made visible its explanatory power in exploring areas such as international relations (Robinson, 1999) or democracy (Tronto, 2013). I argue that re-emphasising dyadicity may have great explanatory potential in other key areas, such as the immediate life-world of eldercare relations directly impacted by technologisation. Also, transcending dyadicity to the extent of defining care as potentially covering non-sentient objects in the world (Tronto, 1993: 100–108) can be problematic in that caring is therefore detached from the ability to self-reflect and to be attentive to the self-reflection of another similar(ly unique) being. My worry is that something essential with regard to caring may be lost in the process. Again, I do not claim that the temporal and spatial *arrangements* where the caring happens do not involve a whole range of economic, political or sociotechnical factors. I claim that the distinct and precious character of the activity and disposition called care resides somewhere beneath such contingencies. Caring actualises as part of networks of relations (what phenomenon would not?), however, it *is* not those networks but rather something that would seem empty without keeping the primary attentiveness to a similarly vulnerable, particular other at the heart of scrutiny.

Before considering the technologisation of eldercare from these theoretical perspectives, relationality and dyadic mutuality need to be placed in the context of the lived world experienced through human bodies. Therefore, an aspect of corporeality is required.

Corporeality situates vulnerability in an affectual life-world of embodied beings

Care professionals are skilled in interpreting situational needs by gestures, postures and expressions (Twigg, 2000), as presence and touch can mediate a good deal of information on experience, intentions, wishes, emotions and general well-being (Turkle, 2011). According to Twigg (2000), corporeality, which has been a neglected area throughout the course of Western philosophy as well as in gerontology, provides an antithesis to the rationalism of enlightenment defined by logical reasoning, control and abstraction, which have marginalised the role of the body and feelings in defining human being. Twigg also connects this to neoliberal and managerialist care practices which leave no room for corporeal existence (Twgg, 2000: 8–9). Corporeality is especially important in terms of ageing, as physical abilities start to wane at the end of life. However, even in the tendency towards the 'sociology of the body' during recent decades, ageing has surprisingly been an almost completely neglected area (Gilleard and Higgs, 2013: 3–4; Twigg, 2000: 7).

As Maurice Hamington claims in *Embodied Care* (2004), the corporeal relationship to another human being is the foundation for the very potential to care:

> "[...] care denotes an approach to personal and social morality that shifts ethical considerations to context, relationships, and affective knowledge in a manner that can be fully understood only if care's embodied dimension is recognized." (Hamington, 2004: 3)

He argues that understanding the other manifests itself in small or unnoticeable gestures, smells, sounds, etc., which bypass our rational and conscious abilities. These nevertheless affect all human interaction, and are thus a constituent aspect of caring and fundamental in analysing care relations (Hamington, 2004: 48). Intentions are not by essence hidden within us until they are expressed as propositions. Instead, they are expressed in embodied action (however subtle) perceptible to others, and thus also as something that can be changed through the process of interacting (Fuchs and De Jaegher, 2009: 469).

Introducing the aspect of corporeality strengthens the argument that vulnerability is at the core of care relations, in that human needs, whether physical or existential, are corporeal in essence. This also noticeably strengthens the argument on the relationality and dyadic mutuality of care ethics by providing these abstractions within the context of a corporeal, inter-related life-world. Fuchs and De Jaegher (2009: 465) write about *mutual incorporation* as "a process in which the lived bodies of both participants extend and form a common intercorporeality". This mutuality is the practical inter-relatedness manifest in embodied practices, as noted by Fuchs and De Jaegher (2009: 472) who write that co-existence in a "dyadic bodily state" mediated through intentional perception, gestures, voices and touch, allows an empathic disposition towards another person. It also suggests that the dynamic, intentional and embodied interplay between "two centres of gravity" creates an in-between where the meaning of the situation at hand and the self-relation of embodied actors are co-created (Fuchs and De Jaegher, 2009: 472–476). An embodied perception of the other (in terms of both perceiving the other and the other's perception) thus defines self-relation through-and-through. This is expressed in a similar way by recognition theorists, but is here rooted more firmly in the lived world of embodied existence. Borrowing from Hamington, *the potential to care is born in the corporeal co-creation of meaning* (Hamington, 2004: 5).

Next, it is argued that, along with relationality, dyadic mutuality and corporeality, a scrutiny of care relations also calls for an aspect of *devotion*, which completes this article's conceptualisation as not simply a descriptive but rather an ethical one.

Demanding reactions: care as *devotion*

So far in this article, the essential aspects of care relations have been presented as ones which allow for the *possibility of being attentive* to the vulnerability of the other. Without relationality and dyadicity, the situatedness and uniqueness of vulnerability would be lost, and without corporeality it would have no affectual world in which to reside. While these aspects provide the potential for responsibility, exploring the obligation for its practical manifestation as *the response* to the profound vulnerability of the other is still required. Ethical questions arising from this ontology, such as 'what ought I to do' or 'why should one care', still need to be presented with caution.

In care ethics, caring is based on both attentiveness and the action which results from it. In Marian Barnes' words, "without action to follow the awareness of need, care cannot be complete" (Barnes, 2012: 21). Following Joan Tronto (1993) and Daniel Engster (2007), Barnes calls this "responsibility" or "obligation" (Barnes, 2012: 21–23). Viewing responsibility as something that expands care into an argument on its democratic potential (Tronto 2013, 50–57) includes an indispensable view on the place of care in societies obsessed by economic production. For my purpose of exploring the more immediate second-person aspects of caring, however, the perspective of ethical obligation must remain at the level of intercorporeal and dyadic settings between historically unique, concrete beings. To distinguish the aforementioned perspectives on responsibility and obligation from what follows, the responsibility related to caring is here named *devotion*.

Paying attention to the intertwinement of the ontological and the ethical found in phenomenology can expand on recognition theories' views on the intersubjective basis of self-relation. First, in Lévinas' influential view, the face (or more broadly, the expression) of another being founds ethics, in that only there one can experience something that does not bend to one's will. It opens up an infinite unknown – it is not simply another person but *otherness* that is revealed, something that is beyond our cognitive or practical grasp. This preconditions ethics in that ultimately it is the naked vulnerability in the other's face that insists upon us not to inflict harm upon them. Analogously to recognition theory, and reaffirming my former arguments of dyadic mutuality and corporeality, this creates an ethical responsibility, because such awareness of otherness founds our own subjectivity as well: only the nakedness of the other's face reveals our own vulnerable existence (Lévinas 1969, 194–201).

Following Anne-Marie Søndergaard Christensen (2015), such an ethical perspective does not yet sufficiently explore how the ethical *content* in this relation could possibly be achieved. The obligation can be reaffirmed, however, with the help of Knud Ejler

Løgstrup's (1997) notion on *the ethical demand*. Løgstrup's thinking rests on the phenomenological fact that we always-already find ourselves in the world, mixed up in relations and exposed to another people's will and mercy, meaning that we find ourselves in *trusting* relationships to each other. Relational ethics requires that *trust is initially primary to mistrust*, because we cannot act without, at least minimally, exposing ourselves to the power of other people (Løgstrup: 8–9).

The ethical demand follows from the fact of this basic trust because it forces us always to make a choice between either regarding the other's trust, i.e. taking care of another person's life, or to act in our own self-interest (Søndergaard Christensen, 2015: 27-8). In concert with this article's view on relationality and dyadicity, Søndergaard Christensen (2015: 30) writes:

> When I am faced with the ethical demand, it returns me to the particular relation that exists between the other and me; it simply points out that *I hold his or her particular life in my hand* [emphasis in original].

It follows from this that, ideally, caring does not involve an expectation of receiving care in return. It also means that care can only be given and received but not demanded, for once care is demanded, it *has to be* demanded*,* which means that an articulated demand for care is already a response to someone's failure to respond to the ethical demand. Reacting to the vulnerability of the other thus cannot mean fulfilling every proposition he or she has made, nor can it mean only acting according to established social norms (Løgstrup, 1997). What is required instead is devotion to the other's practical situation and therefore interest in the particularity of their needs, habits, relationships, institutional positions, and so forth – ethical devotion to whatever particular relationalities constitute the other's life. The fifth essential aspect of care relations is thus devotion, the selfless and attentive response to the vulnerabilities of another similar(ly particular) being.

Conclusion on the essential aspects of care relations

To sum up the theoretical assumptions I have presented thus far, interpersonal care relations need to be regarded:

1. as relational, in the sense that attention needs to be placed on the uniqueness of a particular person's situation;

2. as a mutually dyadic relation between two, self-relational beings, without which the relational aspects of caring would be abstract;

3. as corporeally manifest in embodied gestures, a life-world which makes responding to vulnerability possible;

4. as ethical devotion, in the sense that if care had to be demanded or exchanged it would become merely contractual reciprocity rather than selfless attentiveness to the vulnerability of the other.

However, essential as they are, interpersonal relations do not cover all of our worldly relations, which is why it is still important, in the final section of this article, to complete the argument by placing these relations in the context of care arrangements impacted by technologisation.

Care ethics and the sociotechnical vulnerability transformations related to telecare

The remaining sections explore some influences of technological responses on vulnerabilities in eldercare. Care technologies consist of a plethora of technical appliances and systems, and technologisation of eldercare is of course not simply a "current" or "new" advancement, given the history of walking sticks, wheelchairs or hearing aids. However, a characteristic of recent technological developments in care in the Western world is that they are seen as more systematic solutions to the economic burden caused by ageing populations (see e.g. Roberts and Mort, 2009). Eldercare has also been a testing ground for different technologies for decades, and older people have rarely had any input into these developments (Östlund et al, 2015).

Since the remaining space does not permit an extensive assessment of eldercare technologies, a set of conceptual insights is used to explore the impacts of two telecare technologies. The theoretical scope of this article requires, first, taking into account the sociotechnical interplay between human actors and technological artefacts. Rather than considering artefacts as simply practical objects with negative or positive uses, they can be thought of as entities which are deeply intertwined in care relations and practices, remoulding the human life-world, as has been argued in Social Studies of Science and Technology (STS) and other post-humanistic philosophy (see e.g. Latour and Woolgar, 1986; Latour, 2005; Mol, 2002;2008). This *sociotechnical* perspective cannot be avoided in exploring technology as an aspect of care relations.

Second, technology needs to be thought of as something that transforms certain vulnerabilities into other vulnerabilities. According to Coeckelbergh (2013), technology should be thought of as part of the ontology and ethics of vulnerability. Not only do we use technologies as tool-like extensions in interpersonal relations, but our use (and non-use) of technologies also shapes our experiences, habits and therefore our care relations, depending on how the vulnerabilities are met. Technologies, as responses to vulnerability, have to be regarded as something which always *transforms* vulnerability – not as something that can reduce or rid us of vulnerabilities as modern scientific and technological praxis suggests (Coeckelbergh, 2013:4–5).

However, an ethical framework is also needed in order to analyse care practices in a meaningful way. The use of technology always-already includes an ethical aspect in that, by reshaping human practices, technologies "give material answers to ethical questions" (Verbeek, 2006). Therefore, third, a conceptual framework of care ethics is required to prevent a mere descriptive assessment of the pros and cons of technology use. Relationality, mutual dyadicity, corporeality and devotion become important in considering which vulnerabilities technology can address in eldercare, and at the same time which other vulnerabilities it creates in terms of the essential aspects of care. Next, this consideration forms the final content of this article.

Telecare for older people: why care ethics is needed in scrutinising sociotechnical care practices

Finally, the following two adaptations of telecare provide interesting examples of vulnerability transformations in terms of illustrating how the conceptualisation of care relations presented in this paper can be put to use when exploring practical phenomena related to eldercare.

First, telecare can refer to *screen visits*, as in video calls made by care professionals to home-care receivers, making care and nursing possible from a distance. With this technology, feelings of loneliness can be reduced in the sense that care receivers' social needs can be addressed through interactions which take account of their life-history (Van der Heide et al, 2012). In this light, screen visits respond to home-care receivers' vulnerability with regard to the lack of human interaction and to vulnerabilities related to memory disorders which hinder sufficient self-care, for instance. While we have become more and more accustomed to communicating via screens, compared to physical presence, a screen visit is inevitably a distorted presentation of both persons regardless of the video or audio resolutions. Among other things, this can lead to trivial vulnerabilities of miscommunication and misrecognition of needs.

When exploring how vulnerabilities are transformed by screen visits, it quickly becomes clear that some social vulnerabilities can be addressed, but that new vulnerabilities also emerge in terms of knowing how to use the devices, the quality of the contact and fewer visits. It is difficult to know which of the transformations caused by telecare in terms of vulnerability are, or would be, acceptable unless these sociotechnical practices are viewed through the essential aspects of care defined in this article.

Therefore, concerning *relationality* and screen visits in home care, time can potentially be released for care professionals to interact more meaningfully with care receivers, so that relational needs, such as the need for social interaction or being able to report urgent health issues, can be addressed. Addressing needs via screen visits happens *dyadically*, in that screen visits may focus care professionals' attention better upon one-on-one conversations. Therefore, screen visits do not seem to pose a great risk for the relational and dyadic aspects of caring, given that they are fully considered in the design processes. On the other hand, there is a danger of transforming caring interactions into more technical, monotonous and distant labour, thereby giving rise to new vulnerabilities regarding at least the aspect of relationality.

Concerning screen visits, a key aspect is of course *corporeality* in that it directly impacts all the other aspects of caring. Although screen visits are not non-corporeal in the sense that facial expressions, gestures and tones are involved in audio-visual interaction, they lack a human touch and the feeling that someone is actually there, with all the corporeal nuances that go with meeting someone in person. Touching is also central not only to caring, but also to clinical treatment (Lupton and Maslen, 2017). Anyone would agree that a key element in interaction is missing in a video call to a loved one, and this cannot be underestimated in arranging care. The more physically present caring is substituted with screen visits, the more the corporeal aspects of caring are lost.

Concerning screen visits, *devotion* is possible to a fair extent, within the limits of corporeality. In screen visits it is possible to notice changes in behaviour, gestures or other non-lingual aspects that facilitate devotion. However, neglecting the aspect of corporeal presence prevents care professionals from observing the whole situation, such as minor details in the whole apartment or comforting the home care recipient by corporeal gestures or touches. Going back to Lévinas' notion of the other's face (or corporeal expression) as something that awakens our ethical understanding, the faces presented on screens seem to lack something of this tension, thereby restraining the possibility of fully devotional caring action.

As for the second example, telecare can also refer to *social alarms*, as in bracelets or pendants worn by the persons receiving care, connecting them to care professionals by means of information technology. They have been introduced in home care or long-term care to make both care workers and older people feel safer, and to reduce "unnecessary" visits. Social alarms respond to certain vulnerabilities, such as the danger of not receiving help when it is needed in times of decreasing resources where the number of care workers has been reduced. They also make it possible for older persons with care needs to continue to live at home. However, social alarms have also led to new vulnerabilities which were difficult to anticipate when they were designed, i.e. what was *prescribed* to them (see Akrich and Latour, 1992; Pols and Willems, 2011). Some home care receivers are afraid to go out of the range of the alarm system in case they are unable to get help when they need it, so they no longer go out (Aceros et al, 2015; Stokke, 2017). Some older people also experience the stigma of having to wear items which visibly define them as dependent on care (Cook et al, 2016). Again, these vulnerability transformations seem hard to grasp without the essential aspects that highlight what caring is, or ought to be, about.

First, when social alarms are viewed through *relationality* and *dyadic mutuality*, the focus is on person-specific spatial, temporal, social and psychological needs. Assuming care receivers are recognised as holistic individuals with life histories and particular dispositions and desires, a notable transformation in vulnerability where social alarms are concerned involves binarising the expressions of care needs. If a person does not press a button, they can be taken to have no need for attention. For instance, cognitive disability could impede a person from fully realising what pressing a button on a bracelet means, and the continuous alarms could start to be seen as normal and thus not taken as seriously as they should be. Here, person-specific attentiveness is transformed into more binarised and structured care practices, thereby restricting the relational and dyadic aspects of caring.

When *corporeality* is explored with regard to social alarms, responses to needs differ from situations where care workers recognise and attend to care receivers' needs in person. Being physically present allows care workers to pay attention to gestures, smells, appearance, etc., and to be with clients just for the sake of being there, a corporeal area of care that cannot be disregarded. Of course, the alarms also lead to corporeal interactions, but by impacting on the expressing of older people's care needs, use of social alarms may lead to a reduced presence and thus less corporeally mediated care and attention.

In terms of *devotion*, binarising the expression of care needs into either having or not having a need for care, the responsibility seems to lie more with the person in need of care. Some social-alarm users have reported being uncertain about how to decide whether their own needs in particular situations are serious enough to call for help (Stokke, 2017: 10), which simply means that they do not receive the care they need due to the situation being prescribed by the technology. Of course, this contrasts heavily with active devotion as in holistic addressing of the vulnerability of the older person in need of care.

Discussion

In the light of the conceptual view presented in this paper, assessing certain historical manifestations of eldercare, such as applying telecare technologies in home care or long-term care settings, requires taking into account some essential aspects of care relations. The previous section highlighted that applying telecare as part of eldercare practices reshapes these essential aspects of caring in a number of ways. While the examples provided were limited, they have shown how the practicalities of caring can be viewed through such essentialisations, and that such an ethico-ontological perspective is needed in order to explore how caring may become transformed in complex and fluid sociotechnical settings.

The importance of one-on-one interaction is usually taken into consideration in political strategies involving care technology, but it often seems to be regarded as secondary to other aspects of arranging care. For instance, in telecare discourse in the UK, care work has been divided into monitoring, physical care and socio-emotional care (Roberts and Mort, 2009: 138). Once caring is split up like this, it is easier to make an argument for the increasing use of technologies which can only cover certain dimensions of caring. This article can be thought of as a point of departure for a (care) ethical scrutiny of care technologies, though the framework can also be used in other perspectives on care.

While the technologisation of eldercare also includes great benefits, the danger of eroding human relationships where care technologies are used is twofold: not only may there be *less* human contact but the *nature* of it may change as well (Baldwin, 2005). It is crucial that the relationships between the ones caring and the care recipients are not determined and mediated primarily by technology. Where technology determines care, there is a danger that morality (and other areas of life) will be determined primarily by what is technologically possible (Baldwin, 2005; Mackenzie and Wajcman, 1999). First, according to Baldwin (2005), this shift could mean that the main attention in care practices begins to focus on the technological devices and systems that have become central to caring, instead of care professionals focusing on the care recipient. Care recipients could also begin to be seen through the lens of technology, in that their existence could be mediated by systemic information, or diminishing physical and mental capability could be seen merely as accumulative stages of technological needs (Baldwin, 2005).

According to Verbeek (2006), technologies give material answers to ethical questions. Let us bear in mind that applying new technologies is not a purely technical matter – the habits, values and nature of caring actions are gradually transformed into something else when new technologies are applied. In physically, mentally and socially delicate eldercare settings, it is of great importance to explicitly recognise this delicate nature of caring, thereby focusing on the relational, dyadic, corporeal and devotional essence of responding to vulnerability alongside the demographic, economic and technical arguments.

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II

THE EPISTEMOLOGICAL COMPLEXITY OF IDEAL CARE: LONG-TERM CARE PROFESSIONALS’ PERSPECTIVES

by

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The epistemological complexity of ideal care – LTC professionals' perspectives

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Abstract

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.

Keywords: care of older people; epistemology; corporeality; qualitative methods

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, leading in Finland among other Western societies increasingly 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, referring to an epistemology based on biomedical and de-contextual health information rather than holistic, embodied, intuitive and contextual insight, 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) of

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 and a multitude of epistemological and ethical complexities that reside at the heart of caring.

In light of the concerns presented above, 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 on the different aspects of knowledge in LTC work. Lastly, a discussion chapter 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 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 on the ontological, epistemological and ethical assumptions concerning human being (Foucault, 2012; Gordon, 1988; Lupton, 2012). In social sciences, such reductionist naturalism has become challenged already by late 20th century post-structuralists, starting from Foucault's genealogies on the linguistic power structures of Western medicine in his *Madness and Civilization (1967)* and *Birth of the Clinic (1975)*. 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 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 the rational-technical thought. As Tsoukas 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. (Tsoukas, 1997: 827.)

Due to the fluid and relational nature of care, many nursing and care researchers view that reducing care knowledge to information concerning the body-object has resulted in an overemphasis on empirical experiments, numeric measurements, and 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 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 *pre-fabricated* nature of knowledge (Lykkeslet and Gjengedal, 2006: 79), critical attention has also been directed to the idea of *propositional* nature of language (Pols, 2012; Walker, 2007: 7–8), as the 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 argued that nursing work is essentially about intuitive action, affirming nurses' experiences of their situational expertise worldwide (Purkis and Bjornsdottir, 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 into 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 vs. the intuitive, embodied or contextual epistemologies has also received criticism. Relying purely on intuition, for example, may risk over-emphasising 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 may become neglected by concentrating on contextual ideals. Purkis and Bjornsdottir (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 the 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 the 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 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 decontextual 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(icised) care service providers without some kind of accountability and commodification of care services, for instance, sorting out and putting price tags on care tasks. Resembling Tsoukas’s (1997) notion on informatisation as the epitome of late modernity, Barnes and Henwood (2015) have argued that rational-technical thought has contributed to a hegemony of “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 also as situated forms of knowledge (Barnes and Henwood, 2015: 152).

A fitting example of the 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 LTC of older people (Hämäläinen and Hirvonen, 2020) and telecare technologies in home care (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.

Intensive service housing 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 intensive service housing (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), 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 home care 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 % of over 75-year-olds and 16.3 % of over 85-year-olds were ISH residents. In 2015, 53 % 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 service levels (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 of 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 (ibid.).

In ISH one will find a multitude of care needs; 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, existential vulnerabilities, and so forth. 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 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, the 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 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 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 (ibid.).

Data and method

The qualitative, semi-structured interview data (n=25) was collected in 2018 by the author and their 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.

Approval from the Ethical Committee of University of Jyväskylä was acquired before carrying out the data collection, as well as research permits from the cities' housing services departments. 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, 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 one to one-and-a-half hours. Specific themes concerning daily work practices and habits, emotions, technologies used, responsibilities, etc. were addressed using key questions and prompts when necessary.

The data was analysed using thematic content analysis (Boyatzis, 1998). The interview frame included a distinct theme covering the experiences 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 once again were read through several times, paying attention to how explicit and implicit perspectives to 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 to 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 care professionals talked about when asked how they approached care situations. This was the case especially if they were not yet familiar with the resident.

> Informant 15: 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.

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 quote above, 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 precontextual 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.

> Informant 15: [...] 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.

While clinical information is based on physiological measurements and probability assessments, it is not necessarily gathered only by technical measurements but 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 on care events also *objectifies* the body of the care recipient, framing the epistemological interest concerning the body as that of finding 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 the case especially 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 the everyday care needs in LTC settings are of unlimited duration and therefore also more holistic in nature, and therefore also that the objectification may have its downsides.

Particular knowledge

The informants' notions on 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 on what the entirety of the person's being is about; what is unique instead of general, what a resident as a historical being requires in the very moment. The quote below presents this quite explicitly, as the informant contrasts technical actions based on general knowledge, using the analogy of caring for a baby who cannot yet express needs in detailed language, to knowing what to do resulting from knowing the detailed gestures of a particular and familiar LTC resident.

> Informant 24: Time brings a lot of knowledge of the person. Just one glance might be enough, and I already know what s/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. (Brackets by the author.)

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 the biomedical assesments, as it is easier to assess health information as well 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":

> Informant 15: 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.

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 (ibid.). The informant in the above quote also gives a hint of this tension, in that the primary way 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 combine these sometimes logically conflicting knowledge spaces constantly 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 the residents' cognitive impairments. While suitable treatment of 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 the residents' understanding impacted by cognitive impairments yield 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 within the practices.

> Informant 14: 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 percent 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?

The informants use different methods to work through epistemological conflicts. The informant in the quote above resolves such situations with the help of what she calls “truth therapy”, where, instead of ”clinging to the truth”, s/he “leads” a resident with dementia away from longing for their parents. This is usually done communicatively by searching for the emotions behind the propositions, 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 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 to knowledge and its particular essence. For a conversation with a person with severe dementia the propositional aspects of language may not matter anymore at all, 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 is full of reports where the care professionals point to cognitive impairments as something that forces them to find an alternative solutions in the moment.

> Informant 24: People’s gestures tell a lot about them. Even if the answer is ‘yes’ but the facial expression indicates ”there is no way can you come and do anything”, something s/he doesn’t want. You read it on someone’s face rather than accept the ‘yes’.

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, *ergo* corporeal, in the situation – in the quote above 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. Or 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:

> Informant 13: [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.

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 discarded, a propositional, linguistic insult may appear as an expression of affection. Here, we can return to Draper (2014) and other proponents of 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 is 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 decontextual 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 understanding the inexplicable by paying attention to care situations including persons with dementia; once cognitive and linguistic capabilities are diminished or gone, decontextual and propositional ways of producing knowledge seem to give way to instinct-based care actions:

> Informant 15: 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.

The “sixth sense” mentioned by the informant above 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”, “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 (ibid) and presumes that the body knows what to do without rational deliberation (Benner, 1984).

In line with the aforementioned thoughts of Polanyi and Benner, and the analysis of the present article, Lykkeslet and Gjengedal (2006), with 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* and therefore the character of the action and the knowledge required is always flexible; about situational being and action instead of applying ready-made information. Such a view on caring has been connected with *know-how* and *insight* (Pols, 2012; Kinsella, 2010; Tyreman, 2000; Sellman, 2009), originating in the Greek term *phronesis* and referring to knowledge or wisdom manifest in practical action. The data at hand shows many implicit examples of practical knowledge, but also explications of it:

> Informant 15: 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.

In line with the quote above, 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 know*ing* becomes therefore more important than the noun *knowledge*. Above, 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 agument on the importance pointing out the deficiencies in rational-technical care paradigm. This is in line with the aptly worded findings of Kontos and Naglie 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. (Kontos and Naglie, 2009: 689.)

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 decontextual 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 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, LTC by definition is underpinned by a different ethos than a hospital ward, the point of which in most cases is 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 in order to provide an elderly person with their last home and to address any care needs that come about in the remaining time. Its ontology – its distinct embodied rhythms in its distinctive spaces – is in this way 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) thought 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 professionality to a great extent is also about shifting between knowledge spaces and knowing which script to play by in specific and constantly changing circumstances.

The aforementioned, fluid understanding of professionality (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. As Maurice Hamington 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.” (Hamington, 2004: 48)

Keeping in mind the aspect of particularity, important is not only the resident’s body as an object to be solved but an understanding of holistic *embodiedness*, the intertwinement of the expressional ability of two or more bodies in a situation. The informants not only talked about 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 decontextual knowledge, becomes more and more ambiguous when propositional communication becomes non-factual or withers away.

Therefore, the more general position this article attemped is that, while the descriptive notions that “the head” is needed alongside “the hand” and “the heart” are obviously true and that their epistemological intertwinement is an important position regarding care, considering the direction to which rational-technical paradigm seems to yet steer eldercare in Western societies – digitalisation, marketisation, accountability, efficiency, care poverty – suggests it might be time to better emphasise the core ethical assumptions behind the descriptive epistemological frameworks. Of course, no empirical scrutiny of the development care policies has been carried out in this article, so it 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 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) argues when writing about the plethora of sensory ways of knowing in home care 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 terms (Polanyi, 2009).

And finally, the key aspect of the LTC of older people is the fact that cognitive impairments continue to become more and more common and 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 the flawed epistemological and ethical premises will continue to lead to poor working conditions, ethical dissonance, and overall bad quality of care.

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The Author declares that there is no conflict of interest.

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III

ATTUNEMENT AS A PRACTICE OF ENCOUNTERING DEMENTIA TIME IN LONG-TERM ELDERCARE WORK

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Attunement as a practice of encountering dementia time in long-term eldercare work

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Abstract

Discussing time and temporality in care work is becoming more central as societies with growing proportions of older persons with care needs strive to arrange cost-effective eldercare. As resources become scarcer, the efficiency of care work is emphasised, and care is increasingly sorted into cost-per-minute units. In our paper, we will analyse the different ways care professionals

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themselves describe their temporal experiences and practices concerning care interactions in long-term dementia care. Our data consists of semi-structured interviews with care professionals ($n = 25$) working in round-the-clock service housing in Finland. Using thematic content analysis to analyse the data, we show that, along with a holistic understanding of temporality, good dementia care necessitates understanding alterity, which is insufficiently regarded in linear or quantitative understandings of time. By using concepts of temporal duration (Bergson), crip time (Kafer) and dementia time (Yoshizaki-Gibbons), it is possible to understand another person's alter-temporal experience, into which care can aim to enter and towards which it can attune itself. We argue that a concept of attunement is needed to fully make sense of the ideal temporal practices of dementia care. Our analysis presents attunement as understanding dementia time, receptive practices, and expressive practices, and describes limitations of attunement as temporal discordance.

Keywords
Care, phenomenology, crip time, care of older people, qualitative methods, dementia, memory disorders, sociology of time

Introduction

Discussing the temporalities of care work is becoming increasingly urgent as societies with growing proportions of older persons with care needs strive to arrange cost-effective eldercare. As resources become scarcer, the time efficiency of care work is emphasised. However, as shown by several studies carried out in areas such as sociology (Adam, 1994; Altomonte, 2016), care work research (Bergschöld, 2018; Davies, 1994; Hirvonen & Husso, 2012; Kamp, 2021), disability studies (Yoshizaki-Gibbons, 2020), care ethics (Tronto, 2013) and nursing research (Dierckx de Casterle et al., 2020; Egede-Nissen et al., 2013), time efficiency and good quality care do not necessarily go hand in hand, in that cost-effectiveness, which compresses care into measurable time units, conflicts with the very idea of the 'rationality of caring' (Waerness, 1984): that care should be provided when needed, not when planned.

Expanding the knowledge of existing studies on temporality and care, our attention in this paper is on the temporally idiosyncratic experiences and practices of round-the-clock eldercare work, focusing on care professionals' encounters with residents with dementia. As Eriksen et al. (2020) claim, little attention has been paid to the experience of time in research on dementia. The past research on the temporalities of dementia (Eriksen et al., 2020) and dementia work (e.g. Yoshizaki-Gibbons, 2020) have revealed the urgent need for more research on what dementia means for and requires from our understanding of temporality. A person with dementia can, under the scope of 'normal' understanding of time, causality, memory and futurity, seem like an 'irrational' agent; however, the lifeworld of dementia is no less temporally meaningful in its momentary situatedness. In this paper, we will aim for a conceptualisation of what is at stake in terms of temporal practices in a relation between a caregiver and a person with dementia in need of care and attention. With a focus on *attunement* as a definitive temporal practice in dementia work, we will exemplify how one-to-one care interactions in round-the-clock eldercare practices related to dementia care bring forth temporal meanings, and how this attunement is in conflict with the confinements of neoliberal temporalities (Yoshizaki-Gibbons, 2020: 213).

Analysing Finnish long-term care (LTC) professionals' semi-structured interviews ($n = 25$) by means of thematic content analysis (Boyatzis, 1998), in this article, we ask: *what kind of temporal practices are at play in LTC professionals' care interactions with older persons with dementia?* We will demonstrate the importance and restrictions of attunement to another person's temporal experience as part of carrying out mundane care tasks and giving good care. Our conceptual take on attunement derives from understanding both caregiving and living with dementia as phenomenological lifeworlds. With a focus on intersubjective relationality, we draw our concept of attunement from Henri Bergson's proto-phenomenological concept of 'duration' (durée) (Bergson, 2014), whereby it is possible to focus on time as a qualitative, lived phenomenon. Given that our primary interest lies in the idiosyncratic lifeworlds of caring for persons with dementia, we also utilise sociologically inclined concepts that situate this qualitative perspective explicitly in bodies and alter-temporal embodiedness. Kafer's (2013) 'crip time' and Yoshizaki-Gibbons's 'dementia time' are concepts formulated in the field of critical disability studies, and with the help of these concepts, we approach duration as co-embodied temporality. These concepts strengthen our aim of presenting attunement as a relational temporal practice requiring a profound understanding of the embodied lifeworld of another being. By focusing on the meanings that surface with attunement, we aim to identify the concrete temporal complexities of LTC of older persons, thereby also contributing to the conceptual and theoretical discussions on time and temporalities in the context of care.

In the article, first, some key theoretical perspectives on temporality in care will be briefly introduced. Second, the empirical context, intensive service housing (ISH) in Finland, will be described in detail. Third, the data and method of the study will be presented. After that will follow a section including an empirical analysis of attunement as a dementia care practice. Lastly, a discussion section will consider the theoretical significance of the empirical findings and will present the broader implications of the article.

Attunement as a crip time practice within care interactions

In round-the-clock residential eldercare work, understanding time shifts from dealing with daily, scheduled care tasks, to dealing with unexpected events caused by physical impairments, to dealing with temporal unclarity and complex existential, ethical and epistemological dilemmas brought about by dementia. This article will broaden the scope from *time-use* in dementia care work in the general sense, such as scarcity or allocation of time resources, to a focus on *temporality*, as in the perceived experience of time (e.g. Adam, 1994). Also, following Changfoot et al. (2022), Kafer (2021), and Ward et al. (2022), we do not primarily understand dementia care as a narrative or biographical practice, in that they carry with them implications of linear timescales whereas the lived temporality of dementia and therefore dementia care is often chaotic, visceral and contingent (Ward et al., 2022). Rather, our focus is on the immediate experiences, meanings and practices found in one-to-one dementia care interactions.

Elaborating on the content of such intricate interactions requires a qualitative understanding not only in the methodological sense but also in terms of how time is theoretically understood. Influential accounts of the non-linear, qualitative character of time have been given in philosophy and sociology (e.g. Adam, 1994; Baraitser, 2017; Bergson, 2014; Giddens, 1991; Harvey 1989; Heidegger, 2010). Such accounts are already well covered in the history of time research carried out in philosophy and social sciences, and in this article, we will not engage in a phenomenological or sociological discussion on time or temporality as such. However, our aim of elaborating on the impact of and responses to the temporal alterity of dementia requires some kind of base assumption of temporality understood as a qualitative phenomenon.

Therefore, we engage in a brief reading of Henri Bergson, who wrote of temporality as *duration (durée*) (Bergson, 2014: 100–106), whereby time is essentially understood as qualitative experience, the occurrence that occurs within and as its own duration, rather than quantitative, instrumental change as we have become accustomed to understanding time since the invention of clocks (Guerlac, 2017: 1). In this qualitative shift, the inner, immeasurable temporal experience takes analytical precedence over objectively acclaimed knowledge of time where the world is mediated symbolically. The problem with symbolical temporal mediation is that it suspends and limits what we experience as an immediate occurrence in our temporal flow. (Guerlac, 2017: 19.) For Bergson, any such objectifying attempt is an attempt to reduce time as *space* (as is the purpose of a clock), which, by its very nature, steers focus away from the event itself. This tension is also evident in the conflicts between instrumental time pressures and ethical ideals of care.

Qualitative temporality can be further demonstrated with Alfred Schütz's (1996: 246) famous, phenomenological example of experiencing a music piece, which applies well also to the immediate event of a caring action (or any event of interpersonal interaction for that matter). To experience a piece of music it must be *lived through as the whole piece* in the inner temporal experience of the listener, in that such experience cannot be instrumentally dissected into temporal units in outside (or spatialised) time without losing the content of the duration itself (Goettlich, 2014; Schütz, 1996). In other words, unlike a physical object that can be put aside for a while or assessed from different spatial perspectives, a song *happens* from the beginning till the end; there is no other way to experience it but by synchronisation of temporal experience with the flow of the piece.

To have explanatory power with regard to care relations, duration as a temporally idiosyncratic phenomenon needs to make sense also in terms of the radical alterity that is found in encountering the other person. Notions of the gendered (Davies, 1994, 2001) and the embodied (Twigg et al., 2011) aspects of temporality have been developed, usually denoting clock-time as a by-product of (patriarchal) economic power structures, in that the temporalities in care relations arise from the (often conflicting) demands of bodies, workplaces, social norms, technology and social situations (Twigg, 2010). A body is guided by its organic and individual processes such as sleeping, eating and toileting, which can be in conflict with institutional schedules. However, such alter-temporalities found in the heart of care are not merely instrumental processes – A taking longer than B to accomplish X – but alterity on the level of temporal experience (i.e. 'duration'). In terms of temporality and alterity, this has been elaborated well in critical disability studies with a concept of 'crip time':

> Crip time is flex time not just expanded but exploded: it requires reimagining our notions of what can and should happen in time, or recognising how expectations of 'how long things take' are based on very particular minds and bodies. […]Rather than bend disabled bodies and minds to meet the clock, crip time bends the clock to meet disabled bodies and minds. (Kafer, 2013: 27)

Samuels and Freeman (2021: 246) show an example of crip time by noting that in the COVID-19 pandemic, we live(d) in universal crip time. As the collective nature of our embodied vulnerability was suddenly exposed, the world had to comply with the temporality of our bodies: there was no rushing recovery. However, they continue, this is nothing new to sick and disabled people: 'crip time isn't easy, it isn't fair, it cannot be reasoned with' (Samuels and Freeman 2021: 247). The temporal practices in any care encounter relate to what is meant by crip time: understanding that another person's particular and situational embodied possibilities also mean a temporal alterity that requires serious attention.

Orientation of time has for a long time served as an indicator of the severity of cognitive impairment (O'Keeffe et al., 2011). The aforementioned connection of qualitative temporality and radical alterity brings us to temporal meanings and practices taking place in care encounters with persons with dementia. Studies on temporality and dementia have shown that dementia as a lived experience is not simply 'living in the past', but rather an experience of being engaged with all the dimensions of time – the past, the present and the future, requiring 'time work' (Flaherty, 2011) of persons with dementia themselves (Eriksen et al., 2021). Although few, some recent studies have connected good dementia care with temporal flexibility and an ability to accept the care receiver's time experience. For example, Lillekroken's (2020) study showed that 'slow nursing' in dementia care ward encounters sustains both the personhood and sensory experiences of care receivers. The results of Egede-Nissen et al. (2013) show that good dementia care requires a flexible time culture, emphasis on rhythms and the discarding of clock time in the process, leading to a requirement of 'time ethics' by the writers. Rushton et al. (2016) argued for the importance of past research on temporality, especially plurotemporality, person-centred time and process time for ideal, person-centred dementia care. Important as these outputs are, they do not result in a coherent conceptual outcome concerning the immediate experience in relating and responding to the care receiver's temporality.

However, akin to our argument on attunement in this article is Yoshizaki-Gibbons's (2020: 13) notion of 'dementia time':

> Dementia time, as an extension of crip time and queer time, is a temporal dis/orientation that challenges and disrupts normative and dominant forms of time. Dementia time involves focusing on a particular moment in time and space and embracing that individual moments may be self-contained, nonlinear, intermittent, irrational, and idiosyncratic, yet are no less meaningful or valuable.

As tenets of dementia time, Yoshizaki-Gibbons asserts focusing on the moment, maintaining rhetoricity to practice inclusion and affirm personhood, acknowledging and respecting situated realities, and emphasising a politics of collectivity and care (Yoshizaki-Gibbons, 2020: 191). Her analysis lays out a novel and essential view on the yield of cognitive impairments for crip time theories. On the other hand, it also shows how notions of crip temporality may reveal the lifeworld of dementia. While her work provides us with a productive concept to work with, the content of Yoshizaki-Gibbons's analysis functions mostly on the level of affirming the care receiver's personhood in the dementia ward encounters. Such affirmation of course aligns with our arguments in this paper. However, as Yoshizaki-Gibbons also writes, dementia time is a 'coalitional concept' – it refers to the radical temporal alterity between able body-minds and body-minds with dementia, therefore primarily emphasising the political significance such a gap brings forth.

We take Yoshizaki-Gibbons's idea as part of our analysis, but we argue that a more practical and reflexive concept is needed in order to figure out the full scope of the temporal idiosyncrasy of dementia care work practices. The importance of dementia time is clear in moments of affirming personhood, for example, when older persons with dementia momentarily long for their parents or other emotional contents in their personal histories, but the impacts of dementia time are also present in all other LTC practices and encounters. Therefore, we are interested in what ways care professionals engage, or ‘step into’, dementia time as part of practical and mundane LTC tasks. With our following analysis, we argue that such reflexive-practical engagement is best understood by a concept of *attunement*. With attunement we refer to an idiosyncratic practice where the care professional’s active engagement in the temporal, momentary lifeworld of the resident is presented as a reflexive movement between receptive and expressive practices, typified as ‘listening’ and ‘speaking’. Attunement will be elaborated in the analysis of care professionals’ descriptions of care events and further in the concluding section; however, first, we will briefly present the context of the study in the following section.

Finnish round-the-clock residential eldercare as the context

Round-the-clock intensive service housing (ISH) of older persons provides a valuable context for analysing the temporal dimensions of caring. In Finland, as in many other European countries, ISH has replaced nursing homes and hospital wards, becoming the most common form of LTC for older people. However, ISH facilities greatly resemble nursing homes, in that care staff are present at all times and provide care around the clock. While ISH is often officially described as a homelike living arrangement, they vary from small homelike units to former nursing homes and other settings that are in fact rather institutional in character. The facilities have care staff working around the clock, usually assigned to morning, evening or night shifts. The personnel are relatively highly educated and include nurses, physiotherapists and occupational therapists who have a tertiary degree in health and social work, practical nurses with a secondary degree, and activity instructors, kitchen staff and cleaning staff with a secondary degree or none at all. The facilities are usually separated into group homes of 10 to 20 residents. Services (including care, meals, and cleaning) are paid for by the residents (a maximum of 85% of the resident’s total income). Room rent and medication are paid for separately.

In 2019 in Finland, 7.3% of persons aged over 75 and 15.8% of persons over 85 were ISH residents. It has been estimated that over half of the ISH residents have been diagnosed with Alzheimer’s or another form of dementia (Finnish Institute of Health and Welfare, 2021a, 2021b). The residents of ISH have, as the name suggests, the most intensive care needs, ranging from a constant need for help with hourly bodily functions such as eating and drinking, toileting, and transitions from bed to the toilet, from apartments to general areas and from there to outside. Furthermore, the personnel of ISH are required to address residents’ social needs, understand their psychological conditions, and overall give them round-the-clock caring attention. As being often the last place of living, ISH is a site of care where, ideally, everything about the person is potentially a matter of care.

The demands concerning cost-effectiveness have led to scarcer resources in LTC for older people in Finland (Van Aerschot et al., 2021). Lack of staff and lack of time for care have been prominent issues in Finnish eldercare for years, and at the beginning of 2019, the revelations of poor-quality service levels in private ISH facilities caused a stir in the Finnish media (Jolanki, 2019). Previous studies have shown that feelings of hurriedness in care work have increased and represent one of the main stressors/reasons for care workers' turnover (Kröger et al., 2018; Van Aerschot et al., 2021). Compared with workers in other sites of health and social care work and the workforce in general, significant levels of mental and physical strain, such as work-related poor health, stress, and burnout (Olakivi et al., 2021), have recently been reported by care professionals working in Finnish LTC of older people. As reasons for this, they reported insufficient support from managers, few opportunities to influence their own work, feelings of inadequacy, feelings of time pressure and a poor worker–client ratio (Kröger et al., 2018; Van Aerschot et al., 2021). Along with relatively low wages and a high proportion of temporary work contracts, 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; Van Aerschot et al., 2021), especially among younger care workers (Olakivi et al., 2021). In this article, we use the terms 'informant', 'care worker' and 'care professional' interchangeably, thereby highlighting that working in ISH is hard work but also requires highly professionalised skills.

Data and method

Our analysis is based on semi-structured interview data ($n = 25$), which was collected in 2018 by the first author and his colleague from two Finnish cities. The informants were care professionals working in ISH, representing 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 ($n = 1$). Of these informants, 23 were women and two were men, reflecting the situation in health and social care in Finland. The informants' ages varied between 24 and 57 years.

We acquired approval from the Ethical Committee of the University of Jyväskylä before the data collection. Research permits from the two cities' housing services departments were also acquired. We recruited the informants either directly through care unit managers or by distributing an invitation to an interview on the units' email lists. Especially in the former case, we are aware that this sampling method may have provided us with informants whose participation was not necessarily fully voluntary and may also have left out some who might have wanted to participate. Some informants were familiar to the other interviewer due to his work experience in one of the research sites. Twenty-three interviews were carried out at the informants' workplaces, one on the premises of the University of Jyväskylä and one in the interviewer's home. Afterwards, the interviews were recorded and manually transcribed. Their durations varied from 50 min to one-and-a-half hour. Semi-structured interview themes included daily work practices and habits, emotions, technologies used, responsibilities, etc. and were further addressed using key questions and prompts when necessary.

Analysis of the data was carried out using thematic content analysis (Boyatzis, 1998) including both data-driven and theory-driven approaches. First, the first author read all the data through and copy-pasted all words, sentences and parts dealing with temporality (excluding reports on work careers, temporalities outside work, and interviews with service managers whose work content did not include hands-on care work) into another file, resulting in 52 pages (font: Cambria, size 11) of data. After this, another round of analysis was carried out by the third author, who excluded parts that did not concern temporalities related to LTC workers' immediate care relations with residents (for instance, speech about work schedules), resulting in a data corpus of 28 pages. Next, all three authors read the data corpus separately and carried out their own analyses, concentrating on the manifestations of attunement in the data regarding the informants' first-hand experiences of care of older persons. The resulting analyses were then compared and combined into a structure that is presented in the following section concerning the findings of the study.

Findings

The analysis presents, first, how the informants speak about the importance of *understanding* the alter-temporalities of dementia and the disposition that is connected to this understanding, akin to what Yoshizaki-Gibbons conceptualised as 'dementia time'. Second, attunement is described as receptive practices, meaning that stepping into dementia time requires *listening* and breaking from care home time and also from one's own temporal experience. Third, attunement is shown to function also as expressive practises, that is, as *speaking*, for example, commenting on the upcoming or ongoing care tasks the care professionals address the alter-temporality of dementia and become attuned to the care receiver's lived experience of the event at hand. Finally, we discuss temporal *discordance*, as in what limits the possibilities of temporal attunement in the current ISH settings.

Understanding: Recognising dementia time as an alter-temporal disposition

First of all, when asked about ideal care and practices for meeting the needs of persons with dementia, the informants talked frequently about the general need to understand the alter-temporalities of dementia in order to provide good care. While not yet explicitly referring to practices of attunement as part of carrying out care tasks, these general descriptions are viewed here as dispositions related to dementia time: for example, the informants talk about approaching the care receiver with 'sensitive antennas' and 'recognising their moods', in other words understanding the need to attune to their lived, temporal experience. This dispositional understanding is akin to Yoshizaki-Gibbons's (2020) 'dementia time' – the care professionals feel that they have to make a temporal step into the lifeworld of dementia in order to be good caregivers. This is viewed as an occupational practice and a skill that also develops over time:

> INF17: Having worked here for eight years, I have learned to slow down my pace, since I was sort of a firecracker before. So, I've understood that they really need the time; if I hurry, the restlessness will only grow and so might the aggression too. So, I think that if I now allow the time and get this thing done, then that will be it. But if I don't, I might have to do it all over again later.

The informant above speaks about slowing down as a way of doing things properly, making sure that the residents will be taken care of in a holistic way. However, such a dispositional understanding of temporality is not a given approach in ISH settings. Care professionals do not necessarily learn how to consider dementia time in nursing schools, but do so rather by becoming slowly immersed into the lifeworld of ISH settings. As the informant above describes, as part of these tasks it is important to make temporal adaptations by 'slowing down the pace'. As another informant put it, 'the residents don't have to hurry anywhere and can't perhaps do things quickly, so why require quickness from them?' In addition to this, an aspect of linear time is also evident in the quote: apart from being insufficient care in the lived sense, an insufficient understanding of alter-temporality may lead to having to repeat the same task in the near future.

Listening: Attunement as receptive temporal practices within care encounters

The first practices of attunement regarding dementia care we themed as listening. By listening, we do not refer only to listening to what the care receivers have to say, but to having a holistic, nuanced and receptive awareness of the other's alter-temporality manifested as speech and other embodied expressions. The informants described the importance of being able to halt the actions, and how 'just being there' is, or ought to be, a crucial part of LTC work. Far from passivity, this is a practice of temporal attunement that takes the alter-temporality seriously and prompts an active gesture of listening. Simply focusing on listening to the person with dementia at the moment is a crucial act of attunement. Many informants spoke about how 'just sitting there for a while' can have a great effect on the resident's, as well as the care professional's, well-being.

> Q: What kind of things enable that kind of a good interaction with the resident?
>
> INF14: Well, presence and listening, absolutely. And that there is time for that. If there are lots of people who are sick or if the list, like now [during] the Christmas [the workshift] list is planned so that there are only two [nurses] in the morning [shift], then of course those nurses are in such a hurry and you can yourself be in such a hurry when you're helping that it jeopardises the ability to listen and be present.
>
> Q: So, it's like a basic thing that you sit down [with the residents] if you have time?
>
> INF14: Yes, it is. It's perhaps not that valued, sitting down with the residents.

The informants talk a lot about the importance of complete breaks from care home time as part of good care in the LTC of older persons. A break from predetermined care tasks allows attunement as active listening to the other's lived temporality. The informants often contrast 'sitting down with' or 'simply listening to' the resident to 'conveyor belt' or 'machine-like' ways of carrying out care tasks. These examples show the broad meanings that are related to listening: it is not only about listening to the speech of another person but presence as such. Good care of older persons who live in round-the-clock residential care settings is not only about concrete, established manifestations of attending to embodied needs, but also simply about being present for the residents in their everyday lifeworlds, temporal states and rhythms. Therefore, listening becomes a holistic practice of attuning to the lived time of a person with dementia.

> Q: If we think about a person with a moderate to severe memory disorder, how does it impact the interaction?
>
> INF8: Well usually there's not that much speech anymore, so then you have to interpret gestures and facial expressions, and be even more concretely present. If they aren't able to concretely talk about their situation, then you have to know how to interpret body language.

Apart from contesting care home time, listening can also be understood more broadly as the ability to understand the other person's lived temporality and vulnerability as embodied expressions, as is shown in the quote above. This reveals the idiosyncratic temporality of dementia care as an inevitably embodied practice. In this sense, attunement is not simply about affirming personhood by colloquial listening and conversation, but also involves listening as a radical, embodied ability (to attempt) to step into the lived time of a person with dementia. This embodied character of attunement is also evident in the next theme of 'attunement as expressive temporal practices', where attunement emphasises the meanings connected to the other end of the embodied dyad in the dementia care dialogue.

Speaking: Attunement as expressive temporal practices within care routines

In addition to understanding dementia time, which we determined as dispositionality, and listening as the first practical step into the lived alter-temporality of dementia, we will now present expressive practices as 'the other side of the coin' regarding attunement. We found that attunement not only relates to the lived time of the residents by listening and other means of receptiveness, but also practices of bringing the residents into the shared moment by means of expression, for example, explaining the ongoing event to provide good care. As listening was determined in a broad sense to cover the receptiveness to and interpretation of embodied expressions, we regard speaking as an allegory for the ability of embodied expression in general. The next quote shows a very concrete example of such attunement practice: commenting on the lived experience before engaging in pre-determined care routines. The informant explains how they approach the resident in the morning. They recognise the vulnerable situation as the person wakes up and starts to orient themselves to the present. Carefully and gently the care professional leads the resident to the present shared moment as the day begins:

> [Talk about importance of talking in good care]
>
> Q: What does the talking involve?
>
> INF2: Well, like, absolutely no awful shouting or anything. So you try to go calmly, even though you don't know anything and your head is completely all over the place and you just do these things all the time, but you just have to try to keep yourself calm and, chat a little bit and see. Let's open up the window a bit, and see, 'Oh it seems to be morning' and then just sort of little by little, approach the bed. But if you go straight there and start the situation [more bluntly], it might scare the person, if you're a stranger to them and everything. It might be that the game is over immediately when you get there, so you have to have a calm approach.

Along with waking up, the daily ISH care settings are filled with plenty of other vulnerable and delicate situations, which underline the embodiedness of temporal attunement: the right way of speaking, a calm tone of voice and a careful approach seem to be key. The ability to temporally attune to another person's emotional and experiential state is described by the informants in terms of slowing down the temporal pace and toning down one's gestures. This is also the case in the quote below, where the informant also talks about the importance of speaking as part of this toning down.

> [Conversation about how bed-lifts can be scary for the residents]
>
> INF14: Some of them can express their fear, and then we reassure them while lifting them from the bed. I have noticed this generally as well, the more a nurse talks to the person about what is going to happen, commenting on the event at hand, the safer the resident will feel. But if the nurse is too busy, the hastiness can seem like automated robotics, just doing this and putting things in their place, so there could basically be a robot in his/her stead; then people will become afraid, even those who usually aren't.

Here, the informant's explicit description of the importance of temporal attunement, when residents are moved from their beds by electric lifts, contrasts careful, humane actions with a robot-like implementation of pre-determined tasks. By making a temporal connection with the residents by explicitly commenting on ongoing events from the residents' perspective, care professionals can reassure them in uneasy situations, concerning, for example, where they are at the given moment, what is the shared purpose of their ongoing situation, what is about to happen next and for what reasons, and that they are not and will not be alone during the experience. Other examples in the data where such commentary is seen as an important factor in caring are bathing, toileting and feeding. Care professionals can ease entry into the personal, embodied space of residents by taking an empathetic, embodied stance regarding the situation, and by living through the situations with the residents. These are crip time practices *par excellence*, in that once a person has trouble with their memory and temporal-spatial orientation, the situations highlighted above become situations requiring the utmost delicacy and care.

Becoming fragmented: Insufficient staffing and ill-fitting technologies producing temporal discordance

Finally, along with the previous examples of the idiosyncratic temporal requirements of dementia care work, our analysis also shows how care professionals' ability to practice their ideals of temporal attunement becomes challenged. We identify *temporal discordance* in the informants' speech concerning the everyday events in ISH to further underscore the character of attunement itself. We borrow the term from Julia Twigg (2010, 229), who has written about discordance in the heart of care as 'rival temporal orderings of the body, home and service delivery' in the field of home care of older persons. Of course, discordance is not part of the content of attunement as such, but rather works exactly against its content. By paying attention to discordance we wanted to emphasise the delicate character of attunement. By discordance, we do not refer to just any kind of discordance as part of care but to the temporally experiential discordance that occurs between the care professionals' delicate, bottom-up attunement to dementia time and the top-down demands that attach to linear temporalities. In moments of discordance, holistic attunement is switched to temporal ambivalence. Therefore, rather than clear-cut, instrumental 'disruptions' or 'hindrances' regarding attunement as part of care events, temporal discordance emphasises the profoundly experiential character of both attunement and discordance occurring on the level of the care professionals' experiences at each moment.

As is the case in Twigg's analysis of home care, in our analysis of temporalities in ISH discordance can occur in many ways and due to reasons that may reside on macro and micro levels in care settings. They can be about structural causes or more immediate practicalities, but they always reveal the utmost delicate nature of temporal co-presences that always run the risk of turning into temporal discordance. Attunement as either receptiveness or expression is hard if the sociomaterial settings are set up so that they hinder the ideal aspects of dementia care.

As mentioned previously, insufficient staffing was often noted as the reason for insufficient care practices in terms of temporality:

> INF9: If the shift is busy, if there are only two nurses, and the residents are restless, we are so few that we don't have a chance to figure out who to calm down. There should often be a possibility to give time to them, if I could for example stay with a resident for 15 min and sit down next to her/him, it might help. But if there are many of them, I don't know who to start with, and then the restlessness causes more restlessness. I must somehow stay calm myself in order to calm down the situation.

Reports on the inability to provide care of sufficient quality are extensive and, unsurprisingly, heavily related to not having enough co-workers per shift to help ease the burden. In our data, the picture presented by the informants is somewhat grim. The ethical stress following from having to perform their care tasks as 'machine-like conveyor belt work' against their own care ideals is repeatedly connected to understaffing. This was spoken of as being antithetical to the attunement practices we have elaborated. When asked which three things they would like to change in their work, almost all of the 25 informants wanted increases in staffing. These are important examples of how attunement ought not only to be understood as phenomenological, immediate relationality, but rather something that is also prescribed by instrumental causes that stem from cultural, structural and material circumstances. In Finland, cost-effectiveness has dominated the discussions around the impacts of the ageing society, leading to diminishing resources for the LTC of older people (Van Aerschot et al., 2021). Feelings of hurriedness have been among the main reasons for the rapidly increasing turnover rate in care work (Kröger et al., 2018; Van Aerschot et al., 2021). Other reasons include insufficient support from managers, few opportunities to influence one's work, feelings of inadequacy, feelings of time pressure and a poor worker–client ratio (Kröger et al., 2018; Van Aerschot et al., 2021).

In our data, temporal discordance was also related to speech concerning the technologies that are being used in ISH. Various reporting systems, such as electronic health records, have come to be a significant part of daily work in ISH (Hämäläinen and Hirvonen, 2020) with profound consequences for care professionals' daily time-use and content of care work evidenced in the data as frustration at having to carry out digital reporting tasks instead of the 'real work' of being present to the residents. However, in closer reference to discordance within the care routines themselves, the data reveals one major technological factor: safety alarm systems (referring to bracelets or pendants worn by ISH residents that send a signal to care professionals' smartphones either when residents press a button on the device or the device registers something unusual in the resident's health data) producing discordance is widely discussed:

> Q: […] is technology somehow related to the good and the bad experiences in your work?
>
> INF9: In a way technology is related. We get safety alarms on our smart phones, and you're helping another resident and you can't check the alarm, so then your phone beeps the whole time. Some residents might ask, 'Why are you beeping, what is that sound?', and I might also get a hurried feeling that the next person already needs my help.
>
> Q: If the residents ask about the beeps, will you explain?
>
> INF9: Yes. I just say it's my phone and nothing else. But some of the residents are smart enough to understand that someone is calling, someone needs help. So, some of them have learned that the buzzing in my pocket means that somebody else is also in urgent need of help.

While safety alarm systems are also reported to reassure LTC professionals of the residents' safety and well-being, they seem to constantly inhibit the possibilities of holistic care. This is showcased in onomatopoetic expressions having negative nuances in the informants' speech: the alarms 'beep', 'clank', 'tinkle' and 'buzz' right in the middle of meaningful, delicate co-presences. The alarm inevitably reveals that the one caring is suddenly supposed to be elsewhere, therefore disrupting the ability to attune to the residents' ongoing situation and experience. Given how extensively such irritations were reported, the systems seem to be a major source of temporal discordance concerning dementia care in ISH. Along with the structural resource factors presented before, ideal dementia care is also impacted by technological factors that have come to increasingly exist within the care events themselves. A lot of research on technologisation and care has been written that departs from sociomaterial epistemology and ontology, where the material entities are given performative roles alongside humans within an actor-network (see, e.g. Mol, 2008; Mol et al., 2010; Moser, 2011; Pols, 2015; Pols and Willems, 2011). Sociomaterial care literature offers important perspectives that prohibit analysing care technologies as mere tool-like, technical objects that may or may not have beneficial features in terms of caring but rather as something that constantly reconfigures what is understood as (ideal) care. While such a perspective is needed to fully grasp the tensions between technological actors and ideal care, our analysis shows that understanding the ideality that is connected to the concept of care requires a preliminary understanding of attunement which stems from a more profound epistemo-ontological understanding of temporal alterity, on which the delicate everyday events of care are suspended.

Discussion

The lived experience of a person with dementia is often composed of moments in which the sense of instrumental time is lost, which may lead to feelings of uneasiness, anxiety and depression. For instance, using a bed lift can be a scary experience for a person whose sense of time and place is lost if the task is carried out quickly, without explaining what is being done, by whom, in what manner and for what reasons. We borrowed the idea of 'crip time' in order to showcase the need for the recognition of temporalities of diverse bodies and minds that cannot be adjusted to normate time: rather, the care home time needs to be adjusted to the time of diverse bodies and minds. We argue that LTC of older persons requires 'cripping' care home time.

Taking crip time into account is particularly important in the LTC of older people where dementia affects the relationalities of care, however, shifting the focus on alter-temporalities is important in any care setting, whether dementia was involved or not. Regarding care and old age, the importance of understanding crip time will only increase as access to LTC is being increasingly granted only to persons with more severe care needs in order to save societal costs. This argument is in line with past research on the temporalities of care of older persons, and especially so with Egede-Nissen et al. (2013), who wrote about 'time ethics' in care homes. Attunement as the ability and skill to engage in alter-temporalities reveals the fact that our relational vulnerabilities, which can be met by caring or unmet by negligence, are straightforward ethical practices. Also, we want to emphasise the theoretical yield of understanding dementia as radical alter-temporality for time theories in general. In our view, and considering our results, the different perspectives of crip time can help us understand the plural and social aspects of time and temporality in general, revealing the politics of time in novel areas in the society.

As such revelations of the ethics and politics of care temporalities, our analysis elaborates, first, how care professionals generally emphasise the importance of understanding the alter-temporalities of dementia and the ethical disposition that is connected to this understanding. This perspective is akin to what Yoshizaki-Gibbons conceptualised as ‘dementia time’ – the recognition of the idiosyncratic lifeworlds that concern dementia and the awareness of the ability to shift normate time towards dementia time (Yoshizaki-Gibbons, 2020: 189). Our goal was to use dementia time as a starting point for further conceptualisation of attunement as a practical, alter-temporal engagement in terms of carrying out daily care tasks, routines and events. Therefore, second, attunement was concretely spoken of as receptive practices, meaning that stepping into dementia time requires primarily an active, embodied shift to meet the lived temporality of the person with dementia. This was described as practices of listening, staying, sitting beside the residents and ‘just being there’. We presented listening as an allegory of being able to be fully present to another person on their terms. This also meant breaking from care home time and diminishing the importance of one’s own temporal experience. Third, attunement was shown to have a second function as an expressive practice. For example, by commenting on the ongoing or upcoming care tasks, the care professionals address the alter-temporalities of dementia and attune the residents’ lived experience to the event at hand. This practice is a careful movement between understanding the presence from the alter-temporal perspective of the other person and helping this alter-temporal perspective align with for example an intimidating event such as bathing, lifting or another intricate bodily action. Finally, we also elaborated on the causes of temporal discordance by showcasing the experiences of what limits the possibilities of attunement in the current ISH settings. Quite unsurprisingly, the analysis provided two key limitations for attunement as ideal dementia care: staff shortages and disturbances caused by technology in the form of safety alarm calls. In the hope of increasing care work productivity with the help of digitalisation, further research is needed to determine how increasing technologisation impacts not only time use but temporalities of care.

Our findings show that care professionals hold practices of attunement in high regard in terms of ideal dementia care. One may ask, for instance, why so many of the informants wished they had more time for presence and not necessarily for specific care tasks. What does this presence mean and why does it seem to be so important for the care professionals? We argue that longing for this presence is about acknowledging another person's temporal lifeworld: being truly attentive to the care recipient's momentary need is about attuning one's temporality with that of another person. Of course, this is not to argue that a *full* understanding of another being's experience can be reached, in that being is always to some extent singular and experienced as otherness by others (see, e.g. Lévinas, 1969), but we do argue that the ethical stance of persons who care for other persons includes an *attempt to approach* otherness and alter-temporality despite the categorical impossibility of a full understanding. Attunement, by definition, is like the attunement between notes in a musical instrument – the fact that perfect harmony does not exist does not mean that we do not recognise and prefer better harmony to an off-pitch one or that harmony should not be pursued. Staying on the level of musical analogies, and revisiting the importance of understanding the similarities between the immediate care relation and Schütz's example of duration as experiencing a music piece in its entirety (Schütz, 1996: 246), the ability to attune to alter-temporality of dementia reveals itself also as a philosophically intricate practice. Our analysis shows how good caring is about both reception and expression, the two sides of attunement, showing the dialogically delicate nature of the immediate, ideal care relation, connecting temporality and otherness in a single, dialogical event. Importantly, our analysis also shows how easily these attempts at mindful co-presence, these dialogues of temporality, are shattered by institutional temporalities.

To us, it seems that the world of care, particularly eldercare, has been losing something of great value that resides at its core. In this article, we have argued that the 'something' that is lost might be nothing less than time itself. We do not aim for a future where clocks are got rid of in LTC facilities, or the impacts and meanings of linear time are completely forgotten. Care policies of course become impossible without spatialised temporal units that create some kind of a common ground to analyse and plan courses of action. However, we want to emphasise that there is also a moment in progress where such a stance on temporality starts to work against its initial goals and ideals. In care, these ideals have much to do with having enough time to basically forget the clock. The temporality of the very immediate care relation, emphasising what it really means when the other person's otherness is taken as a starting point of action, goes against too tightly woven and pre-determined regulation – and if this 'something' that resides within care itself is disregarded, we will simply end up with misguided and therefore poor expressions of care.

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IV

ELECTRONIC HEALTH RECORDS RESHAPING THE SOCIO-TECHNICAL PRACTICES IN LONG-TERM CARE OF OLDER PERSONS

by

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Electronic Health Records reshaping the socio-technical practices in Long-Term Care of older persons

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ABSTRACT

Electronic Health Records (EHRs) in Long-Term Care (LTC) of older persons are expected to improve resident-centered care by reducing ambiguities in information coordination between LTC workers and organisations. While there are research findings concerning such intended outcomes, we are interested in analysing what sort of other, possibly unanticipated outcomes the use of EHRs in LTC may produce. We argue that the scrutiny of EHRs in LTC requires an understanding of their implementation as socio-technical processes, whereby EHRs are perceived as performative artifacts of LTC rather than technological tools or passive objects. While EHRs have been extensively studied in health-care settings, few studies have concentrated on eldercare settings. We aim to fill these gaps by drawing from a qualitative interview study (n = 25) conducted with Finnish LTC workers in 2018. Using thematic content analysis, we analyse how LTC workers negotiate and interpret socio-technical practices of EHR-use at their workplace. Our findings suggest that, along with improving workers' accountability, EHRs are also considered disorganised, unrefined and burdening, thereby disrupting both the intended effects of EHRs and the continuity and the nuanced characteristics of caring.

1. Introduction

Professional caring is subject to a growing number of accountability requirements mediated by Information and Communications Technology (ICT).[1] In recent years, the development of documentation and communication practices in care work has focused on Electronic Health Records (EHRs). The electronic recording of clinical treatment, daily care activities, residents' moods and other information is expected to reduce errors and ambiguities related to care work and improve the coordination of information exchange between healthcare organisations. The starting point for this paper is the idea that along with these intended consequences, EHRs impact LTC work in many other complex and unplanned ways.

EHRs have been studied extensively in healthcare settings [1–4] where the anticipated efficiency of their use has been shown to be uncertain [5]. Furthermore, EHRs have been shown to disrupt the complex social and organisational order of healthcare work [6]. From health care settings, EHRs have gradually been extended to LTC and home care for older persons. While there seems to be little research on EHRs in the context of eldercare, using EHRs for 'structured recording' of residents' daily care is encouraged to establish fixed, organisationally appointed information categories to be used for all residents in Finnish LTC and home care [7]. Along with the communication practices between staff, knowledge about LTC workers' experiences of EHRs is crucial in that EHRs also affect the care relations between the care workers and the residents. By standardising the information recorded and applied in care settings, the relational and individual aspects of caring may be affected.

Campbell and Rankin [8] have written on the need to recognize and confront new controversies in redesigning healthcare organisations instead of only looking for pros and cons of specific technological innovations. The authors suggest that practices ruled by EHRs displace the work processes in which nurse-patient interaction is integral to nurses' judgement and action. In this vein, we argue that the scrutiny of EHRs in LTC would benefit from an understanding of their implementation as *socio-technical processes* amenable to sociological analysis, explanation, and intervention [9].

Following this thought, our analysis departs from the proposition that there is a gap between the anticipated use and actual practices of technology use in LTC, and that implementation of ICTs is often directed from the top down with limited involvement from eldercare

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[1] ICT = Information and Communications Technology; EHRs = Electronic Health Records; LTC = Long-Term Care; ISH = Intensive Service Housing.

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professionals [10,11]. We utilise Akrich and Latour's [12] concepts of *prescription,* to describe what EHRs forbid and allow in LTC work, and *subscription,* to refer to LTC actors' reactions to those prescriptions. In addition to this, we have used the socio-technical analysis of telecare technologies by Pols and Willem's [10] who expand the script theory by showing how technologies may *tame* and *unleash,* or *be tamed* and *unleashed* by, their users in care settings.

Our paper aims to fill the gaps in research concerning LTC workers' experiences of EHRs by drawing from a qualitative interview study (n = 25) conducted with Finnish LTC workers in 2018. Applying thematic content analysis, this paper asks *how LTC workers negotiate and interpret the socio-technical practices of EHR-use at their workplace.*

In what follows, first, we describe the extent and context of EHR use in Finnish LTC services. We then explain the theoretical assumptions of socio-technicality in our study and describe our data and methodology. After this, we present the results of the study under two main categories and six subcategories. Lastly, we draw conclusions from the results.

2. Context

2.1. EHRs in the context of LTC work in Finland

Finland has been among the early adopters of health information technologies. EHR coverage reached 100% in Finnish public healthcare in 2007, and in 2017 both public and private healthcare was almost entirely arranged using EHRs [13]. In 2018 87.8% of all eldercare workers in Finland reported using EHRs [14]. There is no earlier research on LTC workers' views of EHR use in Finland. However, in the healthcare sector, physicians' satisfaction of EHRs' ability to support clinical work is relatively low, especially with regard to conducting routine tasks and the amount of training required to learn to use the system [3], reflecting results from other countries [4].

In Finland, LTC of older people consists of nursing home care, LTC wards in hospitals and health centres and assisted living with 24-h assistance. Our study focuses on the workforce in the last of these, Intensive Service Housing (ISH), which is the most common type of LTC service in Finland. It typically consists of small-scale institutional group homes with 24-h care available. While ISH is described as a home-like environment in Finnish policy documents [15], the units can be situated in former nursing homes that have an institutional rather than a home-like atmosphere. ISH is targeted at older persons with dementia and extensive care needs. In line with the current policy emphasis on 'putting home first' [16], ISH units aim to guarantee normalised living for the residents.

The current set-up of work in ISH also begs attention when studying the use of EHRs in this context. The work is carried out as three-shift work with worker/client ratio varying between 0.4 and 0.7 [17]. The residents are fragile, often suffering from some degree of dementia and/or other conditions characteristic of old age. The workforce are relatively highly educated with either a secondary (practical nurse) or tertiary (registered nurse) degree in nursing and care work. In addition, the care staff regularly include an auxiliary workforce with either a secondary (activity instructors) or tertiary (occupational therapist, physiotherapist) degree in health and social care work.

The ISH units in this study are representative of the typical set-up of ISH units. They accommodate 12–18 residents and a total of 15–20 nurses per unit, with 2–4 nurses working in a day shift or an evening shift and usually one nurse per night shift. Communication practices between nurses typically include brief face-to-face exchanges of information between shifts. However, not everyone is always present in these exchanges. The employees are expected to read and record EHR information on a regular basis, but very little time is officially allocated to this. Typically, EHRs were are available on mobile devices and sometimes finding the time or a free computer to read or write EHR entries can be challenging.

Care workers in Finnish LTC facilities have recently reported high levels of mental and physical strain compared to health and social care workers in other posts and the workforce in general. The self-reported reasons include insufficient support from managers, few opportunities to influence one's work, and a poor worker-client ratio. These factors, along with a relatively low level of remuneration, are presented as at least a partial explanation for the high turnover rate and prevalent intentions to quit one's job among LTC workers [18].

2.2. Technology in/as practice: studying the socio-technical role of EHRs as part of eldercare work

Our conceptual departure point is based on the idea that 'the technological' and 'the human' are not easily separated from each other but rather intertwine in complex ways. As has been argued by actor-network theorists and posthumanist scholars, instead of objects of use, all non-human artifacts, i.e. man-made objects, devices, systems etc., can be thought of as actants in care relations and practices that reshape the human life-world [19–22]. In other words, *socio-technicality* cannot be avoided when technology is explored as an aspect of care relations. When humans repeatedly interact with the material and symbolic properties of technology, such as EHRs, the interactions will over time become structured processes [23], whereby the dynamic nature of technological applications and their situated use in care work can be analysed. For a recent commentary on theories on socio-technicality, see Erofeeva [19].

In this study, we describe the socio-technical aspects of EHRs in LTC of older people in two steps. First, this requires attention to the *prescriptions* of EHRs, or in Akrich & Latour's words, to "what a device forbids and allows from the actors" [12]. In our research context this means first of all scrutinising what the intended uses and effects determined in the design of EHRs forbid and allow the other actors to do in the context of LTC work and its daily practices. Second, the understanding of socio-technical aspects of EHR in LTC requires attention to *subscription.* This refers to the actors' reactions to what is being prescribed, meaning that the prescriptions are underwritten, negotiated, adjusted, neglected, and so forth [12]. How EHRs work as actors in the network of LTC of older people depends to a great extent on whether LTC workers know how to use the devices and systems, what their motivation is to use them, whether they choose to use them according to their design, and so on.

Bruno Latour, along with the myriad of proponents of Science and Technology Studies (STS) and actor-network theory, has introduced a variety of descriptive conceptualisations concerning the socio-technical dimensions of human and non-human assemblages [12]. For our study, however, it suffices to continue the line of thought set up by the concepts of prescription and subscription. In addition, and as supporting concepts that help finetune the analysis and reveal the different manifestations of prescription and subscription, we refer to Pols and Willems' [10] concepts of the *taming* and the *unleashing* features of technology. Technologies can tame users to work by its logic or unleash users in the sense of allowing them to find new, technologically mediated solutions to practical problems. The opposite is also true in that while technological prescriptions can be tamed to fit occurring practices or needs, technologies are also always unleashed onto the world in the sense that their prescriptions can never be fully controlled. In the context of our study, the idea of taming and unleashing are particularly helpful to capture the vulnerability that is characteristic to both the human and the material actors involved in care of older people.

Given that LTC of older people is particularly tied to complex and situational vulnerabilities or frail persons, care technologies should not be considered fixed and tool-like utilities but rather as actors that transform certain human vulnerabilities into others—not as something that can reduce or rid us of vulnerabilities as the modern scientific and technological praxis suggests [24]. Technologies inevitably give material answers to ethical questions but cannot remain outside of or indifferent to those questions – as actors of care they take part in forming its

Table 1
The socio-technical aspects of EHRs in LTC work.

Main category	Subcategory	Example quote
4.1 EHRs prescribing LTC work	4.1.1 Incoherent or dysfunctional EHRs	Right when you’ve learned one thing there’s something else, now it goes like this, this isn’t used anymore but that instead, oh but wait now we don’t use it anymore anyway, this doesn’t work, this version apparently will be updated.
	4.1.2 Unrefined information in EHRs	[…] some nuance may be left out, so that’s why our staff has been vocal about the importance of oral reporting.
	4.1.3 Burdening EHRs	Reading everything in EHRs takes a surprisingly long time. […] It’s more efficient to talk things through.
4.2 LTC actors subscribing to EHRs	4.2.1 Individual ways and abilities	The recording system works only as well as we record things, it doesn’t work if we don’t.
	4.2.2 Taming EHRs	I do record information on residents but I also print it on paper, put it on the desk and say go ahead and read this.
	4.2.3 EHRs unleashing care work	The nurses’ perspectives differ from each other, for example whether someone can be lifted from their bed or not, so I lean on [EHRs], the factual information is there.

ethical dimensions [25].

2.3. Data and method

Our qualitative, semi-structured interview data (n = 25) was collected in 2018 from care workers and nurses working in ISH in two Finnish cities. In this paper, we refer to our informants as ‘LTC workers’, as they represented the typical workforce in LTC: most were practical nurses (n = 14) or registered nurses (n = 8) some of whom had a managerial role in their unit, the rest were activity instructors (n = 2) or occupational therapists (n = 1). The gender distribution among the interviewees—23 women and two men—resembled the situation in health and social care. Their ages varied between 26 and 57 years. Approval from the Ethical Committee of University of (anonymized) was acquired before initiating the research, as well as research permits from the cities’ housing services departments. The informants were recruited either directly through care unit managers or by a call that was circulated on staff emailing lists. The workers then contacted us independently to schedule their interview. Especially in the former case, the sampling method may have provided us with informants whose participation was not entirely on a voluntary basis. Some of the informants were familiar to one of the two interviewers due to his work experience in some of the units. The majority of the interviews were conducted at the informants’ workplaces during their working hours, one on the premises of the University of (anonymized) and one in the interviewer’s home.

The interviews were recorded and manually transcribed. They lasted from one to one-and-a-half hours each. Specific themes, such as the coverage of technology used at work, pros and cons of using health information technologies (HIT) and ICT at work, risks of technology use for workers and residents and the impact of technology on recognising residents’ situational needs, were introduced using key questions and prompts when necessary (See Appendix I).

The thematic content analysis [26] was carried out so that first the whole interview data was thoroughly read through. The parts covering EHRs were highlighted and copied to another file, which was re-read highlighting preliminary notions on EHRs as part of LTC work. Eventually, this resulted in 14 empirically closed codes that covered issues such as the different typifications of systemic information, and experiences of the different ways in which EHRs affect LTC work. Finally, using the theoretical frameworks on prescription, subscription [12], taming and unleashing [10], the 14 codes were narrowed down to six and divided into two main categories evidencing how EHRs are situated in/as the socio-technical landscape of LTC work.

3. Results

The thematic content analysis results in categories illustrating the socio-technical aspects of EHRs, as presented in Table 1. It accentuates the ways in which care work is affected by EHRs and how EHRs are again affected by the actors involved in LTC. This is highlighted by the two main categories: (1) ‘EHRs prescribing LTC work’ and (2) ‘LTC actors subscribing to EHRs’, each of which is divided into descriptive subcategories.

3.1. EHRs prescribing LTC work

3.1.1. Incoherent or dysfunctional EHRs

The first subcategory reveals the reciprocal socio-technical complexity of EHRs and LTC work. LTC work is tamed by EHRs in that the EHRs’ logic mediated by the user interface remains unclear to the LTC workers.

> *Informant 11*: […] we’ve sure struggled with [EHRs]. Right when you’ve learned one thing there’s something else, now it goes like this, now it’s done like that, this isn’t used anymore but that instead, oh but wait now we don’t use it anymore anyway, this doesn’t work, this version apparently will be updated.

EHRs include various modules and the software versions change from time to time, complicating their use. This incoherency of EHRs tames LTC workers to use parts of their shift to try and adapt to the systemic logic of arranging care. When the user interface is incomprehensible and its use as part of care work seems arbitrary, both the technological (efficiency) and the caring (attending needs) logics fail.

Along with the user interface, care work practices are tamed by EHRs’ technical unreliability.

> *Informant 18*: There was a maintenance break on Sunday. It was to end at noon but it didn’t end until 4 pm. The night shift couldn’t record anything and we had to correct it. […] It was irritating having to record everything on paper and deal with EHR later. I like to do things right away, medicine for instance. There were falls which should have been documented right away and so it was annoying.

Systemic dysfunctions rearrange care work practices. They reduce the time for caring as LTC workers have to find alternative means for documenting their work and wait for technology to be repaired. This also reveals the vulnerability of technology: attending to ailments does not only cover the elderly residents but also dysfunctional technology, as it requires LTC workers’ care and attention. Caring is complex interpersonal work to which EHRs bring a material element that requires care but also allows them new means of communicating their patients’ needs. EHRs help improve the interpersonal relations of care, but they can also prescribe LTC work in ways that work against this goal.

Hope [27] argues that care is an emotional morality which feeds into the actions of care, for emotion and action are difficult to separate. Yet, digitalization has left nurses with difficulties to express this ethics of care. The effort of writing, Hope [27] points out, is an expression of their care for the patients. The fact that EHRs’ affordance does not allow exchanging this type of information does not prevent LTC workers from doing so. They find alternative ways to exercise their caring mind by writing notes, for instance. Rationalization risks depersonalisation of care. As we have shown in this article, LTC workers are aware of and deal with this risk in various ways.

3.1.2. *Unrefined information in EHRs*

The second subcategory demonstrates how LTC work is tamed by EHRs in that the nuanced characteristics of care collide with the national policy aim of producing structured data in eldercare work in Finland [7]. According to the official guidelines concerning EHRs, LTC workers are expected to record the multitude of caring functions under fixed (organisationally appointed) themes. The goal is to improve the quality of treatment and to support patient safety by reducing ambiguities in interpretation [7]. This practice known as 'structured recording' was also discussed by the informants.

> *Informant 13*: Recording on paper had many advantages. Looking back, [EHR] is, once you've got used to it, it's a good thing. But recording has been made more difficult now with this structural recording. So, like in hospitals before, everything has to be recorded under headings, always to find the right heading under which to write. And, it doesn't go like this, it's stupid that eating and everything are under different headings, it's somehow so inconvenient and stupid trying to read them.

The quote is an example of how EHRs considerably tame LTC work practices. Although the logic of EHRs and the logic of care might contradict each other, LTC workers gradually adopt EHR to use. Structured recording becomes a part of daily care practices, although not without resistance.

The informants also describe the differing contents of oral and structured reporting.

> *Informant 5*: [In oral reporting] one goes through daily events more. For instance, if a resident vomited today, someone might record that 'a person has vomited after lunch', while, by telling a co-worker, it would be so that 'we noticed the resident rushing into bathroom', or 'their roommate reporting that there's vomit on the floor', and we go and ask the resident her/himself and they tell us they've vomited, so, orally a lot more is reported, more accurately about the situation and what has happened.

Care work does not exclude expressions and use of emotion such as empathy, sensitivity and responsiveness to others' situational needs. This makes it difficult to transform caring into systemic information. By contrast, oral reporting was widely viewed as preferable to reading EHR entries, allowing LTC workers to describe their work in more detail and with a more personal touch to one another. Information in EHRs is described as 'bureaucratic' and 'stiff' in contrast to oral reporting where questions can be asked quickly to learn 'what's up' with a resident. Some informants described the role of oral reporting as attending to the whole personality of a resident.

> *Informant 15*: On paper, a human being can be extremely demanding care-wise, and then in reality there's a smiling and able person equipped with relatively good interaction skills and a sense of humour, a person that fascinates. On paper, one is completely different than in a live situation.

The above quote demonstrates the deficiencies of the information in EHRs (here, 'paper' refers to EHRs). EHRs are seen to provide unrefined health information, which seems insufficient in contrast with LTC workers' professional goal to attend to the whole human being.

Oral reporting may also positively affect the general atmosphere of an LTC unit.

> Informant 25: [..] official information is recorded, but in oral reporting other information is conveyed a lot better. And it is maybe easier to remember a lot better, and it is easier to talk with residents, saying 'I heard you did this and that', 'was it fun?‘, and so on, compared to 'I read from the records' [laughs] 'where, you read … where?‘.

Above, oral reporting as corporeal face-to-face interaction is seen as an important part of the atmosphere of the ISH unit in that it includes 'other information' that is also more natural to refer to in conversations with the residents. LTC workers are skilled interpreters of situational needs presented as gestures, postures and expressions [29]. This interactional corporeality can mediate a lot of information on residents' wishes, emotions and general well-being and create the potential to care [30,31]. In light of this, it is problematic to assume that transferring information regarding personal care under systemic structures, could display the care needs of particular vulnerable persons. In line with Bowker and Star [32], our analysis depicts the tension between abstracting away from the local and rendering 'invisible work' visible with EHRs. As the documentation practices and information infrastructure of EHRs originate from medical care, they fit the purpose of LTC work only to a limited degree and encourage workers to employ diverse communication practices to pass on what they think is essential information to their colleagues and residents in ISH units.

3.2. *Burdening EHRs*

The third subcategory depicts another way of how LTC workers' are being tamed by EHRs, and can be read as a consequence of the previous two. It shows how strictly the prescription of EHRs organises their work.

> Q: So it's good to have conversations, the main thing is that the information is received …
>
> *Informant 12*: Yes, of course, but of course the doctor doesn't do anything about anything if it's not in [EHR].

Here, the informant explains how the doctor reacts primarily to systemic information written in EHRs. Moreover, the above should be understood in light of the fact that EHRs have been adopted to LTC from the medical professions where they form and important part of the relationship between the professional and the patient [27]. In a similar vein, EHRs have evolved to handle factual, systemic information in LTC to the extent that in order to make something happen, it needs to be written down. The two sides of the coin with regard to EHRs' factuality are presented well here: the system provides reliable information to determine actions, but it also means that to act is to sit in front of a computer.

The results suggest that to the nurses, EHRs were more often than not a burdening part of care work and something external in relation to caring. The informants often described caring without devices as 'normal' and 'slow', as opposed to 'speed' or 'coldness' related to use of EHRs. The 'core' of caring is seen to reside somewhere outside EHRs, which is viewed as bureaucratic and 'of no real value for the residents'.

Burdening was also often presented in terms of lack of resources such as time.

> *Informant 24*: I still trust oral reporting more, even though they say read [EHR] by yourselves, but our time means that, if there are two people talking, compared to opening and reading eight or 16 resident records, it just takes a lot of time [to read records] compared to going through them in a 15-min conversation. And during the 15 minutes we can quickly talk about previous days as well. Reading everything in EHRs takes a surprisingly long time. […] It's more efficient to talk things through.

Above, reading EHR entries are seen as a time-consuming and inefficient way of communication compared to oral reporting. Lack of time not only restricts the proper use of EHRs, but their use itself takes time away from other tasks. In a hierarchic organisation, this could even lead to professional clashes, as recording the work of registered nurses was sometimes viewed as more important than that of other groups. Lack of resources regarding devices thus leads to lack of time to properly realise the prescription of EHRs. Other expressions of shortages included the lack of organisational resources such as computers and software training to use EHRs. These could be regarded as the key organisational factors preventing LTC workers from realizing the full capacity of EHRs as a part of their work.

3.3. LTC actors subscribing to EHRs

3.3.1. Individual ways and abilities

As the previous subcategories already show, LTC workers' personal ways of working shape the use of EHRs in many ways. The following subcategory demonstrates actors' reactions to what is being prescribed, beginning with LTC workers' individual ways and abilities to use EHRs. The prescriptions, i.e. intended efficiency and accountability, are not always properly realised due to unaccounted for human aspects. The following examples illustrate how EHRs become tamed by human practices because of LTC workers' habits, abilities, errors and refusals to record their work and residents' circumstances to EHRs sufficiently.

> Q: How is a resident's situation described in [EHRs], if you start going through the data?

> *Informant 6*: It depends on how the bi-yearly reviews and such have been written down. If they've been done and everything's up to date, then it should be possible to get information on how the resident should be treated or what are his/her most important needs, but if it's very incomplete, then adequate information isn't necessarily there.

While the LTC workers understood the purpose of EHRs, they often failed to fulfil its intended purpose. EHRs are tamed by care professionals also in that they sometimes simply make errors while recording the information.

> *Informant 13*: […] I wonder if I can say that, in [EHR] one can easily record information for the wrong resident. I also, not so long ago, and someone else too by accident around the same time, wrote down a long text in a wrong treatment plan, so things like this can happen.

The above citation shows how human errors in recording information can disturb caring processes. The prescription of EHRs—to carry important information about residents' care needs—is not met if the information is recorded in the wrong file.

The results suggest that lack of motivation to record information could also disturb the prescription of EHRs.

> *Informant 11*: […] I understand that some things have to be done and you can write decent treatment plans there and so on, but there are many people who don't know how to apply it to daily care work and, to be honest, don't really want to either. So it's a necessary evil.

What is prescribed does not matter if the prescription itself is rejected. When the lack of motivation affects EHR use, on one hand EHRs are tamed by negligence on part of care workers while on the other hand care work is tamed by the resulting incoherencies in the system. This results in further unwillingness or negligence to use EHRs, leading to further incoherency, and so forth. Both the prescription of EHRs (accountability and efficiency) on one hand and the characteristics of care (attentiveness to person-specific needs) on the other become compromised in such socio-technical processes.

3.3.2. Taming EHRs

The deficiencies that LTC workers find in EHRs' prescription may also lead to the modifying of EHRs' prescription, where problems related to technology are avoided by more or less creative means—by taming EHRs to better meet the practices of LTC work.

> Q: Do you record at the end of the shift or?

> *Informant 7*: Yes, usually at the end. I thought that it would be nice if I could record after finishing (a task), although the medications I usually write down right away. If there's something special, I try to write it down manually on paper notes, remember to record blood sugar and so on, or how much medication I gave someone.

Taking notes on paper is frequently used in care work to help remember the contents of care interactions. The prescription of EHRs works best when information is recorded right away, because the daily care tasks in ISH are manifold and complex. They involve dealing with information about residents' health, moods, gestures and other events that may be hard to express in language in the first place, let alone remember and record later. These findings are in line with past studies on nursing in health care settings indicating, for instance, that the lack of contextual information in EHRs is often compensated for with personal paper notes [6,28,33].

Due to time restraints to read and record information on EHRs and the round-the-clock nature of work in ISH, LTC workers find alternative ways to pass information to each other.

> *Informant 22*: I do record information on residents but I also print it on paper, put it on the desk and say go ahead and read this.

The above citation shows that systemic information is also printed out from EHRs to highlight important pieces of information, rather than relying completely on EHRs as a mode of communication. While, in the previous subcategory, the difficulty regarding the prescription of EHRs was sometimes met with opposition or refusal, here technology is tamed because its prescription does not fit the daily practices of LTC work. In this case, LTC workers' attention starts to focus on the printouts instead of the EHR system itself.

Taming can also occur so that the logic of EHRs is harnessed to work for reasons external to care tasks.

> *Informant 14*: Frankly, sometimes with some residents, it depends on whether their relatives are demanding. If a resident doesn't have relatives or any special issues concerning their health, then it is rare that the information written down is very detailed.

The quote above suggests the rigour of using EHRs may also depend on residents' relatives. Here, the motivation for EHR use is partly defined by them. In other words, EHRs are tamed to fit purposes not prescribed in their design. While being an example of taming EHRs, the quote above is also an example of unleashing EHRs into the life-world of LTC, demonstrating the difficulty to control the actual uses of EHRs.

3.3.3. EHRs unleashing care work

The third subcategory depicts a variety of ways in which EHRs unleash LTC workers to carry out care practices in new ways. This relates to the logic of EHRs in general and to the characteristics of systemic information, such as EHRs' ability to compile what one of the informants described as factual information regarding care practices.

> *Informant 14*: I have to admit that I don't often read EHRs, but rather ask the nurses. But then, if nurses' information seems to conflict with each other, I go and check what's written in the EHRs, to get a grasp of things. I sometimes feel that nurses' views differ a little bit from each other, for example whether a resident can be lifted up or not, so I lean on [EHRs], the factual information is there.

The use of EHRs unleashes LTC workers in that it provides systemic and factual information on which to rely on in ambiguous situations. EHR entries create a systemic memory on which to rely as 'factual' information in contrast with human memory.

Another important benefit of using EHRs comes from their statutory role as a repository of information. In terms of LTC workers' accountability, EHRs provide them with a safety net.

> Q: Are there any differences in recording between workers?

> *Informant 10:* Well some don't record every shift. I record those who I've cared for, who's been given to me, because then I cover my own

> back, I've done something to a resident, so if something comes up then it's not good not to have any records for the whole day for example.

In the quotes above, EHRs are described as ensuring LTC workers' legal protection concerning the jurisdiction on patient rights as all the recorded information is available for later enquiry. While accountability is prescribed in EHRs to ensure residents' rights and to manage the contents of care work, it also secures LTC workers' juridical positions and structures their activities by providing records of care tasks [see also 3 2].

The extensive records in EHRs also help in carrying out daily care work in general.

> *Informant 13*: It's of course easier now [with EHRs], we get information much more extensively and everything is immediately visible compared to going through papers, […] if a resident for example is taken to a hospital, we see what's been done there, so we get access to information like this which eases our work a lot.

Here, EHRs unleash LTC workers to get a better grasp on their residents' changing situations. If LTC workers have sufficient resources to write and read entries in EHRs and if the devices and systems work, EHRs can unleash LTC workers to take advantage of person-specific information that could otherwise be lost in the vast quantity of information circulating in an ISH setting.

> *Q*: Is recording burdening to you?
>
> *Informant 14:* Yes, a little. But then again I think it's helpful, when used right, in that I see which residents need something, who doesn't get any attention or any activities.

Here, EHRs are depicted as something that enables a broader understanding of the care of a particular resident. It is also a means of ensuring an equal level of care for all residents. EHRs unleash caring in that they enable insights into how care work is better arranged to suit personal care needs on the one hand and equality of the distribution of care on the other.

Overall, the results regarding LTC workers' subscription to EHRs reveal the complexity of caring as interpersonal work. EHRs bring a material element that requires their care but also allows them new means of communicating their patients' needs while securing their own juridical position as care professionals.

4. Discussion

In this paper, we have presented LTC workers' views on how EHRs impact care work practices in ISH units. The analysis was carried out with a focus on technological prescription of EHRs on the one hand, and the LTC actors' subscriptions to EHRs on the other. To reveal the various manifestations of prescription and subscription, we have referred to taming and unleashing to illustrate the intertwining roles of technological and human actors' in LTC assemblages.

One aspect of the socio-technicality of care work arrangements is that care practices are tamed by what is prescribed by EHRs. First, our results show how this was depicted in terms of incoherent user interfaces and technical dysfunctions. Second, care practices were prescribed by EHRs in that the logic and characteristics of information in EHRs collided with ideal care work practices of LTC workers as the users of this information. These restrictions caused them to sometimes view the use of EHRs as burdening. The results are in line with studies on nurses' experiences of EHRs in health care settings [1,4,33].

Our results also illustrate in which ways LTC work subscribes to the technological and organisational prescriptions of EHRs, which are not realised due to personal habits, tinkering, negligence, errors or lack of skills or resources. Further illustrating how LTC work subscribes to EHRs, our results show in which ways EHRs facilitate person-centered care or otherwise unleash care professionals to work in new, more efficient ways.

This said, and in line with Hope's [27] study on nurses' experiences of EHRs, LTC workers' effort to tinker the technology and to supplement its use with paper recording and oral reporting can be understood as their expression of care for their patients rather than ignorance or negligence to abide rules. The results show how LTC workers reshape and tinker the prescription of EHRs by taming them to better fit care work practices.

Ideally, EHRs should act as boundary objects [34] between communities of practice involved in LTC work: as such, they inhabit the intersecting social worlds of nurses, medical doctors, administration, and the units' residents and/or their families, and satisfy the information requirements of each of them. Our results suggest that LTC workers do their best to code their activities and thereby to situate care work visibly within the memory system of EHRs – the design of which fits this purpose only to a limited degree. Overall, EHRs appeared as something that have been unleashed in LTC settings without the end-users' consultation: once taken into use, it is hard for LTC workers to control the multitude of both positive and negative impacts that are not prescribed in their design. Despite of how EHRs tame LTC workers, the results also show how EHRs have the potential to unleash LTC workers to carry out care tasks in ways that would not be possible without them, such as exchanging information between different care facilities. Through EHRs, the socio-materiality of LTC work is constantly evolving and reshaping, as users tinker with the technology to make it suit their purpose in the best way possible.

The results in this paper suggest that EHRs affect LTC practices in complex and multifaceted ways. On the one hand, EHRs are expected to tackle the ambiguousness of oral reporting of care tasks and produce more systemic recording of care. On the other, the unrefined nature of information in EHR entries causes vulnerability as it can diminish LTC workers' attentiveness to residents' nuanced care needs, as suggested by Hope [27]. Overall, the results suggest the information infrastructure of EHRs does not sufficiently take into account the corporeally mediated, tacit knowledge of LTC work. EHRs cannot therefore contain all aspects crucial for attentive LTC work but only the information that is needed for the smooth running of ISH units.

Care work is about dealing with human vulnerabilities, which can be emotionally burdening. It resembles handicraft work in that many care practices are about contextual and embodied knowledge instead of propositional truths [35]. As one of our informants put it, getting a grasp of 'what's up' with a resident is crucial. Care ethics emphasise the corporeal relations and spatially and temporally particular vulnerabilities over universal guidelines [29,36,37]. Based on our results, we suggest the situated and corporeal character of care work ought to be the primary departure point when introducing EHRs to LTC work.

Keeping in mind the recommendations regarding structured recording, the prescription of EHRs is particularly strong. Along with older persons as service users, LTC workers lack voice in the design of care technologies and the production of nursing knowledge in LTC work. LTC workers are experts in interpreting complex human needs; thus they also have a clear idea of the pros and cons of different technologies applied to their work, and of the vulnerabilities they may create, accentuate or reduce. The conclusion is that experiences of care professionals should be better regarded in the design and management of ICT-mediated care work in order to ensure that the arrangements of socio-technical practices primarily can help support the ideal of person-centered care rather than hampering it. This is a question of how and by whom technologies are designed but also a question of organisational and professional power and autonomy.

Data availability

The data that support the findings of this study are available on reasonable request from the corresponding author, Antti Hämäläinen.

The data are not publicly available due to protecting informants' privacy. After year 2025 the data will be made available through the Finnish Social Science Data Archive (https://www.fsd.tuni.fi/en/) for archiving, dissemination and reuse.

Declaration of competing interest

The authors report no potential conflict of interest

CRediT authorship contribution statement

Antti Hämäläinen: Validation, Investigation, Resources, Data curation, Writing - original draft, Writing - review & editing, Visualization. **Helena Hirvonen:** Validation, Investigation, Resources, Data curation, Writing - original draft, Writing - review & editing.

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Appendix 1. List of interview questions

Care professionals' views on technology used in Intensive Service Housing (ISH) for older people.

Background questions.

- Education, age, work history, family status
- How did you end up working in care of older people?
- Tell us about your previous day at work. What were the good and the bad moments? Explain.
- Was the day particularly busy or heavy? How would you describe a busy/heavy/good day at work?
- Did technology have something to do with these experiences you described?

Mental resources and safety.

- What has recently brought you joy and satisfaction at work? How about anger or frustration? How have you expressed these feelings?
- Have you come across conflicts at work? How have these situations been handled by you/your workplace?
- What is the key factor supporting your well-being at the moment?

Technology in care work.

- What kinds of technological devices and applications have you used at work (a reference list of common devices and applications shown to stimulate conversation if needed)?
- Have you been able to influence the decision-making regarding their implementation?
- How has technology changed your work throughout your career?
- How does technology influence the communication practices and employee relationships in your work unit?
- Does technology use involve risks from the point of view of the residents or employees?

The nature of care, recognition of needs and patient-carer interaction.

- Is the worker's sex a significant factor in care work? Why? Do you remember moments when it felt significant to you?
- How do you recognize the resident's needs? Can you give examples of how their ability to communicate, their memory loss or other condition may have affected this?
- What do you pay attention to if the resident's verbal communication is limited?
- Have you taken care of non-Finnish speaking residents? How has this affected the communication?
- What makes an ideal interaction situation with a resident? What circumstances can inhibit this?
- Has the interaction changed during your time as a LTC worker?
- How can you yourself influence the quality of patient-carer relationship and interaction? Does technology affect this somehow? Explain.

Coping and control over work.

- Do you discuss work matters outside work? What kinds of matters? Does this bother you?
- During the interview, you have told about the drawback of your work. Do you feel you have means to deal with these issues at work? Explain.
- The practices of care work are largely dictated at a higher level outside your workplace. Do you feel you have means to influence this larger picture? Explain.
- Three wishes: what would you change/keep in your current work? What would you most like to do in your life right now?

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